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11 A Meaning-Centered Approach to Overcoming Loneliness During Hospitalization, Old Age, and Dying

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Loneliness is an inevitable part of the human condition. Prolonged life expectancy and urban living have compounded the problem of loneliness. We are probably the most connected generation and the most disconnected one, at the same time. In this chapter, I will first discuss the phenomenon of loneliness and its contributing causes. I begin with my personal experience and then extend the discussion to aging, urban living, and existential loneliness. Throughout this chapter, I will show how a meaning-centered approach can help alleviate the problem of loneliness in various life situations.

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WHAT I LEARNED ABOUT LONELINESS FROM MY HOSPITAL EXPERIENCE

I would not have understood the depths and pain of loneliness without my recent experience of surgery and hospitalization. Nor would I have discovered firsthand the important role of meaning in overcoming loneliness and boredom.

A few months ago, when I fainted in my bathroom as a result of massive internal bleeding, I was rushed to the emergency room (ER) at night. I was still aware of the experience of being carried on a stretcher, naked and wet, to an ambulance. It might have been a matter of a few minutes, but, shaking in sub-zero weather, it felt like an eternity. Alone in the ambulance on my way to the hospital, my overwhelming feeling was one of disconnection and loneliness.

I am no stranger to the ER and have had some bad experiences with the ER, which I have described elsewhere (Wong, 2008a). But this time, I did not have to wait in the hallway for a long time, probably because I was in a life-threatening situation.

The doctor who treated me said that I had lost 50% of my hemoglobin and my blood pressure was dangerously low. The ER medical staff tried to stop my bleeding and gave me a blood transfusion and an IV. Nurses monitored my vital signs frequently. It was a sleepless night, full of drama and anxious moments. I was grateful that my wife was with me during the entire night in the ER.

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In the morning, I was transferred to a regular ward with many patients. The day was quite uneventful, except for the disturbing noises of human suffering. An old man opposite to me was groaning and moaning loudly most of time, day and night, except for the brief time when he fell asleep. Obviously, he was in considerable discomfort, if not in pain. The entire day, not a single person visited him except for a couple of phone conversations.

Another elderly man next to me was crying out repeatedly, "Nurse, Tylenol, nurse, Tylenol." But his cry for help was ignored, either because nurses could not give him more Tylenol than prescribed by the physician or because they simply dismissed it as the old man's way of getting attention. I could not even imagine what it would be like to spend a long period of time at the hospital, alone and in pain.

THE LONELINESS OF BEING ABANDONED AND NOT UNDERSTOOD

The hospital doctor in charge of my case dropped by in the evening to check my condition and told me that a nurse would do a simple procedure on me before the surgery in the morning. That simple procedure turned out to be anything but simple. It took three nurses, one senior clinical nurse, and one specialist, stretched over several hours, and involved inflicting massive pain on me, and still the procedure could not be completed because of scar tissue from my prior surgeries. I felt like a helpless lamb in a slaughter house, anticipating the worst to come. It was another sleepless night of trauma and pain. I screamed so much that I lost my voice.

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The next morning I was wheeled into the surgery room early in the morning. I was already in a state of physical exhaustion due to massive loss of blood, two sleepless nights, and lack of food. For the first time in my life, I was suddenly seized by a panic attack, shaking in fear of more pain. I protested that I was not ready for surgery because it would adversely affect my recovery; I needed some time to calm down. I surprised myself that I still had the presence of mind to say all that on the way to surgery. But no one would listen—they silenced me by putting me to sleep.

When I came out of my general anesthesia an hour later, I could see my wife greeting me in the waiting recovery room and a nurse working at her desk near me. Later, I could hear my wife talking to a doctor nearby and I could also hear nurses talking and walking about in the room, but I could not move, nor could I utter a sound. Every time, I struggled to move my head or body, I could hear the nurse sitting next to me said, "Don't move!" I wanted to say something, but my voice would not come out and no one paid any attention.

I never realized that the feeling of being totally abandoned and ignored by the whole world could be so devastatingly painful. At that time, I felt that being trapped in a paralyzed body with a clear mind must be the second

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worst kind of human existence—second only to physical torture. I had no power to get any attention, nor had I the power to end my life. I was stuck in a no-man's land of overwhelming loneliness and helplessness.

Finally, I emerged from that nightmarish existence when the medical staff and my wife came to talk to me. But to add insult to injury, the medical staff suspected that I was a mental case because of my agitated behavior prior to and after surgery.

The painful experience of my inability to get anyone to listen to my case made me realize that the urgent need of patient care is not to "do things to them" but to do things alongside them with understanding and empathy. Not being heard and understood could be a major source of loneliness and frustration.

My trauma hypothesis for my agitation was supported four months later, when I was readmitted to the hospital for the same surgery because of blockage from the scar tissues from the last surgery. This time, I was spared from the traumatic and unnecessary procedure prior to surgery, and I recovered well after waking up from general anesthesia. I was pleased that I was spared an additional mental disorder label in my medical record and the endless mental status tests from nurses. I was even more pleased in a follow-up visit with my surgeon that the traumatic procedure prior to my surgery was a mistake and could have been avoided.

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COPING WITH LONELINESS AT THE HOSPITAL

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I had plenty of time to process my experience of loneliness. Each night at the hospital was very long. It began at 8 pm—the end of visiting hours—and lasted until I finally fell asleep at 2 or 3 am. How did I spend the sleepless nights alone in a hospital room, where all I could see was four walls and a white ceiling? Loneliness at night is probably the most common challenge for long-term patients.

When no one was around, I communed with God. The first night I meditated and prayed on the theme of my faith in Jesus Christ—no one can separate me from his love. The second night my spiritual theme was the grace of God—it is sufficient for all my needs. I spent a few hours on each theme. I also practiced mindful meditation, focusing on my breathing or some calming image. If I was not engaged in these spiritual activities, I would go crazy with loneliness and boredom.

Loss of instruments of autonomy can deal a heavy blow to our identity and sense of significance. My physical immobility further aggravated a sense of loneliness, helplessness, and boredom. For several days, I was not even able to turn in bed or sit up without help. That meant that I could not engage in any meaningful activity, except for some conversation during a family visit. How does one spend one's long days while confined to a hospital bed?

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Although I was physically restricted, I was still free mentally and spiritually. I could still do some reading and a lot of thinking, reflection, and meditation. It was my rich mental and spiritual life that filled the void and made it easier to spend the time when no one was around. I could process my experiences and discover the deep meaning and rich texture of my daily routines. I could also transcend space and physical limitations to live in a meaningful world, full of ideas and future plans.

Another thing I learned at the hospital was that loneliness has many dimensions. Social isolation is simply one dimension. Being in a hospital is like being transplanted to a new place away from your family, friends, and routine activities. It is like being displaced to a foreign land. It would take time and patience to build relationships, but at the hospital, with different nurses on shift every day, it was impossible to get to know them. The best thing one can do is connect with family and friends. I was also able to communicate with hundreds of Facebook friends worldwide.

HOW TO HELP THE DYING

Death and dying is another dimension of loneliness at the hospital—it is where most people spent their last days. When my pastor friend came to visit me, his opening statement was: "As a pastor, it is my duty to ask you this question: are you prepared to die?"

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I was surprised by his direct and blunt question because, as a pastor myself, I would not have asked anyone this way. My answer to him was: "Yes, I am always prepared to die. In fact, when I was going through severe pain, I would choose death over torture. But right now, I am not ready to die, because I still have so much unfinished business." He just looked at me with a smile. I don't know if he understood my mental and emotional state.

Yalom (1980) lists loneliness as one of the four existential anxieties along with death, fear, and meaninglessness. He refers to the inevitable sense of existential alienation when one feels all alone in the universe with no one truly understanding one's unique predicament or needs. Such existential anxiety becomes especially real and vivid when one gets ready to say the final goodbye and goes through the final stage of life. In those moments, one feels separated by a widening gulf or chasm that separates one from the world of the living.

About seven years ago, when I was diagnosed with the most aggressive type of prostate cancer and went through a radical prostatectomy and CT scan, I experienced a profound sense of existential loneliness for the first time. All of a sudden, I felt that I no longer belonged to the land of the living but to a temporary twilight zone, waiting to be transferred to another world.

I remembered attending the lavish wedding of my niece just two days after my cancer diagnosis. I found myself alone in my musings about what it meant to die when I still had a lot of life left in me. The music, dancing, and all the laughter at the wedding seemed to be far, far away, coming from

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a different world. I felt all alone with my thoughts on death. I was not afraid of death, but I was not ready to say "good-bye" to my wife and children and leave behind so much unfinished work.

Now, once again, I found myself in the hospital facing another life-threatening condition. I was wondering how many pastors, doctors, or nurses had the training to minister to individuals who are alone during the last leg of their life's journey. Fear of death was only part of a larger, complex emotion that included loneliness, fear of the unknown, loss of meaning, lack of readiness for saying the final good-bye, and concerns about the people they leave behind.

IS THERE MEANING IN SUFFERING?

In addition to loneliness and death, meaninglessness is another existential anxiety recognized by Yalom (1980). When life seems absurd, unpredictable, painful, and contrary to our core beliefs, we recoil and struggle to make sense out of it. Somehow, if we can find a good reason for our suffering, we would find it more bearable. Frankl (1985) often quoted Nietzsche's saying that "He who has a 'why' to live for can bear almost any 'how.' "

I spent considerable time trying to make sense of my own suffering at the hospital. My wife said: "Something good has to come from this suffering." At that time, I did not know what good would be the result, but the idea that I could share my experience, so that others do not have to go through the same unnecessary suffering, gave me considerable comfort. In other words, my suffering is worth it if it can spare other people from the same suffering. This is what Frankl meant by turning suffering into achievement.

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It is not what happens to you, but how you interpret it that determines your well-being. This is a fundamental tenet of logotherapy or meaning-therapy (Wong, 2010a, 2012). In every situation, it is always possible to discover the positive meaning for one's misfortune and transform adversity to triumph. I was finally able to overcome my traumatic experience through meaning transformation.

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In sum, I have discovered that loneliness is just an umbrella term that captures the essence of different kinds of lonely experiences. We experience loneliness in a wide variety of life situations: a strange place, social isolation, pain, helplessness, boredom, the valley of death, and the aggravation of not being heard and understood. Throughout these experiences, the presence of family and friends and my capacity for spirituality and meaning-making have been my main sources of support.

SOCIAL ISOLATION AND THE AGING POPULATION

My experience in the hospital can easily be multiplied thousands of times, as more and more older people require hospitalization and long-term care as

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a result of serious physical illness, terminal diseases, and cognitive decline. This poses a serious challenge not only in terms of medical care but also in terms of providing the necessary social, psychological, and spiritual care. Loneliness and meaninglessness are among the recurrent issues in caring for the aging population in both institutional and community settings. How do we meet these psychological and spiritual needs?

There is a growing body of literature that lonely older people not only feel less happy but also are more vulnerable to all kinds of illnesses (Sample, 2014). For example, according to Cacioppo and colleagues (2002), loneliness is associated with age-related increases in blood pressure and poorer sleep quality.

It is inevitable that social isolation comes with advancing age because of decreased social interactions and increased immobility. Adult children tend to be too busy with their own lives to spend time with their aging parents. Loss of a lifetime partner could be devastating because it creates a huge void that is very difficult to fill. Thus, the elderly are most vulnerable to social isolation and loneliness.

MEANINGFUL LIVING IN OLD AGE

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According to Stanford University's Center on Longevity, by 2029, when the last baby boomer reaches 65, one in five Americans will be 65 or older (Meyers, 2014). Meyers points out the need for counseling as people go through major life changes as they age. Given the rising life expectancies, retirement could be very long. The question, "What do I do with the rest of my life?" could become a real concern for those between the ages of 60 and 70.

My own research on reminiscence and life review (Wong & Watt, 1991; Wong, 1995) shows that is not the sharing of their stories but what kind of stories they tell that helps the older people adapt to old age. More specifically, integrative and instrumental types of reminiscence were associated with successful aging, while an obsessive type of reminiscence was associated with unsuccessful meaning. Integrative narratives attempt to make sense of past events and relationships; instrumental narratives focus on past experiences of overcoming difficulties and demonstrating competence and mastery. In contrast, in obsessive reminiscence the older adult ruminates on past misfortunes and unhappy events.

From the perspective of meaning therapy (Wong, 2010a, 2012), the elderly's vast store of memories and their innate capacity for storytelling provide a fruitful avenue of intervention. It would be beneficial to encourage the elderly to focus on those aspects of the past that enhance self-esteem and meaning, whether they are alone or sharing their stories with another person.

In addition to focusing on the adaptive aspects of reminiscence, the very act of writing or telling a coherent life story can be very helpful. It helps to

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make sense of one's life as a whole by connecting the fragmented pieces of the past and discovering a common thread of continuity. This exercise also helps in creating a sense of identity and integrity. It is a task that can add meaning to one's existence and fill many otherwise unoccupied hours.

The best preparation for retirement and old age is to cultivate relationships with family and friends, learn to enjoy moments of solitude, and, more importantly, find new ways to live an active and fulfilling life. These would involve tapping into the eight sources of meaningful living (Wong, 1998a): positive emotions, a sense of achievement, having intimate relationships, belonging to a group, accepting one's limitations and mortality, helping others, engaging in religion or spirituality, and experiencing fair treatment. Activities in all these areas are related to higher meaningfulness and well-being and lower depression; by logical deduction, meaningful activities should also reduce feelings of loneliness, although no empirical study has been conducted.

It is thus suggested that those who practice the principles of meaningful living and discover their own meaning in life will enjoy better health and subjective well-being during their postretirement years (Reker & Wong 2012; Wong, 1998b). However, society can also help by creating community projects or events in which seniors can participate; government and nonprofit organizations can also provide social services such as home visits, hospital visits, and phone calls for the elderly who are living alone.

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THE LONELY BATTLE IN FACING DEATH

The last stage of life is the most challenging. Nothing in life has adequately prepared us for death. In our youth-obsessed culture, death remains a taboo subject and is associated with terror. Unfortunately, no matter how hard we try to deny or suppress death anxiety, sooner or later, we will hear a physician pronouncing our death sentence: "I am sorry that your condition is terminal. There is nothing more we can do medically. You will have only about three months to live."

How to absorb this bad news is a very personal and lonely task. Even though we all anticipate the bad news toward the end of our journey, it is still difficult to accept. Part of meaning therapy involves clarifying clients' death attitudes and working toward some form of death acceptance (Wong, 2008, 2010b; Wong & Tomer, 2011a, 2011b). AuQ19

Life following such a death sentence can be as lonely as inmates on death row. So many turbulent thoughts and emotions can swirl around one's mind: despair, fear, anxiety, regret, loss of hope and meaning, and grasping for straws to make life more bearable. Such is the time that meaning therapy can be helpful, as Frankl (1985) has demonstrated in Nazi's death camps. There is also plenty of empirical evidence on the importance of addressing existential and spiritual issues in death and dying (Tomer, Grafton, & Wong, 2008). AuQ20

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Frankl's basic tenets of logotherapy, which may be utilized in this situation, include: freedom of choice, will to meaning, and meaning of life; his three pathways to experience meaning are: creative, experiential, and attitudinal. In addition, we also teach the eight habits of meaningful living based on my research on implicit theories of meaning and the Personal Meaning Profile (Wong, 1998):

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1. Know and accept yourself, including your past, your dark side, and your mortality.
2. Achieve something with your life by working toward worthy goals, such as developing your potential and pursuing your calling.
3. Cultivate close relationships with loved ones and best friends.
4. Play a meaningful role in a group or in your community.
5. Engage in spiritual or religious practices, such as prayer and meditation.
6. Practice kindness and compassion daily.
7. Maintain a positive, optimistic attitude and positive feelings of joy and contentment.
8. Treat others with fairness and work toward a just society.

Astute readers will notice a built-in balance between achievement and acceptance, between self-interest and caring for others, etc. They may also notice the scope and depth of pursuing a meaningful life as compare to the self-centered pursuit of personal happiness.

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There is now an increasing realization that shallow happiness and financial success cannot fill our inner emptiness or void if we ignore our deeper needs for meaning and spirituality (Haybron, 2014; Smith, 2013).

EXISTENTIAL LONELINESS AS AN INESCAPABLE ASPECT OF THE HUMAN CONDITION

It would be amiss to equate loneliness with social isolation because some people live alone without feeling lonely, while others may feel lonely while surrounded by people. Personality and circumstantial differences play a role in how we react to the lack of social connection. Singles who choose singlehood as a preferred lifestyle would feel less lonely than those who desperately want to get married but cannot find a suitable life partner. Introverts would adjust to aloneness better than extraverts because they are less dependent on other people to provide the stimulation they need. Those who are attuned to the spiritual realm through habits of prayer and meditation would better adapt to aloneness than those who do not have such spiritual habits.

In spite of all the above differences, existential loneliness remains at the heart of human existence. This form of loneliness is unavoidable because of our singularity, our unique experiences, and our aloneness in facing

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suffering and death. The realization that no one fully understands me, even in a marriage relationship, can create a sense of loneliness. From this existential perspective, loneliness is not just a matter of lack of friends and social connections; it is an inevitable aspect of the human condition—it touches all of us. Here is an apt quote from *God's Lonely Man* written by Thomas Wolf (as cited by Carter, 2003, "The Existential Perspective on Loneliness"):

> The whole conviction of my life now rests upon the belief that loneliness, far from being a rare and curious phenomenon, peculiar to myself and to a few other solitary men, is the central and inevitable fact of human existence. When we examine the moments, acts, and statements of all kinds of people—not only the grief and ecstasy of the greatest poets, but also the huge unhappiness of the average soul . . . we find, I think, that they are all suffering from the same thing. The final cause of their complaint is loneliness.

The kind of loneliness described by Wolf is responsible for our unhappiness but, happily, also responsible for our soul-searching and discovery of our unique path of living a meaningful and fulfilling life. We can become fully human through reflecting on our loneliness in life and in death. Tim Ruggiero (2001, "An Existential View of Loneliness") sums up my view on existential loneliness eloquently:

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> There are those individuals, however, who peer into the abyss and do not cower. We think of Gautama who gave up an opulent life and family in his late twenties to travel the world alone in search of meaning. Or Thoreau who retreated to the woods for a few years so that he might gain a decent perspective upon the world. Or to any number of fictional characters: for instance, Lester Burnham in the movie American Beauty, who comes to grips with the fact that he has spent his adult life in an emotional and moral coma, and who chases what bits of meaning and beauty are still available to him in acts of rebelliousness. Or, still yet, to Christopher Reeve, who knew that the odds of returning to a normal and happy life were slim to nil, but who resolved to turn an awful tragedy into a quest to ferret out scientific solutions to such debilitating diseases as Alzheimer's and Parkinson's. So loneliness, on this reading, isn't something to be shunned or afraid of: it is, rather, a possible catalyst for a more purposeful and engaging life, and an avenue for heightened self-awareness.

CONCLUSIONS

A common sense solution to social disconnection is social engagement (Olds, Schwartz, & Webster, 1996). But our deeper emotional and existential needs cannot be met simply by social activities and being connected

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through electronic means. Furthermore, our busyness and self-centered pursuits may make meaningful relationship less likely (Wong & Wong, 2013).

I propose that a more comprehensive way to overcome loneliness is to develop habits of meaningful living, which seek to strike a healthy balance between "I" and "We" and self-interest and the common good. Such a lifestyle is the antidote to loneliness.

Meaning therapy (Wong, 2010a, 2012) is a more professional way to help people with problems of loneliness. The motto of meaning therapy is: "Meaning is all we have and relationship is all we need." (Wong, 2010a; p. 86). This motto captures both the objectives and methods of meaning therapy.

This therapy capitalizes on people's innate capacity for meaning-seeking and meaning-making, especially in storytelling and transforming negatives into positives. It also emphasizes that effective meaning therapy depends on forming a genuine and trusting relationship between therapist and client as a model for building a broader relationship network.

The meaning-centered approach consists of both public education on meaningful living and the professional practice of meaning therapy. Throughout this chapter, I have argued and presented evidence that this is a promising approach in addressing the looming crisis of loneliness that results from the aging baby boomers, the loss of a sense of community in urbanization, and the increasingly dominant role of technology in our culture.

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