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Editorial to the special issue: 'Aging and Spirituality'

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About The Society for Pastoral Counselling Research

The *Society for Pastoral Counselling Research* was inaugurated on May 6, 1994 at Saint Paul University, Ottawa, Ontario. It began as a Saint Paul University and Ottawa area enterprise. It held its first Annual Conference in May of the same year. Augustine Meier, Ph.D., the Founder, was the Society's first president. The Society, from its beginning, was bilingual, reflecting Canada's two founding cultures.

The second year witnessed the expansion of the Society to include scholars and researchers from the Waterloo/Kitchener area. Peter VanKatwyk presented a paper at the Second Annual Conference, was the Keynote Speaker the following year, and became the Society's Third President. Peter VanKatwyk is credited with the expansion of the Society beyond the Ottawa area and with the establishment of a strong network of scholars and researchers in the Waterloo/Kitchener district. By the end of the third year, the Society was well established in both Ottawa and Waterloo/Kitchener.

The Society for Pastoral Counselling Research is an unaffiliated and non-profit corporation and registered charity devoted to the practice of Pastoral Care and Counselling.

Mission of the Society

The Society represents a community of scholars, researchers and practitioners who aspire to integrate the human, social, psychological, and sacred dimensions of persons in their practice. The Society embraces this aspiration and supports the initiatives of scholars, researchers and practitioners to build models and theories and to conduct research which include these various dimensions of the human person. To encourage these activities, the Society provides a forum where researchers, scholars and practitioners interact, share and communicate their newly developed models and research findings with each other and with the broader community. The Annual Conference and the Pre-Conference Workshop are two of the principal forums for this scholarly and professional exchange. To promote and encourage research on part of the pastoral counsellor, the Society presents research awards to recent graduates, young researchers, senior researchers and to researchers with a distinguished research career. The Society is committed to extending research findings and knowledge beyond the conference by publishing its proceedings. Four of its publications are: *The Challenge of Forgiveness*, *In Search of Healing*, *Spirituality and Health: Multi-Disciplinary Explorations*, and *At The Heart of Conflict Resolution*.

About the 12th Annual Conference

The Society held its 12th Annual Conference in May, 2005, at Assumption University, Windsor, Ontario, Canada. The theme of this conference was *Ageing and Spiritual Care*. A Workshop on *Effective Programs for Senior Adult Ministry* was offered the day prior to the commencement of the Conference. Fourteen papers were presented at the conference. Each of the papers related spirituality to a specific topic. The topics included the care of seniors, the terminally ill, those retiring, dementia, amputees, and Australian Aboriginal, among others.

Introduction to Papers

Seven of the papers presented at the conference have been revised by their respective authors to meet the requirements for publication in a journal. The papers were peer-reviewed and submitted for publication.

In his article on *Holistic Applications of Counselling With the Elderly in Dialogue with Pastoral Care Concerns*, **Dr Randolph Bowers** makes the observation that in most Western nations the influence of institutionalized religion is waning and personal, spiritual, and subjective approaches to faith are on the increase. With this change in the practice of faith, the practice of pastoral care has been changing as well. Randolph contends that counselling as a secular and scientific modality is well suited to meet the needs of a highly educated and articulate ageing population whose values, in many ways, represent "post-Christian" and "post-Colonial" worldviews. The application of counselling in dialogue with pastoral care for the ageing is a new area for practice and research. In this article, Randolph explores these issues with reference to a holistic model of counselling that respects how meaning and spirituality are constructed in everyday life through personal and social experiences.

The article, *Encouraging Quality of Life for Aging Persons who have Developmental Disabilities* by **Dwayne Kennedy** is timely given that people with mental disabilities are being moved into community based living often without adequate support and services. As those with disabilities age, there is even a greater need that educators and caregivers develop programs that address the dual concerns of ageing and disability services. Dwayne strongly advocates for community based programs and services that encourage the quality of life and that address the need for psychological, social and spiritual needs and the needs for education and employment.

In their article, *Canadian Spirituality and Health*, etc., **Thomas St. James O'Connor & Elizabeth Meakes** reviewed the publications found on spirituality and health by pastoral counsellors and chaplains in five peer reviewed journals. They found that ten percent of the articles were published by Canadian chaplains, pastoral counsellors and/or theologians and that 20 percent of the articles were published in two Canadian-based journals. Thomas and Elizabeth encourage chaplains, pastoral counsellors and theologians to embrace research and to apply it to their profession. The authors point to some hopeful signs in the efforts made by conduct research with the field of spirituality and to publish the findings.

Seung-Hee Kang, in her article on, *Tending the Soul of the Terminally Ill*, used a phenomenological research method to study how one older terminally female patient preceived her journey of dying. To obtain the data for this study, Seung-Hee designed a semi-structured interview with items keyed to selected dimensions. The results of the study are reported in terms of eight themes directly related to the manner in which the woman transformed her terminal state into a life giving experience.

Annette Marche in her article, *Religion, Health and the Care of Seniors*, examined some of the research that found a relationship between religion and health in order to identify some points of consideration for the religious care of seniors. As a framework for her investigation, Annette used the interrelationship among the dimensions of health including spiritual, physical, psychological, emotional, and social aspects. Her investigation indicated that some studies point to negative outcomes of religion on health but a significant body of research reported a positive influence of religion on health. She concluded that for a number of seniors, religious beliefs and practices can provide means of coping with the aging process, a sense of meaning and purpose to life, and a system of social support.

Given that the people are living longer, *Retirement and Existential Meaning in the Older Adults: A Qualitative Study Using Life Review* is an important study undertaken by **Judith Malette and Luis Oliver**. Life Review was used with seven older healthy adults to help them to reflect upon their life in terms of Strengths, Retirement, Life Goals and Mission. The data obtained from this process was analyzed using a qualitative research method. The results from this study suggest that Life Review can facilitate the retirement process, contribute to older individuals' search for existential meaning, promote conscious ageing and the compassionate re-definition of self.

Rhonda Kane, in *Hope Beyond the Hurt, etc.*, investigated how nine adult people with the dual diagnosis of acquired brain and injury and psychiatric disorder, access, develop and use their spirituality. Rhonda developed a semi-structured interview to collect data regarding a person's perceptions of spirituality in the context of his or her diagnosis and every day life. A phenomenological qualitative research method was used to analyze the interview material. The main findings of the study were as follows: (1) the realization of the provisional nature of life, profound loss and grief, intergenerational impact, disenfranchisement, and despair and the simultaneous awareness of the spiritual dimension that provided a paradigm shift in core values, and (2) relatedness and connectedness become the context for spiritual development and transformation. Spirituality was found to be important in the recovery and rehabilitation of individual with acquired brain injury and psychiatric disorder.

Author Biographies

Randolph Bowers, PhD, is a sociologist, human ecologist, psychotherapist, and counsellor. He teaches at the University of New England in counselling and health sociology. His interests in pastoral counselling date back to study in the sociology of religion and in spirituality. He is an ordained minister with the United Ecumenical Catholic Church in Australia. Randolph is Qualitative Editor of *Counselling, Psychotherapy, and Health*.

Rev. Carlton F. Brown, M.Sc., M.Div., RMFT lives and works in Hamilton, Ontario, Canada (www.mftsolutions.ca). Formerly a physiological researcher, Carl is a Baptist minister, associate teaching supervisor in pastoral counselling (Canadian Association for Pastoral Practice & Education, CAPPE) and a clinical member of the American Association for Marriage & Family Therapy (AAMFT). Carl has worked extensively with psychiatric patients, hospital systems, and individuals, couples and families in private practice. His first thesis was on blood coagulation enzymes and blood pressure regulation and his second on the literary structure of Mark's Gospel. He is interested in the relationship between physiological development and spiritual wellbeing.

Rhonda Kane, R.N.BSc.N, MTS, has worked as a Pastoral Counsellor in private practice since 2001 and previously in the field of nursing and community development for 15 years. In 2004/5 she completed a 9-month counselling practicum in pastoral care on an Acquired Brain Injury Unit in a large teaching hospital in Southern Ontario where she conducted research on spirituality and was awarded the St. Joseph's Grant for Clinical Research in Spiritual Care. She received her Master of Theological Studies in Pastoral Care and Counselling in 2006 from Waterloo Lutheran Seminary, in Canada, and is published in *Pastoral Sciences*. Rhonda works primarily with traumatized and bereaved individuals and families.

Seung Hee Kang, MPhil, MDiv, is a chaplain, a spiritual director and a doctoral candidate in pastoral theology at Faculty of Theology, University of St. Michael's College. She is a certified member of Myers-Briggs Type Indicator, a certified member

of Ontario Multi-faith Council, an associate member of Society of Translators and Interpreters of B. C., a member of Spiritual Directors International and a member of Spiritual Directors of Ontario. Her clinical and research interests include theology of healing, healing methods at the end of life care, the significance of emotional narratives in spiritual growth, integration of psychotherapy and spiritual direction in spiritual/pastoral care, and post-modern appropriation of Carmelite spirituality in spiritual/pastoral care.

Dwayne Kennedy, B.Teach., B.Ed., B. Couns., M.Ed. Hon. (Candidate), is a counsellor and life coach, teacher, and community advocate. He is currently completing his Masters Honours research project looking at personal narrative and transformation as applied to the formation of identity among minority groups. He has worked in the disability field for almost two decades, and is a member of the Australian Counselling Association. He currently holds a position as Job Counsellor and Trainer at Jobs Australia, and works part time in counselling and educational consulting.

Judith Malette, Ph.D., is a clinical psychologist and has been assistant professor in pastoral counselling at Saint Paul University since 2001. She received a Ph.D. in experimental-theoretical psychology and did her post-doctoral studies in clinical psychology at the University of Ottawa. Her research interests include images of God, life review, learning styles, and reflective practitioner models.

Annette Marche, M.A., is currently employed at Luther College, University of Regina. The courses she teaches include an *Introduction to Religious Studies* and *Religion and Health*. She has a Bachelor of Arts degree in Psychology and a Master's degree in Religious Studies. Her Master's research examined contemporary approaches to spiritual healing. Research interests she is currently exploring include: religion as a determinant of health, aging and health, alternative and complementary approaches to healing and community health.

Elizabeth Meakes, MTS, currently works as a pastoral counsellor and family therapist at K-W Counselling in Kitchener, Ontario, Canada. She has worked as a chaplain and supervisor for 13 years at Hamilton Health Sciences and St. Joseph's Healthcare both in Hamilton, Ontario, Canada. She has published over 10 articles in peer reviewed Journals. She has extensive experience with the elderly. She is a clinical member of AAMFT and a Specialist in Pastoral Counselling in CAPPE.

Augustine Meier, Ph.D., is a certified clinical psychologist in private practice, a Professor Emeritus in the Faculty of Human Sciences, Saint Paul University, Ottawa, Ontario, and an Adjunct Research Professor in the Department of Psychology, Carleton University, Ottawa. He teaches a course and provides advanced training in object relations therapy and self psychology. He taught graduate courses in psychotherapy and psychopathology and trained graduate students in individual counselling. He has co-authored articles on psychotherapy and psychopathology in refereed journals and co-presented advanced workshops on the use of mental imagery in psychotherapy and on theme-analysis. He is the author or co-author four books: *The Challenge of Forgiveness*,

Meier A. (2006), Editorial to the special issue: 'Aging and Spirituality', *Counselling, Psychotherapy, and Health*, 2(1), i-vi, April 2006.

In Search of Healing, Spirituality and Health: Multidisciplinary Approaches, and At the Heart of Conflict Resolution. Professor Meier is the Founder and first President of *The Society for Pastoral Counselling Research*.

Luis E. Oliver, Ph.D., C. Psych, is a Professor in the Faculty of Human Sciences at Saint Paul University, Ottawa, Canada. His research interest include how human beings make meaning of their existence and death, and how individuals face loss and major transitions in their lives. Dr. Oliver is also in private practice, where he sees clients for existential individual therapy and marital therapy."

Thomas St. James O'Connor, ThD, is the Delton Glebe Professor, Pastoral Counselling at Waterloo Lutheran Seminary, Waterloo, Ontario. He is a supervisor in both CAPPE and AAMFT. He has published over 30 articles in peer reviewed Journals and two books. The latest is *Spirituality and Health: Multidisciplinary Explorations* which he co-edited with Augustine Meier and Peter VanKatwyk. He is currently the president of the Society for Pastoral Counselling Research.

Dr Joe Quinn is a Roman Catholic priest, a member of the Congregation of St. Basil, and was ordained in 1963. He received his PhD in English Literature from Purdue University in 1969. He was a member of the English department at the University of Windsor for thirty years, and took early retirement from the University to begin studying the spirituality of aging. He now offers religious retreats to the elderly as well as various workshops geared to spirituality and aging. He is a member of the American Society for Aging, and the Forum on Religion, Spirituality and Aging.



Hope Beyond the Hurt: Spirituality and the Dual Diagnosis of Acquired Brain Injury and Psychiatric Disorder

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Abstract

This qualitative research study answers the question of how people with the dual diagnosis of acquired brain injury and psychiatric disorder access, develop, and use their spirituality. A phenomenological approach was chosen to capture a detailed understanding of the participants' perceptions of spirituality in the context of their diagnosis and everyday life. Data was collected from semi-structured interviews with nine adult survivors of acquired brain injury with a psychiatric diagnosis. The main findings of the study were as follows: (1) the importance of the synthesis of opposite poles of experience: The realization of the provisionality of life, profound loss and grief, intergenerational impact, disenfranchisement, and despair mark the trauma of the event. Simultaneous awareness of the spiritual dimension (an encounter with God) provides a paradigm shift in core values. (2) Born out of pain, relatedness and connectedness become the context for spiritual development and transformation. These results demonstrate the importance of spirituality in the recovery and rehabilitation of individual with acquired brain injury and psychiatric disorder.

Introduction

Dual diagnosis, as it is used in this article, refers to the co-existence of both an Acquired Brain Injury (ABI), and a clinically diagnosed mental disorder. An Acquired Brain Injury, often referred to as Traumatic Brain Injury (TBI), is brain damage that is sustained at any point after birth. It can be caused by a physical trauma, such as a collision or fall, or by certain medical conditions and disease processes. It is one of the most common causes of disability and death, with young adult males, ages 15-35, being at greatest risk. Concurrent psychiatric problems, addictions, and behavioural issues can complicate the rehabilitation process. With dual diagnosis, the psychiatric disorder may have pre-dated or post-dated the ABI. Some are the result of chemical changes that occur progressively in the brain after the injury is sustained. These individuals endure numerous cognitive, psychological, emotional, and physical changes. Recovery from a severe brain injury often involves prolonged or life-long treatment and rehabilitation.

The experience of brain injury tears at the very fabric of one's identity and perception of what it means to be human. Distorted images of a life that once was, and can no longer be, torment and challenge those affected. Changes in body image, personality and behaviour, memory, attention, energy levels, motor control, social and communicative ability contribute to a sense of despair and an all too common desire to end one's life. The impact of such an event is often felt across three generations, including the parents, the affected person, and his or her children. It dramatically and permanently alters the family system.

Review of the Literature

A comprehensive review of the literature was undertaken to identify the most pertinent issues as they relate to Acquired Brain Injury (ABI) with concurrent psychiatric disorder and spirituality. Systematic computer and manual library searches were used to ensure an adequate coverage of relevant literature. A total of thirty articles and five books were located and reviewed prior to designing this study.

Six of the articles reviewed, specifically addressed spirituality as it pertained to those with an Acquired Brain Injury. Although the term "dual diagnosis" was not specifically used, the co-existence of a psychiatric disorder, such as clinical depression, was acknowledged and discussed. Fourteen articles addressed spiritual and religious issues in psychotherapy, with ABI referenced in several. Of these fourteen articles, three relevant themes emerged. These were the soul and soul healing as a compelling focus of therapy, the importance of a social constructivist approach, and ethical considerations for practice. Ethical ways of discussing spiritual concepts and issues in therapy, the challenges involved, and recommendations on the inclusion of spirituality as a subject in the education and training of mental health professionals were sub-themes. Four other articles focused on general coping, hope and resilience, and were selected because they specifically discussed spiritual health and the value of having a transcendent belief system. These examined spirituality as a resource. One article addressed women's spirituality as its main subject.

Those articles pertaining directly to ABI and spirituality discussed the findings and results of qualitative research studies from a number of traditions including case studies, phenomenological inquiries and focus groups. These were of particular importance because they provided valuable insights on the spiritual dimension during the recovery and rehabilitation process. Descriptions of those concepts and relationships that reflected the lived experience of these individuals were explored.

There were many different definitions of spirituality referenced throughout the literature. Family therapists and educators, Thomas St. James O'Connor and Elizabeth Meakes (2002,62), indicate that these definitions focus on three areas: transcendence, meaning making, and core values. These three inter-related concepts emerged as central to all discussions on spirituality in this review as well. Religion, marked by an affiliation or identification with an organized faith group, was included as one possible component of spirituality.

With respect to brain injured individuals, transcendence was regarded in two ways. First in connection with what was considered by the individual to be a higher power, or “God.” The second was as a function of “rising above” one’s circumstances through either a connection with the transcendent or through the process of “meaning making.” Being able to transcend one’s circumstances through a greater appreciation of self, others and God, is reported to provide meaning and the impetus to carry on in the face of otherwise overwhelming challenges (McCull et al, 2000,560). Several authors report how individuals with ABI “awaken to” the transcendent or spiritual dimension of life through the event of sustaining a brain injury itself. The often reported “near death experience” (NDE) is described by Harris as a marker event (in Tasker, 2003, 345) and “watershed in a person’s life which makes life after the injury, a more tangible whole” (McCull, 2000, 568). It is typically associated with an awakening of spirituality in the face of increased vulnerability, a deepened awareness, and a changed perspective (Tasker, 2003,338). “The individual with ABI has almost certainly, at some point walked consciously with death. When we become conscious of our involvement with death as a personal reality, the world is seen through sharpened lenses, the quest for meaning in new light” (Tasker, 2003,238). According to Adams, the typical NDE is marked by a peaceful state of separation from one’s body, transition through a dark tunnel, and a transcendent stage of entering the light where one meets loved ones and spiritual leaders. NDE experiences are “significant not so much for their immediate content, but for their enduring impact on the individual and family, and the meanings generated around them” (Adams, 1996, 82).

People with ABI and dual diagnosis describe the experience of a spiritual dimension uniformly as a call to depth. This call is probably best described by Austrian psychiatrist Victor Frankl, as the “quest for meaning.” While interned in a Nazi concentration camp during World War II, Frankl observed that many prisoners died when undergoing less hardship and suffering than those who did not. Survivors tended to be those who envisioned a future for themselves despite their present suffering. They believed that there was a meaning and purpose for their life and therefore could not ultimately surrender to despair. These individuals, according to Frankl (1959), knew *how* to suffer. Similarly, the growth or development of spirituality in people with ABI is cultivated in suffering and is viewed in the literature as involving many things. This would include (1) the attribution of both meaning and a positive appraisal to one’s life and life experiences, (2) the synthesis of two opposite poles of experience, such as hope and despair, suffering and grace, and (3), the integration of the ABI into the relational context of their lives.

The attribution of meaning and positive appraisal are two different but related processes (Adams,1996,75), each paramount to the development of genuine hope, one of the prime ingredients of a healthy self (Beavers and Kaslow, 1981,20). Positive appraisal, a key concept of cognitive behaviour therapies, refers to the ability to reframe trauma positively and more importantly, the ability to perceive that one’s resources are great enough to master the challenges that one is faced with (Adams, 1996, 75). The use of metaphors is particularly useful here. Peck (1993, 142) quotes the husband of a woman with ABI whose image is that of *looking up and down the ladder*, where “it’s too scary to look down or back at where we have been or how far we have come.” The only option is to “go on and look up.” The mutual decision to press on, even in the face of adversity,

reflects the couple's belief that they have the ability to overcome challenges that lay ahead. Tillich (1993) identifies several useful metaphors such as seeing *God as a stream* in which we are all immersed (in Prest and Keller, 1993,145). We can swim against it, represented by times of denial and struggle, or we can turn and allow the stream to carry us. Spiritual meaning then, can be located or discovered in metaphorical references. It is also talked about more directly, as part of the context of God's larger plan, as specifically purposed by God to benefit the self or others either relationally or supportively. (Adams, 1996,82; McColl, 2000,561; Uomoto, 1995,345). Appraising an experience positively, however, does not necessarily require that meaning be generated or discovered. When the sufferer sees the event as strictly senseless, meaning is often found in a sense of responsibility to loved ones (Adams, 1996,76).

That spirituality is cultivated, as well, in the tension that exists between two seemingly opposite and contradictory poles of experience is expressed by a number of authors (Adams, 1996, 77; Tasker, 2003,346; Uomoto, 1995,344). For example, the holding together of hope and despair, acceptance and non-acceptance, loss and growth, apostasy and faith, is a Jungian concept which advocates for both/and as opposed to either/or. White and Epston (1990,27) capture this sentiment in his description of the multi-storied experience which allows for the expression and telling of multiple levels of experience within the person's narrative. The synthesis of such opposites is often evidenced in an enormous growth and awakening of compassion and empathy for others, and an increasing capacity for connectedness, harmony and peacefulness. Adams (1996,81) observes that young males with ABI become noticeably more self-reflective and compassionate towards others. This reflects a transformation of core values.

Finally, spirituality is seen to develop and seek expression during the process of integrating the ABI into the relational context of one's life. McColl and colleagues (2000,559) discovered that people with traumatic-onset disability express spiritual issues in the context of three types of relationships, the intrapersonal (self), interpersonal (with others), and transpersonal (with God or a "higher power"). These three relationships are characterized by themes of awareness, closeness, trust, vulnerability and purpose. They found that individuals with brain injuries seemed to place greater emphasis on the importance of their families and the need for trust in light of their memory deficits (McColl et al, 2000,561). These researchers, found as well a remarkable ability in these individuals to grapple with and express complex spiritual concepts, in spite of their deficits (822). With this the authors found support for the defining of spirituality as the "propensity to find meaning in experience through one's relationship with the self, others, and a supreme power" (555).

Concerning spiritual and religious issues in therapy, there is now a significant body of knowledge and literature that addresses the spiritual dimension. The three main themes that emerge are described next.

The soul and soul healing as the necessary focus of therapy

Bergin (1980) cites disillusionment with science as the dominant source of truth as the catalyst of a broad-based movement to bring the spiritual more fully back into the realm

of psychology (in Shanfranske and Gorsuch, 1984,238). According to Uomoto (1995), the concept of soul care provides a context within which to understand suffering and dissipate some of the meaninglessness that comes with human finitude. Uomoto uses the theology of Nouwen to inform the development of soul care providers and the provision of psychotherapy to the sufferer (345). For many like him who work in rehabilitation psychology, all converges on the concept of the soul. For the sufferer of ABI, this approach is a meaningful response to the *call to depth* reported in their narratives. The resultant communion with one's soul may very well represent protection against a flight into madness as the best defence against emotional death. Ross (1995, 461) suggests that there are both vertical and horizontal elements inherent in this view. The vertical encompasses the transcendent, and the horizontal, the working out of the vertical in the individual's approach to life and relationships. Elkins (1995, 80) believes that a theory of psychology from the perspective of the soul would legitimize other approaches to knowledge rather than just the scientific empirical, which is not the only path to truth. He focuses on the soul as the central organizing construct for psychotherapy with the psychotherapist positioned as the servant attendant work and believed that the recovery of the soul was essential for both the individual and western society. He describes therapy as a safe container for soul making and healing and the therapeutic relationship as the "royal road to the soul" (Buber, 1970).

Social constructivism as a tool for thinking and an approach in therapy whose sentiments are echoed in the needs expressed by those with ABI. Useful because there is such a significant need to empathize and understand their position, it provides a lens by which meanings other than one's own can have validity in their given context. This is useful from an ethical perspective. Holding a *not knowing* perspective with clients gives them room to discuss meanings that are most significant to them (Thayne, 1998,19). We are, however cautioned to avoid ethical relativism and may do so, where it is felt useful, by naming our own motivations and ideas, making it explicit from our own subjective thinking and by having integrity with our own values (Thayne, 1998,22).

Ethical considerations, paramount to practice, emerge from an integrated approach to spirituality in therapy. The key issues, according to Haug (1998,183) include i) *Autonomy and the power dimension in respecting client's rights to self-determination*. This involves sensitively opening space in therapy for the discussion of spiritual beliefs and values, addressing power issues in families where they occur, being mindful of spiritual developmental needs when individuals and couples who determine to re-connect with their original faith traditions, and assessing when it is in the client's best interest to refer to clergy (Haug, 1998,187; Thayne, 1998,20; Uomoto, 1982,352; Ross, 1995,458). ii) *Beneficence and Nonmaleficence: promoting clients' well being and protecting them from harm*. This would include a collaborative approach with the larger religious/spiritual community, sensitivity to the client's spiritual language and terminology, an awareness of the potential for boundary violations for religiously engaged therapists and for those whose personal beliefs make it difficult for them to treat persons struggling with those same beliefs. Care must be given not to persuade the client towards therapist preferred attitudes and beliefs (Haug, 1998,188; Woody and Woody, 2001,157-158). iii) *Justice and fidelity or caring without discrimination*, in consideration of multicultural plurality

and diversity. The perception of spirituality in therapy and spiritual beliefs and values are relevant here. The essential relevant factor is the therapist's spiritual self-awareness and their personal stance towards it (Bergin, 1991,396; Shanfranske and Gorsuch, 1984,238; Haug, 1998,190; Frame, 2000,73). To facilitate spiritual literacy and competence, the intentional inclusion of spiritual issues in training and supervision is advocated in a number of therapy models (Aponte, 1994; Becvar, 1997; Prest and Keller, 1993,138). Hickson and Phelps (1998,44) propose a therapy model that is sensitive to the unique aspects of women's spiritual journeys and involves relevant themes of exploration, interdependence, balance, transformation, and wholeness in the context of a "relational" dialogue between practitioner and client. The omission of specific training in spirituality from the professional education of the therapist increases the potential for problems and complications (Benningfield, 1998,41).

For the person with the dual diagnosis of ABI and psychiatric disorder the process of accessing and developing their spirituality becomes a conscious project with conscious workings. Fitzgerald (1997, 409) eloquently draws us to the conclusion of this effort. She describes a people who remain outside of the norm, largely unaccepted and different and yet strangely enough they represent a threat to the security of the able-bodied perceptions of self, which are embedded in a culture of perfection and control. They are readily subjugated by society because they no longer operate within the dominant communicative discourse and behavioural style and yet they challenge us with their ability to enter into the sacred place which draws us deeper and deeper, away from the comfort of busy-ness toward the still place of reflection where they find their humanity, their soul.

Purpose and Rationale of the Study

The purpose of this study was to examine how people with acquired brain injury and psychiatric disorder experience spirituality. The main research question is *how do people with the dual diagnosis of acquired brain injury and psychiatric disorder access, develop, and use their spirituality?* Elkin's definition of spirituality is utilized in this context as a "way of being and experiencing that comes about through an awareness of a transcendent dimension that is characterized by certain identifiable values in regard to self, other, nature, life and whatever one considers to be ultimate (Elkins,1990, 4). Knowledge of spirituality as it pertains to individuals with this diagnosis can inform the way that health care professionals address the spiritual dimension in therapy and can increase their confidence level in dealing with spiritual issues, to the benefit of clients and significant others.

Description of the Sample and Access to the Sample Field

Nine participants were involved in the study, eight men and one woman. All were in-patients of a large psychiatric facility attached to a teaching hospital in Southern Ontario. Admission criteria required that patients present with both an acquired brain injury and a psychiatric disorder, such as depression. The mean time from the date of injury to the time of this investigation is 23 years (range, 1981 to 2004), and their mean age is 42 years (28 to 56). Brain injuries and psychiatric disorders ranged in severity and participants were selected, based on their developmental and cognitive capacities to

understand and describe their own personal experience. The randomness of the sample was of less importance since the purpose of the study was to procure an accurate understanding of meaning rather than to report generalized findings. All participants were Caucasian and middle class. Most were university educated and previously engaged in a professional career. Some were trades people. All received a Christian orientation in their families of origin. The limitation on diversity of faith group is incidental. Two identified themselves as agnostic, one Anglican, five Roman Catholic, and one as First Nations spirituality. Although gender imbalance in the sample is not ideal it does reflect the naturally higher prevalence of ABI in young adult males. Prospective subjects were approached initially by the unit social worker who was well known to them. A descriptive letter of invitation, detailing the project, and confidentiality procedures was shared with them and a signed, informed consent to their participation was secured. The principle investigator then arranged to meet with and interview each person through their respective prime workers. The informed consent was reviewed prior to each interview to ensure a clear understanding and willingness on behalf of each participant to engage in the process. Participants were allowed the option of discontinuing and withdrawing their involvement and contributions at any point in the project. All procedures received approval for ethical conduct for research involving humans from the hospital Research Ethics Board.

The principle investigator is a female pastoral counsellor, assigned to the unit to provide multi-faith spiritual care to both clients and staff. She is uniquely positioned to study this phenomenon and to meet the on-going spiritual needs of project participants. The researcher has specialized training in the area of spiritual care, has an undergraduate degree in Health Sciences, is a candidate for a Master of Theological Studies in Pastoral Care and Counselling, and practices privately as a pastoral counsellor.

Methodology

This is a qualitative research design. A phenomenological approach was selected to get a deep understanding of the participant's perspective. Primary data was collected through the use of semi-structured interviews, based on the questions outlined in Table 1. These questions served to guide the interviewer in eliciting the interviewees' experience of spirituality. They were designed to be open-ended, flexible and broad to allow for a full range of expressed responses. The interviewer refined and focused the questions as each interview progressed and according to the needs of each participant. The interviews took place on the unit where the participants were admitted. Each interview was audio taped.

Table 1 Interview questions

- | |
|---|
| <ol style="list-style-type: none">1. Did acquiring a brain injury cause you to view your life differently? Describe.2. How might the timing of this event (ABI) be significant to you?3. What is different about you now? Are there differences in how you relate to others, how you relate to yourself, and how you relate to God?4. In what way does this experience add meaning to your life?5. What do you think your soul might be communicating to you through this situation?6. What opportunity for learning does this situation provide for you?7. How do you think your situation might facilitate your growth?8. Which resources that you possess have been stimulated by this situation?9. How might you use this situation to benefit yourself and others?10. What has helped or hurt your spiritual development? |
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Data Analysis and Results

The primary investigator transcribed the audio taped interviews. These transcriptions constituted the data. Notes taken during the interview and field notes taken over nine months were added to the transcriptions to enrich and refine meanings and represent data triangulation (Sprenkle and Moon, 1996, 95). Interviewees were asked to read and edit their responses. The interviewer reviewed the responses with each interviewee and participated in the co-construction of meaning. Interviewees offered letters, diaries and photographs as part of the data as well. “Phenomenological methods of data collection, allow participants to define phenomenon for themselves and to describe the conditions, values and attitudes they believe are relevant to that definition for their own lives” (Sprenkle and Moon, 1996, 96). This approach lends itself well to the study of this particular population, as they often need to rely upon diverse forms of expression. Data collection continued until theoretical saturation was reached. The data underwent several levels of analysis that identified similarities and differences, categories, themes and patterns that were then compared, contrasted and finally classified and categorized in answer to the research question proposed. Table 2, illustrates a sample of the data analyzed at level 1. Immersion in the data, by the researcher, is characteristic of the phenomenological approach. The goal of “objectivity” is substituted for the goal of “connection” in order to enable accurate and meaningful communication of the experience of each of the participants.

Eight of nine participants (88.9%) emphasized the ways in which spirituality contributed positively to their recovery and rehabilitation process. These individuals used spiritual language and/or “God-talk” in their narratives, and metaphors to capture the essence of what some specifically referred to as their spiritual journeys. These storied expressions of their spirituality often contained themes of struggle, faith-based perseverance, meaningful connectedness and relatedness, a transformation of core beliefs, and an emphasis on spiritual values that promote ethical (equitable, fair, just) relationships.

Table 2, Sample of data display (level 1 analysis)

Interview Question:	Patient A	Patient B	Patient C	Analysis
<p>In which ways does this experience of having a brain injury add meaning to your life?</p>	<p>We are obviously here for our loved ones, for the relationships that we develop with them, to help them and to try to create something better than what went before.</p> <p>I am far more empathetic, tolerant, trusting, and compassionate than before. People are closer to my heart now. This event taught me to cherish others.</p> <p>I know now that there is something bigger in control than me. God? I am now more open to possibilities.</p>	<p>My spirituality (developed in the context of ABI) has given me an over-all sense of love and loving compassion, the ability to want to help people in their struggles, to help them to get along. I have been saved/spared for this purpose.</p> <p>I have gone from feeling judged, punished and abandoned by God to believing that life is about free will and choice. With this comes great responsibility for myself and for others.</p>	<p>It has taken away meaning. I have lost everything! My life has contracted instead of expanded. I don't know what goals to set for my relationships anymore, but I would like to. That would make a difference.</p> <p>I am more compassionate with others.</p> <p>I choose not to believe in God. He is just a construct.</p>	<p>Similarities:</p> <p>Relationships are meaningful</p> <p>Purpose and desire is to help others</p> <p>Awareness of the divine</p> <p>Relationship with the divine</p> <p>Increase in compassion</p> <p>Struggle with God</p> <p>Awareness of both loss and gain</p> <p>Differences:</p> <p>Negative appraisal of meaning to life and God.</p> <p>Categories/Themes/Patterns:</p> <p>Meaning and purpose is located in relationships with self, others and God, including in times of struggle</p> <p>Responsibility and ethical conduct in relationships is an important value</p> <p>Compassion with components of love, empathy, tolerance, and trust is an important value</p>

Findings relevant to *accessing spirituality*:

Seven of the nine participants (77.8%) reported mystical, near death experiences that represented an encounter with the divine or higher power. In each case, these experiences served to awaken the participant to a transcendent, spiritual dimension. For some, the near death experience marked the beginning of a relationship with the divine, for others it served as a confirmation, providing the assurance of hope and meaning in one's life. Although the struggles and challenges were great, the memory of near death experiences often provided the courage to go forward, and served as a deterrent to suicide. An instantaneous belief in the value of life was conferred, in these cases. Religious themes were common. The memories of near death experiences were easily recovered and shared in all but one of the seven who reported them, even though these participants demonstrated marked memory deficits in other areas. The narrative of the one, who reported not having an NDE, was marked by despair and hopelessness. Following are examples of near death experiences that illustrate common themes:

Patient A: After having the mystical experience of a deceased friend watching over him and taking care of him during the acute phase of his recovery one man said, *so you can kind of think that even the most non-believer (Sic) has to believe that there is something there. In this area, I have changed. Where before I would have likely dismissed that as a delusion or something...now I am more open...to believe.... and I am Science Guy, requiring proof for everything.*

Patient B: *It was almost like a dream state...seeing snapshots or visions of my life as a child doing good, doing bad, doing good...I felt that maybe our Creator was in a sense judging me...That's when I realized that there is a God. God chose for me to live!*

Patient E: *I saw Saint Bernardo pass outside my window and knew that God had saved me, that He loved me so much that he sent this blessed Saint to protect me. I am reminded from this that suicide is not an option.*

Patient D: *I actually recall seeing Jesus Christ standing in the bathroom with His hands extended out like that...(gesturing with her arms) and I remember saying "I will help you." His hands were cut up. It was a very powerful experience that caused me to view my life differently.*

Near-death experiences allowed for the expansion of and the reframing of the old belief system. Old, unproductive beliefs were replaced by new, more life-giving beliefs. The new core beliefs indicated how they would go on to interpret and interact with the world. NDEs, or encounters with the divine, were often regarded as a summons to change. Table 3 lists a sampling of new core beliefs identified by participants

Table 3, New Core Beliefs

1)	Life is extremely valuable
2)	We all are valuable. We all have inherent worth
3)	There is a reason and a purpose for each person's life
4)	Change (transformation, renewal, regeneration) is possible
5)	I have been protected, kept safe, preserved
6)	God/Higher power does exist
7)	We are here for others (to care for others in both a <i>doing</i> and a <i>being</i> capacity)
8)	God is good
9)	People are worthy of respect
10)	Suffering has a positive value

It is significant to notice the shift from an egocentric position to that of the collective. For example, *we* are all valuable; as opposed to strictly *I* am valuable. Participants reported that they began to view themselves as connected to or part of the universal whole. This served to decrease their sense of isolation and promote well being. They felt that they were somehow being cared for and that this contributed to an ability to trust others more. One participant reported that he could *release into a blanket of security that only a sense of the divine could provide*.

In the absence of the memory of a near death experience, spirituality was reportedly discovered in the context of relationship. This was an on-going experience shared by both groups. Themes included valuing, cherishing, being present to the other, authenticity, and unexplained feelings of peace.

Finally, eight out of nine participants emphasized a full realization of the dichotomy of the co-existence of both good and bad, hope and despair, belief and non-belief. This was expressed in the narratives that they shared. The telling of their stories and the sharing of spiritual ideas appeared to have enabled them to recognize the fact of the tension that existed between the opposite poles of their experience.

Findings relevant to the *development* of spirituality:

The context for the development of spirituality for each participant was connectedness and relatedness. It was achieved in dialogue. Transformation took place during the exploration of spirituality within a relational context. Self-awareness, reflexivity, the capacity to share feelings, an increased willingness to trust others, and qualities of tolerance, empathy, love and compassion were evidence of an expansion in relational ability, and new ways of being. Meaning and purpose were located in relationships with self, others, and God, in the midst of struggle, loss and grief.

Most reported a quick sense of the ethical balances and imbalances in relationships and a drive towards accountable human relating. The struggle in this was recognizing and confronting one's own destructive sense of entitlement within the context of one's own family of origin. For example, one man, who experienced severe abuse at the hands of his father, exacted the same against others whom he perceived to be a threat to those who were weaker. He carried this same behaviour forward into his expectations of his care providers feeling enraged and violent when they did not meet his expectations. Over

time, he worked at applying his new spiritual identity, values and beliefs to those relationships, gained valuable insight into his behaviour, and was able to modify his expectations in fairness to others. He strove to replace the image of his “earthly” father with that of God, his “heavenly” Father. For him, this resulted in a new way of being. He reported and demonstrated a more peaceful, intuitive spiritual inner core. Working against this were the manifestations of psychiatric disorder requiring both cognitive and behavioural therapy. Integrating the new spiritual identity into his personhood and having this reflected consistently in behaviour was a challenge akin to the old adage *two steps forward, one step backwards*.

Meaning making became a spiritual endeavour for all participants. Faith explanations of past and present experiences contributed to a positive re-framing of recovery stories. Participants became more than just wounded storytellers. Participants reported that the telling of these stories was a powerful validation of a profound human experience that held deep meaning for them and their loved ones. Metaphors for these spiritual journeys were a common part of this and appeared to exact a stabilizing effect on the participant’s view of themselves and their life. The attribution of meaning to experience was felt to frame the future. Some metaphors revealed a therapeutic need for the participant to reclaim a voice over the medical voice and a life beyond their medical diagnoses. Following are examples of some of the metaphors shared. Three different participants are quoted:

Patient D: *I see myself as a strong and courageous spiritual warrior. I am on the warpath entering into battle with the belief that I will win because I have faith. God is with me.*

Patient A: *I would liken myself to a forest with the tall spruce and deciduous trees and all of the animals. Then there was a blazing forest fire and yet the forest still developed itself in time. This is a story of hope. My advice to others with ABI is, never give up! There is hope!*

Patient B: *I was drowning and now I have broken free. I am on the surface now. My spirituality, my belief in God keeps me afloat.*

Patient B: *Medicine as opposed to spirituality: There’s only so much that doctors can do. You must open yourself to the Holy Spirit. He is always present in the creation of life, birth, in the passing on, our journey from birth to death. I see the grace of God in every person and every event.*

Following are excerpts from narratives that depict common themes. These narratives were tragic stories of loss with all the elements of confusion, fear, anger, and despair. Common to many was the recognition of the transcendent, and a radical shift in core beliefs that allowed them to reframe the story of their lives. Two participants were non-theists and did not find the language of God to be useful. A reverence of life was the language of their spirituality. Four different participants are quoted:

Patient A: *This event has created meaning for me. We are obviously here for our loved ones. We are here for the relationships that we develop with them. We are here to try to help them out the best that we can and try to create something better than what went before.*

Patient D: In the beginning I viewed myself as power woman. I could do everything and anything that I wanted. With the ABI I lost so much (career, relationships, social status) and I realized that I could no longer do it on my own. I needed my spirituality, which I nourished through the practice of my spiritual rituals. I derived strength from it. It was because of my spirituality and spiritual beliefs that I got through. Through it all, the one thing that did not change was my faith. It only got stronger.

Patient G: There is good and bad, hope and despair. They co-exist. I can handle this now. My spirituality is the mediator. This has allowed me to be more tolerant of other people, more compassionate. I have a terrible sadness about all of the loss and great hope as well. I have a future...a destiny of some kind.

Patient B: I had too many times when I just wanted to kill myself and be dead, but now I have a spirituality in which I believe. Now I need to live. I want to live.

Patient A: Priorly I had started to neglect the significant relationships in my life. I was taking it all for granted. This event helped me to turn all that around and to cherish those relationships, to work on developing and maintaining them.

Patient B: I feel that I beat the devil by seeking God's wisdom and direction. I feel that God is beside me to guide me in the journey of life. As a result I have an overall sense of love and loving compassion, the ability to want to help other people in their struggles.

Participants also reported that they struggled with the fact they would revert back at times to the old belief system. Cognitive therapy techniques were useful in facilitating the return to the new, more desired belief system. For one participant, carrying a list of spiritual beliefs, accomplishments and goals was incentive to remain hopeful. Wanting to set relationship goals reflecting new, spiritual core beliefs was common.

Findings relevant to the use or application of spirituality:

Eight out of nine participants (88.9%) engaged in spiritually informed activities that expressed both core beliefs and existential goals. One example involves a man who successfully restored the chapel cross that had priorly been burned in an act of vandalism. This activity served as an act of atonement, a Roman Catholic rite of passage that brought closure to many of the spiritual and religious concerns generated by his experience of dual diagnosis. Other examples included, looking for ministry opportunities with troubled youth, forming support groups, designing a web-site for sufferers of ABI, doing community service at shelters and food banks and sharing their personal testimonies at conferences and work shops. The desire to be in the service of others by listening, witnessing, affirming, commending and encouraging was a common theme.

Spirituality was used, as well, as a means to cope with stress and to make decisions, to strengthen and to comfort oneself in the face of adversity. Many spoke of using their spiritual morality to inform their behaviours and actions. Many had made a conscious decision to use their newly expanded spiritual identity to promote ethical relationships, through discussions on values and spiritual awareness, and by mentoring family, particularly children and grandchildren. Passing along a spiritual legacy to the next generation became a focus. Several participants described attempts to mediate conflicts

among other patients on the unit where they were admitted. They expressed a desire to instil similar spiritual values in others. These individuals desired to teach by example. Five of the nine participants (56%) expressed a new interest in social justice issues and the desire to set goals for action. Table 5 presents the classification of the spiritual themes identified in the areas of awareness, development and application and concludes the data analysis.

Table 3, Classification of Spiritual Themes

Awareness	Development	Application
<p>Goals: Acknowledgement of spiritual dimension, acceptance, and openness to believe.</p>	<p>Goals: Intimacy and ethics in relationships.</p>	<p>Goals: To impact both the present and the future. Confer a legacy.</p>
<p>Themes: Mystical and Near Death Experiences</p>	<p>Themes: The context is relatedness/connectedness</p>	<p>Themes: Engaging in spiritually informed activities that express core beliefs and values</p>
<p>Acknowledgement of an encounter with the divine (connectedness with God/Higher Power)</p>	<p>Expansion of relational ability</p> <p>Increasing capacity to extend compassion, empathy, tolerance, and trust to others.</p>	<p>Promotion of ethical relationships</p>
<p>Change in some core beliefs</p>	<p>Drive towards accountable human relating. Forging relationships that reflect spiritual beliefs and values.</p>	<p>Defining and sharing a spiritual legacy with the next generation</p>
<p>Realization of opposite poles (hope and despair)</p>	<p>Moral awareness</p>	<p>Drawing on spiritual resources in times of adversity and for on-going strength, comfort and direction</p>
	<p>Personal responsibility for and beyond oneself, from local to global concerns.</p>	<p>Reaching out to others (sharing personal testimonies, providing support, serving in the community)</p>
	<p>Meaning making as a spiritual endeavour</p>	<p>Involvement in social justice issues</p>
	<p>Claiming a voice over the medical voice</p>	
	<p>Struggle with insight into behaviour, and integrating new spiritual beliefs</p>	

Discussion

Spirituality emerged as a powerful element in the recovery and rehabilitation of those with acquired brain injury and psychiatric disorder. An expansion of awareness, openness to new experiences, new meanings of experiences, and new self-organization came with the territory of encounters with the divine or the spiritual dimension. Once recognized, individuals desired to actualize and integrate spirituality into the whole of their life. The components of hope, meaning making, connectedness, and perseverance contributed to an overall sense that one could transcend the adversity and pain of their circumstances.

One can discern both a positive tone and a remarkably articulate nature to the transcribed comments of the participants. This type of clear communication would not be typical of severely brain injured people and can be explained in three ways. First, most participants interviewed had achieved graduate level degrees and worked in professional careers prior to incurring their brain injuries. Second, one of the participants had experienced an unexpectedly higher degree of recovery. Lastly, these results would appear to speak to the intensity and richness of meaning that spiritual concepts hold for those with dual diagnosis. Similarly, researchers in a study on changes in spiritual beliefs after traumatic disability observed that participants “were able to provide cogent and thoughtful responses to very abstract and demanding ideas” (McColl, 2000,822). One interpretation offered to explain this was that people had spiritual experiences that were profound and largely positive. As well, they were considered to have a “well-developed spiritual life”, whether they were aware of it or not (McColl, 2000,823).

Although the interviews were quite positive, field notes indicated that incongruence between the newly formed spiritual beliefs and values and one’s behaviour was quite common. Individuals struggled with the integration of spiritual meaning into their lives. As one’s spirituality developed, the continuous process of transformation was experienced as *two steps forward and one step backwards*. The process of gaining insight into and changing inappropriate, destructive or self-destructive behaviour, and becoming more aware of one’s impact on others, was accomplished with the help of a multidisciplinary team dedicated to consistently implementing both cognitive and behavioural therapy. The role of the pastoral counsellor assigned to the unit was to provide counselling that gave special attention to the spiritual dimension. Chaplains and pastoral counsellors are specially trained to discern which spiritual and religious concerns are problematic and worthy of clinical attention and which ones do or do not attribute to psychiatric disorder. Fallot emphasizes that spiritual beliefs and behaviours be placed in the context of the person’s ability to function in social, educational, familial and vocational roles; of overall psychological organization; and of physical or biological findings (Fallot,2001, 111). In light of the many challenges faced by those with dual diagnosis, including with some, delusional, grandiose or self-deprecating thinking, this role is of particular importance.

The ability to understand and work with individuals from a diverse range of spiritual backgrounds allows for the co-construction of meanings that facilitate health and healing. Recognizing and opening up space in therapy to discuss such universal spiritual concepts as the meaninglessness of trauma and suffering, is required. For example, a spirituality

that embraces paradox is particularly important for those with dual diagnosis. The willingness to wait in ambiguity while spiritual transformation occurs is cultivated in the tension that is sustained between the opposite poles of despair and hope, the provisionality of life and the assurances that faith offers. This concept is perhaps best captured by Dickens who coined the phrase, “It was the best of times; It was the worst of times.” The pastoral counsellor comes along side individuals as they persevere and journey through the meaning making process, facilitating discussions on spirituality, responding to faith-based questions, and supporting the exploration of various stages of faith.

The person with dual diagnosis engages readily in the spiritual endeavour of meaning making and this generally works itself out in the relational context, particularly in the marital relationship and in family life. The adjustment to having a brain injury involves all family systems, intergenerationally. The contextual model of family therapy popularized by Ivan Boszormenyi-Nagy, with its distinct emphasis on the ethical dimension (trust, loyalty, entitlements and indebtedness) in family relationships as they extend over generations has particular application here. With acquired brain injury any psychotherapeutic leverage anchored in relational determinants would benefit the person and promote change in the system. The person who has dual diagnosis looks for new ways to relate to their loved ones. Healing comes from connectedness. In many ways they return as a stranger to their families so that the re-working of relationships becomes necessary to accommodate and adjust. Adaptive functioning depends on their ability to negotiate new role allocations and definitions to suit their new circumstances. Posterity becomes important, driven by the existential goal *to triumph*, as a legacy to pass on and inform the destiny of the next generation. Such an effort would appear to satisfy the need to exact fairness, to achieve balance and to trust in the universe again. Redeeming an intolerable situation through spiritual transformation and relational intimacy becomes the focus for many. With this the challenges are great requiring on-going support and counselling for the family to transcend the identifications and the constraints of both the past and present changes in circumstance.

In light of the information garnered by this study a variety of desired outcomes for individuals with dual diagnosis can be considered, such as the exploration of spiritual experiences, an increased capacity for self-reflection, the integration of losses and lost possibilities, separation from embeddedness in the past, an increased capacity for accepting ambiguity and embracing polarities, the tolerance of uncertainty and emotions, an increased awareness of one’s impact on others, an increased relational ability, and finding richer meaning in life through spiritual endeavours.

Further areas to research

An expansion of this study to involve more participants of both differing faith groups and women would provide more balance and ensure that the perspective of these groups were adequately represented and considered. This study would appear to reflect similar themes to those identified by Hicksen and Phelps (1998) concerning women’s spiritual journeys. These include exploration, interdependence, balance and wholeness in the relational context.

A further area to explore would be that of forgiveness. Hargrave (1994) offers us valuable information on the role and accomplishment of forgiveness in life. Because of the nature of their circumstances, those suffering with ABI often struggle with a lack of forgiveness towards self, others and towards God. The exploration of Hargrave's four stations of forgiveness including insight, understanding, opportunity for compensation, and the overt act of forgiveness can be useful. Using one's spiritual beliefs and values to work through these stages is a recommendation. His emphasis on love and trust as well as destructive entitlement applies.

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Canadian spirituality and health: A pastoral care and counselling perspective

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Abstract

This article highlights the need for Canadian pastoral caregivers and counsellors to embrace the “research” side of spiritual care (in addition to the “faith” side). The article reviews the number of publications on spirituality and health by chaplains and pastoral counsellors in five peer reviewed Journals. Ten percent of the articles are authored by Canadian chaplains, pastoral counsellors and/or theologians – 20 % of the articles in the two Canadian-based publications. Readers are encouraged to embrace research and to follow through to publication. Six bright spots are mentioned. These include the Society for Pastoral Counselling Research (SPCR), the Canadian Association for Pastoral Practice and Education (CAPPE) and various Canadian theological schools that publish research.

Introduction

Central to the practice of pastoral care and counselling is dealing with the spiritual issues of the client/patient (VandeCreek, 1999; VanKatwyk, 2003; Meier, O'Connor and VanKatwyk, 2005). Many other health care disciplines such as nursing (DiCenso et al., 1998), medicine (Levitt, 2005), occupational therapy (Baptiste, 2005), physiotherapy (Clarke et al., 2005) and family therapy (Walsh, 1999) also strive to address the spiritual needs of patients/clients. Pastoral care and counselling is rooted in a theological/religious/spiritual foundation as well as the various theories from the social sciences (MacNeill, 1951; Clebsch & Jaekle, 1967; Holifield, 1983; Gerkin, 1997; O'Connor, 2002; O'Connor and Meakes, 2005). Chaplains and pastoral counsellors receive at least a Masters level education that includes practicums under supervision and/or Supervised Pastoral Education (SPE) in the Canadian Association for Pastoral Practice and Education (CAPPE). These practical experiences with clients and patients focus on how to conduct a conversation with clients/patients around the client's spiritual needs. This is a challenging area. One of the goals is to avoid converting the client to one's own particular belief. (VandeCreek, 1999; Sloan et al., 2000). At the same time, clinicians desire to give clients the opportunity to speak about their spiritual needs especially around the particular situation that

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brought them for help. Certainly, the literature on spirituality indicates a variety of understandings of spirituality and health and this makes the conversation even more challenging (McCarroll et al., 2005). Some clients opt not to discuss spiritual needs and desire to address other issues. Pastoral care and counselling respects that and honors clients' decisions. However, sometimes a psychological problem masks a spiritual problem and vice versa (VanKatwyk, 2003).

In most fields, the clinical work is usually guided and informed by research. Spiritual care in our contemporary society stems from two paradigms: faith traditions and research. (O'Connor and Meakes, 2005). The faith paradigm is based on sacred texts and tradition that require the caregiver to offer spiritual care based on a mandate from the Divine and/or faith community. The faith tradition paradigm of spiritual care is the most dominant one in our society. In the last thirty years, a second paradigm based on research has developed (O'Connor et al., 2002). This paradigm is not based on sacred texts or mandates from faith communities. Rather, this approach to spiritual care is based on empirical research (Barbour, 1997) that indicates that spiritual care is beneficial to the health and well being of patients and clients (VandeCreek, 1995; Koenig, 1997; Koenig, McCullough and Larson, 2001; Levin, Larson & Puchalski, 1997; Levitt, 2005; O'Connor & Meakes, 2005). An evidence based approach to pastoral care and counselling arises from the research paradigm to spiritual care (O'Connor & Meakes, 1998). In evidence based spiritual care, clinicians ought to be using the best available research in service to their clients (O'Connor, and Meakes, 1998; DiCenso et al., 1998; O'Connor, 2002). While evidence based spiritual care is mostly foreign to the faith paradigm, research is crucial in our scientific age (Barbour, 1997). Ideally, research ought to be guided by the experiences and questions that arise from the clinical setting. However, this is not always the case. A previous study by Thomas O'Connor and colleagues (O'Connor et al., 2002) indicates the huge amount of research being published in scientific and medical journals on spiritual care. However, what have Canadian chaplains and pastoral counsellors published in terms of spirituality and health? What kinds of research do Canadian chaplains and pastoral counsellors utilize in their publications? Who is publishing these articles and where are they located? What are the implications for clinical work and research in pastoral care and counselling?

Quantity of publications by Canadian Chaplains and Pastoral Counsellors on Spirituality and Health

The number of Journals published today is enormous. To discover the number of publications done by Canadian chaplains and pastoral counsellors on spirituality and health is challenging. Electronic searches of databases do not contain all journals nor do they identify the country where authors reside. The authors have done previous searches of electronic databases and also manual searches that have been published (O'Connor et al., 2001; O'Connor et al., 2002;). To gain a rough estimate of the quantity of publication by Canadian chaplains and pastoral counsellors on spirituality and health, a manual search of five Journals was employed. This involved searching a Journal, article by article, and noting two items. First, was the article on spirituality and health? Second, was the article published by a Canadian chaplain and/or pastoral counsellor. The first issue was answered by reading the title, abstract and sometimes the full text

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of the article. The second question was answered by examining the author's degrees, professional identification and the address where he/she could be reached.

Five journals were selected. The selection criteria was based on the Journals most used by pastoral care and counsellors to publish. The Journals were searched for a five year period (2000-2004) to discover the number of publications done by Canadians. The five journals are *Consensus*, *The Journal of Pastoral Care and Counselling* (previously known as *The Journal of Pastoral Care*), *Pastoral Sciences/Sciences Pastorales*, *Pastoral Psychology* and *The Journal of Religion and Health*. All five are peer reviewed. *Consensus* is a Canadian Lutheran journal published biannually by Waterloo Lutheran Seminary in Waterloo, Ontario and Luther Seminary in Saskatoon, Saskatchewan. *The Journal of Pastoral Care and Counselling* is published quarterly in Decatur, Georgia and one of the journals that CAPPE members can select as part of their membership. This Journal also has the largest subscription rate in North America for practitioners and theologians of pastoral care and counselling. *Pastoral Sciences/Sciences Pastorales* is a bilingual journal (English and French) published biannually by St. Paul's University in Ottawa. This journal can also be selected by CAPPE members. *Pastoral Psychology* is published six times in the year by Princeton. *The Journal of Religion and Health* is published quarterly by the Blanton-Peale Institute in New York.

Articles in each of these Journals during 2000-2004 were reviewed by the authors to discover if the article focused on spirituality and health. The reviewers also noted Canadian authorship. In the case of many authors, the article was examined to see if one of the authors was Canadian. The results of the search are present in Table 1. Table 1 is the number of articles on spirituality and health written by Canadian chaplains, pastoral counsellors and/or pastoral theologians in five Journals for the years 2000-2004. (See below.) The Table indicates that Canadian chaplains, pastoral counsellors and pastoral theologians published 52 out of 518 or approximately 10% of these articles. Also, in these 52 articles, there were 86 Canadian authors which indicate that most were written by more than one Canadian. Most of the articles had an affiliation with a theological school rooted in the university. The more predominant theological schools are the bilingual pastoral care and counselling program at St. Paul's at the University of Ottawa, the French pastoral counselling program at the University of Sherbrooke, pastoral care and counselling program at Waterloo Lutheran Seminary at Wilfrid Laurier University, pastoral theology at Toronto School of Theology at the University of Toronto and pastoral care and counselling program at St. Stephen's Theological school at the University of Alberta.

Table 1: Articles on Spirituality and Health by Canadian Chaplains, Pastoral Counsellors and/or Pastoral Theologians in Five Journals (2000-2004)

Five journals (2000-20004): <i>Consensus</i> , <i>Pastoral Psychology</i> , <i>Pastoral Sciences/Sciences Pastorales</i> , <i>Journal of Pastoral Care and Counselling</i> , <i>Journal of Religion and Health</i>	Number
Total Number of Articles in the Five Journals	518

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Total Number of Articles authored and/or co-authored by Canadian Chaplains, Pastoral Counsellors and/or Pastoral Theologians	52
Total number of Canadian authors in the 52 articles	86
Percentage of Canadian articles (52) to total number of articles in Five Journals	10.0%

Table 2 presents the articles on spirituality and health written by Canadian chaplains, pastoral counsellors and/or pastoral theologians in two Canadian Journals. These are *Consensus* and *Pastoral Sciences/Sciences Pastorales* in 2000-2004. Table 2 shows that Canadian chaplains, pastoral counsellors and/or pastoral theologians authored and/or co-authored 20% of the articles in two Canadian Journals. This doubles the percentage when compared to Table 1. Table 1 includes three American journals. The three American journals are the ones most known in the field. The number of articles on spirituality and health is lower in *Consensus* than *Pastoral Sciences/Sciences Pastorales* because *Consensus* also publishes sermons and articles on systematic and historical theology. Also noteworthy is that the two Canadian Journals publish twice a year while the American journals publish at least four times a year. *Pastoral Psychology* publishes six times a year!

Table 2: Articles on Spirituality and Health by Canadian chaplains, pastoral counsellors and/or pastoral theologians in two Canadian Journals

Two Canadian Journals: <i>Consensus</i> and <i>Pastoral Sciences/Sciences Pastorales</i> (2000-2004)	Number
Total number of articles in the two Canadian Journals	117
Total number of articles authored or co-authored by Canadian chaplains, pastoral counsellors and/or Pastoral theologians	23
Total number of Canadian chaplains, pastoral counsellors And/or pastoral theologians in the 23 articles	33
Percentage of Canadian articles to total number of articles in the two Journals	20%

Kinds of Research Used in Publications

The reviewers also searched for the kind of research conducted according to the following areas: theoretical, qualitative including case study, quantitative, combined quantitative and qualitative or uncertain. The reviewers had received previous training in this kind of search and have published using electronic and manual search strategies (O'Connor et al., 2002; O'Connor et al. 2001). Table 3 presents the types of research designs used on spirituality and health by Canadian

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chaplains, pastoral counsellors and/or pastoral theologians in the five Journals. The most frequent for of research is qualitative research including case studies which is 48%. This is followed by more theoretical or hermeneutical research design (41%). Last is quantitative (07%) and combined quantitative and qualitative research (04%). Certainly, the tradition of Biblical, systematic and historical theology is more hermeneutical in design. This has carried over to pastoral theology. The clinical nature of chaplaincy and pastoral counselling with its interview method makes an easy fit with qualitative research. Surprisingly, qualitative research has surpassed hermeneutical or more theoretical research design.

Table 3: Types of Research done by Canadian authors in the five Journals.

Types of Research	Number = 52 (%)
Qualitative including case study	25 (48%)
Quantitative	4 (.07%)
Combined Qualitative and Quantitative	2 (.04%)
Theoretical or Hermeneutical	21 (41%)

Who is doing the research

The search of the Journals also indicates some researchers in Canada are in the area of spirituality and health and work from a pastoral care and counselling perspective. These include Deborah Everrett, Gilles Fortin, Terri Lynn Gall, Fred Konig, Pam McCarroll, Elizabeth Meakes, Augustine Meier, Marie-Line Morin, Thomas St. James O'Connor, Kathleen O'Neill, Carol Penner, Martin Rovers, Peter VanKatwyk. This list is not exhaustive but indicates a number of researchers across the country from the English and French sectors.

Implications and Suggestions

The number of publications by Canadian chaplains, pastoral counsellors and pastoral theologians in the area of spirituality and health in the five journals is small. When this is compared to what is published by non-theologically based researchers, the small number gets even smaller (O'Connor et al., 2002). The study on Canadian chaplains' experiences of spiritual assessment tools indicates (O'Connor et al., 2005) that Canadian chaplains prefer to use their own informal tools that they have created from their clinical ministry. They do not proceed to publish these home-grown tools. Research and publication are not strong values among Canadian clinicians in pastoral care and counselling. Service to clients and patients is the more dominant value amongst clinicians. When one moves to the theological school and university, there is more publication. When one examines the list of researchers who publish (see above), the vast majority belong to theological schools and universities. This reality among Canadian chaplains and pastoral counsellors underlines the differences between the academy and clinical world. John Ralston Saul (1999) believes that an apt metaphor for the Canadian people is Siamese Twins. Canada is made up of three founding nations (French, English and Native) that are joined together. Saul

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points out that there is always the temptation to split the Siamese twins. Similarly in Canada, there is both the academy and the clinical world in pastoral care and counselling. One temptation is to separate them. The other challenge is to have both work together for mutual benefit. How can the theological schools and the hospitals and pastoral counselling centres work together to provide the best spiritual care for clients?

In examining the types of research outlined in this study (Table 3), the percentage of qualitative studies including case study is 48% and the percentage of qualitative studies including hermeneutical is 41%. Quantitative research is minimal. Canadian chaplains and pastoral counsellors prefer the more 'soft' kinds of research that are more adapted to the clinical environment. Most chaplains and pastoral counsellors are not familiar with quantitative research methods. Few theological schools even offer a course on research methods that include quantitative research. This is an area of further growth.

Some bright spots exist in the Canadian experience. One is the Canadian Association for Pastoral Practice and Education (CAPPE). CAPPE combines both pastoral care and counselling in one association and utilizes both of these streams in pastoral education. CAPPE is bilingual involving Anglophones and Francophones. Certainly, there have been many tensions between the various groups in CAPPE. However, as Michael Ignatieff (2000) and John Ralston Saul (1999) note, as typically Canadian, there has been much compromise and give-and-take to make the union work.

Another bright spot is the development of the Society for Pastoral Counselling Research (SPCR). This society is over ten years old and is bilingual. This society is designed to encourage research and publication in the area of pastoral care and counselling. Like CAPPE, it holds an annual conference. SPCR, under the guidance and encouragement of its founder, Augustine Meier, has published the proceedings of its conference in four books and in various peer reviewed journals. In truly Canadian fashion, SPCR has made an informal agreement to work with CAPPE to encourage research and publication in the field of pastoral care and counselling.

A third bright spot is *Pastoral Sciences/Sciences Pastorales*. This bilingual journal is peer reviewed and brings together research written from both the academic and clinical perspectives. Most of the authors are Canadian. However, authors from other countries, especially the United States, also publish articles in this Journal. Many of the presentations from SPCR are published in the Journal.

A fourth bright spot are various programs that have attempted to integrate academics, clinical work and research. St. Stephens' theological school at the University of Alberta is working with the Edmonton hospitals and pastoral counselling sites in combining academics and clinical work through Supervised Pastoral Education. Saint Paul University in Ottawa offers an MA in pastoral ministry. This masters level program is bilingual (French and English) and includes clinical placements in the Ottawa hospital as well as pastoral counselling. The University of Sherbrooke offers a masters program in French in pastoral counselling. This program includes clinical work, academics and research. Waterloo Lutheran Seminary offers an MTS, MTh and DMin in

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pastoral counselling and a graduate Diploma in Spirituality in a Healthcare Setting. These graduate programs are connected to St. Joseph's Healthcare system and Cambridge Memorial Hospital. In the residency program at St. Joseph's, residents are required to take a graduate course in research and design a research project based on their clinical assignment that is presented at the SPCR conference in May.

A fifth bright spot is a forthcoming book titled *Spirituality and Health: Multidisciplinary Explorations* edited by Augustine Meier, Thomas St. James O'Connor and Peter VanKatwyk (2005). The book emphasizes spiritual care from both the faith and research paradigms. Chapters are authored and co-authored by researchers and clinicians from a variety of disciplines and a variety of faith groups in Canada: pastoral theology, family medicine, occupational therapy, physiotherapy, chaplaincy, pastoral counselling, oncology, congregational ministry, psychology, Native spirituality, Islam, Christian, etc. This book provides quantitative, qualitative and hermeneutical research in underlining an evidence-based approach. Most importantly, theology and the paradigm of faith are part of the partnership. As indicated above, most of the research and publication on spirituality and health stems from the research paradigm often neglecting the faith paradigm. This book presents ideas and evidence from both paradigms. The book focuses on those partnerships and in truly Canadian style gives no definitive answer but rather offers explorations.

A sixth bright spot between the faith and research paradigms in Canada is shown in a recent study of Canadian chaplains' experiences of spiritual assessment tools (O'Connor et al. 2005). In the study, none out of a sample of 101 said that they always used a spiritual assessment tool that has been published. Many commented on using a more informal, narrative approach that was not rigid. There was lots of criticism of published tools and the chaplains and pastoral counsellors expressed uneasiness with the research paradigm. However, they also saw a need for such an approach. Twenty-nine (30.5%) have created their own tool. These tools created by the chaplains would fall somewhere between the research and faith paradigms. These unpublished tools are associated with the hospitals in which they originated: The Health Care Corp, St. John's Newfoundland; the Ottawa Hospital; St. Michael's Hospital, Toronto; Scarborough Grace Hospital (mentioned twice); General Hospital in Guelph, Ontario; St. Mary's Hospital in Kitchener, Ontario; Riverview Health Center in Winnipeg, Manitoba (mentioned three times); Alberta Hospital, Edmonton (mentioned twice); and the Vancouver Hospital. These unpublished spiritual assessment tools were based on a variety of ideas including Paul Pruyser, George Fitchett, Paul Jones, Christina Pulchaski and James Fowler. The Enneagram and Myers-Briggs are also mentioned as the basis for informal assessments and conversations in ministry. Chaplains are not satisfied with existing tools and create their own that are more user friendly.

Encouraging research by both academics and clinicians is important for the development of the field and profession. One way to increase the amount of research is for clinicians to take a research course as part of the CAPPE training. The course could be given as a pre-institute at the annual CAPPE Conference. A second way is to join SPCR (The Society for Pastoral Counselling and Care Research) or other pastoral research societies and be immersed in the research culture.

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A third way is to develop a research cluster in one's institution, be it hospital or agency, to discuss a research project and be supportive to each other. Fourth, research ought to be done with the intent of publication in a journal. Finally institutions need to be encouraged to value research in spiritual care, particularly if research is a component of the mission statement at the institution.

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Retirement and existential meaning in the older adult: A qualitative study using life review

**Judith Malette
Luis Oliver**

Abstract

Dramatic increases in life expectancy over the past century have created a number of challenges for society as its members age. Life Review can help individuals navigate many such difficulties. Further, existential meaning and personal growth are strongly linked across the lifespan. The purpose of the present study was to explore whether and how Life Review can facilitate adjustment to retirement. A qualitative analysis of Life Review sessions with seven older healthy adults exploring themes of Strengths, Retirement, and Life Goals and Mission was conducted. Results suggested that Life Review can facilitate the retirement process and contribute to older individuals' search for existential meaning. It can also promote conscious ageing and the compassionate re-definition of self.

*Memory is not just the imprint of the past
time upon us; it is the keeper of what is
meaningful for our deepest hopes and fears.*
– Rollo May

The last century witnessed a sensational and unprecedented surge in longevity in industrialized countries, with average augmentations in life expectancy of up to thirty years for men and close to forty years for women (Dubé, 2003; Friedan, 1995; Houde, 2003). Increasingly, people reach retirement in relatively good health, with several years of life still ahead of them. These new, so-called “supplementary” years (Houde, 1999; Friedan, 1995) often present unique challenges for individuals and society. For example, ageing persons may face a number of losses (e.g., professional, relational, physical, cognitive or emotional) often associated with ageing and the mere cumulative passage of time. Consistent with this, it has been observed that an extended lifespan has not guaranteed an increase in the quality, meaning and purpose of life for older adults (Cole, 1984; Gaillot, 1996; Wong, 2000).

Over forty years ago, Birren (1964) and Butler (1963) emphasized the importance of personal meaning in the ageing process, and numerous other authors (Brat, 2000; Frankl, 1963, 1967, 1969, 1988; Kimble and Ellor, 2000; Malette and Pencer, 2003; Monbourquette and Lussier-Russel, 2003) have more recently suggested that personal meaning and personal growth are strongly and intimately linked across the lifespan. Traditionally, but especially in recent decades, one of the major tasks of retirement and ageing consists in discovering new bases for meaning (Brat, 2000; Kimble & Ellor, 2000; Leclerc, Couture & Roy, 2003). The ageing individual is frequently required or invited to shift his/her sources of meaning, to experience them differently, and often to choose activities where being predominates over doing. Consistent with this, Längle (2001, 2004) speaks of ageing as an existential challenge in which one has the choice to redefine one's being-in-the-world by attributing meanings to the joys, accomplishments, and losses of one's life.

Although such meaning-making is typically done more or less effectively as part of a spontaneous process, a number of approaches exist to help the individual more effectively and efficiently deal with life challenges such as losses. One such process is Life Review (hereafter LR), which has evolved significantly since it was first described by Butler in 1963 as a progressive revisiting, re-examination and (hopefully serene) integration of the individual's past. Differentiating among the different forms, names and shades of LR is beyond the scope of the current study. The reader is invited to consult Malette & Pencer (2003) for a more detailed description of the process. For the purposes of this study, however, we wish to highlight the fact that LR not only involves a remembering of past events, but a review and "re-reading" or re-framing of these events. Thus, the individual may come to attribute new, different and possibly more benevolent meanings to past events during the course of LR, based on what he/she experiences in the present. The focus is not to dwell on the past, but to revisit and integrate it in order to live more fully in the present and prepare for the future. A significant body of research has demonstrated that LR can help individuals to integrate losses, resolve "unfinished business" accumulated over the course of a lifetime, and significantly contribute to adjustment to ageing (Birren, 1964; Birren & Deutchman, 1991; Butler, 1963, 1971, 1974; Coleman, 1986; Cook, 1991; Héту, 1989, 2000, 2003; Kaminsky, 1984; Lavallée & Denis, 1996; Lewis, 1971; Magee, 2000; Monbourquette & Lussier-Russel, 2003; Roche, 2000; Romaniuk, 1981; Staudinger, 2001; Watt & Cappeliez, 2000; Watt & Wong, 1991).

Three constructs which are key to this study, retirement, ageing and existential/personal meaning, will now be defined and elucidated.

Retirement

When retirement was officially institutionalized at the end of the nineteenth century, it referred to a monetary allocation compensating individuals no longer able to work. The age of 65 was arbitrarily chosen as the retirement age at a time when life expectancy was 37 years of age (Friedan, 1995). Since then, longevity has significantly increased, but most people still choose to retire at 65 or even earlier (Blanchard de Ravinel & de Ravinel, 2003; Friedan, 1995).

The Webster dictionary defines retirement as a "withdrawal from one's position or occupation or from active working life." Although not erroneous, this definition does not capture the full complexity of the experience. According to Cavanaugh, chair of APA's Committee on Aging

(CONA), “retirement relates more to a self-definition process than a specific point in time” (cited in Greer, 2004, p.10). Thus, retirement may actually involve a re-definition of the self based on something other than one’s occupation and job-related competencies. Further, it implies major changes in daily routines, relationships, work role, and identity (Blanchard de Ravinel & de Ravinel, 2003; Hogue-Charlebois & Paré, 1998; Houde, 2003; Jonsson, Borell & Sadlo, 2000; Price, 2000; Schlossberg, 2004). It is a period of transition during which one leaves a known way of doing and being, often enters unknown territory, and may experience significant feelings of loss and associated grieving. The retiring individual may also be subjected to ageist stigma.

By contrast, many possibilities, both personal and professional, open themselves to retiring adults (Dittman, 2004). In this sense, retirement has the potential to be less of a “withdrawal from” than a “release to.” Blanchard de Ravinel & de Ravinel (2003), Hogue-Charlebois & Paré (1998), Jonsson et al. (2000) and Schlossberg (2004) all suggest that retirement can be a liberation, an opportunity to finally realize projects kept on the proverbial backburner during one’s active professional life. These projects may have to be adjusted in light of age-related challenges, but that does not rob them of their intrinsic value. Jonsson et al. (2000) found that most of the retirees they studied felt a need to commit themselves to a regular activity such as sports, reading, volunteering or consulting. Sharing one’s experience in the context of mentoring is another example of committed activity (Blanchard de Ravinel & de Ravinel, 2003). According to Schlossberg (2004), independent of the nature of the activity chosen is the need to feel appreciated and valued for contributing to the well-being of oneself and of others.

Retirement, like other transitions, prompts many individuals to become at least temporarily introspective. At such times, they may question their values, past professional and personal accomplishments, current life situation, and how to live the rest of their lives. There may be an increased sense of urgency compared to other transitional periods, given an increasing awareness of one’s mortality (Nadeau, 2003). The proximity of death leads many individuals to try to live more fully and to choose more consciously how they want to live their lives.

Ageing

Conceptualizations of ageing have evolved significantly over the years. For instance, Cumming and Henry’s (1961) theory of disengagement stipulated that a good adjustment to ageing involved self-renunciation and acceptance of one’s helplessness. Later, other approaches declaimed such theories as encouraging self-abnegation and conformity to societal pressures exhorting the older adult to disappear from the world. For example, Rosow (1974) and Williamson (2002) both emphasized the active role of older adults in determining the trajectory of their own ageing via the selection of new activities and roles. Atchley (2003) postulated that idea patterns (e.g., attitudes, values, beliefs) and previous lifestyle represent infrastructures of continuity which facilitate adaptation to the personal and professional changes inherent in retirement and ageing.

Rowe and Kahn’s (1987) theory of Successful Ageing (SA) has generated a significant body of research as well as much controversy. The authors define SA as involving (a) “the ability to maintain a low risk of disease and disease-related disability; (b) high mental and physical functions; and (c) active engagement with life” (Rowe & Kahn, 1998, p.38). They put forward that individuals are responsible for their own ageing process, and that most physical and mental

health problems can be avoided by using preventative measures. Wong (1989, 2000) argued that Rowe and Kahn's definition of SA is restrictive and might devalue those who cannot meet the three SA criteria. In response to this, he developed the existential-spiritual model of ageing, based on research conducted with the Ontario Project on Successful Ageing. This model expands Rowe and Kahn's (1998) definition of SA to include religiosity, personal meaning, optimism, commitment, and coping. Wong (2000) found that personal meaning was the best predictor of happiness, perceived well-being, absence of psychopathology and depression in the older adult. From these results, he drew the conclusion that SA is "80% attitude, and 20% everything else" (Wong, 2000, p.26).

Aguerre and Bouffard (2003) were also critical of Rowe and Kahn's definition of SA. They argued that a definition of SA should be multifaceted and include spirituality, sexuality, and emotional openness. They identified three means to promote SA: forgiveness towards oneself and the other, mindfulness-based stress reduction programs, and LR.

Other writers have argued that conceptualizing ageing through a lens of "success" is a limited view which reflects cultural ideals (Moody, 2003) and an over-valuing of vigor and activity (Leder, 2004). Instead of SA, they propose the concept of Conscious Ageing (CA) as the last chance to become what one could have been or was meant to be. These authors conceive of ageing as a developmental phase somewhat akin to a rite of passage or a personal journey or transformation. CA supports values of autonomy, individuality, expressiveness, and self-transcendence. Additionally, CA involves transcending patterns of ego-defence acquired during youth and solidified during mid-life. Moody (2003) writes: "Conscious ageing is a spiritual process that draws its inspiration from religion, art, lifelong learning... reflected in the field of transpersonal psychology and wisdom traditions in the great world religions" (p.139). Taking the concept of CA even further, Tornstam (1997) coined the term gero-transcendence, which refers to connecting with the universe and implies redefining time, death and the self. Moody (2003) suggests that the increased spiritual awareness involved in CA, akin to the Jungian concept of individuation, is a path toward greater wisdom. Thus CA, more than SA, emphasizes the potential for growth in the older adult. Moody (2003) himself admits that it is a difficult path to follow and that it may not appeal to most individuals, for whom the SA model is a better fit. Nevertheless, Moody (2003) suggests that one way to achieve personal growth, and possibly CA, is through LR.

Existential/Personal Meaning

Frankl (1963) and Maslow (1968) saw existential meaning, or personal meaning, as a universal human need. According to Frankl (1988), three major sources of meaning include meaningful work or good deeds, authentic encounters with others, and the attitude one chooses to adopt when faced with an uncontrollable situation. According to Brat (2000), LR can facilitate the finding of such sources of meaning. Related to this, Blanchard de Ravinel & de Ravinel (2003), Hogue-Charlebois & Paré (1998) and Missinne (2003) suggest that the most fundamental sources of meaning pertain to how to love oneself and others. These authors also suggest that LR can help the older adult in his/her search for existential meaning.

Wong (1999a) suggests that personal meaning meets two of four existential needs related to life satisfaction and well-being, those of feeling significant and attributing meaning to events. He

defines personal meaning as “an individually constructed cognitive system, that is grounded in values and is capable of endowing life with personal significance and satisfaction” (Wong, 1989, p. 517). Additionally, he identifies numerous sources of personal meaning, including work, social status and activity. When these sources begin to decline, many older people are faced with the question: “why continue to live?.” Health and life satisfaction may depend on and also affect the way that the individual responds to this question. Wong (1989) has described four strategies to increase personal meaning: (a) LR; (b) engagement, which generates a sense of choice and initiative; (c) optimism, which requires that the older person nourish their dreams and become active in feasible projects; and (d) religious beliefs and practices and spiritual well-being.

Finding meaning in life amidst hardship can be a difficult, if not at times an insurmountable challenge. A number of authors have argued, however, that even if the individual is powerless to change their life situation, they are always free to choose the attitude with which to face their suffering and death, and to extract from this some personal meaning (Brat, 2000; Frankl, 1963, 1967, 1968, 1988; Missinne, 2000; Wong, 1999b). Hope is inextricably linked to this form of freedom, which allows the individual to transcend the present and the inevitable, even if only by changing their attitude toward it (Kimble, 2000). Frankl (1988) considered that the deepest form of meaning accessible to an older person is the freedom to choose their response to the ultimate challenge, suffering and death. In a similar vein, Kushner (1987) suggested that what is most frightening is not death, but the fear that one’s life had no significance.

The Present Study

The present study sought to qualitatively explore a number of questions using LRs conducted with older, retired adults. Specifically, given that LR contributes to the adjustment to ageing, can it also facilitate the retirement process, which is part of ageing? To our knowledge, the present study is unique in the sense that it researches the qualitative link between LR and retirement. The same methodology was used to explore the questions of how older adults experience retirement through the supplementary years. Additionally, we wished to examine how, if at all, the strengths these participants developed over the years and the losses they accumulated help them to adapt to the new way of life and being associated with retirement.

Method

Participants

Seven older adults (six women and one man) volunteered for the study. The participants were all retired and unemployed, and their mean age was 70.7 years (with a range between 65 and 75 years). All were Caucasian and Francophone; although the LRs were conducted exclusively in French, participants could also speak English and had lived in bilingual environments for much of their lives. Two of the participants were currently married, one was a widower, two were divorced, and two were nuns. Two of the participants had completed high school, and the remainder had post-secondary education; five had a current annual family income of less than \$35,000 (Canadian), while the remaining two made over \$60,000. In terms of religious affiliation, all participants were Roman Catholic. Five of them reported attending religious services more than once a month, but two did not attend any religious service. A variety of illnesses, including diabetes, cancer, heart attack and arthritis, were reported by the participants. Participants were not paid for their participation and were treated in accordance with the ethical

principles used in research with humans (Sales & Folkman, 2000). The research protocol was reviewed and approved by an ethics committee.

Measures

The French version of the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994), a 90-item, self-report measure of current psychological distress, was used in this study to assess general emotional functioning in participants. The measure yields scores on 9 symptom dimensions (somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoia and psychoticism), and generates 3 indices: the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). According to Derogatis (1994), the GSI is most indicative of overall distress since it combines information on the number of reported symptoms and the intensity of the perceived distress.

Procedure

The present research was part of a larger project on LR which included the exploration of several themes (e.g., review of family of origin, turning points in life, personal accomplishments, strengths). Data collection for this larger project occurred over the course of 16 individual meetings with the participants in their homes. LRs were conducted by six graduate students in counselling, and the first author. Each student received exhaustive training in LR before meeting his or her participant. The current study focused on three of the aforementioned themes, specifically Strengths, Retirement, and Goals and Mission in life. These themes were explored in meetings 9 to 14, inclusively. Themes were chosen based on recent quantitative and qualitative clinical research (Birren & Deutchman, 1991; Héту, 1989, 2000; Malette & Pencer, 2003; Monbourquette & Lussier-Russel, 2003; Pelaez & Rothman, 1994; Rybarczyk & Bellg, 1997; Zuccoloto, 1993).

LR consisted of six audio-recorded, one-hour meetings which started with a brief guided relaxation period, called “centering on memories.” This procedure involved relaxing and creating a mental space for memory processes by focusing attention and putting aside distracting thoughts and preoccupations. Participants were instructed to (a) close their eyes, creating silence and focusing on maintaining slow, regular breathing; (b) focus on the memory (event from the past) they wanted to discuss; (c) create an image associated with the event from the past; and (d) focus on the thought and/or the emotion which best took into account how they felt about the memory. Semi-structured interviews were then used to gain insight into the meaning that participants attributed to their experience. Examples of the questions used in these interviews are included in Appendix A.

Participants were recruited via an advertisement describing the study posted on bulletin boards at a local university and in community centres. Potential participants were first screened for psychopathology/distress using the SCL-90-R. One individual with a GSI over the clinical cutoff was judged to be suffering significant clinical distress and was referred for psychotherapy rather than for participating in the study. Screening was deemed necessary to establish whether it was appropriate for an individual to embark on a LR process. Other administrations of the SCL-90-R, at meetings 8, 15, and 16, were conducted to monitor participants’ psychological

well-being. This was considered an important ethical measure, given the slight possibility that exploration of a life theme could trigger psychological distress or crisis.

Content analysis was conducted using L'Écuyer's (1990) Closed Model, which stipulates the use of pre-existing categories. In the present study, two sets of such categories were used, specifically Héту's (2000) LR Stages and Categories and Watt and Wong's (1991) Reminiscing Types. Each audio-taped meeting was transcribed and read twice by the entire research team, composed of six graduate students in counselling and the first author.

Tables 1 and 2 present Héту's (2000) Stages and Categories, respectively. The five Stages describe the process of LR, whereas the seven Categories pertain to how the person relates to their past. Thus, Stages are more related to the mechanics of LR whereas Categories relate to what people experience during LR. Watt and Wong's Types appear in Table 3.

Table 1
Héту's (2000) Stages of LR

Stage	Function
Priming	Evoking the past, using a question or a recent event
Immersion	Recalling past events and their associated affect, and reviewing them in detail.
Reaction	Recalling not only past events and their associated affect, but also reacting emotionally to them
Reframing	Using a new frame of interpretation to review past events, and possibly finding new meaning
Integration	Reconciling with oneself, one's life, one's past.

Table 2
Hétu's (2000) Categories of LR

Category	Function
Priming	Recalling an event without exploring the context or associated affect.
Defensive	Putting aside difficult past events or minimizing their impact (LR is not blocked, but is slowed down).
Blocked	Avoidance of the past, and/or struggling with "unfinished business" or obsessiveness
Ongoing	Going to and fro between the stages of immersion and reaction
Consolidated	Experiencing a certain peace regarding the past concomitant with a need to review certain events which are no longer troubling.
Ceilinged	Reaching a certain level of peace due to relating to the past, due to the conclusion that all that could be done was done.
Terminated	Integrating one's past and one's losses peacefully (full integration).

Table 3
Watt and Wong’s (1991) Types of Reminiscence

Type	Function
Obsessive	Ruminating over upsetting events from the past.
Escapist	Finding refuge in “the good old times” to escape the present
Narrative	Story telling
Instructive or transmissive	Sharing instructive stories, life lessons
Instrumental	Identifying coping and problem-solving strategies used in the past; applying those to current life situation, favouring self-control/efficacy
Integrative	Re-evaluating past events; solving past conflicts (“unfinished business”); reconciling ideals with reality; identifying a pattern of continuity between past and present; finding meaning and worth in life as it is lived

Exploration of each of the three themes (Strengths, Retirement, and Goals and Mission in life) allowed participants to revisit past experiences, explore their impact, and to discover or re-discover the origin of certain values related to these experiences. After each reading, the themes described by each participant were linked to one of the pre-existing categories. The graduate student raters presented their categorization prior to that of the first author in order to prevent or at least minimize her influence on the students. Disagreements were discussed until there was consensus among the raters.

Results

During exploration of the Strengths theme, each participant came to realize that the strengths they identified were actually values which had helped them to face many challenges in the past, which could also be used during the retirement period. For instance, a participant identified her generosity, compassion, solidarity and sense of humour as qualities which helped survive a difficult divorce, raise her children alone, and adapt to retirement. In her own words, “Despite these new challenges, I am proud to be able to face life” (please note that the original statements were in French and were translated in English by the authors). Another participant shared the following after being asked to identify her strengths (priming).

I love animals. I was born on a farm. At an early age, I was taught how to feed cows and take care of their calves. I also became aware that those animals that I loved dearly eventually ended up being sold as meat. That made me sad at the time (immersion). Even today, as I recall all of this, I feel grateful that I was taught to respect nature, and take care of it, but I still feel a little sad about those animals. It is sad to know that something you love dies in such a way (reaction)

(ongoing). However, that kind of experience taught me that although every being, human and animal, dies at one point, it remains important to live fully while one is alive! (consolidate) This is what I am trying to do as a retiree: I continue to be a nature lover. I do not eat as much as I used to and I do not eat everything I want, nor do I walk as frequently. Instead of focusing on what I can and I cannot do, I try to focus on how those activities make me feel, and they make me feel good! (integration) (terminated).

Such resilience was typical of the four participants who went through the Stages of priming, immersion, reaction and integration, and who fit into the priming, ongoing, consolidated, and terminated Categories. Those participants could easily identify their strengths, recall past events and experience associated emotions of joy or sadness. Further, they reported feeling at peace with their strengths and values, and how they were using them to better adapt to their retirement and ageing.

The remaining participants identified their strengths, but felt unable to use them currently. For example, one retiree identified her initiative, perseverance, prayers and relationship with God as strengths and values which had previously given her great confidence. However, she added that she worried significantly about her future, as her “sense of initiative when on missionary work has no outlet in [her] present community.” As LR progressed, she came to reframe her strengths to adapt to her current situation, by volunteering to work pastorally with youth. She reported that using her initiative in this new way allowed her to share her life experience (transmissive reminiscence) and deepen her relationship with God (instrumental reminiscence). Another participant shared:

I realize now that prayer allowed me in the past to cope and enjoy the present moment without constantly worrying about the future of my marriage, about money. And, prayers still help me today to cope with what I cannot change (a difficult marriage), and they give me hope about other things, such as studying. Why not, it is never too late, is it?

Upon that realization, he found the confidence to return to graduate school. Thus, for these participants also, reframing and instrumental reminiscence allowed for the discovery of new meaning and a solution to an existential impasse. However, their review of their strengths did not reach integration and peaked at the emotional level. For example, they struggled with unfinished business related to love relationships. At an intellectual level, they reported being at peace with themselves since they had done all they could to resolve a past situation. It is noteworthy that what they called “the past situation” was still very much alive for them.

With regard to the Retirement theme, it became evident that whether retirement was voluntary or involuntary was unrelated to the LR process. With one exception, all of the participants eventually reached the Stage and Type of integration, and the Category of termination. The remaining participant appreciated the extra leisure time she now had, but felt a sense of loss with regard to her personal value. She also felt “lonely and empty”, as she no longer had a significant other in her life. It is noteworthy that having “extra time” was reported as being a mixed blessing. Some participants felt that although they had more time for enjoyable activities, they

did not necessarily have the energy or the mobility to do what they wanted. The other participants also went through the Stage of reframing, in which they came to give a new meaning to retirement. All of them described finding the onset of their retirement as a difficult period of transition and change lasting two weeks to a year (depending on the participant). As one participant said: "the end of active life was also the end of a way of being and doing where I was always on the go, did not have much time just to be with myself."

In relation to their retirement, most participants went through LR Stages of priming, immersion, reaction, reframing and integration. Interestingly, they described having experienced either of the following trajectories of Categories: priming, blocked, beginning anew, ongoing, consolidated and terminated, or priming, ongoing, ceilinged, beginning anew, ongoing, consolidated and terminated.

Participants were prompted to take a second look at their strengths and values, and to apply them to their retirement. In response to this, one participant commented that "retirement is a continuation of life, it is not a withdrawal from life." In other words, retirement is not a specific point in time (Greer, 2004), it is more akin to a life process that requires time and adjustment to new challenges. This adjustment sometimes involved finding ways to navigate around diminished capacities. For example, another participant learned to consciously use her strengths (determination and courage) to ask for help from people she trusted, which allowed her to adjust to her ageing and retirement without feeling guilty.

Because of my sense of humour and optimistic view on life, I give the impression that I am more autonomous than I actually am. When I was working, I was the one in charge of everything. Even at home, it was the same thing. Also, I had a housekeeper. When I retired, I thought I would do the cleaning all by myself, proud as I was! (she smiles) (immersion and reaction; ongoing). I should probably ask for some help, but I hesitate. People have always seen me as an autonomous woman, and I like that. I am not sure if I want to change such an image (ceilinged). – I want to go to the museum next week, but that does not agree with my knees... – Asked how her strengths could help her now, she replied: Perhaps I should ask for some help (reframing; beginning anew).

A week later, the same participant said:

It took all the courage I have to call my former housekeeper and ask her to come back (ongoing). She was happy to hear from me and she is coming to clean the house tomorrow. Plus, I was so determined to go to see the exhibition, that I pushed my pride aside and used all my courage to ask a member of my choir to come with me (consolidated). We had a great time. I am so proud of myself. I am more than what I cannot do! (instrumental and integrative reminiscence; terminated).

According to Aguerre and Bouffard (2003), non-controlling help tends not to undermine feelings of autonomy and competency. The same participant said: "I now realize that life is not only about doing, but also about being, about acquiring new knowledge about myself."

LR was either blocked or ceilinged to the extent that participants adhered to a definition of retirement along the lines of Rowe and Kahn's (1998) three criteria of SA. Such participants tended to express such sentiments as "I should be more active", "I am supposed to have more money at this point", or "If I did not have this disease, I could...."

Other participants described their retirement as their time, a period of internal freedom and reflection. Such results seem to support Nadeau's hypothesis (2003) on the possibility of people becoming more introspective in periods of transition, and the jungian-like concept of increased spiritual awareness characterizing CA (Moody, 2003). One commented:

The only responsibility I have towards my children now is to love them. Living my retirement means giving priority to thinking about certain personal and interpersonal experiences, and to adapt to the new circumstances of my life.

Another participant stated:

Retirement is a period which brings me closer to eternity, to another life. It reminds me of the importance of living in accordance to my values. I am not eternal. But living out my values and spirituality daily allows me to give meaning to my retirement and therefore to my life.

Another participant, by identifying helping and love as a core value during LR, came to experience retirement as:

The beginning of my new life, the chance to be and to do something I have always longed for. As a young man, I wanted to be a priest, but my family could not afford to send me to school. Now, I am studying theology. I have the sense that I am now finally becoming what I was meant to be.

In exploring the final theme, Goals and Mission, participants identified sources of meaning in their life and explored how these could facilitate adaptation to ageing and retirement. The sources of meaning revealed by the LR process were remarkably similar across participants. Loving and being loved was the major source of meaning expressed by all the participants. Although having positive relationships with oneself and others was greatly valued, being in a loving relationship with a spouse or God was identified as the most helpful source of meaning in retirement and ageing. One participant said:

I feel happy with what I have accomplished in my professional life, my children are well educated, I have great friends who welcome me as I am, but I was never loved by my ex-spouse and that still makes me feel sad (immersion, reaction). I realize now that even though I am more at peace with the person I have become, I always wanted to be loved by a man, and it has not happened.

Another participant shared:

Being loved by God is pivotal. Experiencing His presence brings me to be a witness on earth and to continue His work..

Yet another added:

To feel loved helps me to remain true to myself, to feel important and to love myself.

Additionally, living in congruence with one's values and possessing inner peace and freedom were described as important sources of meaning. One participant commented: Although I feel blessed to be loved by my spouse, my inner freedom has allowed me to live and respect who I am. His love has contributed to my inner freedom, to the person I have become, but it was my responsibility to welcome the love he gave me (consolidated) so that I could love myself enough to respect who I am and who I wanted to become. (integration; terminated) (integrative reminiscence)

Finally, two participants identified their involvement in creative projects as important sources of meaning in the past and in retirement. One participant was able to realize a youthful dream adapted to his current reality as an older person, to study theology and pursue a master's degree in pastoral counselling. Another participant felt "blessed" to share her religious and spiritual experiences with youths in pastoral groups.

Discussion

The real voyage of discovery consists not in seeking new landscapes but in having new eyes.

– Marcel Proust

The results indicated that a process of Life Review can help older individuals develop their self-knowledge, find new sources of meaning in life, and even reconcile with certain past events. Such a process can aid individuals in their personal growth and can help them in their adjustment to retirement. In keeping with this, Cossette & Pepin (2001, p.67) state that ..”growth through loss during ageing is centred on an experience of transcendence, such that growth becomes above all a spiritual challenge.” Spiritual growth also appears to be associated with a passage from a focus on “having” to a focus on “being” (Bergeron, 2002; Laforest, 2002). Most of the participants came to realize, via reframing and/or instrumental reminiscence, that their identity is not limited to what they currently do or even what they did in their active working life. Many were at peace with this new awareness, which brought them even further towards an integrated and terminated review of many events in their past and current life. In that sense, our study found that LR promotes the compassionate re-definition of self. Héту (1989, 2003) compares LR to a healing process, stating that it can facilitate the development of serenity, and reconciliation with past events. Our results also seem to buttress Moody's (2003) hypothesis that one of the possible ways to reach CA is through LR. Further, the way participants described their experience of being retired was more in keeping with Moody's (2003) concept of CA rather than Rowe and Kahn's (1998) SA.

It is noteworthy that the sources of meaning identified and used by participants in their adjustment correspond closely to Frankl's (1988) three major sources of meaning. Further, the results confirm the hypotheses of Blanchard de Ravinel & de Ravinel (2003), Hogue-Charlebois & Paré (1998) and Missine (2003) stipulating that the most important source of meaning is self-love and other-love, and that LR can facilitate the search for meaning. Similarly, they also support Schlossberg's (2004) thinking on the need to be appreciated and valued by oneself and a significant other.

In the context of CA, the search for meaning may be likened to a spiritual journey. According to Hamel (1999), there are two main possible paths to take on this quest: personal growth, and transpersonal growth. We would suggest that the participants whose life review ceilinged at an emotional level were in the personal growth trajectory. They could not fully transcend the hurt and sorrow associated with difficult interpersonal relationships they had experienced, despite their considerable intellectual understanding of what had happened. Participants who used integrative reminiscence, or who were in integration or terminated, seemed to follow the path of transpersonal growth and CA. The transpersonal trajectory implies both identifying and actively actualizing fundamental values in daily life. It also implies a deep knowledge of the self which allows the individual to transcend losses and hurts, and to be more fully in the present moment. In this way, it appears that self-transcendence can lead to serenity. LR appears to be one possible effective way of facilitating transpersonal growth and CA in some older retired adults. These findings support the notion that LR can facilitate the retirement process, as well as CA for certain older adults.

We are aware that the present study has a number of limitations. Most importantly, the sample size was quite small. To offset this, the qualitative analysis was thorough and in-depth; each of the three themes was explored intensively with participants and analysed carefully. The purpose of the study was not to yield representative results, but to explore the issues qualitatively to yield a richness of data. Second, the decision to screen out individuals presenting with a clinical profile limits the generalizability of the results. Thus, while this study tells us much about how older individuals successfully cope with retirement and ageing, it can say little about those retirees who fare poorly. Atchley (2003) has stated that most people cope well with retirement. Third, being aware of the limitations of closed models in content analysis, we were vigilant for possible emerging Stages, Categories or types of LR. Based on our findings, we propose that a new LR Category may be useful and appropriate, that of emotional ceiling versus intellectual termination and integration. That is, we observed cases in which LR ceilinged at the emotional level, but was integrated or terminated at the intellectual level.

A next possible step for this research would be to analyze the LR meetings with a content analysis model using emerging categories. The same LR methodology could be used with a population of older adults who present a clinical profile. Despite its limitations, the current study does suggest that LR can be used as a means towards a better self-understanding during a period of transition such as retirement.

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Religion, health, and the care of seniors

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Abstract

This paper examines some of the research that identifies a relationship between religion and health in order to highlight some points of consideration for the religious care of seniors. The interrelationship among the dimensions of health including spiritual, physical, psychological, emotional, and social aspects provides a framework for this investigation. While some studies point to negative outcomes of religion on health, there exists a significant body of research that identifies the positive influence of religion on health. For a number of seniors, religious beliefs and practices can provide means of coping with the aging process, a sense of meaning and purpose to life, and a system of social support.

Introduction

Statistics Canada reports that seniors are one of the fastest growing population groups in Canada (Statistics Canada: 2005). In 1995, seniors made up 12% of the population. It is estimated that by 2041, about 23% of the population will be over 65. Statistics also show that seniors tend to be very involved in religious activity and are most likely to attend religious functions on a regular basis. Given the increase in our senior population, and the importance of religious involvement for seniors, it is timely that further consideration be given to the spiritual care needs of this growing population.

In the course of the past forty years, an impressive body of research concerning the relationship between religion and health has been published. Many recent studies focus even more specifically on aging, religion, and health. Kimble (1995) emphasizes the need to consider the health of seniors from a multi-dimensional perspective of aging that encompasses the whole person. This wholeness, he adds, takes into account the spiritual, physical, mental, emotional, and social dimensions of human life. The purpose of this paper is to identify some of the ways that religion might affect the health of seniors both positively and negatively in relation to these dimensions of health. Consideration will be given to three key areas of research: social support, religion and coping, and the importance of meaning and purpose in the lives of seniors.

For the purposes of conducting research, investigators often employ definitions that distinguish between religion and spirituality (Koenig, McCullough, & Larson, 2001). In order to remain consistent with the research, the term religion will be used to refer to an organized system of

beliefs, practices, rituals, and symbols designed to facilitate closeness to a sacred reality and to foster an understanding of one's connection and responsibility to a community (Koenig, McCullough & Larson, 2001,18). Researchers have sought to measure religiosity based on variables such as church-attendance and involvement in institutionally organized activities.

Spirituality has been defined as "the quest for understanding life's ultimate questions and the meaning and purpose of living, which often leads to the development of rituals and a shared religious community, but not necessarily" (Koenig, George, & Titus, 2004,555). Spiritual health may involve a belief in a supreme being, the feeling of unity with the environment, a sense of meaning and purpose in life, along with the ability to experience love, joy, pain, sorrow, peace, contentment, and wonder (Donatelle, Davis, Munroe & Munroe, 2001,4). Spiritual health can be assessed through conversations with the individual, or through the use of standardized spiritual assessment tools, such as the "Spiritual Well-being Scale" (Ellison,1983) or the "Spiritual Health Inventory" (in Topper 2003,72). Spiritual assessment can be an important means of gaining an understanding of a person's spiritual needs. Spiritual support can involve the sharing of religious experiences and feelings, helping others adapt religious teachings and principles to daily life (Krause 2004), seeking pastoral care, participating in organizational and non-organizational religious activities, and expressing faith in a caring God (Koenig,1994). Some of the dimensions of religion and spirituality identified by researchers include religious meaning, values, beliefs, forgiveness, public and private religious practices, religious coping, religious support, religious history, religious commitment, organizational and non-organizational religiousness, and social relationships with religious community members and clergy.

While a number of people have influenced my reflections on the importance of religion and spirituality in relation to the health and well-being of seniors, Florence's story serves as one case example that will be used in this paper to highlight the importance of religious coping, meaning and purpose, and social support. (The name Florence is a pseudonym used to protect the individual's anonymity.) When Florence was 62 years of age she suffered a cerebral aneurysm. The aneurysm was successfully treated by surgery, but both the aneurysm and the emergency treatment caused permanent damage. Florence spent the next six months in a comma. The prognosis was not good, and the doctors offered the family little hope for her recovery. Florence defied the odds. Two years later, shortly after her return from a holiday to Mexico, Florence informed a gathering of friends that it was her faith in a loving God that sustained her through the many challenges she faced during her long, difficult, and limited recovery. While her retirement years are perhaps not as she imagined they would be, it is her deep sense of faith in a loving God and a feeling of gratitude for life that inspire her to live each day as fully as possible, in spite of her many limitations. Her faith, along with the support and encouragement she receives from her spouse, family, and friends, are as integral to her continued health as is the medical attention she received.

Social Support

Krause notes that "[there] is growing recognition among health care providers that social and psychological factors may exert a significant influence on the physical and mental health of older adults" (2004,1215). Social health has been defined as the ability to adapt to social situations and to have and maintain satisfying interpersonal relationships (Donatelle et al., 2001). Some researchers have reported that older people who are involved in tightly knit social groups tend to

enjoy better health and live longer than those who do not maintain close social ties with others (Krause 1997, in Krause 2004,1215). Social relationships have been found to help buffer stressful situations (Idler, 2004; Krause, 2004); social support and social involvement have been linked to resistance to infectious disease (Koenig, McCullough & Larson, 2001), and social support has the potential to prevent the onset of depression, and speed recovery from depression (George,1992, in Koenig, McCullough & Larson 2001,283). Higher levels of social support from relatives or friends have been associated with earlier recognition of disease (Koenig,1997) and increased treatment compliance (Koenig,2004). Researchers have also found social isolation to be a strong predictor of poor compliance to pharmacological regimens because of a lack of reminders and a reduction in the motivation to comply (Carney, Freedland, & Eisen, 1995, in Koenig 2004, 1198).

Religious affiliations may also help relieve symptoms of anxiety and depression by offering a social network. It is interesting, and yet not surprising that Koenig reports a higher rate of depression in hospitalized as opposed to community dwelling elders (1994:143). Koenig explains that elders in nursing homes and hospitals often find themselves under the direction of institutional guidelines and schedules, which leave little room for personal autonomy, and freedom of choice. Further research is needed to determine the effect of one's environment on conditions such as anxiety and depression, as well as the ways in which religion and spirituality might assist seniors cope in these situations.

Valuable sources of social support can become lost when individuals relocate, or when they encounter interpersonal conflict. Conflict with clergy or members of a religious community has been associated with negative health outcomes (Jones, 2004). Negative social interactions in church have been associated with an increase in symptoms of depression (Krause, Ellison, & Wulff, 1998, in Krause 2004, 1221). Criticism, rejection, competition, and the violation of privacy can result in unpleasant social encounters (Jones, 2004). Krause warns that unpleasant social encounters in the church or other religious communities may be especially troubling to older people, since social relationships become increasingly important in later life (Krause, 2004). Krause highlights two reasons why church-based social ties can be especially important for older persons. First, this stage of life is associated with a change in roles, or for some, significant role loss, which includes loss of important social connections. Church-based social ties may rise to fill this need. The second reason Krause offers is that as people age, some experience a decline in both physical and cognitive functioning. As a result, they may require assistance with tasks they once took care of on their own. Church-based social support systems can be especially helpful in this regard. Church members often provide transportation to worship services, and they frequently take care of fellow members who are ill (Krause 2001, in Krause 2004, 1217).

Florence's life was changed dramatically as a result of her aneurysm. She suffered her stroke when she was at work and she was not able to return to her profession. Withdrawal from her professional life was early and abrupt. Even under normal conditions retirement can lead to a loss of important social connections, loss of sense of self worth, and changes in roles and responsibilities. She was fortunate to have had family and friends close by, so they could provide her with daily support during the months and years of ongoing recovery from the physical trauma caused by the aneurysm and the ensuing treatments. Although Florence is not a

member of any particular denominational church, she does belong to a twelve step group. She has a strong faith and had attended different churches on a regular basis before her aneurysm limited her mobility. Both religious and non-religious social supports have been reported to be important for seniors, especially during times of change, physical illness, and disability. Co-members of a religious community or fellow parishioners offer regular and ongoing support. For Florence, involvement with a support group provided her with a social support network, along with a conceptual framework that helped her to face her weaknesses. Her involvement with other members of her twelve step group also provides her with a continued sense of belonging and importance in the lives of others.

Religion and Coping

While Florence's situation may be somewhat unique in relation to the physical challenges she faces as a result of the aneurysm, her response is not; religious coping has been reported to be more prevalent in groups that show high levels of religious commitment, such as the elderly (Pargament, 1997, 143). Susan McFadden adds that the physical, mental, emotional, social, and spiritual challenges that inevitably accompany the aging process can bring about a number of situations that require some kind of coping response (McFadden, 2004, 148). Among older adults, the coping strategy mentioned most often is religious (Koenig, George, & Siegler 1988, in McFadden, 1996, 167). "Religious coping" refers to the reliance on one's religious beliefs or practices as a means of dealing with some of life's challenges (Koenig, 1994, 30). Later life is a time that is characterized by significant physical and psychological diversity among members of the senior population (Koenig, 1994, 23). While some seniors experience good physical health and minimal change, others might be confronted with some form of physical disability, such as loss of vision, mobility, hearing, or cognitive ability. For Florence, belief in a loving God provides her with the strength to confront the limitations she faces as a result of her disability, as well as with the normal challenges of aging.

Religious coping methods have also been reported to have a positive effect on the physical, mental, and emotional health of seniors. Koenig, McCullough, and Larson maintain that older people who are religious tend to enjoy better physical and mental health than those who are not involved in religion (2001, in Krause, 2004, 1216). This may be partly due to religious practices such as meditation and prayer, which induce what is known as a "relaxation response" (Benson 1996, in Idler, 2004, 29). Religious coping methods, for some, may also help relieve anxiety and depression. Religious beliefs, attitudes and coping behaviours have been identified as contributing to reduced levels of depression, suicide, anxiety, and alcohol abuse (Jones 2004, 319; Idler & Kasl, 1992, Koenig, 1990, Krause, 1991). A correlation was also found between church attendance and a reduction in anxiety. Through a survey of approximately 3000 individuals, researchers at Duke University found that frequent church attenders experienced significantly lower rates of anxiety disorder compared with infrequent attenders, non-attenders or those with no religious affiliation (Koenig, 1997, 63). Anxiety in later life is often associated with a threat, such as a threat of continued pain, or fear of death, or fear of loss, such as loss of bodily function, separation, loss of love, and loss of rationality (Koenig, 1994, 249-250). Medical illness has been reported to be the most common cause of anxiety for seniors (Koenig, 1994, 249); the loss of physical function can be especially distressing, Harold Koenig explains, because the loss of physical abilities are often permanent and irreversible (Koenig, 1994, 25).

Some of the challenges that accompany the aging process such as loss of physical abilities and relocation to nursing homes can also contribute to feelings of despair, loneliness, and grief. Emotional health has been described as the ability to express emotions appropriately, control inappropriate expressions of emotion, and to express feelings of self-esteem, self-confidence, trust, and love (Donatelle et al., 2001, 4). A number of emotions have been reported to impact negatively on physical health. Some elders may feel angry, abandoned, or they may feel disconnected from family, friends, and their homes (Koenig, 1994, 29). “[Loneliness] is often cited as an important contributor to poorer health” (NIH 2001, in Jones 2004, 320). Hostility has been associated with hypertension and coronary artery disease and early mortality (Worthington et al, 2001, in Jones 2004, 322). Some elders might be overwhelmed with grief as a result of multiple losses (Koenig, 1994, 152). Others may be “emotionally disabled because of regrets over wrong decisions or guilt over negative interactions with parents or children that occurred long in the past” (Koenig, 1994, 34). Pastoral caregivers and ministers facilitate expression of emotion by providing seniors with the opportunity to discuss these important issues (Parkam, 1995). Being present for and listening to seniors is a vital service, particularly in relation to supporting the expression of emotion.

Religious coping strategies might also include reading scripture, prayer, meditation, religious beliefs, and community support. These methods of coping have been employed by seniors to deal with stress, illness, disability, dying, bereavement, social isolation, and the impact that their changing role in society can have on their lives. Reading of scripture can be a source of emotional comfort for an elderly person suffering from pain or disability (Koenig, 1994, 41). Scriptural passages that provide role models for seniors, particularly in relation to dealing with suffering, have been reported to be a valuable coping strategy for some seniors (Koenig, 1994, 41). The story of Job or the gospel accounts of Jesus suffering on the cross can provide seniors with a framework for dealing with the suffering in their own lives. The importance of allowing seniors to read and reflect upon scriptures that are meaningful to them was mentioned in the research. Religious beliefs and involvement can influence perceptions about one’s physical condition and they can act as a buffer against stressful events (Idler, 2004; Koenig, McCullough, & Larson, 2001; Pargament, 1997). Prayer and meditation may help relieve feelings of loneliness through a sense of connection with a loving God or a higher power. Prayer has also been found to help reduce depressive symptoms (Nooney & Woodrum, 2002, in Levin, 2004, 81).

In addressing the question “why prayer influences health,” Jeffrey Levin identifies six possible relationships between prayer and health. These include the relationship between prayer and motivation, connection, meaning, hope, love, and transcendence (Levin, 2004, 84). Prayer can provide individuals with a sense of motivation to care for themselves, and in the case of seniors, the motivation to comply with prescribed medical treatments. Congregational prayer can engender a deep sense of connection to others and God, giving a sense of meaning and order to life (Levin, 2004, 84). Synder (2000) found that “hopeful thoughts and attitudes ...are powerful determinants of an ability to withstand pain (in Levin, 2004, 85). In addition, prayer can help foster feelings of being loved by God and others, along with the experience of transcending the body, time, and space (Levin, 2004, 86).

In addition to prayer, meditation, and reading scripture, religious coping responses might include ritual, turning to God for guidance and strength, or trying to see how the problem situation might

be part of God's larger plan (Pargament, 1997, in Krause, 2004, 1218). Pargament describes religious reframing as a coping strategy with potential positive and negative outcomes. Religious beliefs can help individuals reframe and give meaning to suffering associated with traumatic events; "In the process of reframing, suffering may become something explainable, bearable, and valuable" (Pargament, 1997, 221). On the other hand, reframing negative events as punishments from God has been described as a negative religious reframing response.

Rituals for mourning and healing can also be a source of comfort, and they can assist individuals adapt (Idler, 2004, 29). In a study that examined contemporary approaches to spiritual healing, one respondent noted the significance of being directly involved in the creation of a ritual that honoured the passing of her mother, which included personally meaningful symbols (Marche, 2002). It may prove to be beneficial to their sense of autonomy and value to encourage seniors to participate in the creation of rituals that employ symbols that are meaningful to them. W.A. Auchenbaum's survey of age-based Jewish and Christian rituals reveals that there tends to be fewer age-specific rituals for older people than for younger Jews and Christians, fewer opportunities for women and girls to participate fully in the liturgical and institutional life of the religious community, and it is often the seniors themselves who suggest ways to recognize late-life transitions (1995, 212). In recent times, some clergy and lay people have developed rituals that recognize the distinctiveness of this stage of life.

While for some individuals, religion may help them to deal with life's challenges, some researchers have found that for others, religion can serve as a means of denial, as a form of defence, as a psychological crutch, or as a last resort to difficult situations (Pargament & Ano, 2004, 115). Harold Koenig notes that some mental health professionals have described religion as a source of mental inflexibility, emotional instability, and unhealthy repression of natural instincts (Koenig, 1997, 23). Ellis identifies a number of characteristics of religiosity that may have a negative impact on mental health (Ellis, 1988 in Koenig 1997, 26). These include discouragement of self-acceptance and self-interest, intolerance of others, inflexibility, the inability to deal with ambiguity and uncertainty, reliance on God while ignoring or denying reality, and the discouragement of individual actions necessary for resolving problems (Ellis, 1988, in Koenig 1997, 26). For individuals suffering from guilt or fear of punishment in the afterlife, religious beliefs may be a source of psychological distress. The prospect that religion might help and for others cause harm, suggests that caregivers need to be aware of these potentialities. The exploration of beliefs can lead to greater understandings of the effects of religious beliefs and has the potential to mitigate the harmful effects of religion. Ministers, chaplains, and pastoral care providers can offer spiritual support to seniors, by inviting them to explore the nature of their religious beliefs. In Florence's case, the support group she belongs to stresses the importance of dealing with suffering, giving voice to frustrations, expressing feelings of guilt and failure, being present to and listening to others, and the belief in a loving and caring God.

Meaning and Purpose

For many individuals religious beliefs also provide a conceptual framework for understanding the meaning and purpose of life. Because religious adherence is associated with a greater sense of hope, religiously active individuals are more likely to have a reason for living and for wanting to get better (Koenig, 2004, 5). Religions emphasize a shift of focus from oneself to others and

God or a higher power (Koenig, 1997, 67). Through a system of beliefs and ritual activities, religion provides a means by which attitudes can be changed and life circumstances reframed (Koenig, 1994a, 30). For Florence, feeling loved and valued, her spouse's hope and faith in God, and her will to live were important factors in her recovery and in the acceptance of her physical disability. She acknowledges her limitations, but she and her spouse do not allow her life to be ruled by them.

Hope, will, acceptance, and love are linked to spiritual needs. In an article titled, "A Jewish Approach to Healing," Kestenbaum suggests that illness "reflects a spiritual disease" and being well involves a balance of both love and will or power. To be well, a person needs to feel loved. A lack of well-being may be associated with feeling unloved, disconnected, or lacking a sense of empathy from others, or from God. For these individuals, what is required is empathy and bringing the presence of God to them. To be healthy, Kestenbaum writes, a person also needs to have a sense of his or her own uniqueness and power. For a person lacking in a sense of personal power, bringing love and nurturing to them may not resolve the deficiency. If illness, as Kestenbaum suggests, is a spiritual disease, then the work of healing as he describes it, involves first identifying what might be lacking for the individual. Is the person deficient in the will to get well or to live? Is he or she needing a sense of community? Do they lack hope? Helping the individual identify the cause of their distress is an important dimension of spiritual support.

Koenig identifies a number of spiritual needs of physically ill elders which might also apply to physically healthy seniors as well (1994, 284-294). Elders need validation and support of religious behaviour, they need to love, be loved, as well as have opportunities to serve others. Koenig also identifies a need to express emotions, such as anger, frustration, and doubt. Seniors also require a sense of personal dignity and worthiness, which can be challenged if they feel like a burden to others, or when they undergo uncomfortable therapeutic procedures. Elders need support in dealing with loss. According to Koenig, they also need a sense of continuity. Drawing upon Atchley's "continuity theory," Koenig explains that elders are motivated toward internal psychological continuity and external continuity in their social environment. The basis of Atchley's continuity theory is that people seek to preserve long-held patterns of living, which for some include religious involvements and practices. Over time, patterns of thinking and behaviour develop that help to create the foundation from which they deal with life circumstances. Understanding this continuity is important for helping individuals appreciate the significance and meanings they give to the events in their lives (Atchley, 1995, 71). Illness and suffering often raises questions, such as "why me?" or "what is the purpose of my life?" (Koenig 1994; Kinsley 1996). Harold Koenig provides a solution-based approach. He notes that while such existential concerns are common, some patients get "stuck" in these spiritual struggles and without help they are unable to resolve them on their own (Koenig, 2004, 1197). Koenig recognizes that one also needs to be thankful; recognizing the positive aspects in one's life can help offset the negative effects of the challenges associated with aging. Seniors need to forgive and to be forgiven; religions provide a conceptual framework for understanding the importance of forgiveness. Koenig also highlights the need to prepare for death and dying. The elder may need to discuss their fears, deal with unresolved issues, and for some plan how they will live. Lastly, seniors, and especially those suffering from illness, need to find meaning, purpose, and hope in their situation. Koenig observes that suffering without purpose or meaning can quickly become unbearable; "the elder must find some purpose, meaning, or possible good in their illness to

make it bearable” (Koenig, 1994, 284). In some instances an individual’s lack of meaning and sense of being without purpose has been linked to depression and suicide (Kimble, 1995, 137).

Kinsley (1996) notes that while modern medical culture places little emphasis on framing illness or considering illness from a spiritual, religious, or moral framework, “pathographies” written account’s of an individual’s experience with illness, have shown that “patients are often consumed by the search for meaning” (Kinsley, 1996, 185-186). Writing about one’s illness, or in the case of seniors, the changes in one’s life, may prove to be a useful activity in this regard (Kinsley, 1996, 193). Life review, oral or written, can facilitate the process of finding meaning, and it may help the elderly tell their story (Kimble, 1995, 139). Kimble adds that the life review with the elderly might include reflecting upon God’s presence and love throughout their life, which may provide them with a source of comfort during difficult periods (Kimble, 1995, 140). He warns, however, that training and careful monitoring are required if one wishes to conduct a life-review with others. It is important, Kimble argues, to be able to recognize conditions such as depression, in which case a life review would not be conducted and the individual referred to a qualified health care professional.

Discussion

Chaplains and pastoral care providers can contribute to the quality of life of seniors in important ways. McFadden notes that pastoral counsellors and chaplains can help maintain and nurture connections between residents of care facilities and their local congregations. They can also assist in educating others about continued possibilities for religious care and religious coping, especially for those seniors suffering from physical and psychological illness (McFadden, 2004). The literature highlights the significance of providing opportunities for seniors to create and participate in rituals that are meaningful for them. This may become increasingly more important as residents in care homes come from diverse religious backgrounds. Further research is needed to identify ways that multi-faith needs and concerns are being addressed in residential settings. Do spiritual care providers need additional information about religious beliefs and practices from various religious perspectives? What tools and practices have pastoral care providers found to be effective when addressing multi-faith concerns?

Researchers also underscore the importance of not forcing or coercing individuals into participating in religious activities solely on the basis of their health benefit alone. Caregivers need to recognize and respect the various coping methods seniors use to deal with the challenges associated with aging. The research examined herein recognizes the importance of providing seniors with opportunities to explore issues related to spirituality and end of life concerns, while at the same time, allowing individuals the freedom to decide whether or not they want to participate.

Researchers also point to some of the ways in which pastoral providers can help to meet the spiritual needs of seniors. For example, yearly or semi-annual religious services that address issues such as aging, illness, death and dying may provide residents of care homes with a source of comfort and sense of community support. Family members or members of the community might be asked to participate in regular or special services. Intergenerational connections might be nurtured and maintained by finding ways to involve the younger generations in the lives of seniors. One way might be to set up a peer ministry team in which youth can volunteer. Pastoral

care providers may find it useful to establish a means by which they can share ideas in this regard. The development of weekly scripture study or discussion groups, with seniors volunteering to take turns leading the group and initiating discussions may interest some seniors. Groups that discuss multi-faith perspectives may catch the attention of seniors who want to learn more about the religious beliefs of others. This may be especially relevant to seniors who live in a care home or a seniors' residential complex that houses seniors from diverse religious backgrounds. Guest speakers from a variety of faith perspectives might also help enliven discussions. Rituals that incorporate elements of the faith perspectives of the residents may also help to include individuals from religious minorities into the regular worship of the community, whether in a hospital, residence, or a care home.

Florence's experience with illness has brought to my attention some of the issues that accompany aging. The physical and neurological challenges Florence faced when coming out of the coma highlighted the importance of the human will and the strength of the human spirit to face life's challenges. Kestenbaum notes how one's will to live or conversely, their lack of will to live, can have a significant influence on the wellbeing of the individual. While in rehabilitation, Florence spent her days in a state of immobility. She was completely dependent on others. The support of her partner, family members, and friends was instrumental in helping her face and overcome the physical challenges she faced as a result of her aneurysm. For stroke victims or frail seniors with limited mobility, the company and care of others may help to brighten their day. The importance of community support may also help to reduce caregiver burnout. Caregivers with little community support may find the challenges of caring for sick loved ones arduous and exhausting. Florence's faith also provided her with the strength to cope with the many challenges she faced. Exploring the meaning of illness may help to identify the individual's perceptions of illness. This may be especially important if the illness is viewed as punishment or if the senior is afraid of death and dying. Taking the time to listen and explore issues of faith may help to disclose spiritual concerns. Discussing religious beliefs such as beliefs concerning the afterlife may help to relieve fears and anxieties.

The following examination of some of the literature related to aging, religion, and health identifies additional questions requiring furthering investigation. Conversations with pastoral care providers have identified a significant gap between what is possible in terms of the spiritual care of seniors and the involvement that religious specialists have in the health care of patients, especially in hospitals. In spite of the efforts made by social scientists to identify the significance religion can have on the health and wellbeing of individuals, there continues to be a tendency in North America at least to seek biomedical solutions when addressing health related issues. It was brought to my attention that spiritual care providers are often not included in some hospital's "team" approach to managing the health of patients.

Furthermore, the current research tends to focus on seniors located in urban hospital settings. I would be interested in finding out what religious supports are available for seniors in rural communities? In what ways might a religious community help rural seniors cope with the challenges of aging? Or, do seniors find themselves moving to urban centres in order to access quality health care services? If so, what impact, if any, does relocating have on the religious and spiritual dimensions of life, particularly in relation to established community supports?

What are the experiences of elders joining a religious organization in later life? Pargament mentions that it is not unusual for some elders to become dissatisfied with their religious organization and change their affiliations in later life. Fuller identifies a growing trend in North American culture to identify oneself as “spiritual” rather than “religious.” In what ways, if any, are the spiritual needs of the non-religious seniors being met?

It would also be worth examining the ways in which religion is important as an ongoing lifelong experience. Florence’s involvement with religion was not something that developed since her aneurysm, but an integral part of her life. Her involvement with religion and her support group gives her a view of the world that enables her to accept and cope with her suffering. It also provides her with a community of like-minded friends who are willing to support her through her illness.

Given the projected increase in the senior population, what more, if anything needs to be done? If the senior population is expected to rise and the need for caregivers increase, it may also be important to examine the ways in which religious communities and government agencies are currently meeting the care needs of seniors on physical, mental, emotional, psychological, and spiritual levels.

Conclusion

The literature examined herein on aging, religion, and health suggests that religious and spiritual care can impact on the well-being of seniors on a number of dimensions of health. Religious involvements may provide an important framework for seniors to explore the meaning and purpose of their lives, develop or maintain support systems. For some, religion can provide a means of coping with the challenges that accompany aging, such as chronic pain, isolation, dependence, and disability. Religious coping methods such as prayer, reading of scripture, ritual, meditation, and talking with caregivers, ministers or clergy can have psychological, physical, spiritual, and emotional benefit. While Krause warns that religion should not be pursued for health benefits alone, recognizing the interrelationships among the various dimensions of health is important for a multi-dimensional understanding of religion, health, and aging.

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Appendix A

Questions Used to Explore Themes, by Session Number

Sessions 9 and 10, theme: My Strengths

- What are the strengths and strategies that I recognize in myself?
- How did they help me in the past? How do they help me now?

Sessions 11 and 12, theme: My Retirement

- Did I choose to retire?
- What does the word “retirement” mean to me?
- What does it mean to me to be at this point in life and in my life?

Sessions 13 and 14, theme: My Goals and My Mission in Life

- What are the goals in my life today?
- Are these goals important to me?
- Have my goals changed throughout my life? If so, how?
- Which principles have guided my life? Are they the same today?
- Which conclusions or observations do I come to regarding my life?



Encouraging Quality of Life for Aging Persons who have Developmental Disabilities

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Abstract

Studies indicate that people with developmental disabilities are aging at a similar rate to the mainstream. This has occurred from the time of deinstitutionalisation and the move into community based living. Community based programs and services have encouraged quality of life outcomes that address the need for improved medical, physical, and nutritional care. These factors have contributed to addressing psychological, social and spiritual needs, as well as generating opportunities for education and employment. This article discusses encouraging quality of life outcomes for those who are aging with developmental disabilities, and how social educators and caregivers need to attend to training programs that address the dual concerns of aging and disability services. This article gives an overview of the historical background of these issues and highlights the health concerns for those who are aging with developmental disabilities. [135 words]

Keywords: quality of life, aging, age, developmental disabilities, social educator, Caregivers, duty of care, person centred.

Introduction

First of all I would like to thank you for inviting me to partake in presenting a paper on aging persons who have developmental disabilities. I would like to acknowledge my ancestral Australian Aboriginal Culture and acknowledge the traditional custodians of this land Canada.

This article focuses on the issues related to encouraging quality of life for aging persons who have developmental disabilities. Griswold and Goldstein (1999) defined developmental disabilities as conditions which have occurred before age twenty-two that cause impairments in the following areas: independent living skills, self-care and receptive and expressive language. Overeynder (2004, p.1) also refers to a developmental disability which 'interferes with functioning in several life areas, such as learning, mobility, speech, caring for oneself, making life decisions and earning an income. The impairment should first occur prior to age 22.'

Since the change from large, overcrowded, understaffed, and under-funded institutions to community based living services for those with developmental disabilities, the main focus has been encouraging quality of life outcomes for these individuals and giving them the same rights and responsibilities as their able-bodied counterparts while still having supportive service provisions.

In view of the fact that these community based service providers in the past thirty years have developed services and programs which encourage quality of life outcomes through better medical technology, social services, physical activities, nutritional wellbeing, personal spiritual and educational endeavours, people with developmental disabilities are living longer.

This article focuses on encouraging quality of life outcomes for this client group and how organisations that care for these individuals are dealing with and meeting the needs of this aging population.

Historical Background

Prior to the middle of the 20th-century, people who had developmental disabilities were placed into institutions which were over-crowded, under-staffed, and under-funded (Overeynder, 2004). Since community based living programs and services came into existence and following the deinstitutionalisation of large service providers, programs and support systems have focused on giving people who have developmental disabilities the same quality of life opportunities as able bodied people. In the past thirty years community based living programs and services have had to become more innovative and resourceful as the population of people within these community-based organizations is aging. This is due to having improved medical treatments, better nutritional care, employment and educational opportunities, being in caring supportive relationships, living in their own home, supporting their spiritual and religious development, maintaining physical health through sports, recreation, rehabilitation and programs. Griswold and Goldstein (1999) also claim that people with developmental disabilities are living longer due to improved medical, health care and living conditions, which have contributed, to increased life expectancy.

In a US government study, it is claimed that people who have developmental disabilities are living longer due to better holistic care and lifestyle choices, for example, women without a developmental disability live to around 79, men to around 73, and the average

age for women who have a developmental disability to around 67 and for men to around 63 (Brown, 1999). Karp (1999) however suggests that survival statistics are now better than they used to be for those who have developmental disabilities, but in the 1940's people with a disability had a life expectancy of twenty plus and in the 1960s this improved to 30 years plus. Researchers believe that the survival rate for those with developmental disabilities will improve in the twenty first century due to medical advances and enhanced quality of life.

Social Educators, Caregivers, Programs and Services

Community based living programs and services provide assistance to people who have developmental disabilities by employing social educators and caregivers who provide ongoing support for quality of life outcomes. Social Educators and Caregivers are being assisted and educated through training programs to be aware of the impacts of aging for these people. Challenge Armidale (Australia) states in their employee handbook, that disability services are changing across Australia and staff within these organisations will need to gain nationally accredited certificates of competency. This is being achieved through nation wide service providers, such as, Directions Australia and Equalis, a team of Psychologists that ensures training and best practice standards and duty of care requirements are addressed. This training is an ongoing component of employment within these organisations, addressing issues, such as best possible medical treatments, physical care, daily living, functional problems in dressing, toileting and mobility. Other issues will be instrumental, such as change to their shopping, money management, transportation, working and recreation (Karp 1999). Social Educators and Caregivers will need to attend dual educational programs on developmental disabilities and aging. Griswold and Goldstein (1999) also support that there is an increasing awareness of the need for multidisciplinary approaches, improved training of professionals, and development of relevant models of care.

These community based living programs are now presenting special challenges as well as special opportunities for the organisations, which support people with developmental disabilities, the social educators and Caregivers as well as for these older persons themselves. Organisations, which provide generic services for the elderly, have had to adapt to this 'new' population of people living longer, by retraining its workers and designing innovative programs that promote integration between service providers for people who have developmental disabilities (Overeynder, 2004).

Studies also note that people with developmental disabilities have coexisting issues, such as language difficulties, impairment in mobility, hearing or visual losses which degenerate with age. These losses affect the person's communication skills. This in turn may isolate and alienate the person from the social educator and carer. The aging person with a developmental disability and significant behavioural disorders feels a progressive loss of control over the environment so that challenging behaviours will become evident (Griswold and Goldstein, 1999). Social educators and caregivers need to be aware of effective communication skills if they are to address quality of life issues and needs of the person who has a developmental disability.

Challenge Armidale employs a speech pathologist that supports people who have receptive language difficulties, expressive language difficulties, physical difficulties, and social language difficulties. These can be addressed through programs, such as, Augmentative and Alternative Communication (AAC) strategies, which support and enhance the communication of people who have limited oral language skills. People who use AAC systems are non-verbal, partially verbal, visual and hearing impaired, have learning disabilities, and intellectual disabilities. Unaided AAC systems are body, facial, eye-gaze movements, vocalisations, and challenging behaviours. AAC systems can be symbolic, for example, gestures, speech, and the use of signs. Aided AAC systems use objects, pictures, photographs, Braille, written words (Challenge Armidale). Augmentative and Alternative Communication is a form of therapeutic relationship between the social educator, caregivers, and the aging person who has a developmental disability. Carl Rogers (in Corey, 2001, p170) supports that people 'are capable of self-directed growth if they are involved in a specific kind of therapeutic relationship' such as what occurs in Augmentative and Alternative programs. Rogers also emphasized the attitudes and personal characteristics of the therapist (social educator/carer) and the quality of the client/therapist relationship as the prime determinants of the outcome of therapeutic process. The writer believes that social educators and caregivers not only need to address the issues of aging, but also address their own attitudes, values, beliefs and personal characteristics towards the person who has developmental disabilities, otherwise social educators and caregivers are not addressing quality of life and meeting their responsibility to duty of care. The author agrees with Overeynder's (2004, p2) statement that people with developmental disabilities who are also aging '...have the same rights and responsibilities as all citizens while still needing supportive services.'

Health Concerns for those who are aging with developmental disabilities

Studies show that people with developmental disabilities die from causes similar to those found in the general population. Overeynder (2004) states that studies have shown that cardiovascular disease, respiratory disease and cancer are contributing factors to dying. She also states that people who have mobility impairments, mental health conditions, the original disability, and the implications of medications, which have been started in early childhood, might have serious adverse effects after prolonged use. She states that people who have developmental disabilities are more prone to greater risks of developing chronic diseases.

Suggested ideas

Different client groups such as those who have developmental disabilities and who are aging will have different cultural factors which influence their values, attitudes, beliefs and the way in which they communicate their physical and spiritual needs. These factors contribute to their coping mechanisms, meaning and development of life in their communities. It is important for the social educator and caregiver to see what this minority group has experienced in relationship to that of the dominant culture.

What interaction has happened to encourage quality of life between these two social groups? Vanier (1999, p.3) encourages a sense of community remains between these two social groups as part of L'Arche ethos 'communities where people with intellectual

Kennedy D. (2006), Encouraging quality of life for aging persons who have developmental disabilities, *Counselling, Psychotherapy, and Health*, 2(1), 62-67, April 2006.

disabilities and those without a disability come together to share their lives. These communities are places where each person's particular gifts can be revealed and honoured....' The author believes that through Augmentative and Alternative Communication that emotional, intellectual and spiritual quality of life can be addressed more clearly and people who have developmental disabilities will have the opportunities to communicate their needs. These needs are met through different forms of literacy and being literate helps a person to move more freely and be more successful in their emotional, intellectual and spiritual life.

Social educators and Caregivers need to become familiar with the experiences of those who have developmental disabilities; by learning their language. It is about bringing their experiences, understandings, knowledge and skills into a context where they can be understood and experience their intellectual, emotional, and spiritual life forces, rather than just their external physical needs. This will enhance quality of life outcomes.

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Wholistic applications of counselling with the aging in dialogue with pastoral care concerns: A postmodern and transcendental analysis

A Keynote Address, Aging and Spiritual Care: Society for Pastoral Counselling Research Twelfth Annual Conference, 12-14 May 2005, St Basil Institute for Counselling and Mental Health Education, Assumption University, Windsor, Ontario, Canada.

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Abstract

Studies indicate that the influence of institutionalised religion is waning in most Western nations. In contrast, personal, spiritual, and subjective approaches to faith are on the rise. The latter may or may not relate to traditional Christian frameworks. These trends are most apparent with the aging 'baby boomer' population, thus changing notions of pastoral care in many countries. Counselling, as a secular and scientific modality, is well placed to meet the needs of a highly educated and articulate aging population whose values are, in many ways, representative of 'post-Christian' and 'post-colonial' worldviews. Exploring the applications of counselling in dialogue with pastoral care for the aging is a new area for practice and research. This paper explores these issues in light of a wholistic model of counselling that honours how meaning and spirituality are constructed in everyday life through personal and social experiences. This is accomplished through analysis of the social construction of aging via discursive techniques of difference, also admitting the post-secular. Issues of meaning are highlighted that place aging, counselling, and pastoral care into wider social and historical contexts. Deconstructing aging in the postmodern includes articulation of a postmodern transcendental method in critical social analysis, including acknowledgement of theological and philosophical issues. The discussion concludes with suggesting a queer critical social analysis to assist in understanding the politics of aging.

Keywords: aging, age, deconstruction, postmodern, counselling, transcendental, pastoral, care, meaning, critical, analysis, method, queer

Introduction

Thank you to the organisational committee for inviting me to keynote today. I am very honoured to visit you from Australia. Let us acknowledge the original inhabitants of this great land of Windsor, Ontario, and of the First Nations people of Canada. We will begin with setting the scene in terms of cultural trends and professional debates, and then proceed with the focus of the discussion.

Studies report that mainstream organised religious involvement is waning significantly in most Western nations (Acquaviva 1979, Hughes 1994). At the same time, people are looking for spiritual meaning and are constructing meaning in everyday life. In a sense, the landscape of meaning has shifted, and we can now appreciate the significance of terms like post-Christian, post-colonial, post-modern, and perhaps even post-secular. This sense of the social construction of meaning highlights how being human is *constituted by meaning*, to borrow a phrase from Bernard Lonergan (1957, 1972). To be constituted by meaning suggests that creative and original insights can sometimes become commonsense parts of daily life for many people. When shared, meaning creates culture, science, and political economy. These so-called pillars of society are built upon multiple layers of associated meaning. In a postmodern social context, these layers of meaning are actively deconstructed, called into conscious awareness, and revisioned. Indeed, in the postmodern what was commonsense is called into question.

In this context, the concept of ‘aging, and the aged,’ is one area of common sense and professional knowledge that is called into the space of deconstruction. While the categories of aging have significance across the domains of culture, science, and political economy, these categories are also in need of critical analysis. Particularly as the population ages statistically, it is timely to consider the postmodern emphasis on organic and local contexts which are central to personal experiences of aging and how these relate to social and political trends. But the first step in this analysis is to sit with the uncertainties that arise when basic questions of meaning are raised.

Let us take for example the commonsense association with aging and loss. From this point of view, one of the ironies of not aging well relates to realising things too late, and being powerless to change things. There is a disenfranchisement that comes with these unfortunate experiences that rupture our sense of continuity and time, and these experiences of change disrupt our relationship with place. Physical illness and disease cut across the boundaries of daily life with definite power to redefine human life and meaning. These and other crisis of meaning, and/or the ways in which people need assistance to mitigate the physical, emotional, and social issues that arise from aging and becoming aged, are the central factors that instigate need, and constitute meaning, across the health, social, and pastoral care industries.

The term ‘industry’ is used deliberately in this context to suggest that counselling, pastoral care, and health care represent ‘institutions of caring’, a phrase that has a high

degree of irony attached to it in a postmodern context. However, with great respect to the hard work and dedication of countless workers in these fields, myself included, our industries, properly understood, also incorporate politics of care that need to be transparent. The caring industries are not simply humanitarian efforts, nor are they valueless efforts (Fox 1994). In the present climate the landscape of aging and the care of the aged is a contested real estate, bought and sold on the open market, and open to the vestiges of corporate, government, and social agendas that are collectively redefining culture and constituting new forms of meaning, and resistance.

While I acknowledge the complexity of the current climate of care, and that certain bio-ethical and moral issues are raised by the trends of privatisation, corporatisation, and postmodern uncertainties faced by an aging population, in this discussion the purpose is to highlight the unique strengths of counselling and pastoral care approaches in this wider context. It is helpful to understand the perspectives brought to bear on this discussion. As a pastoral worker and counsellor since the mid 1980s, and having shifted into counselling and psychotherapy during the mid 1990s, and having taken on the role of lecturer in counselling and health since the late 1990s, more recently I am revisiting pastoral issues having become ordained to the Order of Deacon and being in preparation for the priesthood in an independent catholic denomination. My approach then tends to be integrative and affirmational towards the transcendental or common values that underpin various fields. In my experience professional life works to integrate secular, religious, personal, spiritual and cultural meanings that incorporate values, ethics, and moral approaches to human and social issues. In the past these domains were in greater opposition, as they remain today for many sectors of society, both religious and secular. However, for various personal and circumstantial reasons, my path in relation to both religion and secular professional work has involved intensive deconstruction and revisioning of values, ethics, and moral frameworks that now encourages me to affirm elements of various traditions in an integrative multidimensional approach.

Integrative approaches are fairly common in the postmodern, because while we deconstruct we also reconstruct (Popke 2003). This action of meaning-making requires the transformation of prior ways of thinking and working. As such, in a postmodern sensibility there is no longer a necessary, nor a clear delineation, between the secular and the religious, the atheist and the theist, the death of God and the life of God, the death of science and the utility of science (Crockett 2003). Instead of an either/or worldview, we now speak about a both/and worldview that recasts alignments and boundaries into new configurations, so that it is commonly acknowledged that people are renegotiating and reconstituting meaning across a shifting landscape of values.

Pastoral care is one contemporary approach that, in its best light, will assist people to adjust and cope with a shifting cultural landscape and the resulting issues arising from change-fatigue. The basic approach of pastoral counselling assumes the spiritual presence of the Divine Other, and issues that arise are approached with existential and spiritual depth, openness to listening, and resonance with the hurts and woundedness of human experience (MacKinlay 2001). In a similar way, the secular counsellor will listen with empathy and understanding to the stories of people, seeking ways to highlight missed

opportunities when appropriate, or to simply listen with respect in circumstances where grief is overwhelming (Rogers 1951, 1957).

In comparison with secular approaches to counselling, pastoral care also suggests the presence of the Divine Other where it is openly acknowledged that God is part of the triangle of interaction (Tisdale, Doehring, and Poirier 2003). Person, care provider, and God make up a trinity of wonder that embraces the lived experience – regardless how painful or disheartening. This space that allows the Divine Presence to be acknowledged, enacted, and invoked is a very unique quality of pastoral counselling within a postmodern and largely secular society. But here again, ‘society’ is something that is better defined by an individual’s worldview, as interpretations of lived experience are many and varied.

Interestingly enough, by suggesting a postmodern social context we open up space in this discussion to acknowledge how the notion of difference in time, space, and identity constitutes social and historical realities in ways that challenge previous assumptions of value, meaning, ethics, and morality (Sarbin 1994). These shifts of awareness can be applied as much to aging as to any other social or personal issue. In raising the postmodern, we are able to speak in the same breath about moving beyond the death of God to acknowledge stubborn intuitions of the immanently divine.

From this space it is possible to speak about a ‘post-secular’ cultural environment that challenges assumptions related to rational science, medicine, social and cognitive science, without necessarily relying on previous constructs of religion because these too are being transformed and reframed. But the process involves much uncertainty, and a degree of existential anguish is created by the dual deaths of God and of Science, of religious and secular. It is easy to doubt even such basic human values as truth and honour in virtual culture. It is precisely these losses of faith that constitute the modern era, and that posit a moment in time and space we call the postmodern. Where there is a loss of faith, there is a loss of hope. And where hope is lost, in the human psyche is created a void like a parched desert yearning for release from chronic pain and suffering.

Meaning and identity associated with aging and the aged are also shifting. In many ways this process is still fragmented, but in other ways our context raises possibilities for new forms of wholistic awareness (MacKinlay 2001). So the postmodern moment must be extended until new forms of identity, meaning, and political economy emerge and these will manifest greater congruence with social services for the aging and other populations that are currently problematic. These issues rightly are acknowledged in almost every era, but hope suggests that among times and places there are ways to facilitate greater social harmony while still respecting differences. A new paradigm is necessary that is unique to our times and that honours personal experience and gives meaning, richness, and depth to the pains and pleasures of life. These types of realisations are the rightful domain of an aging population asking questions of meaning, significance, and looking for some sense of coherence and integrity of belief following years of living a fragmented and busy lifestyle.

Aging, counselling, and pastoral care

The time is ripe to look at possible integration between perspectives. The signs of the times suggest that secular counselling may have a lot in common with religious pastoral care. For example, counselling courses in integrative methods that include aspects of spirituality have grown enormously over the past decade (Corey 2005, McLeod 2003). In the fields of pastoral care, what could be considered traditionally secular frameworks, such as developmental theory or perspectives from Rogerian humanism are increasingly deployed to meet the needs of an emerging discipline (MacKinlay 2001). Pastoral counselling, while having its unique social, religious, and more recently, its professional origins, is a field that makes the most sense when it frames up its methods from an integrative and wholistic perspective.

From a postmodern point of view, pastoral counselling uses the constructs of faith actively while engaging in appreciation of the common wealth found in religious and secular traditions. Counselling is also an emerging discipline that has the potential to articulate a wholistic paradigm that works in dialogue with pastoral care concerns. Whether one works from a basis of faith or secularity is becoming a less useful delineation. What means most in the current climate is how each practitioner frames up their theory of working and how they articulate their practice. The central issue here is not what discipline the practitioner sits within or identifies with, but how well do their theory, and practice, hang together? In other words, how does their articulated theory and practice offer coherence and integrity to their work?

Closing the gaps in care

When approaching issues for the aging, we have an example of one common area for concern that can bring different practitioners together to discuss ways of assisting clients from their unique points of view (Tisdale et al 2003). What boundaries exist between and within each approach? In mainstream counselling, for instance, the practitioner typically will not mention faith or religious meaning unless this is first requested by the client. This appears to be a basic humanist boundary for practice, that is, to allow the client to define the tenor of the interaction in regards to faith or religious belief and for the therapist to remain detached and as valueless as possible (Rogers 1951, Corey 2005). Even in such cases, the well trained counsellor may be fairly reluctant to actively engage in a discussion of faith even when a client raises the issue.

Likewise, the counsellor will often have great reluctance and perhaps be closed to active exploration of faith or religious issues with aging clients. Often, these issues may be discussed from a religious perspective for the client, but for the counsellor they are reframed into existential or psychoanalytic terms (Bragdon 1990). For secular minded clients this may be adequate, but for older people of faith the secular approach may not be helpful. Furthermore, in secular and humanist-based forms of counselling such as Rogerian approaches, it is not common for the presence of God to be invoked through gesture, word, and/or prayer, either by the client and especially not the counsellor (Rogers 1961). This is simply not the role of the secular counsellor.

Indeed, by invocation of divine presence it is implied that 'two or more are gathered in the name' of the Presence, so that when a client may desire to express faith in the divine presence, if this is not shared by the therapist such invoking of the Divine presence will likely not be experienced in any shared sense. In my experience, the result for clients can be a marked absence of Presence, and a resulting sense of emptiness, disappointment, and a perception of lack of sharing within the therapeutic relationship. These issues have particular relevance in multicultural situations where the aging person has a different worldview that acknowledges Presence, whether of Creator, Spirit, God, Goddess or the person's Ancestors. Purely secular forms of counselling do not adequately prepare practitioners to acknowledge *and* to create value-laden spaces where these personal and spiritual meanings can be respected and nurtured.

As the Rogerian tradition suggests, when the work of the secular counsellor focuses on the client's story and on finding solutions to issues, faith and the discussion of religious meaning are part of a much wider agenda that are reframed via non-religious and humanistic constituents of meaning (Rogers 1980, 1990). One can see how difficult it can be to reach a wholistic perspective, depending on where the secular counsellor is coming from and whether or not their frames of meaning are actually conscious, and whether they understand how their interpretative frameworks impact on interactions with clients who are coming from different worldviews. Overall, counsellor's awareness of these and related issues of value, ethic, culture, and aesthetic tend to be inadequate and prone to unconscious and unintended bias (Arrendondo 1999, Johnson 1995, Minichiello, Plummer, and Seal 1996, Pack-Brown 1999). It is likely that similar, and perhaps even more pressing issues will arise in fields of pastoral care where religious and/or spiritual values are foregrounded and make the landscapes of value, ethic, culture, and aesthetic more transparent. Future research needs to address these issues in qualitative frameworks that highlight issues of meaning in everyday interactions.

Professional and/or sectoral identities

In another sense we come against a fundamental problem. This is the issue of signification and identity in our native way of working. If we identify as counsellors, we may take on a secular mandate and code of ethics that requires certain values be highlighted while others are diminished (Canadian Counselling Association 1999). If we identify as pastoral care providers, we may have related but also unique and contrasting ethical frameworks for practice. In both cases, our identity frames up our basic manner of working and defines for the public where we are coming from. While this may be the case overall, it seems important to acknowledge that at times what people think they are seeking is not always what they discover they need. So you can imagine clients coming forward to counsellors or to pastoral care providers seeking what they feel might be the obvious part of what the practitioner offers. However, through the interaction the client and therapist may acknowledge that other issues arise demanding they either flex their style of working or refer the client to another practitioner who can help them. We can also see that for aging clients who have had prior negative experiences of either secular psychology or of religious services, we can imagine there may exist layers of resistance to being helped by either a counsellor or pastoral care provider. Sensitivity to these issues

appears to be an important part of our work regardless of our place in the politics of caring.

In the ideal world, I would hope that each practitioner has the knowledge and skill available within them to assist all clients that come forward to them. But this is not the case. In this ideal world, counsellors would be flexible enough to enter the world of faith and all that this entails. However, in most cases this is not possible for counsellors unless they advance in their own professional practices plus extend their training into other fields. However, shifting one's personal beliefs for the sake of working with certain populations is not an expected part of professional life. Enter the construct of empathy, which suggests that regardless what beliefs the counsellor holds, they can offer respect and understanding for where the client is coming from. This is not always the case. From a clinical and counsellor training perspective, I am not convinced that empathy and the other 'core dimensions' of therapy are adequate to translate otherwise poor cultural and religious understandings into different cultural settings. Likewise, ideally pastoral counsellors would be flexible enough to switch off the faith mandate and enter the world of secular psychotherapeutic counselling strategies. But in either case this flexibility requires extensive education and training that currently does not exist in any unified nor integrated fashion, and the issues raised are incredibly complex and multifaceted.

It seems important to acknowledge that the more 'wholistic' a discipline claims to be, then the greater the need for higher standards of practice and training. When applied to the sensitive areas of work with the aging, it becomes clear how important these issues are to high standards of ethical practice. This is a sobering thought, because when one takes a dialectic analysis of pastoral care and counselling training programs it becomes quickly obvious that the constraints on these programs makes it almost impossible to offer a truly wholistic training package. Likewise, issues for the aging are not covered in any great detail if at all in most basic training programs. Practitioners of whatever modality must gain this experience and training elsewhere. As both disciplines tend to claim a wholistic approach, they ought to differentiate knowledge and encourage integration of the practitioner's awareness of the physical, cognitive, emotional, social, environmental, capability, spiritual, and educational domains of aging. The standards of training in the care of the aged for both disciplines ought to be fairly exacting for members to attain competence in these domains across the areas of knowledge, theory, and practice.

In addition to these basic values of professional education, wider social and historical trends are worth considering as they relate to the politics of caring. While we may find ourselves in a post-Christian culture in many ways, this is by no means clear cut. As stated previously, we also live in a post-Secular culture. What these concepts mean for each person will vary greatly. We can never assume to know where each client is coming from, and what they may need from us. It is important to take a seasoned, detached and critical perspective on our work that allows for challenges to our theories of work, and to our manner of working. Herein lies the importance of attending to a dialectical method of critical self-analysis to actively change our approach on an ongoing basis, so to offer better care and services to clients.

Aging and the discourse of difference

More than any other notion, difference defines, delineates, challenges, and speaks by means of presence and absence (Irigaray 1990, Jagose 1996, Sarup 1996, Warner 1993). These dimensions of difference speak through voices from the margins, through objectification, and through pervasive strategies of silence. By marginal voices, I mean those sounds that arise from previously unheard stories, both in the private context of therapy and in the public discourses of the academe. By objectification is meant the process of 'othering' central to all social tactics of prejudice, bias, and preconception. To objectify is to isolate self from other by contrast and separation. This social dynamic of objectification causes a social, psychic and geographic isolation. The epistemology of aging suggests a silent (and psychically marginalised) awareness that we are all in this boat together. But many of us are in denial. Here is a central point. We are all aging people, and we will all face the effects of becoming aged – should the Creator carry us until we too are 'old and grey'. So we not only marginalise our personal experience of aging, but in a social sense we also segregate and quarantine the aged among us. In this sense, by 'isolation' is meant 'to separate equals' because in terms of aging, and when considering many other types of difference, we come upon an existential and phenomenal truth. We marginalise parts of ourselves, the very things that we share by right of our being human.

If not for our common spirit, the social and psychological effects of isolation would be less devastating. But because our sameness draws our families and communities so closely together, the social dynamics of objectification and prejudice are enormously damaging. This will ring true when considering issues of aging as much as in ways that race, gender or sexuality are objectified. All the more powerfully felt are the traumas created when tactics of objectification, bias, and prejudice are deployed by helpers, whether they be religious, pastoral or secular.

The characteristics of how people isolate themselves from the self and each other are central in guiding a dialectic analysis, because when one understands what is rendered different and *other*, one can begin to appreciate the construction of prejudice in its varied manifestations. The discourse of difference thereby highlights issues of identity that were previously unarticulated in quite the same manner (Warner 1993).

Identity and aging in the postmodern

Identity may be explored by use of the dialectic method, an analytic agenda that honours the local and particular while also highlighting the global and thematic. This dialectic method may lead to greater appreciation and wholistic understanding. In this way, 'wholistic' is understood as a process and a practice. This practice is central to my notion of therapy. These constructs of difference, dialectic, and wholistic practice are herein applied to an evolving notion of pastoral care for the aging, and by parallel analysis are related to a sense of what constitutes aspects of a spirituality of care. Other categories that have benefited from dialectic strategies of difference include sexuality, gender, race, ethnicity, youth, and disability (Bowers and Minichiello 2001, Fox 1994, Giddens 1991, Herek 2000, Noel 1994).

With Luce Irigaray (cited in Ward, 1997, p 193), I call for practitioners to consider multifaceted strategies to elicit the voices of difference, to listen to the silences, to attend to the sounds from the margins. By marginal is meant that which is contra-ordinary, that which is different and stands apart. In another manner of speaking, the marginal is what we separate from ourselves and render the *other*, and in this separation we construct meanings that make the other different from ourselves. Yet voices from the margins sometimes arise to tell their stories, and certain research agendas seek to encourage space for marginal voices to be heard in mainstream discourse.

This discussion raises knotty questions related to how can we facilitate a greater appreciation for the voices of aging and the aged? While I can not presume to answer this and other related questions in this essay, nonetheless, it is important to raise the questions and allow them to ring in the air. The intentions behind questions raise many energies that can be picked up by individuals in many and varied ways. The point here is to live in the questions themselves, and to allow their energy to carry us forward.

Central to these questions is how we might consider particularly the voice of those who have lost their voice, power, and influence, in societies that marginalise the aged? How can we honour their stories by giving space and time to hear them, to write them down, and to know them as valuable and honoured contributions to society? Most especially, how can we honour and respect the voices of those who are physically towards the end of their lifetime and may have little voice left in them, but who desire nonetheless to be heard and appreciated? These questions underpin the fabric of this weaving between discourses of professional practice, dialectic method, critical social analysis, and related issues of applied disciplines like counselling and pastoral care. From this weaving, in what ways can we encourage research agendas that address the pressing needs we now face in our aging societies? And further, how can these agendas of research and social change be viewed in wholistic and long-term ways that contribute to the overall well being of societies, communities, and families for generations to come?

Following from the dialectic space created by these and related questions, we are able to acknowledge that there is no greater margin or separated social space or geographic locality, than that which is created by mainstream society for the categories and institutions relegated to aging. Too often the voices of those of whom we speak do not appear in our decisions, meetings, presentations, texts, nor are they given space to be honoured in the day to day operations of the community. Although prior work has attended to righting some of these wrongs in other spheres by giving space for voices from the margins (Bowers, 2002), this paper stands guilty of this articulation by omission. The purpose here is to frame up a research agenda which will in future continue the process of giving voice to difference, and begins this process by giving a different sort of analysis to the issues of aging.

Postmodern tools for analysis of 'aging'

As is expected in the postmodern, it is helpful to look to the local, particular and contingent as well as to the thematic and general (Irigaray 1990, Jagose 1996, Sarup

Bowers R. (2006), Wholistic applications of counselling with the aging in dialogue with pastoral care concerns: A postmodern and transcendental analysis, *Counselling, Psychotherapy, and Health*, 2(1), 68-85, April 2006.

1996, Warner 1993). These points of emphasis highlight a necessary immanence, a direct and personal relevance that remains the focus even when suggesting wider themes or tentative conclusions. This important loci directs our analytic agenda to the subject, and it is possible to see how this will apply to honouring personal narrative in research and social services such as pastoral care and counselling with the aging.

However, postmodernism in its extreme may warrant a kind of nihilistic relativism that suggests the death of agency that utilises reason and insight to speak beyond the contingent (Ward 1997). Facing up to this challenge is one of the first and obvious tasks of students in the academe at this particular time, regardless if they come from Christian or other backgrounds. Likewise, facing up to the approach of dogmatic theology and/or to fundamentalist interpretations of reality also require sustained critique. Somewhere between these extremes lies a middle-path to wisdom, where we hope that contemporary practices of care can be grounded and enabled to flourish.

To these ideological challenges I bring the seminal work of Bernard Lonergan (1957, 1972). His work is particularly relevant because his enterprise is not ideology or beliefs. His concentration is on the nature of human insight, and so relies on analysis of the meta-epistemological processes that constitute all expressions of human meaning. In other words, *how people construct their beliefs*, not what or why they believe per se. The 'how questions' are of central concern to counselling and pastoral care, where we wish to address how people can activate beneficial and resourceful beliefs to assist in their development, and how they can change unresourceful beliefs to encourage this process. In contrast to ideological approaches and arguments raging in the fields of religion and the academe, the best approaches of counselling and pastoral care tend to apply this focus on 'how' through pragmatic, person-centred, process and outcome oriented strategies.

Lonergan (1957) suggests that human insight is an organic and necessarily contingent process, but that this process is also transcendental. That is, the process of insight relies on subjective awareness and the growth of the subject as the carrier of wisdom – and knowledge itself is meaningless without this active dialectic engagement of the subject who continually revises their concept and interpretations of reality. The ways human beings do this process of insight are both contingent and transcendental, that is, the process of insight is personal and is also shared, and therefore has certain universal components. In this framework people do not seek knowledge per se, but rather seek an expanded sense of wisdom. This sense of wisdom suggests a more complex awareness or consciousness that is able to hold together a range of experiences and insights – a sort of (postmodern) holographic or virtual awareness that has the qualities of depth, width, and height, across multidimensional space.

Lonergan (1957) also argues that the coming to terms with the subjective aspects of transcendental method can only be attained by individuals who take up the personal task of attending to the process of insight. From the point of view of a clinician of counselling and pastoral care, this *praxis-methodology* is not surprising because in a professional sense we acknowledge that clinical insight emerges best from personal experience when taking one's own therapy seriously. Through attending to this subjective process of

insight, experientially, the agent may work toward greater degrees of analytical awareness – taken to mean a wholistic awareness that includes emotion, feeling, sensation, cognition, memory, and degrees or states of rationality. The subjective analytic method, then, if taken seriously, may warrant our ability to reason and to speak to wider truths. This also means that we must take the personal narratives of people who are aging seriously, and honour their stories by reflecting changes in our methods of working, and in institutional changes that support their self-defined well being.

A postmodern transcendental method

To press the point, the subjectivist transcendental method, when explored in the current cultural and intellectual climate, appears to rely heavily on a mystical-based metaphysics that resonates with the relativism and contingency of postmodern sensibilities while also suggesting universal themes. Taken in this light, a *postmodern transcendental method*, when applied to issues of identity, aging, research, or practice, is an expression of the *via negativa* that highlights the absence of faith, reason, and presence (of God, truth, beauty, aesthetic, ethic, and moral value). In the current climate of social and political unrest, it is difficult to avoid the *via negativa* and still maintain integrity.

Let us also acknowledge that in the circular nature of human experience, the *via negativa* and its necessary deconstructive approach with its attendant depressive states of being may reconverge in a place not so dissimilar to that created by the *via positiva*. In both paths the absence or conversely, the active engagement of faith, reason, and presence enter on the threshold of mystical, material, or (non)rational insight (Lonergan, 1972, Pickstock 2003). A certain transcendental quality of darkness and light admits to both having instructive and insightful dimensions in the human psyche. Both light and dark have stories to tell, and functions to play in human evolution.

In terms of research with and for the aging, this discussion raises the importance of withholding judgement long enough to explore deeper connective themes, because what appears as simply negative and disheartening may, in the long term, whether in the analyst or in the subject, emerge into a transformation of meaning that yields new insight into the resilience or creativity of the human spirit. Therefore, in the example of postmodern narratives we have an expression of a profound (and often dispassionate, irreverent, and even crass) loss of hope, and destruction (or deconstruction) of hope. The *via negativa* is intentionally chosen for its discursive utility, although the concept of utility is flawed, because the objective in ‘pure’ deconstruction is to dismantle the discursive into a fragmented string of incoherencies (Pickstock 2003, Moran 2002).

As metaphor of despair in aging

However, taking the postmodern as a metaphor and as an expression of internalised states of being, we have a moment in history and culture of fragmentation and disillusionment that quite naturally happens for us when we are overwhelmed with meaninglessness and the full manifestation of human suffering. The metaphor speaks of despair in aging, and also of a terrible path through despair to regeneration, hope, and rebirth.

The Eastern sensibility is to say, nada. The middle road to enlightenment is found in either direction. Take what path you will. But attend to your process. Be aware. Let go of aware. Zat! This approach is dangerously closer to the Western Christian sensibility than we would at first like to acknowledge, because we Western people have consistently denied the mystical emphasis on personal responsibility and enlightenment. The postmodern highlights this blindness of Western thinking and being, and suggests powerfully that the *via negativa* must be taken. Only by taking this path can we journey towards a post-postmodern insight. We must begin where we are at; in practice, research, and in aging. We can not move from where we are not.

The postmodern *via negativa* tends to lead toward a realisation of the terrible fragility and tenuous thread upon which being human relies. Life itself is contingent. We live in a frighteningly limited world, in an even larger suspended universe that could, in a moment, and without notice, shift beyond the fine line of conditions that sustain human life and consciousness. In this sense, the postmodern notion is correct – there is no truth upon which we can rely, there is only a process of contingencies that sometimes (and in politics, science, or religion) *appears* as absolutes. And while this is true from a poetic, mystical, and analytic sensibility, we hope that we can rely nonetheless on the ‘best approximations’ of truth that exist, as these tend to guide social policy and practices in health and human services.

Postmodern poignancy of ‘aging’

If you step back for a moment, there is a certain and terrible beauty in this contingency, something that a Christian theology of incarnation has always suggested (Ward 1997). There is a radical sense of how the Gospel narratives ended up in despair – how nothing worked quite right, how aging and time highlighted the limited, local, and personal aspects of human frailty, and how all these contingencies led the way to God’s providential manifestation of grace, presence, and absence. Not in an absolute sense. But rather in an insanely graceful and imminently compassionate expansion of subtle energy that continues the process of evolution since the dawn of the universe. This frighteningly erratic, illogical, and yet insatiably graceful and coherent evolution comes forward in postmodern impulses that rely heavily on the discursive and the intuitive, to recast theological and ethical frameworks of the past. This contingent process, from a Christian disposition, is made manifest again and again through the miss-happenstance occurrence we call the resurrection of Jesus from the effects and politics of aging and death. In this sense, postmodern faith is not based in certainties, but rather is disturbingly inspired by the terrifying lack of certainty and chaos that permeates our universe.

Revisioning ‘Christian’ metaphors

In today’s context I believe we are seeking a sort of queer theology of immanence. More will be said about this in a moment, suffice it to say here that this recasting of theology requires a prophetic voice from the margins. This manifestation of insight seeks a radical and sensible awareness of the divine presence found in human contingency. This sensibility is a form of sensuality, reconciliation, and healing of the fragmented self of postmodernism. But this sensual theology speaks directly, intimately, and transparently to the contingencies of aging and difference. Such a queer-sort of theology transcends the

discourse of presence and absence, and will one day emerge from a radical contra-analysis of the Gospels in light of postmodern sensibilities (Ward 1997).

Yes, our condition is contingent, and aging is the primary reality that forces us to experience these states of uncertainty that are so intimately portrayed in the postmodern philosophers. Yet, the deeply mystical, poetic, deconstructive, violent, disconcerting (and indirectly Christian) aspects of the postmodern sensibility are in fact a prophetic voice from the margins that need to be heard. These once silent voices point us toward the largely unacknowledged subterranean depths of Eastern and Western religious spiritual traditions. This work is desperately needed in today's world to continue the deconstructive process that leads to tentative expressions of hope – and that hope which is at its core a spiritual manifestation of the locality of God's own frailty, aging, decay, and death which we must face first in order for the third day to arise.

Meaning as emergent then, resonates with a sense that the human person and their insights are *constituted by meaning*. In our discussion the implications are that aspects of culture like family, gender, and age are locations of more than what may appear at the purely physical level (McBrien 1994: 148-149). While this method of analysis takes the concrete, contingent, and historical seriously, it does not resort to the classical and modernist views which rely on abstract and 'objectified' constructions of reality. Therefore, by uniting Lonergan's (1972) method in theology/philosophy with postmodern critique, I am suggesting an analytic method that can both deconstruct aging as a social locus of meaning and reconsider dynamic, self-constituting, and actively engaged human subjects who may challenge and increase our collective awareness of the epistemological landscape of aging in the future.

For example, by exploring how an older gay male experiences loss and grief compared to a heterosexual male's experience of loss and grief may open up new understandings of how human experiences are registered in different contexts. This exploration of meaning and context is the underlying meta-research agenda by which I approach the notion of aging. In this sense, aging itself is felt to be one example of *difference* – that is, of a human experience that has tended to be assumed. We all age and will be subject to the experience of aging. But aging as a concept and as an experience requires deconstruction.

Because of the normative functions of aging the notion and the experience has been assumed, misunderstood, labelled, codified, and rendered with various forms of bias and prejudice. Likewise, the counter-intuitive notion of *difference* is meant to suggest that the concept of 'aging' performs certain tasks for families and society that attach meaning and place limits on aging persons for various reasons. Aging is, in this sense, a location of multiple subjective markings with associated signifiers that render certain people different from others for specific reasons. Many of these processes of marking a person as 'aged' go unchallenged. Yet we will agree that aging is a critically important location of identity politics that raises many of the most significant questions facing our societies at this time. More so, the field of aging as a social phenomena and performative notion of interaction, ethics, morality, theology, and health requires nothing short of a queer reclaiming.

Aging and queer critical analysis

By 'queer' is meant a borrowed construct of critical social analysis, taken with gratitude from the wisdom of gay and lesbian studies, and prior feminist discourse. Queer is first of all a field of possibilities, the hinterland of potentiality that is newly being articulated. Jagose (1996:3) suggests that 'queer describes those gestures or analytical models which dramatise incoherencies in... allegedly stable relations'. In this case, we look at the relations between aging and the politics of family, social interactions, gender, sexuality, physical and mental ability, and the economies of necessity and the power-differentials involved. By borrowing queer analysis from gay and lesbian discourse, and applying similar discursive techniques in a field that involves gay, lesbian, bisexual, transgender, and heterosexual aging persons in mainstream and in marginal settings, queer analysis suggests another way of thinking about age and aging, another discursive horizon.

Because of the history associated with queer, it necessarily also suggests how marginalised people have reclaimed a pejorative term and turned it around as a word of pride and of political power. Perhaps a reclaiming of aging is also necessary. Will we assume the same limiting meanings of aging that our parents have taken on, or will we reclaim a 'queer sense' of aging that reclaims the positive meanings and the locality of aging? Will we demand greater accountability, rights, and acknowledgements of the position of elders in our society? How might such demands challenge dominant materialistic values that marginalise aging and the aged in modern life? Many profoundly important questions arise when we take a queer stance towards everyday discourses of aging. Acknowledging the liberation-based strategies of queer theory, how might reclaiming a queer sense of aging suggest an agenda of emancipation for the aged, the aging, and for people in society at large in our attitudes towards aging? What new forms of meaning and culture would we like to support that signify new forms of identity as well as a new politics of aging in future?

The importance can not be underestimated of (queer) research agendas and (queer) ways of practicing pastoral care and counselling that take up a post-structural stance of acknowledging the locality and standpoint of marginal voices and narratives. In a sense, to take up the queer approach to aging is to take lightly the seriousness of prior frameworks, and to 'make fun' in a different-sort of mind-opening way of thinking and *doing aging* in the postmodern.

Take for example recent environmental crisis that has destroyed people's livelihood, homes, and lands, and killed many loved ones. In one sense, these experiences have people growing old very quickly, and losing a sense of the signifiers that had made life meaningful. Here you will note my use of aging as a metaphor, but more than this, as a linguistic codifier for loss, grief, powerlessness, and an unnerving sense of the silence that death ushers in. This construct is not necessarily a positive use of the term aging, but it is important to illustrate how the term is deployed in popular culture in order to envision new possibilities. From the unconsciously assumed coded meanings of aging one can understand the logic of how aging = death = the end of what is good and beautiful. Why do we use this notion that aging is death = the opposite of life, when

aging is for so many of us a path of maturing and investment in truth and beauty? Perhaps the paradox admits to many layers of meaning and associations, which at different times and places take on significance.

To take a queer parallel, in similar ways AIDS = death = evil was a commonly deployed linguistic framework used during the 1980s. Aging, like AIDS, is not the good and the beautiful, and is positioned as something to be avoided at all costs. Likewise, during the 1980s many thought about being gay = getting AIDS = death = evil. In the rhetoric of the Christian political right, these parallels have taken on the force of dogmas. It is precisely these underlying or subterranean associations with aging, death, disease, and evil in most Western cultures that is troublesome. Until we render conscious the negative associations with aging and the aged, we will not be able to reclaim aging as a location of pride, honour, and dignity. This is a pressing problem that suggests a primary deficiency in the core ethics and aesthetics that drive materialistic cultures. Facing these issues demands a critical honesty and transparency that may be somewhat rare, perhaps a bit scary, but is far from impossible. If society can come out of the closets of homophobia and reclaim gay and lesbian experiences as part of the reality of social life, and if society can facilitate greater openness to policies that respect and honour racial and ethnic minority experiences, then it follows that we can also find ways to honour the universal significance of aging. Let us then work toward greater care and pastoral sensitivity with our family and community members who are older, and who ought to have a place among us of honour and respect.

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Tending the soul of the terminally ill

Seung Hee Kang

Introduction

Jean Vanier once said, “Death is inscribed in our life. We are losing 100,000 cells in our brain everyday. Life and death are married together and I welcome my life and death, which are my masculinity and my femininity” (Vision TV, Jan. 22/05). Buddhism, in a similar vein, attests that a human person begins to die as soon as he/she is born. Being rather self-contradictory in nature, we seem to be moving simultaneously towards dying and living. Having said that, why do we get so terrified when we are told that death, caused by an incurable disease, is imminent? Are we not always on our journey towards the end of life? Isn’t this movement towards an end happening everyday? Is the reality of death completely foreign to that of our life? What is it that really makes us frightened and horrified?

Death is often considered an unthinkable thought and an inescapable confrontation (Gonda & Ruark, 1984) which means the loss of a known world. Our journey to the unknown coincides with our fear of the unknown world (Dobinal & William, 1984). What makes a human person most apprehensive is the total loss of existence itself which otherwise could be the foundation for all actualization of values (Attig, 1979). The dying people are on their way to a final journey filled with “doubts, fears, regrets and loneliness” (Lancaster, 1997).

From the perspective of aging and spiritual growth, there is no total death. Only the body dies, and the spirit is eternal. Kübler-Ross (1975) suggests that a human person moves through a series of psychological transformations in the process of facing death; from shock to denial, to anger, to hope, to isolation, to bargaining, to depression and eventually to acceptance. It also has been found that positive attitudes and full self-awareness towards death are pertinent to cope with the psychological distress of death (Smith, et al., 1983-4). For Kübler-Ross, dying is considered the final stage of growth to eternity (Kübler-Ross, 1975). This position begs the question, “Can a human person live a life until death, then?”, which, no doubt, derives from accepting the reality of death as part of human journey. In addition to that, it points to another question, “How can we make death meaningful” when death is inherent and inevitable in human existence (Frankl, 1978)? Confronting the end of life elicits the human spirit’s defiant power to look for a meaning. A human person is ultimately concerned about his/her being and meaning

(Tillich, 1951). Spiritual growth in the journey towards the end of life, in this sense, is intimately tied to a choice to live and to search for meaning (Frankl, 1976).

Woman in Darkness

The researcher was introduced to Mrs. Erickson in her residence (a nursing home room). Walking into her room, the researcher found a Bible and an old radio on her bedside table and a cross on the wall. Not many of her belongings were present in the room. Her room looked tidy and institutional. She was a woman of medium stature with a voice of authority and confidence. No personal picture was possible in her room, especially since she had become blind. The phone became a significant means for her to communicate with people outside her residence.

Mrs. Erickson is a 72-year-old woman who lost her husband years ago. She used to have three brothers, but one had passed on. She had eight children in all and lost two; one of them was killed in an accident. According to Mrs. Erickson, she used to be very independent until she had three major strokes and several minor strokes, one of which left her completely blind. Such was the way the darkness, like a thief, slipped into her life. Since then, darkness has slowly and gradually become a reality for her to battle with. Telephone conversations became a very significant part of her life. She became blind a year ago and moved into the nursing home. A doctor said that another stroke might cause her death. No one knows when this could happen. Moving from her home to the nursing home came as another big transition. Mrs. Erickson has been walking her journey towards the unknown and living between two realities, life and death. Without knowing when death will arrive, Mrs. Erickson lives each day to the fullest as much as she can.

This present study seeks to uncover the journey that Mrs. Erickson has been experiencing especially since she became terminally ill.

Review of the Literature

Abundant literature is available with respect to the importance of spirituality to the aged (Kimble, 1990; Thibault Ellor & Netting 1990; Berggren-Thomas & Griggs, 1995; Clark & Heidenteich, 1995; Bower, 1996). Some of the literature considered aging as a part of spiritual growth (Gross, 1985; Clements, 1986; Birren, 1990; Heriot, 1992; Sherman & Webb, 1994; Chinen, 1996; Simmons, 1998; Ai, 2000; Mackinlay, 2001). Saussy renders aging a spiritually developmental process. Following James Hillman's Jungian analysis of aging, Saussy suggests a three-step process of faithful aging. The first step is associated with appropriating an unusable past by means of engaging in life review. This process evolves out of grieving unresolved losses or past disappointments and coming to terms with them. The second step is envisioning a positive future story and dealing with choices and decisions about the desired future experience. The third step entails clarifying and sorting out the values that are worthwhile to pursue and express in the present so as to live more fulfilled (Saussy, 2001).

Some of the literature holds that spirituality and spiritual care are essential parts of care, both for the chronically ill and for dying patients (Grey, 1994; Narayanasamy, 1996; Hamilton, 1998; Dom, 1999; Bogin, 2000; Storey, 2001; Purdy, 2002; Walter, 2002;

Holt, 2004). Other research outcomes signify the recognition of spiritual pain as an ignored element to hospice patients (McGrath, 2003).

Literature directly related dying acknowledges that spirituality is important to terminally ill patients (Taughner, 2000; Friedemann, Mouch & Racey, 2002). The literature in this category indicates that for those who experience fatal disease, spirituality is found to be a bridge between “hopelessness and meaningfulness in life” (Fryback & Reinert, 1999, 1). Spirituality consists of three categories: “1) belief in a higher power (church attendance/religion, spiritual beliefs, transcendence), 2) recognition of mortality (appreciation of life, appreciation of nature, living the moment), 3) self-actualization (self-love/acceptance, finding meaning/purpose in life and disease)” (Fryback & Reinert, 1999, 2-3). This particular article suggests that those who found meaning in their disease came to the realization that they had a better quality of life now than they had before their diagnosis and this in turn made those patients refocus on the little joys of everyday life (Fryback & Reinert, 1999, 1). The findings with hospice patients who deal with impending death show that it is very likely that people become more spiritual as they face their own mortality. Further, those patients see the spiritual world not as a possibility, but as a reality. Spiritual growth means “remembering, reassessing, reconciliation and reunion” (Derrickson, 1996). This research has discovered many facets of spiritual growth such as “deciphering the meaning of cancer for me,” “realizing human limitations” and “learning to live with uncertainty” (Halstead & Hull, 2001). Cancer patients engaged in “attempting to maintain coherence using old and new ways,” “asking difficult questions and letting go,” and “redefining meaning, identifying spiritual growth, reintegration, and facing the possibility of recurrence” (Halstead & Hull, 2001, 1536-1540). Stout also argues that growing into death involves “letting go at our deepest level of being and giving into what may be sensed and felt only by our hearts” (Stout, 1992, 73). Dunbar, et al. pursued research on women living with HIV (34 confirmed HIV-positive women) and how they achieved spiritual growth over time (Dunbar, Mueller, Medina & Wolf, 1998).

Data Sources and Purpose of Study

For this study, various databases have been searched, such as, AARPAgeline 1978-2004, CINAHL 1982-2004, Medline 1966-1995, 1996-2004, and PSYCHOINFO 1985 to 2004. Keywords used to capture the data were pastoral care, pastoral counselling, aging, physiological aging, spiritual counselling, spiritual therapies, palliative care, attitude to death, terminal care, terminally ill, growth, transformation or reconciliation or spiritual healing and attitude to death, spiritual growth, spiritual well-being, older adults, growth or development and dying. All English studies were included in the literature review. Only 15 out of 368 (4.7%) data collections were found to be relevant to the themes of spiritual development at the end of life. While spiritual care is viewed as a core element of quality care of the terminally ill, little guidance is available to practitioners in this area. The findings of this study, accordingly, are intended to help therapists, chaplains and other medical professionals to provide a better quality of care, by accompanying the terminally ill patients, reaching the end of their life, and undergo spiritual, psychological and emotional turmoil in this journey. The purpose of this study, thus, is to explore Mrs.

Erickson's journey towards the unknown and to understand how she sees the end of life and how she is growing into fullness in this journey.

Method and Data Analysis

To discover the participant's journey towards the end of her life, a phenomenological approach was chosen. The nursing home's administrative office gave its approval for the study and the measures taken to ensure informed consent, confidentiality, anonymity and that no harm be caused to the participant. Prior to the data collection, the administrative office reviewed the interview questions used in this study.

The phenomenological approach is a discovery-oriented qualitative approach and is one of the qualitative methodologies used in Marriage and Family Therapy. This methodology is rooted in a philosophical understanding that knowledge is relative (Sprenkle & Moon, 1996). This approach to research assumes that people perceive a phenomenon different ways and, accordingly, develop different meanings with respect to the phenomenon.

The phenomenological approach is based on seven philosophical assumptions. First, knowledge is socially formed and thus is partially tentative in nature. Truth is therefore relative. Second, researchers and the phenomenon are not considered separate. The researcher's interpretation of data is aspired to his/her own values and beliefs. Third, art as well as science are a means for knowledge. The mode of expression is a representation of an agent's own reality and truth. Fourth, bias is indispensable in all research. At the outset of the research, the researcher is encouraged to share his/ her beliefs and values. Fifth, it is acknowledged that everyday knowledge concerning family worlds is epistemologically noteworthy. Sixth, the family's language is a source of information and is rich in meaning. To gather the data, it is recommended that families be visited at times other than when they are in need of professional help. Seventh, objects, events or situations that signify a variety of things to the individual's various interpretation of the chronic illness should be observed. This is because the same objects and events can mean different things to different families (Sprenkle & Moon, 1996, 85-6).

Within in the context of this philosophical background, the phenomenological approach is used to speculate on the lived experience of the participant's implicit motives of an act. This study explores Mrs. Erickson's own lived experience. From the perspective of phenomenology, this research methodology is perceived more like a conversation than an intervention. The therapist-researcher is interested in stories and co-constructing meaning while listening to the participant's lived experience. The emphasis of the research does not, thus, lie in problem solving, but in constructive meaning making (Sprenkle & Moon, 1996, 90-1).

The phenomenological approach is designed to explore the complex nature of the participant's lived phenomenon, than to generalize the participant's lived experiences (Sprenkle & Moon, 1996, 92). The phenomenological approach used in this study will not seek to verify or generalize participant's end-of-life lived experience, but rather to understand the participant's lived experience from her own point of view, that is, an emic

approach (understanding from the interviewee's perspective) and not an etic one (understanding from the researchers' perspective).

In a phenomenological approach, the researcher shuns pre-determined questions. This is because the methodology is keen to invite the participants to define the phenomenon rather than to define the experience for them. The main research question we seek to investigate in this study is, *How does the end of life journey look like to an older terminally ill resident?* This research question is an invitation for the participant to share her journey towards the end of her life. Research findings as well as implications of the study are presented.

In a phenomenological approach, it is essential that the researcher help the participants describe their lived experience without directing the discussion. The interview questions, thus, should be open-ended. Accordingly, the open-ended questions allow the researcher to follow the participants' direction as it unfolds. During the interview, the researcher may help the participant explain things in detail (Streubert & Carpenter, 1995, 43). In so doing, the interview gives the researcher an opportunity to enter into a participants' world. The researcher's role is to closely track a participant's words, ensuring that the dialogue flow where the participant leads and her explanations are discussed in detail. This does not mean that the interview is non-directive, but the researcher has a responsibility to help the participant focus on themes and patterns, because the phenomenological approach seeks to co-construct the reality.

Interview questions used in the data collection were:

1. On a scale of 1 to 10, with 10 being an extremely difficult experience, one being positive experience and five being neither good nor bad, how would be rate your experience?
2. What is it like for you to be in the journey towards at the end of your life?
3. What is most challenging for you?
4. How do you cope with the challenges?
5. What has been the most helpful?
6. Can you tell me about the changes or spiritual growth that has happened to you in this journey?
7. Is there any image, metaphor, symbol or music that captures your experience?
8. What gives you meaning at this time?

The interviews were audio taped and transcribed verbatim. The tape was repeatedly reviewed for the purpose of verifying the wording on the transcripts. Data analysis began

with data collection. In other words, data analysis actually occurred while the data were being spoken (Cohen, et al., 2000, 76). As multiple readings of the data continued, the repetition of writing occurred. Once the overall text had been comprehended, phrases in the text were underlined and themes and patterns were coded in the text's margin. In doing so, the data were examined line by line and the tentative themes were sorted in accordance with the themes and patterns.

The process of writing and re-writing occurred. This process was essential to the phenomenological approach, since "the movement from identification and comparison of themes to a coherent picture of the whole" takes place during the process of writing and re-writing. This was the time when the researcher gained an insight into and a tentative understanding of Mrs. Erickson's lived experiences as they were conveyed through the themes, patterns and other means (Cohen, et al., 2000, 81). In order for the researcher to avoid and reduce my bias and assumptions, she continued to review the audiotape. The data were analyzed and a coding system was developed based on eight themes. In the excerpts that follow, P is Mrs. Erickson and C is the researcher.

Findings and Data Interpretation

Theme 1: Movement from hell to acceptance: psychological movement

The data reveal that Mrs. Erickson rated the beginning of her experience a 10 and then she moved to the stage of acceptance, which she rated a 4. This change emerged four months' after she became blind by her illness. The intensity of her emotion moderated as she moved to the stage of acceptance:

P12: In the beginning 10, very difficult to accept. Now, I'm starting to accept it, so now 4.

P15: It's hell! Not being able to see anything. It's very very difficult and it's very emotional, And I think I am from believing in God and He is at me.....

C16: When did that change happen to you?

P17: Probably, four months ago.

Mrs. Erickson's acceptance took her to a rating of 4, which meant that she gradually found a way to be at peace with herself. As she described it, her faith in God helped her calm down. In four months' time, her psychological transformation took place and was positive in terms of her moving towards acceptance. Kübler-Ross's psychological transformation is reflected in Mrs. Erickson's transformative lived experience. According to Kübler-Ross's stages of psychological movement, Mrs. Erickson has moved from anger to acceptance, which is the last transformative stage.

Theme 2: Coping mechanism: immediate expressions of emotions and feelings, family support, cooperation of nursing home staff, volunteer work at church, persistence and resilience and faith in God.

During her transition from light to darkness (blindness) and her transition from her house to her present residence, Mrs. Erickson accounts for the factors that helped her through this process:

- P27: Sit in the corner cry sometimes....and other times, ...grin my teeth and do it!
P31: Cooperation with the staff. The encouragement from my family.....My family is my lifeline.
P37: If I am really down, my daughter will come from work.....Otherwise, she talks to me on the phone and calms me down and even gets me laughing.
P43:never ever giving up.....
P49: No..no..Fr... The priest said that once you stop coming back to church....It doesn't take you eyes to greet.....Or to go on a different committee....or...better to do not sit one the committee...so There's another encouragement...the church.

Mrs. Erickson dealt with her challenge by expressing emotions (crying alone at times), by forcing herself to move on and by overcoming her challenges. This image appears similar to Sisyphus rolling the rock up the hill. She is the figure who keeps rolling the rock up the hill. How resilient she has been in this experience! She has been greatly helped by her family members and she also found the staff's cooperation helpful in this journey. Finally Mrs. Erickson's priest encouraged her not to fail to do what she has been doing in the church. On the other hand, Mrs. Erickson's soul was open to the priest's advice. This element affirms the finding of a positive correlation between religion and health (Koenig, 1997).

Theme 3: Image, metaphor, stories and others embedded in Mrs. Erickson's experience.

Mrs. Erickson kept reminding herself of a simple sentence, "never, ever give-up," and this kept her moving forward. It seemed that the simple sentence worked like a mantra. In practice, she continued to be a greeter at the church and this participation did not cease even though she became blind:

- P43: .. Never ever giving up. I'm able to take my place in the church. I'm Anglican and take an arrangement that the church to pick me up every Sunday and take me to church.I am a greeter there, because I have a big bounce and I can greet chat to them.

John of the Cross' (1541-1591) dark night of the soul spoke to her and informed her that she was able to see more than the dark side of herself, and she thought that this story resonated with footprints. She continued to articulate the reason that she was able to see more than the dark side of herself in the story:

- P79: It (the story of dark night of the soul) tells me that I can see more than dark

side of myself.

P81: It reminds me of footsteps. You know.....

C82: Footprints?

P83: Yes.

P85: You don't see the prints, because He's been carrying you.

In her recollection of the anecdotes of footprints, Mrs. Erickson realized God's presence in her life's journey and her trust in God's guidance was illuminated in the voice of her witness.

When Mrs. Erickson felt down, she thought of an image of Jesus standing by a tree, near the Holy Water, who rescued the lost sheep that was her, and this image gave her great comfort:

P51: When I am really down and I want an image...Um...I picture Jesus at...tum....standing by a tree, near water Holy N----- and that's to me a beautiful image.

C52: So...what is Jesus doing there?

P53: He's rescuing the ram that's lost and that's me.

C54: How does it make you feel?

P55: Comforting...cause He is the great Comforter!

Theme 4: Mrs. Erickson's Jesus with *homoousion*

Mrs. Erickson's Jesus had a beautiful image. Jesus, to Mrs. Erickson, was, indeed, alive in her life and He showed an existence with two natures in one substance (*homos* (same) + *ousia* (essence)). She did not often use the word, "God", in describing the Divine during the interview. For Mrs. Erickson, the human Jesus was helping her by accompanying her and sharing her struggle and the Divine Jesus was eternally present even though she at times fell into her dark side:

C86: Um.....so I guess when we go back to what you have said...when you are angry, you don't let Him come close to you.

P87: But He carries me anyway.

According to Mrs. Erickson, Jesus was always present even though she was enslaved by her anger, especially in her knowing that He cares her. It was her blindness that she could not see. The Divine Jesus let her be faithful to her emotions and feelings. This was not because He did not care for her, but because He loved her:

C88: Does that mean that He lets you cry and He lets you angry?

P89: Ummhmm...He has all those emotions Himself in His human form.

P91: Well, knowing that I haven't gone through anything that he has gone through....despair, anger, loneliness.....

C92: So... am I hearing that despair, loneliness and anger would be your dark side of yourself?

P93: Yes....

For Mrs. Erickson, Jesus was divine as well as human who went through human desperation as we humans go through, which accordingly she shared with Him. She identified those human moments with her own dark night.

Theme 5: How Mrs. Erickson transformed her dark night: the process of Mrs. Erickson's spiritual growth

It was the devil who erected the barrier (the dark night), according to Mrs. Erickson, and she forced herself to break through it. This was analogous to a beautiful picture that St. Teresa used in her writing. Mrs. Erickson did not specify whether the devil existed externally or if the devil was the manifestation of her ego. Yet the devil, to Mrs. Erickson, was identified with the negative force that prevented her from meeting Jesus. When the dark night came, she had to search for Jesus. She had to make efforts, as John of the Cross made a very lonely and risky journey to realize that his darkness became darker, as the Light became brighter:

C94: So...when you confronted, ...how do you find Jesus in here? When the dark night comes...?

P95: I have to search....for Jesus, because dark night,..... devil whatever puts a barrier...and you have to break down that barrier.

C96: And how do you do it?

P97: Um...by pushing...in other words, pushing myself feel better.

C98: So, the Light eventually comes in.....?

P99: The Light soooo shine came in.....

Mrs. Erickson confronted the devil and did not let the devil destroy her spirit. Instead, she took her Heroine's journey to search for Jesus (Campbell, 1968). As Mrs. Erickson embarked on her Heroine's journey, her battle with darkness (blindness) and desolation emerged. In this process, the devil played the major role of putting up stumbling blocks, by making her unable to see the ever-present Jesus (the Light). In her tremendous efforts, the Light eventually overcame Mrs. Erickson's dark night. This picture coincided with St. Teresa's anecdotes of tending the soul in the garden of her soul. The nature of cultivating her soul through trials had a reflection similar to St. Teresa's four steps of meditation required to reach the degree of contemplation; "from watering the garden by hauling the water from a well in a bucket; to watering by means of a water wheel; to watering the garden naturally from a nearby stream or spring,; to watering the garden with the rain" (May, 2004, 114-5). Mrs. Erickson's endeavours, in seeking Jesus during her dark night, presented the image of cultivating (nourishing) her soul by means of watering in different ways. This image depicted Mrs. Erickson's inner strength in her relentless spiritual yearning. Her choice to search for Jesus in her darkness bore fruit and this whole journey was her *faithing* and depicted her spiritual growth. Mrs. Erickson is the person who lived her life until her death and she lived out her faith, in the pursuit of her own meanings of the challenges she faced as Frankl claims (Frankl, 1976). Her defiant spirit to choose life each moment was clearly mirrored in her statement:

P29: Cause I am not dead!. I want to...and I think there's more to life than just

being fine.

Passive and merely receptive living did not give Mrs. Erickson life and, for her, living life meant doing something meaningful and worthwhile for herself as well as for her community. This meant active participation in life and was reflected in her on-going church participation and her willingness to learn new experiences (brail, knitting, baking and others).

Theme 6: Music as an element that gave Mrs. Erickson life

The music that made Mrs. Erickson feel alive was Beethoven's symphony No. 9 and this music made her feel upbeat, happy and lively:

P101: I think of classics in religions. Beethoven's night...just a quiet music... the hymns.

C102: How does it go? Can you sing it?

P103: I can't...One...I am not a singer. Two...I can't remember the words, but I know the feelings that it gives me. OK. What's the title again?

C104: (Pause)

P105: Birds are singing.....(Singing together...). It's all-upbeat!

C106: So... how does it make you feel?

P107: Upbeat.

C108: Anything else?

P109: Happy....

C110: Lively?

P111: yes.

C112: Does it give you life?

P113: Yes.

Music of her choice was vivacious and full of energy. The researcher witnessed during the interview that Mrs. Erickson became alive when she was singing the hymn and her gesture and voice indeed spoke of her love for life. Other qualities of the music that Mrs. Erickson felt drawn to were peace, quietness, happiness and uplifting nature, and those were indeed of positive energy.

Theme 7: Mrs. Erickson's meaning of life: family

For Mrs. Erickson, family plays a huge role in this journey. Especially after the blindness, her listening has become acute. She is fond of talking on the phone with her family. She finds encouragement, motivation and meaning in her family at this time. In her relationship with her family members, mutuality and a dialogue are present. Her daughter as her prime caregiver provides her with all the support she needs at this time:

P31:....The encouragement from my family. I've had to sell my house and so that I can live here with the assistance living. I've had my dogs put down, because there is no place to live here for them. It was all very very emotional. My family is my lifeline.

P37: If I am really down, my daughter will come from work. She works in the hill

and sits with me. Now this has only happened only once.....Otherwise, she talks to me on the phone and calms me down and even gets me laughing.

P117: Again. My family....My family gives me meaning...I know that I am unconditionally loved by them as I unconditionally love them. We have moment that we disagree, but everybody does. It's over and done with. We talk it out and don't bring it up again.

C118: And they listen to you?

P119: I listen to them.

Theme 8: Will to live until death: a continuous journey of spiritual growth with transformation

Mrs. Erickson experienced serenity after her son died. She went through dark nights of her soul years ago when she lost her son in an accident. The journey to the end of life was, for Mrs. Erickson, not taken as a completely separate reality from living, and was a continuous journey of spiritual growth. After the sudden loss of her son, she experienced serenity, which, for Mrs. Erickson, came from God:

P126: Well, just blindness. But I had a spiritual growth before...years ago. Where I had been in the hospital, because my son had been murdered and I ordealed...Not become...Only God, ...I know that....But I just wanted to go to sleep...cried myself to sleep...but when...so... there was one night...If you ever ordered...where in the hospital...you do not ask for sleeping pill...So there was one night...I was looking out in the window...in the morning...It was about one thirty in the morning...I couldn't sleep...And there was bush out there...I have affinity for trees, flowers and bushes.....I looked down...all of a sudden, I had this quietness that only happens once in a long while. And I said You are out there and You do care what happened to me. And I was looking in this bush now...It wasn't a burning bush or anything.....just a beautiful quietness.....

This experience of serenity was, for Mrs. Erickson, a sheer gift from God. With her experience of serenity, she felt comforted by the realization that God cared what happened to her. This experience was very profound and transformed her life. Her depression left her and she was touched by the reality of God's Love. Her transformative experience was holistic:

C129: That experience changed you?

P130: Yes. Very much...I was supposed to be in a hospital in three and four weeks, and I was there another week.

C131: How did it change you?

P132: Well...It made me feel yes, God is there no matter what...And He is the One who gives you unconditional Love.

C135: With this experience, I guess that what I am hearing from you is that you continue to change and grow. Is that what you are saying?

P134: Yes.....yes...

Mrs. Erickson's experience with serenity seemed like an inflow of God into her soul, as John of the Cross portrayed it (May, 2004, 95). With the tragic loss of her son, and her soul's growth towards God, and the challenge of the dark night with her blindness and her small strokes, she seemed to be on a continuous journey to spiritual growth. She accepted all of these challenges with an open heart. Now, being on the journey towards the end of her life, she continued to cultivate the garden of her soul everyday by watering it with new learning (knitting), activities (baking and others), church participation, family life and others. By tending to her soul through trials and errors, Mrs. Erickson seemed to find her dark night as part of her ongoing relationship with the Divine, and this relationship deepened.

Discussion

In her time of difficulties and darkness, Mrs. Erickson seemed to have been sowing seeds and nourishing them in the garden of her soul. Her life itself was indeed a sacred living document resonating with *the Gospel of John*,: "Very truly, I tell you, unless a grain of wheat falls into the earth and dies, it remains just a single grain; but if it dies, it bears much fruit" (John 12,24, NRSV). Her lived experience of the dark nights reflects theological hermeneutics in her openness to the life as a sheer gift of God and her own positive *I-God* meaning-making in her narratives of terminal illness. It seemed as if the Divine was speaking His/Her story in light of her narratives of terminal illness, by teaching me the lessons. In her lived experience, there was an authentic participation in pain, suffering and resurrection and such was the way she wrote her sacred stories as she moved towards the end of her life. For Mrs. Erickson, those steps were steps forward. In this journey she continued to grow.

By embracing new experiences through learning and continuing to work in the church as a greeter at the door, she did not waste her moment, but lived her life fully. In brief, she transformed her hell into a place to live in. She changed the reality of hell into that of living. This transformation had already begun as she experienced God's numinous reality in the loss of her son. Now, the two realities, hell and the place to live in, were not as contrasted as before, and have even become close friends. The nature of her hell was transformed through her deepening relationship with the Divine God, whom she searched for in her dark nights. The researcher could not find a better explanation of her experience at the end of life than the soul's journey in Dante's *Divine Comedy*. This whole process of transformation spoke of her spiritual journey of growth.

In the process of her spiritual nourishment, she did not disregard her emotions and feelings and she did not find them inadequate. On the contrary, she accepted her inner turmoil and dynamics as part of her journey. She still wailed at times, whenever the whole experience upset her. This was the time, according to her, "when Jesus let her cry and be angry." Her despair still, for Mrs. Erickson, cannot be compared to what human Jesus had to go through. In such a way, she owned them and possessed them, and at the same time she did not let those negative feelings enslave her. She has indeed continuously moved towards freedom, the freedom of love.

Mrs. Erickson's lived experience presented itself as both an aging journey and a dying journey. In this movement, she danced in transformation. She was a soul who answered Victor Frankl's question affirmatively, "Can a human person live until death?" The discovery of her lived experience certainly affirmed this, "Yes, indeed!" Even her terminal illness could not stop her from growing into fullness. Dying, therefore, was not a dead end. It led to eternity and her journey was a continuum. She still participates in her church as much as she used to and, further, she gave witness to people in her faith community.

As she was sharing her journey, the researcher instantly began to weave with her a sense of hope. She had already planted seeds of hope in the garden of the researcher's soul. With Mrs. Erickson, the researcher felt a solidarity in finding her own dark nights through the sharing. Mrs. Erickson and the researcher met each other in the dark nights, as the Divine meets us in that reality of Love, the dance of Love. In my dark nights, I would not be as lonely as before and I hope to be as creative as I can, as Mrs. Erickson's defiant spirit took her journey to search for human Jesus in the Holy Water. Mrs. Erickson taught the researcher not to give up even if she had all the reasons for despair; in the deep desolation, Mrs. Erickson taught the researcher to choose life by searching for Jesus who is human, as well as divine.

This study began with the research question, "*How does the end of life journey look like to the older, terminally ill resident?*" Eight themes were found in answering this question. The discovery of Mrs. Erickson's lived journey to the end of life implied that in spite of her illness, she lived her life to fullness everyday. In choosing to live life, she continued to grow spiritually. For Mrs. Erickson, it seemed, as Jean Vanier asserts, life and death were married together. Mrs. Erickson, nevertheless, continued to make efforts to transform the reality of her terminal illness into living, by tending her soul.

The findings strongly indicate that factors such as family support, church participation with the priest's encouragement, staff support, music and faith in God are found to be significant factors in her journey to the end of life. Most of all, her strong will and resilience served as an avenue for her to meet with the Divine, and it truly was a road to her spiritual growth.

Though hard to generalize, given the fact that its size is small, this study, nevertheless, suggests that an individual's choice to weave hope in the time of life-threatening challenges (illness) and to make a choice to spiritually grow, make the end of life journey more livable and an individual's spirituality continues to grow through transformation and loving relationships when the human and the Divine meet each other. She also left the researcher with a life-giving ripple effect by teaching the lesson to open up to the future's possibilities no matter what, and to accept the reality of terminal illness not as the opposite of life, but as a continuum of life and a gift to fully grow to God's Love.

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