Middle-age (p = 0.95) and older (p = 0.94) adults rated their self-defining memories as portraying similar levels of virtue across conditions. Unlike their middle-age and older counterparts, young adults report embodiment of virtue differently in unique contexts. Findings are discussed in the framework of how individuals' views of the self as virtuous change in relation to time lived and time left to live.

LESSONS FROM WHAKAPAPA AND FILIAL PIETY: CAN SOCIAL WORK CAPITALIZE ON THE CONNECTION THAT SURVIVES DEATH?

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Ageing is part of life, and so is death. Although death will involve all of us over time, it is often regarded as a taboo topic, and bonds with the dead are seldom acknowledged in contemporary times. The paper presents selected insights on the connection that survives death, learned from a qualitative study on two indigenous knowledges—whakapapa (genealogical connections in Maori) and filial piety (respect/care for ancestors). Data were collected from interviews with 49 key informants (Maori=25; Korean=24) in 2018/19 in New Zealand and South Korea. The research findings indicate that the connectedness with ancestors or deceased loved ones is a significant part of the participants' mental and social lives. Māori (the first nation people of New Zealand) have established the unwritten convention of whakapapa as the core value that places whānau (family) at the centre of social relationships. In Korean culture, its filial piety/ancestor veneration tradition has emphasised the connection between deceased and living family members. Criticism about the traditions of whakapapa and filial piety was also raised by a few participants. The significance of this study is situated in the innovative perspective that the post-mortem relationship can be embodied, not only by the living who practise memorial respect for the dead, but also by those older people who establish after-life legacy before death. To help capitalise on this whakapapa connection, the so-called concept of "memorial social work" is presented as a potential area of social work practice, which has critical implications in the ageing/end-of-life related fields.

MEANING MAKING AS A CENTRAL MECHANISM OF DIGNITY THERAPY FOR OLDER ADULTS WITH CANCER

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Nearly 500,000 older Americans die a cancer-related death each year (National Vital Statistics Report, 2018). Following a diagnosis of a serious illness like cancer, maintaining a sense of dignity is central to a patient's wellbeing. Dignity Therapy (DT) was recently introduced as an intervention to enhance dignity for terminally ill patients (Chochinov et al., 2005). This therapy provides patients opportunities to foster a sense of dignity though making meaning of their lives (Hack et al., 2010). To date, whether meaning-making actually occurs as a central mechanism of effective DT has not been tested. The current study investigates (i) how often and in what forms meaning-making occurs during DT, and (ii) how patients' baseline feelings of dignity relate to meaning-making during DT. Participants were 25 male and female cancer outpatients (M age = 63.08; SD = 5.72). They completed the Patient Dignity Inventory (Chochinov et al., 2008) and then participated in Dignity Therapy with a trained provider. Sessions were audio recorded, transcribed, and reliably content-analyzed for meaning-making using an established coding scheme (Park & Folkman, 1997). Content-analysis revealed that all patients made meaning of past life events at least once (range: 1-12 occurrences). Multiple forms of meaning-making emerged, with Finding Benefit and Personal Growth most common. Patients reporting more dignity-related distress prior to DT showed greater meaning-making during the DT session ($r = .46$, $p < 0.05$). This study provides foundational evidence that meaning-making is a key mechanism of Dignity Therapy, helping older adults with cancer enhance dignity at end-of-life.

RELIGIOSITY, COGNITION, AND ENGAGEMENT IN ADVANCE CARE PLANNING AMONG OLDER ADULTS

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Advance care planning (ACP) is an important process of discussion and documentation that may help older adults receive the end-of-life care they prefer. Although existing literature predominantly finds greater self-reported religiosity to decrease the rates of ACP, a clear consensus is not yet evident. Data from 3,182 adults aged 55 and older participating in the 2012 wave of the Health and Retirement Study were used to investigate this association and examine the moderating role of cognition. Participants reporting at least one of two ACP behaviors (written instructions and assigning a health care proxy) were categorized as formal planning only, engaging in only informal discussions was categorized as informal planning, and those who completed both or none were categorized accordingly. Cognition was measured using self-reported memory change over the last two years and with objective cognitive testing scores. Using multinomial logistic regression, three forms of ACP behaviors were regressed on a religiosity/spirituality scale, the two cognition measures, and demographic and psychosocial covariates. Greater religiosity was associated with a lower likelihood of engaging in both plans compared to none (OR=0.91, 95%CI=0.84-0.97), however this effect was no longer significant with the inclusion of race. Higher cognitive scores were associated with greater odds of engaging in informal-only (OR=1.07, 95%CI=1.04-1.10) and both plans (OR=1.04, 95%CI=1.01-1.06); subjective memory change was not associated with ACP. Neither cognitive measure significantly moderated the negative association of religiosity on ACP, suggesting that the awareness of worsening memory does not undermine the tendency to avoid planning among the highly religious.