



# Happily Ever After

SR. JULIA UPTON, RSM, PhD, MPH

**Y**ears ago, a friend and I went to see the Broadway production of Stephen Sondheim’s musical *Into the Woods*. The first act ends with all the fairy-tale characters’ complicated situations resolved in a “happily ever after” style.

“It’s over?” my friend asked, surprised that the show was ending so soon.

“No,” I replied. “This is intermission.”

“But what could come next?” he further probed.

“Not so happily ever after!” I answered, to which he just groaned.

No one’s life journey is as smooth or simple as those fairy tales led us to believe. Throughout life’s ups and downs, twists and turns, we need support and encouragement to maintain health—physical, emotional and spiritual—particularly in our later years. Rather than “happily ever after,” we seek a more realistic and achievable goal: to live the best life possible all our days.

What does the “best life possible” look like? Most people, when asked, value health above all else. The World Health Organization Constitution (1946) defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” As a theologian, I would add spiritual well-being to that list. As people are living longer, often needing to move to long-term care residences, maintaining well-being can be challenging. Too often residences are designed to serve staff needs rather than residents’ needs. Resident-centered or, even better, resident-directed residences are more life-giving for all. Residents report being happier and healthier with fewer hospitalizations and staff report a stronger sense of purpose.<sup>1</sup>

Public health has begun to focus more on well-being rather than the absence of disease or chronic conditions. There are several iterations

of the “domains of well-being,” but the one developed in 2005 by The Eden Alternative, a nonprofit organization dedicated to improving the lives of elders and their care partners in all living environments, is comprehensive.<sup>2</sup> Rather than relying just on the more traditional measure of “quality of life” or “quality of care,” which come from the biomedical model, the “domains of well-being” address the individual person as a whole. They include:

■ **Identity** — being me, well-known, having personhood, individuality.

■ **Connectedness** — being with, belonging, engaged, involved.

■ **Security** — finding balance, freedom from doubt, anxiety or fear.

■ **Autonomy** — seeking freedom, liberty, self-determination, self-governance.

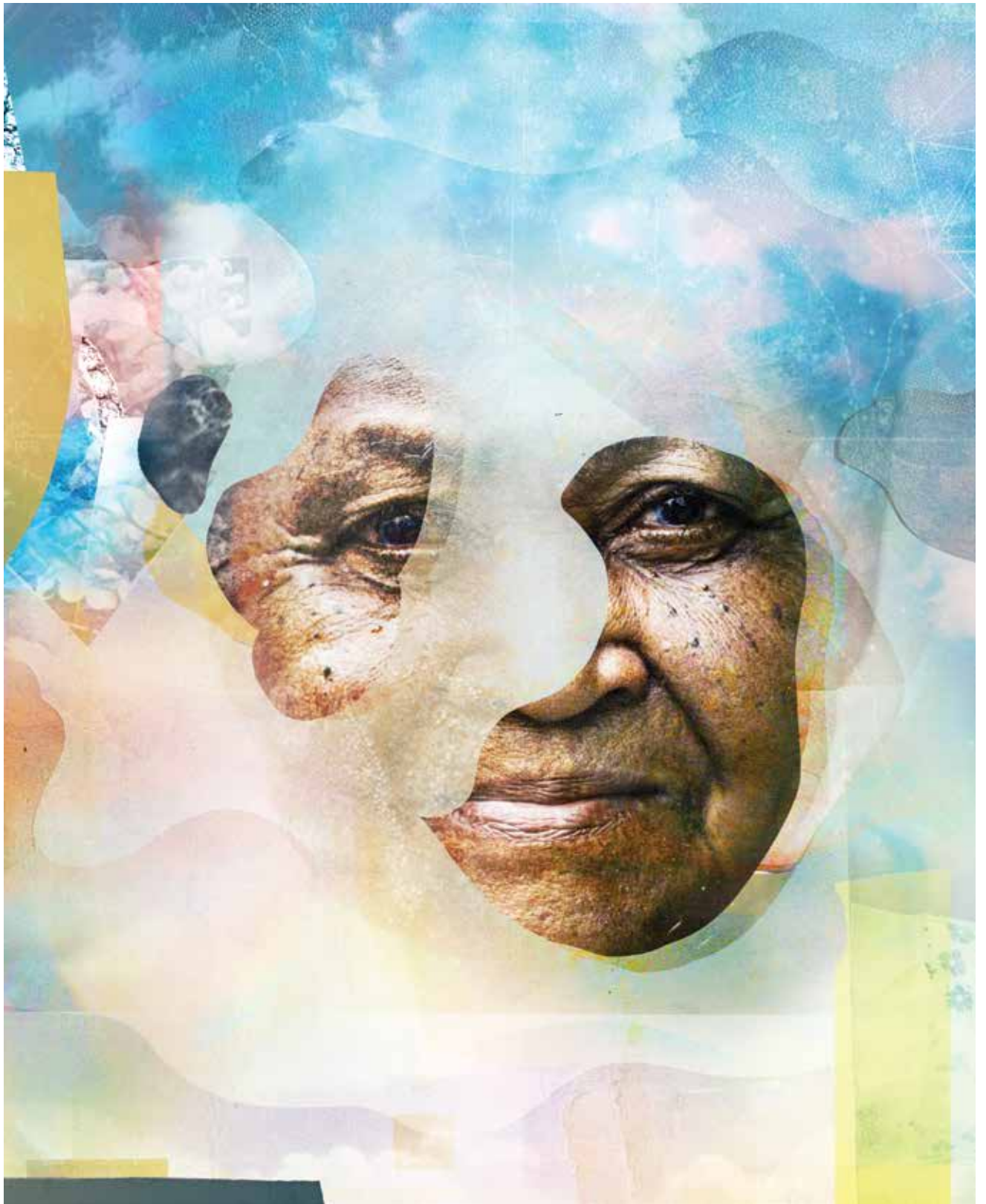
■ **Meaning** — making a difference, significance, hope, purpose.

■ **Growth** — growing and developing, enriching, unfolding.

■ **Joy** — having fun, expressing happiness, pleasure, delight.

It is not difficult to envision how these pandemic times are having an impact on the well-being of us all, but it is possible to address each of the domains in spite of one’s physical health or living situation.

Much of society’s understanding of human psychosocial development is based on the work of Erik Erikson (1902-1994). In a series of essays published in the 1940s he began to work out what



we now know as the stages of psychosocial development.<sup>3</sup> Erikson's theory described the impact of social experience across the whole lifespan, building one upon the other. Each stage was marked by successfully resolving a conflict in a way that struck a balance between two poles. The last stage in Erikson's original construct, occurring during "old age" (age 65 to death) is resolving the conflict between Integrity and Despair. Erikson held that when death is approaching, everyone, whether consciously or unconsciously, enters a life review process, balancing life's successes and disappointments to arrive at a resolution, seeing life ultimately as meaningful or meaningless or somewhere in between.<sup>4</sup>

Since 1950 when Erikson began publishing, life expectancy in the United States has increased 17.7 years.<sup>5</sup> That would give a person almost an extra 20 years to resolve the identity crisis. The Swedish social gerontologist Lars Tornstam pioneered another approach to the last stage of life with his doctoral thesis on aging at Uppsala University in 1973. He theorized a more open-ended approach to the last stage of life which he named gerotranscendence. It was not Tornstam's intention to nullify the work of other theorists, but he believed that some elements of their theories were not applicable to the very old.<sup>6</sup>

Gerotranscendence provides a paradigm for understanding the developmental process of aging, which is evident on three levels: the cosmic level, the level of self, and the level of social and personal relations.<sup>7</sup> Tornstam's construct notes the following characteristics about the very old.

- There is an increased affinity with past generations and a decreased interest in superfluous social interaction.

- There is also often a feeling of cosmic awareness of being in both the past and present simultaneously, and a redefinition of time, space, life and death.

- The individual becomes less self-occupied and at the same time more selective in the choice of social and other activities.

- The individual might also experience a decreased interest in material things.

- Solitude becomes more attractive.

To younger people or even to medical personnel these characteristics might be viewed as path-

ological and therefore they might misunderstand. Such implicit bias might result in discouraging the very aspects that indicate well-being among the very old.

Whenever I have presented the concept of gerotranscendence to older adults, I see lots of head-nodding, and later conversations reveal that participants were actually relieved to have their experiences validated. If staff and family members were aware that the characteristics of gerotranscendence were not only normal, but actually desired, they might alter their expectations and

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personalize their care. This could increase everyone's sense of well-being.

One way to provide support for older adults would be to ask questions regarding their experience. For example, one could say to an elder, "Some people say that their concept of time has changed. The past is so strongly present that they almost live in it at the same time as they live in the present. Have you experienced something similar?" While that might elicit a simple "No!" it might also open up an important conversation about the past, maybe how childhood memories are more vivid than ever before. When I would visit my elderly aunt in her residence, I would take along the family genealogy. Although my aunt was blind by that point, she helped me fill in the blanks on our family tree while relating wonderful family stories I had never heard before. Well-tailored questions can open up the cosmic dimension while acknowledging and appreciating increased interest in the past.

Too often we rely on "How are you feeling?" as the opening question with someone. Intended or not, that question immediately focuses on the elder's physical self, which leads too easily to discussion of decline and limitations. Choose some other topic instead. Consider a conversation beginning like this, "Some people say that as they age they discover sides of themselves they hadn't known before. Have you made any discoveries



like that?” Although that also might lead nowhere, it could also open up an unexpected conversation on self-discovery. Where there is life there is growth and change on many levels.

Make room in the conversation for thoughts about death. If an older person leads the conversation in that direction, it is likely an important issue for them. Too often such conversations are aborted because the family or caregiver is uncomfortable with the topic. As family and staff, it is essential to listen to the elders and acknowledge their feelings. Fear of death generally decreases with age and questions about life after death emerge. Once I was invited to give a sermon at evening prayer in an upscale continuous care residence. In it I suggested residents might approach life’s next great adventure the way they had prepared for other travel adventures in their lives. While there is no Michelin guide to the afterlife, there is Scripture, the work of spiritual writers, the stories of others and even the daily news that can lead one to anticipate crossing to the next world as an adventure.

The third level of gerotranscendence, in which an elder’s attitude toward social and personal relationships begins to shift, is too often viewed negatively as “social disengagement.” The need for positive solitude is not automatically a manifestation of loneliness. Out of choice some elders opt out of activities that lack content, preferring the company of a few like-minded people to a large crowd playing bingo. They might even prefer their own company or that of a good book. Designing new types of activities such as reminiscence therapy or a meditation course could foster the older person’s personal growth. Encouraging and facilitating quiet and peaceful times and places would also go a long way to improving residents’ well-being.

In 1982 Erikson and his wife Joan Erikson (1903-1997) published *The Life Cycle Completed*, but as he grew deeper into the eighth stage of his own life, Erikson began to rethink the completeness of their work. Shortly before he died, Joan Erikson found her husband’s copy of *The Life Cycle Completed* and saw that no page was free from underlining, highlighting or annotation. She began to wonder what they all meant. Soon she began to

revise their work, adding to their understanding of the life cycle. *The Life Cycle Completed – Extended Version* (1998) includes final chapters written by Joan Erikson, revising their schema to include a ninth stage whose focus is on transcendence. She finds fault when gerontologists use the term “gerotranscendence” without fully exploring the new and positive spiritual gifts it brings. “Perhaps they are just too young,” she suggests. “With great satisfaction I have found that ‘transcendence’ becomes very much alive if it is activated into ‘transcendence,’ which speaks to soul and body and challenges it to rise above the dystonic, clinging aspects of our worldly existence that burden and distract us from true growth and aspiration.”<sup>8</sup>

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The concluding lines of Mary Oliver’s poem “When Death Comes” reflect the thoughts of most of the elders with whom I have worked in recent years:

When it’s over, I don’t want to wonder  
if I have made of my life something particular, and real.  
I don’t want to find myself sighing and frightened  
or full of argument.

I don’t want to end up simply having visited this world.

This is the fullest life possible that everyone in the healing professions should be helping to provide to everyone in their care. Eternal life is ours now, today. Living fully in that reality is the challenge of using the gifts that have been given. Some day we will slip across the road and know eternal life in its fullness, but for now we listen to the Holy Spirit who is ours in Baptism, knowing that we are beloved and sharing that love with the world.



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#### NOTES

1. Michael Lepore et al., "Person-Directed Care Planning in Nursing Homes: A Scoping Review," *International Journal of Older People Nursing* 13 (2018), <https://doi.org/10.1111/opn.12212>.
2. G. Allen Power, *Dementia Beyond Disease: Enhancing Well-Being* (Baltimore: Health Professions Press, 2017) 23-37. This model was developed by 12 experts in transformational care called together by The Eden Alternative.
3. These essays formed the basis for Erik Erikson's first book, *Childhood and Society* (New York: W. W. Norton, 1950).
4. Simon Hearn et al., "Between Integrity and Despair: Toward Construct Validation of Erikson's Eighth Stage," *Journal of Adult Development* 19 (2012) 1-20.
5. Jochen Klenk et al., "Changes in Life Expectancy 1950-2010: Contributions from Age- and Disease-specific Mortality in Selected Countries," *Population Health Metrics* 14 (2016) 20.
6. Lars Tornstam, *Gerotranscendence: A Developing Theory of Positive Aging* (New York: Springer, 2005).
7. Lars Tornstam, "Gerotranscendence—A Theory about Maturing into Old Age," *Journal of Aging and Identity* 1 (1996) 37-50.
8. Erik H. Erikson and Joan M. Erikson, *The Life Cycle Completed - Extended Version* (New York: W. W. Norton, 1998) 127.

### QUESTIONS FOR DISCUSSION

Sr. Julia Upton, RSM, is a theologian and public health specialist. She takes a particular interest in older people in terms of a person's spiritual depth and their right to move into their final years with the best opportunities for fulfillment. Her article "Happily Ever After" discusses what elements of happiness are unique to the elderly and what interactions, memories, honest questions and preferences for silence might lead to a more realistic and peaceful transition to the Ever After.

1. Upton argues that "quality of life" is too vague a term and puts forth seven domains of well-being identified by the Eden Alternative that can explore the well-being of elders in a more holistic way. Of the seven, security, autonomy and meaning seem the most obvious. How important do you think identity, connectedness, growth and joy are in older people? How does your organization attend to these domains in the elders you serve?

2. Conversation about death is difficult for most of us. Yet Upton explains it is sometimes the conversation that older people often want to have. How does your organization train caregivers and family members to become comfortable when patients/residents want to talk about death? During the pandemic, how can such conversations take place without adding to the anxiety the patient might have?

3. Upton uses the term "gerotranscendence" to describe how an older person might begin to separate from some of the things, people and interests of their life in order to give greater attention to things that really matter. Have you experienced this in people you love or patients you've felt close to? Is your ministry able to offer activities like reminiscence therapy or meditation courses to support people in this personal pursuit?

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