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The Influence of Spirituality Within Older Adults During Relocation in Long Term Care

Cheryl M. Lantz

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THE INFLUENCE OF SPIRITUALITY WITHIN OLDER ADULTS
DURING RELOCATION IN LONG TERM CARE

By

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A Dissertation
Submitted to the Graduate Faculty
of the
University of North Dakota
In partial fulfillment of the requirements

For the degree of
Doctor of Philosophy

Grand Forks, North Dakota
December
2009
This dissertation, submitted by Cheryl M. Lantz in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the faculty Advisory Committee under whom the work has been done and is hereby approved.

This dissertation meets the standards for appearance, conforms to the style and format requirements of the graduate School of the University of North Dakota, and is hereby approved.

Dean of the Graduate School

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To the wise residents of America’s long term care facilities
ABSTRACT

The purpose of this qualitative research study was to develop a model focused on spiritual influences within older adults undergoing relocation to long term care (LTC) facilities. Today, there are 1.5 million Americans aged 65 or older who experienced relocation and reside in LTC facilities. Nothing has been done to qualitatively study the spiritual aspects of this experience. While the profession of nursing has a diagnosis for Relocation Stress Syndrome, as found in the North American Nursing Diagnosis Association (NANDA) reference, it does not incorporate the specific spiritual stressors older adults undergo during relocation; rather addressing only physiological and psychosocial disturbances. To holistically approach care for the older adult, research is needed to reveal the spiritual influences and stressors during relocation.

The research questions of this study identified the influences (past and present) and uses of spiritual and religious practices by older adults in LTC which supports their state of being during relocation. Blumer’s Symbolic Interactionism was the theoretical underpinnings for this study. Seventeen adults, age 65 or older, who lived in a rural area in an upper great plains state and were relocated to one of three long term care facilities, were interviewed during the first six months from time of admission. Constant comparative analysis was used to analyze the data.

The emergent theoretical model depicts God as the core variable and presents three central with their unique properties: 1) spiritual relationships and resources, 2)
spiritual blessings, and 3) spiritual barriers. An axial coding model and a theoretical model were developed, to visually depict the results.

Implications of this study are specific to understanding and supporting spiritual growth of older adults. The findings support implications for practice changes in the areas of assessment of spirituality and the education of older adults, their families, nurses and spiritual caregivers. Teaching of geriatric theory to student nurses must incorporate the spiritual findings of this study. NANDA should be petitioned to include the role and influences of spirituality in the “Relocation Stress Syndrome” nursing diagnosis.
CHAPTER I

INTRODUCTION

"To know how to grow old is the master work of wisdom, and one of the most difficult chapters in the great art of living," quoted by Henri F. Amiel in Van Ekeren (1988, p. 47). Americans have been pre-occupied with youthfulness for many years, and only recently has society sought answers about how to enter the elder years with wisdom and spiritual wellness. Specifically, the question of how older adults adjust to changes in living arrangements, particularly when they move into long term care (LTC) facilities has not been addressed. What changes, if any, occur in their spiritual domain of health, specifically with regards to their spiritual beliefs and practices, when older adults experience relocation to LTC facilities?

Forty-three percent of Americans aged 65 or greater will require long term care at some time in their lives, therefore it was imperative to understand the role of spirituality within a person during relocation into a long term care facility (Kemper & Murtaugh, 1991). Once this relocation experiences is understood, nursing care can support the adjustment process. Research has not been located to address the aforementioned role of spirituality within the context of relocation. This chapter will address the background and significance of this research problem, present the purpose, research questions, theoretical underpinning, delimitations, assumptions and definitions of terms for the study.
Study Background

Long Term Care Statistics

According to the 2000 American census, there are “nearly 35 million people over the age of 65 and they are the most rapidly growing group within the population” (Tabloski, 2006, p.8). Since 1900, the population in America has tripled while the “population of older adults over age 65 has increased 11-fold” (Mauk, 2006, p.29). The large number of older adults is attributed to increased life expectancy and fertility rates at different times in the history of the U.S. population (Mauk, 2006).

Forty-three percent of those people turning 65 years old will require long term care (commonly known as nursing home care) at some time in their life (Kemper & Murtaugh, 1991). Currently, it is estimated that just under 6% of adults over the age of 65, or 1.5 million people reside in American long term care facilities (Harris & Benson, 2006). In 2005, there were 1,460,185 long term care residents living in a total of 16,435 American long term care facilities (Houser, Fox-Grage & Gibson, 2006). The large number of older adults who will require nursing care in a long term care facility and experience relocation is ever increasing in American society. These statistics emphasize the need for nurses to understand the strategies residents use to facilitate successful relocation.

Defining Relocation

There are several definitions surrounding relocation. Early literature regarding relocation defined it as changes in environment which happened when a person moved from one location to another (Hasselkus, 1981). Other researchers focused on relocation stress, and identified phases and stages of relocation; each stage or phase produced its own stressors (Mitchell, 1999; Tobin & Leiberman, 1976). Mitchell labels the three stages
as Pre-move, Move and Post-Move (1999). Tobin and Leiberman (1976) iterate the three phases as 1) the anticipatory phase, 2) the event or physical transfer, and 3) the settling-in or long-term adjustment phase.

More recently, the term relocation stress syndrome was defined by the North American Nursing Diagnosis Association as “physiologic and/or psychosocial disturbances as a result of transfer from one environment to another” (Mallick & Whipple, 2000; NANDA, 2007, p.178).

**Effects of Relocation**

Requiring long term care is not looked upon favorably in American society, nor is the move to a long term care facility one of a person’s choice; often times the move is precipitated by an adverse change in health status (Castle, 2001; Mitchell, 1999; Oswald & Rowles, 2006; Scocco, Rapattoni & Giovanna, 2006; Smith & Crome, 2000; Thorson & Davis, 2000).

Oswald and Rowles, (2006) together with Ryff, Singer & Seltzer (2002) state that relocation into a long term care facility is not a normal experience since it adds stresses and poses adverse health changes to the recipients of long term care. Literature supports the idea that moving into a long term care facility can evoke discomfort and create relocation stress for individuals (Castle, 2001; Keister, 2006; Mitchell, 1999; Oswald & Rowles, 2006; Scocco, Rapattoni & Giovanna, 2006; Smith & Crome, 2000; Thorson & Davis, 2000).

The defining characteristics of relocation stress have been studied by NANDA and include, “aloneness, anger, anxiety, concern over relocation, fear, frustration, increased physical symptoms, insecurity, sleep disturbance, and withdrawal” (NANDA, 2007, p.178).
NANDA further explains related factors of relocation stress syndrome, which include “decreased health status, unpredictability of experience, impaired psychosocial health, isolation, lack of predeparture counseling, losses, and passive coping” (NANDA, 2007, p. 178). Recognition of the spiritual domain, spiritual well-being and/or spiritual distress is absent from the NANDA definition.

One of the most disconcerting meta-analysis review of 35 research studies focused upon relocation stress effects which involved mortality rates: “mortality rates vary from 0 to 43% post-relocation” (Castle, 2001, p. 304). Castle also indicated that the studies were difficult to compare, due to the varied methods and timeframes used to determine mortality rates. Furthermore, none of these mortality studies addressed spiritual implications or adjustments of these older adults during relocation and prior to the time of death.

Certainly studies have addressed the physical, mental, behavioral and social changes that occur after relocation transpires, and studies concur that relocation is a negative event, acts as a stressor, and is perceived as stressful to individuals (Castle, 2001; Mitchell, 1999; Morris, Rovner, German, 1994; Smith & Crome, 2000; Scocco, Rapattoni & Giovonna, 2006). The impact of relocation stress has been investigated for a variety of health aspects regarding older people, yet no studies have been conducted to examine how or if the spiritual domain of older adults is affected during relocation into a long term care facility.

In summary, while there are differences in the definitions of relocation, all experts agree that it is a physical movement of a person’s living arrangements to another locale. Relocation is seen as negative, evokes stress, and is manifested in varying degrees. Responses differ just as human beings differ in their reactions to change. The more mild
reactions may be seen as slight anxiety and feelings of insecurity, while more severe reactions to relocation involve states of anger, frustration, increased physical health changes and sleep disturbances. The most serious reactions are increased mortality rates. Despite all the studies that have been conducted, none have assessed the spiritual domain nor spiritual responses evoked during the time of relocation into a long term care facility.

**Types of Relocation**

Types of relocation have been depicted in the literature. There are four types of relocation: 1) residential: moving from one home to another, 2) residential/institutional: moving from a home residence into a facility, 3) inter-institutional: transferring from one institution to another, and 4) intra-institutional: transferring from one room to another within the same facility (Mitchell, 1999; Oswald & Rowles, 2006; Smith & Crome, 2000). This study focused on the residential/institutional and inter-institutional types of relocation.

**Reasons for Relocation**

Reasons for moving into a long term care facility are organized into three main categories. Relocation rationales may be voluntary or involuntary and include: 1) changes in health status, 2) changes in personal circumstances, 3) policy and funding pressures related to moving from the hospital and into a facility, due to prospective payment system limitations (Castle, 2001; Smith & Crome, 1999). This study considered why relocation was necessary and what the residents’ health perceptions were at that time.

**Definitions of Spirituality**

Authors have approached the task of defining spirituality in a variety of ways. As early as 1979, Stoll offered a Christian-based, two-dimensional definition of spirituality
Stoll organized spirituality into vertical and horizontal concepts. She stated, “Spirituality involves a vertical dimension (i.e. a person’s relationship with God, the transcendent, supreme values) and a horizontal dimension which reflects the supreme experience of relationship with God through beliefs, values, life-style, quality of life and interactions with self, others and nature” (Stoll, 1979, p.7).

Saunders (1998) explored ontological ideations underlying definitions of spirituality. Saunders reports, “Spirituality refers to the center of people’s being and a life force that gives rise to their sense of wholeness. Faith, hope, trust, the giving and receiving of love, forgiveness, reconciliation and meaning in life are fundamental characteristics of spirituality which are considered the basic determinants of the totality of people” (1998, p.17).

Amenta defined spirituality: “The spiritual is the self, or I, the essence of personhood, the God within, that part which communes with the transcendent. It is that part of each individual which longs for ultimate awareness, meaning, value, purpose, beauty, dignity, relatedness and integrity “(1986, p.117).

Another scholar examined the essence of spiritual relationships. Walton posited, “Spiritual relationships are connections to self or soul, to others, to a higher power, or to nature” (1996, p. 237). Walton views spiritual relationships overlapping with others, a higher power and/or nature.

In 1999, Narayanasamy described the need to expand the holistic understanding of spirituality to include its biological root. He stated that current beliefs in spirituality (based in the mind, body, and soul) did not attend to the need for spirituality as a biological
survival mechanism. His depiction of spirituality explained further how the spirit is needed for the physical body to survive.

As scholars have attempted to define spirituality, critiques of the concept have revealed that it lacks a unified, agreed-upon definition and thus leads to different interpretations and divergent methods of study. However, there is a thread of relationships being present with a higher power and relationships that promote connectedness with others. One particular definition, recently noted in the literature by MacKinlay (2004) reiterates these themes.

MacKinlay (2004) defines spirituality as, “That which lies at the core of each person’s being, an essential dimension which brings meaning to life. It is acknowledged that spirituality is not constituted only by religious practices, but must be understood more broadly, as relationship with God, however God or ultimate meaning is perceived by the person, and in relationship with other people” (p.76). This definition is the one which will represent spirituality for this study since it is the only one that was based on the study of older adults and it incorporates relationships with a higher power perceived by the person and through their connection with others. This definition incorporates the major themes of self as spirit being and it reflects the relationships surrounding the person.

*Human Development Through Spiritual Journeys*

The process for spiritual development in older adults has been studied by a number of researchers through a variety of lenses. As physical abilities and functions decline with age, individuals’ spiritual functioning may not always decline. It may actually increase in its function within the holistic being (Young & Coopsen, 2005; Tornstam, 2005). Gerotranscendence is the term coined to reflect a self-actualized older adult, who has
grown and developed as a mature, older person (Tornstam, 2005). Spiritual awakening and development during physical aging times can provide persons with opportunities for growth and the release of beliefs that are no longer relevant to them (Leetun, 1996).

Scholars of aging topics view spirituality as a journey and a time for growth (Koenig, 2004; O’Brien, 2008; Mowat, 2004; Young & Coopsen, 2005; Wilt & Smucker, 2001).

A theory has been proposed which addresses spirituality for older adults. MacKinlay researched a theory for the spiritual tasks of ageing, specific to older adults (2004). This theory focuses on the person’s response to the ultimate meaning of life. The tasks older adults attend to, in order to arrive at ultimate meaning for life are stated as: 1) to transcend loss and disability, 2) to find final meaning, 3) to find intimacy with God and/or others, and 4) to find hope (MacKinlay, 2004).

Other conceptual models for spirituality exist in the literature but are not age specific. They attempt to define what spirituality is, and how it relates or does not relate to other domains of health (Hodge, 2000; O’Brien, 2008).

However, these theories and models have not been applied during the time frame of relocation to a long term care facility. While they address spiritual tasks at life’s end, they do not address the potential or possible uses and processes that may support spiritual beliefs, practices, and adjustments required during the stressful time of relocation in a long term care facility.

Significance of Study

Given the growing population of older adults, specifically the 43% of adults beyond age 65 who will require long term care services at least once in their lifetime and the mortality rates connected to post-relocation, it is imperative to understand what role, if any,
spirituality plays during relocation to this setting. While there are many definitions of spirituality and a newly developed theory focused upon the older persons' spirituality, little is known about how older persons use or do not use their spirituality, and how relocation may affect their spirituality, particularly if it is used as a coping mechanism, during the transition to a long term care environment. This may be a major life stressor affecting physical, emotional, social, and interpersonal relationships as well as the cognitive well-being of individuals, yet understandings and implications of the spiritual domain in this situation are non-existent. This study was significant in providing information that reduced this gap in knowledge.

The findings of this study give direction to health care providers to assist them with the provision of spiritual care during the relocation process. Certainly the American Health Care Association (AHCA) website addresses adjustment to a nursing home and how families and friends can assist their loved ones with the relocation (AHCA, 2007). However, no mention is made of the spiritual domain, nor is spiritual care addressed in the AHCA document. Additionally, there are guidelines in the literature which speak to maintaining continuity from hospital discharge to placement in long term care facilities to reduce relocation stress, yet they do not include assessment of, nor care of, the spirit (Amenta, Weiner, & Amenta, 1984; Jackson, Swanson, Hicks, Prokop, & Laughlin, 2000; Jackson, Swanson, Hicks, Prokop, & Laughlin, 2000).

Historically, nursing has been a proponent of nursing practice that supports the holistic care of clients. The AHNA (American Holistic Nursing Association) posits these philosophies: 1) clients, families and communities have the right to health care that honors the mind, body and spirit; and 2) disease and distress are opportunities to increase
awareness of the interconnections of the mind, body and spirit (AHNA, 2007). Without a focus on the holistic nature of the person, nursing care merely addresses the physical body and touches lightly upon the emotional aspects of patients; thus deprivation of the spirit-being is a real potential.

Purpose Statement

The purpose of this qualitative, grounded theory study, was to develop a theoretical model that describes the influence of spirituality (including spiritual practices and beliefs) within older adults during the first six months of relocation to a long term care facility. During the exploration of the current adjustment process, aspects of previous spirituality (prior to the time of relocation) were examined for alterations in process due to relocation.

To study the matter of how older adults use their spiritual domain for dealing with life’s stressors, research was undertaken. Nurses need to delve into the meanings of life experiences to gain perceptions of the nursing home residents. Mowat (2004) calls for the use of mixed methods, both qualitative and quantitative research styles, to better understand spirituality. Yet another researcher believes there are multiple varieties of qualitative methods that could be used to study spirituality (Saunders, 1998). Conversely, MacKinlay (2004) negates the use of quantitative methods to study spirituality. She calls for qualitative research to understand more about spiritual life experiences:

We still have much to learn about the spiritual dimension. It is now becoming evident that what is known as ‘narrative gerontology’ has an important part to play in...societies and the affirming or our older people...but at a much deeper level it is engaging with the meaning of life itself than lies at the base of this enterprise (MacKinlay, 2004, p.85).
Narrowing down the typologies of qualitative methods, this study utilized grounded theory and gained understandings and insights into the older adult’s spirituality who have experienced a relocation to long term care facilities. Grounded theory is a unique method which provides a “way of thinking about and studying social reality” (Strauss & Corbin, 1998, p.4). Additionally, grounded theory is useful to generate theory regarding human processes (Wuest, 2007). Underlying assumptions for grounded theory are derived from viewpoints of the persons being studied; they include understandings of the participants’ social interactions, processes for change and their ensuing social changes (Wuest, 2007). The social interactions, processes for change and resultant changes in those persons who experienced a relocation to long term care were studied, specifically as related to their spirituality. There is no other type of qualitative method that would assist the researcher to arrive at a new theory for the spirituality of older adults during relocation to long term care facilities.

When qualitative, grounded theory methods were used, the outcomes delivered rich, in-depth themes about how people experienced the spiritual self when undergoing stressors. This research added to the knowledge base through publication to support the education of nurses and other health care providers of older adults. Nursing care standards and best practices could be built and organized for the delivery of holistic care to ease stressful situations for older adults during relocation times. The findings will support education about spiritual processes of residents and families during relocation and assist the caregivers with meeting identified spiritual needs. When the resident, the family and the caregivers work towards the best possible outcomes of relocation, the spirit-being will be supported and the potential of relocation stress syndrome will be reduced.
In conclusion, research into matters of spirituality related to older adults at the time of relocation into a long term care facility is important and was conducted. As stated so eloquently by a nurse scientist, “We must take the necessary measures to keep spirituality and spiritual care in the forefront of our nursing practice, thereby enriching the lives of those we care for as well as our own lives” (Kociszewski, 2003, p.147).

Research Questions

The research design was a qualitative grounded theory study. Consistent with the qualitative nature of the grounded theory approach, the research questions were broad and general in their scope (Creswell, 1998). The researcher used them as a starting point, from which the theoretical concepts emerged. They were as follows:

1) What are the spiritual beliefs and practices of older adults when they relocate into long term care facilities?

2) How are the past spiritual practices (including beliefs and practices) similar to the older adults’ present spiritual practices during relocation to the long term care facility?

3) How are the past spiritual practices (including beliefs and practices) different from the older adults’ present spiritual practices during relocation to the long term care facility?

4) What meaning does spirituality have for the older adult since he/she came to live in the long term care facility?

5) What adjustments have older adults made to support their spirituality since arrival to the long term care facility?
6) What barriers to spirituality (beliefs and practices) have the older adults experienced, since arrival to the long term care facility?

Theoretical underpinning

The theoretical underpinning for this study was symbolic interactionism (Blumer, 1998). Blumer created the concept of symbolic interactionism to study human group life and human conduct. He was a sociologist who referenced the works of George Herbert Mead (Blumer, 1998). The theory has been in existence since 1969, and is still utilized for research purposes in the twenty-first century.

There are three premises that symbolic interactionism is built upon: 1) humans act toward things based on the meanings the things have for them, 2) meanings develop from social interactions that humans have, and 3) meanings are adapted via interpretive processes when people meet up with the things they encounter (Blumer, 1998).

The main idea behind the concept is "the meanings that things have for human beings are central in their own right" (Blumer, 1998, p.3). Symbolic interactionism is based on the premise that when people interact, meanings develop and come to fruition. One cannot have rich meanings if living in a vacuum, without human contacts. Along these lines of thought, symbolic interactionism also assumes that humans have the ability to observe and analyze their own behaviors and alter their behaviors based on these abilities.

To develop full meanings in his or her life, a person interacts with another. Meaning is not given to him or her by the other; it arises through an interpretive process within himself or herself (Blumer, 1998). Humans communicate intra-personally and inter-personally to handle the meanings of what they encounter in the world and extra-personally as the context in which they live.
To organize the theory of symbolic interactionism, Blumer conveys seven root images, or basic ideas: “1) nature of human society or human group life, 2) nature of social interaction, 3) social interaction, 4) objects, 5) human being as an actor, 6) human action and 7) interconnection of the lines of action” (Blumer, 1998, p.6.) Further discussion and application of symbolic interactionism is provided in Chapter Two.

Delimitations

Delimitations for the study addressed multiple facets of the research project. They were as follows:

The first delimitation was the timeline of the study. The plan was to conduct it from April, 2008 to September, 2008.

The second delimitation was the location of the study. It was conducted in three skilled nursing facilities in a northern plains state.

The third delimitation was the sample. It was a purposive sample of people age 65 and older, who had relocated to the long term care, skilled nursing facility within a six months time period and who had not lived in the LTC facility for more than six months.

A fourth delimitation was the selection criteria for the study. Residents were screened for cognitive abilities. Any person who scored less than 23 points on the Mini-Mental State Exam was excluded from the study. Other exclusion criteria were the eliminations of those who had combined visual and hearing impairments, low English literacy, and experience communication disorders. Participants either read the consent form or had it read to them. Participants were expected to verbally express their responses in English to the researcher.
Assumptions

Assumptions of the study were fourfold. The first assumption was that the purposive sample was typical of older adults in a rural, northern plains state. The second assumption was that the participants’ responses accurately reflected their experiences and gave insights to their adjustment process at that moment of time. The third assumption was that the residents could recall their spirituality as it existed prior to moving into the nursing home. Finally, the fourth assumption was that the researcher created an environment which supported open and honest responses by participants to the semi-structured interview questions.

Definitions of Terms

The terms significant to this study are listed with their definitions.

**Long term care** is the provision of personal care and nursing care, for an indefinite period of time provided in a skilled nursing facility. This is the type of facility where the study took place.

**Skilled nursing facility** is a licensed nursing home that provides 24-hour LPN or RN levels of nursing care. It was used interchangeably with the term long term care.

**Resident** is the term used for the person who resides in a nursing home or skilled nursing facility. It is synonymous with the term patient, as used in a hospital, although resident is the term for the recipient of care in a nursing home.

**Older adults** refers to adults, who are age 65 or older. This is based upon the U.S. federal government’s determination of when people are eligible for full Social Security benefits and Medicare insurance.
Spirituality is "That which lies at the core of each person’s being, an essential dimension which brings meaning to life. It is acknowledged that spirituality is not constituted only by religious practices, but must be understood more broadly, as relationship with God, however God or ultimate meaning is perceived by the person, and in relationship with other people" (MacKinlay, 2004, p.76). It is expected that the definition of spirituality for this study will further evolve through interviews with participants.

Spiritual practices are the actions and activities undertaken by humans, to express and strengthen their spirituality in a physical or psychological manner.

Spiritual beliefs are the thoughts, ideas, viewpoints and/or concepts people hold about spirituality and are expressed as beliefs.

Spiritual care is the provision of needed assistance and watchful oversights, to support people’s spirits. Spiritual care may take a variety of forms, such as: being present, making spiritual assessments, listening to spiritual matters, offering prayer or spiritual readings, respecting and supporting rituals, etc.

Spiritual needs are desired relationships, expressed through beliefs, qualities and/or practices relating to or affecting the person’s spirit.
CHAPTER II

LITERATURE REVIEW

The purpose of this qualitative, grounded theory study was to develop a theoretical model that describes the influence of spirituality (including spiritual practices and beliefs) within older adults during the first six months of relocation to a long term care facility. During the exploration of the current adjustment process, aspects of previous spirituality (prior to the time of relocation) will be examined for alterations in process.

Therefore, the first half of this chapter will review literature which relates to long term care. It will appraise the demographics of aging in America, types of and reasons for relocation, descriptions of relocation stress, effects and outcomes of relocation stress, positive outcomes of relocation, and family responses to relocation.

The second half of the literature review will focus on spirituality. This portion will address the sub-topics of: background of spiritual care in the nursing profession, various definitions of spirituality, religion and religiosity of older adults, theoretical underpinnings and theories of spirituality, health implications of spirituality, the specialization of spiritual care nursing practice, spiritual care interventions and those interventions specific to long term care, ethical importance of the provision of spiritual care, standards of practice for spiritual care, faith formation theories for older adults, and dilemmas in practice.
The final section of the literature review delves into this study’s theoretical underpinning of symbolic interactionism. Finally, the gaps in literature will be addressed, supporting the necessity of conducting this study which examined spirituality and the role it plays in relocating a person to a long term care facility.

Demographics of Aging in America

*Population Statistics*

According to the 2000 American census, there are “nearly 35 million people over the age of 65 and they are the most rapidly growing group within the population” (Tabloski, p.8, 2006). Since 1900, the population in America has tripled while the “population of older adults over age 65 has increased 11-fold” (Mauk, 2006, p.29). Experts who study future trends predict the group of people age 65 and older will double, and consist of 71.5 million people by the year 2030 (Federal Interagency Forum on Age-Related Statistics, 2006). The ever increasing size of the population of older adults is attributed to increased life expectancy and fertility rates at different times in the history of the U.S. population (Mauk, 2006).

*Life Expectancy*

Life expectancy in the United States has changed dramatically since the early 1900s. At the turn of the century, a mere 39% of boys and 43% of girls who were born, lived to age 65 years (Gorina, Hoyert, Lentzner, & Goulding, 2006). One hundred years later, the number of people alive who reached the same age doubled, with 78% of boys and 86% of girls expected to live beyond age 65 years (Gorina, Hoyert, Lentzner, & Goulding, 2006). In the 21st century, babies born in America can expect to live to 80 years old and beyond (Gorina, Hoyert, Lentzner, & Goulding, 2006). The average American male life
expectancy is age 74.5 years, while the average American female life expectancy is age 79.9 years (Gorina, Hoyert, Lentzner, & Goulding, 2006). Another study states that the average life expectancy for all Americans, as of 2004, was 77.8 years of age (Centers for Disease Control, 2007). Increases in the American population coupled with increases in life expectancy, will place a high demand upon long term care services in the future.

Residential Care for Older Adults

There are different levels of nursing care, located in different types of residential facilities, available to persons in their later stages of life. The long term care setting, or skilled nursing care, is one with professional nurses available 24 hours a day and it offers short term rehabilitation services. This type of service is required for people with “chronic ailments or disabilities that require daily attention of RNs in addition to help with personal cares, bathing, dressing or just getting around” (Cress, 2007, p.291). This study concerned itself with long term care facilities.

Long term care facilities are either for-profit, or not-for- profit entities. Sixty-seven percent of them are for-profit, and 26% are not-for- profit while 7% are operated and owned by the government (Harris & Benson, 2006, p.6). Collectively, the industry obtains revenues of $80 billion each year; individually, it costs each resident an average of $4,600 per month to live in a long term care facility (Harris & Benson, 2006). Funding of long term care is difficult for families because Medicare only contributes an average of 9% of the costs (Harris & Benson, 2006). Medicare typically pays for the first 21 days of the stay after hospitalization, and then it pays a portion of the days’ costs until the 100th day of stay. After that, residents and families must seek other sources of financial support (Harris & Benson, 2006).
Rates of Utilization

Forty-three percent of people turning 65 years old will require long term care (commonly known as skilled nursing home care) at some time in their life (Kemper & Murtaugh, 1991). It is estimated that there are just under 6% of adults over the age of 65 or nearly 1.5 million people in this age group who reside in American long term care facilities (Harris & Benson, 2006). In 2005, a total number of 1,460,185 long term care residents lived in a total of 16,435 American long term care facilities (Houser, Fox-Grage & Gibson, 2006). The large number of older adults in American society who will require nursing care in a long term care facility will experience relocation. They will require long term care facilities to accommodate their needs.

The long term care utilization rate has been studied for selected age groups. In 1999, a total of 10.8 people per thousand, aged 65 to 74 years, utilized long term care facilities. This percentage increased to 43 people per thousand, aged 75 to 84 years, who utilized the same long term care services. Among the very old, the proportion was even higher, with a total of 182.5 people per thousand who required long term care services (Federal Interagency Forum on Age-Related Statistics, 2006). The older a person becomes, the more likely it is that they will utilize long term care resources and be placed in a skilled nursing facility.

Functional Abilities in Long Term Care

People aged 65 and over, who are residents of nursing homes, require various types of basic nursing skills for assistance with functional abilities, known as activities of daily living (ADLs). In 1999, only 3% of the nursing home population did not need any assistance with ADLs, while 19.8% required help with one to three types of different ADLs
An astounding 77.2%, or nearly four out of five people in long term care facilities age 65 and older, reported they required help with four to six ADLs (Federal Interagency Forum on Age-Related Statistics, 2006). It is apparent that basic nursing skills are vital to offset the physical limitations for the residents. The majority of residents, nearly 80%, require help with four to six ADLs on a daily basis; very few residents can function independently.

Functional status and mobility has been reviewed specifically with regards to the general population of people age 65 and older who live in America. In the year 2004, of the age group 65 years and older, 57.4% of the population reported at least one physical limitation of any kind, while 32.4% had difficulty with walking (Centers for Disease Control, 2007). This increased when people age 65 or older, who lived in long term nursing care facilities were compared: in 2004, 62.8% had difficulty with walking, 72.1% had problems with toileting, and 91.5% required assistance to bathe or shower (Centers for Disease Control, 2007). Those people greater than 65 years of age who lived in nursing facilities, experienced greater degrees of decline in their functional status and mobility, than the average American population who lived outside of long term care facilities.

In summary, this section reviewed demographics of aging in the American population and identified a large section of this population that will require long term care in the future. If the segment of population age 65 or more doubles in the next 20 years, it may be that nearly 3 million people age 65 or older may require long term care by 2030. This is based on the current figure of 1.5 million adults age 65 or older, who were residents in facilities during 2004. Those who live in long term care facilities have greater functional decline and have a high need for assistance with multiple ADLs, when compared to people
of the same age group, who are not living in facilities. This study focused on the people who reside in long term care facilities.

The Concept of Relocation

Definition of Concept

Definitions of relocation are abundant in the literature. A general description is found in the *American Heritage Dictionary* “relocation – to establish in a new place” (Berube & Devinne, 1985, p. 1044). While this may be depicted in a generic manner, it is developed as a concept by other scholars’ writings with boundaries and varied foci.

Over time, researchers have focused not only on the physical move that occurs during relocation but have also added the person whose experience is at the center of the relocation process. Two researchers focused studies on changes in the environment that take place when an individual moves from one location to another (Hasselkus, 1981; Rosswurm, 1983). Another definition reflects time frames as relevant to the description, stating that it is the “removal of a person from one topographical environment to another for at least 24 hours” (Powell et al., 1990, p.24). Other authors focus on the distance traveled during relocation; they claim relocation refers primarily to short-distance moves, unlike the longer distance moves common to migrations (Oswald & Rowles, 2006).

From these definitions, it can be concluded that relocation is the movement of a person from one physical place to another, typically of shorter distances than in a migration and which endures for longer than one day’s time. The aforementioned definition was used for this study.
Types of Relocation

There are various types of relocation present in the literature. One report splits the types of relocation into three categories: moving from home to home, moving into purpose-built homes and moving into an institution (Oswald and Rowles, 2006). Other studies categorize relocations into four types: 1) residential relocation occurs when a person moves from one residence to another, 2) residential/institutional relocation implies that a person transfers from a residence to an institution, or vice-versa, 3) interinstitutional relocation comes about with a transfer from one facility to another, and 4) intrainstitutional relocation takes place when a person moves from one room or unit to another, within the same facility (Castle, 2001; Rosswurm, 1983; Smith and Crome, 2000). This dissertation focused on older adults as they relocate into long term care facilities whether they moved directly from another healthcare facility or from their private homes, processes known as residential/institutional and inter-institutional relocations.

Reasons for Relocation

There are numerous reasons for relocation of older adults into long term care institutions. The reasons include voluntary or involuntary moves, deterioration in health status, personal lifestyle changes, administrative decisions, and health care payment systems (Morse, 2000; Oswald & Rowles, 2006; Smith & Crome, 2000).

Other researchers have assessed reasons for relocation based on type of move. Residential relocations are often conducted by affluent and mobile Americans who enjoy their familiar residence, but want to experience their latter years in a different climate or part of the country; this type of relocation is a well-planned, personal choice, for seasonal migration from one home to another (Oswald & Rowles, 2006). The familiar and chosen
residence becomes the favorite home, while life in the institution was not described as positively (Barry, 2000). Others move to a new residence in order to be closer to family or a preferred neighborhood (Oswald & Rowles, 2006). Older adults who move into purpose-built homes do so to meet specific needs, such as physical or mental changes that require accommodations (Oswald & Crome, 2006).

The reasons for moving into long term care institutions cited are increasing burdens to the person’s caregivers or spouse, cognitive, physical and mental changes which require basic and skilled nursing care, and lack of close family (Oswald & Rowles, 2006). A case study reveals changes in physical condition, short-term memory deficit, inability to care for self, and lack of caregiver support combined to cause the reason for admission into a long term care facility after a major hospitalization (Morse, 2000).

The health care prospective payment system and administrative policies may facilitate relocation to institutions due to the need to reduce length of stays in acute care settings and keep health care costs lower (Jackson, Swanson, Hicks, Prokop and Laughlin, 2000; Smith and Crome, 2000; Thorson & Davis, 2000). One researcher explored quality of life in older adults who were relocated and lived in nursing homes to discover they believed healthcare “reimbursement issues took precedence over their wishes” (Okonski, 1994, p.7). Given the different responses, physical, emotional, spiritual, that have been identified in connection with relocation to long term care facilities, it is necessary for health care providers to be aware of and assess the residents’ status during this transitional time, no matter what type of relocation occurs, the reasons for the relocation, or the payment concerns.
Description of Relocation Stress

Nurses developed a specific nursing diagnosis named “Relocation Stress Syndrome” in response to observed behaviors of clients during transitions (Ackley & Ladwig, 2006; Mallick & Whipple, 2000; NANDA, 2007). The term relocation stress syndrome originated in 1992 and is defined by the North American Nursing Diagnosis Association as “physiologic and/or psychosocial disturbances as a result of transfer from one environment to another” (Ackley & Ladwig, 2006; Jackson, Swanson, Hicks, Prokop, and Laughlin, 2000; Mallick & Whipple, 2000; NANDA, 2007, p.178).

Over the last 30 years researchers assessed relocation stress in a variety of situations and coined many names for the syndrome: relocation stress, transplantation shock, transfer trauma, and pure relocation effect and admission stress (Castle, 2001; Mitchell, 1999; Smith & Crome, 2000). One definition for relocation stress is similar to the NANDA diagnosis. Relocation stress syndrome was studied in long term care residents during the same time period as NANDA developed their nursing diagnosis and researchers defined it as “a state in which an individual experiences physiological disturbances and/or psychological disturbances as a result of a transfer from one environment to another” (Brugler, Titus, & Nypaver, 1993, p.45).

Italian psychiatrists who studied newly relocated residents of a nursing home defined their subjects’ relocation experience as a “subjective reaction to a stressful event which altered homeostasis, implying unstructured psychological suffering or a disruption preceding the onset of a psychiatric disorder” (Scocco, Rapattoni & Giovanna, 2006, p.281). The study of 68 participants reported negative relocation outcomes in mental health and cognitive declines, when assessed at 1 week and 6 months post-admission.
With understandings of relocation and its definitions, it is apparent residents of long term care homes may experience stress during relocation; stress may be physical, psychological and psychosocial. Another dimension of holistic health must be studied; it is the dimension of a person’s spirit regarding relocation transitions.

Effects and Outcomes of Relocation Stress

Literature supports the idea that there are many human responses and behaviors that result when relocation stress syndrome occurs. Different researchers categorized the results of the stressful period with various names: effects, outcomes, or consequences. It is unclear how each study defined the terms effects, outcomes and consequences. Therefore, the following section will group the resulting human responses by behaviors, including mental health, coping responses, physical health, social interactions and mortality rates regardless of whether they were reported as effects, outcomes or consequences.

There are many mental health changes that occur as a result of relocation. “Effects of relocation include ... psychological distress, and depression” (Castle, 2000, p.291). Other studies reveal distress and depression effects, similar to those previously stated (Mitchell, 1999; Smith & Crome, 2000). Relocation of older adults into long term care places adults at risk for feelings of despair and possible suicide ideation (Haight, Michel & Hendrix, 1998). The NANDA organization uses the term characteristics to describe qualities of actions or behaviors, with respect to each nursing diagnosis. Mental health characteristics of relocation stress syndrome include: “aloneness, alienation, loneliness, depression, anger, anxiety, concern over relocation, fear, frustration, loss of identity and self-worth, dependency, insecurity, worry and withdrawal” (Ashley & Ladwig, 2006, p.1001; NANDA, 2007, p.178). Similarly, another study by nurses cites the effects of
relocation stress syndrome to be: “anxiety, apprehension, increased confusion, depression, and loneliness” (Jackson et al, 2000, p.3). Outcomes of relocation stress were worsened psychiatric symptoms and cognitive decline in patients with prior mental health diagnoses (Mitchell, 1999; Scocco, Rapattoni & Giovanna, 2006). See Table #1 for a composite of clients’ negative responses to relocation derived from the literature search.

Table 1 Negative Human Responses to Relocation Stress

<table>
<thead>
<tr>
<th>Affected Domain</th>
<th>Specific Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Psychological distress, despair, depression, suicidal ideation, (emotional/cognitive) aloneness, alienation, loneliness, anxiety, concern</td>
</tr>
<tr>
<td></td>
<td>over relocation, fear, frustration, loss of identity and self-worth, dependency, worry, self-isolation, apprehension, increased confusion, worsened psychiatric symptoms, cognitive decline, dysfunctional coping</td>
</tr>
<tr>
<td>Coping Abilities</td>
<td>lack of control, lack of trust, displacing anger, experiencing feelings of injustice</td>
</tr>
<tr>
<td>Physical Health</td>
<td>physiological decline, poorer quality of health, increased physical symptoms, GI disturbances, sight change, sleep disturbance, physical illness, deterioration in health and physical functions, increase in falls, increased mortality rates</td>
</tr>
<tr>
<td>Social Changes</td>
<td>losses of friendships, losses of autonomy, becoming uneasy with other residents, feeling insecure in new social groups, withdrawal from others</td>
</tr>
</tbody>
</table>
Coping abilities have been studied regarding relocation. Damon (1982) conducted one of the earlier studies regarding effects of relocation stress in nursing homes for older adult residents. The following reasons elucidate why relocation is difficult and has negative effects on the elderly: “Older persons lack the coping mechanisms necessary for a favorable outcome: control and predictability” (Damon, 1982, p.144). Damon revealed that most moves into a nursing homes are involuntary. He found the older adults lack control and predictability of the situation; therefore, less favorable effects are seen during adjustment to the facility (1982). Immediately after the move into a nursing facility is the most likely time when new residents may cope by expressing anger and a sense of injustice regarding their move into the facility (Kao, Travis & Acton, 2004). Conversely, if the transition to a long term care facility is well planned by a geriatric care manager or geriatric nurse specialist and it enlists family support, the older adult typically copes in a more effective manner (Kao, Travis & Action, 2004; Ramey & Cress, 2007).

Physical changes that occur as a result of relocation stress are multi-faceted. Studies reported a general state of physiological decline or a poorer quality of health was noted after relocation occurred (Castle, 2001; Mitchell, 1999; Scocco, Rapattoni & Giovanna, 2006). NANDA describes more specific physical changes in health related to relocation stress syndrome, including “increased verbalization of needs, increased physical symptoms, GI disturbance, weight change, and sleep disturbance” (Ashley & Ladwig, 2006, p.1001; NANDA, 2007, p.178). Similarly, another study cited effects of relocation stress syndrome to be, “physical illness and deterioration in health or function” (Jackson et al, 2000, p.3). Residents experienced an increase in falls within the first three months after admission to a long term care facility (Capezuti, Boltz, Renz, Hoffman & Norman, 2006; Lander, Brazill
& Ladrigan, 1997). Jackson (2000) stated the outcomes of relocation may be worsened when older adults have “concurrent losses, declining health and inadequate supports” (p.3).

Negative social changes, specifically losses of friendships and autonomy due to the relocation, were identified in a model derived from a meta-analysis of the literature (Castle, 2001). See Figure 1 for Castle’s model of Potentially Important Factors in Relocation of Elders (2001). The model is used with the author’s permission. More specifically, behaviors of becoming uneasy with other residents were noted in people with dementia within the first two months of admission (Morriss, Rovner, & German, 1994). NANDA lists insecurity and withdrawal from others as characteristics of relocation stress syndrome (NANDA, 2007).

Figure 1. Potentially Important Factors in Relocation of Elders (Castle, 2001)
There are various mortality studies which are inconclusive regarding the effects of relocation of older adults into long term care facilities. A meta-analysis revealed that studies are difficult to compare due to the facts that researchers used different time frames and various populations with many variations on health status to arrive at mortality rates post-relocation into long term care (Smith and Crome, 2000). Mortality rates vary among studies from no statistically significant findings to 35% death rate at six months post admission (Smith and Crome, 2000). Additionally, Castle reported mortality rates vary from “0 to 43% post-relocation” (2001, p.304). Researchers agree that it is difficult to compare mortality rates for the previously identified reasons (Castle, 2001; Smith and Crome, 2000).

It is apparent the human responses to relocation stress syndrome may affect an older person’s life negatively, in many realms: mental health, physical health, social health, and even to the end of life with increased mortality rates. The outcomes put forth a descriptive picture of how a person responds when undergoing relocation stress. It is apparent that relocation stress is a negative event that disrupts a person’s normal homeostasis. However, not one study revealed any information which focused on the spiritual reaction to relocation stress syndrome. It is definitely a syndrome which affects people, and the spiritual aspects must be studied if health care providers are to provide holistic care.

Positive Outcomes of Relocation Stress

Other studies report positive outcomes of relocation. One study found increases in health when adults moved to an improved physical environment (Washburn, 2005). Washburn (2005) concluded that relocation stress was present in the population studied, yet it was relatively short-lived. Benefits of relocation were identified and they are increased
attention to physical health needs, improvements in social functioning, renewed interest in meals, increased participation in social activities, enhanced self-esteem when participating in resident council meetings, and opportunities for new friendships (Amenta, Weiner and Amenta, 1984). Still other benefits of relocation to a long term care facility were found in meeting the older adults’ needs for assistance with health and functional abilities, social support, safety concerns and easing fears that arise from increasing disabilities coupled with increased vulnerability (Ramey & Cress, 2007).

Positive outcomes of relocation stress have been studied, yet there are fewer studies that list positive outcomes of relocation, when compared to studies which report negative effects of relocation. Furthermore, no studies addressed the positive side of relocation viewed from the health domain of spirituality. This study seeks to investigate the process of relocation, ascertaining both negative and positive aspects of relocation, specific to spirituality.

Family Responses to Relocation

Negative stressors experienced surrounding relocation of residents’ family members were studied (Mitchell, 1999). These stressful experiences included questioning their decisions to have their loved ones placed in a facility, holding a belief that the institutionalization was the most difficult problem they ever faced, and not knowing how to transition to this stage without their family member living at home with them (Mitchell, 1999). Other difficulties family members of the relocated older adult face are stressors such as: 1) care of their young children and parent at the same time, 2) making time to tour, interview, and select the LTC facility, 3) coping with end of life concerns and emotions for their parent, and 4) selection, disposition of, and the physical moving of their parent’s
belongings (Ramey & Cress, 2007). This study did not focus on the effects relocation has on the family members. However, it needs to be noted as a weakness in the current state of literature surrounding relocation of older adults.

From the literature, many effects and outcomes of relocation stress syndrome have been identified. It affects individuals in many domains of their health and it affects family members, too. However, a discussion regarding the spiritual domain and spiritual well-being or spiritual distress during the time of transition and adjustment to a new way of living in a physically different environment was not found in the NANDA definition, nor was it located in other researchers' findings.

Spirituality

Introduction

This section of the chapter will review the background and current state of knowledge surrounding the topic of spirituality and spiritual care. More specifically, spirituality of the older person will be discussed.

The review of literature regarding spirituality will begin with background information and definitions of spirituality and religion. It will present theoretical underpinnings and theories for spirituality. The following topics will also be addressed: spiritual care, spiritual assessment tools, nursing interventions for spiritual care, the specialization of spiritual nursing care, ethical implications, standards of practice, dilemmas, and health implications for spirituality. The review will end with focus upon a specific population: the older adult and faith formation theories, nursing research of faith and religiosity in the older adult, and spiritual care interventions utilized in long term care (LTC) settings.
Background of Spiritual Care in Nursing Since 1970s

During the last 30 years in American society, there has been a resurgence of interest in spirituality and the delivery of spiritual care within the profession of nursing. In the mid 90's, Barnum found the interest was due to: 1) growing numbers of self-help programs with elements of spirituality, 2) nursing groups becoming advocates for spiritual care, and 3) society demonstrating greater appreciation of holistic well-being concepts (Barnum, 1996). Taylor (2002) credits the increased number of spiritual care courses in nursing curricula and the formation of specialty practice groups focused in holistic care as major factors in the development of spiritual care practices. Furthermore, in the 1970s and the 1980s, nurse theorists began to emphasize the holistic nature and integrated wholeness of a person. These nurse theorists were M.E. Rogers, D.E. Orem, B. Neuman and C. Roy (Chinn and Kramer, 2004). During the same time, in 1981 the American Holistic Nurses Association (AHNA) was organized and began to actively engage in support of holistic nursing care (AHNA, 2008). In April of 2008, their roster held greater than 35,000 members and AHNA was recognized by the American Nurses Association as a specialty practice group of professional nurses (AHNA, 2008). The combined influences created the current interest in spirituality for the twenty-first century.

Definitions of Spirituality

McSherry and Cash (2004) reviewed meanings of spirituality to determine that there are various layers to the concept. They explain that meanings vary from the “extreme left with a spirituality based on religious and theist ideals while at the extreme right there is a spirituality based upon secular, humanistic, existential elements” (McSherry & Cash, 2004, p.152). They conclude that nursing is defining a broad, inexhaustible set of
characteristics which construct a blanket definition of spirituality. McSherry and Cash (2004) caution readers “to avoid becoming so broad that the meaning loses significance” (p.152). Therefore, a taxonomy with shades of meaning for the definition of spirituality was developed (McSherry & Cash, 2004).

As early as 1979, Stoll offered a Christian-based, two-dimensional definition of spirituality (1979). Stoll organizes spirituality into vertical and horizontal concepts. She states, “Spirituality involves a vertical dimension (i.e. a person’s relationship with God, the transcendent, supreme values) and a horizontal dimension which reflects the supreme experience of relationship with God through beliefs, values, life-style, quality of life and interactions with self, others and nature” (Stoll, 1979, p.7).

Saunders (1998) explored ontological ideations underlying definitions of spirituality. Saunders iterated “Spirituality refers to the center of people’s being and a life force that gives rise to their sense of wholeness. Faith, hope, trust, the giving and receiving of love, forgiveness, reconciliation and meaning in life are fundamental characteristics of spirituality which are considered the basic determinants of the totality of people” (1998, p.17).

In 1999, Narayanasamy described the need to expand the holistic understanding of spirituality to its biological root. He stated current beliefs in spirituality (based in the mind, body and soul) did not attend to the need for spirituality as a biological survival mechanism. He stressed that a person could not survive in good physical health, without a strong, healthy sense of spirituality. This researcher linked spiritual health as a support to physical health.
Amenta defined spirituality: "The spiritual is the self, or I, the essence of personhood, the God within, that part which communes with the transcendent. It is that part of each individual which longs for ultimate awareness, meaning, value, purpose, beauty, dignity, relatedness and integrity "(1986, p.117). This definition portrays the spirit lodged within a person’s core being and that it is the part of the self which makes meanings possible.

A recent student of spiritual states developed yet another definition of spirituality. It is “That which lies at the core of each person’s being, an essential dimension which brings meaning to life. It is acknowledged that spirituality is not constituted only by religious practices, but must be understood more broadly, as relationship with God, however God or ultimate meaning is perceived by the person, and in relationship with other people” (MacKinlay, 2004, p.76). MacKinlay’s work was developed by assessing older adults at life’s end with a Christian focus.

A variety of scholars attempted to define spirituality. One critique of the concept is that it lacks a unified, agreed-upon definition and thus leads to many different interpretations and divergent methods of studying it. This study examined the relationship spirituality has with relocation for older adults and arrived at its own specific definition for spirituality through the older adults perceived interpretation of this experience.

*Definition of Religion and Religiosity Among Older Adults*

Health care providers need to understand the differences between spirituality and religion, which are two diverse, yet related concepts. While spirituality focuses on an individual’s spirit, religion refers to organized belief systems and works (or rituals) created by man. Taylor explains:
Religion offers a specific worldview and answers to questions about ultimate meaning. Religion offers guidance about how to live harmoniously with self, others, nature and god(s). Direction is presented through a religion’s belief system (e.g. its myths, doctrines, stories, dogma) and is acknowledged when one participates in rituals or other religious practices and observances (2002, p. 10).

Likewise, another definition of religion states it is the functions of beliefs, practices, symbols and experiences that focus upon “a search for significance in ways related to the sacred” (Pargament, 1997, p. 32).

Older adults who express high levels of religiosity have been studied for their abilities to adapt to the aging process and were assessed for indicators of hope and well-being. Women who were raised in religious homes adapted better to the aging processes than those who did not grow up in religious homes and all women reported that their religiosity helped them cope with the changes of aging (Fischbacher-McCrae, 1988). In a similar study, elderly people with cancer who had high levels of intrinsic religiosity experienced higher levels of hope and well-being than those without strong levels of religiosity (Fehring, Miller & Shaw, 1997, p.663). Likewise, when older adults who lived in two different nursing homes settings were compared, they linked religiosity to living a full and happy existence (Linz, 1990).

Religion is often portrayed as a sub-set of spirituality. It cannot be dismissed when studying spirituality, nor can it be the focus for a study of spirituality. Religion has been found to assist older adults to cope with aging while it also bolsters their sense of hope and well-being. Religion can be thought of as a supporting segment to the total picture of a
person's spirituality; it may possibly be a tool older adults use to develop spirituality during the time of relocation to a long term care facility.

**Theoretical underpinnings of Spirituality**

Spirituality is a universal human phenomenon, yet the theoretical underpinnings used to describe it are varied (Coyle, 2001; Friedemann, Mouch and Racey, 2002; Fryback, 1993; and Hodge, 2000). Upon description, it is apparent the frameworks espouse a multitude of aspects related to a person's spirit.

A holistic framework for spirituality describes a three domain model of a human being (Fryback, 1993). Fryback's model divides persons into a spiritual domain, a physical domain and a mental/emotional domain. The spiritual domain includes characteristics of: belief in a higher power, recognizing mortality, and having a sense of self-actualization (Fryback, 1993).

Nurses devised a framework for a systems organization of spirituality based on open systems theory (Friedemann, Mouch, & Racey, 2002.) The elliptical model places health at the center, with concepts of spirituality and control at opposite ends of the oval. The theory contends that congruence is present when humans buffer tensions in their lives and balance them with spirituality (Friedemann, Mouch & Racey, 2002).

Another framework explored relationships between spirituality and health (Coyle, 2001). After a search of empirical indicators of spirituality, Coyle arrived at a trichotomy of three approaches to spirituality: the transcendent, value guidance, and structuralist-behaviorist (Coyle, 2001). The transcendent approach to spirituality features strong connections to a higher power, God or the universe while the value guidance approach focuses on a spiritual self-identity with attributes of values, ideals and beliefs linked to
understandings of a person’s spirituality (Coyle, 2001). Finally, the structuralist-behaviorist approach to spirituality stresses a “strong sense of religious commitment and practices associated with churches, faith communities and/or religious networks” (Coyle, 2001, p. 591). Coyle stated the three approaches to spirituality are not mutually exclusive and may overlap.

A final theoretical framework is valuable to understanding the spirit and outcomes of spirituality (Hodge, 2000). The framework has three main components: 1) a definition of spirituality and spiritual traditions, 2) pathways in which spirituality occurs within a human being and, 3) outcomes of spirituality (Hodge, 2000). The theory encompasses seven pathways and five outcomes of spirituality. The pathways lead to client outcomes in the realms of mental, physical and spiritual health. See figure 2, The Relationship Between Discrete Pathways and Mediating Outcomes (Hodge, 2000). The diagram is used with the author’s permission.

Nurses are called upon to meet spiritual needs of their clients, yet little is agreed upon regarding frameworks for spirituality. It is a nebulous concept and consequently the theoretical underpinnings vary. Similarities seen between the various frameworks are: 1) each one describes relationships between a higher power and health, 2) the frameworks support balance in the various domains of health, 3) holistic interaction is a predominant theme, and 4) spirituality gives guidance about how to live a person’s life.

Health Implications of Spirituality

Tanyi (2002) conducted a meta-analysis of literature, scanning a period of 30 years, with a search for the meaning of spirituality respective to health. The findings indicated “spirituality is a component of being human and it is subjective, intangible, and
multidimensional” (Tanyi, 2002, p. 500). Tanyi purported mental health is supported positively by a person’s spirituality.

Figure 2. The Relationship Between Discrete Pathways and Mediating Outcomes (Hodge, 2000)

The health consequences of spirituality are many. Upon completion of a literature review, the supportive health consequences of spirituality for a holistic being are inner peace and well-being, successful adaptation in health matters, and personal self-transcendence.

Delgado (2005) explains inner peace and well-being as “necessary for people to take care of, in their concerns, goals and projects” (p.161). She reports that “inner peace,
tranquility or comfort may indicate success in coping with stressors (Delgado, 2005, p.161).

Many authors examine the successful adaptation to health matters as a result of spirituality; whether they are physical, psychological, or spiritual in nature (Delgado, 2005; Narayanasamey, 2002; Taylor, 2002; Tanyi, 2002; Wilt & Smucker, 2001). Narayanasamey (2002) emphasizes the energy of a person is strengthened when they have a strong sense of spirituality within their being.

The consequence of personal self-transcendence implies that a person connects with a higher power, and feels that presence intimately (Taylor, 2002). Some authors call this a connection with a higher being or higher power (Golberg, 1998; Taylor, 2002; Stoll, 1989). Fry (1998) defined the idea as the potentiality of the self. Coyle (2002) posits self-transcendence as a “capacity for inner knowing and a source of strength, a resource always present” (p.590).

Another aspect of spirituality is prayer and its relationship to physical health. Harris (1990) researched positive effects of intercessory prayer for 900 patients, who knew they were being prayed for, in a coronary care unit. A study by Byrd (1997) assessed the use of ‘unknown’ intercessory prayer for patients on a coronary care unit. Byrd found those who were prayed for experienced less ventilator assistance and fewer antibiotics and diuretics than those without prayer. The use of prayer is powerful, and continues to be studied as a complimentary alternative therapy (CAM) in today’s world of medical and nursing care (Chow, 2005). Researchers agree that studies of this kind, regarding the supernatural effects, are not easy tasks to undertake.
Literature reveals there are many health benefits related to a healthy spirit. This study will investigate the health benefits or health detriments, regarding spirituality during the time of relocation and transition to a long term care facility in the lives of older adults.

**Specialization of Spiritual Nursing Care**

Spiritual care is championed by a group of nurses, the American Holistic Nurses Association (AHNA). This group originated in 1981 to support concepts of holism in every arena of nursing practice (AHNA, 2005). Their philosophical statement is, “Clients, families and communities have the right to health care that honors the mind, body and spirit. Disease and distress are viewed as opportunities for increased awareness of the interconnectedness of body, mind and soul. Holistic modalities and therapies provide support and options in healing” (AHNA, 2005, p.1). This group of nurse specialists supports the right of all health care recipients, inclusive of older adults, to receive nursing care that includes the spirit.

**Spiritual Assessment Tools**

When undertaking spiritual assessments, nurses must be cognizant of three precursors to assessment skills: timing, development of trust and age appropriateness (Taylor, 2002). Because spiritual assessments are highly personal to clients, it is imperative the nurse uses these attributes: 1) develops trust, 2) displays authenticity, 3) is open and honest and 4) assesses the client’s cognitive and spiritual development (Taylor, 2002).

An early tool for spiritual assessment has become a template for more recent authors to construct spiritual assessment tools (Stoll, 1979). Stoll’s tool addresses four dimensions of a person’s spirit: 1) concept of God or deity, 2) sources of hope and strength, 3) religious practices, and 4) relationship between spiritual beliefs and health (Stoll, 1979).
Questions are listed for a nurse to gain information regarding the four dimensions. See Table 2 for comparisons of selected elements of various spiritual assessment tools, based on Stoll’s key areas of spiritual assessment. Lantz (2006) elaborates upon the differences in the spiritual assessment tools; nurses need to use the one that best fits their practice area and patient needs.

In 1996, Maugens developed the SPIRIT assessment. This assessment tool is based on a mnemonic that allows a nurse to remember key areas when conducting a spiritual assessment (Maugens, 1996). The mnemonic is: S = Spiritual belief system, P = Personal spirituality, I = Integration with a spiritual community, R = Ritualized practices and restrictions, I = Implications for health care, T = Terminal events. Questions are linked to topical areas; which are helpful for nurses to remember. See Table 2 for comparisons of Maugen’s (1996) tool to other assessment formats.

The JAREL Spiritual Well-Being Scale was developed for the purpose of “a brief, reliable, and valid scale to assess spiritual well-being” (Hungelman, Kenkel-Rossi, Klassen and Stollenwerk, 1996, p. 263.) This tool utilizes 22 questions with a five point Likert-type scale, to quantify the client’s spiritual well-being. A low score in any one question or group of questions reveals an area of concern. The authors caution nurses to avoid use of this type of questionnaire in stressful, acute care settings and to avoid it with clients who are visually, hearing, or cognitively impaired (Hungelman, et al., 1996, p.265). See Table 2 for comparisons of the JAREL scale to the other assessment formats.

A tool was developed as a component of a Wellness Spirituality Assessment and Intervention Protocol in the Older Adult (Leetun, 1996). Leetun’s spiritual assessment tool is part of a protocol for well-being. It was devised from a list of questions organized into
four areas: 1) self-actualization activities, 2) connectedness activities, 3) healing and new life activities and 4) religious or humanistic activities (Leetun, 1996).

*Table 2. Comparisons of Questions from Spiritual Assessment Tools*

<table>
<thead>
<tr>
<th>Key Assess-Areas (Stoll)</th>
<th>SPIRITual Interview Tool (Maugen)</th>
<th>Spiritual Assessment Tool (Hungleman et al)</th>
<th>Wellness Spirituality Assessment Tool Older Adult (Leetun)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concept of S-Spiritual belief</td>
<td>Belief in spiritual well-being</td>
<td></td>
<td>Sense of closeness to God or higher power?</td>
</tr>
<tr>
<td>God/deity system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P- Personal Spirituality</td>
<td>God’s meaning in my life</td>
<td></td>
<td>What is God’s role in this?</td>
</tr>
<tr>
<td>Sources of I-integration hope/strength with spiritual community</td>
<td>Able to give and receive love (from others) Accept life’s situations</td>
<td></td>
<td>In what or who do you find hope and strength?</td>
</tr>
<tr>
<td>Important R- ritualized religious practices and practices restrictions</td>
<td>Prayer is important... Prayer does not help me in decision making</td>
<td></td>
<td>In what way is prayer, scripture, meditation, religious readings or music helpful to you?</td>
</tr>
<tr>
<td>Relationship I-Implications for between health care spiritual T-terminal events beliefs/health planning/end of life care decisions</td>
<td>There is a close relationship between my spiritual beliefs and what I do When sick, I have less spiritual well-being.</td>
<td></td>
<td>Is God/your religion helpful to you in life? Does your relationship with God or a higher power contribute to your sense of well being?</td>
</tr>
</tbody>
</table>
Note. Stoll’s 4 dimensions are listed on the left hand side of the table, with comparisons of selected questions from 3 assessment tools.

See Table 2 for comparison of selected questions from Leetun’s assessment tool to other assessment formats. There are 35 open-ended questions that elicit client’s responses; it is useful in acute care and outpatient settings.

Multiple methods for conducting spiritual assessments can be found in the literature. One tool contains mnemonics, other assessment structures attempt to quantify answers to spiritual care, and are written in a self-report style checklist, yet another has open-ended style questions which lend themselves well to conversations. Regardless of the style or type of assessment tool, it remains imperative that nurses assess their client’s spiritual state (Lantz, 2006). Each style of tool is different, and may elicit various responses. Just as the style for physical assessment tools vary, so do tools vary for spiritual assessments; the content among them is similar. Nurses need to determine which tool best fits the clinical situation and client population.

Spiritual Care Interventions

Nursing leaders call upon nurses to provide spiritual care to their clients (McEwen, 2005; McManus, 2006; and O’Brien, 2008). There is “consensus in the literature that evidence exists to support provision of spiritual care in healthcare settings” (Speck, 2005, p.33). Spiritual care interventions have been studied. Qualitative research has been conducted to understand themes verified by nurses for the experience of providing spiritual care (Kociszewski, 2003).

O’Brien’s text suggests the following interventions may be offered, upon completion of a nursing assessment for spiritual care needs: active listening to spiritual
pain, being present, helping patients find meaning in their experiences, offering pastoral care services, praying with patients, reading significant religious scriptures/texts, providing for religious rituals, supporting use of devotional articles (e.g. prayer beads, phylacteries, prayer shawls, burning sage or incenses, etc.), use of sacred music, and respect for devotional time (2008). Additionally, she suggests a nurse does not need religious training to provide spiritual care, but focuses on alleviating suffering through spiritual interventions, which is what nurses do for other mental and physical health concerns.

McEwan (2005) conducted a meta-analysis with ten years of nursing literature to arrive at a list of spiritual care interventions. Interventions overlapped with O’Brien’s. The following actions were additional methods to address spiritual care and were not captured by O’Brien “connecting with God, convey acceptance, respect and non-judgmental attitude, create trust, demonstrate empathy, commitment to provision of spiritual care, facilitate journals or scrapbooks, provide time and environment for meditation, use of touch, instill faith and hope, and spiritual values clarification” (McEwan, 2005, p.164).

The use of prayer has been discussed in literature, as a means to help patients with spiritual distress (Dossey, Kegan & Guzzetta, 2000; Maier-Lorentz, 2004; O’Brien, 2008; Taylor, 2002; Van Dover & Bacon, 2001). Prayer is capturing momentum in literature and practice with links to mind-body healing; it is known as a complimentary alternative medicine (Maier-Lorentz, 2004).

Spiritual care interventions have been studied among adult cancer patients (Taylor & Mamier, 2004). The researchers reported that while spiritual care was important to the patients, they preferred nursing interventions that were “less intimate, commonly used and not overtly religious” (Taylor & Mamier, 2004, p. 663). Examples of the types of
interventions preferred were discussions about ways to pray and allowing patients to talk about spiritual meaning in illness.

Kociszewski (2003) studied nurses after they provided spiritual care interventions to identify what types of spiritual interventions they provided for the clients. She revealed seven themes: the spiritual nurse, capturing elusive and abstract nature of spirituality, nurse-client spiritual journey, opening doors for the spirit, choosing to be silent, nurse as role model for spiritual behaviors, and reaping the benefits of spiritual care (Kociszewski, 2003, p.131).

The literature reveals there are many types of spiritual interventions available for nurses to offer to their clients of all ages. It is not known if these interventions will transfer to the residents in long term care settings, and more specifically during the time of relocation to a LTC facility. This study seeks to understand the residents’ perspectives of spiritual care needs and interventions.

**Spiritual Interventions in Long Term Care Settings**

Research has been completed in how to administer spiritual care nursing interventions for older adults, outside of their traditional home-life. There are specific interventions that have been studied and advocated for use with older adults in LTC settings: life review, spiritual therapy programs, connecting with local churches, music therapy, therapeutic gardening, and worship services provided in the LTC facility.

Life review is a planned discussion with another person, in which caregivers listen and validate the other persons’ stories of their lives, particularly their spiritual and religious lives (Silver, 2001). A specific program to meet the elderly person’s faith needs is called the “Full Circle, Spiritual Therapy” program (Kirkland & McIlveen, 1999). Spiritual
therapy is defined by the authors as “a program to facilitate healing, resolution, remembering, and experiencing the sacred, the complete, the joyous, the whole” (Kirkland and McIlveen, 2001, p.9).

Another important intervention for a long term care center’s ability to meet spiritual needs of residents is the purposeful development of connections with congregations as support networks. Koenig and Lawson (2004) address the positive impact churches have on nursing homes. Many American long term care facilities are affiliated with churches and the facilities’ missions are to care for the members of the churches they are in relationships with.

One intervention intended to strengthen the spiritual lives of residents in LTC settings is found in music therapy, specific to a person’s religious practices. It brings memories of their past and supports their need to connect with a higher power. “The lyrics to songs are more readily remembered than spoken language, and the feelings aroused from the associations to the music are a vital element of group experiences” (Kirkland and McIlveen, 1999, p.13). Music therapy for strengthening spirituality can be important to residents of LTC facilities.

Other spiritual care interventions for older adults increase socialization through activities. One such activity is therapeutic gardening (Carmen, 2006). Therapeutic gardening focuses on connecting the gardener to nature as the ‘natural world’ nourishes the soul (Carmen, 2006). Additionally, attending church services increases opportunities to socialize with others of the same beliefs and it supports an individual’s personal spirit (Ai & MacKenzie, 2006; Bergland & Kirkevold, 2006). Religious socialization which
occurred through attendance at church services was also found to be important to older adults.

From the literature, various spiritual interventions have been studied on behalf of the patients and the nurses. This study sought to determine if any of the previously mentioned interventions were utilized by the older adults in this northern plains state during the time of relocation to a long term care facility, and what other spiritual interventions were used by them. The aforementioned interventions were studied with long term residents who had all been ensconced in various long term care facilities.

**Ethical Importance of Provision of Spiritual Care**

An implication for spiritual care relates to the ethics of spiritual care delivery. Spirituality continues to be located at the center of nursing care of human beings, into the twenty-first century. Treolar (2001) calls for nurses to be actively engaged in provision of ethically obligated spiritual care to patients and their families, to promote health and relieve suffering. What are the ethical principles upon which care of a person’s spirit is based? Wright (1996) focused on ethical obligations in the provision of spiritual care. She cited the ethical principles of beneficence, non-malificence, autonomy and advocacy as central to spiritual care. Furthermore, respect, autonomy and advocacy were cited by Lantz (2007) as important principles for spiritual care.

Nurses must have the ability to respect religious choice and a client’s use or neglect of their spiritual attributes. Guido (2001) states “respect for others...transcends cultural differences, gender issues, religious differences, and racial concerns” (p.56). Cameron explores respect for human rights in two views: 1) as inclusive of religion; and 2) as a component of spirituality to be valued ethically (2003).
Lantz's (2007) second ethical principle of spirituality is autonomy. When viewing spiritual care through this lens, the nurse must assess the patient's desires for spiritual care, and meet the needs of the patient (Wright, 1998).

A third ethical principle underpinning spirituality is advocacy (Lantz, 2007). The nurse must become an advocate for patients' spiritual needs. Butts and Rich (2005) frame advocacy as "the nurse's moving from the patient to the healthcare system, rather than from the nurse's values to the patient" (p. 42). When delivering spiritual care it is essential nurses gather assessments and move from the patients' spiritual needs to advocate for patients in the healthcare system.

Standards of Practice for Spiritual Care

The role of spiritual care in nursing practice has many implications. Accreditation agencies call for nurse educators and practicing nurses to address spiritual care and support their client's spirituality. Nursing licensure exams call for knowledge in spiritual care to be taught to student nurses. The National Council of State Boards of Nursing (NCSBN) is responsible for re-designing the national test plans for nurses. According to the website, the test plan states "Students must be knowledgeable of religious or spiritual influences on health" (NCSBN, 2005, p.2). Similarly, the American Association of Colleges of Nursing (AACN) sets a standard for nursing education to prepare the students to identify spiritual distress and provide spiritual care (AACN, 1998).

Finally, a standard of practice is upheld by the nation's largest hospital accrediting agency for professional nurses to provide spiritual care through diverse services (LaPierre, 2003). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states "patients have a fundamental right to considerate care...that respects their cultural,
psychosocial and spiritual values” (LaPierre, 2003, p.219). JCAHO enforces the standard by requiring every patient be assessed for spiritual needs upon admission and the resultant spiritual care interventions be provided by a team of spiritual caregivers.

**Older Adults and Faith Formation**

Many Americans seek to understand the aging process and many turn to faith beliefs to strengthen and uphold them, in the latter days of their lives. Yet oftentimes, questions remain about understanding faith and spirituality of the elderly: What are the theories of faith formation, and how do they impact the elderly?

One of the best known theories for faith formation is that published in 1981, entitled “Stages of Faith” (Fowler, 1981). The theory was tested and found to be usable and applicable for many different religions around the world (Nahavandi, 1999). Fowler identified six stages of faith development that are based on age groups and cognitive developmental stages. Fowler proposes that faith is deeper and different than religion (1981, p.9). Fowler explains six stages of faith as a “coming through” of interactions to the next stage (1981). Growth in faith occurs as a person faces challenges in life, with their problems and difficulties.

Another student of faith development, Koenig (1994) arrived at a theory of religious faith development which is centered upon Judeo-Christian religions, entitled “Stages of Religious Faith Development”. It too, has stages of development that are linked to physical age, as does Fowler’s theory. Koenig condensed the number of stages to five, and includes birth to infancy as the first stage. Koenig also felt a person needs to have active factors that stimulate persons to move from one stage to another, just as Fowler claimed.
Koenig based his theory on the nature of man as a bio-psycho-social–spiritual being, who is apart from God and the supernatural. His diagram is typical of those authors in the descriptions of overlapping circles that make up man’s dimensions, yet it is different from others in that God connects to man through faith and grace (Koenig, 1994, pp. 106-107).

Both authors, Fowler and Koenig, state that older adults may or may not reach the higher levels of the faith stages dependent on individual development which stems from one’s life experiences. Some people may be stopped at the middle levels of the stages, while others may reach the highest levels of faith. Both authors’ higher levels are similar to the concept of self-actualization for their spiritual lives, in that the elderly person ‘shares’ their faith ideals with others, so faith can be perpetuated in this world.

**Spirituality, Religiosity and the Older Adult**

In 1995, Seymour studied spirituality combined with physical and psycho-social deficits in aging. Seymour found that as people age, and acquire more deficits as in the physical and psycho-social dimension which limits their religious practices, the subjects reported their personal spirituality deepens (Seymour, 1995).

Church membership was studied by Roen in 1997. Roen (1997) found “73% of women and 63% of men over age 50 stated they belonged to a church” (p.356). In the same study, some subjects indicated they may not attend regularly, but they were members.

Rural older adults of three ethnicities, (whites, African Americans and Native Americans) were studied for reports of well-being which was correlated with levels of religiousness and spirituality (Yoon and Lee, 2004). The findings reveal ethnic differences
in reliance on spirituality, with a significant association between religiousness and well-being. Being religious supported the over-all well-being of participants.

Ross studied older hospitalized adult patients to understand their needs for religion, meaning, love and belonging, morality, and death and dying (1996). She found the patients would have benefited spiritually, if they had been provided information, transported to hospital church services and had access to a quiet room for prayer/reflection time. The patients were not told of nor provided these spiritual supports when hospitalized (Ross, 1996).

From the literature, it can be seen that older adults rely on and strengthen their spirituality, (spiritual beliefs and practices) at the same time as they lose physical abilities and suffer other life losses. Church attendance and religiousness supports their spirits. While hospitalized, older adult patients would have attended to their religious practices and ceremonies if they had been told of the spiritual supports available in the hospital building. With this in mind, no studies have been enacted which identify spiritual beliefs and practices during the time of relocation to a skilled nursing facility. Other health care settings were studied, and older adults were studied, yet no studies revealed the older adults' experiences from a spiritual perspective, when they relocated into LTC settings.

*Dilemmas in Provision of Spiritual Care*

There are three major dilemmas cited in the literature, surrounding the provision of spiritual care. First and foremost, are the many different definitions of spirituality. A second dilemma cited in the literature relates to the teaching of spiritual care to novice nurses compounded with how nurses meet spiritual needs. The third dilemma regards the
various types of spiritual assessment tools and difficulties of conducting spiritual assessments.

The definition of spirituality lacks clarity, which creates difficulties when one tries to conceptualize the spirit as a unique domain or element of a person’s health (Mowat, 2004, p.46). McSherry and Ross (2002) agree the term spirituality does not have a unifying and succinct definition. From difficulties with the discrepancies among definitions, arise problems in the provision of spiritual care. One must have a clear concept of spirituality and obtain that concept from the patient, in order to care for and nurture their spirit.

McEwan writes of difficulties encountered in the British health system, when nurses provided spiritual care for older adults (2004). McEwan cites the following as problems which need to be overcome to fully meet the needs of British elders: nursing programs must teach religious pluralism so students will meet patients needs; nursing students need to know and understand their personal faith views before ministering to others; nurses should set serenity as the goal for patient care so the healing responses can be mobilized; nurses must accept the client’s inner soul when providing care; and nurses must choose to offer therapeutic use of self, particularly in the realm of spirituality (McEwan, 2004). The researchers revealed spiritual care must be taught to student nurses, and practiced by professionals in the nursing field.

Dilemmas in spiritual assessment techniques were examined by McSherry and Ross in 2002. The authors reviewed professional literature to elucidate difficulties in spiritual assessment. Dilemmas cited included: 1) a lack of consensus surrounding the definitions of spirituality, 2) nurses had varying motives for undertaking or not undertaking a spiritual
assessment, 3) timing of spiritual assessments was unclear, 4) the use of direct questioning techniques versus observation techniques for spiritual assessments created variations in findings, 5) it is unclear just who the proper personnel to conduct a spiritual assessment should be: nursing or clergy/chaplain staff? and 6) ethical concerns regarding spiritual assessment abound.

Given the difficulties cited in the literature and the fact that nursing is becoming more and more involved in the provision of spiritual care, it is important to understand the problematic areas that have been researched. It is acknowledged that spiritual care is different than physical care of a person, and the evidence base for provision of spiritual care is still fairly new and under-developed. Nurses must work to recognize and attempt to overcome the dilemmas in spiritual care. This study sought to investigate perceptions of older adults and how spiritual care was or was not provided to them, as they enter a long term care facility.

Theoretical Underpinnings

The theoretical underpinning for this study was Symbolic Interactionism (Blumer, 1998). Blumer created the concept of Symbolic Interactionism to study human group life and conduct. There are three premises upon which symbolic interactionism is built: 1) humans act toward things based on the meanings the things have for them, 2) meanings develop from social interactions that humans have, and 3) meanings are adapted via interpretive processes when people meet up with the things they encounter (Blumer, 1998).

To organize the theory of symbolic interactionsim, Blumer identified seven root images, or basic ideas: “1) nature of human society or human group life, 2) nature of social interaction, 3) social interaction, 4) objects, 5) human being as an actor, 6) human action
and 7) interconnection of the lines of action” (Blumer, 1998, p.6.) Descriptions for the root images follow.

The first root image, the nature of human society or human group life is one of beings who are active and in action. Humans are constantly in action with other humans, and they deal with events they are faced with. Human beings may act and/or react from a range of a single standpoint, to that of a collective standpoint. “Human society exists in action and must be seen in terms of action” (Blumer, 1998, p.6). Thus humans and the microcosm of society present in a specific nursing home environment are in constant interaction with each other. A nursing home exists to care for humans and the care is action that exists continually.

The nature of social interaction is understood when Blumer (1998) states “a society consists of individuals interacting with one another” (p.7). Social interaction occurs between the actors or humans in society, and not between factors given to them. Through the process of social interaction develops an outcome or formation of human conduct. Social interaction in this sense, is more than merely a method to release human conduct. A society is made of people in association with one another; it does not consist of people living in isolation from one another. Today’s LTCFs consist of sub-cultures within American society that have their own systems of interaction.

It is known that isolation supports dysfunctional emotional states, such as depression and prolonged psychosis. Persons who relocate into long term care facilities are at risk of isolation if they do not effectively adjust to the new situation; social interaction is desired when one lives in a nursing facility.
The nature of objects defines what an object is, and then they are categorized. An object is “anything that can be indicated, pointed to, or referred to” (Blumer, 1998, p.10). There are three categories of objects: 1) physical objects such as tables and chairs, 2) social objects such as postal workers, fathers, students, and 3) abstract objects such as ethical principles, doctrines, or values. The nature of any object is touted as “consisting of the meaning for the person for whom it is an object” (Blumer, 1998, p.11). The meanings of the objects are socially created, taught and carried to the members of societies; meanings of objects are a social construct. Additionally, the meanings may be cast off or re-created as society changes. Some meanings for objects may be in a continual state of flux. Meanings are rarely static. One such meaning created by society may be that relocating to a nursing home is a negative process. This in turn may support the creation of relocation stress.

The human being as an actor is another root image for Blumer’s theory. Blumer postulated that human beings can act out three different roles: 1) one role includes that of the self, 2) a second role is within organized groups, and 3) the third role is within an abstract community. When acting in different roles, human beings may see themselves as others see them because they are able to bring that awareness into the self and interpret its meaning (known as feedback). In this study I expected participants to relate how they see themselves from the viewpoint of their spiritual dimension and how this perception may have changed because of their presence in the new community and feedback from this setting.

The nature of human action is defined as “the capacity of the human being to make indications to himself” (Blumer, 1998, p 15). Human action occurs when humans confront their world, interpret the messages, and construct actions which they eventually carry out.
The critical piece to support symbolic interactionism occurs when the human interacts with himself to observe, analyze and interpret the messages. Humans interact within themselves, and do not merely just respond to events taking place in their environment. The actions taken are based on wishes and wants, goals, anticipated actions of self and others, self-image, assessed assets and possible outcomes of the actions. Many facets, both positive and negative, are reflected upon, prior to taking human action. This study will endeavor to investigate humans of older age and their accumulations of life’s actions and interactions, to understand what helps or hinders their adjustment when relocated to long term care facilities, specifically in their spiritual domain.

The final root image is the interlinkage of action. “Human group life consists of and exists within, the fitting of lines of action to each other by the members of the group” (Blumer, 1998, p.17). When lines of action are taken, it is considered a society’s joint action. Joint actions may be seen as collective activities; examples are noted in such topics as marriages or church services. Joint actions are created when individuals take actions with interlinkages. Acts taken by societies help to establish and create meanings within the given society. Today’s American society does not value the aging process while it reveres youthfulness. In fact, American society advocates the building of assisted living and skilled facilities, to place the aged in, under the guise of providing health care services, as opposed to incorporating them into family units. Our society has turned away from family units and taking care of their own older adults; instead society builds nursing facilities which created many more interlinkages among human actions. There are underlying thoughts for interlinkages: 1) interlinkages of actions may be repetitive and/or stable, 2) interlinkages connect activities that make up much of group life, and 3) whether the joint
actions are old or new activities they sprout from the prior societal members' actions (Blumer, 1998).

To conclude discussion about root images specific to symbolic interactionism, Blumer developed a theory of how people engage in societal living (1998). The society is active, and its members constantly interact with themselves and one another, thus, both are dynamic. The meanings of their actions are deliberate, interpreted and influenced by interactions with each other. "Objects, including the object of one’s self, are formed, sustained, weakened and transformed by interaction with one another" (Blumer, 1998, p.21). People live in various types of groups with various meanings, and they are ever changing. When trying to understand objects’ meanings, the activities of the collectivity must be interpreted. This interpretation is affected by intra-, inter- and extra-personal processes.

Gaps in the Literature

Upon review of the literature, there are several gaps in the search for scientific truth concerning the topics of spirituality and spiritual care during the relocation period of older adults to skilled nursing facilities which affects the delivery of care: 1) there is a lack of consensus surrounding the definitions and a unifying theoretical underpinning of spirituality, 2) there are no studies of the processes used by older adults regarding their spirituality during the time of relocation and 3) more pointedly, while there are studies for various spiritual interventions for older adults living in LTC settings, there is a dearth of studies on the uses of spirituality to cope with stressors when a person moves from home into an LTC setting.
The gaps identified above, are consistent with McEwen’s’ meta-analysis of review of spiritual dimensions (2005). She states that nursing research of spiritual issues “was sparse prior to the 1990s” and those studies addressed the topics of “frequency and characteristics of spiritual care, nursing education for spiritual care, description of spiritual needs within specific cohort groups (like hospice and cancer patients)” (McEwan, 2005, p.165) and also included research for discrete concepts.

In a discussion about barriers which separate spirituality and nursing care, a “lack of theoretical paradigms to capture the concepts of spirituality” combined with “a paucity of language to describe the spiritual aspect of human experience” are attributed to the problems in advancing spiritual care (Maher, 2006, p.423). There are too many definitions and theoretical underpinnings that are proposed in the literature, without agreement on the basic premises for spirituality in humans. “The concept of spirituality exists, but a consensus about its parameters does not” (MacLaren, 2003, p.461).

For the older adult population, research has not been carried out to determine to what extent spirituality is used, or if it is used at all, to buffer or alleviate life’s stressors. More specifically, research into relocation stress syndrome has been called for, specific to the older adult. Mallick & Whipple (2000) call for more research to assess variables to continue validation of characteristics of relocation stress syndrome. Other researchers call for studies into relocation stress syndrome, suggesting studies which would reveal subtle dimensions of the relocation process for older people (Oswald & Rowles, 2006).

Therefore, given the gaps in literature and research, it is imperative this qualitative study was conducted to examine the processes used by older adults as they transition into skilled nursing facilities, specific to their spirituality and spiritual needs. Symbolic
interactionism theory became the backdrop against which this study is framed. It will help to understand the rich and in-depth findings of humans who interact with each other and with their new environment found in the LTC settings.

To fully nurture the human spirit and provide holistic care, this topic must be studied. From the understandings that arise, knowledge of the older adults' spiritual needs will be disseminated to those who care for the elderly. Additionally, this research will add to the knowledge base through publications to support the education of nurses and other health care providers of older adults. Nursing care standards and best practices could be built and organized, to ease stressful situations for older adults during relocation times and enhance delivery of holistic care. The findings will support educational processes about spiritual needs of residents and families during relocation, assisting them with meeting identified spiritual needs. When the resident, the family and the caregivers work towards the best possible outcomes of relocation, spiritual needs will be met and perhaps the potential of relocation stress syndrome will be reduced or adjustment needs of relocation stress will be met.
CHAPTER III

RESEARCH METHODS

The purpose of this qualitative grounded theory study was to develop a theoretical model that describes the influence of spirituality (including spiritual practices and beliefs) within older adults during the first six months of relocation to a long term care facility. During the exploration of the current adjustment process aspects of previous spirituality (prior to the time of relocation) will be examined for alterations in process. This chapter will explain the research design, study population and sample, sampling procedures, instrumentation, data collection procedures, data analysis, validity and limitations of the research study.

Research Design

The design of a research study must be carefully considered and developed to find answers to research questions. It was important to choose a methodology that will allow the researcher to arrive at credible answers that fulfilled the research’s purpose. To find the answers to research questions, studies are created and conducted. This is known as developing scientific knowledge (Kazdin, 2003).

There are four key characteristics of scientific knowledge: 1) it is based on parsimony, 2) results are interpreted on the basis of plausible rival hypotheses, 3) replication of procedures is central to the research, and 4) the research is conducted with caution and precision in thinking (Kazdin, 2003). This particular qualitative study, focused
upon the relocation process of geriatric residents in a long term care facility is conducted using a grounded theory design. It strives to meet the aforementioned qualities to discover and explore outcomes which will add to understandings of the relocation process experienced by older adults, the role of spirituality in this process, and transitional needs of older adults.

There are six important characteristics of qualitative research. First, there is a belief in multiple realities which result in broad panoramic views of the phenomena under study (Creswell, 2003; Speziale & Carpenter, 2007). A second quality is the choice and selection of one or more multiple strategies of inquiry to assist in development of meanings specific to the phenomena being studied (Creswell, 2003; Speziale & Carpenter, 2007). A third characteristic is the ability to focus the study on its participants, while the researcher is involved with them in a humanistic manner when data is collected so they might build relationships and rapport which adds depth to understandings since they are placed in context (Creswell, 2003; Speziale & Carpenter, 2007). Fourthly, the research is conducted in the natural setting of the participants; this particular study will be conducted in the nursing home where the residents live (Creswell, 2003; Speziale & Carpenter, 2007). A fifth characteristic occurs when the researcher becomes part of the process, (emic) instead of an outsider (etic) to the process; in other words the researcher acknowledges participation in the study and awareness of how self influences the process (Creswell, 2003; Speziale & Carpenter, 2007). The final characteristic in qualitative research is found in the literary style which reveals data that is reported in a rich manner, replete with participant commentary (Creswell, 2003; Speziale & Carpenter, 2007). This study focused upon older adults living in a long term care facility, to discover and explore their
spirituality during the period of relocation (up to six months from time of admission) to the facility. This study will be conducted in grounded theory methodology, so the researcher can be part of the discovery process of the human actions and interactions regarding the role of spirituality during relocation.

Grounded theory is a type of inquiry specific to qualitative research; it is a research approach utilized to examine social processes that exist within human interactions (Speziale & Carpenter, 2007; Strauss & Corbin, 1998). This study will discover the interaction between older adults and their spirituality while they experience the process of relocation to a LTC setting, inclusive of the changes and adjustments they make. Grounded theory is a unique methodology that "makes important contributions to nursing's development of a substantive body of knowledge, primarily because of its ability to develop middle-range theory, which can be tested empirically" (Speziale & Carpenter, 2007, p.134). Additionally, significant proponents of grounded theory support its use as a systematic method to gather and analyze data to derive theories and models; the method of inquiry is one in which the theory emerges from the data and preconceived ideas are not used as the structure for interpretation of data (Strauss & Corbin, 1998). Memos used within the research process help separate bias (preconceived ideas) from collected data and keep outcomes closely connected to data.

It is appropriate that the research study of relocation and spiritual aspects is designed as a qualitative, grounded theory study because of the topic and subjects to be studied. The topic focuses on the social processes of change through adjusting to life in a long term care facility, specifically targeted at understanding the participants' spiritual domain. The participants are older adults that are admitted to a long term care facility.
Participants were those who had been recently admitted to the facility within the previous six months from time of interview. The subject of study and proposed research questions can be answered best through grounded theory methodology since it will focus on the “hows” and “whats” of this process. Theory to address this time of life is absent in the literature, and it needs to be developed. With the ever-increasing size of the aging American population, more and more people will undergo admission into a long term care facility during their lifespan. The more that is known about the use of human spirituality, specific to the relocation period, the more effectively caregivers can holistically support the older adults during this transition time.

Population and Sample

The population of this study was located in a not-for-profit, religiously affiliated, long term care facility situated in a northern plains state. The population represents older adults, who have lived in the surrounding eight county region where the LTC facility is located. Residents were predominantly rural northern plains people, Caucasian, and of European descent. Persons age 65 and older made up the population. There are a total of 172 beds in the facility, which is typically occupied at 100%.

The study sample includes people age 65 and older, who were either newly admitted to the facility or had been admitted within a six month period prior to commencement of data collection. People interviewed scored a minimum of 23 points on the Mini-Mental State Exam (MMSE), indicative of normal cognitive status (Folstein, Folstein & McHugh, 1975). If it was determined during the interview process that the MMSE is no longer at a level of 23, the interview was not completed. The plan was for total of 20 to 30 residents were to have been interviewed. Twenty-two people were
invited to participate in the study by the Spiritual Care Director, but 5 declined to participate in the study. Data collection ended after 20 interviews, because the point of data saturation was past; no new information was being presented and validation of understandings and potential models by participants was present.

Sampling Procedures

Purposive, theoretical sampling is the process used as the sampling procedure because it is specific to grounded theory methodology (Speziale & Capreenter, 2007). It “is important when exploring new or uncharted areas because it enables the researcher to choose those avenues of sampling that can bring about the greatest theoretical return” (Strauss & Corbin, 1998, p.202). Participants were selected based on their recent experiences with the social process of living a relocation event when they moved into the long term care facility. New participants continued to be invited to partake in the study, until the saturation point was met. The plan was not to exceed 30 participants.

Specifically, either the facility’s Spiritual Care Director, the Associate Chaplain or the Social Worker met with newly admitted residents and informed them of the study. He or she reviewed the medical record for each potential participant’s MMSE score, and only those who score between 23 to 30 points were invited to participate in the study. Based on their interest level, the screener forwarded the names of residents who met selection criteria, to the researcher. From that point, the researcher contacted each resident individually and arranged for a mutually convenient meeting time at the facility. All participants who agreed to be interviewed began the interview and completed it.

The criteria for participation in the study were: 1) the person must reside in the long term care facility, 2) the person must be age 65 or older, 3) the person must have entered
the LTC facility within 1 to 6 months of participating in the study, 4) the person must be able to communicate verbally and in English, and 5) the person must score between 23 and 30 points on the MMSE.

The resident’s Power of Attorney, (POA) if identified, was notified of the residents’ potential invitation to participate in the study. The POA was given five days to have questions answered by the researcher and to discuss the consent for study participation with the resident. If no feedback is forthcoming to the researcher, the resident will be approached to participate in the study. Residents will have consent forms to review or have read to them, before beginning the interview. Participation in the interview will be their informed consent. See Appendix A for the Consent Form. See Appendix B for the Notification of Invitation to Participate in a Nursing Research Study, which was mailed to the POAs.

The research study was approved through the University of North Dakota Institutional Review Board. To safeguard the resident’s medical information, only the facility staff, specifically the Spiritual Care Director, the Associate Chaplain, or the Social Worker accessed the medical records and reviewed MMSE results. The researcher did not keep a log of MMSE results. The MMSE results were merely used to pre-screen for selection of study participants.

Upon agreements from the participant and the lack of dissension from their Power of Attorney (if identified) the researcher arranged a mutually acceptable time for the interview, in a private meeting room at the facility. The interviews were conducted at the specified time, for approximately 60-90 minutes. If the resident needed to reschedule the time, or wished to stop the interview and complete it at another date or time, the researcher
accommodated the request. If a resident chose to withdraw from the study, the researcher will respect the decision and stop the interview at that point in time. If a resident became distressed due to the interview the researcher ended the interview.

Instrumentation

The study used a semi-structured interview guide. The interview was based on the guide and was conducted by one researcher only, who has completed her doctoral coursework. The researcher hired an approved, trained and experienced medical transcriptionist, who transcribed the interviews once they were completed.

*Spirituality and Relocation Interview Guide*

The interview guide was developed by the researcher after review of literature and identification of study purposes and goals. The interview guide was critiqued through consultations with two experienced nurse researchers: Dr. Eleanor Yurkovich and Dr. Evelyn Labun reviewed and assisted with revisions. However, as in all grounded theory studies, this guide evolved with the research process. It was determined that this was necessary to gather a thorough understanding. See Appendix C for the Semi-Structured Interview Guide.

The first seven questions were demographic in nature. They captured the following aspects of each participant: name, age, marital status, educational level, occupation, religious background and circumstances which led to moving into the facility. Obtaining the aforementioned responses allowed for maximum variation in the sample population. The latter 8 questions and their sub-topic questions of the interview guide were descriptive and were crafted to explore the meanings and practices of spirituality before and after relocation, alterations in spirituality since the relocation (adjustments made), barriers to
spirituality since relocation, suggestions for staff to improve spiritual care, and impressions of family and friends regarding the resident's spirituality. The questions are congruent with the research questions. The interview guide is a guideline. It was used to channel discussions and the guide provided the researcher with an organized approach to data collection. The interview guide tool began with questions that asked for simple information which supported a feeling of comfort with the researcher; questions then moved to ones that expected the person to reflect on self, personal spiritual beliefs, and spiritual practices.

The interview guide was pilot tested by two participants at the long term care facility. Testing the set of questions to be used during the interview session was important to establish content validity of the instrument (Creswell, 2003). Additionally, the pilot test was useful to refine questions and further organized the items' format (Creswell, 2003). A question was included for the pilot test participants to inquire about the interview guide's level of difficulty and relevance to their age group. The feedback and suggestions given to the researcher about the interview guide were used to revise the instrument. By testing the set of questions, the researcher followed a scientific process for tool development.

Data Collection Procedures

The MMSE, located in the medical record, is a part of the screening protocol used by the Director of Spiritual Care or the Associate Chaplain, and the Social Worker at LTC facilities. The MMSE is routinely completed by the Licensed Social Workers at the facility, and recorded in the residents' medical charts upon admission and every 30 days. It may be reassessed should a change in cognitive status be noticed by facility staff.

The researcher had the contact person share a copy of the questions with the older adult when seeking their participation. After consent was given, the researcher and
participant met at the nursing home, where a private meeting room or the resident's single room, was designated as the interview site. The more general, demographic type questions were discussed first, after which the open-ended interview questions were asked of the participant. The interview guide was used to confirm if all needed information had been obtained.

The interview process should be conversational in style and the researcher will follow the speed and tone set by the participants (Creswell, 1998). During the interview, the researcher took notes based on observations of the participant as they responded to the questions asked. It is important in grounded theory methodology to observe all that occurred during the interview, since it supports description of the context in which the conversation evolved (Creswell, 1998).

When conducting the interview, an audio-tape recorder was used to record all aspects of the interview with the agreement of the participant. This allowed the researcher and the hired transcriptionist to play back information for transcription purposes and later during the analysis phase of the research, thus supporting accuracy of findings and interpretations. A written record from notes could unintentionally leave out important details. The researcher and her dissertation advisor reviewed the tapes, summarized the communication as necessary and expanded understandings when needed. The hired transcriptionist transcribed the audio-tapes into a word processing program. The interviews were not time limited. They were between 60-90 minutes in length and they were conducted until the questions became answered and participants felt they said all they wished to say or contributed. The researcher focused on the questions that make up the interview guide and made summative statements to validate and clarify understandings
while being careful to avoid offering personal viewpoints, questions or advice. The aforementioned tactics support quality in interview techniques (Creswell, 1998).

Protection of Human Subjects and Treatment of Data

It is important to protect the privacy of human subjects and subsequent data that is collected. There are several methods that were implemented to do so, in this study. The first was through coding of the transcribed materials. The second was through methods used to transcribe and store/destroy the data. The third was through reporting methods.

The consent form was given to the resident of the LTC facility and a notification of study participation form was given to their Power of Attorney (if identified). Lack of dissension from the POA, within 5 days of notification, was the point in time which the resident was asked to consent to participate in the study. The resident's participation in the interview was their consent. The resident names and a master list for the transcribed materials was coded by the researcher, with the key to the coded list kept in a locked file cabinet, separate from the reported data. This list was kept in the event that a second interview was necessary. Neither the residents' nor their Power of Attorneys' names, were used when reporting results. All results were reported in an aggregate with quotes not supporting identification of the participant. This process was to protect their identity, supported assurance that staff can not identify comments and assisted in openness of responses.

The data was collected in three forms: hand written notes and memos by the researcher, word-processed data which will be developed by the transcriptionist, and audio-tapes to be made of the interview sessions. The written notes and memos did not have any identifiable names on them, but were coded according to the codes set by the researcher to
match the transcribed data (with the code key in a locked file, separate from the data) and the date of the interview. The researcher kept all written notes and memos in her possession, in a locked file cabinet. Only the researcher and her advisor have access to the notes and memos for data analysis purposes. The word-processed data was coded, without identifiable names. The hired transcriptionist was educated about confidentiality expected in completing this work by the researcher and through IRB training conducted at the University of North Dakota. For example, names were not used nor were they available to the transcriptionist, taped interviews were not be discussed outside of the work and meetings with the researcher, tapes and materials were secured in a locked file when not being transcribed. The computer files were kept on a flash drive, and turned over to the researcher when the work was completed. Tapes that were to be transcribed were kept in a locked file cabinet in the researcher’s office, and were not be available to anyone but the transcriptionist, the researcher and her advisor. The tapes will be erased at least 3 years after completion of data analysis. Written materials will be kept for 5 years after the completion of the study and destroyed through shredding by the researcher. Names are not be recorded on transcribed materials. Written materials were coded with a number, alphabetical code and the date of the interview.

When data was reported after study completion, names were not used. Fictitious names were used to report findings if necessary. Neither residents nor their Power of Attorney were identifiable. Geographical location of the participants’ prior living arrangements were reported as general in nature. Upon completion of the dissertation, information was presented in grouped data reports.
Data Analysis

The goal of grounded theory is to discover a core variable and illuminate the main themes, characteristics and properties of the social experiences the participants encounter (Speziale & Carpenter, 2007). The core variable becomes the foundational concept to develop a new theory or model.

There are six major characteristics specific to core variables: 1) it recurs frequently in the data, 2) it links various data, 3) it is central and explains much of the variation in the data, 4) it has implications for more general or formal theory, 5) as it becomes more detailed, the theory moves forward and 6) it supports maximum variation when looking for similarities and differences (Speziale & Carpenter, 2007, p.144). This study follows the methodology described by Strauss & Corbin, 1998.

In this particular research study, data was collected, coded and analyzed from the beginning to end of the study using constant comparative analysis. This type of analysis is a circular chain of thought, ever circling and building core variables with their properties and characteristics, which leads to theory development. The word processing program, Microsoft Word, was used to organize data, categorize and build theory.

After data was gathered, it was coded in three ways: open, axial and selective coding. The purposes of coding procedures are “to build rather than test theory, to provide researchers with analytic tools for handling raw data, to help analysts to consider alternative meanings, to be systematic and creative simultaneously, and finally, to identify, develop and relate the concepts that are the building blocks of theory” (Strauss & Corbin, 1998, p.13).
Open coding was the first look at the data when the analytic process identifies concepts and their properties, otherwise known as dimensions (Strauss & Corbin, 1998). During this type of coding, the data was conceptualized or abstracted into smaller pieces. The smaller pieces may include incidents, ideas, events and acts (Strauss & Corbin, 1998). Memos were made by the researcher to record thoughts, impressions, questions and directions for on-going data collection (Strauss & Corbin, 1998). Upon completion of open coding and memoing, the researcher has named categories and subcategories in Microsoft Word.

The next step in data analysis was axial coding. In this step, categories were related to subcategories, around the central axis of a category (Strauss & Corbin, 1998). Categories were linked for their various similar properties. After linking the categories, the researcher looked for cues in the data about the relationships among the categories. The goal of axial coding was to find explanations and gain understandings of phenomena (Strauss & Corbin, 1998). In this step, conditions are labeled as antecedents, causal or intervening conditions. Consequences may also be identified.

The third type of coding completed was selective coding. This is a process of integrating and refining the theory (Strauss & Corbin, 1998). During the integration section of selective coding, the researcher organized categories around a central concept. This does not occur quickly, but over time, as the analyst becomes immersed in data and core variables. Storylines, diagrams, sorting and reviewing of memos were used to arrive at the final integrated theoretical scheme or model (Strauss & Corbin, 1998). At this point the theory was trimmed of excess and underdeveloped categories are more completely developed. Once the saturation point was met, the researcher rested in the development of
the new theory. Oftentimes the theory is depicted in a visual manner such as a flow chart or schematic drawing or diagram, accompanied by detailed written explanations.

Validity

It was important to safeguard qualitative research by promoting validity of the findings. Validity in research processes is defined as “the degree to which an instrument measures what it was designed to measure” (Speziale & Carpenter, 2007, p. 460). There are several ways that validity may be supported: specific methods during data collection, member checking and having a second researcher review the data and verify categories (Speziale & Carpenter, 2007).

During data collection, validity has been safeguarded by planning key interview questions in advance, interviews were open and discussion-like, interpretations were verified with the interviewees through questioning and allowance of additions and corrections to the answers given. Additionally, a journal and memos were kept by the researcher for awareness of the researcher’s views, after each interview was conducted. All interviews were audio-tape recorded for accuracy. These methods to ensure validity were espoused by Speziale and Carpenter in their qualitative research text (2007). During interviews, summative statements to check understandings and clarify questions were asked.

The audit trail was meticulously adhered to by the researcher when she worked with her advisor to review the interview data, transcripts and theoretical findings in a constant comparative manner. Ideas were read, discussed and shared, as the findings unfolded and emerged from the data. Many meetings were held between the researcher and her advisor, to keep the analytical process true to the data. Memos and the journal writings were
reviewed by the advisor, who is a nurse researcher very knowledgeable in the direction and building of grounded theory. Written notes of meetings were taken and stored by the researcher in a locked box in her office.

As the study continued, member checking occurred with selected participants. Changes were made to reflect the members’ input as the study continued. In the end, the final description was reviewed by selected key informants that demonstrated in depth knowledge on the topic and personal insights. Member checking is an effective way to "validate that the interpretation of the interview or observation is authentic and true" (Speziale & Carpenter, 2007, p.69).

A final method to promote validity of the research was the use of nurse researchers who have conducted successful grounded theory research to review the data and development of categories, as the process unfolded. The nurse researchers were Eleanor Yurkovich, RN, PhD and Evelyn Labun, RN, DNSc. The use of a second review by other researchers functioned as a validity check and keeps the researcher true to the data set and purpose (Speziale & Carpenter, 2007).

Specific to grounded theory investigations is the need to enhance rigor of the study. Researchers studied grounded theory methodological issues, and arrived at eight steps to support rigor of grounded theory: 1) allow the interviewees to guide the inquiry process, 2) check the theory against the participants’ understandings of meanings, 3) use the interviewees specific words when writing theory, 4) discuss the researcher’s views and insights about the concept, 5) specify the criteria for development of the researcher’s thought processes, 6) reveal how and why the sample was selected, 7) outline scope of research and 8) illustrate the linkages of literature to each emergent category if present
(Chiovitti & Piran, 2003). As can be seen in the aforementioned discussion, this study attempted to uphold the eight principles set forth by Chiovitti and Piran in 2003.

Limitations

A limitation in a research study is a feature of the study that may negatively impact the results of the particular study (Roberts, 2004). For this research, the focus was to gain the perspectives of the residents who lived in long term care facilities. Those who work at LTCFs have perspectives regarding this phenomenon, as do family members of the residents. They were intentionally not interviewed and it may be seen by others, as a limiting factor to the research. However, the study set out to investigate the perspectives of the older adults in this moment of time and that is what it did.

A second limitation of the study was found in the assumption that the older adults will provide an accurate picture of their spirituality. The study relied on their abilities and willingness to share and recall thoughts, feelings, actions and practices related to spirituality and relocation. It was limited by their abilities even though the researcher was careful to select those who were without cognitive impairment via use of the MMSE.

A final limitation was that of conducting the interviews during an emotionally charged time during relocation to the long term care facility. Given the stressors involved with changes of environment and life practices, the study was limited to the specified time frame because the experience was current to them. However, participants’ responses may have been affected due to their emotions and thoughts at the particular phase of adjustment; some residents may have adjusted quickly while others may have had a more difficult time moving through relocation transitions. It is the hope of this researcher that their sharing of their experiences from a spiritual perspective supported their transitions.
CHAPTER IV

DATA COLLECTION AND ANALYSIS

As stated in Chapter One, this qualitative study examined the spirituality of older adults during relocation. The purpose of the study was to develop a theoretical model that describes the influence of spirituality within older adults during the first six months of relocation to a long term care facility.

Chapter Four will begin by reporting the data collection and data analysis processes according to the Strauss and Corbin (1990) explication of grounded theory including qualitative research process and methodology. The second section of this chapter presents the findings based on the research questions posed in Chapter One. Participants’ demographics will also be presented, including 1) description of the LTC facilities they live in, 2) length of time since admission, 3) reason for admission, 4) gender and age, 5) education, 6) employment, 7) religious affiliations, 8) marital status, and 9) faith community leadership engagement activities. The third section will elucidate the axial model developed from the findings, which helped establish categories and interrelationships of themes. The fourth section will report findings pertinent to the axial model and structured around the research questions; it will be organized by themes and related properties using participant’s quotations and understandings in support of the themes.
Data Collection Processes

This section will present the data collection processes of this study. Specifically, the discussion will include the method of data collection, pilot testing of the interview guide and observations made by the researcher.

Privacy and Interruptions

Once participants were screened by the facility Social Worker or Spiritual Care Provider as specified by IRB procedures and they consented to participate in the study, the researcher met with them in a private location. Some participants were interviewed in their private room in the facility, while others who lived in semi-private rooms were interviewed in a family meeting room or conference room. Privacy was maintained in all but two interviews, when the process was interrupted by a caregiver who knocked on the door, and entered to provide medications or lab tests to the participants. In both cases, when interrupted, the interview was stopped temporarily, and the tape recorder was turned off briefly during the interruption. No significant changes to the tone of the interview occurred, as the participants were used to having their conversations interrupted for things such as medications and blood tests.

Pilot Test of Interview Guide

After the interview guide was reviewed by two qualitative researchers, the guide was pilot tested during the first three interviews. Upon completion of an interview, the researcher asked the following questions: 1) if the questions were understandable, 2) if the type of questions were pertinent to the topic being reviewed, and 3) if other questions should be added to the guide. All three participants reported satisfaction with the
Interview Guide itself, stating that it was understandable and seemed to cover the topic at hand. They did not identify other questions that were missed.

The researcher felt the question which asked the older adults to define the concept of spirituality versus the concept of religion, (Research Question #6) was a difficult one to answer. When participants focused on defining spirituality, they did not answer the second part of the question to define religion. Based on this, the researcher separated the question into two questions during future interviews so they only needed to focus on one topic at a time. This helped to gain a complete answer to the two-part question. No other changes were necessitated after the feedback was obtained during the first three interviews. This process supported the validity of the Interview Guide used by the researcher.

**Length of Interviews**

The interviews conducted between the researcher and the participant varied in length of time; most of them lasted between 45 to 90 minutes. The length of the interview depended on the amount of time the participants took to think through their responses and explain their viewpoints. When necessary, the researcher probed further for interesting points and to uncover meanings hidden in the conversations. Almost all the residents reported the conversations were meaningful to them, and they enjoyed the interviews. Only one participant requested that the interview end quickly due to the fact that she did not feel well that day; her request was honored. This particular interview was not as rich in the details nor did it involve extensive answers to the questions. The interviews were conducted over ten months time, from May, 2008 through February, 2009.
Expansion of Facilities to Increase Participants in Study

During the first three months of the study at Facility A, it was discovered that the pool of subjects was dwindling. To await new admissions to that facility would lengthen the data collection time. Twelve participants were studied, at that point in time. To increase the number of possible participants, it was decided between the researcher and her advisor to include two more facilities in the study. The IRB approval was obtained, as well as permission from the Directors of Nursing and facility Administrators in two more facilities. The same screening procedures were enacted as previously discussed in Chapter Three by each facility’s Social Workers. Participants were added to the study, and data collection continued.

Storing Taped Data

Once an interview was completed, the audio-taped recording was labeled with a code developed by the researcher and maintained in a personal book. The audio-recording was sent to the transcriptionist, who typed the conversation into written form through a word processing program. The written transcripts were delivered to the researcher. The audio tapes and the written records are kept in a locked box by the researcher. The University of North Dakota’s IRB confidentiality standards were upheld, as stated on the IRB forms. All participant names and identifying information have been removed from the records.

Data Analysis Processes

Data analysis methods followed the manner for grounded theory to develop “a substantive theory that meets the criteria for doing ‘good’ science: significance, theory-observation compatibility, generalizability, reproducibility, precision, rigor, and
verification" (Strauss and Corbin, 1990, p.31). When the procedures are followed as outlined by the developers of this research technique, solid research results will be produced.

Data analysis will reveal the following Strauss and Corbin (1990) techniques: writing memos, writing code notes, writing theoretical notes, writing operational notes, using constant comparative methods, and the development of an Axial model and a theoretical model. Logic diagrams were also used to further understand the relationships between categories and sub-categories.

**Memo Writing**

Memos were written immediately after each interview for the researcher to record her impressions, thoughts and ideas that occurred about what transpired during the interview period. Each memo was labeled and dated with a code to identify the participant. The memos were useful when analyzing the transcripts, to gain a more complete picture of the interview. It was useful for recalling details about the participants that were not included in the written transcript.

**Code Notes**

Notes were written during the open coding procedures for the first few times the transcripts were read. Notes were written to indicate what was really being said in the conversation and topics were highlighted. The code notes processes occurred in the right hand margins on each of the typed transcripts. It assisted the researcher to sift through the data and point out pertinent discussion points. This process of open coding is likened to working on a puzzle: “You have to get organized; to sort the pieces by color, which sometimes includes noting minute differences in shading; so as later bit by bit to put the
pieces together” (Strauss and Corbin, 1990, p.204). Code notes became phrases and ideas, which were useful in the next stage of coding processes.

Examples of the code notes developed by the researcher were demographically driven such as age, high school education, marital status and religion. Other code notes revealed ideas and phrases shared by the participants during the interviews, such as a person’s admission to the hospital for a fall and then into nursing home, acknowledgement of God and belief in God during changes in health, discovery of blessings in illness which increased frequency of attending to spiritual needs, and the realization that different priests rotate masses in LTC chapel (this was surprising to the participant).

Theoretical Notes

Theoretical notes were written by the researcher during the stage of axial coding. In this stage, the researcher makes notes that pull the code notes together into themes and categories. Theoretical notes are made to “further explore the questions raised in the code notes... suggest strategies... or consequences of the use of the different strategies (Strauss and Corbin, 1990, p. 214). Theoretical notes appear in the margins of the transcripts as statements or questions with more detailed thought and analysis that gets at the meaning behind the open coding notes.

Examples of progressing theoretical notes made by the researcher include, 1) “very few adjustments in spiritual life since moving to the LTC. Is this because the participant has solid faith beliefs and/or is a mature, well-actualized person, or what else leads to minimal need for adjustments?, 2) says watching TV here, is different than at home, (for religious programming) yet I can’t seem to identify why? May need to go
back to the person for follow-up to this question, and 3) acknowledges participation and strong leadership/involvement in home church at a younger age and was very proud of past church life, yet how is the searching for meaning in participant’s church/religious life is different, now that the participant lives in the LTC facility? May need to explore it further.” The process of making theoretical notes assisted in identification of meaning behind the code notes and leads to beginning hypotheses about the phenomena under study.

**Operational Notes**

Operational notes were written in a separate notebook, to further examine ideas that arose during the data analysis. Examples of topics noted in the researchers’ operational notes to herself included the need to expand the study into new facilities to gain more participants, concerns with the interview guide as explained previously, a variety of possible consequences of the relocation as it affected the older adults’ spirituality, and the need to re-read transcripts to gain further meanings, themes and understandings.

**Constant Comparative Analysis**

The researcher used the method of constant comparative analysis when analyzing the transcripts during the open and axial coding phases of the analysis. In this process, the data fragments and resultant concepts are linked to form themes, categories and characteristics. It is a process whereby the researcher identified threads of conversations, which were useful to create themes and categories, across all the transcripts. Additionally, constant comparative analysis was used across all transcripts to culminate the ideas which supported the central phenomenon uncovered: that of the influences of
spirituality within older adults during relocation to long term care. As eloquently stated by Strauss and Corbin (1990) in support of constant comparative analysis, "Process is the linking of action/interactional sequences as they evolve over time. Bringing process to analysis is an essential feature of grounded theory analysis" (p.157).

The use of constant comparative analysis is illustrated in this study when the theme of Spiritual Blessings emerged as the phenomena's consequence. In nearly all of the transcripts, the participants discussed finding spiritual blessings or spiritual gifts (later renamed spiritual blessings) once they entered the LTC facility and developed the ability and found time to focus on their spiritual life. The use of constant comparative analysis was a process of going back and forth, reading and re-reading the transcripts to pick out the spiritual blessing thread of the interviews, to examine the threads in and out of context identifying relationships to arrive at the theme. From the newly emergent theme, the categories were developed. By reading, analyzing and comparing the transcripts in this manner of constant comparative analysis, the researcher could clearly describe the role of relationships and spiritual blessings. 

*Development of the Axial Model*

The Axial model was developed for this study during the data analysis phase. The model represents the specific characteristics within each category as suggested by Strauss and Corbin (1990, p.96): context, antecedents, phenomena, strategies, consequences and intervening conditions. Each category had properties within it. The Axial model is presented in Figure #1. It emerged from the data analysis. Open coding fragmented the ideas, but helped identify relationships and their influences on each other. These elements were put back together in a way that made sense, during the axial coding and sorting.
process, which resulted in the axial model. The model was created on a PowerPoint program by the researcher.

Use of Logic Diagrams

During the phase of axial coding and thinking through the development of the theoretical model for the phenomena under study, the researcher engaged in many rough drafts of logic diagrams. Logic diagrams are defined as, “Visual representations of analytical thinking that show the evolution of the logical relationships between categories and their subcategories in terms of paradigm features” (Strauss and Corbin, 1990, p.197). These diagrams assist the researcher to further refine thought processes and examine relationships in a visual format. Many arrows, circles and links among and between concepts were noted on the various rough diagrams.

Development of the Theoretical Model

The theoretical model for “Spiritual Influences within Older Adults During Relocation to Long Term Care” evolved during the analysis phases of the study and is presented in Chapter Five. The researcher reviewed ideas in the Axial model, categories and interviews and refined them for the theoretical model. The Axial model gave direction, helped to organize themes with relationships and supported the emergence of new, more abstract concepts created for the theoretical model. When the central phenomena was developed, the outcome of spiritual blessings readily emerged. This is a term coined by the study participants. A few of the participants used the term spiritual gifts, yet many others talked of the blessings they received during relocation to LTC. It was more about being blessed by God, than receiving gifts. Gifts or presents could be given by any person, and were not seen as sacred as the term spiritual blessings connoted.
Member Checking for Correctness of Theoretical Model

Once developed, the theoretical model was reviewed during three separate interviews, of three study participants. The researcher contacted key informants for a second interview, to review a draft of the theoretical model. Wording of the themes, categories and characteristics were reviewed, in addition to the shapes and placement of the thematic ideas. All three of the study participants reported they had not thought about spirituality through use of a diagram, but they agreed with the central ideas and themes, and liked the shapes and placement of the thematic content.

While it was new for the participants to grasp a diagram, several keyed in on words used in the categories that “did not make much sense to them.” Among the terms that required explaining were the concepts of Intrapersonal and Interpersonal Spiritual Relationships, and Extrapersonal Spiritual Resources. Once the terms were defined, they agreed to the properties that supported the terms. One particular comment was that the terms (noted above) were “too high level or too fancy to be understood.” No other terms were suggested. This feedback was carefully considered by the researcher, yet the choice to remain using the terms was made. Careful definitions were written and reiterated so understandings could come about.

A change was made to the outcome box of the study; it was renamed spiritual blessings instead of spiritual gifts. About half of the original 17 participants interviewed used the term spiritual gifts or blessings interchangeably, to define the positive aspects of life during relocation to LTC. The feedback from one participant, who critiqued the model, suggested a change from spiritual gifts to spiritual blessings. He stated the term gift was tied to the offeratory during communion, when gifts of wine and bread and the
parishioners' offering are brought to the alter during the Mass. He saw spiritual gifts as humans giving items to God, not God imparting them on the people. This feedback was considered and changes made accordingly, as discussed in the previous section. A fair number of other participants' original interviews revealed they used the term "blessings" when discussing positive aspects of their spiritual life during relocation.

A final observation of the member checking process was during the discussion of the properties of the theme Spiritual Barriers; participants validated them as being accurate. Many agreed with the barriers and relayed stories about how they see others struggle with the same barriers. The member checking process not only incited changes in the model, but validated terms and properties found in it. This process of confirmability added credibility and rigor to the study's process and findings.

Preconceptions and Researcher Bias

Prior to beginning this study, the researcher identified her preconceptions and bias toward the research topic in writing notes to self and in discussions with her advisor. The researcher had worked as a parish nurse for five years and had worked in a nursing management position in two long term care facilities in her past, prior to conducting the study. From the parish nurse role, in which the researcher provided spiritual care to elderly persons who were homebound, she noted many homebound persons who became upset and/or angry at God due to their health changes, which necessitated a move to a skilled nursing care facility. From this viewpoint, the researcher held preconceived ideas that the study participants would continue to be angry toward God and suffer decreases or upsets in their spiritual state during relocation to LTC. However, the opposite condition emerged from the study. Once the decision to relocate was made, persons drew upon their
spirituality to assist them with relocation. Indeed, their spiritual needs were met and allowed to flourish when they were released from physical chores and the duties of living on their own. Spiritual influences altered their perceptions and feelings towards God and the afterlife, while closeness and desire for God grew within their holistic being.

A second preconception the researcher experienced was made during observations of older adults in chapel worship settings at the LTC facility where she worked as a nurse ten years ago. These observations were those of people participating in worship, just as they would in their chosen home parish located in the community. They appeared content, sang hymns, prayed, and listened to worship leaders just as they did in their home churches. After the chapel services, when residents were returned to their rooms in the LTC facilities, they were content, at peace and discussed the church happenings with their caregivers. In this case, the older adult in LTC appeared spiritually fulfilled with the available chapel services held in the facility. The researcher casually observed few differences in the outcomes of spiritual care and spiritual practices in LTC when compared to those of elderly persons in their chosen parish, located in the community. This observation was made five years ago when the researcher was employed as a Parish Nurse.

From the above observations made while in nursing practice, the researcher questioned: What happens in the time between entering the LTC facility and adjusting to it, to gain peaceful states and a sense of the sacred from spiritual practices? It was from these observations that the study questions became apparent. It was refreshing and interesting to note that the biases developed as a parish nurse were disproven in this study; that during relocation to LTC the older adult draws upon their spirituality and
allows its influences to support adjustments to life in the LTC facility. Along the way, older adults discover very positive Spiritual Blessings.

Demographics of Sample

Description of Long Term Care Facilities

Study participants lived in three different long term care facilities located in a northern plains state. Twelve interviews were conducted at long term care facility A. Four interviews were completed at long term care facility B, while one interview was completed at long term care facility C.

Facility A is a 182 bed long term care facility, licensed by the state for delivery of 24-hour skilled nursing care in an urban area. It has an adjoining assisted living building. The not-for-profit facility is sponsored by a parochial health system. The campus offers a large, modern, airy chapel which has stained glass windows; it is used daily for religious services to meet needs of Catholic and a variety of Protestant faiths. Residents’ rooms are either private or double occupancy.

Facility B is an 84 bed long term care facility, licensed by the state to deliver 24 hour skilled nursing care in an urban area. The not-for-profit facility has a walkway which joins it to apartments for independent elderly living. This facility is sponsored by eight churches affiliated with one faith group. There is a chapel located centrally in the nursing facility, which hosts Protestant and Catholic religious services. Residents’ rooms are either private or double occupancy.

Facility C is located about 60 miles from the nearest urban center, in a more rural area of the state. The long term care facility is licensed by the state as having 62 skilled nursing beds and six basic care beds. The facility is part of a private group of health care
entities comprised of a community hospital, clinic and independent apartments for the elderly. This facility does not have a chapel. The nearest chapel is across the street, located in the hospital. One must walk across the street to access the chapel. Residents' rooms are either private or double occupancy in the skilled nursing facility.

In summary, there are more similarities than dissimilarities among the three facilities. All facilities are privately owned, residents of the facilities have access within close proximity to spiritual resources, and have a person responsible to assess and provide for spiritual needs, and all are located in rural regions of an upper great plains state. The one difference is that two of the facilities have a religious affiliation while one is not associated with any religion.

Length of Time Since Admission

Length of time since admission was reported at an average of 2.4 months. The shortest length of time since admission, at date of interview was one month while the longest length of time since admission, at date of interview was six months. The study was limited to persons within their first six months of admission to the long term care home, thus all participants met the criteria.

Reasons for Admission

Most participants, 88% (n=15), were admitted to the various facilities after encountering a hospitalization that validated the need for LTC services. A small amount of participants, 12% (n=2), were transferred from other types of assisted living facilities directly to the long term care facilities. Reasons for admissions were reported by the total 17 participants in Table Three.
Table 3: Reasons for Admission

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent fall(s)</td>
<td>35%</td>
<td>6</td>
</tr>
<tr>
<td>General health decline</td>
<td>35%</td>
<td>6</td>
</tr>
<tr>
<td>Specific disease*</td>
<td>30%</td>
<td>5</td>
</tr>
</tbody>
</table>

(*stroke, Parkinson’s Disease, pneumonia, cardiac disease, renal failure)

Gender and Age

Within the total of 17 participants, 65% were female (n=11) and 35% were male (n=6). The age of the participants averaged 86.9 years, with a range of 74 to 100 years. The participants were obviously in an age range for older adults, also known as geriatric clients or residents of the LTC facilities.

Education

Diversity within the two categories of formal education and religious affiliations (both current and past) among the participants provided a richness in experiential variations of life. Formal education reported by participants averaged 11.7 years. The range in years of education was from seven to 16 years. Given the age of the participants, their peers would perceive them as a very educated group of older adults. This is striking due to the limited opportunities for education in the rural plains states at that time in their youth.

Employment

Occupations of the participants reflect the common diversity present in ruralness, which were, farming 35% (n=6), teaching 29% (n=5), and business ownership 18%
(n=3). These occupations were dominant in their life’s work. Additionally, other reported occupations present during part of the participants’ lifetimes were: clerk, bookkeeper, waitress, naval decoder, electrician, construction work, railroad baggage clerk, naval gunner and instructor, salesman, civil service worker, and apartment complex manager. Again, the diversity added to the richness of their lived experiences thus expanding the spiritual perceptions they shared, adding rigor to the study.

Religious Affiliation

Religious affiliation of the participants reflects the denomination of the Catholic faith (64%, n=11); this was noted in their particular religious practices reflected Catholicism. Such religious practices were: praying the Rosary, communion, confession, and attending daily mass. However, this population did not present as different in their responses from other participants who reported different religious affiliations.

Table 4: Religious Affiliation

<table>
<thead>
<tr>
<th>Present Religion</th>
<th>Percentage</th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>64%</td>
<td>11</td>
</tr>
<tr>
<td>Lutheran</td>
<td>18%</td>
<td>3</td>
</tr>
<tr>
<td>Methodist</td>
<td>6%</td>
<td>1</td>
</tr>
<tr>
<td>Baptist</td>
<td>6%</td>
<td>1</td>
</tr>
<tr>
<td>Christian Scientist</td>
<td>6%</td>
<td>1</td>
</tr>
</tbody>
</table>
Previous religious affiliations, described by participants who no longer practiced that particular faith, were: Episcopalian, Lutheran, Catholic, Nazarene, Congregational, Methodist, and Latter-day Saints. While it is interesting that previous religious affiliations were shared with the researcher, participants did not perceive that their past religious affiliations affected their current denominations’ spiritual practices and beliefs.

Marital Status

The majority of the participants reported being widowers was 59% (n=10). The remaining 41% of the sample reported being either married 23% (n=4), were single, 12% (n=2) or were divorced, 6% (n=1).

Faith Community Leadership Engagement and Activities

When asked about religious affiliation, all but one participant, reported working or volunteering in their chosen churches. This church work occurred at some time in their life, prior to admission to the long term care facility and a few participants participated in church work while living in the LTC facility. Roles reported were those of: Sunday school teacher, usher, distributing bulletins for mass, church board member, helping to construct a church building, Rosary leader, earning a ‘practitioner certificate’ (similar to a Sunday School superintendent and leader of women’s groups), youth group leader, Bible Camp teacher/counselor, presenting the “Message” when pastor was out of town, leading daily table prayers at spouse’s nursing home, and instructing Bible study groups. These participants were engaged as active church members and faith community leaders within their home parishes during their life time. Diversity in the demographics added to richness of data and breadth of understanding about each person’s unique spirituality and religion.
Axial Coding Model

This section will explain the axial model that emerged from the analysis of data. Please refer to the axial coding model, Figure 1. Axial coding is a process of grounded theory to assist in the categorizing of findings and to identify linkages between categories of data (Strauss and Corbin, 1990). The findings were not forced but emerged into categories of context, antecedents, phenomena, strategies, consequences and intervening conditions. Strauss and Corbin's grounded theory approach and definitions are the framework for this discussion (Strauss and Corbin, 1990).

The first box at the top of the diagram addresses the “Context” in which this study was conducted. Context is defined as “the specific set of properties that pertain to a phenomena; that is, the locations of events or incidents pertaining to a phenomena along a dimensional range. Context represents “a set of conditions in which the action strategies are taken” (Strauss and Corbin, 1990, p.96). In this study, the participants’ shared context emerged as: 1) institutional environment of LTC, 2) unsupportive LTC staff regarding spiritual matters, 3) rural, frontier culture and surroundings, 4) changes in religious leaders, 5) changed religious practices, and 6) altered access to religious practices and environments.

The second box located to the far left side of the diagram is titled “Antecedents”. Antecedents, also called Causal Conditions, are defined by Corbin and Strauss (1990, p.96) as, “events, incidents, happenings that lead to the occurrence or development of a phenomenom.” In this study, the antecedents that emerged as having significant spiritual influences during the older adults’ relocation to LTC were: 1) relocation to the LTC facility (for this study, within a six months timeframe before the interview), 2) health
Figure 2: Axial Coding Model

**Spiritual Influences on Older Adults During Relocation to Long Term Care: Axial Model**

**CONTEXT**
- Institutional environment of LTC
- Changes in religious leaders
- Unsupportive LTC staff re: spiritual matters
- Rural, frontier culture and surroundings
- Altered access to religious practices & environments

**ANTECEDENTS**
- Relocated to LTC
- Health changes required LTC dwelling
- Losses of autonomy
- History of spiritual practices & beliefs
- Engaged in faith community leadership activities

**PHENOMENA**
- Spiritual influences during relocation to LTC through intrapersonal and interpersonal spiritual relationships and connections with extrapersonal spiritual resources

**STRATEGIES**
- Converses with God
- Hopes in the Lord
- Draws strength from Lord and spiritual beliefs
- Accepts/accesses God's plan for self
- Seeks spiritual purpose
- Prays
- Meditates
- Bible reading
- Journals spiritual thoughts
- Communicates with faith friends and religious leaders
- Develops new spiritual relationships
- Explores faith through daily activities
- Attends religious services
- Sings familiar religious songs
- Participates in church activity groups
- Visits with formal religious leaders
- Accesses home parish information
- Uses technology to engage in religious broadcasts

**INTERVENING CONDITIONS**
- Degree of wellness and illness
- Amount of time available for spirituality
- Degree of family involvement maintained in spiritual life
- Technology
- Access to form faith friends
- Access to chapel, worship space, religious practices
- Reduction in ADLs and responsibilities
- Presence or absence of facility spiritual care providers

**CONSEQUENCES**
- Time for spirituality
- Seeks spiritual guidance
- Searches for meaning in life and spiritual life
- Experiences spiritual comfort
- Looks forward to the afterlife
changes requiring LTC dwelling, 3) losses of autonomy, 4) a strong, history of spiritual beliefs and practices (prior to admission in LTC) and 5) engaging in faith community leadership activities.

The listed “Antecedents” impact the focused “Phenomena”. A study’s phenomena is “the central idea, event, happenings, incident about which a set of actions or interactions are directed at managing, handling, to which the set of actions is related” (Strauss and Corbin, 1990, p.96). In this study, the phenomena focused on the spiritual influences during relocation to LTC through intrapersonal and interpersonal relationships, and connections with extrapersonal spiritual resources.

For the “Phenomena” to occur or maintain, “Strategies” were employed by the participants that influenced their personal experiences of spirituality. According to Strauss and Corbin (1990), strategies may also be called “Actions or Interactions”; they are defined as “devised to manage, handle, carry out, respond to a phenomenon under a perceived set of conditions” (p.97). The strategies used by the older adults that influenced their spirituality were: 1) converses with God, 2) hopes in the Lord, 3) draws strength from Lord and spiritual beliefs, 4) accepts and accesses God’s plan for self, 5) seeks spiritual purpose, 6) prays, 7) meditates, 8) reads the Bible, 9) journals spiritual thoughts, 10) communicates with faith friends and religious leaders, 11) develops new spiritual relationships, 12) explores faith through dialogue, 13) attends religious services, 14) sings familiar religious songs, 15) participates in church activity groups, 16) visits with formal religious leaders, 17) accesses home parish information, and 18) uses technology to engage in religious broadcasts.
“Intervening Conditions” (Strauss and Corbin, 1990, p.96) are defined as: “The structural conditions bearing on action/interactional strategies that pertain to a phenomenon. They facilitate or constrain the strategies taken within a specific context”. This study found intervening conditions to be: 1) degree of wellness and/or illness which influences ones spirituality, 2) amount of time available for spiritual practices, 3) degree of family involvement maintained in spiritual life, 4) technology (for making connections to spiritual resources), 5) access to former faith friends, 6) access to chapel, worship space, and religious practices, 7) reduction in activities of daily living (ADLs) and responsibilities, and 8) the presence or absence of facility spiritual care providers.

The antecedants, phenomena, strategies, and context and intervening conditions all converge into creating “Consequences.” Consequences are defined as “outcomes or results of actions and interactions” (Strauss and Corbin, 1990, p.97). The consequences in this study of the influences of spirituality on the older adult during relocation to LTC are: 1) has time for spirituality (practices and thoughts), 2) seeks spiritual guidance, 3) searches for meaning in life and spiritual life, 4) experiences spiritual comfort and 5) looks forward to the afterlife. These same consequences emerged into the theme of “Spiritual Blessings” in the theoretical model.

The axial model presents the connections among the themes and categories of this study as participants reported during the interviews and as they emerged during analysis. It is evident many spiritual strategies were utilized during relocation to LTC. Spiritual influences dwelling in older adults presented as intrapersonal and interpersonal spiritual relationships in addition to the use of extrapersonal spiritual resources during the time of
relocation. Further delineation of these relationships and resources will be explicated in the next section of relevant research questions.

**Findings Related to Research Question 1**

**Research question one:** “What are the spiritual beliefs and practices of older adults when they relocate into long term care facilities?”

The answer to this question as reported by the participants, is multi-faceted. It is centered in their lives’ stories and faith journeys. All participants reported a strong spiritual influence in their background and/or religious upbringing. This particular background led to and supports their current spiritual practices and beliefs. It is noted in the antecedent box on the axial model.

The spiritual practices and beliefs noted by this group of people emerged into three central themes, which are: Intrapersonal Spiritual Relationships, Interpersonal Spiritual Relationships and Extrapersonal Spiritual Resources. Before beginning a description of the characteristics or properties of each category, definitions of the three types of spiritual relationships will be presented. Findings for each category will follow.

**Definition: Intrapersonal Spiritual Relationship**

An Intrapersonal Spiritual Relationship is the participant’s internal expressive process in which they communicate with God. This relationship occurs internally between the person and God. It is what happens to connect them with God during their daily life routines, maintain their spiritual beliefs, and enrich their religious practices. Participants explained that formal and informal prayer were mechanisms to support their internal dialogue with God.
Definition: Interpersonal Spiritual Relationship

The Interpersonal Spiritual Relationship is the participant’s connections with other people in their life that support and enhance their spiritual beliefs and practices. It is through relationships that fellowship occurs and the external manifestation of spirituality ensues; this is the older adult’s vehicle (faith actions) for enacting their spiritual practices.

Definition: Extrapersonal Spiritual Resources

The Extrapersonal Spiritual Resources are those external items, both tangible and intangible, which assist participants to enhance their spirituality. These are physical places and material things related to religious practices and actions carried out by the older adults and/or significant people in their faith lives, which support spiritual/religious practices that are meaningful to the older adults.

Findings: Intrapersonal Spiritual Relationships Prior to Relocation

Within the category of Intrapersonal Spiritual Relationship, the participants reported several properties which strengthened their personal spiritual relationship with God: 1) they had strong beliefs in God, 2) they listened to/for God, 3) they dialogued with God. This intrapersonal theme and its properties was present before they moved into the long term care facilities. To maintain this relationship, they used prayer, meditation and Bible readings to keep and enhance their relationship with God at the time of relocation. The following quotes represent a few of the many statements related to their belief in God being essential to their spirituality. “I think in life, in Christianity, faith has got everything to do [with us]. I think from the day we are born, even before we are born, God said we have a life on this earth until we pass away. Yes, He has a plan for us.”
Another participant stated, “I was a strong believer before I came here. I continue to believe in the Lord and His plan.” Participants believed relocation was part of God’s plan and living at the LTC facility was God’s will for them. This reframing made their use of spirituality meaningful as a coping process.

*Listening to God* was a property that emerged as part of the Interpersonal Spiritual Relationship conversations. One participant felt God guided her when she listened. She shared how she prays and consequently how she listened to God. “I hope I understand Him.... It takes a lot to listen and try to understand what the higher power is trying to tell us. He will say ‘No, no, don’t do that’. I think He is trying to guide me along.”

*Dialogue with God* was the third intrapersonal property present in participant interviews. The dialogue took place during daily life events and provided comfort and reassurances for the participants. The following quotes exemplify these understandings: “I talk to Him every day, in that when my time comes to go out of this world, my soul will go to heaven with my creator,” and, “I sit down and talk with God…and He comforts me in many, many verses that are a part of my life. They [verses] just come to my head. Yes, I am [intimate with the Lord].” Another person indicated that “it goes well for me” when she sits down to talk with the Lord.

*Prayer* was one of the behavioral properties inherent to the Intrapersonal Spiritual Relationship characteristic. Prayer assisted in the maintenance of several behavioral properties that were significant spiritual practices to the participants; it was integral to their lives prior to entry into the long term care facility. Types of prayer included those said at worship services, meal prayers, blessing prayers, bedtime prayers and formal prayers like the Catholic Rosary.
The importance of frequent, routine prayer during the residents’ lives was noted in these quotes: “I did a lot of praying...(relates a story about losing wedding rings, and finding them after praying with a relative)...that was an action of prayer. I pray in the mornings, when I wake up,” and “We [husband and children] said the Rosary prayer all the time, but sometimes, not so much. We were busy [raising the family on the farm].” Additionally, giving thanks at mealtimes was a noted prayer practice. Prayer had a daily presence in the lives of the participants in a variety of formats.

*Meditation* was an intrapersonal property practiced prior to entering the long term care facility. One resident described it as a helpful to communication with God, but said that she did not meditate as often in the new surroundings of the LTC facility. She explained that recent health changes caused her to lose the ability to focus on meditation, “Well, I have not meditated here as much as I would like to, like before I came here.”

*Bible readings* have been a part of some participant’s lives before they moved into long term care settings. During the interview, one participant showed the researcher a Bible she had recently received as a gift from her daughter, to replace one in which she “had worn out the covers.” This same participant quoted many scripture verses during the interview, very naturally, to emphasize points she was making. Another participant drew upon Bible teachings when reflecting on her life’s lessons: “The Bible speaks about love so much that you need to love not only your neighbor, your family, but everyone and to serve Him.”

In summary of the Intrapersonal Spiritual Relationship theme, the participants shared many properties that included strong spiritual beliefs and practices they engaged in before they entered the long term care facilities. This group of participants
incorporated meaningful internal spiritual behaviors to support their intrapersonal spiritual relationship with God during the relocation period. They were able to utilize and transfer most of these processes to quite a different setting.

*Interpersonal Spiritual Relationships Prior to Relocation*

Within the theme of Interpersonal Spiritual Relationship, most of the older adults stated they had a strong presence of faith friends and family; thus their spirituality was supported by this community of believers. About half reported they knew and were supported by their formal religious leader, while the other half lost the connection to that leader at the time of the relocation.

The presence of faith friends and family was important to the participants before they entered the long term care facility. The term faith friends was used to describe those persons who had interconnected spiritual lives with the participants. Faith friends were spouses, grown children attending the same church, church activity group friends, church prayer partners, formal worship leaders (ministers, priests, pastors), friends who met and sat by each other at worship services, and friends who shared transportation to church services and events. Many people related stories about their life’s partners in spirituality, both practices and beliefs. Not only were spouses and children significant to sharing their religious beliefs and practices, but so were the friends they had made through church activities. One participant stated: “We never missed church. When my husband was living, we were always there. We always got up early and went to Easter Sunday services, too.”

One participant spoke of becoming friends with his local parish priest: “Then he [the friend/priest] was transferred to [town name]. Every Monday he had the day off. We
[participant and another church friend] hopped into the van every Monday and drove
down there. We had breakfast with him at the café.”

Another participant described her relationships with the church women’s quilting
group, and her identification as a church quilter for 15 years of her life. “I was part of the
church quilters. We always took them to [town name] by the carloads. We also made
quilts for the seniors of high school. I suppose I did that for 15 years.”

One participant described the value of her relationships in staying connected with
her church friends: “It sure helps to see them, the group of ladies at the church.”

The social aspects of the interpersonal church/faith relationships were integral to
their spiritual life in a rural setting. Relationships with persons from the home parish
were strong and thus were important to the participant’s connections to a faith
community that supported their spiritual lives.

Extrapersonal Spiritual Resources Prior to Relocation

Prior to entering the LTC facilities, the theme, Extrapersonal Spiritual Resources
had many properties identified by the group of older adults. Spiritual resources consisted
of religious practices, activities within spiritual community, worship space, and use of
technology to support religious and spiritual needs. See the following table which
elaborates on the spiritual resources by listing the key characteristics described by the
participants.
<table>
<thead>
<tr>
<th>Category</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Spiritual Practices</td>
<td>Worship services and/or Mass</td>
</tr>
<tr>
<td></td>
<td>Prayer services / Rosary</td>
</tr>
<tr>
<td>Activities within Spiritual Community</td>
<td>Religious programs/Hymn sings</td>
</tr>
<tr>
<td></td>
<td>Bible study/religious instruction</td>
</tr>
<tr>
<td></td>
<td>Church activities through service groups</td>
</tr>
<tr>
<td>Worship Space</td>
<td>Local community churches/chapels</td>
</tr>
<tr>
<td></td>
<td>Private homes</td>
</tr>
<tr>
<td>Worship Technology</td>
<td>Radio for religious music/prayer/programs</td>
</tr>
<tr>
<td></td>
<td>Television for religious music and programs</td>
</tr>
<tr>
<td></td>
<td>Personal Computer to access religious information and connect with faith friends</td>
</tr>
</tbody>
</table>

**Formal Spiritual Practices**

Nearly all the participants described routine attendance at a community church which they attended, prior to admission to the long term care facility. Most stated they tried to attend their chosen churches weekly, which was planned around the chores and needs of home ownership and working and living on a farm. One participant stated:

Well, I was raised in a Catholic school. I was born a Catholic, went to church every weekend…we went to church every Sunday unless the country roads were blocked. Other times we went at all holidays and special days. We said the Rosary
all the time, but sometimes not as much because we were busy [raising the family, on the farm.]

Another person described her use of Formal Spiritual Practices as,

Oh, [before I moved in to LTC] I always went to Bible study and church every Sunday. And there were special services during Lent and Advent seasons. Bible study was one time per month. I went to everything and anything they had at the church.

Types of Activities within the Spiritual Community participants engaged in, prior to admission to LTC, provided spiritual growth and maintenance of well being for self and family. These activities built interpersonal relationships among a social community with a common spiritual focus.

The Worship Space discussed by the participants reflected happy memories and positive regard for their physical places of worship such as home parish, church building and personal home spaces. Worship space outside of the church building was noted when persons spoke of practicing personal prayer times alone in their home, prior to admission to long term care. If persons could not travel to their preferred church or place of worship, a relative or friend often assisted with this need. Whereas another participant spoke of her approach to a place of prayer in the following quote:

In the last 30 years I have been a member of what they call a metaphysical church. It was the Unity and Religious Science church. They don’t have one here. [It was when she lived in another state]...Now I am tending back to what I was taught in the Unity and Religious Science. It is a way, where you live your life in a better place, where you meditate and pray in your own space.
Several participants discussed use of *Worship Technology* to help them tap into religious programming or information from their homes. Use of the radio, television, and a personal computer were discussed by the participants. In all cases, the persons pointed out their favorite program which they felt supported their spirituality by assisting them to focus on God. One person stated: “I listened to a Lutheran minister on TV, and sometimes it was on the radio. I think he was a very important minister...I can’t think of his name now. Oh, it was Billy Graham that I liked.” Another person stated, “I don’t have a computer anymore. [Person had one at home and misses it]. I liked to do research when I had questions you know, [about] spiritual life and beliefs.”

Extrapersonal Spiritual Resources utilized by the participants indicated they used external supports and structures to strengthen their patterns of religious activities for a large part of their lives, which gave them a sense of belonging and well being within a particular religion or spiritual community. Worship space existed for the participants as a formal church building or in their homes. Worship technology was used as a resource to support their religious practices; radio and television broadcasts were important avenues for religious programming among a variety of participants. The use of the computer to connect with the Internet as a tool for researching spiritual questions was also noted by a participant.

In summary of research Question #1, the three themes that emerged in response to the research question regarding spiritual influences that included beliefs and practices used when older adults relocate to LTC, were found to be Intrapersonal and Interpersonal Spiritual Relationships, and Extrapersonal Spiritual Resources. Each of these three themes had properties and characteristics derived from their unique situations and
personal belief systems. The participants drew upon their life-long system of spiritual beliefs and practices, as explained in the previous section to reframe and assist with the process of relocation to LTC.

Findings Related to Research Question 2

**Research question two:** "How are the past spiritual practices (including beliefs and practices) similar to the present spiritual practices during relocation to the long term care facility?"

To answer this question, the themes of Intrapersonal and Interpersonal Spiritual Relationships, and Extrapersonal Spiritual Resources emerged again as an appropriate framework for the properties reported by the participants.

*Intrapersonal Spiritual Relationships: Past and Present Similarities*

Most of the participants responded that they felt their Intrapersonal Spiritual Relationship with God or their Lord, did not change since admission to the LTC facility and during the relocation adjustment period. Only one participant replied she felt like she had a lesser relationship with the Lord, “Since I have been ill, it [belief in God] has sort of backslid...I can’t meditate as much as I want to now, with my nerve problems, you know?”, whereas another replied it was stronger since she was admitted, “I would not quit being a believer since I came here. My beliefs have not changed.” Another person stated, “I think it is better [religious beliefs]....I feel good, I feel real good. I don’t know how to describe it [joy in faith], but I feel good.”

*Interpersonal Spiritual Relationships: Past and Present Similarities*

Many of the participants stated that their spiritual relationships remained similar since their relocation to LTC; these involved connections to church friends from their
home parish, maintaining ties with their previous formal religious leader (pastor or priest), and continuing relationships with family members who were supportive of their spiritual needs.

Connections to church friends from their home parish were maintained through letter writing, visits and phone calls. It was important for the participants to connect with their long standing church friends, to be aware of events and happenings in their home parish. All participants reflected positively on the need to stay in touch with their past long-standing church/faith friends, as a participant stated, “I talk to them [referring to church friends] (she points to her cellular phone) often. I have letters from them, and I write to them, too. We stay in touch; it helps [with the relocation].” It was significant for the participants to maintain these “helping relationships” on an interpersonal level because they were core relationships in their life prior to relocation.

Maintaining ties with the formal religious leader, (past priest or pastor) was accomplished through the religious leaders holding worship services, providing sacraments of communion or special blessings at the facility, visitations of the leaders to the residents of the facilities, or through phone calls or letter writing by the leader, to the residents of the facilities. One participant indicated, “The pastors [from her community’s church] come to the church here [in the nursing facility] or they visit me in my room. They bring me communion, like they did when I lived at home. It has not changed, they still come.” Another participant discussed an enhancement of her relationship with the minister since relocation,

I get a bang out of the minister from [names home church]. He came up here and visits me every time he comes to town. I did not even know him that much when I
lived there. Now, after I moved here, the pastor visits me and I like to visit with him. When you can talk to a minister for an hour, just visiting, it is so nice.

Family support of spiritual needs was noted when the participants reported how their families assisted with meaningful religious activities that carried over from their home parishes. One older adult stated, “My daughter helps me to mail out the ‘Daily Bread’ for our church. It is a devotional booklet, to about 90 people in our church. It is mailed out quarterly. I still do it, from here... she helps me.” Likewise, family attendance at religious or worship services with the participants at the chapel in the LTC facility was a positive experience.

Well, we always used to go to church together, [spouse and self] but now he comes here...at Christmas, ah, my three grandchildren and their parents, we went to the mass together. I have a supportive family that visits me here. I liked going to church with them.

Participants reported it was satisfying to have their family attend worship during the relocation which was similar to how they used to attend church together prior to relocation.

Extrapersonal Spiritual Resources: Past and Present Similarities

Extrapersonal spiritual resources that were similar from relocation to before admission to LTC, included attendance at church and prayer services. All participants stated they still attended worship and prayers services, yet they related that the location of the church or chapel had changed to the one in the LTC facility (this is explained further during the discussion of Research Question #3). Worship services had increased since the older adults were admitted to the LTC facility. Many related it to the close proximity
of the chapel in the building, and the assistance they received from the staff to help them
to dress and provide physical assistance/transport to the chapel. One participant stated:

I go as often as I can here. I would go every day if I could. I am a Catholic
Christian by faith. So if I could go to mass every day, I will. They have it here all
the time....they remind me when it is scheduled and help me to get there. I like
the chapel here.

Another Extrapersonal Spiritual Resource was described as maintaining material
connections to the person’s home parish. Connections were described as accessing home
parish information in a variety of ways: 1) receiving mailed bulletins and church
newsletters, 2) obtaining audio-taped copies of weekly sermons, 3) having church visitors
arrive weekly to discuss church news, and 4) reading copies of Bible studies from their
home parish. Participants said it was important to have home parish information
regarding: who to pray for, who had funerals or births, and/or who was in Sunday school
classes. They felt supported by staying in touch with their previous congregation and
church happenings which increased their system of social supports during the relocation
time. They felt they could support others in their home parishes by giving back to them
through prayer efforts, which made them feel capable of doing meaningful activities in
physically compromised states. The positive actions they took when given home parish
information gave them a sense of purpose and usefulness to others.

Findings Related to Research Question 3

Research question three: “How are the past spiritual practices (including beliefs and
practices) different from the older adults’ present spiritual practices during relocation to
the long term care facility?”
Differences in spiritual practices from the participant's past to the relocation period were reported and framed in the categories of Interpersonal Spiritual Relationships and Extrapersonal Spiritual Supports.

**Interpersonal Spiritual Relationships: The Differences**

In the category of Interpersonal Spiritual Relationships, participants related that they formed new relationships with: 1) the residents of the LTC facility who attended the same church services, 2) pastors or priests who provided worship services at the facility, 3) pastoral care staff at the facility, and 4) healthcare providers at the facility who were supportive of their spiritual needs. The relationships were spoken of highly, and the participants were pleased that they found others in this new environment who supported and focused upon their spiritual needs. Prior to this time, some participants said their spiritual needs were of a more private, personal nature between themselves and their pastor or priest. Now, it was a welcome addition to be able to talk about care of their spirit openly, with others. One participant stated:

This morning, the priest came up [after mass], because he knew I was here or something. He said 'Well hi, [name] I did not think you were here.' I was glad to see him. He visited me awhile then he wanted to see somebody else so he left. He was from [participant’s home town].

Another participant reflected on the spiritual care staff by replying, “[Name of spiritual care staff person], he comes in here once in a while to talk with me, in my room. It helps me focus on God and get through life...helps me to sort through issues”.

One participant spoke of a personal relationship with a nurse:
There is one nurse who is real nice. She goes out of her way to get coffee for me. She does not have coffee [on the med cart], but she knows I like coffee in the morning. After the morning Rosary, she brings me a cup of coffee and a cookie, and we talk about what we prayed for. I tell her 'I will pray for you', and she prays for me.

Whereas another participant spoke of a resident relationship, “My roommate is real nice, she goes to Bible Study with me and we talk about it in our room. She goes to the same church I do.”

From the quotes, it is evident that new spiritual relationships develop during the time of relocation to LTC. These are different relationships than the participants had in their past spiritual lives because they are more open to spiritual interaction at this time in their lives’ journeys. Participants spoke favorably of these relationships.

*Extrapersonal Spiritual Resources: The Differences*

Differences in structure and utilization of Extrapersonal Spiritual Resources since relocation were identified as increased access to church services, prayer services, hymn sings, and Bible studies; improved health enabling them to give attention to their spiritual needs; engagement in a wide variety of spiritual activities at the LTC facility; and a physical change to a the location of a new/different church or chapel. Many participants stated the differences in church services and activities were a welcome way to spend time, and they appreciated that church activities were offered and available to them within the facility.

Participants had the following quotes to share about the Extrapersonal Spiritual Resources. 1) “I go to church or Rosary here every day, I don’t miss it. When I am in
church, I pull my hands together and it sort of knits you together to bring yourself closer together with God,” 2) “I like to sing. I like their hymn sings; different groups come in for us. I think God enjoys it when we praise him with singing,” and 3) “I go to all the services and Rosary, too. Sometimes, I work my way [ambulates with walker] up to the chapel. Sometimes there are maybe two or three people in there. I just walk there and like to sit. It takes me 10 minutes from the time I start until I get there. It’s my exercise, too. Oh ya, everything [spiritual health] works out fine. It feels good [when prayer time is completed].”

Another participant noted the differences in health, while she spoke of how her state of wellness related to spirituality in this quote, “I go to church when I feel well. I pray that I will get better and get stronger. I want to go home again.” This participant was relaying her recent health change which requires dialysis, and her good days and bad days. When she feels well, she participates in church and prayer services at the LTC facility.

A final difference in Extrapersonal Spiritual Resources emerged when discussions of the location of the facilities’ chapels occurred. Attendance at church and prayer services was accomplished in all three LTC facilities, either at a chapel located within the LTC facility or services organized in a common meeting room (when the facility did not have a specific worship space). Most participants discussed the differences between attending church and prayer services in the facility, which were different than their previous home parish. Only one respondent reported she was able to attend church at her community church, outside the facility, when she was able to secure a ride with a family member or friend. She preferred to go outside the facility to her home church, for
worship service. However, she was satisfied with the church and prayer services offered by the facility, when she could not attend her preferred community based church. For all the participants, the location of church and prayer services changed during the relocation to long term care services.

The differences in spiritual beliefs and practices centered on the development of Interpersonal Spiritual Relationships with the people who lived or worked in the setting of the LTC facility, while Extrapersonal Spiritual Resources espoused many differences when the participants relocated to LTC facilities. The Extrapersonal Spiritual Resources that differed from the past, to the time of the relocation process focused on increased attendance at church and/or prayer services, increased participation in church activities, feelings of wellness which leant itself to meeting spiritual needs, and a different physical location of the place for church and prayer services. The differences were spoken of in a highly positive manner, by nearly all participants.

Findings Related to Research Question 4

Research question four: “What meaning does spirituality have for the older adult since he/she came to live at the long term care facility?”

Definition: Spirituality

From this study a theoretical definition of spirituality emerged, specific to the older adults who live in the LTC facilities. Spirituality is having an intrapersonal relationship with God, fostered through other relationships while manifesting and maintaining the person/God relationship, and through utilization of channels and mechanisms provided to the older adults living in the LTC environment.
The study revealed participants felt that since living at the LTC facility, they discovered and experienced “Spiritual Blessings”. The meaning of their spirituality expanded into the outcome of receiving “Spiritual Blessings”. This category of spiritual meaning reveals positive spiritual states identified by the participants. (After the definition is discussed, the spiritual blessings properties will be reported.)

Definition: Spiritual Blessings

Spiritual blessings is a term coined by participants to reflect discovery of positive states and qualities in themselves, experiences of time to grow spiritually during the relocation, and the search for new understandings in their lives, while living in LTC. The spiritual blessings were given to them by God. Spiritual blessings are defined as a desirable state of comfort regarding matters of the spirit. This state supports spiritual growth and promotes new spiritual understandings to be gained. This finding will be discussed more fully in Chapter 5, when the theoretical model is examined.

Meanings of Spirituality Since Living in LTC Facilities

Study participants discussed their discovered blessings in their spiritual lives which occurred during relocation to LTC facilities. The category was found to have the following properties that supported an increased desire for spirituality: increased time for spirituality, a search for spiritual guidance, a search for meaning in life, experiences spiritual comfort and looks forward to the afterlife. The following discussion will elaborate on these properties.

Study participants related they had a new sense of time to focus on their spiritual life, since admission to LTC. Their health status (good or bad) became a spiritual opportunity because the participants were based in faith and open to God’s
communications. Many discussed their past lives were busy, in which they spent time working at a profession or working in the home to raise a family. This created less focused time on their spiritual lives. Now, when living in the LTC facility, they were not as busy nor were they responsible for the actions of daily life, so they could devote time to Bible study, worship service attendance, listening to religious programs on TV or radio, prayer time, conversations or meditation with God, writing or journaling their faith questions or ideas, and spending time in conversation with others about their spiritual thoughts and questions. A participant stated, “Being able to sit down and talk with the Lord when I want to [brings him the most pleasure in life]. I now have time to talk with Him and think about things... before I was always too busy doing something else.” It was noted that as they focused more time on spiritual practices, it lead to more time desired with their God.

In conjunction with having more time for spirituality, many study participants reported the spiritual blessings of their release from responsibilities, which added to their increased focus on time for spirituality. Since moving into LTC, they revealed a sense of relief from their lives’ activities. One participant was the primary caregiver for an ill spouse, coupled with upkeep of their family home and yard. Another expressed relief at release for the cooking, cleaning and preparing meals as a lone widow. They explained the blessings in being admitted to LTC, as it was a release from responsibility of chores and caregiving, allowing them more time for spiritual matters. They welcomed the release from the responsibilities; it was noted as a blessing to have others cook, clean and care for them in the LTC facility. One participant summarized this blessing as,
I was so busy taking care of my wife. She has Alzheimer’s, you know. I cooked, cleaned, did all the yard work and stuff. It was a big house with trees and a yard. I could not leave her alone. She was a good person. Now, they take good care of me and I have time to go to church every day. It's a blessing. I was not sure I would like it here, but what a relief it is.

*Seeking spiritual guidance* was identified as a blessing, which the participants recognized during the relocation to LTC. The older adults reported they sought spiritual guidance while they focused more on their spiritual needs and practiced their religion. A number of ways were discussed in which they looked for spiritual guidance: 1) Bible study, 2) dialogue with God, 3) prayer time, 4) questioning their purpose in the facility, and 5) spending time with others in a variety of spiritual relationships. Many participants stated they sought and found spiritual guidance, which they revealed was a spiritual blessing.

Several participants also felt they enhanced their meanings of spirituality when they looked forward to the afterlife. At this latter stage of their lives, and with so many participants experiencing declines in health, looking forward to the afterlife became a focus for them which gave them comfort. Life review was a large part of the interviews conducted. Many participants believed in an afterlife and looked forward to meeting deceased loved ones again, after they die. A strong property of belief in heaven was noted, with a focus on Christianity. One participant discussed her anticipated joy at meeting with a child who died young:
Well, I lost a little girl when she was just three months old and [I] had some miscarriages. Someday, I will see them all again. Some think the end of life is different [fearful]...but I sure know I will be reunited with my loved ones again.

Yet another participant focused on the happy time when he meets God at his death, “Yes, [I think a lot about God] every day. There is not a day that goes by that I don’t think of my faith and my God, and when I will meet up with Him [joyously] in heaven.”

Searching for meaning in life and in spiritual life became another property apparent in the interviews with the older adults. While they did not use the term directly, many discussed their role and purpose at the LTC facility. Participants revealed that they found their purpose in life was to aid others at the LTC facility to have a more full spiritual life. Examples given by the participants who found their purposes were to lead Rosary in the chapel, assist with the worship services by singing and participating when other residents could not do so, and to help others in activities such as Bingo or Bible studies which demonstrated sharing God’s love by caring for others. Meanings in life at the LTC facility were found by participants after they relocated to the facility and were engaged in their spiritual lives.

Many participants stated they found spiritual comfort in the time of the relocation process to the LTC facility. Participants found they could adapt to the new spiritual practices at the facilities, and arrive at a place of spiritual comfort. Nearly all participants felt spiritually cared for, through the facilities’ focus on meeting spiritual needs; thus their spirit gave them comfort during the relocation to LTC. One participant related how she found spiritual comfort during her relocation to the LTC facility:
I told them, no matter what happens, God is with you, he’s there. He is not going to ask you to go through this kind of life and leave you. Didn’t He say in Joshua 1, verse 9, ‘Have I not commanded you to stay strong in the faith, for the Lord thy God is with you wherever thou goest?’ So that’s what helps me a lot...I tell myself to only listen to the Lord...I praise God more now than ever before.

During the time of relocation, evolution of the meaning of spirituality became a part of the relocation process and an outcome for the participants based on particular aspects focused on increased time for spirituality, searching for spiritual guidance, finding spiritual life and life’s meanings, looking forward to the afterlife, and experiencing spiritual comfort. It was surprising to find that the meaning of spirituality for the institutionalized older adults was very positive and grew in process to provide significant outcomes. Conversely, very few, if any, meanings of spirituality (including the participant’s relationship with God) during the time of relocation were expressed with negative connotations by this group of study participants.

Findings Related to Research Question 5

Research question five: “What adjustments have older adults made to support their spirituality since arrival to the long term care facility?”

The answer to this research question will be framed in the themes of the Intrapersonal and Interpersonal Spiritual Relationships, plus the Extrapersonal Spiritual Resources. It is interesting to note the adjustments were reported mainly among the Interpersonal Spiritual Relationships and the Extrapersonal Spiritual Resources. This of course, is reflective of the impact of environmental changes on spirituality.
Nearly all of the participants stated they did not have to make adjustments in their Intrapersonal Spiritual Relationships; 76% of the participants (n=13) denied making adjustments to their spiritual beliefs upon relocation to the LTC facility. This property is exemplified in the following response, “No, they [spiritual beliefs and practices] are about the same [and denies adjustments since admission to LTC].”

It is interesting to note that while their spiritual beliefs did not change, this same group of participants reported adjustments were made in their Intrapersonal Spiritual practices. An increase in prayer time or praying the rosary was reported by 76% (n=13) of the participants. Prayer time was welcomed and highly thought of as supportive to the residents in the LTC facility. One participant responded: “I go [to mass and Rosary] as often as I can, once a day... I think I am closer to God now, than I was before. I was too busy taking care of my folks before to go [to mass and Rosary].”

The remaining 24% (n=4) acknowledged they made intrapersonal adjustments in both their spiritual beliefs and practices since moving to the LTC facility. Most adjustments were positive ones. However, some negative intrapersonal adjustments were reported. The negative adjustments were found in: 1) adjusting to personal prayer time in absence of their spouses, and 2) adjusting to illness that affected their personal dialogue with God.

One participant reflected sadly on the lack of her husband during shared prayer time which affected how she prays, “Me and my husband prayed daily [together, at bed time and meal prayers prior to admission to LTC], and now I have to say prayers without him. It’s not good; I miss him. It changes how I pray.”
Another older adult discussed difficulties with illness and how it affected personal dialogue with God. The participant stated, “I feel rejected [discussing dialysis treatments with worship time and role of God in her life] …I cannot attend Mass like I used to on Fridays, because of dialysis. It [dialysis] takes up all of Friday. I feel bad, very bad [about missing worship and time with God].”

While most participants stated their Intrapersonal Spiritual Relationships did not require adjustments when they relocated to the LTC facility, a few participants noted negative effects to their Intrapersonal Spiritual Relationship with God. The negative effects were revealed in changes to prayer practices and in illnesses which interrupted their personal dialogue with God.

**Interpersonal Spiritual Relationships and Adjustments**

Positive Interpersonal Spiritual adjustments emerged when respondents reported they adjusted easily to new formal religious leaders, new spiritual care staff and new faith friends at the LTC facility.

At the opposite end of this spectrum, difficult adjustments were conveyed when the respondents missed their family, faith friends, and formal religious leaders, from their lives prior to entering the LTC facility. When health care providers supported the participants in their spiritual needs, adjustments went well. An example of a positive Interpersonal Spiritual adjustment in formal religious leaders was made by one participant: “They take you to church…there are different priests all the time in the chapel. From the start I was kind of surprised. But everything is a little different here, [when compared to her home parish] but time goes on. I am used to it now. It doesn’t
bother me.” Another participant adjusted to the supports of having spiritual care staff attend to his needs and he stated:

I think they call him the chaplain assistant [spiritual care staff] and we can go to him with any problems. It sure helps. If you have a death in the family or something like that they are here to help until we get to our priest or minister... he helped me when my sister-in-law died.

One participant explained how her roommate became a new faith friend, as they both adjusted to living together, “I have a roommate that goes to the same church services, too. I have her to talk to. She is a good, good gal. She goes to Bible study with me, too. It is good you know [having a roommate who became her new faith friend].”

The opposite was true when health care providers did not support the residents’ particular spiritual needs or requests; adjustments to the facility became more difficult. Difficult spiritual adjustments occurred when respondents discussed missing their family, faith friends and religious leaders from their previous home churches. Participants relayed the following comments when asked of adjustments they made upon relocation to the LTC, “My sister in law went to the same church I did in [name of home town, 30 miles away from the LTC facility]. We don’t go together [to church] anymore. The winter is so bad she can’t visit me often. It’s tough without her.”

One participant expressed a difficult adjustment due to changes in formal religious leaders:

I don’t know the priest here very well. I can’t even tell you his name. I know he is from [name of a church]. The priest in [previous home town] was an Irish man and he always had something to say to you, something jolly and funny...it was
like you were a long time friend, and well, he still is. He writes to me about once a month; I will get a pamphlet [church bulletin/newsletter] with a little note on it. He knew me personally. I miss him. It’s hard [to adjust to the new priest].

Interpersonal Spiritual Relationships with health care providers were perceived as either supportive or non-supportive to the participant’s adjustment to the LTC environment. Supportive relationships were ones where the residents reported the health care providers reminded them of the worship schedules and assisted them physically to attend the church services which met their spiritual needs. These spiritual relationships supported the participants’ adjustments to the LTC facility in a positive manner. One participant stated:

They tell you when to attend church, if you want to go. They put me in a wheelchair and take me. It is a lot of work [for the staff]. Once a week they have communion. They bring it to me if I cannot go to church.

Non-supportive spiritual relationships with health care providers were ones in which the residents’ felt their specific spiritual requests were not met. A few participants’ spoke of scenarios where staff did not have the time to meet special spiritual requests. When asked about problems with spiritual adjustments, a participant stated:

Some days they crowd you out [staff are too busy] when you want to do something religious, ‘oh that is not necessary’…well, it is too necessary! Like if you want to go to [names a church in the local community] for prayers and they do not think it is necessary. There are so many others [residents in the facility] and so many things they [staff] have to do. Yeah, it is a problem for me.
Extrapersonal Spiritual Resources

The theme of Extrapersonal Spiritual Resources which emerged, helped participants to adjust to the LTC facility in a positive manner. Properties that helped people to adjust were: 1) attendance at religious worship services, 2) availability of religious activities to participate in, and 3) ability to access home parish information.

Worship attendance increased in frequency in many participants. Most of them discussed the easy accessibility of the chapels located in the facilities and because staff supported them with verbal and written reminders in addition to physical assistance to go to the worship services. “I like to go to the chapel for mass and rosary…I go sometimes four times a week. Sometimes they have that sing along in the chapel after church. I like that too,” this particular respondent lived out of town and reported that before admission, he only came to church (in town) on Sundays. The increased access and available church and worship services emerged as a strong property that supported the participants.

Available religious activities was a common property during adjustment to the facility that many participants reported. When asked how she adjusted to the LTC facility, one resident replied favorably to being encouraged to attend activities:

They have lots of [religious] activities here and they remind you to go to them. [She pointed to the activity schedule on her wall]. They encourage you and I am glad they do. If you just sit in the room all the time it would not be good…they help me get dressed and push my wheelchair to the chapel for mass or rosary each day.

Obtaining information from their home parish helped participants to stay connected to their previous spiritual life, which in turn eased them into making
adjustments for their new spiritual life, upon relocation. Methods used by participants to gain information from the home parish to stay connected were: 1) exchanging letters with news from faith friends and formal religious leaders of their home parishes, 2) receiving audio-taped copies of the weekly sermons, 3) receiving church newsletters and/or weekly bulletins, and 4) discussing church news with friends or relatives, to keep updated on parish happenings. The news from the home parish spurred further spiritual practices, such as prayers, for the participants. The connections to others helped the adjustment to the LTC facility to become easier, as they looked back on the past while building a new future with a new spiritual community at the LTC facility.

In summary, adjustments made by the participants which supported their spirituality during the relocation to LTC emerged along the themes of Intrapersonal and Interpersonal Spiritual Relationships, and in Extrapersonal Spiritual Resources. Most participants stated they did not have to adjust or change within themselves. Many adjustments fell under the theme of the Interpersonal Spiritual Relationships; participants noted both negative and positive adjustments. It was expected that when they relocated to the LTC setting, the people they were in relationships with would change and adjustments would be required.

Under the theme of Extrapersonal Spiritual Resources the adjustments were made in worship service attendance, worship service availability and in obtaining home parish information. When participants focused on adjusting to the new setting and changes in spiritual practices, combined with retaining ties to their previous spiritual life and faith community, positive adjustments were made by the participants. Life is a give and take
situation. Similarly, adjustments are processes in which a letting go and looking forward to the new situation occurred simultaneously; hopefully this is a balance of these forces.

**Findings Related to Research Question 6**

**Research question six:** “What barriers to spirituality (beliefs and practices) have the older adults experienced, since the arrival to the long term care facility?”

One or more barriers to spirituality were noted by all participants. The older adults expressed a loss of autonomy upon relocation to the LTC facility. Living in an institution is different from living in their chosen home, and they expressed a change in their lifestyle because of it. Additionally, other barriers reported by the participants were: 1) degree of illness, 2) loneliness, 3) lack of technology, 4) lack of worship space, 5) unavailable religious activities, 6) questioning their faith life and 7) loss of contact with previous formal religious leader.

**Barrier: Loss of Autonomy**

A loss of autonomy was present in all the participant interviews. They discussed what it was like to move into the LTC facility and how it felt to lose aspects of their autonomy. They could no longer make personal decisions about activities of daily living such as providing their own cooking and food choices, deciding what activities they would do and when to do them, working on household cleaning projects and yard care, caring for others in their homes e.g.: spouses and grandchildren, and when and how they would engage in spiritual practices. One participant stated: “I have been here a month...I am hoping and praying to go back home, but I doubt it [will happen]. It’s different here. I miss being in charge [like she was at home].”
Barrier: Degree of Illness

Many participants described episodes focused on their degrees of illness which prevented them from engaging in worship activities whether those were in the chapel, activity room or in their private room spaces. Illness became a barrier to spiritual practices. A participant focused on effects of medication which hindered her spiritual practices:

A lot of times I cannot go to church. You know, they give me all these pills at once and then I have to go straight to the bathroom for number two, so I do not feel safe going to church. They would not get me back [in time to use the bathroom]. I asked them to delay my pills on Sunday, but they tell me I have to take nine pills all at once. They [nurses] cannot delay them too much.

Another participant related difficulties with medical treatment for her illness, as a barrier to practicing her spirituality:

My day is interrupted with dialysis every Monday, Wednesday and Friday morning, but other than that I can go to Rosary or church whenever it is offered. [when asked how she feels about dialysis] I think it bothers me. It takes four hours of your day to go through dialysis and I have to go on the bus to the hospital, so it is six hours of the day to do dialysis, three days of the week.

Yet another participant discussed loss of physical strength that has become a barrier to the practice of her spirituality, “I don’t do much anymore [regarding church activities]. I just don’t have the strength…. Ever since I have been hurt I have slowed down.”
Barrier: Loneliness

Another barrier described by the participants was the change in whom they interacted with for worship and prayer time after relocation to the LTC facility, which led to feelings of loneliness. Married persons spoke of missing their spouses for daily prayer activities such as mealtime and bedtime prayers and/or attending worship services with their spouses. Widowers described feeling lonely when their children could not visit them in the LTC facility, or when the children were not able to attend worship services with them as they had done frequently, prior to moving into the LTC facility. One participant expressed the feelings of loneliness regarding meal prayer changes, “In [hometown name], we [participant and husband] said a table prayer together. It’s funny that they don’t do that here.” Another participant missed her children:

I miss my son and my daughter [as she described how they helped her with church related activities]. I am going to call him in December and have him come in [to the LTC facility]....You have not met my daughter, I suppose? Her and her husband come for six months to live in [state name]. The rest of the time they live in [state name]. She helps me with the sending of the [devotional booklet mailing] and takes me to our church [located in the community].

From these quotes, it is evident that spiritual barriers occurred in the absence of others with whom the participant had developed prior spiritual practices with. The presence of a significant loss was due to distance from or death of a loved one, was noted in the conversations.
Some participants related the lack of technology as barriers to obtaining spiritual information. Those participants who recently relocated to the LTC facility who had patterns of listening to religious programming on the radio, television, or the Internet prior to the move into LTC, stated they had some difficulties with maintaining the use of technology once they relocated. A couple of participants said their roommates did not always want to listen to the programming they preferred in the resident rooms, one stated a favorite program came on after lights were to be for quiet time, and another person reported she did not bring her own personal computer into the facility. Losing the Internet connection, which was her source of spiritual readings and connections to faith friends, became a barrier for her spiritual needs. One participant reported, “Well, we (participant and roommate) turn the TV off at 10:00. Those are the ones I would listen to [they come on later in the evening]. My favorite is Joel Osteen. It comes on when the TVs are to be off at 10:00 [PM]. I miss seeing him.”

Another person experienced loss of a computer, which became a barrier for spiritual information, “I don’t have a computer anymore. I miss it in a way, I liked to do a lot of research. I used it mostly when I had questions [regarding spiritual life and among her faith friends]...now I keep in contact with several of my friends with a cell phone.”

The quotes give examples of how losing access and ability to use technology for the purpose of obtaining spiritual information and enjoying religious programs becomes a barrier to the participants’ spirituality.
Barrier: Lack of Worship Space

Several participants related lack of worship space became barriers to fulfilling their spiritual needs. One person discussed not having a physical space or designated chapel in the facility was a barrier for her. She preferred going to a physical place, specifically dedicated to worship. She disliked the fact that services were held in the activity/dining room.

Others reported personal worship space for private prayer or meditations became a problem when they had to share a room with another person. They did not feel their individual private worship space needs were met. A participant related: “One night I said, we are going to go to bed and say our prayers [to her roommate, who became upset]. She did not understand my need for prayer nor did she respect it.” Over this concern, the participant requested and was later moved into a private room.

Prior to admission to LTC facilities, these participants stated they enjoyed being a part of a church, a physical place in which to worship, within their various communities. Not having a designated physical place for chapel services or for private devotional time was a change for the participants, which became barriers to their spirituality.

Barrier: Unavailable Worship Activities

Many participants discussed difficulties that arose when their specific type of preferred worship activity or spiritual practice was not offered in the LTC facility. The lack of the preferred spiritual practices became a barrier and an unmet spiritual need. Types of unavailable worship activities were: favorite hymns and songs from previous church, church choir, women’s groups based at home church, being a reader in church services, being a prayer leader, and religious services for a specific faith not offered in
the LTC facility. One participant reported: “I used to read in the church [leading the scripture for worship] sometimes. Some said it was real good. I miss doing that.” One participant discussed the lack of her specific type of religion as a barrier:

For the last 30 or 40 years I have been a member of what they call a metaphysical church. There is not any of them here. There are no services.... I miss talking to the leader of my church, back in [state name]. [When asked what she does for worship] I go to the other services here...I go mostly to the Lutheran ones. I like them because of the good words they use...not many people understand my kind of religion.

Lack of preferred spiritual practices was a barrier for most of the participants. This type of barrier emerged in nearly all the interviews. It makes sense that this would be a barrier; when people live in a community they are free to change churches and investigate other religions at their will. When living in an institution, the participants are not able to go to other places for different religions or different spiritual activities; they are dependant on what activities the LTC facility will provide.

**Barrier: Questioning Faith life**

Another barrier reported by participants was noted by a few people; they questioned their faith life and discussed uncertainties regarding their spiritual understandings. This was seen as a barrier to their spiritual life. One participants reported questions specific to her prayer life, “Yet, I find myself wondering...I trust the prayer, but not what I am asking for. I think it is a barrier. I gotta remember that God hears every prayer. I gotta remember that everyone has their own way. Maybe I compare the way I pray to others, and I should not.”
One person discussed the role of God in her illness, “I just want more of Him. Will He be there for me?” Another person reported questions that were not answered regarding her interpretation of the Bible, “I would have loved to have them [church leaders] help me with the metaphysical interpretation of the Bible. It would help me to understand more and discuss it. I have questions, you know.”

When a person questions their faith and spiritual beliefs, persons tend to see this as barriers to spirituality. Uncertainties leave people with a feeling of uneasiness and they then lack confidence in their spiritual lives and are forced to fall back on their trust in God.

**Barrier: Loss of Contact with Formal Religious Leader**

Throughout the interviews, many participants revealed their struggles with losing their home parish pastor, priest or minister when they moved into the LTC facility. A small group of participants felt fortunate that their home parish religious leaders made a point to visit them or stay in touch with phone calls or letters. The participants who did not have that connection said it was a barrier to their spirituality; they felt at a loss without that person to lead them through their spiritual journeys. It is apparent that relationships with religious leaders are important, and when those relationships are lost due to relocation, a barrier develops in or to that person’s spiritual journey.

The spiritual barriers theme that emerged had many properties that participants revealed. There were a total of eight different properties that were discovered during the interviews. Many barriers were apparent to many of the participants.
Chapter Summary

This chapter presented the findings of this grounded theory research study which examined the influences of spirituality within older adults during relocation to LTC. Data collection and data analysis processes were reviewed. Findings were reported specific to the six research questions posed at the beginning of this study. The latter part of this chapter reported the Axial Model developed by the researcher, to further analyze the study’s results.

In conclusion, this study examined 17 older adults’ perceptions through 20 interviews, regarding the influences and uses of spirituality during the time of relocation to LTC facilities, in three different facilities in a rural, frontier area of a Northern plains state. The findings revealed the population had a varied religious background and came to the LTC settings with a rich spirituality and strong religious history. The participants expressed the desire to attend to their spiritual needs during relocation and in most cases, found ways to do this while effectively overcoming spiritual barriers. During the adjustment period they were pleased to identify Spiritual Blessings as part of the process and as an outcome of spiritual influences during relocation. Spiritual barriers were also present, and when/if the nursing care facilities assist in minimizing the barriers, a more positive state of spirituality with increased blessings, may be attained by the older adult in long term care.
CHAPTER V

THEORETICAL MODEL

This qualitative study examined the spirituality of older adults during relocation. The purpose of the study was to develop a theoretical model that describes the influences of spirituality within older adults during the first six months of relocation to a long term care facility. This chapter will introduce and examine the theoretical model which emerged from the data analysis. Additionally, the framework of symbolic interactionism (Blumer, 1969) will be addressed within the discussion of various aspects of the theoretical model.

Theoretical Model Description

The theoretical model that emerged from the data is depicted in Figure 2: “The Influences and Uses of Spirituality by Older Adults During Relocation to Long Term Care.” This explication will address the pictorial model. There are four main foci to the theoretical model: 1) God as central to the lives of the older adults, 2) the circles in the center of the model focus on older adults’ spiritual relationships and resources for spirituality, 3) spiritual barriers and, 4) spiritual blessings. Each theme of the model will be examined more fully.

Blumer (1969) stated that meaning “arises in a process of interaction between people...their actions operate to define the thing for the person” (p.4). Furthermore, symbolic interactionism (S.I.) defines meanings as “social products” and “creations that
are formed in and through the defining activities of people as they interact” (Blumer, 1969, p.5). It is the openness to the influences of God present in the spiritual interactions of people within themselves, between/among others and involved with spiritual resources available during relocation to LTC facilities that this theoretical model describes. Spirituality of the older adult during relocation flows as in the symbolic interaction process. This process supported the creation of new behaviors which resulted in the spiritual blessings as the social products.

Circles of Relationships and Resources

The three intertwined circles at the center of the model depict the findings of how the study participants perceived God’s presence in their engagement in this relationship (internally) and with others (externally). Additionally, it connects the resources used to support their spirituality development during the time of relocation. Parts of the circles overlap onto each other, with God at the center of the diagram; the circles are not distinct separate entities. Participants expressed the notion that God is at the core of all they do, all that happens to them and all they believe, regarding their spiritual life.

Core Variable: God

God is located at the center of the circle. All participants felt their Intrapersonal and Interpersonal relationships and resources drew them closer to God; they had connections to God through utilization of strategies that supported their spirituality in all three circles. Thus, the care variable in this model is God. God is central to the core of spirituality within the older adults. Note the term for their supreme being or higher power is God, which is the term used almost exclusively by all study participants.
The Influence of Spirituality Within Older Adults During Relocation to Long Term Care

SPIRITUAL BARRIERS

- Loss of Autonomy
- Degree of Illness
- Loneliness
- Questioning Faith Life
- Lost Connection to Spiritual Leader
- Lack of Technology
- Lack of Worship Space
- Unavailable Religious Activities

INTRAPERSONAL SPIRITUAL RELATIONSHIP

- Self and God
- Listening to God
- Dialogue with God
- Prayer
- Meditation
- Scripture Reading

INTERPERSONAL SPIRITUAL RELATIONSHIPS

- Faith Friends
- Formal Religious Leaders
- Family
- Spiritual Care Staff
- Health Care Providers

EXTRAPERSONAL SPIRITUAL RESOURCES

- Time for Spirituality
- Seeks Spiritual Guidance
- Searches for Life's Meaning
- Looking Forward to Afterlife
- Experiences Spiritual Comfort

GOD

Degree of Wellness
Religious Practices
Worship Space
Technology
Home Parish Information
All participants reported belief in God, and all reported Christian denominations for their religion; hence the term God fits this study’s theoretical model well.

The S.I. premise that “humans act toward things on the basis of the meanings which these things have for them” (Blumer, 1969, p.2) relates to the participants’ placement of their interactions with God at the center of their lives. The belief in God as central to their lives created behavioral responses described by the participants including the time they lived outside the LTC facility continuing to the time during relocation to the LTC facility, e.g., attending church, enacting prayer rituals, and participating in church activities and church leadership roles.

*Intrapersonal Spiritual Relationship: Circle*

From the strategies box of the axial model, it became apparent that there were degrees of relationships fostered by spiritual and religious practices that occurred among the participants, which helped them to connect to God. The approaches to their relationships were grouped together under the theme of Intrapersonal Spiritual Relationships. One of the relationships was between God and the person. As defined in Chapter 4, the term Intrapersonal Spiritual Relationship reflects the participant’s internal expressive process in which they communicate internally with God. It is what happens to connect them with God during their daily life routines, which maintains their spiritual life, and is supported by their religious practices.

Within that circle are the specific unique properties of having a spiritual relationship between the person and God. To enhance that relationship, study participants reported properties of: listening for God frequently, dialoguing with God alone and in worship, using prayer and meditation to enter into God’s presence, and engaging in
scripture readings to learn more about God’s word. The participants were very eloquent when describing how they connected to and maintained their personal relationships with God and the meaning it held for them. They felt it was necessary to engage in the behaviors present in these properties to support themselves during the time of relocation to LTC.

*Interpersonal Spiritual Relationship: Circle*

The second relationship reported by the participants was the theme denoted as Interpersonal Spiritual Relationship. This interpersonal relationship emerged during the study when participants talked of how they relied outwardly on other relationships with people, to support their spirituality during relocation to LTC. As many participants explained it, they first had God within their persons and secondly they needed people around them to support their spirituality and their particular spiritual practices.

The term Interpersonal Spiritual Relationships is defined as: the participant’s connections with other people in their life that supports and enhances their spiritual beliefs and practices. It is through this fellowship that the external manifestation of spirituality ensues; this is their vehicle for enacting their spirituality.

The properties of this circle’s theme were part of context and intervening conditions present in the axial model; they were grouped when participants discussed their connections with others before and during the relocation time period. Participants expressed a need to maintain connections with others who supported their spirituality prior to relocation, and they expressed happiness when new people in their lives (such as spiritual care providers and staff members in the LTC) supported their spirituality during the time of relocation.
The specific connections within them that were important to the participants were with: faith friends, formal religious leaders such as priests and pastors, family members who supported their spirituality, and spiritual care staff at the LTC facilities, including specific health care providers who acknowledged and supported their spiritual needs. When they maintained and strengthened their Interpersonal Relationships and had adequate Extrapersonal Resources, many participants felt supported and able to adjust spiritually and cope with the stressors of the relocation to LTC.

The social interaction that supported the participants’ spirituality is a part of symbolic interactionism; Blumer (1969) stated “meaning is derived from or arises out of the social interaction that one has with one’s fellows” (p.2). It is the connections with others, the social interactions which the participants experienced with the variety of persons whom they leaned on during the relocation and interacted with about their spiritual beliefs that helped them to sustain a sense of spirituality and to grow spiritually at this time in their lives.

Extrapersonal Spiritual Resources: Circle

Portions of the Extrapersonal Spiritual Resources circle overlap with the circles of Intrapersonal and Interpersonal Spiritual Relationships, again with God at the center of the circles depicting Him as the central focus of the participants’ lives. The definition of this theme reflects those external items, both tangible and intangible, which assist participants to enhance their spirituality and relationship with God and are meaningful to the older adult. These are physical places and material things which support spiritual practices, e.g. rosary beads, praying the rosary, and presence of chapels.
This theme emerged when analyzing participants’ conversations, when they stated what actions they took in their lives, both before and during relocation, which supported their spirituality. The theme and its properties emerged from intervening conditions present in the axial model, including some properties in the strategies box. Properties of the Extrapersonal Spiritual Resources include: having a degree of wellness with which to enact their spirituality; practicing their religion as they needed to in the manner in which it was important to them; having worship space in which to attend to their spiritual needs; using technology such as radio, television or the computer to connect to religious programming; and finally connecting to their previous home parish for information regarding church services and happenings. All of these are external resources to the participants, that support their spirit and assist them to engage in spiritual practices.

According to Blumer (1969), people ascribe meaning to things by interpreting the meaning of the thing to be considered. This is known as an “interpretive process” (Blumer, 1969, p. 5). The various physical places and material things that emerged as Spiritual Resources for the people in this study, were interpreted through their views of life and spirituality at that time and place; specific to the relocation process. The study painted a picture of what they interpreted their spiritual resources to be in that moment.

Spiritual Barriers

The next theme of the theoretical model that emerged during data analysis was entitled “Spiritual Barriers” (depicted by the rectangular shaped box). Participants described the barriers as something undesirable, not wanted, or something that got in the way of their normal spiritual state. The rectangular shape has arrows pressing down on
the relationships and resources circles, to express how barriers’ weight can burden or press down and inhibit the person’s spiritual self.

The Spiritual Barriers in this study emerged when participants were asked to report barriers to spirituality noted during relocation to the LTC facility, as compared to life prior to entering the LTC facility. The properties of the spiritual barriers theme can be found on the axial model located in context and antecedents.

Symbolic interactionism posits that actions of human beings occur when they take into account different things they experience and to which they subsequently react, based on how they interpret that particular thing (Blumer, 1969). The spiritual barriers in this study were the reactions to the variety of new things in the participants’ lives that were experienced during relocation to the LTC facility. These items/things were interpreted as barriers that negatively impacted their spiritual lives.

Spiritual Barriers properties can be viewed within the context of Intrapersonal and Interpersonal Spiritual Relationships and Extrapersonal Spiritual Resources. The first Barriers to Spiritual Relationships are noted in the properties of: loss of autonomy, degree of illness, feelings of aloneness/loneliness, and questioning faith life. These clearly related to the person’s Intrapersonal spiritual development. The Interpersonal Barrier to Spiritual Relationships is losing connections to known spiritual leader, which relates to their spiritual development. The last three Barriers to Spiritual Resources are lack of technology (for religious programming), lack of worship space and unavailable religious activities, which reduce extrapersonal resources for spiritual growth.

In summary, the Spiritual Barriers emerged when participants were asked about barriers to their spirituality during relocation. The properties impact their Spiritual
Relationships and Resources (depicted as overlapping circles). Spiritual Barriers impact the study participants’ spiritual being and the ability to grow spiritually. Not all participants expressed each and every property; the ones identified emerged as the interviews’ conversations were analyzed for themes and were determined as significant to fleshing out the logic models.

**Spiritual Blessings**

The Spiritual Blessings square (located on the right hand side of the diagram) incorporates the consequences found in the Axial Model; also considered outcomes of the interactions of the three themes with God and their indentified Spiritual Barriers. The participants shared how the move into LTC resulted in many positive outcomes: 1) having time for spirituality, 2) seeking spiritual guidance, 3) searching for meaning in their life, 4) experiencing spiritual comfort and 5) looking forward to the afterlife. Spiritual blessings were noted by the participants as outcome experiences related to the influences and uses of spiritual relationships, resources and God during their relocation to LTC. The term was used frequently by participants. Spiritual Blessings are ongoing and influence their spiritual beings.

Similarly to how symbolic interactionism was viewed for Spiritual Barriers, the framework is viewed in the same light for Spiritual Blessings. The theory posits that actions of human beings occur when they indicate to the self, different things they experience and which they subsequently act upon, based on how they interpret that particular thing or incident (Blumer, 1969). The Spiritual Blessings in this study were responses to a variety of new things and encounters (both positive and negative) in the participants’ lives that were experienced during relocation to the LTC facility. These
situations/things were interpreted as positively impacting their spiritual lives. Indeed, the participants felt spiritually blessed with life at the LTC facility, for numerous reasons. It is through the process of symbolic interactionism the participants could figuratively take a step back from their lives, examine their behaviors and arrive at the conclusions that they had received spiritual blessings during the relocation process to LTC and were still experiencing them.

*Time for Spirituality*

Many participants discussed the increased amount of time they had to spend on spirituality, after the relocation to LTC. They stated it resulted as a release of responsibility in their lives occurred; many no longer had to cook, clean, do laundry, or care for spouses in their lives once they relocated to LTC. While their labor tasks decreased, they had increased time for spirituality and to delve into spiritual matters of their choosing. This was acknowledged by many participants as a blessing to them, which they were pleased to experience upon relocation to LTC.

*Seeks Spiritual Guidance*

Another property of the theme Spiritual Blessings came about when the participants expressed a need to talk about spiritual matters more frequently or more openly with others of the same faith, with a religious leader, or to gain spiritual guidance through reading the Bible. Having the desire to seek more spiritual guidance and understandings was looked upon favorably by the participants.

*Searching for Life’s Meanings*

Many participants stated that with their increased focus on their spirituality since the relocation to LTC, they also sought meaning in their life and/or in their spiritual life.
Some attributed this to the positive process of searching for meaning because they were growing older, had more illnesses, or had more time to ponder the question of life’s meanings. Regardless of the reason, many participants stated or implied that they were glad this relocation prompted them to seek meaning in and about their life and spiritual life.

*Looking Forward To the Afterlife*

Upon analyzing the data, another Spiritual Blessing emerged; participants found with relocation to the LTC facility, they were moving into the ending stage of life. With this realization, many expressed a desire and aspiration for their spirits to go to heaven, or that they looked forward to their spiritual life after their physical body dies. Many participants expressed delight when they talked about the spiritual blessings waiting for them at the end of their lives; that of going to heaven to see or meet their Savior and others who had died before them. This was seen as a positive aspect of having relocation because they now had time to think these thoughts.

*Experiencing Spiritual Comfort*

A final property that emerged in the theme of Spiritual Blessing was that of experiencing a state of spiritual comfort. Many of the participants stated that after they had settled into the LTC home, they found comfort in the facility routines of spiritual care and spiritual practices. Most of the participants who found this state of spiritual comfort adapted and adjusted to the routines of the facility for spiritual care and religious services. The participants described it as a blessing, that they could adjust to a different state of comfort than before, and accept the change to life in the LTC facility. One person spoke of spiritual comfort as being “well in his spirit” and another described it as
"being good" with her. The gift of experiencing spiritual comfort lent itself to a positive state of spirituality.

In summary, the Spiritual Blessings theme was a term coined by many participants in this study. It reflects a state of positive feelings regarding the participants’ spirituality which were an outcome for the influences and use of spirituality during relocation to LTC.

Blumer’s (1969) theory of symbolic interactionism was the framework informing this study. The S.I. theory is predicated on the premises that humans need groups to interact with (nature of social interaction) that people must interpret and give meaning to the experiences and things in their lives. This theory informs the processes of spirituality within older adults during relocation to LTC.

Theoretical Model Summary

The theoretical model that emerged from this study’s Axial Model and its representative categories presents the relationships between themes and their properties. Various terms were arrived upon during the course of the data analysis, which lead to recognition of the importance of spiritual relationships and resources that make up the older adults’ spiritual realms. Barriers were identified that impacted the older adults’ spiritual relationships, maintenance of spiritual beliefs and practices, and their abilities to use spiritual resources. Spiritual Blessings were the outcome of the process of being influenced by spirituality and using spiritual practices during relocation. Blumer’s (1969) theoretical framework of S.I. informed this study effectively. Posits of Blumer’s theory were functionalized during the discussion of the main themes of the theoretical model which emerged from the data analysis of this study.
CHAPTER VI

CONCLUSIONS

*Brief Overview of Study and Findings*

The purpose of the study was to develop a theoretical model that describes the influences of spirituality by older adults during the first six months of relocation to a long term care facility. This qualitative study was undertaken to examine six research questions regarding spirituality of older adults during relocation to long term care facilities. Heretofore, the literature had not addressed this problem. In a discussion about barriers which separate spirituality and nursing care, a "lack of theoretical paradigms to capture the concepts of spirituality" combined with "a paucity of language to describe the spiritual aspect of human experience" are attributed to the problems in advancing spiritual care (Maher, 2006, p.423). "The concept of spirituality exists, but a consensus about its parameters does not" (MacLaren, 2003, p.461). In order to further understand the lived experience of the older adults who relocated to LTC, this study was begun to discover an understanding of the role spirituality has in the adjustment process and its needed provision of nursing care. Findings of the study explicate this experience and provide perceptions of the role and influences of spirituality for these older adults in the social context of life in LTC facilities. Three interactive themes emerged from the data as reported by the older adults when they connect to their spiritual selves; 1) intrapersonal spiritual relationship, 2) interpersonal spiritual relationships, and 3) spiritual resources. Additionally, results indicated spiritual blessings and spiritual barriers are experienced by this population.
Chapter Content

The first part of this chapter will address study limitations. Next is a discussion regarding the study and its findings, specifically the term of spiritual blessings. In doing so, it will address the literature related to this new term that emerged during the participant interviews and analysis. The discussion will explore the importance of spirituality during the first six months of relocation by older adults to LTC facilities.

Implications from the findings, based on this qualitative research study will be discussed. Implications will be couched in the form of practice, teaching of theory and policy development. Finally, the chapter will entertain ideas for future research endeavors. Research opportunities abound, and are called for by this author and others in the field of spirituality of the elderly.

Limitations

Several limitations to this study were noted: 1) the rural nature of the population, 2) the participants self-selected into the study after meeting study criteria, and 3) all participants expressed a religious affiliation based on Christianity. The following paragraphs' discussions will examine limitations more fully.

The population of this study currently lives in a rural frontier area of a Northern plains state. All but one person were born in the same state and raised in a rural setting. Rural people of that era, raised during the depression and World War II, oftentimes used their church life as a social life. Due to the remoteness of their living environment, church was a welcome relief from the isolation of a farm. Church may have been more central in their lives and upbringing than their urban counterparts.
Another feature of rural living is the self-determination of the rural pioneers. In a study conducted among elders living in a rural area in the southeastern United States, religious faith was used as an important coping mechanism when the elders dealt with health problems (Koenig, George and Siegler, 1998). Older adults rely on their faith to deal with health changes, and they become more reliant on it when living in a rural area. These factors of the study population need to be recognized when comparing findings to others who live in more urban settings and relied on other community supports to assist them through their life’s tougher times, such as social workers and welfare relief. For these reasons, the ruralness of the population may have influenced the study’s findings of a reliance on religion and a well developed spiritual awareness of participants in comparison to other sections of the nation.

A second limitation of the study is the self-selection of the participants. Once participants met screening criteria, they were invited to participate in the study. Those who volunteered were willing to talk openly about their spiritual practices and beliefs. This self-selection into the study may have swayed the findings of highly positive spiritual blessings. It is unknown what outcomes would have been discovered by a person who was more private and not comfortable talking about their spirituality.

A third limitation is that of the participants’ expressed religious belief in Christianity. All participants stated they were affiliated with a Christian faith denomination; none were of other religious sect such as Buddhism. This limits the study to a Christian-based belief system. It is unknown what findings would have emerged as findings if persons of different religious ideologies had been included.
Discussion

Meaning of Spirituality

“Spirituality is more than the response to a religion or set of beliefs. It refers to the core of a person’s being and his or her connection to the universe” (Krieger-Blake, 2006, p.338); this descriptive statement aligns with the findings of this research study. Connections to God, to others and to spiritual resources make up the core of the findings. These findings reiterate that spirituality is much more than a response to a certain religion or belief system. Connections to self and social systems are very apparent when the older adults discussed their faith beliefs and practices. The study indicates that God is at the core of the person’s being. God is represented on the theoretical model as being at the core of the spiritual relationships and directive in the use of spiritual resources. It is therefore concluded that God is the center of spirituality for the adults in this study and is the core of their being.

Meaning of Spiritual Blessings

The term “Spiritual Blessings” emerged from the study. Spiritual Blessings were an outcome of life spent in the long term care facility, specific to this group of older adults in this moment of time. Upon completing another literature search, focused on spiritual blessings, the results indicated the term was minimally located or infrequently used in nursing and allied health literature. One facet of the term ‘spiritual blessing’ denoted blessings heralded upon a sick person by a formal faith leader for purposes of bolstering the sick person’s spirituality (Chang, 2001; Conley, 2009; Sanders et al., 2009). Another thread, similar to the use of the term in this study, was that of spiritual blessings or gifts received by older adults at the end of their lives or by adults and

Spiritual blessings heralded upon a sick person by formal faith leaders or healthcare practitioners for the purposes of bolstering spirituality or healing the sick person, were noted in the literature for diverse populations. These populations included: 1) the Polynesian culture found in Hawaii (Chang, 2001), 2) Mormon women in the state of Utah (Conley, 1990), and 3) children with special health care needs in the state of Arizona (Sanders et al, 2009). These three separate studies are related, in that spiritual blessings were given by a formal religious leader to the ill person in support of the ill person’s spirituality and/or to improve their healing status. None of these studies focused specifically on older adults, nor did they examine LTC settings. This use of spiritual blessing arrives at the ill person’s persona via a formal religious leader or healthcare practitioner who is permitted to invoke blessings from God which alludes to a ceremonial process. This requires a middle man who asks for spiritual blessings directed at the ill person; it is different than the description found among older adults in LTC who described spiritual blessings on a personal basis, granted to them by God directly. When the term is used in this manner by older adults, it relates a great deal to intrapersonal spiritual experiences.

Other research used the term spiritual blessings as something that is given the person from God directly (Chang, 2001; Conley, 2009; Sanders et al, 2009). A phenomenological study of chronically ill adults described their “lives as being blessed, or as a gift” (from God) “despite or through the life-threatening illness” which the participants faced (Albaugh, 2003, p.596). Life was seen as a blessing or a gift; this is
similar to the older adults’ views of spiritual blessings during relocation to LTC facilities. The older adults also felt they had been gifted with their life, and could perceive it as a gift or blessing from God.

Another geriatric practitioner (Jenkins, 2004) discusses the view of perceiving American communities of older adults as “elderly blessings” that could teach many lessons to those whom they interact with, as opposed to viewing the elderly American population as a geriatric burden to society. Jenkins’ use of the term “elderly blessings” focused on spiritual lessons the elderly could teach others who were younger than they were at the time (2004). Jenkins (2004) uses the term in the form of a descriptive label for a group of people. This use is quite different than the research based studies reported in this section because it does not refer to God or a higher power.

A mixed methods study of older adults at the end of their lives described how the survey participants reported that “life was a gift or a blessing”, and that they “felt no fear while they were being called by the Lord” (O’Brien, 2003, p.296). This study reported that older adults felt they received gifts or spiritual blessings directly from God at the end of their life. O’Brien’s explanation for spiritual blessings (2003) is similar to the findings of the relocation study of older adults, when they discussed the outcome of receiving spiritual blessings during relocation to LTC. It can be concluded, in this study, and from Albaugh’s (2003) and O’Brien’s (2003) studies, that spiritual blessings are outcomes of a spiritual nature, felt by adults at the end of life and in life-threatening situations, in which the person develops positive feelings involving their spiritual selves, which they feel are given to them directly from God.
Additionally, Lantz's study involved the older adult in a questioning process as they journeyed through the relocation period to LTC. The act of asking questions and thinking through their spiritual beliefs indicates the older adults are not merely resting or waiting for life to be over. It is evident the older adults in this study were growing and developing in spiritual and life understandings. This finding of spiritual growth and development reflects King's (2004) findings of spiritual flourishing: “I have shown that aging can be a positive experience and that spiritual development can still occur at a time when physical and mental powers decline” (King, 2004, p.141).

In conclusion, the literature reflects a minute number of studies that examined the term spiritual blessings and presented two main dichotomies of thought related to the term. The first group of studies used blessings as prayers or wishes granted to someone by another person to invoke a higher power to bless the ill person. The second school of thought was found in adults who were ill or at the end of their lives, when they experienced a blessing in their life, given to them directly from God. This second school of thought is similar to this dissertation study findings in that it is given directly from God to the person, and the persons who received it have multiple health problems and are older adults. See the Table Four which is a synopsis of the literature and this study’s findings.

Implications for Practice

Based on this study, nursing care standards and best practices could be built, to ease stressful situations for the elderly who relocate into institutionalized settings. Implementing best practices for spiritual care during relocation would benefit the older adults ultimately. Coordinated nursing interventions and standards could be utilized to
help older adults use their spiritual dimensions to adjust to life in LTC facilities. Best practices regarding promotion of spiritual care relationships and spiritual resources, while minimizing spiritual barriers, should be organized and thus, delivery of care will be improved.

**Table 6: Spiritual Blessings Literature Synopsis**

<table>
<thead>
<tr>
<th>Concepts from Lantz, 2009</th>
<th>Concepts: Literature and Various Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blessings come directly from God</td>
<td>Blessings come from God, through formal religious leaders (Chang, 2001; Conley, 2009; Sanders et al., 2009)</td>
</tr>
<tr>
<td>Blessings purpose was to increase and understandings &amp; self-awareness</td>
<td>Blessings purpose was to call for physical spiritual health and emotional healing (Chang, 2001; Conley, 2009; Sanders et al., 2009)</td>
</tr>
<tr>
<td>Blessings are different than gifts</td>
<td>Blessings are equated with gifts (Albaugh, 2003; Jenkins, 2004; O’Brien, 2003.)</td>
</tr>
<tr>
<td>Blessings are outcomes that lead to feelings positive feelings about relocation</td>
<td>Blessings are outcomes that lead to positive feelings about self at end-of-life (Albaugh, 2003; O’Brien, 2003)</td>
</tr>
<tr>
<td>Blessings are views of the afterlife</td>
<td>No discussion</td>
</tr>
</tbody>
</table>

A place to begin is the assessment of the older adult’s spirit and spiritual practices upon admission to LTC. The assessment would lead to discovery of spiritual barriers that could interfere with their spirituality or could put a person at risk for spiritual distress. Such questions are: 1) Have you practiced religion or spirituality during your life? 2) What specific ceremonies and practices would you like to continue in this facility? 3) Are there any specific people that could be contacted to support your spiritual and/or religious beliefs while you are living in this
facility, and who might they be? 4) What particular space concerns do you have for practicing your religion or spiritual routines? 5) How could the staff of this facility help you to fully meet your spiritual needs? and 6) Please notify the staff should any concerns or problems arise with your religious or spiritual practices and beliefs.

Older adults and their families should be educated about the spiritual needs of LTC residents based on these best practices, so they could assist with meeting those spiritual needs to remain connected to God, to others, and to their identified spiritual resources. When the older adult, the family, and the caregivers are all working for the best possible spiritual outcomes, the needs of the LTC residents will be met.

Best practices regarding spiritual care of the older adult during relocation to LTC should be shared and implemented not only by the caregivers, nurses, and nursing administration but also by the spiritual care providers in LTC. The practices gleaned from this study would be: 1) conduct immediate assessment of spiritual beliefs and practices upon admission, 2) take actions to meet the requested spiritual needs of each older adult as soon as the need is identified, 3) have routine visits from spiritual care providers to assess and discuss spiritual life with the older adults, 4) involve the older adults’ family, friends and faith friends (from pre-admission life) in their current life in the facility, 5) introduce the older adults to other residents who have similar spiritual and religious needs, and 6) link the older adults to religious and faith resources provided in the facility as quickly as possible after the time of admission.

Chaplains, formal religious leaders and social workers in charge of organizing religious and spiritual care interventions will be given the study’s findings. The spiritual care of the institutionalized older adult is a team effort and all team players should be involved in this aspect of care through educational offerings. This thought is echoed by a study conducted by Daaleman,
et.al. (2008) when they explained that a spiritual care team is made of many entities who provide care to elderly at the end of life such as nursing, social workers and chaplains.

Implications for Teaching of Theory

Greenstreet (1999) postulated nurse educators do not teach spiritual care content well, and they have a poor record in preparing student nurses for the delivery of spiritual care. After completion of a literature review, she called for clarification in teaching methods and research into how the subject of spiritual care may best be taught. Knowing this, the relocation study is a beginning; the theoretical model developed could be used as a starting point for teaching student nurses the theory behind meeting spiritual needs of older adults in the early phases of relocation to LTC settings. Students must be taught the theoretical stance behind care decisions. When theory is understood, care decisions flow from it.

Student nurses must be taught gerontological principles, and even more specifically, principles of spirituality as they affect older adults. Several ideas are supported by the American Association of Colleges of Nursing to increase gerontological content that could be enacted by nursing faculty. The ideas are to 1) fully infuse geriatrics into the student nurse curriculum and 2) develop faculty expertise in gerontology (Thornlow, Latimer, Kingsborough and Arietti, 2006). With this push to increase gerontological content in nursing curriculum, a learning objective for spirituality of the older adult should be added. Such an objective could be: Identify spiritual assessment techniques and spiritual care interventions for older adults during relocation to long term care facilities. It would behoove the leaders in colleges of nursing to assign the content to faculty members who have had backgrounds in the provision of spiritual care or to those who could spend time to learn and develop skills in spiritual care of the older adult.
This theoretical model should be shared with practicing nurses; the model should be advanced at conferences and in nursing journals to impact a wide audience. Practicing nurses should be taught new knowledge so they can update their thought processes about spiritual assessments and spiritual care interventions. Research is the basis for practice; the more research a nurse understands the more likely she is to support the client care needs and change subsequent practice patterns.

One such avenue to reach practicing nurses to inform them of the findings is to present at conferences specific to holistic care or to conferences focused on care of the geriatric patients. The researcher has made application to present this study at a national conference of holistic nurses, and has plans to present the findings at a state-level conference for those who work with older adults. These avenues would best fit the dissemination of findings to those who are in practice.

*Implications for Policy Development*

McSherry and Ross (2002) iterated the lack of research in assessment and delivery of spiritual care. They called for development of scholarly work in the arena of spiritual care. Scholarly work should translate into policy change. One necessary change in particular is that of the NANDA nursing diagnosis labeled “Relocation Stress Syndrome” and “Risk for Relocation Stress Syndrome” (2009). These particular nursing diagnoses only address the physiological and psychosocial disturbances noted when a person transfers from one location to another; they do not address the spiritual aspects of the person during relocation. To be considered holistic and reflect the total person, the nursing diagnoses should address spiritual needs during relocation. The NANDA committees should be addressed and this research added to their knowledge base.
so that policy change can begin with the Nursing Diagnoses Definitions and Classifications to include the spirituality of relocation.

This researcher anticipates petitioning the NANDA organization to request relocation stress syndrome include the spiritual aspect of relocation, specific to the LTC environment. They may request a literature review be conducted to examine the issue further. This could be done and the findings be consolidated, for presentation to the NANDA organization.

Additionally, the study’s findings should be written into manuscript form and disseminated through scholarly publications in the fields of nursing and geriatrics. There are plans for this written work being made by the researcher and her advisor.

**Future Research Endeavors**

The discipline of nursing must continue to investigate the definitions of and theoretical underpinnings for spirituality of older adults. Park calls for theory to be developed in this arena: “A thorough conceptual model of the relations between multidimensional constructs of religion/spirituality and multiple dimensions of health...is greatly needed” (2007, p.330).

Another nurse researcher calls for research to improve conceptual clarity specific to different belief systems regarding religiosity and spirituality at the end of life for older Americans (Field, 2007).

Nurse scientists need to meet at conferences and generate ideas to test and validate the plethora of theoretical underpinnings and definitions for spirituality of older adults, specific to those who reside in institutional settings such as LTC. They must reach a consensus, so that other issues in the arena of spirituality and spiritual care can be investigated. If basic understandings were agreed upon, the nursing world could look into other concerns for the human spirit. From the conferences and generated ideas, researchers could conduct studies and publish results in
journals and texts, so that others would learn from their findings. Both types of research are needed, quantitative and qualitative, to arrive at definitions and theoretical underpinnings for the abstract term known as “spirituality”, and its inherent links to holistic care. This study arrived at this definition of spirituality: Spirituality is having an intrapersonal relationship with God, fostered through other relationships while manifesting and maintaining the person/God relationship and through utilization of channels and mechanisms provided to older adults living in the LTC environment.

When the aforementioned processes are used, the outcomes will deliver rich, in-depth themes about how people experience the spiritual self when coping with adjustments and stressors; there is a need to study relocation through the eyes of older adults, into other settings. Older adults who move into assisted living, or to homes in other towns so they are closer to family members, should be studied in a qualitative manner, too. This type of a research program would certainly add to understandings for future publications and continued education of nurses and others who care for the elderly.

To summarize the benefits of generating new research and knowledge with the spirituality of older adults in mind, research into matters of spirituality are important and must be conducted. As stated so eloquently by a nurse scientist, “We must take the necessary measures to keep spirituality and spiritual care in the forefront of our nursing practice, thereby enriching the lives of those we care for as well as our own lives” (Kociszewski, 2003, p.147).

Chapter Summary

In conclusion, this chapter reviewed limitations, discussed findings regarding Spiritual Blessings and the implications for practice, teaching theory and policy development. Ideas for future research endeavors were stated. Through all the
discussions, the importance of caring for a human spirit was highlighted. As nurses, whom or what are we healing, if we do not espouse the care of the whole person? A person is much more than the physical, social and psychological being; it is the spirit that binds the person together. To promote healing in our patients, we must support and care for the holistic being. This study gives health care providers direction to accomplishing this task by supporting what older adults have perceived as useful spiritual relationships and resources during relocation.

Conclusive Perceptions

When one reviews the entire study, there are five important points to make: 1) this population of older adults drew upon God during relocation to LTC, 2) they had a strong spiritual base of beliefs and practices to draw upon, which supported them during the relocation, 3) they realized engagement in relationships with others strengthened their spiritual lives, 4) they drew upon diverse external spiritual resources to meet and expand their spirits’ needs and understandings, and 5) they experienced spiritual blessings as the outcome of relocation to life in LTC facilities. The shortened version of the aforementioned points is this: people need God, others and diverse resources in their lives to meet their spirits’ needs and for growth during relocation. When those aspects are present, the older adults arrive at a place of spiritual blessings centered in God. The process of becoming a holistic being who lives in LTC is not static, it is dynamic. This is what Blumer’s symbolic interactionism stated; people must interact with others and things in their lives, to understand and gain enhanced perspectives on life.
APPENDICES
APPENDIX A

Consent Form
Consent Form

Dear Resident of a North Dakota Long Term Care Facility,

You are invited to participate in the research study “The Spirituality of Older Adults During Relocation to Long term Care”, being conducted by Cheryl Lantz, RN, MS a doctoral student at University of North Dakota, College of Nursing under the supervision of Eleanor Yurkovich, RN, EdD, her dissertation advisor. The study focuses on older adults, and how they experience spirituality when they relocate to long term care facilities. You are being asked to participate in the study because of your recent move into the long term care facility. This study could not be conducted in any other manner. No one else can provide the information needed for this study.

This study will provide understandings to develop a new theory of how older adults view spirituality and more specifically, how you use your spirituality regarding spiritual beliefs and practices, during the transitions of moving from a home or the hospital into the long term care facility. The study will consist of open-ended interview questions asked solely by myself, the nurse researcher. Approximately 30 people will take part in this study. It will take approximately 60-90 minutes to complete the interview. The interview will be conducted privately, in a meeting room at the long term care facility. The interviews will be audio-tape recorded, to assure completeness of records. There is the possibility of a second meeting with the researcher to clarify responses within 1-3 months of the initial interview. If this is needed, you will be asked if you are willing to complete a second interview, and the consent will be read to you again.

The possible risks of the study are minimal. A person may experience some anxiety if negative feelings and emotions are discussed. Should you experience anxiety upon completion of the interview, Cheryl Lantz will refer you to a helpful source such as the social work department and/or the spiritual care department at the long term care facility. If during the interview you become anxious or upset, I, as the researcher, will terminate the interview and contact helpful resources for support.

The benefits of this study may not affect you directly. However, the results will be significant to scholars and those who care for residents of long term care facilities as they strive to understand spirituality and the relocation process for an older adult. The information you provide may be part of presentations and publications in the field of gerontology and/or spirituality studies. We cannot guarantee or promise you will receive any benefits from this study.

If you choose to participate, a token of appreciation for your time and sharing of ideas will be provided to you. A $5.00 gift certificate for your use will be given to you.

The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.
Any information learned during this study will remain confidential. The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies, the UND Research Development and Compliance Office, and the UND Institutional Review Board. Actual names will not be identified, but participants will be recoded and transcribed tapes will be coded. A list of participant names will be coded and kept in a separate locked file with the nurse researcher. Tapes and written notes from the interviews will be kept for a minimum of 3 years after completion of the study. Only the researcher, the advisor and people who audit IRB procedures will have access to the data. After 3-5 years, both written and taped data will be destroyed.

Participation in this study is strictly voluntary. You may choose not to participate, or to quit at any time during the interview. If so, there is no penalty. By reading this consent form and engaging in the interview, you are giving your consent. Your responses will remain confidential.

Should you be interested in the findings of this study, please contact Cheryl Lantz, the researcher. Findings will be available upon completion of the study.

The researchers conducting this study are Cheryl Lantz and Eleanor Yurkovich, her advisor. You may ask any questions you have now. If you later have questions, concerns or complaints about the research please contact Cheryl Lantz at 701-483-7988. Eleanor Yurkovich may be contacted at 701-777-4520.

If you have questions regarding your rights as a research subject, or if you have any concerns or complaints about the research, you may also call the University of North Dakota Institutional Review Board at 701-777-4279. Please call this number if you cannot reach research staff or you wish to talk with someone else.

Your participation in the interview implies that this research study has been explained to you, that your questions have been answered and that you agree to take part in this study. You will receive a copy of this form.

Cheryl Lantz, RN, MS
Researcher
681 5th Ave. SW
Dickinson, ND 58601
701-483-7988

Eleanor Yurkovich, RN, EdD
Academic Advisor
College of Nursing, UND
Grand Forks ND 58202-9025
701-777-4554
APPENDIX B

Notification of Resident's Invitation to Participate in A Nursing Research Study:

The Spirituality of Older Adults During Relocation to Long Term Care
Notification of Residents’ Invitation to Participate in a Nursing Research Study
“The Spirituality of Older Adults During Relocation to Long Term Care”

Dear Power of Attorney for a Resident in a North Dakota Long Term Care Facility,

The resident to whom you are Power of Attorney, has been invited to participate in the research study “The Spirituality of Older Adults During Relocation to Long Term Care”, being conducted by Cheryl Lantz, RN, MS a doctoral student at University of North Dakota, College of Nursing under the supervision of Eleanor Yurkovich, RN, Ed.D., her dissertation advisor. The study focuses on older adults, and how they experience spirituality when they relocate to long term care facilities, with an emphasis on spiritual transitions. They are being asked to participate in the study because of their recent move into the long term care facility. The purpose of the study can not be achieved with any other population or process.

This study will develop new understandings of how older adults view spirituality and more specifically, how they use their spirituality (spiritual beliefs and practices) during the transition of moving from a home or the hospital into the long term care facility. The study will consist of an interview with questions asked solely by the researcher (see enclosed interview guide). Approximately 30 people will take part in this study. It will take approximately 60-90 minutes to complete the interview. The interview will be conducted privately, in a meeting room at the nursing home. The interviews will be audio-tape recorded, to assure completeness of records. The tapes will be transcribed for analysis. No names will be connected to the taped interviews. Information will not be shared with health care providers, unless the resident gives their permission. There is the possibility of a second meeting with the researcher to clarify responses within 1-2 months of the initial interview. If a second meeting is needed, the study participant will be asked if they are willing to do the second interview and the consent form will be read to them again.

The possible risks of the study are minimal. A person may experience some anxiety if negative feelings and emotions are discussed. Should they experience anxiety upon completion of the interview; the researcher will refer the resident to a helpful source such as the social work department and/or the spiritual care department at the long term care facility. The benefits of this study may not affect them directly. However, the results will be significant to scholars and those who care for residents of long term care facilities as they strive to understand the relocation process for an older adult. The information provided may be part of presentations and publications in the field of gerontology and/or spirituality studies. All data will be presented in group information; no personal identity or personal identifiable factors will be disclosed.

The protocol of the study will follow the Institutional Review Board approved protocol by the University of North Dakota.
There will not be any cost to the resident for participating in this study, other than their time. If they choose to participate, a $5.00 gift certificate will be given for their time and sharing of ideas.

Any information learned during this study will remain confidential. The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, the resident’s name will not be identified. The study record may be reviewed by Government agencies, the UND Research Development and Compliance Office, and the UND Institutional Review Board. Actual names will not be identified, but participants will be recoded and identified by fictitious names. A list of names with codes will be stored in a separate locked file by the researcher, so she may return to the participant for a possibility of a second interview. Tapes and written notes from the interviews will be kept for a minimum of 3 years after completion of the study. Only the researcher, the advisor and people who audit IRB procedures will have access to the data. After 3-5 years, both written and taped data will be destroyed.

Participation in this study is strictly voluntary. They may choose not to participate, or to quit at any time during the interview. If so, there is no penalty. All responses will remain confidential.

Should you be interested in the findings of this study, please contact Cheryl Lantz, the researcher. Findings will be available upon completion of the study.

The researchers conducting this study are myself, Cheryl Lantz with my advisor, Eleanor Yurkovich. Please contact me for any questions you might have. You may also call the University of North Dakota Institutional Review Board at 701-777-4279. Please call this number if you cannot reach research staff or you wish to talk with someone else.

This letter has been sent to you for notification that the resident to whom you are Power of Attorney has been asked to participate in this study. I wanted to make you aware of the purpose for the research, and its importance to the care of elderly persons in this region. Should you have any concerns, please contact me within 5 days of receipt of this letter. If I do not hear from you, it will be understood you have no questions/concerns and I will approach the resident to gain formal consent to participate in this study.

Thank you!

Cheryl Lantz, RN, MS
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701-483-7988

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Academic Advisor
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APPENDIX C

Semi-Structured Interview Guide:
Spirituality of Older Adults During Relocation to Long Term Care
Interview Guide
Spirituality of Older Adults During Relocation to Long Term Care

Demographics

1. What is your name?

2. What is your age or what year were you born?

3. Describe your marital status.

4. Describe your education by highest level completed, or what grades did you complete? What ways have you engaged in learning throughout your life (e.g., certificates, etc.)?

5. What did you do for a living? Were you employed outside your home?

6. Describe your church or religious affiliation or spiritual beliefs.

7. Describe the decision or circumstances that led to your move into the nursing home.

Semi-Structured Interview Questions

8. Tell me about your move to this LTC facility, what was this like for you? Did spirituality play any role in your move to the LTC facility? If so, can you describe that?

9. What does the word spirituality or being spiritual mean to you? Is this the same or different from being religious?

10. Tell me about your spiritual practices and beliefs, in general.

11. Now that you are at the LTC facility, describe your spiritual beliefs and practices.

   11a) What meaning does spirituality have for you, now that you live in this facility?

   11b) Has anything changed for you, regarding your spiritual beliefs and practices since you have been here?

   11c) What has stayed the same, regarding your spiritual beliefs and practices since you came to live here at the LTC facility?

   11d) In what ways has your spirituality been supported in this LTC facility?
11e) What adjustments have you had to make in your spiritual beliefs and practices, since you came to live here? What is that like? How does it feel to you?

12. What barriers or problems have you experienced, since you came to live here, regarding your spirituality, including beliefs and practices?

13. Tell me what suggestions you would like to make for the staff, regarding ways to support your spirituality while living in this LTC facility.

14. Tell me what suggestions you would like to make for the staff, regarding ways to support your relocation transition to this LTC facility.

15. Have your family members or friends noticed any change in your spirituality since you have come to this LTC facility? If so, what have they noticed and how have they and you responded to that?
REFERENCES


Harris, W., Gouda, M., Kolb, J. (1999). A randomized trial of the effects of remote, intercessory prayer on outcomes of patients admitted to the coronary care unit. Archives of Internal Medicine. 159, 2273-2278.


