

# Digital Storytelling as a Medium for Continuity, Reminiscence, and Narrative Engagement in Later Life

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**Abstract:** Older adults are repositories of life experiences whose life stories embody cultural, social knowledge that warrants attentive listening and long-term preservation. Sharing such stories is not merely a nostalgic exercise but a crucial process for sustaining personal identity, reinforcing self-worth, and fostering intergenerational bonds. Within the context of aging, where experiences of loss, isolation, and reduced participation are common, narrative practices serve as a therapeutic and empowering tool. Digital Story Telling (DST), short, user-created narratives that combine recorded voice, photographs, and simple editing techniques, offers a dignified platform for older adults to document lived experiences. Beyond a creative outlet, DST operates as a psychosocial intervention. To explore these dynamics systematically, this paper employs a desk-based narrative review methodology to map existing evidence on DST with older adults. Studies consistently demonstrate that participation in DST strengthens social connectedness, enhances communication skills, improves cognitive engagement, and elevates perceived well-being (Stargatt et al., 2022; Chang et al., 2023). These benefits extend across diverse aging groups, including those with cognitive decline, where DST facilitates memory stimulation, supports reminiscence, and restores a sense of identity and self-confidence (Rincón et al., 2022). Such findings echo the principles of reminiscence therapy, narrative gerontology, continuing theory and life-story approaches, in which structured recall and audience interaction are linked to improved mood, resilience, and quality of life (Woods et al., 2018). DST modernizes these traditions by harnessing multimedia tools, enabling participants not only to preserve but also to share their stories to the community. Importantly, DST also addresses broader societal challenges of digital exclusion. When embedded within community-based digital literacy initiatives, it provides older adults with valuable technological competencies, reducing the digital divide and enhancing participation in contemporary cultural practices. The paper discusses the possibilities and benefits of digital storytelling and the digital inclusion of older adults.

**Keywords:** Digital Storytelling; Narrative Gerontology; Older Adults; Reminiscence; Identity; Social Connectedness; Digital Inclusion; Continuity Theory.

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## I. INTRODUCTION

Population ageing has intensified interest in interventions that preserve identity, connection, and participation alongside physical health. The United Nations Decade of Healthy Ageing (2021-2030) sets out four action areas, combatting ageism, fostering age-friendly environments, delivering person-centred integrated care, and ensuring access to long-term care, placing older people's voice and participation at the centre of policy and practice (World Health Organization [WHO], 2025; WHO, 2020).

Within clinical and community gerontology, narrative approaches, life review, reminiscence therapy, guided autobiography, and life-story work, have accrued decades of evidence for psychosocial benefit. Meta-analyses and reviews indicate that reminiscence-based interventions can yield moderate improvements in depression and ego-integrity and smaller gains in well-being, mastery, social integration, and cognition; structured life-review formats often perform best (Bohlmeijer et al., 2007; Pinquart & Forstmeier, 2012). In dementia care, an updated Cochrane review concludes that reminiscence therapy is acceptable and may improve mood

and communication, though effects are heterogeneous (Woods et al., 2018). Life-story work, collating biographical materials to support person-centred care, has been shown to help staff and family see “the person behind the patient,” with promising effects on identity and relationships (McKeown et al., 2010; Lai et al., 2018).

Digital storytelling (DST) updates these traditions by enabling older adults to create concise multimedia narratives, typically 3–5-minute videos that integrate photographs or drawings with personal voice-over and simple editing. In health research, DST is recognized as an arts-based, participatory method that can elicit complex experiences, increase engagement, and communicate findings accessibly (Rieger et al., 2018; Briant et al., 2016). Scoping-review evidence specific to ageing suggests DST can promote mental health, social connection, and digital literacy for older adults, including those with cognitive impairment (Chang et al., 2023).

This conceptual paper advances a synthesis of DST for healthy ageing. Specifically, it (a) consolidates cross-disciplinary evidence on DST with older adults, (b) articulates an integrative theoretical model linking DST processes to identity, connection, and inclusion, and (c) sets out design, equity, and ethical principles to guide gerontological practice.

## II. METHODOLOGY

For this study, methods were kept simple and practice-focused: a secondary, desk-based narrative review mapped existing knowledge on digital storytelling (DST) with older adults and aligned insights to the paper’s findings. Using the PCC framework, Participants: adults  $\approx 60+$  including those with mild cognitive impairment or dementia; Concept: DST as short, participant-authored multimedia combining personal voice with images and sometimes music; Context: any community, clinical, long-term care, library, or intergenerational setting, targeted searches were run in PubMed, PsycINFO, Scopus, Web of Science, and Google Scholar, plus select grey sources (2000–2025). Inclusion covered studies actually using DST with older adults; exclusions removed purely non-digital reminiscence and technology papers without storytelling. From each source, only essentials were charted: setting and participants; delivery (dose, facilitation, intergenerational support); outcomes (identity/meaning, mood, social connectedness, cognitive engagement, digital inclusion); and design/ethics notes (tiered consent, accessibility supports). Simple counts of identified/screened/included records were maintained; only public materials were used, so ethics approval was not required.

## III. NARRATIVE GERONTOLOGY AND IDENTITY

Narrative gerontology’s central claim that humans are “storied beings” who make sense of ageing through the composition, revision, and sharing of life narratives provides a powerful theoretical lens for understanding why digital storytelling (DST) is such a resonant practice in later life. In

this tradition, ageing is not a mere trajectory of decline but a continuing authorship in which older adults interpret past events, negotiate present roles, and envision possible futures; stories confer continuity and meaning amid change and loss (Randall & Kenyon, 2004; Kenyon & Randall, 2015). DST operationalizes these ideas in a modern, pragmatic form: short, participant-authored multimedia narratives (typically three to five minutes) that interweave personal voiceover with photographs, drawings, place-images, and sometimes music. When older authors choose the moments that matter and assemble them with their own voice, DST translates narrative gerontology’s abstract commitment’s identity continuity, personhood, and wisdom-in-the-making into accessible, repeatable practice. It also opens a path for research and evaluation, because the process and the product can be intentionally designed, facilitated, and studied in clinical, community, and intergenerational contexts (Kenyon & Randall, 2015; Randall & Kenyon, 2004).

Psychological work on narrative identity deepens this rationale. Narrative identity is defined as the internalized and evolving life story that integrates reconstructed past and imagined future to provide the self with unity, purpose, and meaning (McAdams, 2001; McAdams & McLean, 2013). Longitudinal evidence suggests that specific themes in how people narrate their lives greater personal agency, redemptive sequences, and fewer contamination sequences prospectively predict better mental-health trajectories over several years, including for mid- to later-life adults (Adler et al., 2015). Broad reviews further indicate that narrative identity provides incremental validity in predicting well-being over and above traits and circumstances, implying that *how* older adults tell their stories matters, not only *what* resources they possess (Adler et al., 2016). DST is a practical scaffold for this identity work: it supports the articulation of agency (“what I did when...”), the crafting of meaning (“what it meant then and now”), and the transformation of setbacks into growth while preserving the author’s perspective through recorded voice. In short, DST is a portable laboratory for narrative identity processes that gerontologists care about and that psychologists have linked to adaptation and well-being (McAdams, 2001; McAdams & McLean, 2013; Adler et al., 2015, 2016).

What distinguishes DST from other narrative methods is its multimodality and its participatory ethic. As a research and practice method, DST developed within community health, adult education, and human-computer interaction; the core protocol invites participants to focus a single, meaningful insight, storyboard a brief narrative arc, select a small set of resonant images (often eight to twelve), record a voiceover of 200–400 words, and then align images and voice in a simple editor. Reviews in health research characterize DST as a rigorous qualitative method that “elucidates complex narratives” and “increases participant engagement,” precisely because the work of selecting, sequencing, and voicing one’s story renders tacit knowledge visible and shareable (Gubrium, 2009; Rieger et al., 2018; West et al., 2022). For older adults, this participatory structure does more than capture content; it confers authorship, agency, and audience three ingredients that narrative, motivational, and

lifespan theories each identify as crucial to late-life adaptation. When a story is screened to peers, family, or care staff, the artifact moves beyond private reflection to public recognition, enacting identity in relation and, often, strengthening bonds that can fade under the pressures of illness, relocation, or bereavement (Gubrium, 2009; Rieger et al., 2018).

Gerontological syntheses specific to DST confirm both its promise and its current limits. A systematic review of DST in older adults including those with typical ageing and those living with mild cognitive impairment or dementia mapped 34 studies, most of them small and qualitative or mixed-methods, with aims clustered around reminiscence, identity, memory, and self-confidence. Feasibility and acceptability were consistently high; psychosocial outcomes trended positive but were heterogeneous, and the authors called for more robust trials and clearer reporting of dose, facilitation, and measurement (Ríos Rincón et al., 2022).

The mechanics of why DST “works,” when it does, are likely multi-determinant. At the cognitive level, autobiographical memory is cue-dependent; images of family, neighbourhoods, and meaningful objects unlock rich, episodic recall. Music is a particularly powerful cue and can evoke emotionally intense, self-relevant memories even under cognitive decline, likely via medial prefrontal and broader cortical networks that remain relatively engaged by familiar music. Incorporating a favourite song or theme into a DST narrative can therefore function as more than soundtrack, it can be a retrieval scaffold that helps authors find and sustain the thread of their own story when other channels are unreliable (Janata, 2009; Cuddy et al., 2015). At the motivational level, self-determination theory predicts that interventions supporting autonomy (choosing the story), competence (learning and completing small editing tasks), and relatedness (sharing with others) tend to be more engaging and effective; DST was effectively built to press these levers. At the lifespan-motivational level, socioemotional selectivity theory suggests that as time horizons narrow, people prioritize emotionally meaningful goals and close partners; DST’s focus on cherished people, places, and moments aligns with these priorities, both in topic selection and in audience (McAdams & McLean, 2013; Ryan & Deci, 2000).

Continuity theory and the related model of Selective Optimization with Compensation (SOC) offer further purchase on DST’s fit for later life. Continuity theory argues that older adults prefer to adapt by preserving links with internal structures (self-concepts, roles, values) and external structures (habits, relationships, places) where possible, modifying them gradually when change is unavoidable; SOC describes the strategies by which people select valued goals, optimize practiced skills, and compensate for losses. DST is essentially “continuity-through-media”: it invites people to bind past and present with familiar materials, family photographs, heirloom images, neighbourhood landmarks, favourite songs, while experimenting with a new format and audience. In doing so, it provides a gentle bridge between long-standing identities and contemporary participation,

whether the context is a community library workshop or a memory-clinic visit (Atchley, 1989; Baltes & Baltes, 1990). And because many older adults already communicate with relatives via smartphones and messaging apps, DST often leverages tools that are present in everyday life, lowering the barrier to repeated use beyond a single program or research session.

In practice, DST with older adults is most effective when it is narrative-first and tech-second. The heart of the method is a clear, specific insight a turning point, a lesson learned, a sense of place that the author cares to share. Facilitators then scaffold the arc (beginning-middle-end), co-select a small number of powerful images, and help the author find the *voice* of the story in a short script. Low-cognitive-load support (large-font scripts, high-contrast interfaces, a clip-on microphone to reduce re-recording) makes the process manageable; story circles with three to five peers bring audience and feedback while keeping social demands contained. When cognitive impairment is present, co-authorship with a trusted family member can protect authorship while compensating for working-memory limits, and visual storyboards keep the structure externally visible. Across community and care settings, these micro-design choices honour authorship and sustain dignity while keeping the emotional labour of storytelling safe and contained (West et al., 2022; Gubrium, 2009).

Evidence from adjacent “life story” practices in dementia care clarifies DST’s value within person-centered frameworks. Life Story Books (LSBs) photo-based, often paper artifacts combining images and captions are associated with improved autobiographical memory, mood, communication, and relationships in care settings, although reviews emphasize heterogeneity and the need for larger trials. DST adds voice and sound to these gains and often includes a social screening moment that can shift how staff and family *see* a resident or patient, thereby influencing everyday interactions. Notably, randomized work on Online Life Story Book (OLSB) a home-based, volunteer-supported digital reminiscence intervention shows that while group-level changes in neuropsychiatric symptoms may be small or nonsignificant, caregiver distress can decrease during the intervention, and satisfaction and engagement are high. These findings point to DST’s relational mechanisms: when families have a dignified, co-created artifact and a structured opportunity to reflect, the *tone* of care can change even before clinical scales do (Elfrink et al., 2018; Elfrink et al., 2021).

Because DST produces media that can circulate widely, ethics and governance are integral to gerontological adaptation. A situated ethics approach for participatory visual and digital methods recommends (a) iterative, tiered consent (e.g., “private,” “family only,” “closed group,” “public”), (b) clear authorship and ownership policies, (c) options to revise or retract after initial screening, (d) attention to “the power of shaping” during editing (i.e., ensuring the storyteller’s voice guides selection and sequence), and (e) secure storage and controlled sharing (Gubrium et al., 2014). For participants with fluctuating decision-making capacity, facilitators should plan brief consent refreshers at each step and designate a

proxy who understands the storyteller's preferences. These measures centre personhood and enable the *benefits* of audience to be realized without undue risk, especially when stories include sensitive material about relationships, loss, or migration. Ethical clarity also supports sustainability: when families and organizations trust the process, DST can be integrated into routine programming rather than remaining a pilot curiosity (Gubrium et al., 2014).

From the standpoint of digital inclusion, DST is a double opportunity. On the one hand, it motivates novice users to practice digital skills that generalize to telehealth, messaging, and online services recording audio, organizing photos, uploading files, because the task is meaningful. On the other hand, it risks exacerbating exclusion if programs presume devices, connectivity, or prior literacy. Reviews of DST and ageing recommend embedding workshops in age-friendly, resource-rich settings, libraries, community centres, and clinics with device loans, Wi-Fi, and trusted helpers, and pairing older adults with students or volunteers who act as technical scribes. Clear role definitions are essential: the older adult is the author; the helper is a scribe/engineer who executes the author's choices. This arrangement protects autonomy and tends to increase satisfaction for both partners, while building bridges across generations (Chang et al., 2023; West et al., 2022). Evaluation should be fit for purpose. When DST is used for identity and meaning, mixed-methods designs that combine standardized well-being scales (e.g., life satisfaction, ego-integrity, purpose-in-life) with qualitative analysis of narrative themes can capture both breadth and depth. When the aim is social connectedness, loneliness scales and social-network indicators can be complemented by audience feedback and observed engagement at screenings. For cognitive engagement, short attention and verbal fluency tasks can be administered pre/post story construction; for dementia-focused adaptations, caregiver-reported neuropsychiatric inventories and burden indices should be included. Process metrics, enrolment, retention, story completion, and usability logs provide critical feasibility signals for ageing populations. The systematic literature on DST already emphasizes heterogeneity in measures; a scoping approach encourages clarity about mechanisms and outcomes a priori so that programs can learn cumulatively rather than re-inventing measures each time (Ríos Rincón et al., 2022; Rieger et al., 2018; West et al., 2022).

Crucially, DST is not a panacea. It is a medium, a scaffolding for authorship, connection, and continuity, that acquires its effects from design and context. Programs that rush the process, overload participants with technical choices, or treat the story as a product rather than a relationship event often fail to achieve the benefits that narrative theory predicts. Conversely, programs that lean into story (not software), offer micro-steps, respect authorship, and plan an audience usually see the gains described in the literature: a stronger sense of voice, moments of recognition within families and peer groups, and practical artefacts that support person-centered care. The research agenda going forward is clear: larger, well-controlled trials with defined mechanisms (autobiographical retrieval, basic psychological-needs support), attention to moderators (cognitive status, culture, facilitation quality), and

attention to sustainability (cost, staffing, integration into services) will help move the field from promise to standard practice (Ríos Rincón et al., 2022; West et al., 2022). At its best, DST is a way of honouring the narrative intelligence that older adults have been practicing all along. It makes space for the “small stories” that comprise a life; it enlists familiar materials and practices (photos, songs, local places) to sustain identity continuity; it builds bridges across generations; and it offers clinicians and community workers a concrete, ethical tool for person-centered care. Narrative gerontology has long argued that ageing is, in part, a matter of telling, re-telling, and living out the stories that give life its shape; DST brings that argument down to earth, and onto the screen, where it can be created together, re-watched, and carried forward. In doing so, it aligns theory and practice: identity is reconstructed in the telling, and participation is realized in the sharing.

#### IV. REMINISCENCE, LIFE REVIEW, AND PERSONHOOD

Digital storytelling (DST) offers a contemporary, media-rich vehicle for the long-standing aims of reminiscence and life review by translating their core therapeutic tasks, selecting meaningful memories, organizing them into a coherent arc, and sharing them with an audience, into short, participant-authored multimedia narratives. Across classic meta-analyses, reminiscence and life-review programs have been associated with moderate improvements in depressive symptoms, ego-integrity, life satisfaction, and related outcomes, with structured life review typically outperforming unstructured reminiscence (Bohlmeijer et al., 2007; Pinquart & Forstmeier, 2012). More recent syntheses reinforce these effects in community and clinical contexts, while also emphasizing protocol variability and attenuation at follow-up for late-life depression, signals that point toward the value of maintenance and booster components (Tam et al., 2021; Lin et al., 2024). For dementia care, systematic and Cochrane reviews converge on small-to-moderate but heterogeneous benefits for mood, communication, and quality of life, coupled with high acceptability and wide uptake (Park et al., 2019; Woods et al., 2018). Within this empirical landscape, DST functions as a practical bridge: it retains the identity-affirming, person-centred logic of reminiscence and life review while adding the distinctive affordances of voice, image, and shareable media objects.

The DST process itself is designed to scaffold authorship and meaning-making. In typical programs, older adults identify a single insight or turning point, storyboard a brief narrative arc, select a small set of resonant images (often family photographs, neighborhood places, or cherished objects), record a 200-400-word script in their own voice, and align images and audio into a three- to five-minute story using simple editing software. This practical protocol, popularized by Lambert and colleagues at Story Center, emphasizes “story first, technology second” and has been widely adopted across community, clinical, and research settings (Lambert & Hessler, 2018). Health-research reviews describe DST as an arts-based, participatory method that “elucidates complex narratives,” increases engagement, and enhances the meaning of findings precisely because participants select, sequence,

and voice their own experiences (Rieger et al., 2018; West et al., 2022). For older adults, these features place control back in the hands, and the voice, of the storyteller, aligning the method with person-centred gerontology while remaining feasible with low-cost tools and brief facilitation. DST is also theoretically well-positioned within narrative gerontology and narrative identity research. Narrative gerontology emphasizes that humans are “storied beings” who preserve coherence and meaning in later life by (re)authoring and sharing life narratives (Randall & Kenyon, 2004; Kenyon & Randall, 2015). Psychological work on narrative identity shows that the self is an internalized, evolving life story integrating reconstructed past with imagined future; longitudinal studies link agentic and redemptive narrative themes with better mental-health trajectories over several years, including among mid- to later-life adults (McAdams, 2001; McAdams & McLean, 2013; Adler et al., 2015; Adler et al., 2016). DST provides a concrete medium for this identity work: it encourages authors to articulate agency (“what I did when...”), construct meaning (“what it meant then and now”), and transform setbacks into growth, while preserving authorship via recorded voice and a final artifact that can be revisited and shared. The fit between theory and method helps explain why even brief, well-facilitated DST workshops often yield felt gains in self-confidence, recognition, and connection that extend beyond formal scale changes.

Mechanistically, several processes likely contribute to DST’s effects. At the cognitive level, autobiographical memory is cue-dependent; personally meaningful images and especially familiar music can unlock vivid, affectively rich recall. Neurocognitive evidence indicates that music can evoke autobiographical memories via medial prefrontal pathways implicated in self-referential processing, with such music-evoked memories often remaining accessible even when other channels of recall falter (Janata, 2009; Cuddy et al., 2015). Incorporating a favorite song or soundtrack into a DST piece can therefore operate as a retrieval scaffold, particularly salient for individuals with cognitive change. At the motivational level, self-determination theory predicts that interventions supporting autonomy (choosing the story), competence (learning and completing bite-size editing steps), and relatedness (sharing with others) enhance engagement; DST’s participatory design is structured to press these levers. At the lifespan-motivational level, socioemotional selectivity theory suggests that as time horizons narrow, people prioritize emotionally meaningful goals and close partners, which maps naturally to DST topics and audiences. In combination, these mechanisms make DST an efficient way to “stack the deck” for recall, motivation, and connection in later life. Person-centred care provides the conceptual context for DST’s use in dementia. Kitwood’s framework reoriented dementia services around personhood, dignity, and relational identity, urging carers to see “the person behind the patient” and to build everyday routines that sustain that personhood (Kitwood, 1997). Life-story practices operationalize this stance. Systematic reviews of Life Story Books (LSBs) report promising signals for autobiographical memory, mood, communication, and relationships, while calling for larger, rigorous trials and clearer implementation guidance (Elfrink

et al., 2018). DST extends the life-story tradition by adding voice, pacing, and the social energy of screenings. In the small but growing body of controlled work with online or digital life-story formats, caregiver distress sometimes decreases despite modest changes in neuropsychiatric symptoms, an effect consistent with DST’s relational mechanisms, in which shared authorship and a dignified artifact shift the tone of everyday interactions (Elfrink et al., 2021). In day-to-day practice, care teams often report that a three-minute DST piece rehumanizes a resident, staff can “see and hear” the relationships, places, and roles that matter, thereby improving communication and individualized care planning.

Empirically, DST with older adults is no longer a novelty but not yet a mature clinical technology. A systematic review focused on older adults with typical ageing and with mild cognitive impairment or dementia mapped 34 studies; aims clustered around reminiscence, identity, memory, and self-confidence, with generally positive psychosocial signals but heterogeneous measures and low overall certainty of evidence (Ríos Rincón et al., 2022). A complementary scoping review framed benefits across connecting (relationships and belonging), mediating (sense-making and emotion regulation), and setting (digital skills and participation), emphasizing feasibility and acceptability while inviting more rigorous trials (Chang et al., 2023). Methodological reviews in health research, meanwhile, underscore DST’s rigor as a qualitative/participatory method when protocols safeguard authorship and ethics; they also detail common pitfalls (over-engineering the tech; treating stories as “data extraction” rather than co-authored meaning-making) that degrade both experience and outcomes (Rieger et al., 2018; West et al., 2022). Together, these reviews suggest that DST’s strongest use cases in gerontology are identity and relationship work, communication with families and staff, digital inclusion, and community engagement; where symptom reduction is the primary endpoint, benefits may be modest unless DST is paired with maintenance, social embedding, and caregiver involvement.

Design principles flow directly from these lessons. Narrative comes first: begin with a single, specific insight or moment that matters to the author; storyboard a simple arc; and limit the media set (often 8-12 images) to reduce cognitive load. Facilitation should be light-touch but structured, story circles of three to five peers for feedback, large-font scripts, high-contrast editing interfaces, and clip-on microphones to minimize re-takes. Technical helpers act as “scribes/engineers” and are explicitly instructed to execute the author’s choices rather than steer content. When cognition is compromised, co-authorship with a trusted family member can preserve the author’s voice while providing necessary compensations (e.g., a visual storyboard that keeps sequence visible, scheduled breaks, and simplified export/sharing steps). Plan an audience moment, a small screening for family, peers, or staff, to convert private reflection into public recognition, while offering opt-in consent levels (“private,” “family only,” “closed group,” “public”) that can be revised after screening (Lambert & Hessler, 2018; Gubrium et al., 2014). Ethics require special attention because DST produces

durable, shareable media. A “situated ethics” approach for visual and digital methods highlights six recurring challenges: fuzzy boundaries; recruitment and consent; power of shaping during editing; representation and potential harm; confidentiality; and release of materials. Practical responses include staged consent with tiered sharing options; explicit authorship/ownership statements; edit logs that document who made what choices; opportunities for revision after first screening; and secure storage with clear retention policies. For participants with fluctuating capacity, brief consent refreshers at each step, involvement of a proxy familiar with the storyteller’s preferences, and default-private distribution are prudent. Ethical clarity not only protects participants; it also makes programs sustainable by building trust with families and organizations that control access to images, devices, and venues (Gubrium, 2009; Gubrium et al., 2014).

Digital inclusion is both a rationale and an outcome for DST. Storymaking motivates novices to practice generalizable skills, recording audio, organizing photos, exporting files, because the task is meaningful and socially rewarded. At the same time, programs must avoid reproducing the digital divide. Reviews recommend delivering DST in resource-rich, age-friendly settings (libraries, community centres, clinics); providing loaner devices and Wi-Fi; pairing older adults with students or volunteers as technical scribes; and keeping software choices simple and consistent across sessions. Clear role definitions, “the older adult is the author; the helper is the scribe/engineer”, protect autonomy while creating intergenerational bridges that often persist beyond the workshop. These implementation details are repeatedly cited in reviews as determinants of feasibility and acceptability in ageing populations (Chang et al., 2023; Rieger et al., 2018; West et al., 2022).

For clinicians and program designers, outcome selection should be “fit for purpose.” When DST is used primarily for identity and meaning, mixed-methods designs that pair standardized scales (ego-integrity, purpose-in-life, life satisfaction) with qualitative analysis of narrative themes capture both breadth and depth. When social connectedness is the aim, loneliness and belonging scales can be complemented by audience feedback and observed engagement during screenings. For cognitive engagement, short attention or verbal-fluency tasks can be administered pre/post story construction; in dementia-focused work, caregiver-reported Neuropsychiatric Inventory scores and burden indices are important. Process metrics, enrolment, retention, story completion rates, user-experience logs, signal feasibility; fidelity checks (e.g., proportion of author-led edits, presence of an audience event) illuminate what “dose” of DST is being delivered. Such measurement discipline addresses concerns raised in meta-analyses about heterogeneity and maintenance, and supports cumulative learning across sites (Lin et al., 2024; Park et al., 2019; Woods et al., 2018; Ríos Rincón et al., 2022).

Several practical variations deserve consideration. Music-anchored DST leverages the robust retrieval power of familiar songs in both healthy ageing and Alzheimer’s

disease; programs can prompt authors to pick “a song that takes you back,” then build images and narration around the feelings and scenes it evokes (Janata, 2009; Cuddy et al., 2015). Place-anchored DST uses neighborhood landmarks and home images to centre the story in familiar environments, an approach that resonates with “ageing in place” logics and can be valuable in relocation or care-transition planning. Family-bridging DST explicitly invites a younger collaborator (grandchild, student) to act as producer/engineer, opening space for intergenerational exchange while protecting ownership. Care-team-facing DST creates short “about me” pieces co-authored with the older adult and family, screened during staff orientation to support person-centred routines (e.g., preferred morning rituals, conversation starters). These variants keep the core narrative task intact while aligning distribution and audience with specific goals.

It is also worth recognizing limitations. DST is not a panacea; it is a medium whose effects depend on context, facilitation quality, and alignment with participant priorities. Programs that over-engineer the technology, compress the timeline, or treat stories primarily as research “data” tend to produce weaker experiences and smaller gains. In contrast, programs that keep the cognitive load low, honour authorship, and plan for audience moments tend to realize the benefits seen in narrative and reminiscence literatures. The broader evidence base for reminiscence and life review suggests moderate, immediate gains with some attenuation, so DST programs that build in follow-up viewings, periodic “new story” prompts, or family-led reuse (e.g., playing a story during visits) are more likely to sustain outcomes. Ongoing trials of digital life-story interventions indicate high satisfaction and sometimes reductions in caregiver distress, hinting that system-level effects may emerge even when symptom scales move slowly (Elfrink et al., 2018; Elfrink et al., 2021).

In sum, DST aligns the best-supported psychosocial traditions in gerontology with accessible contemporary media. By guiding older adults to select and voice personally significant memories, structuring those memories into a short arc, and sharing the finished story with chosen audiences, DST advances the aims of identity continuity, mood support, and social connection that reminiscence and life review have pursued for decades, now with artifacts that can circulate across families and care teams. The empirical base for DST in ageing is promising, particularly for identity, belonging, and digital inclusion, and is convergent with meta-analytic literatures on reminiscence and life review as well as person-centred dementia care. Continued work on rigor, fidelity, maintenance, and ethics will help convert that promise into standard practice, ensuring that older adults’ stories are not only told but preserved and put to work in the relationships and settings that matter most.

## V. CONTINUITY ACROSS THE LIFE COURSE

Continuity theory offers a powerful lens for understanding why digital storytelling (DST) resonates so deeply with many older adults: in later life, adaptation is often achieved by preserving links with earlier selves and routines,

maintaining internal structures (self-concepts, values, roles) and external structures (habits, relationships, environments) where possible, and adjusting them gradually when change is unavoidable (Atchley, 1989). When this perspective is set alongside the lifespan model of Selective Optimization with Compensation, which posits that people select goals aligned with long-standing interests, optimize practiced skills, and compensate for losses, DST emerges as an ideal modality for “continuity-through-media.” By inviting curatorship of personally meaningful materials and practices, choosing which photographs to include, which life episodes to emphasize, which music to pair with a scene, DST allows older adults to draw on familiar strengths while experimenting with new digital formats. Empirical work on “aging in place” underscores the point: attachment to home and neighborhood contributes to identity continuity and everyday competence when social and environmental supports are present. In this light, DST does not ask people to abandon the past; it offers structured means to weave the past into present participation, social connection, and care encounters (Atchley, 1989; Baltes & Baltes, 1990; Wiles et al., 2012).

The cognitive and affective mechanics of DST build on robust science concerning autobiographical memory cues. Familiar music, for example, is a potent trigger of vivid, affectively rich recollections, even in the context of cognitive impairment, because it engages medial prefrontal and broader cortical networks associated with personally salient episodic recall. Photographs and place-based imagery operate similarly as “entry points” into autobiographical memory, but music’s privileged pathway is especially relevant when assembling short, voice-narrated stories that aim to capture felt significance in two to five minutes. Converging evidence shows that music-evoked autobiographical memories recruit dorsal medial prefrontal cortex as a hub, that healthy older adults readily access such memories, and that people living with mild-to-moderate Alzheimer’s disease retain musical engagement and can retrieve music-linked experiences despite broader deficits. Integrating familiar music into DST, therefore, is not an embellishment but a mechanism, one that preserves access to emotional meaning when other channels falter (Janata, 2009; Cuddy, Sikka, & Vanstone, 2015).

Against this neurocognitive backdrop, DST can be defined precisely for gerontological practice. It is an arts-based, participatory method that guides people to produce compact (typically 3–5 minute) autobiographical films that interleave recorded voice with photographs, scanned ephemera, and music. In health research, DST’s appeal lies in how it elicits complex lived experience, fosters engagement and agency, and translates personal meaning into shareable artifacts that can circulate among families, peers, and care teams. Methodologically, DST descends from the StoryCenter model popularized by Lambert, which teaches a “Seven Steps” approach to clarifying a personal insight, focusing a narrative arc, selecting images and sound, and shaping the final edit for a specific audience. These practices map well onto therapeutic and community settings in aging, where short peer workshops or one-to-one facilitation can scaffold story development, help participants practice digital

tasks at a manageable pace, and culminate in screenings that confer social recognition (Rieger et al., 2018; Gubrium, 2009; Lambert, 2018).

Evidence syntheses focused specifically on older adults, including those with typical aging and those with cognitive impairment, suggest that DST is feasible, acceptable, and associated with a constellation of psychosocial benefits, albeit with heterogeneity in designs and outcome measures. A systematic review by Ríos Rincón and colleagues mapped 34 studies, identifying recurring aims in memory, reminiscence, identity, self-confidence, and social connection; while signaling generally positive outcomes, the review also cautioned that much of the evidence base comprises small qualitative or feasibility studies, underscoring the need for rigorous trials. A complementary scoping review by Chang and co-authors likewise concluded that DST can reduce loneliness and depressive affect, strengthen relationships, and cultivate a sense of voice, though protocols and measurement vary widely across settings. Broader methodological reviews of DST in health research converge with these findings, characterizing DST as a participatory, meaning-rich method that can enhance engagement and knowledge translation, qualities especially relevant to gerontological care where motivation and relational fit determine whether an intervention “lands” in everyday life (Ríos Rincón et al., 2022; Chang, Do, & Ahn, 2023; Rieger et al., 2018).

Within dementia-focused practice, DST aligns with person-centered care precisely because it enacts personhood in a tangible, shareable form. Life-story approaches, assembling photographs, artifacts, and narratives into book or multimedia formats, help relatives and staff “see the person behind the patient,” improving individualized support, communication, and mood. Systematic reviews of Life Story Books (LSBs) report benefits for autobiographical memory, relationships, and well-being, while calling for larger, more rigorous trials to consolidate effects; this literature provides a conceptual and practical bridge into DST, which adds voice, sound, and the social experience of co-viewing to the life-story toolkit. Importantly, randomized studies of Online Life Story Book (OLSB), a digital reminiscence intervention delivered at home with volunteer support over approximately 8–10 weeks, suggest that while primary outcomes on neuropsychiatric symptoms may show no group-level differences, caregiver distress can decrease during the intervention period, and process evaluations indicate strong acceptability and engagement. Taken together, these strands of evidence justify DST’s deployment not as a cure-all but as a dignified, relationship-centered practice that can complement clinical care, support identity continuity, and offer families concrete artifacts around which to convene (Elfrink et al., 2018; Elfrink et al., 2017; Elfrink et al., 2021).

Mechanistically, DST sits at the intersection of continuity theory, narrative identity, self-determination theory, and socioemotional selectivity. Narrative identity research conceptualizes the self as an internalized, evolving life story that integrates reconstructed past with imagined future; by supporting the articulation and sharing of such stories, DST provides scaffolding for adaptive meaning-

making in later life transitions. Self-determination theory highlights that motivation and well-being hinge on satisfying needs for autonomy, competence, and relatedness; DST readily targets all three through participant authorship (autonomy), graduated skill-building in recording and editing (competence), and audience feedback and co-creation with peers or family (relatedness). Socioemotional selectivity theory predicts a preference for emotionally meaningful goals as perceived time horizons narrow; DST's focus on cherished people, places, and moments leverages this shift to sustain engagement. These convergent theories help explain why DST can be both acceptable and sustaining in older adulthood, and why tailoring facilitation to amplify authorship and connection is pivotal (McAdams, 2001; Ryan & Deci, 2000; Carstensen, Isaacowitz, & Charles, 1999).

From a design standpoint, DST with older adults benefits from low cognitive load, high personal relevance, and predictable structure. A prototypical workflow uses brief prompts to elicit a focused episode (“a time I learned resilience,” “the place that always brings me peace”), followed by guided selection of 8–12 images and a 200–400 word script, recorded in the participant's own voice. Facilitators then support basic editing, often in two or three short sessions, to align voiceover and images and to add a familiar song or ambient sound. Story circles, a hallmark of StoryCenter practice, can be adapted for gerontology by ensuring small groups, clear turn-taking, and check-ins for comfort and fatigue. This pacing aligns with continuity theory's gradualism and with SOC's emphasis on selecting attuned goals and compensating (e.g., using larger-font scripts, high-contrast interfaces, external microphones to reduce re-recording). When the process culminates in a family or community screening, the social recognition aspect reinforces identity and relatedness, translating private meaning into public acknowledgment (Lambert, 2018; Baltes & Baltes, 1990).

Choice of materials matters. Family photographs and heirloom images anchor the visual thread; neighborhood landmarks and domestic spaces situate the story in a familiar geography; and music, when used judiciously, can “unlock” scenes that are otherwise difficult to narrate. These design choices are not merely aesthetic; they are mechanistic levers that recruit spared or resilient memory systems and support continuity. The neural literature on music-evoked autobiographical memory provides a translational rationale for integrating a favorite song, and the observational literature on musical engagement in Alzheimer's disease supports its use when cognitive resources are strained. The result is a form of continuity-through-multisensory media: continuity with treasured people and places, continuity of roles (e.g., grandparent, craftsperson, teacher), and continuity of affective tone, all framed in a new, shareable format that meets contemporary media practices (Janata, 2009; Cuddy et al., 2015).

Delivery models can flex across contexts without losing the core of autobiographical authorship. Community libraries, senior centers, and adult education programs can host 6–10 week workshops with alternating story

development and basic editing sessions, while primary care or memory clinics might offer briefer, one-to-one DST appointments that culminate in a single 2–3 minute narrative tied to a meaningful health moment (e.g., “how I keep walking with my friends,” “the neighborhood that helps me feel safe”). Long-term care settings often pair DST with life story work so that the final videos augment paper-based profiles in care plans; evidence shows that such profiles improve staff understanding and family–staff communication, consistent with person-centered care principles. In all cases, co-creation can involve family or volunteers to reduce cognitive and digital burden while preserving authorship, an approach validated in OLSB trials where trained volunteers scaffold the process over 8–10 weeks in home settings (McKeown et al., 2010; Elfrink et al., 2017; Elfrink et al., 2021).

Accessibility and inclusion are central to gerontological DST. Interfaces should offer high-contrast displays, large buttons, and minimal on-screen choices. Bilingual or vernacular-language narration supports cultural resonance; printed scripts in large font and simple storyboards aid planning when working memory is limited; and captions or transcripts support hearing impairment and improve accessibility for screenings. The StoryCenter “Seven Steps” can be adapted explicitly for older adults by building in “micro-steps” that distribute cognitive load: one session to settle on a single insight, another to select 8–12 images, a third to record voiceover, and so forth. These features support autonomy and competence, satisfying self-determination needs that are predictive of engagement and well-being in later life. When such adaptations are paired with intergenerational teams, students or younger community members acting as “digital doulas” of a sort, DST doubles as a digital literacy bridge and a site of intergenerational reciprocity (Lambert, 2018; Ryan & Deci, 2000).

Ethics, privacy, and representation require explicit attention in DST because the artifacts can circulate far beyond the original workshop. A widely cited ethical framework for participatory visual and digital methods outlines practical safeguards across six recurrent challenges: fuzzy project boundaries, recruitment and consent, the “power of shaping” during editing, representation and potential harms, confidentiality, and release of materials. Applied to DST in aging, this entails tiered consent for different audiences (family-only, closed group, public), options to edit out sensitive content after the first screening, secure storage, and clear ownership policies that keep control with the storyteller or their proxy. In clinical contexts, careful coordination with guardians and care teams is essential, especially for participants with fluctuating decision-making capacity. Transparent facilitation and consent refreshers throughout the process honor personhood and mitigate risks while preserving the narrative benefits that make DST valuable (Gubrium, Hill, & Flicker, 2014).

Outcome evaluation in DST should match the aims. For identity and meaning, validated scales such as life satisfaction, ego-integrity, or purpose-in-life can be paired with qualitative coding of narrative themes (e.g., redemption

sequences, turning points) to capture depth. For social connectedness, measures of loneliness and social network participation can be supplemented by audience feedback at screenings. For cognitive engagement, brief attention and verbal fluency tasks administered pre/post story construction can indicate stimulation effects; for dementia-focused programs, caregiver-rated neuropsychiatric inventories and caregiver burden indices are appropriate. The OLSB randomized trial illustrates the importance of multi-actor outcomes: even when the person with dementia shows stable neuropsychiatric symptoms, reductions in caregiver distress may still represent a meaningful benefit, especially if stories catalyze new conversations and shift the emotional tone of care routines at home. Process evaluation, attendance, completion rates, usability logs, and participant reflections, should be standard, given heterogeneity in protocols and the centrality of feasibility for aging populations (Elfrink et al., 2017; Elfrink et al., 2021; Ríos Rincón et al., 2022).

Conceptually, DST also advances continuity across the life course by translating everyday artifacts into durable cultural memory objects. A short film about a marriage ritual, a neighborhood courtyard, a crafts bench, or a favorite devotional song becomes a communicative bridge to younger kin and a practical aid for staff in times of transition or distress. Such artifacts support identity continuity during hospitalization or relocation to long-term care, where unfamiliar routines can unsettle role and place. The life-story literature shows that even paper-based books can improve communication and relationships; adding voice and music deepens affective resonance and can be replayed on demand by family or staff, extending continuity beyond a single interaction (Elfrink et al., 2018; Wiles et al., 2012).

At the same time, a scoping perspective warrants caution against overgeneralization. Reviews agree that effects vary by format (group vs. individual), dose (number and spacing of sessions), facilitation quality, and participant cognitive profile. Digital exclusion remains a structural risk if programs presume device ownership, broadband, or prior familiarity with editing software. These are solvable design problems: loaner devices, offline-capable apps, and workflow simplification can lower barriers; embedding DST in community hubs (libraries, resource centers) or clinical services (occupational therapy, memory clinics) can stabilize access and staffing; and partnerships with cultural organizations can ensure that imagery, language, and music reflect local lifeworlds. The point is not that DST is universally effective, but that, when anchored in autobiographical authorship and supported by accessible design, DST is a highly adaptable medium for continuity, connection, and inclusion in later life (Ríos Rincón et al., 2022; Chang et al., 2023; McKeown et al., 2010).

For practitioners, a practical template emerges: begin with continuity by asking for a single, meaningful moment; scaffold autonomy by letting the storyteller pick the images and sound that “feel right”; bolster competence with stepwise micro-tasks and accessible tools; and amplify relatedness through story circles and screenings that invite family and peers. Where cognitive impairment is present, build in

compensations: co-authorship with a trusted relative, visual storyboards to externalize working memory, cueing with music and objects, and shorter recording sessions. In long-term care or home care, layer DST onto existing life story work so that every video explicitly adds to the person’s care profile, with clear instructions for staff about when and how to use the stories (e.g., before personal care, during agitation, or to initiate meaningful conversation). Such alignment ensures that the digital artifact is not an isolated product but a living component of person-centered care (McKeown et al., 2010; Elfrink et al., 2018).

Programmatically, intergenerational DST deserves emphasis because it addresses two aims at once: reducing loneliness and ageism through meaningful contact, and closing the digital divide through peer teaching. Scoping reviews report that DST projects often foster social bonds and self-confidence, particularly when participants co-create and discuss their stories in groups; pairing older adults with students or community volunteers adds sustained contact and skills transfer. Clear role definitions, older adult as author and narrator; younger partner as technical scribe, protect autonomy and avoid the “power of shaping” drifting from the author to the editor. When coupled with ethical guardrails (tiered consent, secure storage, post-screening edit options), such programs can safely scale in community and educational settings (Chang et al., 2023; Gubrium, 2009; Gubrium, Hill, & Flicker, 2014).

Finally, DST’s compatibility with contemporary media ecologies makes it a forward-looking strategy for healthy aging. Most smartphones and tablets now include built-in voice recorders, photo scanners, and simple video editors; accessible guides, whether Story Center’s “Seven Steps” or open digital storytelling handbooks, lower the technical floor, allowing facilitators to focus on the story work rather than software troubleshooting. In this sense, DST leverages continuity not only in the content of stories but in the tools people already use daily to communicate with family (messaging apps, photo galleries), thus increasing the odds that DST becomes a repeatable practice rather than a one-off event. The scoping evidence base is not complete, and further randomized and mixed-methods studies are needed to pinpoint mechanisms and moderators; yet across reviews and early trials, the signal is consistent: when grounded in autobiographical authorship and delivered with ethical, inclusive design, DST sustains identity, supports relationships, and offers older adults dignified participation in the cultural practices of the present (Lambert, 2018; Rieger et al., 2018; Ríos Rincón et al., 2022; Elfrink et al., 2021).

## VI. DISCUSSIONS AND FINDINGS

Anchored in continuity theory and Selective Optimization with Compensation, digital storytelling (DST) fits later life because it enables “continuity-through-media,” letting older adults curate familiar photographs, places, and music to bridge past and present while experimenting within a manageable format; this alignment is reinforced by socioemotional selectivity’s emphasis on emotionally meaningful goals and close partners, cue-dependent

autobiographical memory (especially music-evoked recall), and self-determination theory's focus on autonomy, competence, and relatedness (Atchley, 1989; Baltes & Baltes, 1990; Carstensen et al., 1999; Janata, 2009; Cuddy et al., 2015; Ryan & Deci, 2000). Building on meta-analytic evidence that structured reminiscence and life review yield moderate gains in depressive symptoms, ego-integrity, and life satisfaction, with variability and some attenuation at follow-up, DST preserves person-centred logic while adding voice, sound, and a portable artifact whose social screening can convert private reflection into public recognition; in digital life-story trials, caregiver distress sometimes decreases even when primary symptoms shift modestly, underscoring relational mechanisms and system-level value (Bohlmeijer et al., 2007; Pinquart & Forstmeier, 2012; Tam et al., 2021; Lin et al., 2024; Woods et al., 2018; Park et al., 2019; Lambert & Hessler, 2018; Rieger et al., 2018; Elfrink et al., 2018; Elfrink et al., 2021). Empirically, a review mapping 34 studies reports high feasibility and acceptability with promising signals for identity, memory, self-confidence, and connection, while a complementary scoping review synthesizes benefits across connecting (belonging, relationships), mediating (sense-making, emotion regulation), and setting (digital skills, participation); methodological syntheses emphasize DST's participatory rigor when authorship and ethics are safeguarded, and flag pitfalls such as over-engineering technology or treating stories as extractive data (Ríos Rincón et al., 2022; Chang et al., 2023; Rieger et al., 2018; West et al., 2022). Within person-centred dementia care, life-story practices improve autobiographical memory, relationships, and communication, and DST extends these gains by adding recorded voice and co-viewing moments that rehumanize residents and inform individualized routines (Elfrink et al., 2018; Woods et al., 2018). Given that DST produces durable media, a situated-ethics stance, tiered consent options (private/family-only/closed group/public), explicit authorship and ownership, revision or retraction opportunities after first screening, attention to the "power of shaping" during editing, and secure storage, together with consent refreshers and proxies for fluctuating capacity, is non-negotiable (Gubrium et al., 2014). To prevent digital exclusion while leveraging DST's motivational pull for generalizable skills (recording, organizing, exporting), reviews recommend resource-rich settings, loaner devices and Wi-Fi, simple consistent software, and intergenerational pairing in which the older adult remains author and the younger partner acts as technical scribe (Chang et al., 2023; West et al., 2022; Rieger et al., 2018). Implementation heuristics converge on a narrative-first, tech-second workflow, one clear insight, a simple arc, 8–12 images, a 200–400-word voiceover, plus micro-design choices (large-font scripts, high-contrast interfaces, clip-on microphones, small story circles) and compensations for cognitive change (co-authorship with a trusted relative, visual storyboards, shorter sessions); evaluation should be "fit for purpose," pairing standardized scales (e.g., life satisfaction, ego-integrity, purpose, loneliness, belonging; attention/fluency; caregiver burden and neuropsychiatric inventories where relevant) with qualitative analysis of narrative themes, and should include process and fidelity indicators (enrolment, retention, completion, usability logs;

proportion of author-led edits; presence of an audience event) to address heterogeneity and support cumulative learning across sites (Lambert & Hessler, 2018; West et al., 2022; Lin et al., 2024; Park et al., 2019; Woods et al., 2018; Ríos Rincón et al., 2022; Rieger et al., 2018).

## VII. CONCLUSION

DST brings the commitments of narrative gerontology and person-centred care into a concrete, ethically governed practice that older adults can author, rewatch, and share. By inviting people to select personally significant moments, structure them into a brief arc, and voice them in their own words, DST advances identity continuity, social connection, and digital inclusion, the very outcomes that reminiscence, life review, and narrative identity research indicate are malleable and meaningful in later life (Randall & Kenyon, 2004; McAdams & McLean, 2013; Bohlmeijer et al., 2007). The empirical signal is promising across typical ageing and cognitive impairment, especially for belonging, meaning, and caregiver experience, though stronger trials with clear mechanisms, moderators, and maintenance plans are needed (Ríos Rincón et al., 2022; Elfrink et al., 2021; Lin et al., 2024). Practically, programs that are narrative-first and tech-second, that plan for audience moments, and that embed tiered consent and inclusive supports tend to realize the benefits predicted by continuity theory (Atchley, 1989; Ryan & Deci, 2000; Carstensen et al., 1999; Gubrium et al., 2014). In short, when delivered with ethical clarity and design fidelity, DST is a scalable, dignified medium for "continuity-through-media," aligning theory and practice so that identity is reconstructed in the telling and participation is realized in the sharing (Lambert & Hessler, 2018; West et al., 2022).

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