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Wisdom at the end of life: Hospice patients’ reflections on the meaning of life and death

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The processes of aging and confronting mortality are often accompanied by unique psychological challenges. From the perspective of positive psychology, such challenges can yield opportunities for growth, including increased wisdom. This qualitative study explored 15 terminally ill hospice patients’ perspectives on wisdom, the dying process, and the meaning of life using consensual qualitative research methods. Most participants cited humility as a key component of wisdom, emphasizing that “Wisdom is when we realize ‘I don’t really know much.’” Other components of wisdom included self-knowledge, rationality, experiential learning, listening to and learning from others, and sharing knowledge with others. Participants also suggested that the process of facing illness and death presents opportunities for positive growth, including changing priorities and learning to appreciate life more fully in the present moment. In considering the sources of meaning in their lives, participants emphasized relational connections, personal growth, spirituality, vocational fulfillment, and living a full life. Participants also shared their reflections on important past experiences and regrets. Lastly, participants offered advice to others based on their experiences facing illness and mortality. Implications for psychological care of the dying and future research are discussed.

Keywords: wisdom; terminal illness; positive psychology; end-of-life; posttraumatic growth; hospice; meaning

Globally, the proportion of older adults (aged 65 and over) is rapidly growing compared to any other age group, whereby older persons will outnumber children ages 0–9 by 2030. It is estimated by 2050, the aging population will to grow from 8.5 to 17% of the world’s population (He, Goodkind, & Kowal, 2016). As the world population ages and the average lifespan continue to increase, there is increased recognition of the need for psychological care for people facing advanced illness. The process of dying, beyond the physical consequences recognized by the medical paradigm, has psychological, social, and spiritual implications including profound challenges like loss of autonomy and sense of meaning in life (Chochinov et al., 2009). The continued debate over, and legalization of, physician-assisted suicide for the terminally ill in some regions of the world provides

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further impetus for the role of professional psychology in quality end-of-life care (American Psychological Association, 2016). Despite this recognition, research on psychotherapy for patients with advanced illness who are receiving palliative care is limited compared to other areas of clinical practice (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003; Kasl-Godley, King, & Quill, 2014; Nydegger, 2008).

Counseling psychology, a discipline that emphasizes strengths including resilience in the face of developmental challenges (Gelso, Nutt Williams, & Fretz, 2014; Steffen, Vossler, & Joseph, 2015) is well-positioned to work toward better understanding and caring for those at the end of life. Unfortunately, however, the lack of research in this area has hampered our knowledge of this often marginalized population. Although the American Psychological Association (2014) has published guidelines for clinical practice with the elderly, a literature search yielded no corresponding guidelines for competent practice with the dying.

Death presents a great and unavoidable challenge for all human beings, and is the source of much concern and anxiety (Yalom, 1980). In fact, some theorists suggest that much of human behavior may be motivated by the unconscious awareness of mortality (e.g. Terror Management Theory; Solomon, Greenberg, & Pyszczynski, 1998). In Western culture, people may tend to respond to awareness of death by openly denying it or repressing thoughts about death as a strategy to buffer against existential anxiety (Becker, 1973).

On the other hand, Kübler-Ross’s (1969, 1975) seminal work with the dying paved the way for increased attention to the psycho-social-spiritual aspects of death and dying. Notably, her work suggested that the process of confronting death can yield an opportunity for growth in addition to suffering (Wong & Tomer, 2011). A positive psychological approach, consistent with the work of Victor Frankl (1959), would suggest that the processes of seeking meaning and reorienting one’s sense of self at the end of life can be paradoxically productive and life-affirming (Breitbart, Gibson, Poppito, & Berg, 2004; Wong & Tomer, 2011). Based on this perspective, we conducted the present qualitative study with hospice patients in order to explore the positive dimensions of facing the end of life.

Wisdom and positive psychology

“Positive psychology” is a movement within psychology which suggests that social and behavioral science researchers should work to identify positive qualities, strengths, and actions that contribute to personal well-being, rather than focusing on the negative aspects of human experience or functioning (Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005). Further, in their review of the literature, Lopez and Snyder (2004) concluded that peak individual functioning, attained through hope, coping, and relationships are predictive of better health outcomes, including lower mortality.

As one aspect of well-being, wisdom is a valued trait across cultures (Seligman & Csikszentmihalyi, 2000). Recently, the construct has gained the attention of researchers as a hallmark of optimal human functioning (Bangen, Meeks, & Jeste, 2013; Choi & Landeros, 2011). In their review literature on virtues and character strengths across various philosophical and religious traditions, Dahlsgaard, Peterson, and Seligman (2005) concluded that wisdom is explicitly mentioned or implied as a major human
virtue in Confucianism, Taoism, Buddhism, Hinduism, Athenian philosophy, Christianity, Judaism, and Islam.

Although a single theoretical definition of wisdom has not yet emerged (Staudinger & Glück, 2011), wisdom is generally agreed to consist of cognitive, affective, and behavioral components (Staudinger, Dörner, & Mickler, 2005). Ardelt and Edwards (2016) defined personal wisdom “as an integration of cognitive, reflective, and compassionate (affective) personality qualities” (p. 503). Of relevance to the present study, in the context of aging and dying, Erikson (1964) described wisdom as an “informed and detached concern with life itself in the face of death itself” (p. 133). Based on the findings of studies in positive psychology, Peterson and Seligman (2004) defined wisdom as a set of character strengths, including creativity (the ability to solve problems in novel and flexible ways), curiosity (maintaining interest in continuing experiences), open-mindedness (examining things from different perspectives), love of learning (interest in gaining knowledge and skills) and perspective (the ability to share advice or wisdom with others).

In a recent comprehensive review of the theoretical and empirical literature on wisdom, Bangen et al. (2013) concluded that the most commonly cited elements of wisdom included: (a) social decision-making/pragmatic knowledge of life (practical life skills and knowledge, social reasoning, ability to give good advice); (b) prosocial attitudes/behaviors (attitudes that benefit others or society as a whole, and includes empathy, compassion, warmth, altruism, and sense of fairness); (c) reflection and self-understanding – (self-knowledge and awareness, and the ability to introspect and gain insight and intuition to the self); (d) acknowledgement of coping effectively with uncertainty (the ability to recognize and navigate through ambiguity); (e) emotional homeostasis (controlling and regulator one’s emotions in the midst of difficult circumstances). Less prominent subcomponents of wisdom, present in fewer than half of the reviewed definitions in the wisdom literature, included “(1) value relativism and tolerance, which involves a nonjudgmental stance and acceptance of other value systems; (2) openness to new experience; (3) spirituality; and (4) sense of humor” (Bangen et al., 2013, p. 1256).

Literature in development across the lifespan suggests that life-long psychological growth contributes to positive aging (Ardelt & Edwards, 2016; Erikson, 1982; Maslow, 1971). Erikson (1982, 1964), in his influential model of psychosocial development, divided the lifespan into eight stages consisting of specific developmental struggles. According to that model, wisdom is linked with the resolution of the final stage, integrity versus despair, suggesting that wisdom acquired throughout the lifespan may help older adults face the inevitable challenges that are part of the aging process with acceptance as opposed to despair (Ardelt & Edwards, 2016).

Wisdom is associated with better health and higher quality of life among the elderly (Ardelt, 2000). Indeed, some research suggests the combination of wisdom and other positive personal traits such as sense of mastery and sense of purpose in life may contribute more to elderly adults’ subjective well-being than factors like socioeconomic status or physical well-being (Ardelt, Landes, Gerlach, & Fox, 2013). Similarly, Ardelt and Edwards (2016) found that wisdom was positively related to late life subjective well-being even after controlling for advantaged life conditions and demographic factors, suggesting that well-being is not only affected by circumstances, but also by the degree of wisdom accumulated by older adults over the course of a lifetime.
longitudinal study, Ardelt (2016) found that wisdom appeared related to positive subjective well-being, sense of purpose in life, mastery, and physical well-being in older adults.

Limited research has examined the mechanisms through which wisdom affects well-being. Etezadi and Pushkar (2013) found that higher levels of wisdom substantially predicted positive affect and the relationship between wisdom and positive affect was fully explained by adaptive coping style, sense of meaning, and perceived control. The relationship between wisdom and sense of purpose in particular is consistent with findings that a person’s sense of meaning and purpose in life are primary to flourishing and well-being (Park, 2014). In the context of terminal illness, wisdom may help the dying to set and achieve meaningful attainable goals, even while facing the social and physical losses that accompany life’s end stages (Ardelt & Edwards, 2016; Baltes & Freund, 2003).

Wisdom and post-traumatic growth at the end of life

Evidence from studies in positive psychology indicates that in many cases growth arises from adversity – a phenomenon known as post-traumatic growth – wherein experiencing and overcoming suffering helps people to experience positive psychological changes (Tedeschi & Calhoun, 2004). Indeed, individuals demonstrate personal growth through facing challenging or traumatic challenges (Bonanno, 2008; Linley & Joseph, 2004), the positive benefits of which may include increased wisdom (Webster, 2013; Webster & Deng, 2015), intrapersonal strengths, psychosocial growth, and increased psychological well-being. Moreover, traumatic events can lead people to question their values and core assumptions (Webster & Deng, 2015).

A growing body of research suggests that facing the profound challenges of aging and facing serious illness may represent an opportunity for post-traumatic growth. One systematic literature review (Barskova & Oesterreich, 2009) of 68 empirical studies on post-traumatic growth after illness diagnosis concluded that post-traumatic growth appears to be an adaptive trait in the face of serious illness, and is associated with patients’ approach to coping, social support, and various mental and physical health factors. The role of post-traumatic growth as a protective factor has been supported by a growing body of research. Sawyer, Ayers, and Field (2010), in a meta-analysis of 38 quantitative studies exploring the post-traumatic growth among patients with cancer or HIV/AIDS, concluded that post-traumatic growth can both arise from adversity associated with illness and help patients in coping with it:

The findings from this study suggest that shortly after the event [such as diagnosis or illness onset] PTG may be used as a coping strategy to manage and reduce emotional distress associated with the illness threat. However over time PTG grows and is more significant in enhancing positive well-being. (p. 444)

They found that post-traumatic growth was associated with fewer negative and more positive mental health symptoms, as well as higher subjective ratings of physical health. A systematic review of 57 qualitative studies (Hefferon, Grealy, & Mutrie, 2009) on growth and life-threatening illness found four major common themes across studies, suggesting that people facing life-threatening illness: (1) reappraise their priorities in life; (2) often associate trauma with the development of the self; (3) experience existential
re-evaluation (e.g. of spirituality, meaning in life, and mortality); and 4) come to a new awareness of their physical selves.

While the literature described above appears to support the relationship between illness and post-traumatic growth, only a small number of studies have explored this relationship from the first-person perspectives of those facing advanced illness. One study of patients suffering with chronic pain (Owens, Menard, Plews-Ogan, Calhoun, & Ardelt, 2016) found that participants identified a number of improvements in growth and wisdom as a result of facing illness, including improvement in relationships, greater clarity, and changed perspectives. In one qualitative study, Kinnier, Tribbensee, Rose, and Vaughan (2001) found that those who had faced a life-threatening situation were less worried and more optimistic about humanity, endorsed less materialism and more pro-social feelings and spirituality. In another qualitative study, Choi and Landeros (2011) interviewed older adults, who had been nominated as wise, about their perceptions of wisdom gained from life challenges. Participants reported having learned lessons about acceptance, forgiveness, patience, focus on the present, positivity, ability to accept support, gratitude, and perseverance from their confrontations with aging and life’s challenges.

Prior research on this topic provides a glimpse into the potentially positive aspects of confronting advanced illness and mortality. However, these questions have not previously been explored from the first-person perspective of those currently facing imminent death (a population which, intuitively, possesses unique “expertise” in this area). The present qualitative study explored terminally ill hospice patients’ perspectives on wisdom, meaning, life, and mortality as they confronted death and the dying process. Specifically, the present study sought to explore how a group of terminally ill patients nominated as “wise” defined wisdom and its relationship to the dying process, their perspective on personal growth over the lifespan (including at the end of life), and their sense of meaning in life in the context of terminal illness. The present study contributes to the research literature in its exploration of connections between wisdom, post-traumatic growth, meaning in life, and the experience of terminal illness, from the unique vantage point of people actively confronting the end of life. In addition, we anticipated that participants’ first-person narratives would offer counseling psychologists a more nuanced understanding of the lived experience of an often-neglected and marginalized clinical population.

Method
Participants
Fifteen (11 women, 4 men; 14 European Americans, 1 African American) terminally ill people enrolled in a home-based hospice care program in the Northeastern United States were interviewed for a study on “wisdom.” Participants were informed that we were interested in their perspectives on wisdom and what is important in life and facing the end of life. Information on participants’ age, sex, primary diagnosis, religious affiliation, and education level were obtained via electronic medical records at the hospice organization providing care for participants. Participants’ average age was 74.47 years (SD = 15.86). Primary medical diagnoses included various cancers (n = 9), congestive heart failure (n = 4), amyotrophic lateral sclerosis (n = 1), and pulmonary fibrosis.
Participants identified their religious affiliations as Protestant Christian \((n = 6)\), Roman Catholic \((n = 4)\), unaffiliated/nonreligious \((n = 3)\), Mormon \((n = 1)\), and Native American spirituality \((n = 1)\). Educational information was only available for 11 participants through electronic records, with highest attained education levels including some high school \((n = 1)\), high-school diploma \((n = 5)\), college degree \((n = 3)\), master’s degree \((n = 1)\) and doctoral degree \((n = 1)\).

**Interview protocol**

A preliminary semi-structured interview protocol was developed based on a review of the current literature and the authors’ clinical experience. Some questions were adapted from prior qualitative studies of wisdom among the elderly (Choi & Landeros, 2011) and those who had faced death (Kinnier et al., 2001). Some questions were also adapted from the interview protocol for dignity therapy (Chochinov, 2012), a psychotherapeutic intervention designed to help terminally ill patients create a written “legacy document” expressing their important memories, beliefs, and values. The protocol was modified through consultation with two experienced physicians with expertise in palliative care who had each served as chief medical officers for a hospice and palliative care center in the northeastern United States. The final protocol contained 13 questions designed to elicit participants’ perspectives on wisdom, the dying process, and the meaning of life (see Appendix 1). Interviews were conducted in a semi-structured fashion, and all participants were asked each question in the protocol in the same order as listed in Appendix 1. Additional probing questions (e.g. “Could you say more about that?”) were utilized to elicit deeper or more detailed discussions. For all participants, the final question (What has it been like talking about this with me today?) was used to facilitate debriefing.

**Procedures**

Potential participants were identified through a nomination procedure, designed to identify participants who exemplified the qualities of wisdom, similar to the procedure used by Choi and Landeros (2011). An interdisciplinary team of hospice clinicians (physicians, nurses, social workers, chaplains, and expressive therapists) was presented with the results of a review of the wisdom literature (Bangen et al., 2013). Based on their end-of-life expertise and the five major components of wisdom identified by that review (i.e. Social decision-making and pragmatic knowledge of life; Prosocial attitudes and behaviors; reflection and self-understanding; acknowledgment of and coping effectively with uncertainty; emotional homeostasis), clinicians identified and nominated hospice patients who they perceived as being particularly wise and who met the inclusion criteria.

Inclusion criteria for this study included: Enrollment in a hospice home care program, a life expectancy of fewer than 6 months, and aged at least 18 years. Participants with a significant barrier to communication or a thought disorder (e.g. delirium, dementia) were excluded from consideration.

Nominated potential participants were approached by one of the first two authors and informed about study’s procedures, risks, and benefits. The primary risk identified was potential emotional distress elicited by discussing illness and mortality. This ethical
consideration was addressed through careful monitoring of participants’ emotional state, informing participants that they were free to withdraw from the study or take a break at any time and referral to participants’ social workers and chaplains. In order to minimize potential burden or fatigue for the terminally ill participants, only one interview was conducted with each participant. The procedures for this study were reviewed and approved by the Institutional Review Board (IRB) at a University in the northeastern United States.

Sixteen of the nominated patients satisfied study inclusion/exclusion criteria, provided informed consent and agreed to participate. One participant who experienced a severe physical decline prior to the interview was excluded, resulting in a final sample of 15 participants. Interviews were conducted in participants’ homes, and began with an overall discussion of the purpose of the study. The 15 interviews averaged 49 minutes in length (SD = 15.41). The first author conducted 7 of the interviews, and the second author conducted 6. Two interviews were conducted jointly by both the first and second authors. All interviews were digitally audio-recorded and transcribed by a third-party service following IRB-approved data security procedures.

Analysis

A qualitative method was chosen for this study due to limited prior research on the topic and our goal to explore participants’ first-person narratives about wisdom and the dying process. For this reason, transcribed data were analyzed using the consensual qualitative research (CQR; Hill, 2012; Hill et al., 2005) method. This type of investigation utilizes a group approach to analysis as a way of offsetting individual team member biases, including the use of an external auditor who checks counterbalances the primary coding team.

Through an alternating process of individual analysis and group discussion, the four members of the primary team worked through the CQR process of defining major domains (coding material into major topic areas), identifying core ideas (extracting and summarizing the main points from each participant’s narrative within each domain), and cross-analysis (identifying themes across core ideas within each domain). During group discussions, the primary analysis team (the first four authors) negotiated to consensus regarding the best way to conceptualize findings, exploring them through the lens of primary team members’ differing perspectives.

The first four authors served as the primary team for CQR analysis, while the fifth author served as auditor for that analysis. The first author was a 29-year-old European-American male PhD student in counseling psychology. The second author was a 31-year-old European-American female clinical researcher at a hospice organization. The third author was a 29-year-old European-American female clinical researcher at a hospice organization. The fourth-author was a 36-year-old Asian-Canadian female director of research at a hospice organization. The fifth author was a 35-year-old female European-American professor of psychology with research interests focused on the intersections of identity development and health. The first four authors all had at least two years of research experience in a hospice and palliative care setting and prior experience with CQR methods. The first three authors possess master’s degrees in counseling and have had prior counseling experience with hospice patients.
All members of the primary team had participated in prior qualitative and quantitative studies of hospice patients’ experiences, including previous experience conducting CQR. At each stage of the process, the auditor (the fifth author), an experienced researcher with expertise in the areas of personal identity and health, provided feedback and suggestions regarding the primary team’s analysis. The primary team revised their findings in light of the auditor’s feedback. In CQR, this auditing process helps to offset the potential for group-think amongst the primary team.

**Researcher biases and expectations**

Due to the personal philosophical nature of questions about wisdom and the meaning of life, it was important to consider all findings in the context of research team members’ personal worldviews. In accordance with CQR principles (Hill, 2012), the team members examined and discussed their biases and beliefs surrounding these questions, and considered the relevance of these biases during each stage of analysis.

Team members’ religious affiliations ranged from practicing Christians to agnostics and atheists. All expressed a sense of the importance of spirituality, and the influence of the dominant Euro-Christian worldview in the United States on their beliefs. Due to the relative homogeneity of the team in terms of age (range 29–36), race/ethnicity (4 European-Americans, 1 Asian-Canadian), and gender (4 women, 1 man), the analytical process emphasized reviewing findings critically in light of the team’s dominant cultural perspectives while considering alternative viewpoints.

Team members emphasized their perception of wisdom as a trait, which is often developed with age or experience. The team members expressed the belief that wisdom includes learning to appreciate connections in the form of relationships, love, and spirituality. Additionally, traits like openness to new experiences or ideas, humility, and reflectiveness seemed important to wisdom. Having worked with hospice patients for some time, the team members expected that participants’ responses would be consistent with what they had previously heard about wisdom from patients facing death.

**Results**

Following CQR methodology (Hill, 2012; Hill et al., 2005), the representativeness of emerging qualitative themes was calculated based on the number of participants’ narratives that fit into each category. Categories were labeled “general” if they occurred in all or almost all cases; “typical” if they represented more than half of cases; and “variant” if they occurred in fewer than half of cases. Due to the large number of categories in the present analysis, only the general and typical categories are discussed in depth, with the exception of variant findings that the team deemed clinically relevant or pertinent to the aims of the present research study (consistent with recommendations from Hill, 2012). For example, one of the study’s primary aims was to explore terminally ill hospice patients’ perspectives on wisdom. Therefore, variant findings regarding the nature of wisdom are reported in more depth. For this study, general categories emerged in 14–15 cases, typical categories were found in 8–13 cases, and variant categories occurred in 2–7 cases. In instances where core ideas emerged from only one individual’s transcript, data were placed in the “other” category under the respective domain and are not reported here. All domains and categories are summarized in Table 1.
Table 1. Domains and categories of participants’ discussion of wisdom at the end of life.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Category/subcategory</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Nature of wisdom</td>
<td>Humility</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Intellectual understanding</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Learning from experience</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Sharing knowledge with others</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Listening to and learning from others</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Spirituality</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Self-knowledge and self-awareness</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Acceptance of life or present circumstances</td>
<td>Variant</td>
</tr>
<tr>
<td>(2) Facing illness and death</td>
<td>Dying is an opportunity for positive growth</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Changing priorities and values</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Enhanced appreciation of life in the present moment</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Provides opportunity to reflect</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Increased wisdom</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Leads to self-improvement</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Increased sense of purpose</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Strengthened relationships</td>
<td>Variant</td>
</tr>
<tr>
<td>Challenges at the end of life</td>
<td>Inability to do important or meaningful things</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Family challenges</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Physical challenges</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Legacy</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Aftermath concerns</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Loss of autonomy</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Isolation</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Learning to accept help</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Difficulty accepting impending death</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Dying with dignity or dying well</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Fear and/or uncertainty</td>
<td>Variant</td>
</tr>
<tr>
<td>Coping with illness and death</td>
<td>Receiving support from others</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Developing an accepting attitude</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Religious/spiritual comfort</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Humor</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Hospice care</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Finding or making meaning despite illness</td>
<td>Variant</td>
</tr>
<tr>
<td>(3) Personal meaning</td>
<td>Relational meaning</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Helping others</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Social connections</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Passing on wisdom to younger people</td>
<td>Variant</td>
</tr>
<tr>
<td>Development of self</td>
<td>Being a good person/living in accordance with values</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Finding meaning in challenges</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Openness to learning</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Pursuing a purpose</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Career and vocation</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Spirituality and religion</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Living a full life</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Hobbies or enjoyable activities</td>
<td>Typical</td>
</tr>
</tbody>
</table>
The most prominent theme, a typical finding emerging from participants’ discussion of wisdom, was the importance of humility. As Participant 14 explained, “I think we should be humble. Because you know when you think you’re doing really well and you’re patting yourself on the back, that’s probably not when you’re at your best.” Participants typically emphasized the perspective that humility involves acknowledging the limitations of one’s own knowledge. As one participant succinctly stated, “Wisdom is when we realize ‘I don’t really know much’” (P8). Another participant expressed awareness of the apparent paradox that wisdom can arise from surrendering the idea that one has knowledge: “A lot of people think they have to have the answer. It is okay to say ‘I don’t know.’ That is wisdom there” (P5). Others noted that the process of cultivating humility is difficult but worthwhile:

### Table 1. (Continued).

<table>
<thead>
<tr>
<th>Domain</th>
<th>Category/subcategory</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Living in the moment</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Sense of humor</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Attaining a sense of peace</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Dying with dignity</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Lessons learned</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Importance of connections and relationships</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Worry less what others think</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Challenges can lead to growth</td>
<td>Variant</td>
</tr>
<tr>
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<td>Increased self-awareness</td>
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<td>Missed opportunities</td>
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<td>Not treating others well</td>
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<td>No regrets</td>
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<td>(4) Reflecting on the past</td>
<td>Advice for caregivers</td>
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<td></td>
<td>Be caring and compassionate</td>
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<td>Listen to the dying</td>
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<td>Take care of yourself, too</td>
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<td>Advice for those facing illness and death</td>
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<td>Strive for acceptance</td>
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<td>Develop a positive attitude towards illness and death</td>
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<td></td>
<td>Seek support</td>
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<td></td>
<td>Resolve unfinished business</td>
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<td>Be open</td>
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<td>Advice for all</td>
<td>Typical</td>
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<td></td>
<td>Seek out the positive and live in the moment</td>
<td>Variant</td>
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<td>Be open-minded</td>
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<td></td>
<td>Reflect and/or learn from experience</td>
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<td></td>
<td>Be considerate of and help others</td>
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<td>Pursue happiness and fulfillment</td>
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<td>No advice – everyone’s journey is different</td>
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Note: General = 14–15 cases; typical = 8–13 cases; variant = 2–7 cases.

**Nature of wisdom**

The most prominent theme, a typical finding emerging from participants’ discussion of wisdom, was the importance of humility. As Participant 14 explained, “I think we should be humble. Because you know when you think you’re doing really well and you’re patting yourself on the back, that’s probably not when you’re at your best.” Participants typically emphasized the perspective that humility involves acknowledging the limitations of one’s own knowledge. As one participant succinctly stated, “Wisdom is when we realize ‘I don’t really know much’” (P8). Another participant expressed awareness of the apparent paradox that wisdom can arise from surrendering the idea that one has knowledge: “A lot of people think they have to have the answer. It is okay to say ‘I don’t know.’ That is wisdom there” (P5). Others noted that the process of cultivating humility is difficult but worthwhile:
Humility is probably one of the hardest things it is for a human being to do … and with humility comes wisdom. I think they go hand in hand together. I don’t think you can have one without the other. (P3)

Variant components of wisdom identified by participants included intellectual understanding, learning from experience, sharing knowledge with others, listening to or learning from others, spirituality, self-knowledge, and self-awareness, and acceptance of life or present circumstances. As one participant summarized, “[Wisdom is] a combination of intellect and experience, taking what you have gone through in your life … and utilizing it either to help somebody else in their life…or to help your own life” (P5). Similarly, another participant said, “[A wise person] would have a lot of empathy and listen well … a lot of book knowledge as well as experience knowledge and knowledge of the environment, the people around them, and acceptance” (P9). One participant who emphasized the importance of both rationality and sharing knowledge with others said,

[Wisdom] is marshalling a lot of facts and then making use of them so that they don’t just sit in a bunch of facts but you can manipulate them so that you can solve problems and share it with others. (P12)

Some participants also noted the importance of spirituality and acceptance in wisdom. For example, one participant described wisdom as “accepting that life is not perfect. Life doesn’t have to be perfect. I just need to take the blessings that come to me and make progress from yesterday.” (P1)

Facing illness and death
Participants generally described their experience of confronting mortality as an opportunity for positive growth. As one participant stated, “A tremendous opportunity for growth comes out of being sick, and growth often comes from things we don’t want to deal with” (P8). Specific opportunities for growth fell into several typical and variant categories.

Participants typically reported that facing the end of their lives had changed their priorities and values in a positive way. For example, one participant suggested that

[getting cancer] opens up your eyes to the possibilities of life can be cut short. I don’t think people get that perspective very often … I treat [my life] so much better as a beautiful journey and gift and don’t take it lightly.(P10)

Another stated, “[Illness] has taught me to be a nicer person and not be in such a hurry … Because what am I am hurrying for? It is going to happen anyway” (P7).

Participants also typically reported that confronting illness and death had taught them how to appreciate life more in the present moment. As one participant put it, “I want to live until I die. I don’t want to die until I die” (P1). Another participant stated, “illness itself will make you appreciate the value of life more, especially when it gets terminal” (P6). Participants expressing this point of view often emphasized that they were able to find ways to appreciate life despite the limitations they were facing. As one participant said
I know I have cancer. I know there are things that I cannot do. I can’t bend down without falling over. I have to be careful with stuff like that. But I don’t feel like my life is over. I still go to dinners, go out to lunch with my friends or do what I can when I want to actually [depending on] how I feel. (P7)

One variant finding relevant to the aim of this study was some participants’ view that illness can foster wisdom: “[Illness] definitely makes you wiser, smarter if you let it” (P10). The growth-promoting component of facing death was further exemplified by participant 10’s statement that “[facing illness] has made me stronger. It has made me capable of things I never thought I was capable of.”

Participants also generally acknowledged the many difficulties and sources of suffering associated with the end of life. Typical challenges included an inability to do important things (e.g. spending time with loved ones, pursuing passions and hobbies), family-related difficulties (e.g. caregiver burden, concerns about the aftermath of one’s death), and the physical aspects of illness (e.g. pain, functional limitations, side effects of medication). Despite these challenges, patients’ approaches to coping with the dying process exemplified a positive growth orientation. Typical approaches to coping included seeking support from others, developing an accepting attitude, and finding comfort in spirituality or religion. As one participant reported, “Death doesn’t have to be a bad thing. It can be a thing where you just look at it and accept it for what it is” (P3).

**Personal meaning**

The personal meaning domain included participants’ perception of the meaning of life and reports about the sources of meaning in their lives. Generally, participants reported finding a sense of meaning through relational connections. Typical sources of relational meaning included helping others, family, and social connections. Examples of these themes are highlighted in responses such as

> The connection that you have with somebody else, whether it is man, woman or child … [is what] we were put on Earth for, in my opinion … You can find out a lot about yourself by paying attention to how your relationships go with others. (P5)

and “The point is you live and you keep on living and loving and giving and that makes you feel good” (P4).

Participants also generally described finding meaning in their experiences of growing and developing as people. Typical responses within the “development of self” category referred to the importance of being a good person and living in accordance with one’s values, finding meaning in challenges, being open to learning, and pursuing a sense of purpose. One participant connected her personal development to relational meaning, “I guess [the meaning of my life] is to be the best I could possibly be and offer to others as much as I could possibly offer to others. Those are my goals. Nothing fancy. Very simple.” (P8) Another participant connected her personal growth to her vocation, “The more I learn to help me grow as a person, I know that is helping the students. And the better I can help the students I feel like I am doing my job as a teacher” (P1).
Participants typically indicated deriving a sense of purpose through their career and vocation. For example, one participant who ran a family restaurant stated, “There is joy in another person liking what you have done. That was my homemade soup” (P15). Another typical source of meaning was spirituality and religion, including one participant who stated, “I feel like the universe was built, it was created on a spiritual foundation and we are spiritual beings, and to take that and try to grow with it” (P3). Participants also typically expressed the value of living a full life in terms of finding meaning, or as one participant elaborated, “Being satisfied with what I was challenged with” (P4). Typical responses that accompanied those individuals who expressed their lives as being full included the pursuit and development of creativity and enjoyment through hobbies in music, art, design, gardening, travel, or personal collections and interests. “We were happy planting a tomato garden … not that I am telling everyone how to live their life you know. But I found it made for happiness. We look for happiness. More than money” (P6).

Reflecting on the past

Most participants discussed the importance of past events on the course of their lives. Typically, participants identified previous life experiences that they deemed significant in terms of lessons learned. Specific lessons learned included several variant results: the importance of developing and maintaining connections and/or relationships; worrying less about what others think; increased self-awareness; the idea that challenges can lead to growth; the importance of self-awareness; and the that perfection is neither important nor attainable.

Participants’ reports of lessons learned within this domain are exemplified by one participant’s reflective response, “I have learned this, to be as sane and serene and peaceful as possible” (P1). Another participant reported, “You can live your life so honestly when you really come to terms with what it is that makes you happy in life and go with it. I have become a much better person for that, you know” (P10). While reflecting on what was once important in the past but was currently not as important, Participant 10 continued,

I think [when you are] younger in life you get caught up in what other people think of you … and you want to be somebody for somebody else. I think when you can find out who you are and do things for yourself, you made it. I think that has changed for me.

Another participant shared, “I don’t think I care about pleasing other people as much as I used to … Everybody has a different path to take in life and they should follow that, they shouldn’t follow what other people want them to do” (P14).

Participants also typically reported regrets, which typically involved missed opportunities. For example, one participant responded, “I never finished high school. I regret that I didn’t” (P11). Another participant shared, “Looking back, I should have done more instead of thinking ‘this is good that I’m doing this’. No, I should have been a little more humble and challenged myself more.” (P14) Other, more variant regrets involved not treating others well. As one participant reported,
My biggest downfall to myself has always been to hold a grudge … now I see that spiritually it not only hindered me, I held myself back. It didn’t do me any good … I wish I would have been more of a forgiving heart. (P3)

Some participants indicated having no regrets (a variant finding). These participants reported a sense that the experiences throughout their lifespan had helped shape the course of their lives. They explained that dwelling on regrets would have prevented them from becoming who they are. As Participant 10 stated, “I wish I would have believed in myself a little bit more earlier on in life but other than that I am so lucky because I have lived a really beautiful life.”

Advice
Participants were asked for their suggestions to other people about living life and facing the dying process, including advice for those providing care to the terminally ill. Typically, participants emphasized the provision of compassion and kindness. As one participant stated, “Kindness and compassion go a long, long way” (P8). Another participant specified the importance of being present and supportive, “support them. Try to be understanding, talk, communication is the most important thing that you can do” (P10). A related variant category included the importance of listening to the dying:

listening and communicating are the two biggest pieces of advice I could give … talk about everything. Don’t be afraid to just say your feelings because the person knows it if you are hiding things like that. A person feels it. (P10)

Yet another variant category was the importance of self-care for caregivers. In the words of one participant, “You are number one … if you don’t take care of yourself it will show … in your eyes … in your face … in everything you do” (P16).

To people encountering challenges while facing illness or their own impending mortality, participants offered several variant categories of advice including: develop a positive attitude, strive for acceptance, resolve unfinished business, be open, and seek support when needed. As one participant described, “whatever the thorns are in [a person’s] heart that are hurting see if they can’t find someone to help them understand what’s going on and help pull the thorns out so they can heal before they die” (P1). Another participant shared, “It is your attitude that will do it … just the idea of what you do with it and how you handle it. That makes the difference” (P4).

Participants also offered variant categories of life advice to others in general (i.e. people not necessarily facing terminal illness). These suggestions included seeking out the positive in daily life and living in the moment, being open-minded, and being considerate of and helpful to others. As one participant summarized, “Happiness is not necessarily getting out on the floor and dancing … there is a contentment that goes along with what you do …whatever you are doing” (P15). Emphasizing the importance of living for today, one participant suggested, “I would say you shouldn’t put off doing what you want to do until tomorrow because you might not get tomorrow” (P13). Another cautioned against living according to others’ expectations, stating “You can take advice from other people but at the end of the day, you only get one life, you might as well live it the way you want” (P14).
Finally, the dying process was described by some participants as a highly personal experience. Several participants explained that they felt it would be inappropriate to give general advice because it is such a personal experience ... Everybody is going to deal with it different. I don’t want you to think you are doing it wrong if you don’t do it the way I do it. This is just what works for me. (P10)

Discussion

This study sought to explore questions surrounding wisdom, meaning in life, and the dying process from the developmentally unique perspective of terminally ill hospice patients.

Despite the many challenges they were confronting, participants generally viewed the dying process as an opportunity for positive growth, with some participants associating dying with increased wisdom. Consistent with the tenets of positive psychology (e.g. Park, 2014; Tedeschi & Calhoun, 2004), participants described having benefited in a number of ways from facing the considerable adversity associated with terminal illness.

To this extent, the present results are consistent with the view that for some people at least, the end of life presents an opportunity for continued growth and development. While these results do not provide evidence of a causal link between the challenges faced in terminal illness and post-traumatic growth, participants did describe the belief that they had learned and grown from confronting their mortality.

These results are also consistent with prior qualitative studies in which participants discussed having learned lessons about acceptance, pro-social attitudes, perseverance, spirituality, and focusing on the present from their confrontations with aging and death (Choi & Landeros, 2011; Kinnier et al., 2001; Owens et al., 2016). These results further reflect Breitbart et al.’s (2004) suggestion that struggles at the end of life can yield meaningful growth: “feelings of anxiety, guilt or hopelessness that seem punishing or unrelenting at the end of life can be transformed into ways of actively exploring the relationship to self and others.” (p. 367) It may be that in addition to contributing to well-being among the elderly (e.g. Ardelt & Edwards, 2016), wisdom may also be a positive consequence of facing illness and mortality (e.g. Kinnier et al., 2001). The present thematic results stand in sharp contrast to the widespread marginalization of the elderly (Richeson & Shelton, 2006) and historically dismissive view of death (Becker, 1973) and the dying process (Kübler-Ross, 1969).

The present study also provides a unique perspective on how people at the end of their lives perceive the nature of wisdom. Interestingly, the strongest finding in this domain was participants’ belief that humility is essential to wisdom. Specifically, participants seemed to equate humility with the willingness to embrace and accept their own ignorance, epitomized by one participant’s suggestion that “Wisdom is when we realize ‘I don’t really know much.’” This finding presents a paradoxical commentary on the nature of wisdom, which is often associated with the accumulation of knowledge about life (Bangen et al., 2013).
Interestingly, this finding echoes the idea popularly attributed to the ancient Greek philosopher Socrates, often called the *Socratic Paradox*, that he could be considered wise only insofar as he knew what he did not know:

I am wiser than this human being. For probably neither of us knows anything noble and good, but he supposes he knows something when he does not know, while I, just as I do not know, do not even suppose that I do. I am likely to be a little bit wiser than he in this very thing: that whatever I do not know, I do not even suppose I know. (Plato's *Apology*, 21d, Trans. G. M. A. Grube)

In the contemporary psychology literature, this Socratic idea is reflected in the concept *intellectual humility*, which refers to one’s ability to accurately assess and portray how much one actually knows. Intellectual humility may be considered a major component of the broader construct of general humility (Samuelson et al., 2015). Contemporary research suggests the most common elements in definitions of general humility include a willingness to perceive oneself accurately, orientation toward others’ well-being rather than self-enhancement, openness, and acknowledgment of one’s own limitations (Bollinger & Hill, 2012; Tangney, 2000).

Positive psychologists locate humility in a taxonomy of positive human virtues according to the Aristotelian philosophical tradition (Peterson & Seligman, 2004). Research suggests that humility is associated with positive health (Krause, 2012), relationship quality (Peters, Rowat, & Johnson, 2011), prosocial behaviors and generosity (Exline & Hill, 2012), forgiveness (Powers, Nam, Rowatt, & Hill, 2007), and resilience to trauma (Krause & Hayward, 2012). The finding that the present study’s sample viewed humility as an important component of wisdom also reflects the results of another recent study (Samuelson et al., 2015) which found that “folk” understandings of the traits of a wise person and intellectually humble person appear to be closely related.

Aside from humility, participants also identified several variant components of wisdom, including intellectual understanding, learning from experience, sharing knowledge with others, listening to and learning from others, spirituality, self-knowledge and self-awareness, and acceptance. Broadly speaking, participants identified cognitive, affective, and behavioral components of wisdom, consistent with contemporary empirical and theoretical definitions (Bangen et al., 2013; Staudinger et al., 2005). Some of these themes in particular reflect those of positive psychology theorists Peterson and Seligman (2004), whose definition of wisdom includes open-mindedness, curiosity, and interest in continued learning, and ability to share advice or wisdom with others.

The present results are also consistent with the conclusions of Bangen et al.’s (2013) review of wisdom definitions in the literature (i.e. social decision-making and pragmatic knowledge of life, prosocial attitudes and behaviors, reflection and self-understanding, acknowledgment and coping effectively with uncertainty, and emotional homeostasis). Participants in the present study described social decision-making and pragmatic knowledge of life in terms of learning from one’s life experiences, developing intellectual and experiential knowledge, and in the importance of sharing one’s accrued life-knowledge with others. Additionally, participants explicitly emphasized reflection and self-understanding in their expression of the importance of developing self-awareness and developing a sense of humility about one’s own knowledge.
Participants also expressed the importance of acknowledging and coping with uncertainty in their emphasis on accepting what is living in the present moment. Two of the less-common subcomponents of wisdom identified by Bangen et al., openness to new experience and spirituality, were also reflected in the present study’s findings.

The sources of meaning in life described by participants echo the results of earlier CQR studies focused on meaning in life (e.g. Hill et al., 2013; Wright, Grant, Depner, Donnelly, & Kerr, 2014), which emphasized the value of connecting with others, continuing to learn and grow, engaging in spirituality, finding a sense of purpose in work, and living a full and rich life. The categories of meaning identified in the present study are also consistent with the sources of meaning summarized by Breitbart and Applebaum (2011): engaging in life via work, hobbies, and other pursuits; connecting with life through relationships, love, and other meaningful experiences; encountering life’s limitations by overcoming adversity; and the legacy associated with one’s history and enduring effect on future generations. These results also emulate tenets of positive psychology, which Park (2014) describes as encompassing the “successful pursuit of five endeavors or pillars: Positive emotions, Engagement, Relationships, Meaning, and Achievement.” (p. 1645)

Limitations

One limitation of the present study is that although hospice clinicians were asked to refer “wise” patients to the study based on a specific research-based definition of wisdom, these clinicians’ personal biases and beliefs about wisdom likely affected their choices of which patients to refer (for example, many participants were referred by hospice chaplains with a Christian orientation). Additionally, because participants who were nominated as wise might be those whom clinicians viewed as having more positive affect (Etezadi & Pushkar, 2013) and relatively less distress in the face of dying, the present results regarding the positive growth opportunities in dying may not reflect normative experiences for those struggling with terminal illness. Similarly, because entry into hospice programs requires a terminal diagnosis, it is possible that participants (who were enrolled in a hospice program) may have had relatively more time to process and begin to accept their mortality compared to terminally ill patients not enrolled in hospice. However, because data regarding time of diagnosis/prognosis were not collected in this study, this possibility is merely speculative.

Due to the innate challenges of conducting qualitative interviews with terminally ill participants (e.g. frequent interruptions, participants physically declining), some suggested procedures of CQR research were not followed. For example, only one interview was conducted with each participant, and participants were not able to review study results as all participants had died at the conclusion of the study. Furthermore, some of the questions in the interview protocol may have constituted leading questions, insofar as participants were asked to comment on how facing illness and mortality had influenced their sense of meaning in life, beliefs about wisdom, and personal growth. While these questions were designed to target specific research questions, the framing of questions might have skewed the results of the study toward confirmation bias.

Finally, the cultural and religious homogeneity of this study’s sample and the research team should be considered in interpreting these results. Because both the sample and research team comprised primarily of white, Christian women, the study’s
findings are likely to reflect Eurocentric and Christian beliefs surrounding wisdom and the meaning of life. Furthermore, because the sample comprised primarily of older adults, these findings may not be reflective the experience of younger people facing terminal illness.

**Implications for counseling**

This study represents a strengths-based and developmentally-oriented exploration of a group of people that counseling psychology, despite its emphases on positive strengths and development across the lifespan (Gelso et al., 2014; Steffen et al., 2015), has largely neglected. Despite the recognition of need for increased attention to psychological care at the end-of-life, attention to these areas in counselor training, practice and research is limited (Haley et al., 2003; Kasl-Godley et al., 2014; Nydegger, 2008). We believe the findings presented herein provide several instructive points for reflection and practice in therapeutic work with the terminally ill.

Participants in the present study described many psychological challenges associated with facing death, consistent with studies that suggest care of the dying should encompass psychological treatments in addition to physical treatments (Chochinov et al., 2009). Participants’ descriptions of how they cope with illness and facing death, and the sources of meaning in their lives are relevant to counselors working with clients who are struggling at the end of life. In particular, participants emphasized the value of seeking support from others, developing an accepting attitude, and finding comfort and meaning through spirituality. The ability to view one’s own aging and mortality with acceptance supports what research has found regarding the understanding of wisdom as living and experiencing life while accepting the unavoidable consequences of aging, illness, and death (Ardelt & Edwards, 2016; Erikson, 1964). All of these are factors which counselors may incorporate into their work to facilitate coping and growth.

Participants’ ability to identify positive growth opportunities in the difficulties of the dying process underscores the value of counseling approaches which specifically seek to help the terminally ill find meaning and generativity in the final stages of life. As Barskova and Oesterreich (2009) note,

> Interventions [for those facing serious illness] may benefit if they address re-evaluating values and priorities of life, and inspire positive changes in PTG-related domains like interpersonal relationships, discovery of specific individual strengths, appreciation for the little pleasures in life, spiritual feelings and awareness of new possibilities. (p. 1730)

Two such approaches have gained preliminary empirical support in the literature and may be helpful to therapists in work with terminally ill clients. Meaning-centered psychotherapy (e.g. Breitbart et al., 2012), adapts a structured approach to Frankl’s (1959) Logotherapy to help clients reflect on sources of meaning in their lives and find new ways to find or make meaning in the face of terminal illness. A second approach, dignity therapy (e.g. Chochinov et al., 2011), aims to foster a sense of generativity in clients by assisting them in writing a brief book (intended to be bequeathed to loved ones) capturing important memories, recording the patient’s legacy, and reflecting their most important values and beliefs. Training manuals and trainings exist to assist therapists in implementing both interventions. The present study contributes participant
narratives that underscore the importance of further scientific and clinical attention to how positive psychological elements of the dying process can be integrated into therapeutic interventions to foster well-being among the aging and dying.

The counseling profession has long conceptualized the clinician’s self, including one’s beliefs and attitudes, as a key instrument in the practice of psychotherapy (Baldwin, 2000). As Kübler-Ross (1969) noted, conducting counseling with dying patients requires maturity and awareness of one’s own feelings and beliefs: “we have to take a good hard look at our own attitude toward death and dying before we can sit quietly and without anxiety next to a terminally ill patient” (p. 269). To that extent, studies presenting qualitative narratives (as the present study does) may be useful in providing a starting point for counselors and trainees to explore their own affective reactions and worldview. Reflective inquiry into these aspects of the self is important for the development of counselor self-awareness (Pieterse, Lee, Ritmeester, & Collins, 2013). The present study’s findings may be useful in this regard, as they include some participant perspectives which challenge prevailing negative cultural attitudes (e.g. Becker, 1973) toward death and dying (for example, most participants’ endorsement of the idea that dying can be an opportunity for positive growth).

The typical finding that participants identified humility as a major component of wisdom may have relevance for therapists. Both wisdom and humility have been proposed as traits which support the development of therapeutic skill and expertise (e.g. Nissen-Lie & Rønnestad, 2016), and humility in particular has been described as being supportive of best therapeutic practice insofar as it may promote accurate self-perception, openness, cultural competence, resolution of alliance ruptures, and willingness to seek consultation (Paine, Sandage, Rupert, Devor, & Bronstein, 2015). The related construct of cultural humility, which has received increasing attention in the counseling psychology literature, refers to a counselor’s ability to accurately perceive his or her own cultural values and approach clients with respect and without a sense of superiority regarding beliefs or values (Hook, Davis, Owen, Worthington, & Utsey, 2013). While the present study did not investigate psychotherapeutic processes, these results may serve as a useful reminder to counselors that humility may play an important role in the process of helping. In the context of terminal illness in particular, therapists might apply the concept of humility by not making assumptions about clients’ views of death, being open to the client’s experience and beliefs, and acknowledging the limitations of one’s own knowledge about the experience of facing mortality.

A final interesting point arises not from the study’s results, but from the process of conducting interviews. Most participants expressed a sense of appreciation for having been asked to share what they had learned from life and facing death. It appeared that just as the interviewers felt privileged to learn from the participants, the hospice patients in this study felt gratified by the chance to discuss questions of such profound importance. As Participant 1 put it,

By this conversation I am living now. You are allowing me to be me and you listen and to me that is everything, because it shows that we care about one another in this world and I don’t know any other way to make the world better than people trying to help each other.
As studies such as those on Dignity Therapy have found, the opportunity to share one’s views on what is important in life can in itself be healing and therapeutic for those at the end of their lives (Chochinov et al., 2011).

Implications for future research
This study provides a glimpse into how fifteen people facing imminent death viewed the “big questions” of what it means to be wise, what brings meaning to human life, and how the challenge of facing mortality may lead to growth at the end of life. The present results are therefore relevant to research in positive psychology, human virtues, post-traumatic growth, and psychological well-being in the context of terminal illness. Because the present study is among the first to explore the intersections of these domains from the developmentally unique perspective of those facing imminent death, we believe it provides a basis for further clinically-relevant research into fostering well-being at the end of life. Future research could expand upon the present findings by replicating this study with a more culturally diverse sample and research team. Toward that end it may be useful to utilize triangulation methods, for example by using quantitative measures of wisdom, sense of purpose, and subjective well-being to corroborate qualitative findings. A separate quantitative study exploring the relationship between wisdom, post-traumatic growth, and well-being at the end of life might yield further interesting data regarding the connections participants in this study identified between those constructs.

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Disclosure statement
No potential conflict of interest was reported by the authors.

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References


**Appendix 1.**

Semi-structured interview protocol:

1. From your perspective now, what do you think matters most in life? What, if anything, once seemed important to you but no longer seems so important?
2. What is the meaning of life (or your life)?
3. How, if at all, has your illness changed your sense of meaning in life?
4. What, if anything, have you learned about life from your experience of illness?
5. What is wisdom?
6. Has facing illness and death had any impact on your wisdom?
7. If you could live for many more years, what would you do with your time?
8. How would you like to be remembered?
9. Do you have any regrets?
10. What advice would you give someone who is facing death and dying?
11. If someone asked you what is most important in caring for someone who is facing terminal illness, what advice might you give them?
12. What advice would you give someone who has many years left to live?