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Life review work

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ABSTRACT

This article discusses structured life review activity with psychotherapy students at Auckland University of Technology (AUT). Overseas research is cited indicating that structured life review group activity may prevent or ameliorate depression in older people, which is under-diagnosed in Aotearoa New Zealand. The article suggests undertaking New Zealand research to support seeking funding to initiate life review group work with older people in the community.

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Life story work with adult students

In the Human Development Paper (a course taught by the author) in the Graduate Diploma in Psychotherapy at Auckland University of Technology (AUT), adult students in their twenties, thirties, forties and fifties study psychosocial and psychodynamic theories of human development from conception to ageing, then critically apply developmental theories to their own life experiences. In the paper the students use the ideas of 'developmental tasks' (Erikson, 1982) and 'creative adaptations' to shape their analysis of how they became unique individuals with their own personalities, and, specifically, of ways in which they are both similar to and different from their parents. Creative adaptations refer to emotional and/or physical strategies adopted by the individual to manage unconscious or conscious anxieties. A simple example of creative adaptation is a child who feels that her mother is emotionally fragile and not capable of looking after her and who might adapt by becoming the caregiver of her own mother in a reversal of roles. The child who adopts this strategy in relation to her mother may become an adult who cares for others at the expense of her own well-being. Another example is a child who was bullied and who may, in an attempt to negate the feeling of being a helpless victim, bully others both in childhood and adulthood. In supporting students through their reflective process and reading and assessing their analysis of their own life histories over the last 15 years, I am left with an appreciation of the emotional depth and integrity that emerge as they make meaning of their histories. Their stories reveal how they have faced sometimes painful or traumatic life events; how they have overcome adversity, achieved healthy adjustment and become functioning adults; and how they have developed the volition to help others by training to be psychotherapists.

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One learning outcome of the paper is that students will 'demonstrate the ability to describe [their] own emotional responses and creative adaptations to life experiences, and critically reflect on the meaning in the context of [their] own development' (AUT, 2017) – and in acknowledgement of this approach to the work, this year the paper was renamed 'Psychosocial Life Review'. The abilities required by the paper are considered to be requirements of working successfully as a psychotherapist, and while the paper/course itself is not intended to be psychotherapy, students report that writing their life story and using psychosocial developmental theories to understand it in a new way is a therapeutic experience for them. This was one of my reasons for investigating the possibility of using reminiscence and life story work for older adults.

International research (in Canada, Holland, Japan, the UK and the USA) on 'structured life review' and 'reminiscence' work cites empirical evidence for the effectiveness of various life story activities in increasing emotional and psychological well-being and mitigating symptoms of depression and anxiety in adults of all ages, including those in advanced age (Housden, 2009; Hsieh & Wang, 2003; Korte, Bohlmeijer, Cappeliez, Smit, & Westerhof, 2012; Webster, Bohlmeijer, & Westerhof, 2010). This affirmed my impressions of the effects of the life history analysis activity in the human development/life review paper. Somewhat surprisingly, I was unable to find any research published in Aotearoa New Zealand indicating the presence of active reminiscence and life story work here.

The New Zealand context of positive ageing and mental health

Investigating the New Zealand context of caring for elders, I attended a day conference on spirituality in palliative care at Selwyn Village, Point Chevalier, Auckland. Conversations with two gerontologists (Dr Michal Boyd of Auckland University and Dr Chris Perkins of Selwyn Village) confirmed that they were not aware of any reminiscence and life story work happening on a formal structured basis in Auckland, although individual nurses when time permitted were encouraging patients to reminisce. An email to the CEO of Age Concern Counties Manukau confirmed the lack of structured reminiscence and life story work in Auckland. However, I was invited to attend the Age Concern research planning day in November 2015. Both Selwyn Village and Age Concern represent possible venues for a group activity or research study. (In 2017, I intend to investigate the possibility of undertaking a research study through the AUT Centre for Active Ageing.)

In its Healthy Ageing Strategy, the New Zealand Government (2002) acknowledged that 'depression is often missed at the primary care level or misidentified as loneliness, ageing or dementia' (p. 41). The strategy includes a plan to support community-based group activities to help facilitate the diagnosis and treatment of depression in old people. Despite the apparent clarity of government strategy, in terms of mental health and emotional well-being, the focus of the health system as it currently operates seems to be on helping those who are already depressed or mentally unwell, rather than on actively promoting well-being. It is hard to avoid the inference that government strategy represents aspiration rather than reflecting the presently existing reality of the New Zealand health system. The national depression initiative (NDI) focuses on cure rather than prevention. Television advertising featuring ex-All Black John Kirwan aims to de-stigmatize depression by associating it with an admired sporting high achiever, and encourages depressed people in the community to seek help. However, there appears

to be no government-led or health system-led proactive initiative to encourage positive ageing or the prevention of depression in older people.

An Australian report on psychology and ageing (Pachana, 2013) notes that in residential care only a minority of older patients with anxiety or depression (15–36%) are recognized in this setting; most of these patients go untreated. Pachana has worked as a psychologist in New Zealand as well as Australia, and reports that the situation in this country is similar to that in Australia; this would seem to be confirmed by the New Zealand *Best Practice Journal* (*BPJ*, see next section).

Depression is regarded in the medical context as a discrete diagnosable disorder that can best be treated by manualized, experimentally validated treatments or EVTs; this is reflected in the choice by the administrators and doctors in New Zealand District Health Boards (DHBs) to treat depression using cognitive behavioural therapy (CBT), which is considered to be an EVT. However, there is a discourse within the psychotherapy world that sees the term 'depression' as a convenient portmanteau within which to locate a vast and varied array of differing forms of human mental suffering, with each sufferer needing individualized treatment. On this basis, the validity and relevance of the evidence that supports CBT is questioned. For example, Nancy McWilliams, a contributor to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) (*DSM-5*), puts it like this:

> To reason backwards to the conclusion that therapists, in working with complexly suffering people who are often filled with shame for seeking help, should treat disorders as separable from personality and context, should manualize their work, and should take objective measures before and after a delimited treatment conflates the demands of one field (empirical research) with the demands of another (applied clinical practice). (McWilliams, 2010, p. 71)

A manualized standardized treatment takes no cognisance of individual differences in personality, temperament, learning style, culture, belief, sexual orientation, socioeconomic status and other factors, and it ignores the possibility that individual differences in practitioners may also influence treatment outcomes. A fuller exposition of the debate can be found in work by House and Lowenthal (2008), but in a neoliberal health environment, business-oriented health authorities, such as New Zealand DHBs, will probably continue to purchase EVTs because they appear to administrators to be the best value for money, representing a brief time-limited treatment. Psychodynamic psychotherapy can frequently be long term, because it aims at personality change rather than symptom relief; the structured life review is time limited, usually to eight sessions, and on that basis may appeal to DHB administrators.

As mentioned above, I would like to initiate a structured life review activity in the community or in a residential care setting; when this has been completed, it may be possible to seek funding from a DHB for further structured life review activities in health settings, and possibly also to seek funding to train care professionals in facilitating the process. 'Selling points' for a DHB might include that the activity is supported by research as a brief and effective intervention to alleviate symptoms of depression and anxiety.

Positive ageing, losses and depression

The New Zealand Ministry of Social Development (MoSD) has a positive ageing strategy (MoSD, 2014) that advocates individuals ageing in good health and being independent,

connected, respected and able to enjoy life. The vision statement includes older people contributing expertise and skills to the community and workforce, and providing positive role models for younger generations. The strategy names 10 goals from which government agencies and communities can develop initiatives for positive ageing, 'spanning the spectrum of health, financial security, independence, self-fulfilment, personal safety and living environments'; goals include secure income, equitable, timely, affordable and accessible health services, housing, transport, ageing in the community, culturally appropriate services and positive attitudes. Mental and emotional health are clearly included, but the prevailing under-diagnosis and under-treatment of depression in New Zealand (see above) indicates that the strategy is aspirational rather than descriptive of present reality.

A challenge for older people is to retain positive mental and emotional attitudes in the face of the inevitable physical losses of ageing. Gawande (2014) describes a daunting list of the processes of physical ageing, and it is no surprise that some ageing people experience difficulty in accepting and integrating these losses, and consequently become depressed. The challenge of retaining mental health is complex: the next section will discuss how Erik Erikson's life stage theory can help us understand this. From a sociological perspective on ageing, Edmondson (2015) mentions the social construction of ageing, with an attendant concatenation of prejudices, habits and structures that are pervasive throughout Western societies, and cites Simone De Beauvoir's (1996) often-quoted comment:

> the meaning or the lack of meaning that old age takes on in any given society puts that whole society to the test, since it is this that reveals the meaning or the lack of meaning of the entirety of the life that leads to that old age. (Cited in Edmondson, 2015, p. 83)

In the light of de Beauvoir's comment, the strategy of the New Zealand MoSD can be seen as an attempt to counter negative prejudices and evoke a positive change in societal views of ageing and its meaning.

Referring to both physical and psychic causes of depression, Couve (2007) mentions that the 'connection between loss, separation, and depression is quite accepted today, both within and outside psychoanalytic writings on the subject' (p. 35). Couve notes that within the psychoanalytic tradition, 'depression is not seen as a result of loss but, more specifically, as a result of an inability to deal with loss or as a result of an inability to do the work of mourning' (p. 36). I will suggest in this article that a structured life review group activity has the potential to provide support for older people to deal with the inevitable losses of the ageing process, and to do the emotional and psychological work of mourning.

Therapeutic aspects of reminiscence and life review

The process of writing one's life history and thinking about its meaning in a structured framework was experienced as therapeutic by adult psychotherapy students; one important therapeutic aspect seemed to be the reworking and re-evaluation of memories in a new and more positive way. Students re-evaluate where they started and where they have arrived and, to paraphrase T. S. Eliot (1947/1971), came to know the place for the first time or in a different way. Events that had been negatively evaluated can be seen as difficulties overcome, or as building blocks of a new capacity to cope with life's challenges.

More positive evaluation of one's success in handling difficulties appears to contribute to more positive evaluation of the self who overcame them.

Of course, the challenges of becoming an adult psychotherapist differ from those of facing into the ageing process. In his seminal (1963) paper, Robert Butler, a geriatrician, gerontologist and psychiatrist, described the positive benefits of reminiscence in later life. His paper marked a change in societal attitudes to the ageing process, and it was he who coined the term 'ageism'. Butler found that most health professionals in the US ignored and disparaged 'elderly' adults, and was consequently enraged and spurred into action. In his first book, *Being Old in America*, he warned: 'when we talk about old age, each of us is talking about his or her own future' (Butler, 1975, pp. 2–3), and he set about encouraging a national plan to empower older persons.

Before Butler's paper, the view was common in many human service occupations that 'reminiscence encourages people to live in the past' and could cause or deepen depression or other pathology and cause people to turn away from the present, and occupational therapists 'were to divert the old from reminiscing through activities such as bingo and arts and crafts' (Gibson, 2004, p. 43). In his 1963 paper, Butler stated that he believed reminiscence was a universal, spontaneous and natural phenomenon occurring throughout the lifespan, and it was 'characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence of unresolved conflicts' (p. 66). Butler wrote about his clinical observation 'of an increase of reminiscence – the act or process of recalling the past – in older people' (p. 67) and postulated that this was due to the universal occurrence of an inner experience or mental process of reviewing one's life. Butler hypothesized that this was caused by the 'realisation of approaching dissolution and death, and the inability to maintain one's sense of personal invulnerability' (p. 67).

Butler later introduced the idea of life review as a therapeutic intervention that helped older adults with the developmental task 'to clarify, deepen, and find use of what one has already obtained in a lifetime of learning and adapting' (Butler, 1974, p. 531). Therapeutic benefits accrue from revisiting unresolved conflicts: this was based to some extent on Erikson's epigenetic model of identity formation, where 'identity is never established as an achievement, as something static or unchangeable, but is a continually revised sense of reality of the self within social reality' (Erikson, 1968, p. 211). Epigenesis, a term from biology, refers to the self or ego developing through an organic process, where different qualities and capacities unfold through a series of bipolar, psychosocial 'crises', leading to eventual psychosocial integration of the individual in the world.

Each bipolar crisis is resolved more or less successfully, forming the basis for the next crisis or developmental stage. For example, in infancy, the bipolar tension is between trust and mistrust; between one and three years of age, the child faces the crisis between autonomy and shame. Without defining every life stage here, I note that in adulthood the crisis is that of generativity (being procreative, or productive in other ways) versus stagnation, and in old age it is ego integrity versus despair, as we face the deaths of loved ones, losses of ageing, and our own imminent mortality. The developmental crises can be viewed as occurring naturally in every human being. Each crisis first arises in the individual at a particular point in the lifespan, assumes primacy, and is negotiated more or less successfully, to whatever extent; it is not resolved once and for all, but constantly revisited over the lifespan whenever the individual encounters circumstances that evoke it. For example, we emerge from infancy with some experience and understanding of trust and mistrust, but our

trusting will be challenged and extended in future experiences of going to school, making and losing friends, first job, losing a loved one – and ageing.

The developmental task of old age is understood as a quest for meaning, dependent on resolving the tension between what Erikson terms the bipolar opposites of (1) ego integrity and (2) despair. Failure to resolve this tension leads to depression, the medical term for despair, and the process takes place within the search for meaning, personal and societal.

Developmental experiences, memory and reminiscence

Just as we revisit each developmental crisis many times over the lifespan, thus extending our coping capacity and modifying our self-concept, we also revisit and remake memories each time we recall them or share them. According to Gibson (2004), contemporary brain science suggests that our memories are not fixed and unchangeable, but are dynamic and 'provide the basic bricks for constructing and re-constructing our life stories that represent our unique identity' (p. 3). While we cannot consciously remember our earliest infancy, according to Erikson (1968) we carry with us the capacities, abilities and assumptions about ourselves in relationship that we developed during our pre-verbal life, as well as memories that we can consciously recall from later life stages. Gibson (2004) reminds us that our memories are not accurate records of events, but are constantly reconstructed, and while there is no agreed standard definition of reminiscence, it is probably more accurate to refer to 'reminiscence, recall, review, and partial reconstruction' (p. 5).

If I may offer a (simplified) personal example. I served in the Israeli army between 1964 and 1967. In my thirties when I shared this story I presented myself as a brave young man among men fighting for right; in my fifties the story had changed to one of regret at my youthful folly, and the sadness and futility of attempting to solve political problems by military means. The experiences I had at 20 were still with me in my fifties, but their meaning had changed, and I had also changed my self-concept. Needless to say, the memory, and aspects of my self-concept derived from the memory, were repeatedly revised and remade in my sixties and seventies. My changing view of my history is perhaps consonant with Heidegger's (1927/1962) comment: 'What we have in mind with the term "history" is not so much "the past" in the sense of that which is past, but rather *derivation* [herkunft] from such a past' (p. 430). The past, in Heidegger's view, can still be present with us and affect us in the here and now. In a life review activity like the above brief example, the actual past events are irretrievably in past time, but they continue to have effects in the unfolding present subjectivity of the individual, and are susceptible to continuing revision and reinterpretation; the act of reinterpretation modifies the present subjective reality.

I will leave a more thorough discussion and definition of memory and reminiscence for another occasion, but note that it is the possibility of reconstruction and re-evaluation of memories and self-concepts that point towards the therapeutic potential of life review and reminiscence in later life. To some extent, our memories are myths that we construct, and we live by them; myths, while they may not have happened, embody the truths of our subjective experience. A similar theme is discussed by developmental psychologist and psychoanalyst Daniel Stern (1985), who differentiates between the infant who can be directly observed by a developmental psychologist and the 'clinical infant' that is 'reconstructed by psychoanalytic theories in the course of clinical practice primarily with adults' (p. 14). Stern notes that a clinical infancy is a construct 'created to makes sense of the

whole early period of a patient's life story, a story that emerges in the course of its telling to someone else' (p. 15).

Discussion: reminiscence and life review

> Reminiscence is regarded as part of autobiographical memory and life review as a special kind of reminiscence. (Gibson, 2004, p. 3)

What differentiates the life review from a spontaneous introspective process of reminiscence is an evaluative process in the reviewer. The process may be facilitated by the presence of an active listener who supports the reviewer; the listener may be trained or untrained. The listener may provide a structure within which the review takes place. For example, Haight and Haight (2007) describe a 'structured life review' model that prescribes eight sessions, with questionnaires for each session based on Erikson's eight life stages model (discussed above).

The desire to be heard and the potential power and significance of attentive listening presence is well encapsulated in this plea from Seneca the Younger, the ancient Roman philosopher and statesman:

> Here I am: this is me in my nakedness, with my wounds, my secret grief, my despair, my betrayal, my pain which I can't express, my terror, my abandonment. Oh, listen to me for a day, an hour, a moment, lest I expire in my terrible wilderness, my lonely silence. Oh, God, is there no one to listen? (Seneca, cited in Saunders, 2006, p. 219)

Cecily Saunders was the founder of the modern hospice movement.

To a psychotherapist's ear, Seneca's heartfelt plea to be listened to and heard prefigures the 'talking cure' of Breuer and Freud in the nineteenth century, and the proliferating host of talking therapies that exist in the twenty-first. These include reminiscence in the sense employed by Butler (1963) in his seminal article, in which he noted the importance of reminiscence and life review in successful adaptation of older adults. Research on the effectiveness of psychotherapy (e.g. Roth & Fonagy, 2004; Ryan, 2005) notes the centrality of the relationship between the client and the psychotherapist whose trained listening and relationship skills facilitate a healing process in the client.

Butler thought that the life review could be silent or oral, conscious or unconscious. It might be experienced through dreams, or for some individuals as fleeting thoughts, or it might take the form of nostalgia and regret, or in a more negative form as anxiety, guilt and depression rather than integration and contentment. In the 50 years since Butler's article, much research has been done on reminiscence, and on facilitating life review activity in a structured form, in groups or individually (e.g. Gibson, 2004; Haight & Haight, 2007; Westerhof & Bohlmeijer, 2014). Jeffrey Webster (1993) produced a 43-item reminiscence functions scale (RFS) organized according to eight functions of reminiscence, by administering questionnaires to males and females of various ages and educational, cultural and ethnic backgrounds from young adulthood to later life:

1. Boredom reduction: having something to do.
2. Death preparation: valuing the life lived and becoming less fearful of death.
3. Identity: discovering and better understanding a sense of who we are.

4. Problem-solving: drawing on strengths and experience from the past for coping in the present.
5. Conversation: rediscovering common bonds among old and new friends.
6. Intimacy maintenance: remembering personally significant people.
7. Bitterness revival: sustaining memories of old hurts and justifying negative thoughts and emotions.
8. Teach/inform: teaching younger people including family members the value of history.

Webster's scale constitutes an experimentally validated taxonomy, which is useful to guide research and practice. It can be seen that function 7, bitterness revival, is unlikely to aid the psychological integration of the individual and is likely to accentuate depressive tendencies. Function 8, teach and inform, may be of benefit to the reviewer and to the listener, but probably lacks an evaluative component that could lead to ego integration. Gibson (2004) notes that reminiscence is unlikely to be suitable for 'people who are excessively private; have psychotic ideas; are very hostile toward others; or are hyperactive, habitually fearful, or obsessive' (p. 27). Similarly function 1, boredom reduction, offers only transient entertainment benefits. However, Gibson observes 'for most people facing present difficulties recalling and reviewing the past can illuminate the present and provide hope for the future' (2004, p. 27).

Ageing in a neoliberal health system

The term 'neoliberalism' comprises two ideas, namely neo meaning new, and liberalism meaning freedom from government intervention. Liberalism stems from the work of Adam Smith in the eighteenth century, who advocated a minimal role for government in economic matters so that trade could flourish. In developed Western economies like the US, the UK and in New Zealand, this economic mindset was displaced in the 1930s by Keynesian economics, and government intervention in welfare and health came into favour. However, in the 1970s there was a resurgence of neoliberalism (in the UK with the rise of Thatcherism's call to 'roll back the state', in the US under the aegis of Ronald Reagan's 'Reaganomics', and in New Zealand with the rise of Roger Douglas's 'Rogernomics' [Collins, 1987]). This created a political climate driven by an ideology of worker self-sufficiency and individual responsibility, with citizens seen as consumers who always make rational economic choices in their own economic self-interest. Welfare states like New Zealand 'were accused of exerting a damaging fiscal drag on Western economies and discouraging working at a time when a rapid transformation of those economies was needed' (Macnicol, 2015, p. 35). In the 1970s, the rising price of oil triggered inflation and massive economic restructuring, with private capital moving out of manufacturing and into service-based sectors such as the privatized health care, insurance and private pensions industries.

In the neoliberal environment, the ageing person remains a rational consumer of public goods, with health care being one of these goods. The term 'consumer' fails to highlight inequalities between various social groups because patients, unlike consumers, do not have any significant power when it comes to influencing decisions made in relation to health care (Horton, 2007). Older people often experience economic hardship, inability to work, and poor physical or mental health, and therefore have more need of help and

care, which under neoliberalism become goods and services to be purchased from a health service structured as a profitable business.

An ideological tenet of neoliberalism (not supported by research) is that private markets are more cost-effective and consumer friendly than the state; consequently, the essence of neoliberal health care reformation is cost cutting. Discussions of the health care system involve a special vocabulary:

> spending cuts, dismantling, deficit-cutting, downsizing, declining welfare state, competitiveness, inefficiencies, inevitability, closures, cutting services, de-insured, user pay fees, for-profit health care, escalating costs, free markets, erosion of health care, difficult policy choices, unfortunate necessities and justifiable sacrifices. (Horton, 2007)

The New Zealand Ministry of Health's (2011) policy document 'Better, Sooner, More Convenient Health Care in the Community' advocates moving aspects of health care from hospitals into the community with services being provided by GPs and nurses, with guidance from hospital medical professionals. In what could be seen as an ironic counterpoint to 'Better, Sooner, More Convenient', an article by Corazon Miller in the *New Zealand Herald* reported that members of the Public Services Association (PSA) working in DHBs were considering strike action on the grounds that 'a plan to stretch staff across seven days when we aren't even funded or staffed for five will put patient care at further risk and push staff to exhaustion' (Miller, 2015).

In the overstretched New Zealand public health system, it is hardly surprising that 'depression in older people is often under-detected and untreated and should never be regarded as a normal consequence of ageing' (*BPJ*, 2011, p. 2). The journal further notes that the diagnosis of depression can be confounded by other disorders associated with ageing, or depression may be incorrectly accepted as a normal part of the ageing process. Currently there would seem to be some dissonance between the New Zealand government's *Health Of Older People* (2002) strategy and the reality of under-detection and treatment of depression.

As mentioned above, this author would like to initiate a structured life review activity in the community or in a residential care setting; when this has been completed, it may be possible to seek funding from a DHB for further structured life review activities in health settings, and possibly also to seek funding to train and supervise care professionals in facilitating the process. 'Selling points' for a DHB might include that the activity is increasingly supported by research (Housden, 2009; Hsieh & Wang, 2003; Korte et al., 2012; Westerhof & Bohlmeijer, 2014) as a brief and effective intervention to alleviate symptoms of depression and anxiety. However, the status of much of the existing qualitative research on structured life review might not satisfy the evidence base criteria for research acceptable by the Cochrane Collaboration, the leading source for systematic reviews in health care. The Cochrane Collaboration website has a 2005 systematic review on 'reminiscence therapy' for dementia sufferers, but to date (2015) does not have an entry for the 'structured life review' intervention, which is not a therapy per se, but does have therapeutic effects, as described above (http://www.cochrane.org/search/site/life%20review%20therapy). I imagine that structured life review interventions might attract funding from DHBs if there were Cochrane-accepted studies that provided evidence of the efficacy of structured life review as an intervention that ameliorates or prevents depression and improves quality of life in older people.

As Jan Baars, Professor of Interpretive Gerontology, argues, the thinking of most gerontologists and health system administrators is constrained by a quantitative and chronometric approach to gerontology and social legislation that measures social, demographic, health and other characteristics of older persons taken from the outside (see my review of his book *Ageing and the Art of Living*, in this issue [Solomon, 2017]). The result is that 'all aspects of human beings that cannot be captured in quantitative models are neglected' (Baars, 2012, p. 145). This makes it hard for administrators to value, and fund, the subjective experience of older people who are preoccupied with making meaning of their overall life history, while integrating what Eric Erikson (op. cit.) called the psychosocial crisis of ego integrity versus despair (see above). With a chronometric and qualitative mindset, administrators are ill-equipped to value the subjective need of older people for an attentive and empathic listener who can respond to what Seneca characterized (see above) as their nakedness, their wounds, their secret grief, their despair, their betrayal, their pain which they can't express, their terror, their abandonment, their lonely silence. A psychosocial life review group, conducted by a psychotherapist, can provide a facilitative and trusting climate in which older adults might share and integrate troubling unresolved life experiences. I would like to see psychosocial life review group activity become more available to older adults in our communities.

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No potential conflict of interest was reported by the author.

Notes on contributor

Paul Solomon is a psychoanalytic psychotherapist. He teaches in the psychotherapy programmes at Auckland University of Technology, and has a private practice in Grey Lynn in Auckland. Born in the UK, he lived in Israel (kibbutz Mahanayim) from 1962 to 1965, then served in the Israeli Defence Force until 1967. After returning to England, he gained a Certificate in Education at Goldsmiths College, and later became a social worker on the Isle of Dogs, London, qualifying in psychiatric social work also at Goldsmiths College. On arriving in Aotearoa New Zealand in 1984, he practised social work in the psychosomatic pain programme in Auckland Hospital, then in the Starship Child and Family Unit. Paul has practised vipassana meditation and Taiji for some years.

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