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FROM LOSS TO REBUILDING: SENIORS AND THE GRIEVING PROCESS



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Pluralages is published by the Centre de recherche et d'expertise en gérontologie sociale (CREGÉS) of the Integrated Health and Social Services University Network for West-Central-Montreal. This magazine is designed to inform the public and raise awareness of social issues surrounding aging by, among other things, presenting the research initiatives and expertise being developed by members of the CREGÉS. Pluralages also aims to promote and foster ties between the research, education, practice and citizen action - for and by seniors - communities. Issues related to aging are presented through the lens of social gerontology, touching on such themes as diversity in aging, social and citizen recognition of the elderly, experiences with social exclusions and solidarities, political concerns, State directives and public policy targeting the aging population and its needs.

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What do we know about the losses and grief of seniors?

Aging is often accompanied by loss and grieving. Yet, despite frequency of these experiences, we tend not to know much about them.



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Loss and grief necessarily involve letting go. Whether they are directly or indirectly related to death, they are clearly part of life.

In May 2015, the Centre for Research and Expertise in Social Gerontology (CREGÉS) held the conference "From Loss to Rebuilding: Seniors and the Grieving Process". Several hundred individuals attended a variety of inspiring presentations and workshops. This issue of *Pluralages* aims to share many of the thoughts and ideas presented at the conference with a wider audience. The short articles offer a variety of theoretical, clinical and more personal perspectives, painting a broad and diverse portrait of the losses experienced in late life.

The articles show the different faces of loss and grief, as well as their more universal aspects. They encourage us to avoid reductive thinking, which too often leads to a pathologization and medicalization of grief, advocating instead a more nuanced approach, which examines both the pain and solace in these experiences. Loss and grief necessarily involve letting go. Whether they are directly or indirectly related to death, they are clearly part of life. To preserve what is vital in these experiences, we need to recognize them and remain attentive to those who are living them.

These reflections help to better identify the needs of grieving seniors and their loved ones. They also aim to reveal forms of grief that are less well known or recognized in our society: the grief of homosexual seniors, the ambiguous loss experienced by families of patients with Alzheimer's, the grief of homeless seniors.

In a context where death is often taboo or denied, a source of fascination or great discomfort, the grief of seniors is often passed over in silence, both at the social level and in terms of research. Several articles in this issue offer a careful, nuanced analysis of how this silence affects experiences of grief.

What can we do to support seniors who are coping with loss and grief? Many people feel ill-equipped to confront loss or to support grieving loved ones. The articles in this issue look at different ways to support bereaved seniors and end-of-life patients and those close to them. ➔

The articles are also related to the research pillars of the Centre for Research and Expertise in Social Gerontology (CREGÉS). In describing the many faces of grief in late life and in noting that seniors are also “survivors” who can continue to change (by reviewing their priorities, for example), Valérie Bourgeois-Guérin encourages us to see older people as “social actors” (Research Pillar 1). Luce Des Aulniers similarly notes that seniors, with all their life experience, are just as confronted by “the new” as younger generations. Perhaps even more so, since they are “out of sync” with the modern cultural imperative to be “brief, intense and compact.” The article by April Hayward, Gisèle Poirier and Jessica Seidman on the grief experienced by family members of Alzheimer’s patients invites readers to discover the “heterogeneity of aging” (Research Pillar 2) and to reflect on the various aspects of grieving in this context. The moving personal account by Jean Lalonde is also clearly aligned with this research pillar, which reminds us of the importance of viewing aging from multiple perspectives. Christopher MacKinnon and Deborah Ummel invite us to pay attention to the grief of practitioners. In a similar vein, the article by Isabelle Van Pevenage, Pam Orzeck, Zeldia Freitas, Claire Van Pevenage and Patrick Durivage proposes a tool to identify loved ones who likely need additional support following the death of a family member. The practice of harp playing in palliative care settings, described by Mehdi Azri and Florence Vinit, also opens up interesting avenues for future interventions. These articles are aligned with our third research pillar, “service delivery to seniors and their loved ones.” The study conducted by Victoria Burns, which explores the various forms of loss (family, work, health) that can contribute to late-life homelessness, is related to our fourth research pillar, “living environments,” and how they affect the experience of seniors. Finally, in line with our fifth research pillar (“public policy”), several articles in this issue note the importance of developing interventions that meet the needs of grieving seniors and their loved ones.

These articles invite us to reflect openly on the grief and losses that come with aging. What if these painful experiences could also help us to forge ties and rebuild, in a different way, that which has been lost? Perhaps, in the final analysis, our efforts to understand and support bereaved seniors should be guided by this question: how, without denying the painful aspects of these experiences, can we help to turn the person’s loss and grief into something that is also . . . fertile?

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Alzheimer's Disease and Ambiguous Loss

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This past May, it was an honour to present "Alzheimer's Disease and Ambiguous Loss" at the conference "From Loss to rebuilding: Seniors and the Grieving Process". With an audience composed primarily of health care professionals, our goal was to define and explain ambiguous loss; to describe the impact of this loss on a person living with dementia, as well as family members, caregivers and health care workers; and to propose concrete strategies to support people experiencing this form of grief. Above all, we hoped to provide some insight into the experiences of people facing ambiguous loss and grief.

To help us achieve this goal, we were fortunate to be joined by Gisèle Poirier, former caregiver for her husband, who courageously shared with workshop attendees the ways in which her journey as a caregiver had been interlaced with ambiguous loss and grief. Mrs. Poirier described specific moments such as recognizing the first signs of dementia and her husband's diagnosis; the loss of verbal communication between her and her husband, and the resulting changes

in their relationship; giving up many of their dreams and plans for retirement; his move to long-term care, which she described as "tearing them apart"; and, finally, adjusting to his passing away and finding herself no longer a caregiver. Despite the devastating disease process, she described how the loving bond between the couple remained strong, leaving her with beautiful memories. Mrs. Poirier found strength by connecting with her network of family and friends,

linking with support services (counselling and groups), and learning more about dementia. Although each person's story and experience of grief will be distinct,¹ Mrs. Poirier's account captivated the audience, and brought a human face and voice to the theory being presented.

Grieving is a universal, natural, personal, necessary and often complex response to many types of life events. Still, we live in a culture where the process >

*The Alzheimer Society of Montreal is a leading non-profit health organization working to improve the quality of life of people affected by Alzheimer's disease and other dementias, and to advance the search for causes and cures. The Society provides direct services to people affected by dementia, including counselling, education, support groups, respite-stimulation programs and education. Currently, more than 33,000 Montrealers are living with Alzheimer's disease or a related form of dementia.

of grief is primarily associated with death and dying. Kenneth J. Doka² describes grief as “a companion to Alzheimer’s disease at all phases of the disease and following death” (p. 144). Alzheimer’s and other dementias involve multiple losses for the person living with the disease and their family members. The person experiences losses in their functioning, role and autonomy, as well as their sense of identity. Family members and friends lose elements of the person and their relationship, along with hopes and dreams for the future. They may face other losses, including friends and social networks. Their grief often begins well before the person dies³. This type of grief is complex and ambiguous. It differs

spouse may feel she is no longer married, since her husband does not know who she is. She may feel she is living in a state of uncertainty, which she does not know how to resolve. In addition, caregivers may not recognize their experiences and feelings as stemming from loss and grief⁵.


Alzheimer’s disease is progressive and irreversible, meaning losses will continue to occur, often for many years. Caregivers must continually adjust to changes that occur as the disease progresses. It can be helpful to assist caregivers in acknowledging these changes as losses. Common events include: initial symptoms and the diagnosis; loss of a driver’s license; loss of autonomy (when the person

Of course, in addition to the grieving process, there are very real stressors associated with caregiving. Traditionally, health care providers working with caregivers focus on the stress and burden of caregiving, paying less attention to the emotional impact of the losses experienced by the patient and their caregiver(s). Over the past 30 years, research has shown that grief and sorrow significantly contribute to caregiver stress, and that it is not only the tasks and responsibilities that become overwhelming and make it difficult for the person to carry on⁴. Unidentified and unattended grief may be expressed through a variety of emotions and symptoms: sadness, anger, denial, fatigue, anxiety, loss of appetite and guilt,

Western culture is focused on fixing, curing and solving. Living with loss is often discouraged; instead, we seek closure.

from the grief that typically accompanies death, because it is unclear, indeterminate and irresolvable. Closure is not possible, because the person is physically present but may be psychologically absent⁴. In other words, the person is still there, but not the same way as before. Caregivers may not know whether or how to grieve these losses as they arise. They may have trouble connecting with the person who remains. Ambiguous loss brings complexity and confusion into relationships—for example, a

can no longer be left alone); loss of friendships; the need for respite care; incontinence; a move to a long-term care facility; aggressive or embarrassing behaviours; failure to recognize family members; palliative care and death; bereavement and mourning; and, for the grieving person, loss of the caregiving role.^{5,6} Helping people to identify, name and acknowledge these losses can assist them in processing their grief.

among others^{5,6}. Unfortunately, the symptoms associated with ambiguous loss are often not well understood or recognized by caregivers themselves or by health care workers, and may overlap with signs of caregiver burden. “Grieving takes energy and caregiving takes energy” (p. 12)⁵. Therefore, the emotional load may be doubled for a person caring for someone living with dementia. Allowing the individual to explore, understand and recognize their grieving process, all the while addressing and 



attending to practical means of support, may ensure that neither component is neglected, allowing the person's stress to be alleviated^{1,5}.

Western culture is focused on fixing, curing and solving. Living with loss is often discouraged; instead, we seek closure. However, if we wish to support people facing complex losses, we must normalize grief. Following are some suggestions of ways to support those experiencing ambiguous loss and grief associated with dementia.

- ▶ Identify, name, validate and normalize this experience. This can help people cope, move forward and gradually make sense of what they are facing. Healing happens as people allow themselves to process their emotions

and grieve losses along the way^{4,5}.

- ▶ Help the person work towards "paradoxical thinking"—that is, to acknowledge the paradoxical situation they are experiencing (the person is there, and yet isn't), and to gradually become more comfortable with these seemingly contradictory ideas^{1,5}.

- ▶ Encourage caregivers to stay connected with others, such as family and friends.

- ▶ For caregivers who appear more isolated, try having them identify their "psychological family"—those people in their lives who may not be their biological family but who are present, reliable and able to offer support^{1,5}.

- ▶ Consider addressing issues of grief and loss in support groups, which may help caregivers to normalize and share their experience with others.

- ▶ Help caregivers find new ways of connecting with the person, despite their grief. Even at the more advanced stages of dementia, the person can be reached and may enjoy the presence of others through music, touch, humour, etc. This may relieve distress^{4,5}.

- ▶ Provide information about dementia. Help the person recognize and anticipate the changes that may accompany the disease. Be especially aware and sensitive in moments that are known to trigger a grief response, >

such as moving a family member to a long-term care facility⁵.

- ▶ Encourage caregivers to attend to their own well-being by taking time out for their own needs, eating well, being physically active and nurturing their spirituality.
- ▶ Provide assistance with the more practical aspects of caregiving (respite, home care, domestic tasks, etc.).
- ▶ Be aware that each person grieves differently and adjust your approach according to the person's style and needs³.
- ▶ Recognize that there is no solution for ambiguous grief; this does not, however, mean your efforts have failed⁴.

Finally, it is important for professionals who apply these principles in their work to acknowledge and allow space for their own grieving. As human beings we connect with others and feel their loss, sometimes very deeply. Professionals can equally benefit from normalizing, validating and expressing these feelings, engaging in rituals or symbolic gestures that help them remember the person and achieve closure, and obtaining formal support from supervisors and the administration⁷.

The Alzheimer Society of Canada has developed three practical resources to help health care professionals better understand the loss and grief associated with dementia. These can be accessed free of charge⁸.

Special thanks to Mary Schulz, Director of Information, Support Services and Education, at the Alzheimer Society of Canada, for her assistance in preparing this workshop.

1. Boss, P. (2006). *Loss, Trauma, and Resilience: Therapeutic Work with Ambiguous Loss*. NY: W.W. Norton & Company.
2. Doka, K. J. (2004). Grief and Dementia. In Doka, K. J. (Ed.), *Living with Grief: Alzheimer's Disease*. Washington, D.C.: Hospice Foundation of America.
3. Doka, K.J. (2010). Grief, multiple loss and dementia, *Bereavement Care*, Vol. 29 (3) 2010, 15-20.
4. Boss, P. (2011). *Loving Someone Who Has Dementia: How to Find Hope While Coping with Stress and Grief*. CA: Jossey-Bass.
5. Alzheimer Society of Canada. (2013). *Ambiguous loss and grief: A resource for health-care providers*. Accessed at: http://www.alzheimer.ca/~media/Files/national/For-HCP/for_hcp_ambiguous_loss_e.pdf
6. Alzheimer Society of Canada. (2013). *Ambiguous loss and grief in dementia: A resource for individuals and families*. Accessed at: http://www.alzheimer.ca/~media/Files/national/Core-lit-brochures/ambiguous_loss_family_e.pdf
7. Alzheimer Society of Canada. (2014). *Dementia and staff grief: A resource for healthcare providers*. Accessed at: http://www.alzheimer.ca/~media/Files/national/For-HCP/staff_grief_e.pdf
8. www.alzheimer.ca/healthcareprofessionals, French version: www.alzheimer.ca/professionnelsdelasante.

The threat of being less than we are when encountering loss

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Professionals who have chosen to work in the field of aging are often confronted with the complexities of loss and bereavement. Some perils of working with loss include the risk of stressful circumstances that can evoke feelings of hopelessness, powerlessness, and meaninglessness. It is incumbent on us to attend to these perils lest we risk job dissatisfaction, heightened absenteeism, and burnout. This article explores some of the personal and professional challenges for those working in the domain of aging, identifying responses that may foster resilience, as well as renew meaning and fulfilment at work.

The most painful state of being is remembering the future, particularly the one you'll never have.

Søren Kierkegaard², 1954, p. 54

If you work with elders, you may be faced with the dual hardship of witnessing not only the losses of others, but confronting your own losses as well. In this cumulative encounter with loss we are reminded that our lives are finite. We sometimes sense our

inherent vulnerability; we are at the mercy of a universe that can visit loss upon us at a time of its choosing. Lurking somewhere in our consciousness is the realization that one day we will lose it all at the moment of our death. During our dark nights of the

soul, some of us may ask several difficult questions:

- ▶ "What does it say about me that I work with aging and loss?" ➤

“How do I marshal ways to sustain myself in this complicated enterprise?”

- ▶ “How do I respond constructively when my reserves erode in the face of suffering?”
- ▶ “What can continue to give my work (and my life) meaning?”

Wrestling with these questions, which some would say is compulsory if we are not to slip into burnout³, is not for the faint of heart. To honour these misgivings, it is necessary to dig down deep and find courage. Working with loss demands nothing less than periodically revisiting questions like these, all expressions of our profound need for purpose, direction, and meaning in both the personal and professional spheres of our life.

Perhaps part of a reply to these queries lies in rediscovering what drew us to this discipline that some might call a vocation. Oftentimes we can trace our motivations to experiences from early life that set in place a defining social script we continue to follow into adulthood. After all, being a caregiver of others is a common role many of us assumed as children and adolescents, for better or for worse. We might also try to better understand what gives, or gave, us some sense of fulfilment and satisfaction in our

work. Furthermore, we might probe those deep parts of our humanity which are stirred when confronted with loss to discern what message our psyche is trying to relay to us.

LOSS: A COMPULSORY PASSAGE

People cope with the death of those they love with remarkable and sometimes inspiring resilience—except when they don't, in which case they risk becoming immobilized in a world seemingly devoid of that one, compellingly essential attachment figure, unable to assimilate the apparent impossibility of the death into a life story now bleached of meaning by bereavement.

Robert Neimeyer⁴, 2010, p. 88

As a starting point, we will ground what follows within the narrative-constructivist tradition of psychology and psychotherapy, and more specifically within the meaning-reconstruction paradigm⁵. This theoretical framework presupposes that humans tend to organize their lives around the stories they tell⁶. All good stories have turning points, be they moments of triumph or unexpected reversals. Over time, changes in both the personal or professional domains are guaranteed, and thus the story changes. Changes can be of our own choosing, but more often the painful ones are imposed by forces greater than

ourselves and compel us to chart a new course for our life story.

The death of someone important is often a watershed moment, bringing about a moment of great transition. A primary character of our life story exits the scene and we can find our very meaning and purpose in life derailed. The ways in which we react can be unprecedented; we panic, we get depressed, we criticize ourselves for not dealing with things better⁷. We discover how much we tend to make plans for the future, at the same time lamenting the fact that these plans will not be realized. The world becomes less safe and predictable than it once was. Difficult questions arise, which evade all our attempts to answer⁸.

When encountering loss, be it a loss of our own or the loss of those for whom we work, there is a significant risk that we can be diminished by our own response. We are diminished when we disengage from our lives, descend into bitterness, ruminate about past decisions, lament over regrets, or even stagnate⁹. When the metaphorical clock of our lives stops ticking, we are held captive by our tendency towards lethargy, putting off the inner work that a constructive response to loss necessitates. Lethargy can take the form of avoiding certain situations or responsibility, as well as more ➤

problematic behaviours like pernicious substance abuse or other addictive activities.

We are proposing here the existence of a paradoxical response to loss, namely that said loss can be a summons for us to participate in a deeper engagement with our lives^{9, 10}. It is an opportunity, albeit a painful one, to cultivate a more profound maturity. Now, while all of this sounds great, when we are most ho-

If you work in the sometimes harrowing field of aging, no doubt you are often faced with the complexities of people who are confronting loss. Let us never forget that our elders are veterans of loss. The steady march of time brings with it a myriad of losses that encompass not merely the loss of relationships, but also the more subtle and pervasive losses of identity, autonomy, control, respect and confidence in life.

The steady march of time brings with it a myriad of losses that encompass not merely the loss of relationships, but also the more subtle and pervasive losses of identity, autonomy, control, respect and confidence in life.

nest, nobody really wants to respond to this summons from life. Growing up is often excruciating work, and there are protective forces inside each of us that will always choose the path of security (and lower anxiety) over the path of expansion. The risk is that our response to bereavement can reduce us, halting the discovery of a possibly richer and fuller life.

THE CHALLENGE OF ENCOUNTERING LOSS

Meaninglessness inhibits fullness of life and is therefore equivalent to illness. Meaning makes a great many things endurable—perhaps everything.

Carl Jung¹¹, 1963, p. 340

To illustrate some of the complexities of this subject, here is a real-life story with the fine details masked to preserve anonymity and confidentiality. Warren, a gentleman in his mid-sixties, came to consult with one of our psychologists several months following the death of his spouse in our palliative care unit. He was suffering greatly, and one day he arrived at a session with tears streaming down his face. "I miss her so much. My life is over without her. I have no value. Nothing matters anymore." He arches his head back towards the ceiling. "I am so tired," he says with a whimper. "I just want to sleep and never wake up. I don't want to kill myself, but I am through with life."

Warren's despair was palpable and powerful. His story stirred in the psychologist his own anxiety. The depth of Warren's pain was almost overwhelming, evoking a sense of powerlessness in the clinician. It also brought up his own longstanding fears of incompetence, his concern that he is unable to make any real difference in the lives of those he accompanies. He asked himself, "Are there any words of comfort that would assuage even slightly the torrent of despair Warren is sharing?" Moreover, the story reminded the psychologist of his own losses, recent reversals in his marriage, and turns of fortune in his career. "How can I be a good helper to Warren when I too am overwhelmed by shattering loss?"

In these moments of witnessing the suffering of the other, we can be deeply touched by the resonance of our own loss history. A metaphorical chasm opens before us and the road seems impassable. We are reminded, in a humbling way, of our own limitations. We stumble, hesitate, and desperately look for guidance.

In this case, the psychologist unwittingly fell back on his well-honed strategies of avoidance. He changed the subject, gave advice, minimized the distress, and essentially neglected to meet Warren where he was at. It was only later, in consulting with his own therapist, that ➤



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some of the deeper truths about what transpired between himself and Warren came into conscious awareness.

THE RISKS OF NEGLECTING LOSS

Sometimes the minimization of loss as a valid subject harkens back to messages from our historical authorities (i.e., parents or guardians) who neglected to mention, or shielded us from, the fact that death is an integral part of being human. Perhaps this oversight comes from the understandably strong desire of parents to protect their children from some of the tragedy of life.

However, there are also strong and implicit anxieties at work in the background that advance this agenda of minimization. Imagine the reaction of parents or teachers to the introduction of a death education class in schools! Despite the monumental pushback we could realistically expect from such a radical idea, the neglect of loss as a valid and important topic for all ages carries with it important ramifications. Many bereft individuals who have consulted with us in psychotherapy have often expressed feeling betrayed that no one took the time to warn them that people in fact do die, or to inform them of what the

aftermath of death can look like. Neglecting loss across the lifespan reinforces the idea that avoiding these difficult realities of life, even unavoidable realities like death, is preferable.

Moreover, there is always a tendency to minimize the impact of loss in our lives, often because loss carries with it an excess of heavy-hitting emotions. For many of us in the aging business we call gerontology, there is often the understandable desire to stay afloat; after all, we need to come back to work in the morning to keep plowing our particular field. ➤

The fallback position for many of us is found in the professional boundaries literature, further enshrined in the ethics codes of the various licensing bodies. Professional boundaries are the various forms of symbolic insulation that keeps us buffered from those we serve. Yet, while boundaries and ethics are certainly important, a part of us senses that the failure to attend to the cumulative effect of loss on our personhood demands of us a more considered response than simply falling back on those codified partitions. We cannot forget that a rigid adherence to boundaries often leads to other problems, such as a further de-humanized health care system¹².

If you have read this far, you may be working up the nerve to challenge your internal tendencies to minimize the impact of exposure to loss. When this happens, a more anxiety-provoking question surfaces: what are the risks of failing to grieve our personal and professional losses?

You may have already discerned that the risk is disengagement, not only from our work but from our lives. Because work is such a critical part of who we are, when we disengage from work we risk disconnecting with ourselves. Part of the answer to the question of risk is that when we fail to grieve our losses, we risk not fully showing up to our lives. Put another way, if we

neglect to acknowledge the impact of working with loss on our personhood, we may risk being less than we are, or diminished in some ways and not fully living the life we can.

The ways in which we acknowledge loss will vary as each person follows the dictates of their conscience. We might consider whether we lean towards more instrumental or intrinsic approaches to coping with loss¹³. Individuals following an instrumental grief style tend to engage in problem-solving as a means to cope and immerse themselves in activities such as work, all the while expressing fewer emotions. An intuitive grief style is characterized by more expression of feeling, sometimes with more depth and intensity. Correspondingly, intuitive grievers may benefit from talking more about their loss and may seek out formal or informal support. On what end of the continuum do you find yourself?

REKINDLING WHAT MATTERS MOST: CHOOSING A CONSTRUCTIVE RESPONSE

The central paradox of our current feel-good culture is that we grow progressively more and more uncertain and less and less persuaded that our lives really mean something. Feeling good

is a poor measure of life, but living meaningfully is a good one, for then we are living a developmental rather than a regressive agenda.

James Hollis¹⁰, 2006, p. 232-233

James Hollis is perhaps one of our most thoughtful psychologists when it comes to addressing the profoundly human dilemmas that keep us from fully showing up to our own life. In his latest book⁹ argues that we are usually defined by either the stories that have shaped us, or a path in opposition to these stories. For example, if we have been visited by a series of tragedies in life, we can perpetually fall back on a narrative of a doomed future that no amount of effort on our part will change: "Nothing ever goes my way." If we are defined in opposition to these tragedies, we might seek to not take any risks so as not to be caught off guard by tragedy again: "I will never put myself in a place where an event like that will occur again."

Regrettably, neither of these two paths is a genuine expression of who we are. Hollis quite compellingly places the responsibility for our life path squarely on our shoulders. The implication for those working with loss is clear: between the two paths described above, you have a choice of how you are going to respond when encountering loss¹⁴. A constructive response usually ➤

demands creativity on our part in order to break away from the two polarizing narratives. If we fail to respond to this summons from our psyche, we risk diminishment, disengagement, and living life more on the surface¹⁰.

Often the constructive response is the meaningful response. We are, after all, meaning-seeking creatures that need our lives to make sense, to be purposeful and, ultimately, to be worthwhile¹⁵. Below we consider the implications of such a creative or meaning-based response¹⁶.

A MEANINGFUL APPROACH TO LOSS AND BEREAVEMENT

I would say that our patients never really despair because of any suffering in itself. Instead, their despair stems in each instance from a doubt as to whether suffering is meaningful. Man is ready and willing to shoulder any suffering as soon and as long as he can see a meaning in it.

Viktor Frankl¹⁴, 1961, p. 5

It is in our response, sometimes as challenging as learning a new language, that we create for ourselves the possibility of discovering new, authentic, and more meaningful expressions of ourselves. This deeper engagement can help us get in touch with what matters most for each of us in life¹⁰.

To encourage a more personal treatment of these topics, we offer a series of prompts you may use as a rough scaffolding to help you map a constructive and meaningful response to the presence of loss in your life. Your answers to these prompts will, of course, be highly personal, with certain questions being more or less useful, depending on your particular sensibilities, developmental phase in life, and current circumstances.

- ▶ What initially drew me to work in the field of aging and loss?¹⁷
- ▶ What do I most want for the patients and families I serve?¹⁷
- ▶ When have I recently made a difference in the life of someone I am working with?¹⁷
- ▶ What is fear making me, or keeping me, from doing in my work with aging and loss?¹⁷
- ▶ What was one of the more meaningful moments I had in working with aging and loss?⁹
- ▶ What is the most valuable thing I have learned in working with aging and loss?¹⁸
- ▶ What changes do I hope my research in the areas of aging

and loss will bring about?

- ▶ What is my vision for my organization and how do I wish the future to look?

CONCLUSION

There has been a recent upsurge in scientific research on loss and bereavement. Perhaps it is an indication that bereavement is playing a more fundamental role in scientific inquiry, commensurate with the role it has always played in human life⁹. Bereavement challenges us to live again, resist diminishment, and learn ways to salvage some happiness from heartbreak²⁰.

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2. Kierkegaard, S. (1954) *Fear and trembling and the sickness unto death*. Garden City, N.Y., Doubleday.
3. Leiter, M. (2014). Évaluer et traiter l'épuisement professionnel. Accredited continuing education workshop at the annual meeting of the Ordre des psychologues du Québec, Montreal, Quebec.
4. Neimeyer, R. (2010b). Reconstructing the continuing bond: A constructivist approach to grief therapy. In J. D. Raskin, S. K. Bridges & R. Neimeyer (Eds.), *Studies in meaning: Constructivist perspectives on theory, practice, and social justice*. (pp. 65-92). New York, NY: Pace University Press.
5. Neimeyer, R. A., & Sands, D. C. (2011). Meaning reconstruction in bereavement: From principles to practice. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer & G. F. Thornton (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 9-22). New York, NY: Routledge.
6. Neimeyer, R. A., & Bridges, S. K. (2003). Postmodern approaches to psychotherapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies: Theory and Practice* (2nd ed., pp. 272-316). New York, NY: The Guilford Press.
7. Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R. A., Duan, N.,... Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, 28(2), 103-117.
8. Katz, R. S. (2006). When our personal selves influence our professional work: An introduction to emotions and countertransference in end-of-life care. In R. S. Katz & T. G. Johnson (Eds.), *When professionals weep: Emotional and countertransference responses in end-of-life care* (pp. 3-9). New York, NY: Routledge.
9. Hollis, J. (2013). *Hauntings: Dispelling the ghosts who run our lives*. Asheville, NC: Chiron
10. Hollis, J. (2006). *Finding meaning in the second half of life: How to finally, really grow up*. New York, NY: Gotham.
11. Jung, C. (1963). *Memories, dreams, reflections*. (R. Winston & C. Winston, Trans.). New York, NY: Vintage Books.
12. Kopacz, D. R. (2014). *Re-humanizing medicine: A holistic framework for transforming yourself, your practice, and the culture of medicine*. Alresford, UK: Ayni Books.
13. Doka, K. J., & Martin, T. L. (2010). *Grieving beyond gender: Understanding the ways men and women mourn*. New York, NY: Routledge.
14. Frankl, V.E. (1961). Logotherapy and the challenge of suffering. *Review of Existential Psychology and Psychiatry*, 1, 3-7.
15. Neimeyer, R. A. (2009). *Constructivist psychotherapy: Distinctive features*. New York, NY: Routledge.
16. MacKinnon, C. J., Milman, E., Smith, N. G., Henry, M., Berish, M., Copeland, L. S., ... Cohen, S. R. (2013). Means to meaning in cancer-related bereavement: Identifying clinical implications for counseling psychologists. *The Counseling Psychologist*, 41(2), 216-239.
17. Lawlor, K., & Vachon, M. (2014). *Cultivating resilience in a specialized palliative care multidisciplinary team*. McGill University Health Centre, Montreal, Quebec.
18. Breitbart, W., Poppito, S., Rosenfeld, B., Vickers, A. J., Li, Y., Abbey, J., ... Olden, M. (2012). Pilot randomized controlled trial of individual meaning-centered psychotherapy for patients with advanced cancer. *Journal of Clinical Oncology*, 30(12), 1304-1309.
19. Neimeyer, R. A. (2006). *Lessons of loss: A guide to coping*. Memphis, TN: Center for the Study of Loss and Transition.
20. Simmons, P. (2000). *Learning to fall: The blessings of an imperfect life*. New York, NY: Bantam Books.

How to support practitioners in their care of the caregivers: mapping factors that affect the grieving process¹

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BACKGROUND

A number of studies have shown that families and friends are the primary source of care for seniors. Contrary to what today's individualistic trends might suggest, it is still a widely held belief that families should be primarily responsible for the care of their aging family members. >

This responsibility is reinforced by policy guidelines on providing care to vulnerable individuals. Since the shift to ambulatory care, these guidelines have encouraged families to maintain older family members at home or in the community.^{2,3,4} In 2007, in Quebec, 728,000 caregivers aged 45 and over provided care to individuals aged 65 and over who were suffering from a long-term health problem or a physical limitation. Given the increased life expectancy, families provide care to an elderly family member parent over a longer period of time.

Caregiving experiences are diverse and influenced by several individual, family cultural and societal factors. A number of studies have explored the various ways in which this caregiving role can affect loved ones' physical or psychological health, family dynamics and professional life. Regardless of the family member's caregiving experience and the location where the care is provided (long-term care facility, hospital or at home), the death of a loved one represents the last stage in the caregiver helping relationship. The caregiver's experience with their grief and bereavement process will also vary according to several factors. The grief literature supports that most individuals go through a "normal" grieving process. For some, however, this is a long and complex phase.⁵ Without

describing in details the distinction between a normal, complicated or pathological grieving process, it is worth noting that some individuals require more active supportive intervention and follow-up, while others will work through this difficult time without requiring a professional intervention.

How do healthcare practitioners currently identify caregivers who require professional intervention? In Quebec, the home care program (SAPA: *soutien à l'autonomie des personnes âgées* i.e. support for the autonomy of seniors) have propensity to view caregivers as a resource in the client's care evaluation form and in the intervention plan. Caregivers' are can therefore be viewed (not seen) as having any needs of their own and are therefore not systematically evaluated. Furthermore, At the time of death, the client's file is closed and, unless their needs are not systematically screened or assessed. They simply disappear unless they are receiving some professional support of their own, identified as a client. (Caregiver is already receiving some form of professional support, he or she simply "disappears.")

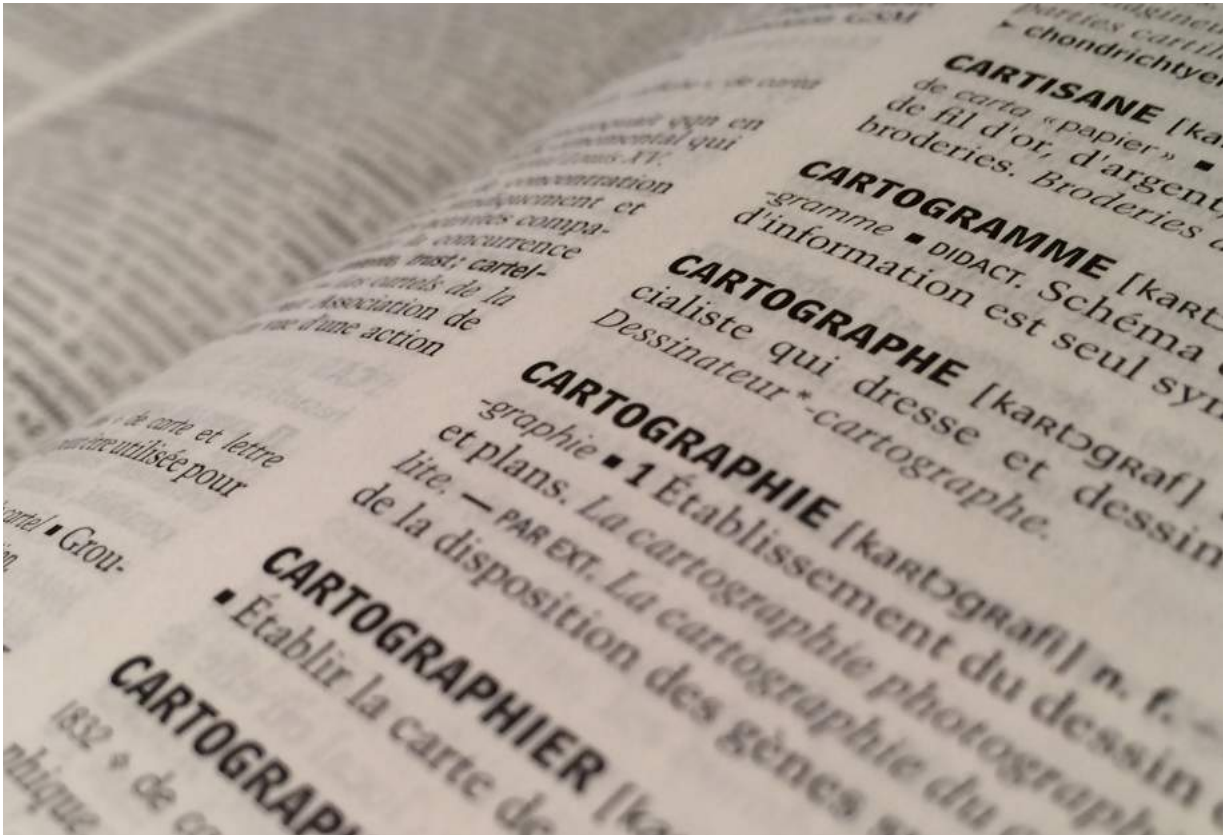
It is therefore left to the discretion of the practitioner to decide whether or not to follow up or open a file for a caregiver who may be at risk of developing complications in their grieving

process. This decision is based on the practitioner's knowledge, experience and their professional judgement. Although this practice is common, it is not systematic, which may result in some family members who may require additional bereavement support might fall through the cracks.

It is due to this shortcoming that a multidisciplinary team adapted a mapping tool, initially developed in the context of pediatric palliative care. This tool was a relevant starting point, since it was designed to help practitioners identify and monitor more vulnerable caregivers, assess the resources and obstacles in their lives, and determine the ongoing support they may require.

METHODOLOGY

A number of studies have looked at factors affecting the grieving process from a number of different perspectives such as psychology, sociology, social work and nursing. (Most are in the field of psychology, but some offer perspectives from sociology, social work and nursing fields (science).) Certain studies consider the specific circumstances of the death, such as suicide, cancer, degenerative disease and palliative care. While others, examine the specific characteristics of the bereaved, and others, the context of the relationship with the deceased (spouses, >



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young children, older adults, etc.).

The first version of the mapping tool was developed as part of a study aimed at determining whether the parents of seriously ill children had received adequate support. Based on a literature review and analyses of in-depth clinical interviews with parents, the researcher drew up a preliminary list of factors influencing their experience during palliative care and following the death of their child. In addition to the complicated grief risk factors identified in the literature, some 50 factors were grouped under six topics: the child; the parents; the nuclear family; the relational and

cultural environment; and professional and financial situations. It is important to note that, with the exception of complicated grief factors, all of the factors are presented in an unbiased manner—to be evaluated as either obstacles or resources, depending on the situation or person. For example, the health of a loved one can be good or poor. The practical availability of the family can be considerable or nil. We describe below how this choice is made.

Once these factors were identified, we then had to consider how practitioners could apply these factors in their clinical practice. First, the authors opted to

list all of the factors on a single page. This provided a complete visual overview of the situation. Furthermore, the factors could be colour-coded according to whether they were a resource or obstacle (this underlines the importance of presenting the factors in a neutral manner). Once the practitioner or team determined the implication of various factors, they would be able to answer two questions. First, does this person currently have more obstacles than resources in his or her life? If so, bereavement follow-up could be considered necessary. In addition, if a person requires more intensive support, the practitioners have already identified resources ➤

that may be mobilized as part of this intervention.

Undoubtedly, the pediatric and geriatric contexts are different. However, having participated in the development of a mapping tool in a pediatric context, we felt that the procedure used to identify at-risk individuals, potential obstacles and/or resources during the grieving process, could be adapted to a geriatric context since grief and loss are universal human experiences, and as already mentioned, there is currently no tool in place to systematically identify individuals at risk of developing complications following the death of a loved one.

The Leading Practices in Caregiver Support and later joined by the Leading Practices in Community Palliative Care for Seniors at the Centre for Research and Expertise in Social Gerontology (CREGÉS), with the support of the researcher on the initial project, therefore concurred to adapting the above-mentioned tool to a geriatric context. Based on an extensive second literature review, some 60 factors influencing the losses experienced by loved ones were identified. While we cannot review all of these factors here, we have grouped them into seven broader themes related to the loss experience of older adults:

- ▶ the person with diagnosis;
- ▶ the caregiver;

- ▶ the relationship between the patient and caregiver;
- ▶ the family network;
- ▶ the social network;
- ▶ the professional and financial situation of the caregiver;
- ▶ the caregiver's experience with the health care and social services system.

In addition to these, factors that are recognized in the literature as signs of complicated grief are included. In addition, the mapping tool includes a glossary of factors identified. Each one is listed in the form of a question and accompanied by examples.

USE OF THE MAPPING TOOL

It is important to bear in mind that this tool has two main objectives:

- ▶ to provide a procedure or process to systematically observe families in order to identify those that are more vulnerable;
- ▶ to identify resources that practitioners can help mobilize to develop a bereavement support plan with the caregiver.

Alone or with their interdisciplinary teams, practitioners colour-code factors that are considered to be resources (e.g., using a green highlighter) and those considered to be obstacles (e.g.,

using a pink highlighter). When in doubt, they do not highlight the factor.

Once the map has been colour-coded (even partially), it provides practitioners with an overview of the situation and allows them to answer two main questions:

- ▶ Based on the colour-coding, does this person have more resources than obstacles, or vice versa?
- ▶ If this person requires follow-up, what resources should be mobilized to provide the necessary support?

TESTING THE MAPPING TOOL

Once the factors related to an adult context had been identified and grouped according to the various aspects of grieving, we began testing the tool by asking three social workers from the CLSC René-Cassin and Benny Farm sectors, in Montreal, to use it in a retrospective manner. They were given instructions on how to color-code the map, and were asked to use a recent client from their palliative care caseload in the community. In addition, they were asked to comment on the tool and one meeting was held with them to discuss the results.

The conference on grief held by CREGÉS in May 2015 was an ➤

opportunity for us to present the preliminary version of the tool to approximately fifty participants who had registered for the session on post-caregiving grief. We asked these participants to test the tool the same way as the first three practitioners (i.e., retrospectively). They were then instructed to form small groups to discuss the pros and cons of the tool, based on this experience. Seven copies were completed. We present here some of these results related to the content of the mapping tool, its application and the professional context in which the tool could be administered.

In terms of content, the participants pointed to the extensive nature of the factors. One participant expressed concern at the number of factors and the length of time it may take to complete. This concern, after some discussion, proved to be not substantiated by the other participants. However, to code all of the factors relatively quickly, practitioners noted the importance of being well acquainted with caregivers and their individual situations. Although the tool seems to be all-inclusive, several participants remarked that additional factors (information) could be added to the various categories. Several said they liked the fact that the tool included positive aspects of the person or situation, since these are often neglected in an intervention. Finally, they

observed that the comprehensive quality of the tool would ensure that practitioners do not overlook certain elements when evaluating a situation, and would force them to consider aspects that are often neglected, such as the caregiver's experience with the health care and social services system.

Regarding the application of the mapping tool, participants commented that it was practical and easy to understand, although many would have liked to have more descriptive information on certain factors. Participants appreciated the visual aspect of the tool and noted that the colour-coding scheme gave them a rapid overview of the person's resources and obstacles. A number of participants stated that using the tool would help them save time in evaluating the situation of caregivers. However, they also mentioned that the static, rigid quality of the tool could be problematic. The map leaves little room for nuance. It provides a snapshot, whereas situations tend to be more fluid and evolve over time. Some participants expressed reluctance to use the tool at this time, as it has not been scientifically validated. In addition, the participants in the conference workshop did not have the glossary and therefore lacked information that may have clarified some of the factors.

Practitioners expressed an avid interest in using the tool in an interdisciplinary work setting. Several noted that the tool allows information to be shared among team members and highlights the often stressful situation of the caregivers and how it may affect their post-caregiving bereavement. They also noted a number of problems, notably that since the caregiver is not considered a client with a file of their own, the tool does not have a legitimate place in current practices in the health and social services system. In addition in certain situations, it could be difficult to single out one caregiver when several persons are involved in the care. It was also noted that clinical judgement is an important element to consider when evaluating a multi-faceted situation of this nature. Finally, several participants asked about the most opportune moment to use the mapping tool. As one social worker pointed out, it should not be used immediately after the patient passes away, since caregivers usually have a lot of support at this time.

CONCLUSION

The participants' response to the mapping tool was generally positive. However, their feedback illustrated a number of issues must be resolved before the tool can be implemented and used effectively. ➤

The first step is to begin the validation process. This would not only ensure the effectiveness and relevance of the tool; it would also reassure some practitioners who might be reluctant to use it. Validation would also allow us to answer a number of questions raised about the use of the mapping tool. For example, what skills are required to use the tool? Who should be involved in the process? When is the optimal time for administering the tool? To what extent should the caregiver be involved in the process? For example, should a self-administered tool be developed in addition to a clinician administered one?

6. Van Pevenage, C., Van Pevenage, I., Geuzaine, C., Schell, M., Lambotte, I. & V. Delvenne (2013). Les besoins des parents confrontés aux soins palliatifs et au décès de leur enfant – étude exploratoire. *Neuropsychiatrie de l'enfance et de l'adolescence*, 67(7-8): 433-440.

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 2. Lavoie, J. P. & N. Guberman (2010). Les politiques québécoises à l'égard des personnes âgées avec des incapacités. Combattre ou gérer l'exclusion? In M. Charpentier, N. Guberman, V. Billette, J. P. Lavoie, A. Grenier and I. Olazabal (dir.), *Vieillir au pluriel. Perspectives sociales*. (pp. 413-430). Quebec City: Presses de l'Université du Québec.
 3. Ministère de la Famille et des Aînés (2012). *Vieillir et vivre ensemble. Chez soi, dans sa communauté, au Québec*. Quebec City: Government of Quebec.
 4. Ministère de la Santé et des Services sociaux (2003). *Chez soi, le premier choix - La politique de soutien à domicile*. Quebec City: Government of Quebec.
 5. Hanus, M. (2006). *Les deuils dans la vie. Deuils et séparations chez l'adulte et chez l'enfant*. 3rd Edition. Paris: Maloine.



Cultural Reflections on "Aging, Death and... Change"

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TO START: CAN WE LEARN HOW TO GRIEVE?

As you well know, with grief comes the recognition that life does not always match our dreams. These dreams are filled with fantasies about love ("If I love Louis enough, he'll survive"), thoughts ("Where there's a will, there's a way"), and techniques ("They've found a new gene therapy, combined with drug x"). All of these beliefs, legitimate as they may be, are more or less manifestations of our child-like fantasy of being all-powerful.

Naturally this fantasy comes up against reality, and not only the reality of death—the ultimate limit! The aging process foreshadows a truth we must all recognize at a given point: the **limitation** of this fantasy of omnipotence. Civilizations temper the shock of this unwelcome realization through institutions, rituals, rules and taboos. And through solidarity. Human beings become powerful, because they are connected to others. This support also limits the potentially totalitarian nature of our individual will. In a sense, it is reassuring to be guided and supported in this

way. We live not as braggarts blinded by our pretensions; rather, we become lucid about our capacity for invention, precisely because we are confronted by this challenge. We don't get rid of the challenge; we overcome it. We surpass *ourselves*.

In other words, our capacity to think, connect and create stems from the act of **renouncing** this fantasy of omnipotence. Our humanity is born of the very experience of grief. The dynamic of grief is set in motion when we choose to examine, sort, let go or prolong in a different way,

so as to keep something alive. Something civilized.

As I lead you toward the topic that is the focus of this conference, it is to celebrate our aptitude for grief, which we show from a very young age. A small child learns that his fantasy may be both lessened and channelled into a project that will make him grow. When death occurs, he learns to survive through the support of a person with a clearly defined identity and through the expression of complex emotions in the face of what no longer is and will no longer be. ➤



Gradually, the sense of absence shifts from a cruel void to a source of inspiration.

In approaching grief as a limit to omnipotence, I have considerably shortened our intended presentation. An act of renouncement, indeed.

I will therefore focus my talk on what is **changing** for older generations. A 90-year-old woman put it well:

"I think they invented the Internet at the same time as floating floors. I have both. Some days I have the impression there is water under the floor and it's moving. I'm not saying that because I have a floating brain! That's another matter. To put it simply, could it be that the ground I'm walking on is more slippery than before?"²

QUESTION: HOW DOES ONE QUALIFY, IN CULTURAL TERMS, THE ENVIRONMENT IN WHICH TODAY'S SENIORS AGED 60 TO 100 ARE LIVING? OR: WE SHOULD RECOGNIZE THAT OLDER GENERATIONS (AND OUR OWN!) ARE ENVELOPED BY AN OFTEN IMPERCEPTIBLE MIST THAT AFFECTS US AS A COLLECTIVITY.

First layer of mist: We are affected by the materiality of the aging body and, at the same time, a dematerialization of the

world (if only partial).


To put it bluntly, today's seniors are experiencing an unprecedented, massive and unique phenomenon in the history of humanity: our world is becoming dematerialized, notably through communication technologies and the omnipresence of images. This social dematerialization, which our seniors cannot ignore, curiously coincides with the growing importance of a very personal form of **materiality**. What type of materiality is this? That of the body maintaining physical and spiritual life—a materiality that, with age, makes its presence increasingly felt with a growing list of "things falling apart," as some might jokingly remark. Without over-generalizing, we could say that today's older generations are experiencing a psycho-cultural clash between two worlds. On the one hand is the empirical, everyday, personal world of sensations—a world that can prove challenging. On the other is a largely dematerialized world, reflected in new forms of virtual expression and control of daily operations. As they experience this clash, older people may quite reasonably think that the end of their own existence will coincide with the "end of a way of being in the world", as my dear 90-year-old woman would say. The end of an era.

This more or less confused impression of **slipping** deserves

our attention.

When we stop to consider today's generations of seniors, we realize they are the first, in thousands of years, to experience the evanescence, if not the disappearance, of traces of death. There are far fewer tombstones in cemeteries: more than half of all corpses in the West are cremated, and the ashes are less and less frequently stored in official burial places. If they are, it is usually in columbaria, which connote a neat, orderly storage area. The flat, uniform rows do not necessarily allow for personal ornamental features that surpass the hard, cold reality of death. Both literally and figuratively!

Here the raw, empirical way in which a past existence is recognized often takes precedence over the metaphor of our shared human destiny. Throughout the world, burial places are a physical reminder of this destiny.

How can we surpass our individual existence and how should we store it? In other words, how has civilization taught us to **transcend**? We learn from the experiences of those who came before us and those who will follow. We learn by becoming aware of our terrestrial existence within an infinite cosmos. Finally, we are able to transcend our individual destiny by seeking comfort in the many variations of the world of the *spirit*, both in this 

life and the next. You are familiar with the exultant thoughts, the mythologies, the many beliefs in our daily lives and, of course, religions. We can all agree that it is easier to be poetic and serene when we detach ourselves from our observations of concrete reality by trying to give them some kind of meaning.

Let us return to the idea of disappearance, which silently shapes our collective and personal relationship with death. This is how we observe a correlation between two opposite tendencies: on the one hand, as I have just noted, the gradual disappearance of funeral practices and material traces of death; on the other, the rise of individual visibility, the public showcasing of each person's life and acts, particularly online. On the one hand, a disappearing act; on the other, an ego-driven call for attention. Our seniors are not unaware of this: in recent months, they have had to consider how they would like to die. Adding to this confusion is an increased uncertainty about the beyond, and an insecurity about how their traces and even their legacy will be treated.

Today's seniors experience this slide into dematerialization with all of their senses, even when those senses have been altered. We need to examine this impression of slipping into **dematerialization** in further detail.

Second layer of mist: I propose we examine this dematerialization **in terms of our relationship to time.**

Our relationship to time is a collective phenomenon, as witnessed by the statements of today's seniors, even though we are tempted to hear in them only specific accounts of suffering focused on what and whom they have lost, as we have seen at today's conference.

How does our relationship to time invite us to disappear?

We are all witnessing a swelling, a hypertrophy of the present. Phrases such as "live for today" or "everything, right here, right now" reflect how the present has become a religion, which we might call *presentism*. Each one of us is ordered to worship time, understood as this cult of the present. What are the characteristics of this presentism?

First characteristic: our era is focused on **the new**. Ironically, seniors are continually faced with new situations, as they notice changes in their physical vitality or perhaps have to move to a new living environment. Of course they can rely on past experience to deal with these new developments. But unlike the new approaches readily embraced by today's managers, the new situations faced by seniors are more subtle. They

need to be recognized and processed. They require a capacity for discernment...

Our experts on change observe how we can run after anything, provided it is new... Run, yes, since the present is mobile and constantly being reinvented. Which leads us to our second characteristic: the imperative to be **brief**, intense and compact. We have to keep things concise, make an impression, grab attention, get a reaction.

In this sense, seniors are clearly swimming against the tide. We all know how difficult it is for them to **be brief**, for a number of reasons. For some, the reason might be related to the extent and variety of their knowledge. Since all knowledge belongs to an environment, which it seeks to symbolically control or in which it seeks to find coherence, the very **expression** of this knowledge takes on a unique significance: the more the environment moves and shrinks in daily life, the more words, that basic symbolic form, turn into long, detailed accounts with many twists and turns, with arguments by turns chaotic, by turns organized. Behind these accounts is a symbolic gesture of survival. In essence, people aged 60 and over are experiencing a cultural arrhythmia, given the emphasis we place on reactivity. However, this **arrhythmia** reveals strategies and ideas that many younger generations >

can appreciate, provided they see beyond the idealized image of an old person telling stories about the “good *old days*” . . .

These treasures of the imagination may be enjoyed by all when young people ask seniors about today’s world as well.

In the length and slow pace of the older person’s account lies perhaps an aptitude for discernment, which we hope is intergenerational. It involves **taking time** or allowing people time to settle, to “process”... A “flash” is not the equivalent of a strong opinion and even less a thought. When we “settle,” we unfold what is happening, we open the petals of our “impressions,” we analyze the ins and outs, and then we prioritize and organize what is worthy of our attention. By “settling,” we decide what to keep to guide us.

The fact that seniors reflect, taking the time to discern, brings us back to the idea I mentioned at the beginning of my talk: namely that grief is an ability to receive reality as it is, to deal with the mixed emotions resulting from loss, and to choose what to let go, and what to keep as something essential to our vital spirit. What the cognitive processes behind both grief and aging teach us is very different from the constant stream of information that reaches us in an undifferentiated mass. These

processes require an effort of sorting and weighing. Rather than embracing brevity, seniors, in the way they see the world and fight against the dissolving quality of death, can learn and teach us about the time required to grieve a loss. Any loss. This deeply energizing learning requires us to be present... and patient.

Let us return to the cult of the present. There we find a third characteristic: Apart from newness and brevity, the world as a series of instants can give rise to an **urgency** to see everything before moving on to the next thing. (Rarely do we think about how this sense of urgency might result from a mess of unresolved problems . . .). This world of the now and the new is one of **fragmentation**; it is a world that values provisional meanings which are only **valid** in the moment in which they occur. In this regard as well, seniors are out of sync. Their aptitude for discernment, which I mentioned just now, is part of a *unified* logic that allows them to feel they are participating in *worlds*, with all of their mysteries, and are able to act in a coherent manner. This integrative logic of worlds stands in opposition to the current dominant definition of knowledge. How does this dominant trend work? By valuing the interpreter more than the knower, in the sense that the interpreter does not give priority to what is

handed down to him by his predecessors, but rather to the form that he gradually creates through his experience of cyberculture. What is valued must come from HIS world before he can turn to OTHER worlds of meaning-making and analysis.

We are therefore experiencing the loss of a form of knowledge that even affects how knowledge is **transmitted**. For all of the generations before us, transmitting knowledge involved coming to terms with the enigmas of existence and finding ways for human beings to use their meaning-making capacities as part of a cultural group. People transmit a culture that is created out of an awareness of death and ways of confronting this reality.

For today’s generations, transmitting is more about communicating information from our self-referential world. This is hardly an exaggeration. In any case, we seem to have abandoned the art of living and shaken off our responsibilities in our quest to “live life to the fullest,” in the present.

This world of presentism, through brevity as well as an obsession with the now, is slowly becoming a world of non-attachment. I don’t think I’m mistaken in saying that the fourth characteristic of this world is **ephemerality**, which undermines the very principle of attachment. ➤

In today's presentist climate, our societies are organized by the ephemeral, through the complex and capricious operations of economic and technological globalization. This obsession with the ephemeral, with being on the move, necessarily obliterates everything else, although paradoxically, for all its conventional discourses on memory, our era is particularly forgetful.

For older people, regardless of whether they have cognitive impairment or not, the reality of the ephemeral is traced on **the very arc of their existence**. Seniors feel on ever more slippery ground, given these different types of ephemerality—that associated with constant movement (giving the impression we are living) and that of our own finite existence.

If an older person decides to "move with the times," he or she will seek solutions in the things **of this world**—practical, short-term strategies that are legitimate, in principle. However, this person runs the risk of lamenting his losses. He might allow himself to be persuaded by those who magnify these "unbearable" and painful losses in order to sell him forms of relief—soothing platitudes or a premature end to his life.

We are witnessing the banalization of the ephemeral nature of our existence, as if life were

simply a treadmill, without mysteries and hidden paths to be discovered.

As a result, both the **past** and **future** are obliterated, since neither meets the criteria for what is agreeable and pleasant. Sources of embarrassment, they must be quietly done away with.

The future is necessarily frightening for a person who is focused on the self or, worse yet, has only "himself" as a reference. The cohesive force of social ties will naturally come apart. A self-centred person consumes and destroys. He cannot internalize the fact that he is just *passing through and is connected to others*.

Those who feel downgraded, "past their expiry date" or put away, might oscillate between shying away from the future and politely withdrawing.

Nonetheless, you know people for whom the future is not just a hopeless abyss. Some see it as a sort of welcoming nest. It is as if the fact of recognizing one's mortality, with all of its joys and sorrows, allows people to **go beyond the notion of time**. We call this acceptance, although I prefer to think of it as honouring the law of all living creatures, including at the time of our own death.

HOW TO IMAGINE AN ART OF GRIEVING?

The resolution of any crisis—seen as something that upsets and separates—requires us to **take time**. Anyone who has experienced the death of someone close will tell us they need time out, a time to just be. It is a physical need. We need time to cry. Our tears do not translate the feeling of being abandoned, of finding no meaning in life following the loss of a person we held dear. Crying creates space, a moment out of time in the jagged process of grief.

If I were to create a formula, I'd say that the art of grieving is one of **3 Ss**: silence, solitude and solidarity.

It is in silence, solitude and solidarity that people can find solid ground. A ground more solid than that which moved beneath the feet of our 90-year-old woman.

The art of grieving can also be seen as building a house. A process of building a house in the sun, at a variable pace. A house that is never completely finished.

After 40 years of dialogue with people facing death, I would like to share with you five points to consider **slipping into** the conversation. >

1st point. Grief, like art, is not a linear, univocal process. It involves making room for a sort of chaos ... a creative chaos. That is why, like any relationship, grief is experienced as an intermingling of contradictory feelings or **ambivalence**: among all the feelings brought on by death, there is a tension between relief and devastation; between guilt at being relieved and confusion as to what may be learned. Even if we are often asked to decide on one attitude or another, I believe we need to accept this ambivalence. It is reassuring to work through grief knowing that we are divided. It allows us to lay the foundations that will help us cope with these losses in our life with more serenity. We need to identify and explore this ambivalence

in everyday events and anecdotes. This rich ambivalence is also present in our collective acknowledgement of death: funeral rites.³

2nd point. The work of grief, like art, is not a solitary exercise. The person we are accompanying has experienced grief and sorrow. She can talk about it. But how can she relate her experience to what she has seen in her own society and in other cultures? Through these different cultural palettes, are there ways of experiencing grief that the person has admired and sought to understand? An approach she may have wanted for herself and her loved ones? What does the person think of the famous expression "coming to terms with

loss," as if grief were something that could be neatly packed away after a certain time? How does the person cope with the pain of possible remorse or the melancholy of regret? Does she counterbalance moments of solitude and fragility with moments of sharing? How does she balance her hopes and fears? And what does she fear and hope for?

3rd point. Grief, like art, is a call to reflection. Grief not only confronts people with the vertiginous sense of facing the void, the absolute unknown that gives us a sense of what lies in store. At any age, grief is unsettling. It undoes our usual, comfortable ways of dealing with the unknown, especially when we cling to the known. The "elderly" >



certainly don't have a monopoly on that.

Clinging to the known and, as a result, trying to recognize ourselves as we were BEFORE, is self-deceptive. This misleading imperative is the source of increased suffering, which is often ignored in theories of grief.

But we can also suffer more when we seek, at all costs, to seal the past and brutally turn the page.

Grief changes us. It etches itself on our consciousness. And if we do not insist on returning to how things were before, or on "moving forward," eventually, surprisingly, grief makes us lighter. This happens without warning when we are open to it. That is what we have to accept!

4th point. The work of grief, like art, is a step into the unknown. Grief is made up of memories that arise unexpectedly, of smells, scraps of conversation, minor and major hurts, fragments of dreams. It is an adventure in which one has the strange feeling of being stripped and discovering one's strength: "I never thought about that. I never thought about things that way . . ." When you hear these words, all you have to do is stay quiet and wait. There is an opening. Being open does not mean making a list of the many ways one can lose control and become overwhelmed. It does not mean

worrying about how old you look or the many miles you have travelled. It means welcoming with kindness and saying what you think. The secret to aging successfully, with or without a diploma, is that twinkle in the eye that shows the person's openness to difference.

[...] grief is experienced as an intermingling of contradictory feelings or ambivalence: among all the feelings brought on by death, there is a tension between relief and devastation;

Solitude is their lot. I've been told that the older we get, the less we need to say everything. Those who remain silent as they think about how to better express themselves are different from the silent ones who feel they are marginalized and no longer themselves. It is important to draw a distinction between reflective solitude and loneliness that screams in silence. And to get people to talk about their many apprehensions, past and present.

5th point. The work of grief, like art, involves recognizing the trace of others, the trace that is not only spectacular and ephemeral. Knowing that we will leave or that we are in the process of leaving, it is always possible to take stock. This involves recognizing our debt or what we have

received. It involves transmitting knowledge of what humanity achieved prior to our arrival on Earth... Considering this heritage allows us to gain perspective on what has been, what was of its time and what cannot exist outside of this time. In other words, admitting as well that some things will disappear into

the void of necessary oblivion and cannot be recovered. This is part of the grieving process.

Here we distinguish better what can remain present from the past and how the present makes us **responsible** for the future.

We think of last wills and testaments. We understand that something of us will be filtered down to those who come after us. However, if we are fixated on the fate of our precious selves, for example, indicating in detail what others should remember of us, we face a painful stumbling block: the weight of culturally unspoken anguish increases and condenses in a manner that is devastating to us. The more worried we are, or even obsessed with the traces we leave, the more our impression of loss ➤

will augment. A wise person once told me that we do not know the content of everything we know. What we have to leave to others is not necessarily what we know, but much more the pleasure of learning, and knowing we are sharing this pleasure.

TO CONCLUDE...

Of course, there is the pleasure of linking astonishing elements of time, connecting past and future, debt and legacy. Which raises a question, never fully answered, that helps us to remain open: **how do the various forms of lack experienced by different generations help to *build* them, not to *rebuild* them?**

In inviting you to answer this question, I suggest we step back from a very contemporary concern, which is to sometimes psychopathologize grief, especially the grief of older people.

In asking the question about the lack that builds us, we are helping to limit the follies of omnipotence and, once again, we are creating strengths that are targeted, fruitful and essentially alive—strengths that emerge from our encounter with others, whoever they are.

In accepting the very idea of lack, we are conceiving of grief as the wellspring of a civilization that might have forgotten the extent to which death can also be a source of inspiration.

What do you think?

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1. In addition to performing as a mime artist, Marie Lefebvre helped to prepare this article.
 2. This excerpt was read by actor Marie Lefebvre. It reflects a certain unease felt by some seniors who, at the same time, doubt the validity of their impressions.
 3. In addition to my work on requests for euthanasia, I am currently conducting research on contemporary death rites, to be published in 2016.

Supporting references:

- Auger, M. (2003). *Le temps en ruines*. Paris: Galilée.
- Balandier, G. (2012). *Carnaval des apparences*. Paris: Fayard.
- Debray, R. (2014). *Le bel âge*. Paris: Flammarion.
- Delsol, C. (2008). *Qu'est-ce que l'homme ? Cours familial d'anthropologie*. Paris: Cerf.
- de Montigny, J. (2010). *Quand l'épreuve devient vie*. Montréal: Médiaspaul.
- Des Aulniers, L. (2009). *La fascination, nouveau désir d'éternité*. Québec: Presses de l'Université du Québec.
- Dupré, L. (2014). *L'album multicolore*. Montréal: Hélio trope.
- Hanus, M. (1994). *Les deuils dans la vie*. Paris: Maloine.
- Massicotte, S. (2014). *Avant d'éteindre*. Montréal: L'Instant Même.
- Thomas, L.-V. (1991). *Traces de mort. Mort des traces*. Paris: L'Harmattan.
- Viro, L. (Director). (2012). *Le sens de l'âge* [documentary film]. France: Coloured Plates Production, Ludovic Viro, Inca, Bernard Cochin.

Ways to understand the grief and losses experienced by seniors

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*"The night is never completely dark
There is always . . . at the end of sorrow, an open window
A light in the window
There is always a watchful dream
A desire to fulfil a hunger to satisfy
A generous heart
A hand held out an open hand
Attentive eyes
A life to share."¹*

INTRODUCTION

With aging inevitably comes the experience of grief, of small and major losses. Although aging is clearly not limited to these losses, it is important to recognize that they are part of the reality of getting older. As Bacqué² has noted, seniors are well versed in grief, since losses multiply at this life stage.

Although seniors experience grief more often than others, that does not make it any easier to bear². Whether grief is experienced by an older or younger person, the emotional pain and upset are the same. However, the grief experienced by seniors has certain specific characteristics. If we better understand

and recognize the different faces of grief experienced in late life, we will be better able to listen to and accompany the grieving seniors in our lives. To invite reflection on the experience of grief among older adults, we offer here an overview of how this grief may look.

This short article draws on both our clinical practice with grieving seniors, the literature on grief among the elderly, and the partial results of a study we are currently conducting on grief among seniors in residences. To promote a more nuanced understanding of this phenomenon, we have adopted an >

interdisciplinary perspective, rooted in a humanistic psychological framework and complemented by views from other disciplines such as social work, anthropology and sociology.

SUCCESSFUL AGING AND THE GRIEF OF SENIORS

For decades, in the field of gerontology, aging was perceived in terms of degeneration and loss³. In reaction to this perspective, the more recent “successful aging” trend has sought to present a far more optimistic view of this life stage. Successful aging has been defined by some in terms of maintaining good health (physical, cognitive, etc.) and remaining active and involved in the community. Obviously this is an ideal for most, but one that remains out of reach for many seniors, such as those suffering from health problems³. Furthermore, some proponents of successful aging have focused so much on the positive aspects that they have overlooked some of the more difficult realities experienced by seniors. Although aging is not exclusively about loss and grief, these are an inherent part of this life stage. This article examines the experience of grief among seniors, recognizing the pain, difficulties and challenges involved, as well as the consolation and opportunities for learning.

REFLECTIONS ON GRIEF AND LOSS

Although aging is a time of many losses, not all of these losses result in a grief process. Grief has been defined in a number of ways over time⁴. These definitions belong to different paradigms and reflect a certain way of relating to the world, life and death. Some definitions of grief are broader, others narrower. To invite reflection on the various losses that may lead to a grieving process among seniors, we will adopt an expanded definition of grief that could be formulated as follows: “Grief is the process of detachment that may occur following an experience of significant loss.” This definition is not limited to grief caused by death.

GRIEF FROM AN OLDER PERSON’S PERSPECTIVE

The grieving process is very different from one person to another. Factors that influence this process include the personality and life experience of the person; his or her attachment to the individual, state, situation or object that has been lost; previous experiences of grief and loss; recognition of the loss; and gender⁴. That said, certain aspects of grief are more frequently experienced by older people.

FREQUENTLY EXPERIENCED TYPES OF LOSS

The quantity and nature of losses experienced by older adults are not the same as those experienced by younger people. Many seniors experience grief following the death of loved ones—for example, brothers or sisters, their spouse, their friends or their children². Some of them also face the loss of their home, physical capabilities, autonomy, projects, status and so on.

AN ACCUMULATION OF LOSSES

In addition, a number of seniors experience an accumulation of losses⁵. Precisely because these losses are more frequent, they are sometimes less easily recognized or are under-estimated, since they are considered more normal (statistically speaking) at this stage of life. Nonetheless, recognition of loss is a fundamental aspect of working through grief.^{2, 5}

In certain cases, without any deliberate effort on the part of the older person, losses may remain unknown or unspoken. Some losses are simply not named by those experiencing them. Seniors have reported not telling others about the loss of a close friend or person they cared for. ➤



It has also been observed that current losses frequently stir memories of previous losses. The accumulation of losses can affect the grieving process of seniors and can revive former experiences of grief, adding more complexity, intensity and depth to the person's suffering. This explains why the experience of grief among seniors can be so powerful.⁶

SOLITUDE

In most cases, this accumulation of losses gradually reduces seniors' social network². In addition, some seniors are reluctant to form new ties with people their age, since they are all too aware of the fragility of life and these new relationships. Consequently, grieving seniors can become increasingly lonely or even isolated as their losses accumulate.

EXPERIENCE OF CERTAIN FEARS

Whatever their age, those who are grieving are confronted by archaic fears. The death of another person brings up existential questions about the finiteness of one's own life, and can give rise to a variety of fears. Some of these fears are more frequently experienced by grieving seniors. Fear of abandonment and death, and feelings of insecurity may be experienced following a loss.^{7,8} This is particularly true in cases of grief following death. The way the person was treated before his or her death and the rituals that were carried out (or not) colour the fears of some seniors, particularly when the person's death has gone unnoticed or their end of life seemed difficult or painful.

SECONDARY LOSSES

A significant loss tends to bring about secondary losses, which can also be a source of emotional upset. As people get older, these secondary losses can be quite significant⁴. For example, in a relationship where both partners rely on one another to remain independent, the death of a spouse can result in the surviving partner no longer being able to live at home. When a senior faces a major physical loss, he or she may also lose certain important social roles (e.g., helping to take care of the grandchildren). These losses can compound the person's grief.

CONSERVING AND PASSING ON MEMORIES

For many seniors, it is very important to conserve memories and traces of what has been lost. They sometimes fear >

that these memories will be lost when they too pass away, especially when they are the last generation.⁹ As a result, a number of seniors have a strong desire to share and pass on their memories, to keep the past alive. This is a reminder of how important it is to listen to these precious stories when they are offered.

POSSIBLE COMPLICATIONS

People sometimes experience complications in the grieving process. Obviously, this is also the case for grieving seniors although, in general, this age group copes better with bereavement than other age groups.¹⁰ Nonetheless, some seniors find the grieving process very difficult. They can experience anxiety, or increased or new forms of cognitive loss, and can develop a variety of psychological disorders.¹¹ Bereaved seniors

tremendous emotional distress, which is why it is important to recognize their grief and provide adequate support to those who need it.

RESILIENCE AND LEARNING OPPORTUNITIES

As mentioned above, most seniors get through the grieving process without complications. Many show a strong resilience in the face of grief. If, as Bacqué² notes, seniors tend to experience loss often, they are also survivors who have dealt with losses throughout their lives. What helps seniors become resilient and cope with their grief? Rituals, religious beliefs and spirituality help many to build resilience and experience their grief in the community, which greatly facilitates the process.¹² Those who have an optimistic outlook and who remain active also

It has also been shown that, for many seniors, grief brings about significant and meaningful changes and transformations. It can be an opportunity for people to change, review their priorities and adopt a more authentic way of being, which can make for a happier, more meaningful life.⁶ Experiences of grief and loss are not only negative; they can also be opportunities for growth.

CONCLUSION

This article invites us to become aware of how grief is experienced by older adults and provides information that can guide those who are accompanying people faced with the loss of a loved one. At the same time, it is essential to recognize that each grieving process is unique, just like every relationship. Reflecting on the grief of seniors can help us to be open to the many faces and ways of grieving, to be em-

It can be an opportunity for people to change, review their priorities and adopt a more authentic way of being, which can make for a happier, more meaningful life.⁶

can also experience functional losses and hospitalizations, and will generally die more rapidly than non-bereaved elderly people.⁹ Finally, as with people in other age groups, some grieving seniors might have suicidal ideation or could even attempt suicide.⁹ Seniors may experience

seem better able to cope with their grief.¹² Finally, as noted earlier, recognition of loss and social support are vital in helping people get through the grieving process.⁹

pathetic towards individuals in their suffering and ambivalences, and to gently accompany them in the gradual process of detachment. We hope, in this way, to help people find meaning as they work through this difficult process. ➤

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1. Éluard, P. (1951), *Le phénix*. Paris: GLM, p. 55.
 2. Bacqué, M.-F. (2004). Augmentation de la longévité, multiplication des deuils. Les nouveaux « vieux » sont aussi de grands endeuillés. *Études sur la mort*, 126(2), 149-158.
 3. Grenier, A. (2012). *Transitions and the Lifecourse: Challenging the Constructions of growing Old*. Bristol : Policy Press.
 4. Hooyman, N. R. et B. J. Kramer (2008). *Living Through Loss: Interventions Across the Life Span*. New York: Columbia University Press.
 5. Chen, S.-I., Brown, J. W., Mefford, L. C., de La Roche, A., McLain, A. M., Haun, M. W. et D. J. Persell (2008). Elders' Decisions To Enter Assisted Living Facilities: A Grounded Theory Study. *Journal of Housing For the Elderly*, 22(1-2), 86-103.
 6. Moon, P. J. (2011). Bereaved Elders: Transformative Learning in Late Life. *Adult Education Quarterly*, 61(1), 22-39.
 7. De Broca, A. (2010). *Deuils et endeuillés* (4th édition). Paris: Elsevier Masson.
 8. Hecquet, M. (2013). Accompagner le deuil chez la personne âgée. *Le Journal des psychologues*, 305(2), 33-36.
 9. Azaïza, F., Ron, P., Shoham, M. et T. Tinsky-Roimi (2011). Death and dying anxiety among bereaved and nonbereaved elderly parents. *Death studies*, 35(7), 610-624.
 10. d'Epinay, C. J. L., Cavalli, S. et L. A. Guillet (2009). Bereavement in very old age: impact on health and relationships of the loss of a spouse, a child, a sibling, or a close friend. *OMEGA-Journal of Death and Dying*, 60(4), 301-325.
 11. Shah, S. N. et S. Meeks (2012). Late-life bereavement and complicated grief: A proposed comprehensive framework. *Aging and Mental Health*, 16(1), 39-56.
 12. Damianakis, T. et E. Marziali (2012). Older adults' response to the loss of a spouse: The function of spirituality in understanding the grieving process. *Aging & Mental Health*, 16(1), 57-66.
 13. Sachet, A. (2004). Mourir âgé en institution. *Études sur la mort*, 126(2), 115-124.

Harp accompaniment in palliative care: A preliminary exploration of an emerging practice

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When all possibilities for medical treatment have been exhausted, a multidisciplinary, whole-person approach to care is particularly appropriate. So-called complementary approaches such as "bedside arts" are increasingly used in care settings, but these practices and their therapeutic effects have yet to be explicitly defined and documented. Since Antiquity, music has been described as beneficial for patients.¹ Several literature reviews confirm that music can enhance patients' well-being, reduce stress and pain, and can even have an effect on physiological measures.^{2, 3}

This study aims to explore an emerging practice in palliative care settings, namely harp playing at the patient's bedside. Part therapeutic, part artistic, this practice is tailored to each patient's needs and seeks to promote a sense of well-being. We will look at the possible effects of harp playing on participants' sense of their own mortality and on the grieving process of loved ones. >



OBJECTIVES AND METHODOLOGY

The main objective of this study was to explore the experience of hospitalized elderly palliative care patients while listening to harp music, played at their bedside by a professional musician. Within this general framework, we aimed to analyze the effects of the music on patients' physical experience (including stress and pain), to understand the ways in which it captured their

imagination, and to observe the interactions (eye contact, reminiscences) between patients, their loved ones and the musician.

This qualitative research follows the work of social scientists A. Giorgi and R. Anderson (1997) on the exploration and translation of lived experience into phenomenological terms.⁴ Our two patient recruitment sites were a mobile palliative care unit at Hôtel-Dieu hospital (CHUM) and the Source Bleue hospice. The

study included 28 participants aged 65 and over (on average) who were receiving palliative care. Among these participants, 72% were women. Only 9% were able to enjoy two or more harp-playing sessions, given the short period of their stay at either of the two care facilities.

The participants answered questions on their perception of pain (Visual Analog Scale for Pain) and stress (Likert scale) before and after the harp-playing session. During the session, the research assistant used an observation chart to note the various reactions of patients and their loved ones. Participants were then invited, during a short interview (maximum 30 minutes), to relate their experience of listening to the music and its effects on their imagination, emotions and physical sensations. In addition, some interviews were carried out with members of the health care team.

THE HARP: HISTORY, CULTURE, IMAGINATION AND THERAPEUTIC PRACTICES

The harp has a particular symbolic resonance, frequently appearing in myths and stories about care and healing. Apollo, God of musicians, physicians as well as the sun, made the harp his instrument of choice, while King David cured Saul with its harmonious melodies.⁵ The Celts called ➤

the harp an instrument of joy, because of its ability to elicit laughter and contentment, and to induce sleep. Through his system of modes (or keys), Pythagorus recognized the effects of sound on people's moods and emotions (e.g., stimulating, calming, relaxing) and recommended plucked-string instruments for optimal results. Today musicians practising harp therapy, an approach developed in the United States, play for patients in the spirit of these ancient traditions.⁶

devoted to them ("she [the musician] came to play for me")—a welcome surprise in their daily routine. The unexpected visit was also perceived as a time-out ("I don't have to think about anything").

Three participants were able to enjoy several sessions, which allowed the team to see how the interactions between patient and musician evolved. Over the course of the sessions, the patients became more invested in

(the health care setting, intrusive thoughts about health and mortality). The music was also associated with closeness—in relation to the self (patients reported feeling connected to themselves through a memory or pleasant thoughts inspired by the music, such as beautiful landscapes or birdsong)—and in relation to others ("I love that the music brings us together... we're being silent together, without doing anything").

The harp sessions created a "unique atmosphere" for both participants and their loved ones. The music brought people together, allowing them to share a special moment in the context of loss and grief.

PATIENTS' RECEPTIVENESS AND RESPONSES

The vast majority of participants in the study responded positively to the harp-playing session (smiles, gazing at the musician, comments on the beauty of the music, curiosity and questions about the instrument). Two patients declined the harp-playing session, because they were in too much pain or did not have a particular affinity for that instrument.

During the first meetings, participants described the harp sessions as a "surprise" and "gift." They saw it as a musical moment

the relationship, shared more of their personal tastes (songs and styles), and adopted more directive behaviours. The harp session became increasingly tailored to the desires of each patient.


MUSIC THAT IS GENTLE AND SOOTHING

The words "gentle" and "soothing" were frequently mentioned during the sessions and interviews: "it's peaceful, not at all jarring"; "it's like being stroked with a feather"; "it's a balm for the heart." Patients echoed popular perceptions of harp music. They used words referring to inner peace and a break from habitual concerns

IDEA OF TRAVEL: GOING FAR AWAY

While the non-verbal behaviours of patients during the sessions (closed eyes, falling asleep, relaxing) reflected a body in stasis, their thoughts, as expressed in the interviews, were very mobile. The plucking of harp strings allowed them to travel in their mind, to go "far away": "We don't get to move around much here, but this is like a vibration that fills the room"; "you don't need words; you can immerse yourself through music." The music also evoked personal memories for some patients, which they shared with the musician or loved ones who were present.

HARP MUSIC AS A BRIDGE BETWEEN TWO WORLDS

The "elsewhere" patients travelled to in their mind often had a spiritual dimension. The harp 

has long been associated with the world of the spirit. In the popular imagination, the female harpist plucking the strings of her (often) white instrument has an angelic quality. The palliative care setting is like a transition point between two worlds: life as we know it and the mysterious afterlife. In interviews, participants described being at the threshold of their existence, feeling a tension between their mortality, a letting-go of possibilities and an anticipation of their departure. The harp was associated with travel, with another world where existence continues in a different form. These thoughts gave patients a sense of peace. They were happy to be transported by the music—in spirit rather than in body, since in most cases, physical movement was impossible.

For most participants, the harp music was a pleasant, soothing symbol of movement and departure. However, one patient did not want to take part in the sessions, because for her the music symbolized the end of her life: “it’s music for my death.”

BEDSIDE MUSICIANS: ADAPTATION AND ADJUSTMENT

Bedside arts require constant adjustment to the patient’s needs. During each session, the patient and musician interacted, creating a musical moment together.

After playing the first notes, the musician always asked whether the patient liked the piece, or whether he or she had a special request. The artist took part in a spontaneous musical game, creating plenty of room for improvisation according to the patient’s wishes, physical condition and openness.

The bedside musician must have a broad repertoire and must be able to switch from gentle to more lively melodies, depending on the patient’s mood and desires. The artist must also be able to look up from her sheet music in order to be present and maintain visual and verbal communication with the patient.

The bedside musician not only adjusts her playing according to the patient’s needs, but must also adapt to different hospital settings and palliative care units. Over the course of the study, the musician was welcomed by medical teams. The harp was not seen as intrusive, but rather as a means to create a pleasant musical environment without compromising care (“the volume of the instrument did not drown out the machine beeps.”). The medical staff tended to adopt a participatory approach, which allowed them to step out of their usual professional roles.

LIMITATIONS AND PRELIMINARY RECOMMENDATIONS

One of the limitations of this study was our inability to analyze the effects of the harp music on patients who were experiencing significant pain or stress. One might wonder why these patients declined the invitation to take part in the harp sessions. Was their pain too overwhelming for them to listen to music and interact with the harpist? Another limitation of the study is related to the interviews, which had to be cut short, given participants’ limited concentration. We were therefore not able to discuss topics in greater detail.

FAMILY AND LOVED ONES: POSSIBLE AVENUES FOR FUTURE RESEARCH ON GRIEF

Although families were not the main focus of this study, we gained insights into the experience of grief when older family members pass away.

Those accompanying the end-of-life patients in this study described the bedside harp sessions as:

- ▶ a moment of sharing and pleasure in a context of loss and mortality. When family members were present, the musical session became ➤

a lot more festive, often inspiring people to sing together and choose songs from a variety of styles (jazz, pop, etc.);

- ▶ a moment that brightened up their days at the patient's bedside;
- ▶ a moment of beauty that provided comfort to the dying patient and support to the bereaved family (many wanted the musician to play at the patient's funeral);
- ▶ a moment creating happy memories, which could help with the grieving process.

The harp sessions created a "unique atmosphere" for both participants and their loved ones. The music brought people together, allowing them to share a special moment in the context of loss and grief. In the words of one family member, "I love that we're brought together by the music. It's rare. Usually, we're busy filling the gaps, checking information online, chatting. But here we are in silence, doing nothing." As the philosopher Charles Pépin has noted, when we are touched by beauty, we "relearn how to trust our instincts, to listen to ourselves... to open up... to face what usually frightens us, the mystery of things, our own obscurity. Beauty gives us the ability to love what is and to hope for what could be" [Translation].⁷

This notion of "aesthetic pleasure" is helpful in considering how caregivers experienced this musical moment. They said they felt more confident and closer to their loved one. They were able to act like they did before their family member became ill. They gave themselves permission to touch, to sing together and to lower their defences in the face of loss.

The fact that family members invited the musician to play at the funeral, or asked for a group photo during the harp-playing sessions, can be seen as elements facilitating the grieving process. Conserving an image or memory of a dying person is an act not of sadness or defeat, but rather of vitality and shared joy.

CONCLUSION

The bedside harp sessions in this exploratory study were perceived as a gift and a surprise, helping participants to enjoy an experience of calm and closeness, to take a break from the medical routine, and to be transported in a spiritual way. The musical moment did not interfere with the work of the medical team and created a moment of sharing for loved ones who were present. This approach requires sensitivity and flexibility on the part of the musician. This first musical contact allowed us to consider possible avenues for future research on caregiving and

understanding the experience of grief, whether the person is grieving the loss of a loved one or the loss of his or her own life.

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1. Williams, S., (2015). *The Mythic Harp*. Macungie, PA: Planet Harp.
2. Aragon, D., Farris, C. et Byers, J. F. (2002). The effects of harp music in vascular and thoracic surgical patients, *Alternative Therapies in Health and Medicine*, 8(5), 52-60.
3. Macdonald, R.A.R. (2013). Music, health, and well-being: A review, *International Journal of Qualitative Studies on Health and Well-being*, 8, 1-13.
4. Repéré à <http://www.harptherapy.com>.
5. Pépin, C. (2013). *Quand la beauté nous sauve*. Paris : Robert Laffont.

Aging out of place into homelessness: The role of grief and loss

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Homelessness is on the rise among older adults in large Canadian urban centres, including Montreal, with many becoming homeless for the first time.^{1,2} Despite some recognition that various forms of loss (i.e., family, work and health) contribute to late-life homelessness^{3,4,5}, there has been little research on the role of grief and loss in relation to the experiences of older homeless adults.⁶ Rather, the assumption that homelessness in later life results from personal liabilities, individual responsibility, deviancy and choice continues to prevail.^{2,7}

This article examines two case studies of newly homeless older adults (NHOAs) through the lens of grief and loss—a framework that examines normative reactions to the loss of important elements in individuals' psychological, social or physical worlds.⁸ The two case studies have been drawn from a larger ethics-approved McGill University research project that considered 15 NHOAs' encounters with first-time homelessness.² Here, it is argued that using a lens of grief and loss to understand late-life homelessness is a promising framework that shifts the focus from an individual-blaming discourse towards a less stigmatizing, more

normative understanding of late-life homelessness.

METHODOLOGY AND METHODS

Using semi-structured, face-to-face interviews, the larger study from which these case studies are drawn explored the personal histories of 15 NHOAs (8 men, 7 women), their relationships to everyday places, the meanings they attributed to home and homelessness, and the events leading up to their homelessness.² Each interview was recorded using a digital voice recorder and transcribed verbatim. All of the participants' names were

changed to protect their anonymity. The constant comparative method (a systematic method of analysis that compares within and between cases⁹) was used to analyze the data. Participants were given a \$10 honorarium (in cash) to compensate for their time.

Participants were recruited from Montreal emergency shelters for men and women. To be eligible to participate, they had to be experiencing homelessness for the first time at age 50 years and over, and had to have been homeless for no more than two years at the time of the interview. The age criterion was set at a minimum of 50 years, since the health >

status of older homeless adults tends to resemble that of people 10 to 20 years older, and this is the age most widely used in the aging and homelessness literature.³ The two-year cut-off point for homelessness was used in or-

homelessness with little warning. The following two case studies and associated quotes illustrate the two different pathways into homelessness characterized by chronic and acute experiences of

not been able to overcome the grief she experienced as a result of this loss. Even though she subsequently lived in the same apartment for 13 years prior to becoming homeless, she explained that, without her husband

However, family breakdowns seemed to have a greater financial impact on the women, which in turn put them at a greater risk of homelessness.

der to be consistent with existing research on what is considered “newly” homeless¹⁰, and to ensure that participants would be able to recall the events leading up to their homelessness.

MAIN FINDINGS

In the larger study, two different pathways into homelessness were identified. About half of the participants had gradual pathways, experiencing social, health and occupational losses over an extended period. Their grief was chronic, in the sense that they seemed to have never fully recovered, and commonly experienced feelings of fear, rejection and insecurity over the course of their lives. The remaining participants had rapid declines into homelessness. This group had more stable personal, housing and employment histories, and experienced a series of multiple, acute losses (i.e., social, health and occupational) in later life that propelled them into

grief and loss. The participants' names have been changed to protect their anonymity.

CASE STUDY 1

Charlotte, age 64: Unresolved losses over her life course contributed to a gradual decline into homelessness

Charlotte, age 64, was born in the United States and came to Montreal with her Quebec-born husband. University-educated, she worked a series of odd jobs until the birth of her son in her late 20s. During her 20-year marriage, she had no financial troubles and lived in a large, 13-room suburban home. When she was in her early forties, her husband unexpectedly filed for a divorce, leaving her for their 18-year-old babysitter. When Charlotte was forced to leave the residence she had shared with her husband, she felt that her home was literally being stolen from under her. She has

and son, she “never felt at home again”:

V: *Is there a certain residence you consider to be home more than others?*

C: *The home that was my home that the babysitter had rights to.*

V: *That the babysitter had rights to?*

C: *Yes, the one who replaced me [crying]. That was my home! That was my home! [crying loudly]. The difference between my apartment and my home is that my home was our home, it was a shared environment, whereas my apartment, I don't call it my home, it was my apartment. To me there's a difference. Home to me includes other people, because that's what makes any place a home, because you have people with you. ➤*



Grief by Cynthia Angeles, n.d.

Charlotte's housing instability increased over the years. With age, her mental health issues (hoarding) worsened, and she continued to struggle financially (she was receiving \$740/month from basic social assistance and a small Quebec pension, and was paying \$596/month in rent). After receiving several warnings, she was evicted from her apartment for hoarding and came to the women's shelter.

CASE STUDY 2

David, age 70: Serial, acute losses in later life contributed to a rapid decline into homelessness

David, age 70, was born in Montreal. University-educated, a widower and father of two, David attributed his homelessness to a combination of losses, including his retirement, followed by the sudden deaths of his wife, daughter and mother over the span of

five months. These consecutive deaths led him to relapse into alcohol abuse, after more than 30 years of sobriety:

Everything happened at the same time. Two and a half years ago, there were three consecutive deaths. My mother died first, then my daughter, my oldest, who died second, and then my wife was third. All of that in the span of five months. Let's just say that it took about a month before it all started. I already had a problem with alcohol, which I had under control for the past 30 years. It was foolish of me to retire. I don't feel very good, because there are lots of opportunities that are out of reach for me because of my age. It's like there are barriers, in terms of work. If I was 20 years younger, I would have gone two days without work, it was easy for me.

David's wife ran the household and helped him manage his home-based business—he referred to her as his “right arm.” After her death, David isolated himself from his friends and family who “reminded him of her.” He explained that he no longer felt at home in his apartment, because it also reminded him of his late wife. After he retired, his home also reminded him of his lost professional role. He eventually sold off all of his possessions, got behind on his rent and bills, and within two years, went from living in a stable home

where he had resided for 27 years with his wife and had run a successful home-based business, to becoming widowed, jobless, and living on the street:

DISCUSSION

Temporality of social losses affects pathways into homelessness

While the loss of a spouse affected trajectories into homelessness for both the men and women in this study, some gender-based differences were revealed. David, in his late sixties, became increasingly disorganized in his home following his retirement and the death of his wife, and was propelled into homelessness within a couple of years. This finding supports existing research suggesting that widowhood may be a particularly strong trigger for homelessness in older men, many of whom become “volitionally homeless” after selling their property and find it “too painful and upsetting to remain in the house after the death of their spouse” (p. 9).¹¹ While none of the women in the study experienced widowhood, their homeless trajectories were also affected by family breakdowns (i.e., separation and divorce). However, family breakdowns seemed to have a greater financial impact on the women, which in turn put them at a greater risk of homelessness. Charlotte, for example, ➤

had never worked full-time and left the workforce after the birth of her son, whereas David maintained stable employment up until his retirement at age 68, and was not as financially affected by the death of his wife.



Old Man Grieving by Vincent Van Gogh (1890)

Charlotte's case echoes existing research suggesting that family breakdowns (including divorce) are a primary trigger for homelessness in women, as the latter tend to opt out of the workforce more often due to caregiver responsibilities, and are more financially dependent.³ Nonetheless, Charlotte showed innate resilience. Despite her precarious living situation (she was spending more than 80% of her income on rent), she maintained a private market rental for over 20 years.

PRACTICE RECOMMENDATIONS

It is suggested that service providers ask newly homeless older adults questions about losses that occurred in the past, because, as Charlotte's case demonstrates, unresolved chronic losses greatly affect their present-day housing stability. For people like David, who experience acute losses in later life, a more systematic outreach is required to prevent rapid disorganization and a decline into homelessness. Whether the person has experienced chronic losses over their life course or a series of acute losses later in life, prompt, grief-focused interventions are required to help them come to terms with their losses, gain a sense of security, and function in their living environments in the absence of loved ones.


CONCLUSION

This paper sheds light on the role that grief and loss may play in pathways to late-life homelessness. Understanding how grief and loss are associated with housing instability and homelessness marks a shift away from an individual-blaming discourse towards a more normalized understanding of homelessness. Older people face multiple losses, including physical changes, health problems, the loss of a job and loved ones, that may complicate

the grieving process and put them at a greater risk of homelessness. More research is needed to understand how multiple losses across the life course affect pathways into late-life homelessness. If left unaddressed, issues related to grief and loss may continue to put older adults at risk of homelessness, and may also affect their stability following re-housing.

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1. Latimer, E., McGregor, J., Méthot, C., & Smith, A. (2015). Dénombrement des personnes en situation d'itinérance à Montréal le 24 mars 2015. Montreal, Quebec: Ville de Montreal.
2. Burns, V. (2015) Oscillating in and out of place across housed-homeless trajectories: Experiences of newly homeless older adults in Montreal, Quebec. Doctoral thesis, McGill University School of Social Work. 267pgs.
3. McDonald, L., J. Dergal, and L. Cleghorn (2007). Living on the margins: Older homeless adults in Toronto. *Journal of Gerontological Social Work*, 49(1-2), 19-46.
4. Cohen, C. (1999). Aging and homelessness. *The Gerontologist*, 39(1), 5-15.
5. Cohen, C., Ramirez, M., Teresi, J., Gallagher, M., & Sokolovsky, J. (1997). Predictors of becoming redomiciled among older homeless women. *The Gerontologist*, 37(1), 67-74. doi: 10.1093/geront/37.1.67
6. MacNeil, K. and Darnell, J. (2010). Grief and loss as a contributing factor in the homelessness of older adults: A qualitative study. *The Good Neighbours Club: Toronto, Ontario.* 

7. Parsell, C. and M. Parsell (2012). Homelessness as a choice. *Housing, Theory and Society*, 49(4), 420-434.
8. Regehr, C. and Sussman, T. (2004). Intersections between grief and trauma: Toward an empirically based model for treating traumatic grief. *Brief Treatment and Crisis Intervention*, 4(3), 289-309.
9. Glaser, B.G. and A.L. Strauss (1967). *The discovery of grounded theory*, Chicago, Illinois: Aldine Publishing Company.
10. Crane, M., Byrne, K., Ruby, F., Lipmann, B., Mirabelli, F., Rota-Bartelink, A., Warnes, A. M. (2005). The causes of homelessness in later life: Findings from a 3-nation study. *Journal of Gerontology: Social Sciences*, 60B(3), 152-159.
11. Crane, M., & Warnes, A. M. (2010). Homelessness among older people and service responses. *Reviews in Clinical Gerontology*, 20(04), 354-363. doi: doi:10.1017/S0959259810000225

Collage: an art therapy intervention facilitating an experience of loss among hearing-impaired seniors

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Collage is an artistic technique that involves choosing images in order to arrange and combine them in a new way. In art therapy, this technique has proven to be beneficial for a variety of clients, including seniors¹, the bereaved² and individuals with a hearing impairment.³ During my art therapy training at Concordia University, I completed an internship within the program for seniors at the Institut Raymond-Dewar, a rehabilitation centre specialized in deafness and communication. During this clinical experience, I witness how collage can be used to accompany the elderly through an experience of loss, particularly its potential in facilitating rehabilitation in hearing loss cases.

HEARING IMPAIRMENT AMONG SENIORS

Sudden or progressive hearing loss can cause a major identity shift in seniors, resulting in a number of life changes. One of the effects noted by hearing loss specialists is "a reduction in seniors' social interactions because of the effort required

to compensate for the loss" [Translation].⁴ Seniors and those around them also have to learn entirely new ways of communicating. For example, the hearing-impaired person will have to put into practice new communication strategies or get accustomed to using a hearing aid. Losing one's sense of hearing can lead to feelings of powerlessness, isolation,

sadness and anger. Each person experiences the loss in his or her own way and sometimes it may be difficult to express these emotions. During my internship, I discovered that collage was an effective therapeutic tool to facilitate emotional expression, which is essential within a positive rehabilitation experience. ➤



Image 1. Title: *It's a cold collage.* "It's a story that speaks about people of a certain age . . . Soon, there will be too much water and the man won't be able to walk as easily . . . We can't see the consequences of the natural disasters . . . Since losing my hearing, I feel like I'm up against a wall."

WHY CREATE COLLAGES WITH AN ART THERAPIST?

Anyone can make a collage at home. However, in a therapeutic context, collage making is a symbolically powerful activity, given the personal meaning associated with images. As a witness to the client's creative process, the art therapist provides a framework—a free and safe space in which authentic expression is received without judgement.⁵ This sense of safety allows clients

to express themselves freely and spontaneously, which happens less often following a hearing loss. Furthermore, a safe space is essential to explore feelings that may be threatening for one.

Like a mirror reflecting an inner reality, the collage creates a distancing effect, offering a new perspective on the problem (hearing loss) and allowing one to re-evaluate the impacts of this loss in his or her life.⁶ The person may then be invited to talk about the collage, through

storytelling for instance, in order to give meaning to the produced images (**Image 1**). In art therapy, collage may simultaneously reveal conflicts and solutions, the client's preoccupations and strengths. The therapeutic process allows one to name their inner resources such as perseverance and resilience, which could facilitate a grieving experience (**Image 2**). The revealed metaphors through collage may bring awareness about concerns, as well as positive aspects within their lives. ➔

It is important to note that art therapists adapt interventions to the client's ability and needs. like I've finally come out of my cave." During a short-term follow-up, another client noted, "I a sense of control and autonomy throughout the creative process, and requires no artis-

Over the course of my art therapy internship with hearing-impaired clients, participants reported an enhanced sense of well-being in expressing feelings of sadness, anger and isolation related to their hearing loss.

With their extensive knowledge of how art materials can be used⁷, art therapists ensure a satisfying creative process. It is not necessary to master artistic techniques to benefit from art therapy. In evaluating the hearing-impaired client's needs, the art therapist offers the appropriate tools and guides the client toward a positive experience, focusing on his or her strengths and validating each steps of the creative process.


THE BENEFITS OF COLLAGE IN ART THERAPY WITH THE HEARING-IMPAIRED

Over the course of my art therapy internship with hearing-impaired clients, participants reported an enhanced sense of well-being in expressing feelings of sadness, anger and isolation related to their hearing loss. As one participant stated, "I feel free when I do this [collage]. This introspective work has allowed me to externalize my feelings. It's

knew it was OK for me to express my anger in art therapy and that it would give me wings afterwards. I had the right to be myself." Others were proud of their creative accomplishments: "I was surprised to discover my creativity; it gave me self-confidence." Clients can generalize their discovered or rediscovered skills and strengths into other areas of their life—for instance, by persevering in their efforts to learn lipreading and integrating more effective communication strategies. Finally, I observed that providing a space for emotional expression also reduces the level of anxiety, which allowed hearing impaired seniors to engage more easily in dialogues with loved ones. The simple act of creating "makes you want to be in the present," as one participant stated.

Collage is a way to make pain instantly visible, a healthy vehicle for expression during hearing rehabilitation. This technique is also easy to use, giving

tic knowledge or skill to be enjoyed: "It's easier for me to use images to express my thoughts." In other words, creating a collage with an art therapist may reduce the anxiety associated with artistic performance, by simply selecting, arranging and pasting the images on paper. The artistic value of the collage is by no means diminished: the work is rich in meanings, symbols and eloquent metaphors. In art therapy, collage is also an effective way to foster reminiscence⁸, a need throughout adulthood⁹. Photographs may stir memories, giving freedom to travel beyond body limitations and age.

1. Hinz, L. D. (2009). *Expressive Therapies Continuum: A framework for using art in therapy*. New York, NY : Routledge.
2. Allen, P. B. (1995). *Art is a Way of Knowing: a guide to self-knowledge and spiritual fulfillment through creativity*. Boston, MA : Shambhala Publications.
3. Silver, R. (2000). *Studies in art therapy 1962-2000 (2e éd.)*. Sarasota, FL : Ablin Press Distributors.
4. Pouliot, L. M., Beauregard, L., Boivert, J.M. et Plante-Jean, M-A. (2011). L'adaptation à la perte auditive chez la personne aînée : une transformation profonde insoupçonnée. *Vie et vieillissement*, 9(3), 26-33. 

5. Malchiodi, C. A. (2012). Handbook of art therapy, (2e éd.). Repéré à : <http://Owww.myilibrary.com/mercury.concordia.ca?ID=334047>
6. White, M. et Epston, D. (1990). Narrative means to therapeutic ends. New York, NY : Norton.
7. Hinz, L. D. (2009). Expressive Therapies Continuum: A framework for using art in therapy. New York, NY : Routledge.
8. Woolhiser S. J. (2010). Collage as a therapeutic modality for reminiscence in patients with dementia. Journal of the American Art Therapy Association, 27(3), 136–140. <http://doi.org/10.1080/07421656.2010.10129667>
9. Webster, J. D. et McCall, M. E. (1999). Reminiscence Functions Across Adulthood: A Replication and Extension. Journal of Adult Development, 6(1), 73–85. <http://doi.org/10.1023/A:1021628525902>



Image 2. Title: *Where there's a will, there's a way.* "Who would've thought that hearing is as important as sight? But even those who are hearing impaired can persevere and make their way in life."

Being gay in a heteronormative society

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It is with pleasure and great humility that I share my thoughts with you today. I'm certainly not an expert on seniors and the grieving process. On a personal level, I have grieved the loss of loved ones. But my greatest grief is of an entirely different kind. I'll come back to that in a minute.

Let me tell you a bit about my life. After dating a number of girls, I decided to settle down with a wonderful woman who told me from early on in our relationship that I wouldn't allow myself to be loved. "Finally, someone who understands me better than I understand myself!" I thought. I was married for 23 years and I have four children and seven grandchildren. They certainly help to give the impression I'm "normal"!

didn't know why. I was living a kind of personal and social schizophrenia: not understanding who I was and often feeling like a fake. When I began to understand, I constantly found ways to hide it. What if it were just a phase? What if I were bi? Did I need therapy? To put things in perspective: for most of my life, homosexuality was a sin, a crime and a mental illness. It's not a great way to start out in life—realizing you're not like other

greatest sadness is not being normal, according to our society. This sadness will stay with me for the rest of my life.

I decided I deserved to be myself. It was a risky move, because I had to control my image and I wasn't always sure how! Over the past 16 years, I've been able to come out to my kids, my grandchildren and a few special people. I choose who I tell and when. I came out of closet gradually and from time to time, but I often went back inside for fear of being judged and marginalized.

My greatest sadness is not being normal, according to our society. This sadness will stay with me for the rest of my life.

It was 23 years and four children later that I finally understood and was able to explain to my wife why I couldn't be loved. I didn't accept who I was, but I

people. At the time, I had no references, no role models.

I decided to be who I was and accept my homosexuality. My

I must confess I was somewhat reluctant to tell you my story today. I have good reason to be! Am I completely out of the closet? I'm not sure. I'll no doubt mention my children again ➤

when I feel the need to come across as normal. It works: "He can't be gay; he has kids!" It's a false stereotype, but it comes in very handy.

I still have trouble thinking about how people see me and worrying about being ostracized. I really don't want people to see me as a "queen," a pedophile or anything in between. I'm grieving the loss of a normal life, whatever normal is, as the ad says. We all know we live in a heteronormative world.

Psychoanalyst Elisabeth Kübler-Ross, a pioneer in the field of death and bereavement, once said, "Humans' greatest fear is not death; it's being judged by others."¹

My experience as a senior has officially begun—I'm 65 years old! For a few months now, I've been vice-president of Aînés et retraités de la communauté (ARC), an association founded 15 years ago with close to 200 members. We organize social, cultural and sports activities to break gay men's isolation (www.algi.qc.ca/asso/retraitegais). You'll notice that the word "gay" is conspicuously absent from our association's name. You could almost say we're a bunch of closeted gay seniors!

I agreed to come and talk to you today, because nobody else in our association was willing to do

it. Initially I planned on telling you their stories about grieving, but I soon realized that, to be authentic and engaging, I would have to focus on my own experience.

Divorce is a loss experienced by many gay men—an often brutal rupture with a person they have loved. It often involves a rupture with children and friends as well. "That's the price you pay for being a hypocrite," some mean-minded folks might say.

A difficult stage for the vast majority of seniors is moving into a retirement home. Several losses are experienced at the same time. For us gays, it could mean having to go back into the closet, because other residents in that micro-society might be homophobic. Even staff members are not always comfortable with this reality!

Let's talk now about real grief, following death. You can read some astonishing obituaries: "He joins Alice Robitaille on the other side, leaving behind his son, Paul, and many relatives and friends." Oops . . . they forgot to mention that he lived for 20 years with André. Was he his roommate? How is André coping with his grief?

When I was a teenager, I read a poem that touched me deeply. I thought about this poem the other day and finally understood its meaning, more than 50

years later:

*"I deny myself joy / A joy that is not mine / A joy of mine that I can't live / I deny myself a joyful me / I hear my light-hearted steps beside me / But I can't switch places on the sidewalk / I can't walk in those shoes and say: this is me."*²

Hector de Saint-Denys Garneau
[Translation]

1. An observation made by Elisabeth Kübler-Ross at a seminar/workshop given in Hull, Quebec, in the 1980s.
2. Excerpt from the poem "Accompagnement," by Hector de Saint-Denys Garneau, in *Regards et jeux dans l'espace*. Montreal: Biblio Fides, 2013, p. 81.

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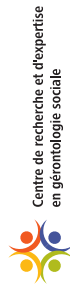
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Soins palliatifs à domicile pour les personnes âgées : l'approche interdisciplinaire
2 jours de formation

DATE & HEURE

Mercredi
20 janvier 2016
9 h -17 h

Jeudi
11 février 2016
9 h 00 -17 h 00

Jeudi
25 février 2016
9 h -17 h

Vendredi
26 février 2016
9 h -17 h

Mardi
8 mars 2016
9 h -17 h

Mercredi
23 mars 2016
9 h -17 h

Vendredi
1^{er} avril 2016
9 h -17 h

Jeudi
5 et 12 mai 2016
9 h -16 h 30

FORMATEURS

Zelda Freitas
Soutien aux proches aidants

Patrick Durivage
Soins palliatifs communautaires pour les aînés

Zelda Freitas
Soutien aux proches aidants

Samia Moussalam Issid
Santé mentale et vieillissement

Manon Parisien
Prévention-promotion, santé et vieillissement

Norma Gilbert
Prévention-promotion, santé et vieillissement

Samia Moussalam Issid
Santé mentale et vieillissement

Isabelle Van Pevénage et Patrick Durivage
Soins palliatifs communautaires pour les aînés

Site CLSC René-Cassin
5800, boul. Cavendish

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* 80 \$ (dîner non inclus)

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* 80 \$ (dîner non inclus)

6^e étage, salle 31
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6^e étage, salle 31
* 80 \$ (dîner non inclus)

6^e étage, salle 31
* 40 \$ (dîner non inclus)

6^e étage, salles 19-20-21
* 40 \$ (dîner non inclus)

6^e étage, salle 31
* 80 \$ (dîner non inclus)

CLSC Benny Farm
6484, Av. de Monkland
3^e étage, salle 304
* 160 \$ (dîner non inclus)

PERFECTIONNEZ VOS CONNAISSANCES SUR LE VIEILLISSEMENT.

INSCRIVEZ-VOUS AU CERTIFICAT DE GÉRONTOLOGIE.

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Femmes et vieillissement
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Le grand âge
Méthode de recherche en sciences
humaines et sociales
Physiologie et vieillissement
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La relation d'aide en gérontologie
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maltraitance chez les aînés
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