HOW SPIRITUALITY TRAINING IMPACTS THE PRACTICE OF SOCIAL WORKERS ASSISTING ELDERLY CLIENTS IN END-OF-LIFE CARE: A HERMENEUTICAL PHENOMENOLOGICAL APPROACH

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ABSTRACT

Social workers in end-of-life care settings are presented with many challenges. They are not only confronted by the common stressors associated with death and dying, but also with the existential concerns of the patients and their families. Social workers typically outnumber spiritual advisors or chaplains in a hospice palliative care unit, and therefore have more frequent exposure to these needs of the patients. As an elderly patient, in particular, approaches end-of-life, the notions of religion and spirituality can take on a more significant role in acceptance of mortality. Social workers have reported reluctance in addressing the spiritual matters of their patients and have also expressed feeling ill equipped to deal with these issues. Spirituality training seminars have been linked with significant improvements in self-perceived compassion for the dying, compassion for oneself, and in reducing work-place stress. The research goal for this project was to seek to understand how spirituality and current spirituality training impacts the practice of social workers assisting elderly clients in end-of-life care settings. A secondary goal of this study was to explore the phenomenon of what it is like to deliver spiritual care as an end-of-life care social worker. A tertiary goal was to define and describe the nature of spirituality as social workers in hospice and palliative care settings conceive of it today. This study employed a hermeneutic phenomenological research approach (Gadamer, 1998) to explore the experience of five social workers in a local hospice/palliative care setting utilizing spirituality training with their elderly clients. Participants were sampled based on convenience from the cities of Winnipeg and Regina. Themes relating to the impact of spirituality training on participants' practice emerging from the data include: *feeling poised in difficult circumstances*, *appreciating different perspectives*,

complementing innate skills, and *perception of greater connection.* The themes emerging from data relating to how participants experience delivery of spiritual care include: *being curious and aware*, *listening and being present*, and *drawing on interdisciplinary teams*. Finally, the main themes expressing how participants describe spirituality are: *the disparity between spirituality and religiosity*, *belief in a greater power*, *feeling of connectivity*, and *the pursuit of meaning and purpose.* The conclusions of this research help to illuminate how spirituality training exercises are implemented in practice, as well as provide a better understanding of how spirituality education could be integrated into the post-secondary curriculum of social work study.

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CHAPTER ONE: Introduction

Social workers in end-of-life care settings are presented with many challenges. They are not only confronted by the common stressors associated with death and dying, but also with the existential concerns of the patients and their families (Daaleman, Usher, Williams, Rawlings, & Hanson, 2008; Morita et al., 2004; Sulmasy, 2002). Social workers typically outnumber spiritual advisors or chaplains in a hospice palliative care unit, and therefore have more frequent exposure to these needs of the patients (Wesley, Tunney, & Duncan, 2004). As an elderly patient approaches end-of-life, the notions of religion and spirituality can take on a more significant role in their acceptance of mortality (Chochinov & Cann, 2005; Tornstam, 1997a). Social workers have reported reluctance addressing the spiritual matters of their clients (Babler, 1997). They have also expressed to be ill prepared to deal with the existential issues their clients or the clients' family may be experiencing (Wesley et al., 2004). Participation in spirituality training seminars may ease this reluctance as such seminars have been linked with significant improvements in self-perceived compassion for the dying, compassion for oneself and in reducing work-place stress (Holland & Neimeyer, 2005; Wasner, Longaker, Fegg, & Borasio, 2005). The goal for this study, therefore, was to understand how current spirituality training impacts social workers assisting seniors in end-of-life care settings. This was accomplished by utilizing a hermeneutic (interpretive) phenomenological research design, consisting of in-depth interviews of five social workers who work with elderly patients. The primary concern of this study was to inquire into the lived experience of utilizing spirituality training practices (e.g., legacy making, ethical will writing) with elderly patients who are experiencing existential dilemmas. A secondary

goal of the study was to define and describe the nature of spirituality as practicing social workers may perceive of it today. The conclusions of this research help to illuminate how spiritual training exercises are implemented in practice, as well as provide a better understanding of how spiritual education could be integrated into the post-secondary curriculum of social work study.

Before examining the literature on spirituality training in end-of-life care, I will discuss the background and conceptual framework for the study. Then, I will define key concepts related to this project. Finally, I will present a reflexive narrative of how I came to be interested in this research area.

1.1 Background and Rationale

In Canada, seniors comprise the fastest growing age group. In 1971, seniors accounted for eight percent of the Canadian population. This almost doubled to 14.8 percent or 5 million people in 2011 (HRSDC, 2013). According to Statistics Canada (2010), this trend will project several decades in the future and by 2061 seniors will make up a quarter of the total population of Canada. With this expansion in the elderly population comes a higher demand for end-of-life services such as hospice and palliative care (Carstairs, 2010). According to Senator Sharon Carstairs (2010), of the approximately 250,000 people who die in Canada each year, 90 percent can benefit from palliative care.

Spirituality and religiosity are predominant traditions in the field of end-of-life care, however, like many health care professionals, social workers are ill prepared to deal with existential concerns or spiritual dilemmas their clients may have (Babler, 1997; Wesley et al., 2004). While the chaplain is the primary spiritual advisor in a hospice and palliative care facility, the social worker interacts with the client on a more regular basis,

and is thus more susceptible to questions about spiritual or existential matters (Wesley et al., 2004). Babler (1997) indicates that social workers are not provided with the necessary tools to deliver spiritual support and frequently struggle as professionals to recognize the extent to which their role allows for provision of spiritual care. Russel (1998) found that seventeen graduate social work programs in the U.S. offered separate courses on spirituality or religion. While studies from Canada are limited, a scan through five graduate social work programs across Canada (i.e., Memorial University of Newfoundland, University of Manitoba, University of Toronto, University of Regina, and University of Calgary) demonstrates the lack of spirituality specific courses. Courses like 'Loss and Grief' at Memorial, or 'End-of-Life Issues' at the University of Regina may incorporate spirituality into lectures, but none seem to make spirituality the focus of a particular course (Memorial University, 2013; University of Calgary, 2013; University of Manitoba, 2011; University of Regina, 2013; University of Toronto, 2013). Furthermore, studies have shown that social workers in a hospice palliative care setting are typically reluctant to address spiritual or religious issues when confronted by them in a professional situation (Canda & Furman, 1999; Crisp, 2008; Gilligan & Furness, 2006; Stirling, Furman, Benson, Canda & Grimwood, 2009).

However, this theme could be trending in the opposite direction, as alluded to by a 2004 study of 62 social workers within a hospice setting (Wesley et al., 2004). Eighty three percent of the respondents stated that religion and spirituality were extremely important or very important to their clients. The remaining 17 percent claimed that the concepts of spirituality and religion were somewhat important to their clients. The majority of respondents also reported that they were very or somewhat comfortable in

attending to their patients' spiritual or religious needs (Wesley et al., 2004). Despite this study's somewhat small sample size, it does provide evidence that social workers could be transitioning into new roles as spiritual advisors within the end-of-life care practice environment.

1.2 Conceptual Framework

1.2.1 Gerotranscendence

Tornstam's (1989) theory of gerotranscendence served as the initial framework and justification for focusing on social worker interaction with elderly hospice clients and not all hospice clients, regardless of age. Tornstam (1989) posits that human beings reach a stage in life where they begin to accept their own mortality and therefore redefine their notions of the self. The individual experiencing old age has been found to experience a shift in consciousness; from a materialistic, rational paradigm, to a more *cosmic* and *transcendent* one (Tornstam, 1997a). This metaphoric shedding of masks he/she may have hidden behind in earlier life allows the aging human to transcend and change his/her perspective to focus on more spiritual and reflective life goals. For example, Rosen (2001) posits that many 'Generation Xers' (people born between the early 1960's and early 1980's) have a tendency to conceal their true selves as a response to the pressure and expectations of their adult lives (e.g., A business person constantly immersed in a competitive atmosphere may lead him/her to develop deceptive traits in order to gain status and recognition). According to the tenets of gerotranscendence however, this 'chameleon personality,' as Rosen (2001) refers to it as, would eventually subside as one nears the end-of-life.

Due to its reflective and introspective attributes, gerotranscendence has often been confused with the disengagement theory of aging (Cumming & Henry, 1961). One of the

traditional theories of aging (the others being activity theory and continuity theory), disengagement theory argues that aging inevitably results in attenuation of social interaction and participation in social systems (Cumming & Henry, 1961). However, Tornstam (1989) insists that the aging individual experiences much more than simply a withdrawal from society and relationships, rather, as one transcends into this stage of life, a higher sense of purpose and meaning is reached which can positively influence their peers and society at large (Tornstam, 1989). As a theory of aging that is considered to be more contemporary, gerotranscendence has been gaining traction within the academic community (e.g., Degges-White, 2005; Gamliel, 2001; Lewin, 2001) and as such will form the beginning framework from which to engage in a study of hospice/palliative care social workers implementing their spiritual training skills with elderly clients.

Before an in-depth examination of the literature concerning social workers in hospice/palliative care is performed, key terms must be defined. The focus of the next section will clarify the concepts of elderly, spirituality/religiosity, end-of-life care, hospice/palliative care, and the social worker.

1.3 Key Terms

1.3.1 'Elderly' or 'Senior' Age Group

The Government of Canada defines the age group of elderly, or *senior* as those 65 years of age or older (Turcotte & Schellenberg, 2007). While there are several distinct age groups within the 'elderly' definition (e.g. old-old, oldest old), for the purpose of this study, the terms 'elderly' or 'senior' will encompass those who are 65 years of age or older.

1.3.2 Spirituality

Spirituality has been defined in different ways several times in recent years (Canda, 1988; Carroll, 2001; Frankl, 1959; Kubler-Ross & Kessler, 2000). Despite differences, there are consistent themes within these definitions that emerge, such as:

- The conscious search for meaning, purpose and fulfillment;
- Connection and relationships within the self and with others, with nature, the cosmos, and/or a Transcendent Other;
- God/god(s)/Transcendent Other;
- Transcendent Self (Transcending pain or experiencing empathy);
- Vital principle (Creative, animating force that transcends or integrates subject-object dichotomies);
- Unifying force or integrative energy (non-personified, incorporeal common energy that unifies reality;
- Personal and private (Subjective nature);
- Hope (Will to live) (McCarroll, O'Connor, & Meakes, 2005).

Many people associate spirituality with religion or religious practice; however, this is merely one aspect of a complex idea. Spirituality is said to be a common experience throughout the human species, whereas not every person is religious (Burton, 1998; Chochinov & Cann, 2005). According to Burton (1998), religion can be viewed as being 'subsequent' to spirituality. In other words, "religion is an organized expression of spirituality, and therefore it succeeds, but assumes, spirituality, and is more specific and defined in its structures" (Burton, 1998, p.123). Religion is a human construct or a tool to

convey one's spirituality using unique doctrines and rituals. Burton (1998) incorporates the notions of several different thinkers and offers this definition of religion:

> Religion is a cultural phenomenon, involving mutually interacting systems, whereby symbol, myth, and ritual serve to organize and bid personal and group anxiety about nonbeing, to validate norms and behaviours via reference and in relation to a commonly shared conception of the ultimate. (p.123)

Spirituality is therefore a much broader term than religion. This, at times, ambiguous notion refers to a person's or group's relationship with the *transcendent* or something beyond regular experience and therefore should be characterized as the search for ultimate meaning in one's life (Chochinov & Cann, 2005). Spirituality is distinct from religion in that human beings are intrinsically spiritual whereas religion requires a devotion to organized laws and principles (Chochinov & Cann, 2005; Morita et al, 2004; Sulmasy, 2002). Burton (1998), once again, offers a suitable definition of spirituality that integrates several considerations on the matter. "Spirituality is the expression of self-in-relation, incorporating both material and nonmaterial realities, and reflecting the tension between the possibilities and limitations of human existence in history" (Burton, 1998, p.128).

While the definition of spirituality can be nebulous at times, research in neuroscience has shown that spiritual practices have tangible effects on the human brain (Bergemann, Siegel, Eichenstein, & Streit, 2011; Newberg & Monti, 2011; Walach, Schmidt, & Jonas, 2011). According to Newberg and Monti (2011), the two methods of attaining a spiritual experience are from either group ritual, or individual contemplation (e.g., meditation). Electroencephalography (EEG) studies have linked meditation to

changes in brain activity such as an increase in frontal lobe activity, temporal theta activity, and central beta spindling, all relating to feelings of bliss (Fenwick, 2003). Spiritual experiences tend to stimulate the autonomic nervous system, which controls bodily functions such as respiratory rate, blood pressure and heart rate, among others (Newberg & Monti, 2011). When in a spiritual state, the nervous system activates, expressing itself as a "profound sense of alertness and awareness (sympathetic) or oceanic blissfulness (parasympathetic)" (Newberg & Monti, 2011, p. 30). Religious or spiritual belief has been linked to a decreased amount of the immune protein interuekin 6 in the elderly, resulting in an up-regulation of the immune system (Helm, Hays, Flint, Koenig, & Blazer, 2000).

1.3.3 Spirituality Training

Spirituality training, or education, is referred to in the literature as being distinct from skills and techniques received through an undergraduate or graduate degree program curriculum. Training in spirituality is received once a professional is working in the field of their choosing and can come in many forms. Methods of obtaining spirituality training include presentations and discussions, reflective writing or storytelling, experiential exercises on self-care and well-being, lecture, self-study, shadowing a chaplain, small group seminars, retreats, and taking a spiritual history on oneself (Holland & Neimeyer, 2005; Marr, Billings, & Weissman, 2007; Wasner et al., 2005). Spirituality training can focus on a wide array of topics such as attitudes toward spirituality, definitions of spirituality and religion, common spiritual issues that occur at the end-of-life, comparing how different cultures and religions view and address death, recognizing spiritual distress, rituals, skills, completing a spiritual assessment, and

responding to spiritual distress (Marr et al., 2007). The available spirituality training literature will be reviewed in further detail in chapter 2.

1.3.4 End-of-life Care

End-of-life care describes the range of care provided to people of all ages suffering from a terminal illness. Provisions for patients/clients in Canada include pain and other symptom management; social, psychological, cultural, emotional, spiritual, and practical support; support for caregivers; and bereavement services (Health Canada, 2009). The two predominant approaches to end-of-life care that will be the focus of this project are hospice and palliative care.

1.3.4 Hospice Care

According to the Canadian Hospice Palliative Care Association (2012), Hospice care is defined as being a "whole-person health care that aims to relieve suffering and improve the quality of living and dying" ('About Us' para. 1). It is applicable to the patient or client who is dying but also their families as it strives to: 1. "Address the biological, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears. 2. Prepare for and manage self-determined life closure and the dying process. 3. Cope with loss and grief during the illness and bereavement" (CHPCA, 2014a, para. 2).

Hospice is most effective when applied by a team of interdisciplinary healthcare professionals who are not only in communication with the patient, but also one another. This team is usually made up of nurses with specialized palliative training and skills, the client's family physician, another physician who specializes in palliative medicine, a social worker, a spiritual counselor (i.e. chaplain), and a pharmacist. Specialized

professionals such as occupational therapists or music therapists are common additions to the interdisciplinary hospice team (CHPCA, 2012).

1.3.5 Palliative Care

Distinct from hospice care, palliative care is a phase of disease treatment that falls in between the ‘curative’ phase, and the ‘terminal’ phase (Jeffrey, 1995). The curative phase is somewhat self-evident; health care provision at this stage aims at curing the disease or at least allowing a patient to experience an extended reduction of an ailment. The ideal outcome of this stage would be simply the survival of the patient. The terminal phase follows palliative care in the disease treatment process in that it enables health-care providers to allow their patients to ‘die with dignity’ (Jeffrey, 1995). During this stage of disease treatment, death is anticipated to occur in the near future; therefore, treatment becomes focused on the physical and emotional comfort of the individual rather than the eradication of the disease (Jeffrey, 1995).

Palliative care, as mentioned above, fits somewhere in the middle of these two phases of disease treatment. When curative measures are exhausted, treatment focus shifts from a quantity of life philosophy, to a quality of life philosophy. The World Health Organization contributes to the definition of palliative care by providing the following characteristics of the approach.

Palliative care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;

- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (Sepulveda, Marlin, Yoshida, & Ullrich, 2002, p. 94-95).

Therefore, in terms of palliative care, the health care provided to the diseased individual has yet to reach the terminal point of comfort care, but rather, it tends to focus on encouraging patient autonomy and maximizing quality of life (Jeffrey, 1995).

Although there are clear distinctions between hospice and palliative care, there is a tendency to use the terms interchangeably in North America and the United Kingdom (Barnard, Towers, Boston, & Lambrinidou, 2000). For the purpose of this project, I will use the term end-of-life care or the combined term of hospice palliative care (HPC) interchangeably when referring to the approach being focused on due to the similar expectations social workers have in each field and end-of-life care settings in general.

1.3.6 The Social Worker

The traditional function of the social worker in Canada is to foster healthy relationships between parties of interest, with a focus on provision of support services, their community's formal structure, and the societal and cultural standards that form

these relationships (Canadian Association of Social Workers, 2008). With regard to their role in a hospice palliative setting, social workers are tasked with addressing the physical, psychological, social, and practical issues of clients (Bosma et al., 2010). Recently developed HPC social work competencies have focused on: advocacy, assessment, care delivery, care planning, community capacity building, evaluation, decision making, education, research, information sharing, interdisciplinary team participation, and self-reflective practice (Bosma et al., 2010); each of which will be elaborated on in the review of literature with attention placed on the spiritual component of care delivery.

The following is a list provided by the National Association of Social Workers (NASW) of potential tasks a social worker in a HPC setting will perform:

- Counseling and psychotherapy for individuals, couples and families;
- Psychosocial education for patients and family caregivers about coping skills, hospice and palliative care philosophy, and non-pharmacological symptom management strategies;
- In-services to other service providers and organizations;
- The delivery of community education workshops;
- Planning for discharge, coordinating care, and helping clients navigate systems;
- Facilitating advance care planning and lifespan planning;
- Intervening in crises;
- Mediating conflicts with families, between clients and the interdisciplinary team, and between service organizations;
- Participating in interdisciplinary team meetings, care planning, and ethics consultations;

- Advocating on behalf of the patient and family;
- Identifying and linking clients with resources;
- Facilitating psychoeducational support groups; and
- Documenting social work activities (NASW, 2010).

1.4 Origin of the Study

In qualitative inquiry, and phenomenology in particular, the researcher is the principal tool of data collection. It is therefore important for me, as the researcher, to not only be reflexive or introspective throughout the research process (which will be elaborated upon in chapter 3), but also to reflect on why I chose to focus my attention on this work in order to locate myself as an investigator (Smith, 1999).

I began the process of deciding upon this particular area of study during an 'end-of-life' issues course offered in Social Work that I was taking during my second year of graduate school at the University of Regina. While reading the directed articles, I noticed a particular need in the literature on palliative and hospice care. This common theme that emerged was the unpreparedness of social workers when asked to handle existential or spiritual questions from their clients.

The first experience that sparked my interest in death and dying however originated from an undergraduate seminar class in psychology. The seminar was about the importance of gerontology and how it is relevant for psychology students upon completion of their undergraduate work. Deciding to pursue and study aging was fitting for my personality and experiences. Growing up at a golf course introduced me to the world of the wise, traditional, and often frail elderly community. I quickly realized that interacting with the elderly population was easy for me as I perceived many of them to

have shed their proverbial ‘masks’, therefore living at an older age was synonymous with authenticity and being genuine. This reverence led me to wonder how they experienced life, how they approached the ultimate question of meaning, and how they coped with the finitude of life and experience.

I have always viewed myself as a spiritual being. My father is Jewish and my mother was born Christian but converted to Judaism after they married. I attended a Hebrew school, however, my home life was secular and religion was a negligible facet of my upbringing. Instead, my parents allowed for curiosity to shape my spiritual beliefs, which led me to scientific inquiries about the nature of the universe. I studied comparative religion and different types of philosophy in my undergraduate education including epistemology, logic and metaphysics. These investigations have shaped my overall understandings of personhood, identity and the spirit. I concede that spirituality is a journey and that my own spiritual growth is still in its infancy but I cannot ignore my Judeo-Christian history and upbringing, along with the fact that Western culture has shaped me and this current project.

Throughout my life, I have possessed a will and desire to help those who are less fortunate than I or who are simply in need; a value that I perceive as being a defining attribute to my character. I find meaning in doing such acts and, in turn, nourish the spiritual side of my ego. Combining this desire to help those who are in need or suffering with my ever growing curiosity of the afterlife and spiritual quest in general has led me to explore the tangible practices of spiritual care delivery by social workers in a hospice palliative setting. In doing so, I seek to gain a better understanding of the phenomenon

for the aforementioned societal benefits, but also to prepare myself for working in hospice settings in the future.

1.5 Purpose

While scanning through the previous research on spirituality in social work practice, I noticed significant information missing about what kind of spirituality training social workers receive, as well as the experiences of social workers delivering spiritual care in an end-of-life care setting. As a result of these gaps in the literature regarding spirituality training and its impact on social workers providing services to elderly clients in hospice care, the purpose of this interpretive phenomenological study is to explore the meaning and experience of spirituality training and spiritual care delivery from the perspective of the social worker assisting seniors in end-of-life care settings. A secondary purpose is to identify the availability and accessibility of such training to social workers in HPC. The research questions guiding this study include:

1. How do social workers in end-of-life care settings define and describe spirituality?
2. What is it like to deliver spiritual care as an end-of-life care social worker?
3. How do social workers experience implementing the skills and techniques that they receive from engaging in spirituality training with their elderly clients?

In chapter 2, I provide an overview of literature pertaining to social workers in the hospice care environment, and outline gaps in our understanding of their experience. Specifically, I elaborate on the goals of HPC and needs of a client within the setting, along with the role of a social worker in the end-of-life care environment. Next, I define spirituality and spiritual care according to the available literature and explore what we know about spiritual interactions between the social worker and the elderly client.

Finally, I discuss the concept of spirituality training and the apparent need for it both in social work curriculum and during practice.

In chapter 3, I describe the research method and design for my study. Within this description, I provide a detailed justification of why a qualitative approach can best answer my research questions, along with an examination of the phenomenological method that will be used to collect data. Finally, the research design of my study is presented followed by a discussion of reflexivity and the role it has within this investigation.

In chapter 4, I delineate findings from the discussions I had with my participants during the course of data collection. Data are organized into emergent themes and subthemes including how palliative care social workers define spirituality, how spirituality and spirituality training has impacted their practice, and how they experience delivering spiritual care.

I then delve into the data throughout chapter 5 where I synthesize my interpretation of my conversations with participants with previous research in an attempt to form a cohesive description of spirituality, ways that spirituality influences palliative care social workers, and the phenomenon of delivering spiritual care for end-of-life care social workers.

CHAPTER TWO: Literature Review

2.1 Introduction

Studies regarding the level of spirituality training that social workers in HPC settings receive are limited. Furthermore, it is unclear how social workers experience implementing the skills and techniques learned from spirituality training with elderly clients. In this literature review, I will explore current understandings of hospice care, social work, spirituality training and the theory of gerotranscendence.

2.2 Hospice Care

Since time immemorial, human beings have been wary of the dying process and the unknowns that come with it (Kastenbaum, 1998). The concept of a 'good death' has been the priority for not only a person at the later stages of life, but also for the younger and healthy individual. Compassion for the dying individual is a development in human capacity that can be dated back to the ancient Greeks (Kastenbaum, 1998). Suffering was recognized as not only physical but psychological as well, therefore, healing temples were established for the ailing and anxious person to attend to in order to undergo diverse therapeutic processes (Kastenbaum, 1998). These compassionate settings can be viewed as the precursor to what is known today as the 'Hospice Movement.'

In 1967, Dr. Cicely Saunders, considered to be the founder of modern hospice care, established the St. Christopher's Hospice in London, England where she incorporated healers from diverse backgrounds to assist patients in the dying process (Kastenbaum, 1998). Her holistic model of care then spread to North America where in 1975, Canadian physician Balfour Mount instituted the first 'palliative care ward' at Royal Victoria Hospital (Kastenbaum, 1998). Today, hospice care has become an integral

part of society and the need for it is increasing. The goals of hospice care have remained consistent throughout its existence and will be discussed for the purpose of this review.

2.2.1 Goals of Hospice Palliative Care

According to the Canadian Hospice Palliative Care Association, the main goal of Hospice Palliative Care (HPC) is to alleviate physical, psychological, social, and spiritual suffering and to improve the quality of life of "persons who are living with or dying from advanced illness or are bereaved" (CHPCA, 2014b, para. 1). One of the central tenets of HPC is the healing of the whole person, therefore, HPC incorporates care on four distinct but interrelated fronts, which can be further divided into two tiers. The first tier of modern HPC involves the first three levels of care posited by Engel (1977) and the second involves the integration of spiritual care (Sulmasy, 2002). The first level of care in the first tier is identified as the physical or "biomedical". This aspect of care addresses patients' pain caused by imbalance in bodily functioning. The second level of HPC care investigates various psychological problems that could cause pain (e.g., emotional turmoil, pessimism). The third aspect of end-of-life care addresses the social needs of a dying patient by seeking to understand how factors such as economic status and culture can influence the suffering of the individual and their family (Engel, 1977). Finally, HPC incorporates a second tier, and fourth aspect, when it aims to relieve the spiritual angst of the patient. Spiritual pain can be manifested in the form of the hopes and fears that the individual may have about the dying process or questions about their existence and place in the universe (Sulmasy, 2002). This biopsychosocial-spiritual model of care for patients dying of terminal illness has become widely accepted as the standard philosophy for palliative care units and hospice care facilities around the world (Daaleman et al., 2008; McKee & Chappel, 1992; Puchalski et al., 2009).

2.2.2 Experience of Hospice/End-of Life-Care

More than 250,000 Canadians died in 2011 (Statistics Canada, 2012) and of those, 16-30% had access to hospice care (CHPCA, 2012). HPC programs are more prevalent in the United States as The National Hospice Palliative Care Organization (2012) estimates that 44.6% of Americans died in hospice care in the same year. This review will focus on the experience of people who decide to die using hospice services.

Individuals and their family members choosing the hospice care route are in search of a 'good death' (Kehl, 2006). The definition of a good death and the concept of quality of death have evolved, and continue to evolve. However, the Institute of Medicine provides a generally accepted definition: "A decent or good death is one that is: free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards" (Field & Cassel, 1997, p. 4). To further elucidate what constitutes a good death, it can be helpful to consider the contrast. Characteristics of a 'bad death' may include a lack of accordance with patients' wishes, including location, length, dependence, trauma, suffering, pain or distress, cognitive impairment, fear, anger, feeling unprepared, disorganized care, knowledge (as opposed to 'recognition' or 'acceptance') of impending death, the affliction of family members, dying alone, dying young, and dying having not left a perceived legacy (Kehl, 2006). Many of these undesirable experiences can be alleviated by admitting the patient into hospice care in a timely manner (Weckmann, 2008). The median length of stay in hospice is three weeks, however, ten percent of persons who receive hospice care were only referred during the last 24 hours of life (Casarett & Quill, 2007). The philosophy of hospice and palliative

care attempts to maximize aspects of a good death for patients, and attenuate the attributes of a bad one (Cohen, 1979).

Studies comparing experiences of patients and their families using hospice care with conventional care are limited, but several distinctions can be made. The National Hospice Study sought to distinguish American hospice care from conventional care in terms of quality of life. Differences included better pain and symptom control, however, no significant differences for patients were found that would indicate a superior experience in hospice as opposed to conventional care (Greer et al., 1986). In an English study, hospice patients were reported to be more aware of their death as well as reporting a higher level of satisfaction with hospice home nursing care than conventional care (Seale, 1991). Quality of death measures were used in an American study to verify the hospice philosophy by concluding that cancer patients in hospice care were more satisfied with the last three days of life than patients in conventional care (Wallston, Burger, Smith, & Baugher, 1988). Overall, the multi-disciplinary team approach to hospice care is regarded as providing high-quality end-of-life care that results in exceptional patient and family satisfaction (Casarett, Crowley, & Hirschman, 2004; McHale, 1998).

2.2.3 Needs of a Hospice Palliative Care Client

A person who is nearing the end-of-life who has chosen to be treated via HPC requires an assortment of information in order to manage the dying experience. Information needs of the dying can be divided into four categories, including physical, emotional, financial and spiritual (Baker, 2004).

The physical needs of a dying individual are effectively related to general quality of life measures such as pain management, loss of bodily functions, and concerns about the body itself (i.e. where to die, plans for the deceased body) (Baker, 2004). Other

symptoms that should be addressed are nausea, vomiting, respiratory difficulties, pressure sores, insomnia, incontinence, weakness, fatigue, and confusion (Kastenbaum, 1998).

Psychological or emotional information needs can include: hoping for remission or a pain-free death; fear of the unknown and/or loss of mental control; and depression from regretting life events and concerns over legacy (Baker, 2004). Pain control can also be incorporated into emotional need as the stressful experience of pain can hinder one's ability to address existential matters or mitigate opportunity for reflection (Kastenbaum, 1998).

Financial needs comprise issues regarding establishing a durable power of attorney, creating a living will, pensions and general costs related to memorial services. Kutner, Steiner, Corbett, Jahnigen, and Barton (1999) complement this data by demonstrating the need for information about changes in functional status, role change, symptoms, and stress of the illness on family members. While physical, emotional, and financial needs are essential to a person experiencing the dying process, spiritual needs are comparable in terms of significance.

2.2.4 Spiritual Needs at the End-of-Life

Historically, spiritual needs have been neglected, but the health-care community has now accepted exploring spirituality as an important component of a healthy dying process (Coleman, 2004). When reviewing the literature, common themes emerge that bolster the necessity for spirituality at the end-of-life. Many patients at the end-of-life report being concerned with the search for meaning (Fry, 2000; Grant et al., 2004; Tornstam, 1989). Theories such as Tornstam's (1989) gerotranscedence and Frankl's (1984) logotherapy assert that finding personal meaning to one's existence is not only paramount to a successful dying process, but is also a natural occurrence as one nears the

end-of-life. Frankl (1984) claims that logotherapy can be a guide for enhancing quality of life when faced with terminal illness. It is based on three concepts: 1. The freedom of will 2. The will to meaning and 3. The meaning of life (Frankl, 1969). According to Frankl (1959), "Man's search for meaning is the primary motivation in his life" (p. 105) and therefore, a person must attempt to find the meaning "of the question which life asks of them" (Brat, 2000, p. 104). The logotherapist facilitates the patients' discovery of how they can change their attitude about their particular circumstance. Through this process, logotherapy provides a method where one might also inquire into the meaning of their life, which is often difficult to perceive if terminal illness is pervasive at the end-of-life. Frankl (1984) maintains that if a dying person can accept the tenets of logotherapy and the pursuit of meaning, then he/she can achieve life satisfaction.

Similarly, gerotranscendence contends that attempting to find meaning in later life is part of the natural aging process. According to Tornstam (1997c), being human in the later years of life involves reaching a deep, contemplative state for the purpose of achieving a high level of existential wellbeing. Wellbeing for the aged is therefore grounded in the motivation to be internally changed through a profound reflective process. Furthermore, Fry (2000) demonstrates that religious involvement and the pursuit of meaning are predictors of increased psychological wellbeing.

Along with pursuit of meaning, the search for peace is a substantial need expressed by patients suffering from terminal illness (Grant et al., 2004). Patients at the end-of-life have conveyed the desire to gain a sense of 'inner peace' when they realize that death is imminent (Baker, 2004); a genuine relinquishment of fearing death and the unknown reality that accompanies it (Grant et al., 2004).

A more tangible spiritual need that people at the end-of-life, and older adults in general, require is the ability to perform religious ritual. Older individuals often view spiritual practices (e.g., prayer, reading holy scripture or inspirational books on spirituality, meditation, singing worship music, listening to devotional music) as sacred; as tools for transcending reality and reaching a state of meaning or peace. They are perceived to strengthen the older individuals' capacity to cope with the stressors of the health care system (Hodge, Horvath, Larkin, & Curl, 2011).

To summarize, Kellehear (2000) describes the complex spiritual needs at the end-of-life as multi-dimensional. Spiritual needs are therefore divided into three major groupings: situational, moral and biographical, and religious. The 'situational' dimension includes necessities such as purpose, hope, and meaning in life, and a sense of mutuality, connectedness and social presence. The 'moral and biographical' aspect encompasses ideas such as peace and reconciliation, reunion with others, prayer, moral and social analysis, forgiveness, and closure. The final element of the three pronged concept of spiritual need is 'religious,' which incorporates components like religious reconciliation; divine forgiveness and support; religious rites/sacraments; visits by clergy; religious literature; discussion about God, or eternal life and hope (Kellehear, 2000).

Many people in a hospice care environment may require a guide to not only facilitate spiritual needs, but also their ultimate journey into the unknown (Grant et al., 2004). Taking on this important role has traditionally been the responsibility of the spiritual advisor or chaplain of the hospice/palliative care organization. While the spiritual advisor is specialized in the area of religiosity and existential matters, all other

caregivers in the hospice or palliative care unit are expected to provide spiritual care, including the social worker.

2.3 Spirituality and Social Work

Recently, there has been interest in the amalgamation of spirituality and religiosity with the traditionally psychosocial specific field of social work (Callahan, 2009; Canda & Furman, 2010; Canda, Nakashima, & Furman, 2004; Graham, Coates, Swartzentruber, & Oullette, 2007; Crisp, 2010; Dane & Moore, 2005; Derezotes & Evans, 1995; Furness & Gilligan, 2010; Gray, 2008; Groen, Coholic, & Graham, 2012; Reese, 2013; Sheridan, 2009; Wiebe, 2014; Yoon & Lee, 2006). Traditionally, social work practice has adopted a positivist paradigm that did not allow spirituality or religiosity to facilitate new knowledge because they were subjective and non-quantifiable philosophies (Tyson, 1992). This is changing however, and, as mentioned previously, social workers in general are being encouraged to be well versed in spirituality for the benefit of clients, peers, and themselves (Stirling et al., 2010). The spread of spiritual diversity and acknowledgement of spirituality as an important aspect to the human experience has also caused the fields to merge. The culturally competent and anti-oppressive goals of social work are harmonious with the complex and diverse qualities of spirituality (Canda, 2002; Holloway, 2007).

However, this linkage is not simply a modern phenomenon. The social work and social justice historical past is deeply connected with social and spiritual movements such as the Social Gospel, labour, peace, feminist, welfare rights, and civil rights movements (Christ, 2004; Kruger, 1999; Lee & Barrett, 2007; Smith, 1996; West, 1981; West & Blumberg, 1990). The Aboriginal and Indigenous movements are also examples of past

associations of the social work/justice and spirituality fields (Baskin, 2002; Marcos, 2009). The impact of spirituality was also experienced in liberation theology, Black churches, and other various movements for social fairness (Dudley & Helfgott, 1990; Lincoln & Mamiya, 1990).

2.3.1 Competencies for Social Workers in Hospice Palliative Care

The social worker is an integral part of the hospice care team. The team usually includes the Medical Director/Doctor, Palliative Care Coordinator, Palliative Home Care Nurse, Clinical Nurse Consultant, Palliative Home Care Aide, Occupational Therapist, Chaplain, Music Therapist, Volunteer Services, Bereavement Coordinator, Pharmacist, Dietician, and Social Worker (Regina Qu'Appelle Health Region, 2010). While it is imperative that a hospice employ at least one of each of these professionals, there are usually more professionals in one field than the other. For example, a recent survey suggests a disparity in the ratio of chaplains to social workers. According to Wesley, Tunney, and Duncan (2004), there is a mean number of five social workers per hospice, compared to a mean of one employed chaplain per hospice. This disproportion may lead to a situation where other hospice palliative professionals, including social workers, would provide spiritual care to patients/clients who require it.

While the social worker has been a key component to the hospice palliative team for many years, until recently, the role of the position has not been clearly defined. Many perceive the function of the social worker in a HPC environment to be somewhat of a family organizer who assists in financial issues and arranges meetings between the parties involved. However, according to the Canadian Hospice Palliative Care Association (2012), social workers must have a wide range of expected competencies if they are to assist their clients successfully. Oftentimes, the roles of the social worker and chaplain or

spiritual advisor in the interdisciplinary team can overlap, which may lead to territorial challenges amongst the staff (Soltura & Piotrowski, 2011). For example, if the spiritual care specialist realizes that a client prefers the services of the social worker, there could be confrontation, which may negatively impact both team and client. To gain an understanding of the various obligations current social workers have, it is necessary to briefly touch on such competencies, which include skills in advocacy, assessment, care delivery, care planning, evaluation, community capacity building, decision making, education and research, information sharing, interdisciplinary team work, and self-reflective practice (Bosma et al., 2008). Elaborating on the numerous attitudes/values, knowledge and skills required to be capable at fulfilling each competency is beyond the scope of this review, therefore, only the aspects that are relevant to the social worker's understanding of spirituality or religiosity will be discussed. The competencies to be examined include: advocacy, assessment, care planning, care delivery, evaluation, interdisciplinary teams, self-reflective practice, and education and research.

2.3.2 Advocacy

The social worker in hospice/palliative care is charged with the responsibility to "advocate for the needs, decisions, and rights of clients and families" (Bosma et al., 2008, p. 6). Being capable in this facet of their work requires social workers to be sensitive to "familial, cultural, religious and ethnic diversity" (p. 6). They must also have the ability to empathize with their clients, defining needs in accordance to their cultural and spiritual beliefs regardless of their own understanding of spirituality (Holloway, 2007). For some social workers and clients, holistic care does not involve the concept of spirituality, and the biopsychosocial approach is a sufficient paradigm for practice; however, if spiritual

needs do exist, addressing them would be crucial for successful care because the "assessment and meeting of need are [social work's] core business" (Holloway, 2007, p. 275).

2.3.3 Assessment

It is within the responsibilities of social workers to assess their clients and families in order to enable delivery of suitable end-of-life care (Bosma et al., 2008). Assessment is at the core of the social workers' competencies and they must recognize that assessment is a fluid process that communicates the physical, emotional, and spiritual state at the present moment to the rest of the support team (Gwyther et al., 2005). Individually, however, social workers should be prepared to assess the physical, financial, social, emotional, spiritual and psychological aspects of clients in need (Zabora & Loscalzo, 1998). Focusing on spirituality, there are several assessment tools available to social workers who are tasked with gauging the level of spirituality of their client. Generally, spiritual assessment tools use acronyms so that they are remembered and accessed with ease. Three prominent tools include:

FICA. A reliable tool used for clinical assessment of spirituality. It stands for:

- **F**aith or belief;
- **I**mportance of spirituality;
- Individual's spiritual **C**ommunity;
- Interventions to **A**ddress spiritual needs/Action in Care (Borneman, Ferrell, & Puchalski, 2010).

HOPE is a formal and practical tool that can be used by all clinical professionals to assess patients' spiritual state. The professional would ask questions about:

- Sources of **H**ope, strength, comfort, meaning, peace, love and connection;
- The role of **O**rganized Religion for the patient;
- **P**ersonal spirituality and practices;
- **E**ffects on medical care and end-of-life decisions (Anandarajah & Hight, 2001).

SPIRIT is a mnemonic guide to ascertaining key aspects of the patient's/client's spiritual history. The acronym stands for:

- **S**piritual belief system;
- **P**ersonal spirituality;
- **I**nteraction with a spiritual community;
- **R**itualized practices and restrictions;
- **I**mplications for medical care;
- **T**erminal events planning (Maugans, 1996).

There are obvious commonalities between the aforementioned tools, such as investigating about the spiritual group that the client belongs to as well as their own personal spiritual beliefs. The shared qualities that these assessment tools possess should provide social workers with the confidence and structure to properly evaluate their clients' spirituality needs.

2.3.4 Care Planning

Another responsibility of the social worker in HPC is to work together with the family and client to develop an adequate care plan, specifically suited for the relevant parties (Bosma et al., 2008; Gwyther et al., 2005). In order to maximize effective care, the social worker must be adaptive to evolving needs, different age groups, ethnicities,

cultures, socioeconomic and educational backgrounds along with focusing on enhancing communication between the client, their family, and also the support team (Gwyther et al., 2005). To establish a specialized plan, it is imperative that the social worker hold certain attitudes or values including recognition of the "social, cultural, and spiritual issues and power differentials" (Bosma et al., 2008, p. 9) associated with the client and family.

2.3.5 Care Delivery

The social worker is expected to provide care to clients and their family members. In order to deliver the highest quality of care, the social worker must possess an understanding of "religious, spiritual, cultural and social factors that can influence expectations of HPC" (Bosma et al., 2008, p. 8). A widely used intervention technique that social workers employ with their clients nearing the end-of-life is reminiscence therapy, or life review. In this circumstance, social workers would inquire into the clients' memories of life so that they can "put their experiences in perspective, resolve past conflicts, grieve losses and changes, forgive themselves and others, celebrate successes, and feel a sense of completion" (Kunz & Soltys, 2007, p.1).

2.3.6 Evaluation

After care has been delivered, a critical role social workers have is to evaluate the process. Social workers in a HPC environment will often evaluate the specialized program for their client and family to ensure efficacy of the interventions. As part of their knowledge base, social workers should be aware of the previously mentioned "assessment tools and strategies relevant to medical, psychosocial, and spiritual dimensions of palliative and end-of-life experiences of [their] clients and families" (Bosma et al., 2008, p. 11) to best evaluate the proposed program.

2.3.7 Interdisciplinary Team

Holistic care is a unique component to HPC, therefore, the social worker is part of a group that will ideally communicate thoroughly with each other in order to provide the best care possible. According to Bosma et al. (2008), the social worker plays a crucial role in ensuring psychosocial care for clients, families and the interdisciplinary team itself. To enable this care, HPC social workers must possess the "ability to facilitate team planning meetings by providing input and consultation on the bio-psychosocial, economic, and spiritual needs of clients and families" (p. 17).

2.3.8 Self-Reflective Practice

Introspection and 'big-picture' thinking is core to being a successful HPC social worker. To maintain good health and optimum care capacity, one must consistently reflect on the "reciprocal nature of the relationship between self and work" (Bosma et al., 2008, p.19). Reflecting on one's own spirituality and personal biases/history, and how they can influence interactions with clients, is crucial to successful practice.

2.3.9 Education and Research

One of the most important functions of the social worker in hospice care is to inspire new education and research directives from the psychosocial perspective to identify community specific needs, explore ethical issues and address practice questions (Jansson & Dodd, 1998). This role requires professionals to not only be confident in their knowledge of psychosocial research, but to also be competent in communicating that information to their peers (Christ, Siegel, & Weinstein, 1995).

Given the current expectations regarding spirituality in the social work realm and in HPC in particular, social workers may benefit from a spiritual component in their

education. Several researchers highlight the importance of, and link between, spirituality and social work (Canda & Furman, 1999; Daaleman & VandeCreek, 2000; Reese, 2001).

2.4 Contemporary Expressions of Spirituality/Social Work Theory

There are two notable recent theories that provide evidence for a rational connection between social work and spirituality. These include Transpersonalism (Wilber, 1980) and ecospiritual social work (Coates, Gray, & Hetherington, 2006).

2.4.1 Transpersonalism

Transpersonal theory suggests that the human being develops through two stages of consciousness throughout life. The first stage, referred to as 'preegoic', is where a child is unaware of the distinction between the ego and the rest of the world. The 'egoic', or second stage, occurs when the ego develops autonomy, ability for rational thought and mature social relationships (Reese, 2001; Strohl, 1998). Wilber (1980) posits that there is a final stage however, and that humanity is evolving toward a "unitary consciousness" or "ego-disidentification" where individual identity is interconnected with the entirety of existence. This final stage is described as 'transegoic' and cannot be attained without deliberate intention (e.g., meditation) but can be a source of strength for clients if attempted (Reese, 2001). Recently, advocates of Transpersonalism have added the theory to the social work lexicon, positing that the psychosocial issues central to social work are simply expressions of "spiritual factors and thus require a paradigm shift in social work practice that incorporates spiritual content" (Derezotes & Evans, 1995, p. 4). Reese (2001) proposes that hospice social workers can utilize the transegoic stage in working with terminally ill patients to provide enhanced social support and encourage a comfortable, 'good' death. However, this can only be accomplished if policy changes are made within the hospice structure to accommodate this theory, such as expanding the

hospice budget and length of stay as well as continued promotion of interdisciplinary teams (Reese, 2001). An expansion of budget along with longer periods of time for patients at the hospice may allow for more social workers at a particular facility as well as for time to counsel instead of just assess their clients. Attention to roles within interdisciplinary teams is also an important factor to allow for high quality care as chaplains and social workers may encounter issues confusing definitions of spirituality as well as responsibility to proceed with spiritual counsel (Reese, 2001).

2.4.2 Ecospiritual Social Work

In addition to Transpersonalism, ecospiritual social work provides another perspective in support of the connection between social work and spirituality. Inspired by the disconnect between Canadian Indigenous groups and "effective, acceptable, and culturally relevant" (Coates et al., 2006, p.381) social work provisions, ecospiritual social work aims to create a more open model of care that facilitates cultural diversity and respect for ecology. Gray (2008) argues that while social work has always been influenced by the religious community despite its secular nature, it has been hi-jacked by 'New-Age Spirituality' or the 'self-help cult' in recent times. This alteration has therefore caused social work practice, and western society as a whole, to take on a more individualistic paradigm, which is expressed in the predominant ideology of finding purpose and meaning in one's life. Gray (2008) instead, advocates for social work to return to its foundational principles such as collectivism, communitarianism, environmentalism, and spirituality with the end goal of providing high level, holistic care to all of the world's people, while respecting the planet's ecological equilibrium.

2.5 Spirituality in Social Work Practice

As mentioned previously, spirituality has been included into the educational policy and standards a social worker should be competent in (Bosma et al., 2008; Council on Social Work Education, 2008). However, due to the broad and often nebulous nature behind the definition of spirituality, it has expectedly proven difficult to measure how social work practice is responding to the integration of spirituality with social work (Senreich, 2013). There have been recent attempts to address this gap in the literature by inquiring into the perceptions of current practitioners and social work students (Carroll, 1998; Sheridan, 2009).

For example, Shier and Graham (2011) found that mindfulness – traditionally recognized as a spiritual practice, enhances social work practitioners' subjective well-being. This contributes to the growing research that spiritual exercises such as reflection and contemplation can allow for greater empathy for clients and enhance sense of one's own health as a social work professional (Jacobs, 2015). Incorporating spiritual based social work practice such as mindfulness may also influence how practitioners adapt to the pluralistic cultures of their clientele. Considering the diverse makeup of people who require social work care, the empathy developed via spiritual based techniques can allow social workers to relate to their client's unique needs (George & Ellison, 2014).

However, despite their required education and cultural involvement in spirituality and religious matters, recent studies have shown that the majority (66-84%) of social work students receive little to no instruction about spirituality in SW education (Furman et al. 2004; Gilligan & Furness, 2006; Heyman, Buchanan, Marlowe, & Sealy, 2006; Murdock, 2005), so it appears as if social workers are ill prepared to assist clients that are

mired in a spiritual dilemma (Bosma et al., 2010; Canda & Furman, 2012; Reese, 2013; Sheridan, 2009). A recent survey in the United States also revealed that the training social workers received regarding disparate cultures or spirituality was not adequate and therefore, the social workers were compelled to avoid conversations of this nature instead of addressing the problem (Csikai & Raymer, 2005). This apparent gap in the social work curricula represents the need for a more in-depth education process for future professionals (Bullis, 1996; Holloway, 2007). Social workers, along with social work students, have expressed this desire for more spirituality education and training to curb this glaring hole in their skill set (Kovacs & Bronstein, 1999; Kvarfordt & Sheridan, 2007; Murdock, 2005; Wesley et al., 2004).

2.5.1 Spirituality Training

Several authors recommend social workers accept the challenge of addressing their clients' spiritual questions directly (Callahan, 2009; Dane & Moore, 2005; Wiebe, 2014) with the aid of reliable spiritual care interventions such as the ones mentioned earlier in the chapter. Spirituality training is one method for social workers and hospice care professionals in general to utilize that not only helps build their skill set for providing services to patients, but also contributes to a healthier work environment (Wasner et al., 2005). Such spirituality training has been attempted in two recent studies. Wasner et al. (2005) recruited 63 hospice care professionals to take part in the 'Wisdom and Compassion in Care for the Dying Course.' The course was influenced by the Tibetan Buddhist tradition which demonstrated "practical ways in which the wisdom and compassion of the Buddhist teachings can be of benefit to those facing illness or death and also to their families and caregivers" (Wasner et al., 2005, p. 100). The participants in the course learned active and compassionate listening methods along with ways to

address spiritual suffering. The intention was to provide participants with practical coping strategies to assist them, their families and caregivers with illness or death. The course lasted four days and participants were asked to fill out questionnaires before, immediately after, and then six months after the program. Hospice care professionals identified some key problems they encountered when attempting to care for a dying person or the family prior to taking the course. The most prevalent was dealing with one's own uncertainty (45%), followed by communication difficulties (31%), handling difficult family members (27%) and finally, one's own emotions (25%). After course completion, 77% of the hospice care professionals who participated in the study believed that their ability to cope with these concerns had been improved as a result of the spirituality training (Wasner et al., 2005). In this case, spirituality training and work related stressors were negatively correlated, which builds the case for repeated trials.

In the second study, Holland and Neimeyer (2005) recruited 80 end-of-life professionals attending three presentations on death and dying in Tennessee. Unlike the previous study, data were collected only once. The authors measured burnout and daily spiritual experiences. Burnout was separated into four different categories using the Shirom-Melamed Burnout Measure (SMBM). The four factors were physical fatigue, emotional exhaustion, cognitive weariness, and then a total burnout composite. The Daily Spiritual Experience Scale (DSES) was used to measure occurrences of secular (non-religious) spirituality during participants' daily lives. Findings indicated that spiritual experiences might alleviate physical, cognitive, and emotional forms of burnout in the workplace. Also, reinforcing the conclusions of the Munich study, end-of-life training

exhibited a negative correlation with physical and cognitive burnout, with the exception being emotional exhaustion (Holland & Neimeyer, 2005).

Despite the wealth of information demonstrating the need for spirituality and spirituality training in social work, particularly in the hospice/palliative care setting, there are some who believe that spirituality is not a homogenous part of human development and not all staff in HPC should be obliged to deliver spiritual care (Larimore, Parker, & Crowther, 2002; Walter, 2002). Moreover, instead of assuming that all palliative care clients are within a search for meaning and purpose, the staff should treat each patient separately to discover their needs, therefore attenuating the burden staff may feel about delivering spiritual care (Walter, 2002). This research brings forth the very notion of integrating spirituality into end-of-life care and demonstrates the need for a deeper exploration as to how professionals such as social workers are using spirituality and spirituality training with their elderly clients in HPC.

2.5.2 Gerotranscendence

In order to provide a foundation to begin to address spirituality and spirituality training among end-of-life care social workers, it is useful to examine a concept that links the spirituality with aging. Tornstam's (1989) theory of gerotranscendence provides the conceptual framework for this study. This recent theory of aging characterizes transference from a positivistic paradigm to phenomenological gerontology (Tornstam, 1996). Tornstam (1996) demonstrates this shift by comparing the Zen Buddhist and the Western ideology:

> To reach a new meta-theoretical paradigm we shall have to leave our normal positivist way of thinking. For example, contrast our picture of the world with that of a Zen Buddhist. The Zen Buddhist lives within a cosmic world paradigm with

> many diffuse and permeable borders. In this world much of the difference between subject and object is erased. The statements made by a Zen Buddhist are often difficult to understand from the point of view of our meta-theoretical paradigm – for example, that you and I are not separate objects but parts of the same entity. Past present, and future exist not separately but simultaneously. (p. 41)

Tornstam (1989) posits that as people age, their paradigms become more aligned with that of a Zen Buddhist, experiencing a cosmic communion with the universe, change in the perception of time, and fear of death, and more time spent in meditation.

The theory itself has been investigated and empirically tested using both qualitative and quantitative methods. Participants in Tornstam's (1994) study were asked their opinions about 10 statements regarding gerotranscendence. Participants either agreed or disagreed with the statements, and the results were then interpreted by the researchers in relation to life satisfaction. 'Ego' and 'Cosmic' transcendence correlated with life satisfaction though transcendence did not seem to increase with old age. Tornstam (1996) further pursued validation of his theory by describing signs of gerotranscendence to 90 nurses who discussed their perceptions of it in their patients. A follow up survey was mailed to the nurses to gauge impact of their awareness of the phenomena which revealed that almost half of the participants came to a new understanding of their patients (Tornstam, 1996). Tornstam (1997b) investigated the 'cosmic' and 'ego' levels of gerotranscendence by correlating participant statements about such experiences with age. In another study, Tornstam (1997c) interpreted data from participants who recognized the phenomenon of gerotranscendence throughout their

lives. Changes over time were acknowledged by some but not all participants as they reflected about their personal development.

Using the theory of gerotranscendence as foundation, Wadensten and Carlsson (2003) developed practical guidelines for supporting older people as they age. General guidelines revolved around focusing on the *do's* and *do not's* with regard to caring for the individual or patient in a nursing home setting, activities staff could arrange, and organization of the patients' day. A three part study (Wadensten, 2007; Wadensten & Carlsson, 2007a; Wadensten & Carlsson, 2007b) was conducted that demonstrated potential changes in nursing home residents' social life as a result of implementation of the aforementioned guidelines. Wadensten (2010) concluded that these guidelines may provide nurses with the necessary tools to assist their patients' unique needs as they approach and experience gerotranscendence.

This theory of aging, while growing in popularity, is not without scrutiny. For example, Jonson and Magnusson (2001) question gerotranscendence's empirical strength as a theory of aging and posits that it "runs the risk of creating a blindness to the diversity of old people's interests and needs, and old people who do not transcend can be viewed as deviant and noncompliant" (p. 329). They eventually conclude that gerotranscendence should be perceived as only a potential experience of aging and not part of the normative aging process (Jonson & Magnusson, 2001). Hauge (1998) highlights how dependent the tenets of gerotranscendence are on eastern traditions, which could consequently lead to isolation from the western scientific approach. Tornstam has also been criticized for unfeasible assertions such as the need for a "self-critical spirit in gerontological theory and practice" (Moody, 1992, p. 294) which researchers may not have the cognitive

capacity to address. Considering the disparate views of this theory, my study may provide insight into the current state of gerotranscendence as perceived by HPC social workers working with their elderly clients.

2.6 Summary

Since its inception, the goals of hospice care have been to provide high quality, holistic care that is focused on attenuating the physical, psychological, social, and spiritual pain of people at the end-of-life and their families (CHPCA, 2014a). The social worker is a fundamental component of the hospice care delivery team and should be well trained in providing holistic care (Bosma et al., 2008). Research suggests that many social workers are either not prepared or are not willing to engage in spiritual care with their clients for a number of reasons (Babler, 1997; Wesley et al., 2004). Spirituality training has been associated with enhancing the confidence and abilities of health care providers, along with the added benefit of reducing workplace burnout rates of such providers who partake in them (Holland & Neimeyer, 2005; Wasner et al., 2005). A gap in the literature exists with regard to how social workers in hospice care have utilized spirituality training, as well as their experience delivering spiritual care to their elderly clients.

CHAPTER THREE: Methods

"A lot of what can be counted, doesn't count, and a lot of what counts can't be counted."

-Albert Einstein

3.1 Introduction

Considering that the objective for this study was to seek to understand the social worker's experience of utilizing spirituality training in hospice practice, a qualitative approach was adopted. A qualitative approach directly related to the research questions and goals of my study, as I aimed to investigate the inner experiences of the participants in a very unique environment and circumstance (Corbin & Strauss, 2008). According to Denzin and Lincoln (2005), qualitative research takes on a naturalistic approach to reality and "consists of a set of interpretive, material practices that make the world visible" (p. 3). Qualitative research is ideal for examining "research problems inquiring into the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2007, p. 37). Furthermore, I decided to use qualitative methods because I enjoy connecting with people on a personal, human level. On a more selfish note with regard to the methodological approach for this particular project, I valued the opportunity to interact with my participants so that I may gain some insight into a prospective career path. In this chapter, I will discuss the epistemology guiding this study, philosophical assumptions that qualitative researchers have when approaching their work, my research approach and design, along with commentary on trustworthiness and reflexivity.

3.2 Epistemology

While reflecting on my present perception of reality and how to investigate it, I found that my worldview as a whole did not fit nicely into one category of paradigm, but

rather it included aspects of them all. Creswell (2007) outlines the four categories of worldview which most researchers can relate to. To an extent, I ascribed to the *post positivist* perspective due to my quantitative research background along with my inclination towards creating a hypothesis as to how my participants may respond; I certainly had an *Advocacy* paradigm stemming from my empathetic tendencies and history of activism to create awareness and help marginalized communities; and I can also fit into the *Pragmatic* point of view citing my concern for practical outcomes from my research (Corbin & Strauss, 2008). However, the paradigm that best described my worldview is the *Social Constructivist* position.

The nature of my inquiry reflected my paradigm of social constructivism, interpreting the subjective meaning of my participants' experience. I viewed the multiple perspectives of participants as the principal source of forming themes and ideas, using interactions between us as the research tool (Creswell, 2007). These multiple, intangible constructions were dependent on the individuals' perceptions that are being studied, while the researcher co-creates findings in an attempt to construct a subjective truth (Guba & Lincoln, 1994). The end goal for the social constructivist then is to "distill a consensus construction that is more informed and sophisticated than any of the predecessor constructions" (Guba & Lincoln, 1994, p. 111). This paradigm of meaning making in a subjective world spoke to my ontological suppositions along with other philosophical assumptions I held as a qualitative researcher.

3.3 Philosophical Assumptions

There are five distinct philosophical assumptions a qualitative researcher must flesh out (Creswell, 2007). As mentioned previously, my paradigm is most in line with

that of a social constructivist, so it stands to reason that my perspective of the world or ontological assumption is that reality is subjective, and able to be inferred upon. Subjective research can sometimes be viewed in a negative manner due to its perceived distance from objective meaning by the scientific community; however, the two contexts are more related than one may think. To elaborate this point, the following guiding statements stemming from the perspective of sociological phenomenologist Alfred Schutz (1945) are presented:

1. All knowledge of the world involves constructs. Constructs are abstractions which synthesize simpler ideas into more complex units.
2. An individual's common-sense knowledge of the world is a system of constructs of its typicality.
3. Concepts (theoretical constructs) formed by social scientists are constructs of the constructs formed in common-sense thinking by actors.
4. Actors form first order constructs (as typifications) from the array of sensations of their lived experience. For example, people make prior assumptions about the behaviour of a teacher or doctor.
5. The meaning of individual (and collective) constructs and concepts are part of on-going dialectics between what has been called objective and subjective meaning-contexts. (Rehorick, 1990)

Some might argue that identifying ontological understanding of reality as a continuum rather than a duality between objective and subjective meaning could serve to bridge the perceived gap between quantitative and qualitative research (Newman & Benz, 1998).

A second assumption is made epistemologically, and in this context, refers to the proximity at which the researcher is to the participants while collecting data. In qualitative studies such as this, a researcher attempts to be as close to the participants' environment as circumstances would allow (Creswell, 2007). Guba and Lincoln (1988) refer to this as making an effort to attenuate the "objective separateness" (p. 94) between researcher and participant.

Another important characteristic of qualitative research is the capacity of the researcher to position oneself or allow his/her values to influence the study. Creswell (2007) describes this as the axiological assumption. As previously mentioned in the first chapter of this work and introductory paragraphs of the current chapter, I have reported my biases as a person and researcher coming into my project and will continue to refer to them throughout the research process in order to be reflexive.

A fourth assumption relates to the particular rhetoric that is unique to qualitative research. A typical qualitative researcher will subscribe to a more personal discourse in their writing style, where poetic, literary and narrative language emerge as the dominant forms of communication. An example of this is referring to myself in the first person and using the pro-noun, "I", which is self-evident in my writing to this point and beyond (Creswell, 2007).

The final philosophical assumption made by the qualitative researcher is regarding the study's procedures, or its methodology. Qualitative researchers recognize the need to allow the process of research to emerge rather than have a rigid outline of hierarchical procedures to follow. The approach that has emerged as an ideal

methodology and that best fits my research goals and question is Heidegger's phenomenology.

3.4 Phenomenology

Rooted in the writings of Edmund Husserl, phenomenology is concerned with the world as one finds it (van Manen, 1997). Reality, according to phenomenologists, is not an objective, homogenous experience; rather, reality from the perspective of phenomenology is subjective and aims to elucidate individual lived experiences. It aims to explore the essence or nature of a particular phenomenon, and to provide a deeper understanding of what experiencing the phenomenon entails (Creswell, 2007; van Manen, 1997). Several researchers have chosen a phenomenological methodology when studying the phenomena of spirituality and spiritual care in older adults (Carroll, 2001; Stephenson, Draucker, & Marsolf, 2003; Tongprateep, 2000).

Phenomenology at its core is concerned with lived experiences or the life world (van Manen, 1997). Despite the enigmatic nature of human experience, predominant themes eventually emerge which most likely describe the life world. The life world (or Lebenswelt) can be operationalized into four distinct themes or existentials that include *lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived other* (relationality).

Understanding one's *lived space* is based upon reflection of how a space or location makes one feel [e.g., being "overwhelmed by the silent sense of the transcendental" (van Manen, 1997, p. 102) when walking into a church or holy place], as opposed to an empirical description of their physical environment [e.g., the dimensions of an apartment] (van Manen, 1997).

Lived body or corporeality refers to our awareness of reality through our senses, and body as whole. The significance of acknowledging the body's role as a guide to reflection is illustrated by conceptualizing the change in 'naturalness' the body undergoes while being observed or in the presence of another body:

> Under the critical gaze the body may turn awkward, the motions appear clumsy, while under the admiring gaze the body surpasses its usual grace and its normal abilities. Similarly, the person in love may incarnate his or her erotic mode of being in a subtle glow or radiant face or sometimes, under the eyes of the beloved, in a blushing response. (van Manen, 1997, p. 104)

This shifting of experience to special proximity or sensory recognition will most likely play a significant role in how social workers interpret their experience of using spirituality training while interacting with their clients.

The third interrelated aspect of the life world is temporality or *lived time*. Phenomenologists are concerned with how one experiences the subjective phenomenon of time. The partiality of time is most recognizable to a person when they are enjoying an experience (time seems to speed up) or when they feel bored (time seems to slow down). van Manen (1997) describes lived time as being in a state of flux; that one's memories of the past and consequent projections into the future influences how the present is experienced. Yet our perceptions of our past selves are fluid as well; changing as our present self evolves (van Manen, 1997). My participants' perception of their time during communication with clients is of interest due to the existential nature of the interactions.

The final life world existential is relationality or *lived other*. This concept revolves around the notion of experience through knowing other personalities. This

interpersonal relation can be attained through corporeal (e.g., through a direct handshake or face-to-face conversation) or non-corporeal means (e.g., telephone conversation or reading about a person in a book) and has often been recognized, as a fundamental means of finding meaning in one's life (van Manen, 1997). Some have maintained that spirituality itself is the search for the 'absolute other' (God) and that the self cannot fully actualize in terms defining identity without an understanding of the absolute other (Tacey, 2003).

Although these life worlds can be distinguished from one another, it should be understood that they are also interrelated (van Manen, 1997). The life world existentials have played an integral role in describing the nature of spiritual phenomena in previous studies (Hyde, 2005) therefore, I used them to guide my data collection and analysis.

Husserl's first iteration of phenomenology was coined 'transcendental' due to its focus on the objects of experience that is certainly outside epistemic grasp. Nevertheless, transcendental phenomenology provided the adequate foundation for additional orientations (i.e. realistic, existential and hermeneutical) to be realized (Moustakas, 1994). The perspective that is most appropriate for my research question is hermeneutical phenomenology.

3.4.1 Hermeneutical Phenomenology

An important aspect of Husserl's original form of phenomenology is a suspension of presuppositions. Referred to as *epoche*, phenomenology writers should attempt to acknowledge and compartmentalize their preconceptions in order to perceive data with a "natural attitude" (Creswell, 2007, p.58-59). While Husserl's transcendental phenomenology aims to describe a phenomenon objectively, "bracketing" out researcher bias; hermeneutical phenomenology, first postulated by Martin Heidegger and extended

by Hans-Georg Gadamer, acknowledges the near impossibility of this endeavor and instead, puts the onus on the researcher to interpret the meaning of the phenomenon from participants' lived experiences (Cerbone, 2006; van Manen, 1997).

While Husserl's aim was to grasp at the object of experience with almost certainty, Heidegger shifted the focus onto a more attainable goal from his perspective. Heidegger disagreed with Husserl's claim of subject/object duality and instead claimed that the two are combined, that you cannot separate the person from the experience (Laverty, 2003). Dasein (*Da*-meaning "there" and *–sein* meaning "being") as referred to by Heidegger, are the types of beings we are and are the primary focus of understanding experience. To Heidegger, consciousness is an integrated part of being and not something that can be perceived, recalled or even thought about as different from the self. Dasein rather has an ontological, a priori, pre-understanding of the world that is present in the being that can be accessed through interpreting language and texts (Heidegger, 1927/1962). As Gadamer (1960/1998) explains:

> Hermeneutics must start from the position that a person seeking to understand something has a bond to the subject matter that comes into language through the traditionary text and has, or acquires, a connection with the tradition from which it speaks. (p.295)

Understanding is therefore based on interpretation, which becomes a fundamental methodological aspect of hermeneutical phenomenology. Interpreters are said to have 'horizons' which is a "range of vision which includes everything that can be seen from a particular vantage point" (Laverty, 2003, p.25). During the process of questioning a participant, new horizons will tend to emerge due to unity of ideas, allowing the

interpreter's horizon to evolve and transform into a new perspective (Polkinghorne, 1983). This notion of embracing preconception and denouncing Husserl's theory of bracketing permeates hermeneutic phenomenology and allows the researcher to become an intimate part of the study. The object of experience that I have merged with is end-of-life care social workers' experience of existential interaction with clients and how spirituality training has influenced their interactions.

3.5 Research Design

In order to understand the experience social workers in hospice care have when utilizing spirituality training, semi-structured, face-to-face interviews were employed. Resulting data were analyzed following van Manen's (1997) steps for interpretive phenomenological analysis. In accordance with phenomenological research, I kept field notes of observations I made, along with a personal journal of thoughts.

3.5.1 Participants

According to Polkinghorne (1989) an appropriate sample size for a phenomenological study ranges from 5 to 25 participants. As mentioned in chapter 2, Carroll (2001) researched the phenomena of spirituality and spiritual care in a United Kingdom hospice care setting involving 15 nurses. Considering that Carroll's research question is similar in nature to my current endeavor and Polkinghorne (as cited in Creswell, 2007) suggests having as few as 5 participants; I aimed to ensure geographic representation across two provinces (i.e. at least one person from each location) by recruiting a purposive sample of at least 5 participants for the limited scope of my study.

3.5.2 Participant recruitment

I gained ethical approval for my study from the University of Regina's Research Ethics Board (Appendix A) and the Regina Qu'Appelle Health Region Research Ethics

Board (Appendix B) prior to commencing the study. Participants were recruited in two cities (Regina and Winnipeg). The rationale behind choosing these cities was based on convenience sampling due to my close proximity to them. I was also interested in any provincial differences of perspective between the participants in the two cities being sampled. Calgary was initially considered to be an appropriate city that would yield further participants, however, the Conjoint Health Research Ethics Board in Alberta required a local investigator to gather data from participants. Since I did not have the resources to recruit such an investigator, nor did I want someone other than myself performing the interviews, considering the nature of my research method, my supervisor and I decided to forgo attempting to recruit from Calgary and focus on Regina and Winnipeg. I contacted the Health Authorities in Regina (Regina Qu'Appelle Health Region) and Winnipeg (Winnipeg Regional Health Authority) and inquired into the availability and interest of their palliative care social worker(s) to take part in this study. Representatives from each Health Authority provided me with the contact information of five potential participants; two from Regina and three from Winnipeg. Once contact was established via phone or email with the five potential participants, I briefly explained my study to them and they all agreed to take part in it. I then emailed the participants a letter of invitation (Appendix C) that explained the study. Participants then contacted me to set up an interview at a location of their choosing. Recruitment was based on the following inclusion criteria: Participants must have been working as a social worker in a hospice or hospice care unit for at least one year; and participants must have participated in at least one spirituality training seminar or class to prepare for work in their field or to complement their skill set. Participants must have also worked with elderly clients (aged

65 and over) to be eligible for this study. Informed consent was obtained from each participant before the study was conducted (Appendix D). Consent was a fluid, on-going process as it was obtained via consent forms but verbally as well. Participants chose the interview location so as to create a more comfortable and empathetic environment, which I elaborate upon in my section on reflexivity.

3.5.3 Data collection

To develop a strong and consistent understanding of the phenomenon of utilizing spiritual training in practice, I used semi-structured, face-to-face interviews, which provide enough structure in the questioning to allow for comparisons and the freedom to explore opinions in more detail (Wimmer & Dominick, 1997). This potential derivation from the prepared interview guide could deliver more in-depth, rich data, which could eventually lead to a more thorough understanding of the phenomena in question. However, semi-structured interview guides require close attention to planning to avoid leading questions. This method of interviewing can also be time consuming and resource intensive (e.g., travel costs) (Wimmer & Dominick, 1997).

Specifically, I utilized the 'active interview' procedure as described by Holstein and Gubrium (1995). In this type of interview, the interviewer and interviewees are equivalent, allowing for each party to complement one another with the goal of building meaning around the interview. In my interviews, each participant was asked a series of open-ended questions that stimulated discussion about their lived experiences working with elderly clients. I began by asking a set of prepared questions; however, I was not limited to these questions alone, as new questions will likely arise as a result of an interviewee response. Three examples of prepared interview questions are: 1.What kinds of spirituality training have you received? 2. What spiritual experiences have you had

working with elderly clients? 3. How has spirituality training influenced your interaction with elderly clients? (Appendix E). Interviews were digitally recorded and transcribed verbatim. Initial interviews ranged from about 20 minutes in length to about 70 minutes. Follow up interviews were conducted via telephone after a 3-4 week period which provided an opportunity to go deeper into the phenomena (Creswell, 2007). The duration of follow up interviews ranged from about six minutes to just over 45 minutes. Following data transcription, participants were provided with a copy of their interview transcripts and with an opportunity to review, add, alter and, delete information from the transcript (Appendix F).

3.5.4 Participant Description

One man and four women who work in an end-of-life care social work setting agreed to participate in my study. Participants had been working in palliative care ranging from 2 to 35 years. A brief biography and description for each participant is presented below. Participants have been given pseudonyms to protect confidentiality.

3.5.4.1 Rachel

Rachel is a social worker in spiritual care services at a hospital and is almost finished her master's degree. She has been working as a social worker since 2001 and specifically in end-of-life care since 2011. She grew up in Eastern Europe and was raised in the Catholic tradition. Organized religion was a fairly pervasive aspect of her early life as she attended church on a regular basis, but her curiosity about spirituality was intrinsically based as she was "drawn to" existential questioning along with questioning "the structure of religion and the rules and regulations particularly around women's rights, right, and issues around marriage and divorce and things like that." When she moved to Canada and attended University, she was exposed to other religious traditions

and was “drawn to all of them for different reasons”. Rachel studied World Religions in University but her spirituality training has mostly been self-directed as she has attended a variety of relevant seminars including workshops focused on spiritual diversity.

3.5.4.2 Noreen

For the last six years, Noreen has been a social worker in the palliative care unit of a hospital. Graduating with a degree in social work in 1973, she has worked in several social work settings such as: crisis stabilization, foster care, addictions, psychogeriatrics, and oncology. Noreen was raised in the Catholic Church tradition but has since shed the “dogma and rituals” that she was taught as a child. She still identifies with Christianity as her faith perspective but has a more relaxed view of the aspects she incorporates into her daily life. Noreen has had a variety of training in spiritual related areas including: bodywork, cranial psychotherapy, and somato-emotional release techniques, however, most of her knowledge of spirituality has developed informally through experiences working with clients.

3.5.4.3 Joe

Joe graduated with a Master’s degree in social work in 1978 and has been an integral part of the social work and palliative care field ever since. He has had experience as a clinician, consultant, and a teacher within the palliative care community and now works as a health region program specialist. Joe has also contributed to numerous published works regarding palliative care including taking part in the development of core competencies for Canadian social workers in palliative care settings. His religious upbringing was in the Lutheran Church but now chooses to identify himself as spiritual without affiliation to any structured religious community. Most of Joe’s spirituality

training has occurred after his formal education in social work via spirituality centered workshops and conferences.

3.5.4.4 Ashley

Ashley has been a social worker for almost nine years and has worked in palliative care for over two years. Before her current position, she worked in Long Term Care, specifically a Veteran's/Extended Care Program, as well as a Mother-Baby Unit. Prior to her work in health care, she worked in Corrections and Public Safety. Ashley grew up going to church on a regular basis and eventually had her children baptized, so religion plays a significant role in her life. Though she does not "live by the bible," she maintains her belief in God and feels that "believing in something bigger than yourself" is an integral part of spirituality. Ashley did not have a significant amount of formal spirituality training during her social work degree but she has learned about spirituality through the various teleconferences she regularly takes part in as well as experiences with how Chaplains and other spiritual advisors assist her clients.

3.5.4.5 Maggie

Maggie is a palliative care social worker and has worked in palliative care for six years. She has a strong foundation in spiritual belief, growing up in a religious family "where God was held up as the centre of our home". Maggie attended a Christian high school and Christian university. Her spiritual foundation stems from an intrinsic desire to explore the transcendent which has led to her core values and morals being significantly influenced by the Christian faith and belief in God. Maggie did not receive spiritual education in her social work degree but her current role has allowed her to explore how spirituality can benefit her practice through seminars and conferences put on by external bodies like the American Hospice/Palliative Care Association.

3.6 Data Analysis

All collected data (including interview transcripts, field notes from observations and my journal of thoughts, observations and impressions) were analyzed using van Manen's (1997) phenomenological reflection technique in which the objective is to gain a natural or essential meaning of the phenomenon being explored. Reflection is a thoughtful, sober practice of self-awareness that links the data with the researcher in an intimate fashion. The phenomenological reflector attempts to 'grasp' at the world through empathetic and sympathetic means, which often results in a highly significant life experience for the researcher (van Manen, 1997). I followed the steps of van Manen's reflective, thematic analysis. The detailed steps included:

1. Reading individual transcripts and field notes several times (van Manen, 1997) to get a sense of the lived experience as a whole.
2. Carefully reading each sentence or sentence cluster while considering what it revealed about the phenomenon being described. Significant statements were underlined (van Manen, 1997).
3. Themes were identified by hand. As themes began to emerge, those that recurred were considered as potential commonalities and appropriate phrases were lifted to describe the meaning of the themes (van Manen, 1997).
4. Themes across all data were compared for commonalities and differences. Overall themes that best describe the essences of the participants' lived experience were identified.

5. The essence of the phenomena were explored and verified with all of the participants to see if they agreed with my interpretations in the follow-up interview (van Manen, 1997).

The method I employed to analyze the five transcripts is known as the hermeneutic circle (Kafle, 2011). As mentioned previously, hermeneutic phenomenology diverges from the traditional form or transcendental phenomenology by embracing the subjective nature of interpreting written language, and therefore foregoing the need to bracket one's preconceptions and assumptions about the phenomenon. Hermeneutic ontology maintains that a deeper understanding of phenomena occurs through a cyclical process of reading, reflective writing, and interpretation (Kafle, 2011).

In accordance with the hermeneutic phenomenological research circle, I read each transcript, highlighting statements that I deemed significant to my research goals. I then re-read the transcripts and laid out significant statements so that each was of equal value and importance in order to be analyzed (i.e., horizontalization) (Creswell, 2007). Horizontalized statements were given meaning units, which were then clustered into common themes. The phenomena of spirituality, delivering spiritual care, and the impact of spirituality training and education on practice are described in Chapter 4.

3.7 Trustworthiness

As per qualitative research standards, I employed tactics to ensure the rigour of my study. Traditional criteria for appraising trustworthiness of a qualitative study include attention to its credibility, (equivalent to internal validity in quantitative research), which measures the congruency of study findings with reality; transferability (equivalent to external validity or generalizability in quantitative research), which is the extent that

study findings are applicable to other situations and populations; dependability (equivalent to reliability in quantitative research), which is a test of whether or not the study can be replicated; and confirmability (equivalent to objectivity in quantitative research), that describes the extent to which the researcher has described his or her preconceptions (Guba, 1981).

To strengthen these aspects of trustworthiness, I have adopted a number of tactics. For example, to bolster the credibility of my study, I have adopted a well-established research method (Shenton, 2004) in Heidegger's interpretive phenomenology, and van Manen's (1997) phenomenological reflection techniques for data analysis. I also triangulated several sources of data (Shenton, 2004) in the collection process including transcripts, field notes, and a journal of my thoughts and reflections. Triangulation can be defined as an "attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint" (Cohen, Manion, & Morrison, 2000, p.254). To further support the credibility of my study, I confirmed the accuracy of my transcripts along with my subsequent interpretations or theories with participants through member checking (Shenton, 2004). After I completed analysis of the data, my interpretations were sent to participants for their review. Upon review, general support was offered for my interpretations and although findings were not altered, my understanding of the phenomena was authenticated. The other three criteria (transferability, dependability, and confirmability) involved with traditional qualitative measures of trustworthiness are somewhat difficult to adhere to when undertaking an interpretive phenomenology. Instead, I looked to more contemporary guidelines that apply directly to hermeneutics.

de Witt and Ploeg (2006) have established an evaluation of rigour for an interpretive phenomenological inquiry. The criteria include: balanced integration, openness, concreteness, resonance, and actualization. To ensure that my study results are presented with balanced integration, I must interweave philosophical concepts with transcript excerpts in order to maintain balance between analysis and participant voice. Openness is crucial to a thorough interpretive study and will be maintained by my willingness to provide the details of my decision making process through reflection and reflexivity. The concreteness of my findings is evident in how useful the information is, along with how well the reader can relate to the context of the described phenomenon. The penultimate expression of rigour in interpretive phenomenological studies is how well the study findings resonate with the reader. I strengthened the potential for this by utilizing empathetic rhetoric in an attempt to 'move' the reader so that they are influenced experientially and intimately understand the described phenomenon. The final expression described by de Witt and Ploeg (2006) is actualization. Actualization of a study is accomplished when its findings are deemed to resonate or persist long after the study has concluded. Although it is difficult to measure this expression, I aimed to produce a document that can be interpreted and analyzed by future readers.

The aforementioned traditional measures of trustworthiness established by Guba (1981), along with expressions of rigour, specifically intended for interpretive phenomenological work guided the data analysis of my study. To further confirm my findings and subsequently produce a more thorough study, I was reflexive throughout the research process.

3.7 Reflexivity

The concept of reflexivity has become commonplace in qualitative research in recent years and will therefore be adopted as an essential tool in my research practice. Holland (1999) defines reflexivity as "that which turns back upon, or takes account of, itself or the person's self" (p. 2). This awareness and empathy toward oneself and the research process is a central tenet of good qualitative researchers and interpretive phenomenologists in particular (Finlay, 2005; Walsh, 2003). Reflexivity can be classified into four distinct categories that researchers should address in their work, which include personal, interpersonal, methodological, and contextual reflexivity (Walsh, 2003).

Personal reflexivity entails detailed expressions of the researchers' assumptions, expectations, reactions and unconscious responses that could influence the research process (Finlay, 1998). In hermeneutical phenomenology for example, not only should the researcher interpret the data received from participants, but also the data compiled regarding the researchers' attitudes and perceptions before, during, and after the process (Walsh, 2003). I was personally reflexive with regard to this study by keeping a journal of thoughts and feelings during the data collection process. The information from this journal contributed to the discussion of my findings and led to a deeper understanding of how my personality influenced the study.

Interpersonal reflexivity requires the researcher to be cognizant of the relationship between the conductor of the study and participants. According to Walsh (2003), interactions during data collection should be given proper consideration and dialogue after data is collected should be equally scrutinized. With regard to conversational awareness and being interpersonally reflexive during data collection, I was sensitive to

the nature of questioning that I was pursuing with my participants. Prior to the interviews, I sensed that there was potential for some participants to be apprehensive about discussing their own spiritual views with me as the investigation moved forward. My concerns were misplaced though as they were very open to a discourse about their personal spirituality. Nonetheless, I attempted to display embodied empathy with them (Finlay, 2005). Briefly put, reflexive embodied empathy as described by Finlay (2005) involves mutual construction of meaning through awareness of bodily relationship between the two parties. Using this philosophy, I feel that I fostered an empathetic environment while connecting with the participants' experiences through conversation.

Methodological reflexivity demands a forthright recognition of the limitations involved in the researcher's theoretical perspectives with respect to the phenomenon being investigated. This reflection of one's presuppositions should take place both before and after the research process so the commentary can be further enriched by the author's understanding of the study (Walsh, 2003). As previously mentioned in this chapter, I brought a social constructivist perspective to my study and accept the limitations that go along with that stance such as my reliance on language and my vocabulary to properly describe and interpret the phenomenon being studied. I acknowledged these limitations post hoc as well as during the interview process with participants.

The final component to reflexivity according to Walsh (2003) is the contextual aspect which acknowledges the cultural and historical relevance to a phenomenological study. The importance of this facet relates to the field of study that the project is investigating. My study has implications spanning from the hospice/palliative care field to the social work community with a background in spirituality. Being reflexive in this

domain required me to consider how the results of my study may impact social work curriculums, contribute to the literature on spirituality at the end-of-life, change perceptions of the theory of gerotranscendence, and enhance the scientific community's understanding of how the hospice social worker discusses spirituality with their elderly clients.

CHAPTER FOUR: Findings

4.1 Introduction

In this chapter I present findings from phenomenological data analysis of five interviews conducted with end-of-life care social workers practicing in the city centers of Regina, Saskatchewan and Winnipeg, Manitoba. The purpose of these interviews was to explore the experience of spiritual care delivery and how spirituality training, education, and experience impact the practice of these social workers. A secondary goal of these interviews was to discover how these particular social workers experienced the concept of spirituality themselves. A third phenomenon that emerged from data collection is the experience of delivering spiritual care. Therefore, the three separate phenomena of *expressing spirituality*, *delivering spiritual care*, and *the impact of spirituality on practice* will be described using themes that have emerged from data analysis. The emergent primary and corresponding subthemes are presented in Table 1.

Table 1

Primary Themes and Subthemes

Expressing Spirituality	Delivering Spiritual Care	Impact of Spirituality Training on Practice
Disconnect between Religion and Spirituality	Being Curious and Aware	Poised in difficult circumstances
Feeling connected	Drawing on Teams	Appreciating different perspectives
Believing in a Higher Power	Listening and Being Present	Complementing innate skills
Finding Meaning and Purpose		Perception of greater connection

The core themes established for the phenomenon of expressing spirituality have a pyramidal relationship with the more fundamental notions as the base and most pervasive

themes atop. Exploring spirituality comes first by acknowledging *the disparity between it and religiosity*. Once this is established, a common experience of expressing spirituality is the *belief in a greater power* or ultimate observer within reality. Intimate relationships and *feelings of connectivity* with people, places, and objects is a theme that more accurately describes expressions of spirituality but is still below the *pursuit of meaning and purpose* in being most relevant to the essence of spirituality (Figure 4.1).

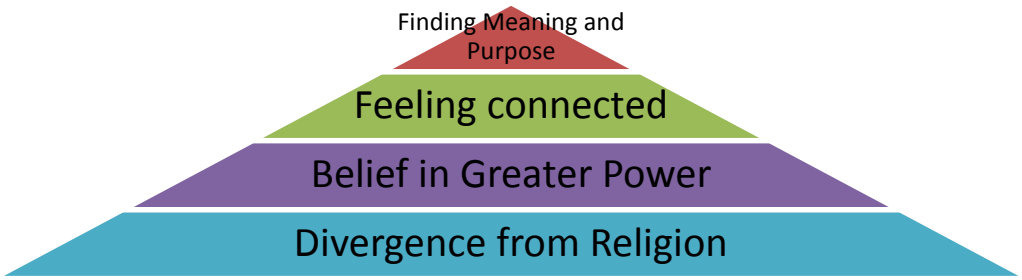

Figure 4.1: Expressing spirituality

The themes comprising the phenomena of delivering spiritual care for end-of-life care social workers can be illustrated (Figure 4.2) as individual cogs functioning in the mechanism of care. Each cog or theme (*being curious and aware*, *listening and being present*, *drawing on interdisciplinary teams*) represents a tool or concept that participants use to deliver a high level of spiritual care. Each of the themes are of equal importance to the social worker and occur simultaneously.

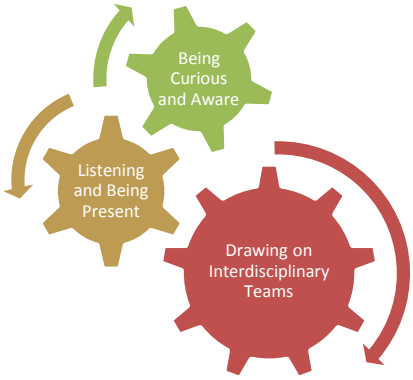

Figure 4.2: Delivering spiritual care

The four themes that describe how spirituality education and training impacts the practice of end-of-life care social workers are situated in a tree like diagram. Two of the four themes (*feeling poised in difficult circumstances*, and *appreciating different perspectives*) are experienced by multiple participants and are therefore combined in one branch. These two themes seem to be felt equally by participants. The remaining two, *complementing innate skills*, and *perception of greater connection* are experienced by individual participants respectively and are represented by two different branches converging to depict the impact of spirituality training and education on practice (See Figure 4.3).

Figure 4.3: The impact of spirituality education and training on practice

4.2 Expressing Spirituality

The concept of spirituality is nebulous in nature and the experience of it is interpreted in several different ways by people throughout their lives. Expressing spirituality refers to the ways in which participants of this study personally understand and experience spirituality. Participants described expressing spirituality in terms of using religion to express spirituality, believing in a higher power, performing ritual, and meaning and purpose.

4.2.1 Disconnect between Religion and Spirituality

The experience of expressing spirituality for these five end-of-life care social workers can be characterized first by how they distinguish it from religion. As Joe points out: "spirituality is kind of pretty broad" (Joe, Interview 1), and encompasses all religions. Noreen acknowledges the dynamic relationship between spirituality and religion by claiming that "religion isn't something that a spiritual person has to have, but religions often seek spirituality, that kind of connection" (Noreen, Interview 1).

Religion's role within spirituality can be equated to a vehicle of expression, as Maggie conveys: "I think religion is one way that we demonstrate spirituality or it's involved, or it's kind of like the practice of some of our spirituality" (Maggie, Interview 1).

Expression of spirituality through religion manifests itself in different ways for these palliative care social work professionals. Being raised in Eastern Europe in a highly traditional, Catholic environment, Rachel's religiosity became intrinsically motivated; she stated:

> I was attending Church as a child without my parents so obviously it was speaking to me, obviously it was something I was drawn to, and in fact as a child I was wondering like, how do you know if you were supposed to be a nun? (Rachel, Interview 1)

As she transitioned into her life in Canada, she began to "question the structure of religion and the rules and regulations particularly around women's rights, right and issues around marriage and divorce" (Rachel, Interview 1). For Rachel, the guidelines that traditional religion taught were not in line with her sense of justice and morality, and she therefore sought out other forms of spirituality. Joe has had a similar experience with traditional religiosity:

> What really turned me off, more structured religious practice early on in my life, probably how it was interpreted by people who had extreme ideas of beliefs, and people who believed that there was only one way and no other way, and that you were frowned upon if you didn't believe their way. (Joe, Interview 1)

The contrast between religion and spirituality continues as I explore the meaning of two concepts that are usually emblematic of religion: belief in a higher power, and rituals.

4.2.2 Believing in a Higher Power

The lines between spirituality and religion continue to be blurred with another common expression of spirituality, believing in the existence of a higher power or deity. Central to Ashley's definition of spirituality is "believing in something bigger than yourself; and that could be anything to anybody right? Whether it's a god or something like that" (Ashley, Interview 1). She continues by conveying that belief in a higher power does not have to be synonymous with religiosity: "Do I believe in God? Yes. So does that make me religious? I don't know. I don't live by the Bible, and some people would say that that means you're not religious" (Ashley, Interview 1). Rachel reinforces this idea of allowing the belief in a higher power to exist in a non-religious, yet spiritual paradigm. Spirituality to her is about a relationship "with potentially something higher than yourself, but not always. I do believe that people can be spiritual without believing in a god…it is separate from religion, in my mind" (Rachel, Interview 1).

Within the context of palliative care, Maggie views the role of spirituality as "understanding a person is more than just their physical symptoms and their emotional feelings, but also those bigger questions and then certainly continue on the spectrum of searching for higher power, whatever that might be, up to God." The search for, or embrace of, a higher power in a person's life may be a defining characteristic of spirituality expression, especially at the end-of-life care settings; however, just as someone close to death may acknowledge a relationship with a higher power, that relationship can also degrade depending on experience:

> I guess it's about relationships right because your relationships; you know how they say that crisis can either make a relationship or break a relationship? It's the same with the relationship with god or something greater than you right? Some

> people's relationships get stronger and they draw on that strength…but for some people they feel betrayed, they feel that they don't want anything to do with it. (Rachel, Interview 1)

A higher power is not only an influential idea for clients in end-of-life care but it also has significance for social workers. Noreen exemplifies this connection as she talks about what spirituality means to her:

> I am a creation of God, and I take that with me, I take that with me into every room I go into, every person I speak to because that makes me a better person, and that makes me a good helper around here, it just does, I know that for a fact. (Noreen, Interview 1)

Her relationship with God or a higher power has a substantial impact on her self-esteem, which she exudes when interacting with people in her life, personally and professionally.

4.2.3 Feeling connected

Another way participants define spirituality is a feeling of deep connection with people and to their world. Joe recalls the experiences he has had with people and what others have conveyed to him about feeling spiritually connected:

> the importance of communication, the importance of touch, but not only physical touch but being in touch, being heard, being connected, that whole sense of what's important, legacy…that connection with life after us and how do we leave a legacy, and it is a continuation in some ways of spirituality, spiritual connection over time. (Joe, Interview 1)

Connectivity is understood in numerous means, from physically sensing a connection, or an emotional bond, to a linkage with time and space itself; feeling connected is a defining

characteristic of spirituality. When asked what spirituality means to her, Ashley responds by talking about how she feels it is:

> like karma, like I believe that things really do come around, like if you're good and you put good things out in the world, I believe that good will come back, and it's the same way, if you're negative and you're not good to people I believe it will come back. (Ashley, Interview 1)

Ashley has spiritual belief in a karmic universe that she feels is connected with hers and everyone else's actions. Rachel has a similar perspective in the way spirituality is classified: "You may call it Buddha; you may call it Krishna it doesn't really matter. We seek that connection with something or ourselves with others so to me it's all the same" (Rachel, Interview 1). The search for that feeling of a deeper connection with the world is pervasive in the experience and expression of spirituality for participants. Developing a connection to people and the universe is part of a meaningful life, which is the subject of the following sub-theme that defines spirituality for social workers in end-of-life care.

4.2.4 Finding Meaning and Purpose

The idea that resonated most with participants when asked about how they experience spirituality is the concept of purpose. The search for meaning and purpose in one's life is one of the hallmarks of expressing spirituality due to its universality. For many, pursuing the reason for why they exist is a lifelong search that is aided by learning about and expressing spirituality. To Noreen, spirituality "has meant growth…it gives me my purpose in life" (Noreen, Interview 1). For her, spirituality is an omnipresent quality to her life and "meaning and purpose is the biggest part of why we're here" (Noreen, Interview 1). Joe begins his description of spirituality with a definition of it from a favourite author of his, Christina Puchalski. The definition he likes the most is:

"Spirituality is the aspect of humanity that refers to ways individuals seek and express meaning and purpose and the way they experience their connectivness to the moment, to self, to others, to nature and to the significant and/or sacred" (Joe, Interview 1). The first part of that definition speaks to the exploration of one's purpose and search for meaning in life, but Joe adds a significant facet to this notion as he continues to ponder what spirituality means to him. "Spirituality is a lot about mystery, a lot about what's going on out there? Trying to make sense of your world and what is the meaning to you" (Joe, Interview 1). For Joe, the experience of spirituality is not a process of discovery, it is the idea that non-discovery, or 'mystery' as he aptly puts it, is the true goal if there is a goal. The search for understanding is the spiritual experience where real meaning is derived and encapsulates the part of the essential nature of the phenomenon.

Maggie provides another example of how meaning and purpose are tied to spirituality as she separates her notions of personal spirituality with how she experiences delivering spiritual care professionally. For Maggie, private spirituality means belief in a higher power with a focus on the Christian faith perspective. Spirituality in her professional role as a palliative care social worker "is the search for meaning of life" (Maggie, Interview 1) and is highlighted by questions like: "Why has this happened? What does it mean?" (Maggie, Interview 1). For Maggie, spirituality not only enhances her passion for the mystery of life and search for purpose, but it also strengthens her ability to practice: "because of my personal beliefs and confidence in my beliefs, I am able to do a lot, I think field and handle discussion and questions from people" (Maggie, Interview 1).

The overarching theme of expressing spirituality is experienced by the social worker in three distinctive sub-themes. The end-of-life social worker characterizes their expression of spirituality as a belief in the transcendent, or something greater than themselves; the search for meaning in life and the reason for existing; and finally a feeling of connectivity with others, the universe and themselves. The experience of practice for an end-of-life care social worker, and more specifically, the experience of delivering spiritual care will be the focus of this next section.

4.3 Delivering Spiritual Care

Delivering spiritual care reflects the experience of spending time with clients or their families and conversing about what is important to them as they near death. Spiritual care for health practitioners is about serving clients, not trying to "fix" them; it is about empathizing with their pain and accompanying clients in their suffering (Puchalski, 2001). The experience of practicing spiritual care is multi-faceted and unique to every professional end-of-life social worker, but some commonalities arose from my discussions with the participants. Themes include being curious and aware, drawing on an interdisciplinary team, and listening.

4.3.1 Being Curious and Aware

Being aware has a dynamic meaning for these social workers within the context of delivering spiritual care. Awareness for an end-of-life care social worker is about being cognizant of who they are as people and professionals. As Noreen describes: "We have hard work to do to be helpers, we need to help ourselves first, then we can do that other stuff". It seems that before professional care can begin, it is necessary for the caregiver to be self-aware and comfortable with her or his own emotional and spiritual state. When describing how he delivers care, Joe echoes this notion of knowing oneself

prior to spiritually caring for clients: “It’s really important to be self-aware and to know where you’re coming from yourself” (Joe, Interview 1). It is a matter of health and wellness of the caregiver and consequently the good of the client as well. When confronted with all the emotions that go along with families experiencing terrible angst, it is important to “have your backyard in order because otherwise you’ll get sucked in” (Noreen, Interview 1). As Noreen explains, it is necessary in this type of care to inject self into the scenario but having awareness of boundaries is critical to maintaining a healthy environment for all concerned parties. Joe describes what inappropriate use of self is like, explaining how at times, past co-workers of his have exhibited characteristics of egocentrism when delivering spiritual care:

> they had such a need to be in control, they had such a need to prove themselves that they lost track of the person in front of them, that they didn’t really hear what that person was saying because their own voices were talking. (Joe, Interview 1)

He identifies awareness of self and the ability to be humble about the role of caregiver and demonstrates how it can be a detriment for the client when the professional transfers too much of themselves into the situation:

> it’s really having a balance of knowing what you’re about and being able to practice in a world that demands that, with clarity and always seeking to learn and gain more knowledge but, yea to be very; humility is big. To not have *the* word and the only word and beware of…beware of ‘either or.’ (Joe, Interview 1)

Being conscious of the human tendencies to want to provide answers in end-of-life scenarios and rejecting those inclinations is important for Joe when providing spiritual care to clients and families.

The phenomenon of being aware is also experienced through the desire to understand what the client is feeling throughout the process. Rachel feels a responsibility to initiate a spiritual discussion with her clients: "You have to ask a lot of questions about, so, you know, are you religious? Do you celebrate events? Do you have a relationship with spiritual leaders in your community? Who are they?" (Rachel, Interview 1). This genuine curiosity about who the client is and how they have evolved as a person is an essential experience for social workers delivering spiritual care. Joe adds to this experience of inquisitiveness and eventual understanding: "My goal often is to understand, as a social worker, a big role is really understanding people and what are people really about…and help understand what works for them and what makes them tick". Recognition of the broader impact on a person receiving spiritual care is another important aspect as he continues to question, "how does that impact on the rest of their lives, how does that impact on their family, other relationships with other people, their sense of community, the interactions there?" (Joe, Interview 1).

Having awareness of the situation and themselves represents part of the experience of delivering quality spiritual care for end-of –life social workers. This awareness of their role and limitations often leads social workers to draw upon the aid of the palliative interdisciplinary team.

4.3.2 Drawing on Interdisciplinary Teams

The participants emphasized the support that they derived from their interdisciplinary teams. Ashley explained when asked about her experience providing spiritual care: "If something comes up where we don't feel comfortable, we have somebody to call on." Noreen adds to this notion of drawing on support of others when

she experiences an inability to bond with her clients. When the situation seems unmanageable, and there is a spiritual disconnect between her and her client, she says:

> you know what, I think I'm going to go talk to someone on the team and I think we're going to see if someone else can come and see you, because maybe this is just not meant to be for you and I.

Sometimes it takes another person's perspective and expertise, such as a spiritual care advisor or chaplain to resolve spiritual angst. Maggie stated:

> [I] would never shy away from a conversation on spirituality, religious practice, the emotions and feelings about that, but I would not take sole responsibility for that. I would bring in our chaplain to either be with me or refer to him to go on and explore that further.

These social workers experience humility when confronted with situations that are beyond their abilities, and Joe advocates for this reaction:

> within teams sometimes you will see people who represent certain areas…everybody comes from their own place, and the ideal team in my perspective are people that are very strong within their own disciplines but they're also strong enough to be secure enough to be able to blend those disciplines together. (Joe, Interview 1)

Drawing on the assistance of their teams allows social workers in end-of-life scenarios to incorporate their own style of care while accepting the multidimensional support of the team around them.

4.3.3 Listening and Being Present

Another facet of spiritual care delivery that social workers draw upon is the ability to be fully present and attentive to their clients. The capacity to simply listen and

to “just [be] a witness to” her client’s spiritual dilemmas, as Rachel explains, is something she employs daily while conversing with clients and families. She continues to describe her experience of being a conduit for healing by saying “it’s like holding a mirror to them right, and really, therapy is sort of like that it’s not providing the answers, it’s more about asking questions, questions that will hopefully help them figure it out for themselves” (Rachel, Interview 1). For Maggie, being a good listener during spiritual care is about providing an opportunity by “[creating] time and space for discussion”. She elaborates on her observations of practice in that:

> a lot of these conversations are very hard and part of my job here is not to solve things, not to fix them, but to give them the opportunity to consider and discuss if they want…my responsibility is to open the door for that discussion.

Maggie stresses the importance of this spiritual care component: “They’re not necessarily looking for knowledge and factual, encyclopedia type information from us. They’re looking for a chance to talk about what they’re feeling”. Joe similarly understands his role as a spiritual care provider in a way that acknowledges the reality of clients who are faced with a terminal illness and says: “we’re not here to fix things but we’re here to be part of a way of providing care for people that is going to be meaningful and compassionate in support of care for people”. The experience of compassionate listening is an essential feature of the spiritual care phenomenon.

Delivery of spiritual care from the perspective of an end-of-life care social worker represents an opportunity to apply both their innate and learned skills as a care provider. This experience is categorized by the social worker’s proficiency at listening to their client’s and family’s needs, by their ability to clear the mind of distractions and focus on

the present moment of caregiving; by their awareness of how their own health and personality can influence the caregiving process; by having an innate curiosity about their clients' lives and sense of wonder about what they are experiencing; and finally, by their recognition that the interdisciplinary team in end-of-life care is necessary for a holistic and positive dying experience. A full explanation of the experience of spiritual care delivery for end-of-life care social workers is not complete without an exploration of how spiritual education and training may impact these participants while practicing. The following section will communicate how participants in this study may have been impacted by their education and training involving spirituality.

4.4 How Spirituality Education and Experience Impacts Practice

In this section, I will explore the phenomenon of the impact of spirituality training and/or education on social work practice in end-of-life care settings. Participants described this impact in terms of being poised in difficult circumstances, appreciating different perspectives, complementing their innate skills and knowledge, and a perceived increase in connection and compassion. However, before findings of this phenomenon are delineated, a premise of how participants experience the availability of spirituality training and education will be considered.

4.4.1 Spirituality Education and Experience

Education and training about spirituality comes in many forms for social work professionals. Maggie has accessed seminars, webinars, and conferences in her experience and views the abundant opportunity for attendance as "there's always options for spiritual classes that's led by chaplains or ministers about spiritual end-of-life care." Ashley echoes this sentiment by saying that she thinks that palliative care social workers

"have opportunities quite a bit, it depends if you're paying attention…you just gotta watch for it, and look I do see a lot of spiritual stuff" (Ashley, Interview 1).

On the other end of the spectrum, participants also receive a portion of their knowledge about spirituality and spiritual care from independent learning, or "personal development" as Rachel refers to it. She says that often times, "the onus is on the social worker to learn what they need to learn" (Rachel, Interview 1) and that spiritual professional development is somewhat scarce in availability to them.

4.4.2 Poised in difficult circumstances

Although opportunities for formal education may be limited, participants described the impact of personal investigations into spirituality on their practice. First, participants experienced being poised when faced with difficult professional circumstances. This theme reflects the participants' feelings of confidence in providing spiritual care. As Maggie started to investigate spirituality both on her own and professionally, she noticed that she was more confident in her abilities to enable discussion regarding spirituality with her clients. "I started to learn how to better facilitate conversation about spirituality and how to open that door without saying, 'Do you go to a church?' 'Do you believe in God?' 'Do you believe in Allah?'" Maggie maintains the importance of assertiveness with clients that develops from her experience with spirituality and continues to describe providing the opportunity for spiritual dialogue as opening up a doorway.

> It's about opening or closing doors or not opening them for people, and often as people bring up things about their lives, I think they crack windows about spirituality and the meaning of life, and if you don't actually throw the door open for them, then they close that window. (Maggie, Interview 1)

Another way she talks about facilitating discussion for her clients is "[creating] time and space" (Maggie, Interview 1) to allow conversation about spirituality.

In our follow-up interview, I asked Maggie about how her knowledge and experience of spirituality gave her confidence to provide that time and space for a discussion and she explained how important it is to be well versed in spirituality to feel at ease in these circumstances. "Because I have a personal comfort zone with it…it's just easier to bring up...so that just allows me much more easily to present it, to acknowledge it" (Maggie, Follow-up). According to Maggie, her past experience and current investigations of spirituality have led her to feeling poised when confronted with the spiritual angst of her client's and their families. Being comfortable in difficult situations can only serve to enhance Maggie's ability to foster conversation and therefore care for her clients when they are experiencing spiritual distress.

When situations with her clients or their families become challenging, Noreen also relies on her instincts and training to remain poised and deliver care:

> I have been present when there's been oh, real angst in a family and there was a crisis and somebody died right then and there when I was in the room and it was just horrific, I mean, just really horrible, catastrophic bleeding and so; in the moment, you just do what you do. My hand went underneath the person's head and on top of her temple, temples, like I just held her and the family were all kind of crying and doing whatever, and I said: It's ok; like the words just kind of came out of my mouth. (Noreen, Interview 1)

To react as she does to such an occurrence speaks to not only the strong person Noreen is, but also to the experiences in spiritual training such as therapeutic touch that has led to this type of measured response.

4.4.3 Appreciating different perspectives

Learning about spirituality not only allows for greater comfort discussing existential dilemmas with clients, but can also potentially let palliative care social workers see life from alternative points of view. For example, Rachel believes that in order to best care for her clients, she must learn as much as she can about them as possible. Investigating divergent religions and belief systems gives her a unique perspective into how her clients may be experiencing spiritual questioning at the end-of-life. Her core beliefs have evolved to the point where:

> somebody may say, oh, you're spiritual but not religious right, so some people might categorize it like that, but I know if that's true because I've been to synagogue and find it very meaningful, I've been to Catholic church and find it somewhat meaningful, I've been to whatever, Buddhist temple, find it meaningful, I go to sweat lodge and find it meaningful so am I religious? Maybe, I'm probably all of them, but also none of them. (Rachel, Interview 1)

Becoming aware of the assortment of spiritual inclinations available to her has essentially "allowed me to really have a deeper and a broader understanding of people's perspectives" (Rachel, Follow-up).

Joe provides another example of how researching spirituality can influence his practice, allowing him to see different angles to care than what he started with:

> Sometimes you hear things that people say or maybe people, from a knowledge perspective you might know that the way that they say them, or it might trigger a

> thought in your own mind, that says oh, I never thought about that way, it kind of pushes you to sort of think about things differently. (Joe, Follow-up)

Joe expressed the value of humility during our conversation and made it clear that he "has a healthy respect for not knowing everything" (Joe, Follow-up), so drawing upon the knowledge of different spiritual writers and thinkers over his career has helped him to appreciate the mystery of being human and be empathetic to others' outlook on life.

4.4.4 Complementing innate skills and knowledge

Spirituality education had a slightly different impact on Noreen than with the other participants. Starting with a strong foundation of belief, Noreen recognizes the benefits of accepting a higher power in her life, stating:

> I am a creation of God, and I take that with me, I take that with me into every room I go into, every person I speak to because that makes me a better person, and that makes me a good helper around here.

Having a well-developed sense of spirituality coming into social work practice, she views her exploration of spiritual concepts such as cranial sacral therapy or bodywork as opportunities for growth as a professional and as a person. She describes her experience receiving knowledge about different ways spiritual exercises can heal a person as "life changing" (Noreen, Interview 1) and identifies the time she began her training as a highly momentous occurrence.

The metaphor that she uses most often to describe her growth with spirituality education is that accumulating knowledge for her spiritual or social work 'toolbox'. She explains, when discussing the information she's accrued: "those are tricks that I put in my tool bag too that are spiritual based" (Noreen, Interview 1) or "all kinds of different shall we call secular tools and how we can use them in a spiritual and helping way," (Noreen,

Interview 1) and "all those things brought together are added to the toolbox, the practice toolbox" (Noreen, Follow-up). Noreen amasses knowledge of spirituality onto an already refined base of experience and serves to enhance her abilities to care for her clients. It becomes a natural, unconscious process for her:

> it's easy for me to connect with people, but it is from my spirituality that I connect, that's where it comes from, and it's all these other things that have allowed the; what would we say they are? The pull it together so I know what I know. (Noreen, Interview 1)

4.4.5 Perception of greater connection and compassion

Feeling compassionate or developing a connection with clients is vital to care from Noreen's perspective, as aforementioned, and for Rachel in particular. Spirituality education and being a spiritual person in general enhances this compassion for clients and herself:

> for me my spiritual beliefs help me be compassionate to others and myself right so that means, be kind to yourself be kind to others and I think about; I think that settles things, that's the best way I can describe it, it just settles everything, so it puts everything in perspective, I think that's the biggest thing for me in my clinical work with that…so I think that it brought more compassion into the relationships, any relationships, including the relationship with yourself. (Rachel, Interview 1)

Her investigations into spirituality help her connect and empathize with her clients. Rachel continues to stress the importance of connectivity when coping with spiritual angst at the end-of-life:

> something greater than yourself can be healed by feeling connected here with humans right? And if you don't feel heard, you don't feel connected, you don't feel loved and appreciated and being cared for then you kind of lose sense of meaning. (Rachel, Interview 1).

Rachel underlines how experiencing diverse cultures and belief systems has given her a deeper appreciation for the other and made her more aware of the connection she has with people:

> when you look at people who seem different that you you're kind of reminded that they aren't. You know, they aren't, everybody has a story. Everybody has crises in their lives, big or small. We all want the same thing; we want to be loved, we want to feel cared for, we want to love another, I think we just all want the same thing. (Rachel, Interview 1)

Feeling connected to, and compassion for, clients is reflective of not only the unique individuals they are, but also of their knowledge of spirituality. Gaining a deeper understanding of spirituality allows participants to empathize with their clients' situation and augments their overall caregiving skills. Spirituality education from formal training or personal investigation impacts these participants in ways that enhances their perceived connection with not only their clients and families, but with themselves and the Universe.

4.5 Generational differences with clients

Another goal for this project was to examine possible differences end-of-life care social workers experienced when assisting clients along the age spectrum. I asked participants if they recognized any differences when interacting with elderly clients as opposed to younger clients and the responses were mixed.

Ashley conveyed that her elderly clients had a more developed sense of spirituality and that her experience has demonstrated that "younger people don't believe in anything" (Ashley, Interview 1). For Ashley, utilizing the chaplain and the entire interdisciplinary care team is central to her style of practice, so she explains that it is "usually the older people that want a chaplain" because "it has more to do with their understanding of what's happening to them, if they're more accepting that they think they're dying opposed to not" (Ashley, Interview 1). Younger people may be less prepared to handle the end-of-life than their elderly counterparts as Ashley points out. Rachel views her elderly clients as more compassionate towards themselves:

> The self-forgiveness part is way more developed in older people than younger people. Younger people tend to be a little bit more self-critical, you know so the whole idea of self-forgiveness and self-compassion I find tends to; that's the difference I find between younger and older. (Rachel, Interview 1)

Also, elderly people may be more accepting of the reality of their situation because of their physical state.

> I think younger people, particularly in this type of care, they're usually stronger, because they're physically you know; they may have cancer but they tend to live on longer than the elders and because the elders may have got two or three other things, like they may have high blood pressure, they may have you know, other medical issues on top of having had cancer and so they're more compromised that way, whereas the younger people have a tendency to be stronger physically and they get cancer but they're usually around longer. (Noreen, Interview 1)

Another factor that may contribute to elderly people accepting the terminal nature of their situation more so than younger individuals nearing death is the amount of loss they have experienced. Noreen explains from her experience that elderly clients are:

> dealing with all these layers in the marriage, layers in the person's life, they've already lost; they can't walk anymore maybe, maybe they're bed bound, like they can't get to the bathroom, they're incontinent, but so much loss of pride, loss of personhood. (Noreen, Interview 1)

Coping with layers of physical and emotional pain and loss may diminish a person's ability to hold on to life and therefore a younger person without these years of loss would have an impact on their drive to stay alive.

However, some participants felt that there were more similarities than differences between generations. From a spiritual standpoint, Joe does not identify much difference between age groups as: "everyone has potential to sort of, really [try] to make meaning, fulfill purpose and [make] meaning of what their life is and really [delve] into their own pain and suffering and what does suffering mean to them" (Joe, Follow-up). Maggie echoes the idea that younger people facing death are also capable of reaching the point of spiritual reflection:

> even the younger people are catapulted into that same spot that someone who is elderly may be at because they had lived their life and they see it coming to an end, so they start to ask those questions and think about what's next. Whereas even if you're thirty, and by natural development of life, haven't reached that point, suddenly those questions are right in front of you. So I think I don't notice,

> probably, the difference as much between the ages, because they're standing in front of the same line. (Maggie, Interview 1)

There may be some differences when distinguishing the experience of end-of-life for older and younger people, including the maturation of belief systems, extent of self-forgiveness, acceptance of their terminal illness, physical deterioration and pain level; but commonalities are present in the dying regardless of age in the attempt to make meaning out of their circumstance and develop existential questioning. Participants therefore seem to have a difficult time distinguishing the differences with age at the end-of-life and rather perceive it as a continuum of experiences that are not exclusive to any group.

CHAPTER FIVE: Discussion

After reflecting on conversations with participants and the literature pertaining to my study, I have gained valuable insight into the world of social workers in end-of-life care. In this chapter, I will begin by conveying the lived experience of relationality

participants have to the ‘other’ in their work. Next I will define spirituality as participants view and experience it. I will then interpret the experience of delivering spiritual care in a palliative care environment, followed by exploring the impact of spirituality, spirituality training, and their own investigations into spirituality on how the participants practice social work. Finally, I will explain how the findings from my study regarding generational differences both reflect and diverge from the theory of gerotranscendence.

5.1 Relationality

To reiterate, phenomenological research is essentially concerned with the world of lived experience or ‘lifeworld’. The ‘lifeworld’, which is the daily experience of humans as they move through space and time is understood to have at least four components or ‘existentials’, including lived space (spatiality), lived body (corporeality), lived time (temporality), and lived other (relationality) (van Manen, 1997). Of the four lifeworld existentials that van Manen (1997) describes, relationality, or the ‘lived other’, is most significant to this study because of the interpersonal connections participants have during their work. The experience of relationality emerges predominantly from the participants’ interactions with clients as they assist in making sense of their circumstances.

Social workers in a palliative care setting allow their innate empathetic traits to dominate communications with their clients, attempting to help them search for meaning in seemingly hopeless scenarios. During this dance of meaning co-creation, however, they find themselves needing to strike a balance between complete immersion in the moment of caring for their clients and compartmentalizing their feelings so that they can protect their own health and well-being. Although challenging, once they discover how to safeguard their own mental health, immersing themselves in the caring process may bring

great purpose when they find a bond with a client and allow them to understand something about life they were unaware of before.

Social workers also have a relational connection to their co-workers – the *interdisciplinary team*. If the goal is quality, holistic care, then communication between professionals in the team is essential. My participants conveyed that they are continuously supported by their co-workers, which alleviates some of the pressure of working with a client that they are unable to fully care for. A healthy relationship between the social worker and other team members benefits not only the client, but the professionals themselves as some participants feel as if their longevity for working in the area is augmented. Understanding where they fit into the caring team along with making sure there is limited role confusion contributes to client and professional satisfaction.

Finally, connection to the lived other for a palliative care social worker is experienced through the Absolute Other, or God. Not all, but some participants felt as if their relationality with a higher power or God contributed to their ability to care for their clients in a meaningful way. To reiterate, the end-of-life scenarios that palliative care social workers encounter are difficult and emotionally straining at times. Experiencing a connection to the Absolute Other is a source of strength and confidence for some of the participants who feel they may need extra help to care for particular clients. While they make sure to separate their own spirituality from verbal communications with clients, the idea of God or the Absolute Other acts as an emotional and philosophical foundation for some participants under difficult circumstances.

van Manen (1997) noted that the lifeworld existentials are connected to one another and do not exist in isolation. The lived experience of time, space, and body

thereby all impact the experience of lived other. Further research may lead to a better understanding of lived spatiality, temporality, and corporeality, and their impact on relationality.

5.2 Understanding spirituality from the end-of-life care social workers' perspective

While the lifeworld existentials provide some insight into the experience of providing spiritual care at end-of-life, exploration of how participants understand spiritual work allows for further insight into their care. The root word of spirituality – 'Spirit' or 'Spiritus' (2013) in Latin is defined as 'breath' according to the Merriam-Webster Dictionary, one of the core features of life or vitality. Although the concept of spirituality itself has evolved over time to represent much more than its derivation, it is clear from conversing with my participants that their lives and work have been heavily influenced by spiritual experiences. In this section, I explore how spirituality has come to be understood in healthcare and social work specifically, and how participants in my study align or dissent with the recent definition. I will dissect four core ideas that have contributed to understanding spirituality as social workers in end-of-life care view it: the distinction of spirituality from religion, the idea of a higher power, the feeling of connectivity, and the search for meaning and purpose. Finally I will provide a composite essential description of spirituality based on my findings that contributes to existing literature.

5.2.1 Differentiating Spirituality from Religion

After reflecting on my conversations with participants about how they define spirituality, it became clear that the foundational characteristic of spirituality for my participants is how it is distinguished from religion or religiosity. For participants, their

experience of spirituality can exist within the context of religiosity such as Maggie's belief in "Jesus as being sent as [her] saviour", or a mural of numerous historical figures that formed the face of Jesus in a picture Noreen felt gave her a "spiritual connection." Religion, and in this case, Christianity, plays a significant role in contributing to the definition of spirituality for not only these participants but for many others as well (Hill et al., 2000). While participants acknowledge aspects of religion such as the bond with a greater power (e.g., Jesus Christ) is connected with their spirituality, they also concede that spirituality embodies more broad characteristics and therefore diverges in many ways.

For participants in my study, religiosity was a part of their childhood experience, attending church or being raised in a particular denomination of Christianity. However, all have a shared experience of evolving from a state of structure in religion to abstraction in spirituality. For example, Noreen came from a place of organization with her religion, but she does not "need that anymore" to feel spiritual. Structural and organizational aspects of religion like rituals such as going to church or being baptized were prevalent in Ashley's past as well, but her experience of spirituality has come to exclude such practices from her present day life as she does not "live by the Bible" and is not in the "strict sense, a strict strict Christian religious person," rather, her definition has transformed to include notions of karmic balance and believing in something greater than oneself, which I will consider shortly. This transition away from organization that participants have seemingly made could be indicative of why many people tend to exhibit spiritual yet not religious qualities, which is in keeping with the recent trends regarding the idea of spirituality (Sanzenbach et al., 1989). Over time, religion has evolved to

become a more rigid concept, "from an abstract process to a fixed objective entity expressed through a definable system (e.g., denominations, theological traditions, major world religions, etc.)" (Hill et al., 2000, p. 56), while spirituality has been recognized as a more multidimensional construct applicable to natural human experience (Hill et al., 2000).

5.2.2 Acknowledging a Higher Power

The experience of spirituality has been deemed to be nebulous and abstract for some time, but the dimensions of spirituality are beginning to crystallize for scholars, especially in health care (King & Koenig, 2009). Organizations like the Canadian Hospice and Palliative Care Association have come to accept the wording of the European Association of Palliative Care taskforce for Spirituality in Palliative care stating that:

> Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred. (Cooper, Barnes, Horst, Sinclair, & Associates, 2013, p. 10)

While this definition captures the essence of our current state of understanding what spirituality is, which will be discussed later, it seems to leave out an attribute that was common in my participants' descriptions of what spirituality meant to them; the relationship with a higher power. The actual term "higher power" appears often in Alcoholics Anonymous literature, referring to a greater entity that one should embrace or surrender to during the process of recovery from addiction (Baker, Sellman, & Horn, 2001). When my participants use the phrase "higher power" or "something higher/greater

than oneself", it seems as if they are speaking of either a traditional deity figure like a god or Jesus Christ, or a higher order to existence, such as Ashley's mention of a karmic universe where "things really do come around".

Traditionally, the idea of a higher power has been exclusive to various religious doctrines. Today, however, a greater power or presence can be understood through secular or empirical means as well, with new theories in quantum physics requiring a metaphysical "ultimate observer" to complete the mathematical equations for uniting the laws of the micro and macroscopic realities (Bass, 1975; Kanitscheider, 2000). In total, four of the five participants in my study referred to a higher/greater power as a significant attribute of experiencing spirituality. For the participants that shared this experience, the notion of god or something greater than themselves is a defining quality of their spirituality, but remains not as significant as the next theme to be discussed – connectivity.

5.2.3 Feeling connected to the other

Participants stressed a sense of connectivity to a higher power, their environment, people, and themselves as a central aspect of their spirituality. Connectivity, which is synonymous to relationship(s) with their world, is a common experience that these social workers share in their definition of spiritually living. Whether it is Maggie's "relationship with God and Jesus" or Rachel's "relationships with people, with the Earth, with the world," a feeling of interconnectivity with the objects of experience for participants is a valued characteristic of spirituality. Interconnectedness with people and the environment is part of the experience of spirituality but it is also finding relevance in eco-spiritual social work, where awareness of the impact of work and the concept of a holistic

understanding of humanity's place in the cosmos is viewed as key components to the approach (Gray & Coates, 2013).

Furthermore, not only do relationships with other people and the environment matter from the perspective of participants, there is an intrapersonal relationship and self-awareness component to the broader idea of connectivity. Intrapersonal connectivity is about having a relationship with oneself and obtaining personal empowerment about understanding one's spirituality (Pesut, 2003). As aforementioned, participants in my study were generally raised with religious values but underwent a transformation that led to a pursuit of their own understanding of what spirituality meant to them. This ongoing pursuit of understanding what spirituality means to them has led to personal investigations of spirituality literature that provides a foundation for not only who they are, but how they approach their professional lives. Participants recognize spirituality as a part of their identity; it can influence their daily attitude about reality and their place in it.

5.2.4 The pursuit of meaning and purpose

Having a sense of connection with oneself, others, and the world can give life meaning and purpose; the essential feature of spirituality for my participants and for many (Burkhardt, 1989; Carroll, 2001; Frankl, 1959). All but one participant expressed how their own spirituality and investigations into spirituality give them the urge to seek out meaning in their lives, "to make sense of [their] world" (Joe, Interview 1), "make sense of what is happening to you" (Rachel, Interview 2), to fulfill purpose, according to Noreen, and simply an attempt at the "understanding of life" (Maggie, Interview 1).

This desire to pursue meaning in life and have a purposeful role in society that participants share when thinking about what spirituality means mirrors the experience of many other caregivers, and the average person alike (Chung, Wong, & Chan, 2007).

When participants attempt to make a sense of their world searching for meaning, they are acknowledging responsibility for their attitudes and actions due to the intimate connection they feel to themselves, and the world around them (Frankl, 1959). Discovering meaning in life can be understood as focusing the individual on goals and experiencing that focus on a constant basis, making it a lifestyle (Landmark, Strandmark, & Wahl, 2001). There is also the experience of humility when pursuing meaning from a spiritual standpoint, as Joe aptly describes as "embracing the mystery." While traversing the spiritual landscape, it is improbable to find the signs or road map that will guide you to your particular purpose or meaning to life. The answers are often unclear, therefore the goal may be instead to grasp at the central questions that spiritual curiosity brings, and respect the unknown.

5.3 The Necessity of Spirituality Training

Having established the pillars of spirituality as defined and experienced by participants, our conversation turned to how spirituality training or education impacted their practice in end-of-life care. Confirming what previous studies have shown about social workers and nurses (Baskin, 2002; Bullis, 1996; Holloway, 2007; Kenny, 1999), participants found it difficult to describe how education or training exercises in the spiritual realm have influenced their work considering that they have had so little of it from formal education or professional development means. Baskin (2002) posits that the potential reasoning behind such a lack of spiritual education for professionals is due to the field's recent adoption of a more positivist, reductionist worldview to enhance its credibility within the social sciences. Kenny (1999) perceives a similar phenomenon to have occurred in the field of nursing that forced curricula to exclude spirituality as it contradicted with the scientific paradigm. While spirituality is now accepted as an

important part of holistic health care (Canda, 1988; Carroll, 2001; Crisp, 2008; Derezotes & Evans, 1995), it stands to reason that many current practitioners would not be properly educated or aware of spiritual teachings with regard to their social work practice. Not wanting to wait for the complete shift in the social work paradigm, participants felt the intrinsic motivation to become involved in the study of spirituality and how it could apply to their practice.

Palliative care is a difficult field for all parties involved due to the inevitability of death and clients' potential loss of dignity as they near end-of-life (Chochinov, 2006). As mentioned in chapter 2, social workers are challenged to provide high quality care for their elderly clients and families as death becomes imminent as well as following the passing of the loved one. For some families, spirituality permeates the dialogue and it has been shown that knowledge of existential ideas can benefit the social worker by giving them confidence that they are able to have a meaningful dialogue when questions emerge and by providing many health benefits to the care giver themselves (Sulmasy, 2006; Wasner et al., 2005).

While it has become almost universally accepted that spirituality training has a very important role in palliative care, there exists a counter perspective that should be addressed. One of the perceived strengths of integrating spirituality into palliative caregiving for all associated healthcare providers is that it ensures that the innate spiritual needs of all clients are addressed by any team member despite their potential hesitations to do so (Babler, 1997). The problem that Walter (2002) sees in this philosophy is two-fold: it could be burdensome on healthcare providers who feel they are unable to provide spiritual care, and it could fail to address the social and cultural needs of individual

clients. Walter (2002) argues that it is unlikely for a healthcare provider whose specialty is anything other than spirituality will be able to appropriately gauge how to interact with a client that will be in their best interest, and avoiding transference of their own beliefs to clients. Although a majority of the literature suggests that spirituality is a recognized core facet of the human experience and that palliative care should reflect this new understanding (Puchalski, et al., 2009), these concerns that shifting policy could mitigate personalized care are noteworthy.

5.4 Self-directed Training

Palliative care social work literature demonstrates both the perceived importance and structured guidelines for the role of spirituality within the field but is lacking when it comes to how social workers should be trained in this area (Puchalski, 2009). Participants in my study did not have the opportunity to study spirituality in their training process as it was not a valued aspect of care at the time they were aspiring social workers (Derezotes & Evans, 1995). Their desire to learn about spirituality and positive value they place on it reflects previous studies that looked at perceptions of social workers about spirituality in their practice or education (Holloway, 2007; Wesley et al., 2004). During our conversations, they communicated to me that the opportunities to gain knowledge or experience regarding spiritual care were varied and limited, often times forcing them to seek out their own ways of learning about spirituality.

As it became clear that spirituality was an integral part of their caregiving practice; seeking out books, articles, or seminars about spirituality on their own emerged as a suitable means to remedy this gap in their knowledge base. This self-directed process that my participants underwent is a seemingly reasonable reaction to the lack of guidance they received in formal education and narrow scope of options they have available to

them with regard to professional development in spirituality today. It is difficult to find a precedent for self-directed spirituality training in palliative care social work, but if my participants' experiences are any indication, it is likely not an isolated phenomenon.

5.5 Implications for Gerotranscendence

Interviewing palliative care social workers gave me a rare opportunity to investigate any possible generational differences between younger and older clients. The significant shifts in personality as one ages, detailed first by Tornstam (1989) and coined as the theory of gerotranscendence, were examined through my interviews. Findings from my study both reflect and diverge from Tornstam's notions about how people successfully age along with their recognition of the importance of spirituality in later life.

After examining how participants responded to my inquiries about generational differences, it is clear that their experiences are unique from one another when differentiating between the two population groups. One participant, for example, noted a distinct difference in the amount of religiosity both generations displayed. Within her clientele, the older generation felt as if their religious belief systems were more important to them towards the end-of-life juxtaposed with the younger clients not expressing religiosity as often if at all, in the same situation. This trait mirrors the cosmic dimension within gerotranscendence in that as people age, they may feel a greater connection to notions of spirituality even if they never ascribed to it in the past (Tornstam, 2011). It is also indicative of how interest in spirituality will persist even though their physical bodies may be failing as they near death (Lewin, 2001).

Rachel indicated that the older clients that she had worked with on average have a more apparent sense of self-forgiveness and compassion for their past and present situation. This quality can be interpreted as aligning with gerotranscendence due to their

acknowledgement of past mistakes and being able to find meaning and purpose through them (Tornstam, 2011). Self-awareness and acceptance of the reality that their corporeal time is coming to an end is an important tenet in the cosmic dimension of gerotranscendence, where the fear of death is mitigated by shifting one's perspective to a more connected and meaning laden understanding of their place within the cosmos (Wadensten & Carlsson, 2003).

For gerotranscendence to be classified as a legitimate theory that describes the psychosocial and spiritual changes that take place as humans age, there must be significant differences between the two population groups; in their experience, Joe and Maggie were hard-pressed to find any. Reflecting on their work with people across the age spectrum, they concluded that people of all ages are able to find meaning in the situation they are in, no matter how dire. Maggie even specified that her younger clients have sought out spiritual counselling even when they have not fully developed their own sense of belief or spirituality. This data gives credence to the possibility that a shift in perspective and a heightened sense of spirituality could be attributed to personal or cultural factors, instead of being related to the aging process as some studies demonstrate (Jewell, 2014; Jonson & Magnusson, 2001).

Participants possessed contradicting perspectives regarding how they experienced differences in caring for a people on opposite ends of the age continuum. What we can learn from this data regarding gerotranscendence is that it continues to be an optimistic theory of successful aging that may still need some adjustments in order to be fully representative of the human experience. Since it is challenging to perform longitudinal studies to test the validity of gerotranscendence, projects like this that examined social

workers' experience with people of all ages may serve as an example for future investigations into the theory.

5.6 Reflexive considerations

After rereading the interview notes I recorded and reflecting on my thoughts and feelings about the research process, I found that my perceptions about research had evolved significantly from when I began the endeavor. Prior to conducting the interviews, I had only a limited amount of experience with qualitative inquiry and perceived that there was a correct and incorrect way of extracting data from open-ended interviews. However, the extraction of data did not turn out to be the primary focus at all, rather the process of conversing with participants proved to be essential to my progressive evolution as a researcher. After only the second interview, I began to realize that I was not adhering entirely to my interview guide and was instead having meaningful conversations with participants where data was co-created through active interpretation. While I perceive this experience to be a mostly positive one for my future as a researcher, I do feel as if my findings would have been more consistent had I followed the interview guide with more rigidity.

Along with perceptions about how I experienced the research process, I also accounted for how I believed my participants reacted to the experience. Though I was primarily focused on the content of our conversation, I found the tone of their delineations to be strikingly similar to one another. My participants all shared a passion for their work and an appreciation of the importance of spirituality in health care even if they had little training or experience with it. While speaking with participants, I felt that they were fully present with me and wanted to assist in the exploratory process of their field wholeheartedly. In addition to their radiant attitude throughout our discourse, some

participants even offered me resources where I could find further information in the literature or small gifts that could deepen my understanding of how they have been touched by spirituality; which also served as mementos of my experience with them.

Finally, after speaking with the five participants, I feel as if my perspective on spirituality in palliative care social work has evolved from a position of academic interest to mirror their genuine passion for wanting to apply the benefits of spirituality education with real people. This research has strengthened my desire to continuing learning about aging and the dynamic needs of people experiencing the dying process.

5.7 Implications for practice

Every research study is a snap shot of time depicting the current state of affairs. In this study, I inquired about the phenomenon of spirituality training and its applications in palliative care social work. Though the number of participants was limited to five, there are still important implications of this research that palliative care social workers and health care providers in general will find useful. My study provides some insight into the continued desire for more spirituality based training opportunities for social workers still in school preparing for their career or established social workers looking to augment their knowledge base in order to feel better prepared in a death and dying environment.

While there is still a debate in social work on how to address these concerns, my study shows the necessity of requiring or simply offering courses related to spirituality within social work curriculum. Palliative care social workers in Canada have a particular responsibility to have training in spirituality because of the indigenous population that continues to grow and require specific, culturally sensitive care (Gray & Coates, 2013). This study also demonstrates that there are options for palliative care social workers who have yet to receive formal education in spirituality. Therefore, it is imperative that

employers take some responsibility to recognize this absence of training and provide spirituality centered learning opportunities to their social workers, such as personal development seminars, webinars, and conferences, and encourage and support social workers to take advantage of local and external educational opportunities. Regardless of their employers, however, social workers today are taking responsibility for their own training and discovering information about spirituality and how it can be beneficial to their practice via self-directed means such as seeking out reading material or seminars they can attend.

Gerotranscendence served as a theoretical foundation for this study for explaining the generational differences between caring for younger and elder clients. While results of this study were inconclusive and no formal link between social work practice and gerotranscendence currently exists, aspects of Tornstam's theory of aging may provide social workers with insight into how to approach their elderly clientele. For example, reminiscence or life review therapy has had a presence in social work practice for a long period of time (Pincus, 1970). One of the many functions of reminiscence therapy is that it allows people to reconstruct their past life history and change their view of current reality (Tornstam, 1999). This change in perspective is a central tenet to gerotranscendence and if aware of it, the social worker may be better prepared when their clients wish to reminisce, or during general assessment.

A skill that was revealed to be critical to palliative care social workers' success in interacting and caring for their clients was the ability to actively, or empathetically listen. Actively listening is an attempt to understand the inner voice of the client, taking notice of the pauses and tonal changes in conversation so that the social worker absorbs all of

this extra information and incorporates it into their care (Wiebe, 2014). Instead of thinking about what to say next, successful active listening for a palliative care social worker is of a guiding nature through the 'labyrinth' of their client's mind and navigating back out again (Cunningham, 2012).

This study also speaks to the nature of spirituality as a concept and how diverse and constantly evolving the definition is. What was apparent in my findings however is that the distinction of religion from spirituality is quite clear with this population and they all seem to view the broad idea of spirituality as a search for meaning and connection. Moreover, as the literature on how knowledge of spirituality can benefit social workers and their clients is delineated, organizations will continue to advocate for its integration into their training philosophy as many already have.

5.8 Future directions

Although there are many things professionals will be able to extract from this study, I believe it to be a pilot project and a glance at what could be explored in the area of spirituality and palliative care social work. This study was limited to the health care regions of Regina and Winnipeg and participants were sampled based on convenience. Considering the specificity of this population, it would be a logical next step to branch out and account for the perspectives of not only Western Canada but a national sample to get a broader and deeper sense of how spirituality training can impact palliative care social workers. Furthermore, future research may look to determine any resulting differences from studying participants in rural settings as the current study was of a primarily urban sample.

Future studies with more robust sampling could also potentially enlighten palliative care social workers and healthcare providers in general about how spirituality

training would impact care for the Canadian Aboriginal population. In 2006, Indigenous people comprised 16% of the total population in Saskatchewan and Manitoba. By 2031, the percentage of Indiginous people in Saskatchewan will rise to 21-24% and 18-21% in Manitoba. Not only is the Aboriginal population expanding in Canada, but aging as well. In 2006, the median age of Aboriginal people was 27, and will rise to 35-37 in 2031 (Statistics Canada, 2011). While Indigenous perspectives were not a central focus of this study, previous research has shown that Aboriginal people have a desire for cultural and spiritual specific care (e.g., 'completion of the circle of life'), implying that healthcare providers would fulfill the holistic goals of palliative care by being well versed in Aboriginal customs (Hampton et al., 2010).

I also feel as if the emergent themes from this study could potentially be utilized in a more precise inquiry. It is imperative that we continue the qualitative research process with this work as professionals can gain a rich understanding of the lived experiences of their present or future colleagues.

Another avenue that future studies could explore is the surprising similarities between different generations regarding their approach to the dying process. Researchers may choose to focus the inquiry on these similarities and differences and refine the interview questions so that the results may be more reflective of this phenomenon.

5.9 Conclusion

As providing spiritual care becomes more aligned with the central tenets of social work, it is apparent that the HPC social workers who participated in this study were thoroughly prepared to assist their clients in this important area. This research challenges previous studies that demonstrate how social workers may be reluctant to address the existential issues of their clients (Babler, 1997; Wesley et al., 2004). Although these

results are encouraging, they may not be representative of all social workers who work in end-of-life care may due to the purposive sampling employed in this study. Spirituality training, especially self-directed in nature, was critical to participants' overcoming potential apprehensions about delivering spiritual care. This study endeavored to examine the lived experience of five hospice/palliative care social workers interacting with their elderly clients with regard to spiritual matters to contribute to the literature on spirituality and social work and potentially influence social work curricula and organizational training for current social workers. These social workers were recruited from two major city centres (Regina and Winnipeg). Participants' experiences were explored using a qualitative, phenomenological approach to gain an understanding of the meaning they attribute to their training and implementation of spiritual care with their elderly clients. Three phenomena were investigated including how palliative care social workers express spirituality, how they deliver spiritual care, and what the impact of spirituality training is on their practice. Four themes emerged for expression of spirituality (i.e. divergence from religion, belief in a greater power, feeling connected, and finding meaning and purpose). There were three emergent themes for how palliative care social workers delivered care (i.e., being curious and aware, listening and being present, and drawing on interdisciplinary teams). Finally, four themes were identified describing the experience of the impact of spirituality training on practice (i.e., poised in difficult circumstances, appreciating different perspectives, perception of greater connection, and complementing innate skills). It is my hope that this work can provide some insight into the world of spiritual care delivery from the palliative care social work perspective and that the

experiences of these five professionals will lead to more studies inquiring into the versatility of social work practice.

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Appendix A: UofR Ethics Approval

University of Regina

OFFICE FOR RESEARCH, INNOVATION AND PARTNERSHIP

MEMORANDUM

DATE: March 14, 2013

TO: Michael Jordan Goldberg
903 - 3520 Hillsdale Street
Regina, SK S4S 5Z5

FROM: Dr. Larena Hoeber
Chair, Research Ethics Board

Re: **How Spirituality Training Impacts the Practice of Social Workers Assisting Elderly Clients in End-of-Life Care: A Hermeneutical Phenomenological Approach (File # 65S1213)**

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☑ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F). **ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS.** Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB.** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB.** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

Larena Hoeber

Dr. Larena Hoeber

cc: Dr. Rebecca Genoe – Kinesiology and Health Studies

** supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office for Research, Innovation and Partnership (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca

Phone: (306) 585-4775

Appendix B: RQHR Ethics Approval

Regina Qu'Appelle
HEALTH REGION
Research Ethics Board

March 14, 2013

Dr. Rebecca Genoe
Faculty of Kinesiology and Health Studies,
University of Regina,
3737 Wascana Parkway
Regina SK S4S 0A2

Dear Dr. Genoe,

RE: REB-13-29 and U of R #65S1213
Title: How spirituality training impacts the practice of social workers assisting elderly clients in end-of-life care: A hermeneutical phenomenological approach

Your application for research ethics review has undergone a harmonized review by the Regina Qu'Appelle Health Region (RQHR) and University of Regina (U of R) Research Ethics Boards (REBs). In accordance with the *Research Ethics Review Reciprocity Agreement* signed by the University of Saskatchewan, University of Regina, and Regina Qu'Appelle Health Region, the RQHR REB accepts the Certificate of Approval issued by U of R REB. **This letter is issued to you in lieu of a Certificate of Approval by the RQHR REB.** This letter permits you to conduct research activities as approved by the U of R REB, provided that you maintain a valid and up-to-date Certificate of Approval.

All continuing ethics review will be conducted by the U of R REB. The U of R is authorized to share all communications pertaining to this file with the RQHR REB at their discretion. The RQHR REB may provide input into continuing ethical review activities, as agreed upon by both REBs.

The RQHR REB reserves the right to revoke the privileges described in this letter at any time in order to conduct their own independent research ethics review of your project. Such a decision would be communicated to you and the U of R REB in writing.

This letter also serves to acknowledge that you have obtained all necessary operational approvals within the RQHR and are permitted to proceed with this research on operational grounds. If at any time you will require resources, participants, or data from any additional departments, you must provide the RQHR REB with the required signatures before proceeding.

Best wishes for your continuing research endeavours.

Sincerely,

Michelle McCarron

Dr. Michelle McCarron, Chair
Research Ethics Board
Regina Qu'Appelle Health Region

Appendix C: Letter of Invitation

I invite you to take part in a research study, which is being conducted as part of a Masters thesis of the principal researcher, Michael Goldberg. Taking part in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about what you will be asked to do, and any risks, inconvenience, or discomfort you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Michael Goldberg [mikegoldberg@shaw.ca; (306) 501-6240] or his supervisor Dr. Rebecca Genoe [Rebecca.Genoe@uregina.ca; (306) 585-4781].

The purpose of this study is to gain an understanding of how current spirituality training impacts the practice of social workers assisting their elderly clients at the end-of-life. Secondary objectives are to inquire into how social workers describe spirituality and to determine if there are any differences between interactions regarding spirituality between social workers' older and younger clients. It is hoped that by doing so, I will be able to gain valuable information that can be used in contributing to social work curricula and current social work training programs.

This study is designed to analyze your thoughts, feelings, and emotions, and involves a discussion and question and answer session regarding your spirituality training experiences and the discussion questions I will be asking involve discussing your spiritual interactions with your elderly clients. Interviews will be audio recorded and written out so that you can read what we have talked about. Audio recording will allow me to listen to the interview carefully both during and after the interview so that the information can be analyzed to the best of my ability. The questions are open-ended and flexible. I will be taking notes during and after the interview to assist me in understanding what we have talked about.

You may participate in this study if you are a social worker who has been employed by a hospice or palliative care unit, have had some kind of spirituality training in your formal education or personal development programs, and have interacted with elderly clients regarding spirituality.

In this study, you will be asked to take part in one face-to-face discussion approximately 30 minutes to one hour in length. The interview will take place in the location of your choice. Once the interviews have been completed, the typed copy of what we have

discussed will be returned to you for your review. You may add anything to the copy of the discussion, including comments and questions, or take anything out of the discussion.

There are some minor risks involved with participation in this study. There is a possibility of experiencing some apprehension as we discuss your own spiritual or religious views. Economic risks may be involved if you require transportation to get to the location of the interview.

There are also some possible benefits that may result from your participation in the study. Direct personal benefits include the opportunity to reflect on and share your experiences with others. Other benefits include contribution to knowledge, which will potentially lead to alterations in social work curricula and training requirements for established social workers.

The researcher will do his utmost to protect the identity of the research participants and confidentiality of the data you provide. You will not be identified in any reports or publications. Names will be changed in order to protect confidentiality of the participants in the final thesis and any publications that result. Any information in your copy of the discussion that identifies you will be removed. Discussions will be numbered to help protect your anonymity. The interviews will be stored in a secured location at the University of Regina for five years after the publication of the study. Only my supervisor and I will have access to the data. Direct quotations from your discussion may be used, with your permission, in order to explain the results of the study to others.

You will be provided with any new information which might affect your decision to participate in this study, or continue ongoing participation in the study. Upon completion of the study, you may request a copy of the findings if you would like to have them.

If you feel, at any time you would like to withdraw from the research study, you may do so freely and without consequence. You also have the option to remove your data from the research study at any time.

Once again, if you have any questions about the study, Michael Goldberg can be contacted by telephone at (306) 501-6240 or by email at mikegoldberg@shaw.ca. Dr. Rebecca Genoe can also be contacted by telephone at (306) 585-4781 or through email at Rebecca.Genoe@uregina.ca.

Thank you in advance for your participation,

Michael Goldberg, M.A. candidate Rebecca Genoe, PhD

Appendix D: Consent Form

University of Regina

Participant Consent Form

I invite you to take part in a research study, which is being conducted as part of a Masters thesis of the principal researcher, Michael Goldberg. Taking part in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about what you will be asked to do, and any risks, inconvenience, or discomfort you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Michael Goldberg [mikegoldberg@shaw.ca; (306) 501-6240] or his supervisor Dr. Rebecca Genoe [Rebecca.Genoe@uregina.ca; (306) 585-4781].

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You may participate in this study if you are a social worker who has been employed by a hospice or palliative care unit, have had some kind of spirituality training in your formal education or personal development programs, and have interacted with elderly clients regarding spirituality.

In this study, you will be asked to take part in one face-to-face discussion approximately 30 minutes to one hour in length. The interview will take place in the location of your choice. Once the interviews have been completed, the typed copy of what we have discussed will be returned to you for your review. You may add anything to the copy of the discussion, including comments and questions, or take anything out of the discussion.

There are some minor risks involved with participation in this study. There is a possibility of experiencing some apprehension as we discuss your own spiritual or religious views. Economic risks may be involved if you require transportation to get to the location of the interview.

There are also some possible benefits that may result from your participation in the study. Direct personal benefits include the opportunity to reflect on and share your experiences with others. Other benefits include contribution to knowledge, which will potentially lead to alterations in social work curricula and training requirements for established social workers.

The researcher will do his utmost to protect the identity of the research participants and confidentiality of the data you provide. You will not be identified in any reports or publications. Names will be changed in order to protect confidentiality of the participants in the final thesis and any publications that result. Any information in your copy of the discussion that identifies you will be removed. Discussions will be numbered to help protect your anonymity. The interviews will be stored in a secured location at the University of Regina for five years after the publication of the study. Only my supervisor and I will have access to the data. Direct quotations from your discussion may be used, with your permission, in order to explain the results of the study to others.

You will be provided with any new information which might affect your decision to participate in this study, or continue ongoing participation in the study. Upon completion of the study, you may request a copy of the findings if you would like to have them.

In the event that you have difficulties with, or wish to voice concern about, any aspect of your participation in the study, you may contact Meigen Schmidt, the Senior Research Officer the University of Regina's Office of Research Services for assistance: Meigen Schmidt at (306) 337-2372, or email: meigen.schmidt@uregina.ca.

Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____	_____	_____
Name of Participant	*Signature*	*Date*
_____	_____	_____
Michael Goldberg, Researcher	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix E: Interview Guide

Interview Guide for Social Workers in End-of-Life Care

Time of interview:

Date:

Place:

Interviewer: Michael Goldberg

Interviewee:

This study is intended to explore the phenomenon and provide an essential explanation of how current spirituality training impacts the practice of social workers assisting seniors at the end-of-life. If at any time you feel you feel uncomfortable with the interview and wish to do discontinue, the recorder will be turned off and no further questions will be asked.

Questions:

1. What does spirituality mean to you?

2. Would you describe yourself as a religious person? Why or why not?

Prompts:

- What are the characteristics of someone is religious?
- Which of these characteristics describe you?

3. To what extent were you formally educated in spirituality?

Prompts:

- Tell me about any spirituality education you received.
- How many spirituality courses have you taken?
- What was the general content of the courses?
- What, if anything, did you learn about spirituality from the courses?

4. From your perspective, what is the connection between religion and spirituality? What are the differences?

5. What aspects of spirituality would you have liked to have been incorporated into the social work curriculum?

Prompts:

- What was missing from your formal spirituality education?
- What have you learned through practice that you think other social work students should learn about?
- What advice do you have for social work programs/instructors regarding spirituality?

6. What kind of spirituality training have you attended?

7. What did you learn from the spirituality training program you attended?

Prompts:

- What did you learn about spirituality?
- What practical skills did you learn through the program?
- What knowledge did you gain from the program?
- What, if any, techniques did you learn to address spirituality among older clients specifically?

8. How do you incorporate the knowledge and skills you acquired during the spirituality program

into interactions with your elderly clients?

Prompts:

- How did your practice change as a result of attending the program?
- Tell me about a time where spirituality was effective. Provide an example of a time you used spirituality training with an elderly client.
- Tell me about a time where you were unable to incorporate knowledge and skills gained from a spirituality program into interactions with clients.

9. What, if any, are the differences between providing spiritual care to older clients, compared to younger clients?

10. How, if at all, has spirituality training impacted your working environment?

Prompts:

- Has spirituality training impacted your stress level?
- Has spirituality training impacted how you interact with co-workers and clients and their families?
- What positive outcomes have resulted from spirituality training in terms of your overall work?

Appendix F: Transcript Release Form

TRANSCRIPT RELEASE FORM

I,_____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Michael Goldberg. I hereby authorize the release of this transcript to Michael Goldberg to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

_____	_____
Name of Participant	Date
_____	_____
Signature of Participant	Signature of Researcher