Hear to Care:

The role of caregivers in the spiritual care of residents in New Zealand Rest Homes

by

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A thesis

submitted to the Victoria University of Wellington

in fulfillment of the requirements for the degree of

Master of Arts in Religious Studies

Victoria University of Wellington

Te Whare Wananga o te Upoko o te Ika a Maui

2014

Abstract

This thesis argues that caregivers are exposed to the spiritual needs of rest home residents much more than might have previously been recognised, and that they are a more important part of the matrix of spiritual care than has been understood or acknowledged. By employing a qualitative research methodology, staff, residents and management at two rest homes in the greater Wellington region were interviewed to address the question: *to what extent and in what ways is spiritual care a part of the caregiver role in New Zealand rest homes?* The research explores current understandings and perceptions of the caregivers' role in attending to the spiritual needs of the residents by addressing a key set of related questions that arise from consideration of the rest home milieu. The research indicates that the move into a rest home is a turning point in the life of the residents. The changes involved in this transition may lead to a spiritual search for meaning, and to questioning that arises from a sense of being in transition from life to death. In the course of daily work, caregivers, as members of the team that provides holistic care, therefore relate to residents who are experiencing various spiritual challenges associated with rest home life and the vulnerability of ageing. Caregivers' confidence to respond to residents' spiritual needs was explored. The thesis suggests that there would be value in extending caregiver training to strengthen their capacity to recognise and respond to spiritual issues when they occur in the course of their work. Such training is seen as important if provision of care in rest homes for the aged population in New Zealand is to be truly holistic.

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Acknowledgements

The preparation and writing of this thesis has been a challenge. It would not have reached completion without the invaluable support and help of the many people who have taken time to explore and help me develop the thoughts now presented in this paper.

This academic path has been walked with the caring support of my husband, Ross, and my family, who, although finding it difficult to understand why I chose to accept the discipline of research and study in my retirement years, have nevertheless always been there to encourage me on. I thank them for all they have sacrificed to enable me to realise a lifelong ambition.

My thanks go to my supervisor, Geoff Troughton, who gave his time and wisdom to focusing my thinking and writing as he patiently endeavoured to keep me on a scholastic path. Thanks also to Paul Morris for past and present guidance. Paul's teaching in undergraduate years inspired me to continue this course of research.

Thank you to two others who have read, corrected and commented on my work as it developed – my son Richard Hardie and my friend and mentor, Neil Bechervaise. They rescued me in times of despair, encouraging me to be a life-long learner, and I am truly grateful. Thanks also to Alikali Kallibetsos upon whose knowledge of the workings of the Religious Studies Department and Victoria University of Wellington I have regularly drawn. Thank you for subsequently guiding me through the maze of academic administration with grace and cheerfulness.

My thanks also go to Dr Chris Perkins and the Selwyn Foundation for the Scholarship funding which helped make this research possible, and to the Professional Development Committee of the Anglican Diocese of Wellington for its financial assistance. My hope is that this thesis will encourage others to be aware of the significant role of caregivers in recognising the spiritual needs of the frail elderly in New Zealand Rest Homes.

I express my appreciation to the management, residents and staff of the two rest homes in which this research was carried out. You remain anonymous but thank you for your support

and guidance as I worked amongst you. Your cooperation was essential to my research and I was grateful for the help I received.

To all caregivers, residents and chaplains who have talked to me about their experiences in the rest home sector I give my thanks for their willing contribution to my understanding of their work and needs. Spending time with those whose lives are nearing the end is an extraordinary privilege.

Chapter 1: Introduction

“And then we talked about the fact that he was having to sleep downstairs; and then it was that actually he wasn’t sleeping, ‘cos he was laying in bed thinking about things. And when I said, ‘And how do you feel about the things that you’re thinking about?’ And there was a huge pause ... and suddenly it all just came out, all of the fears, all the anxieties. He began with, ‘Well I’m here, and I’m gonna be here; and being here is okay, but it’s getting from here to here that’s the frightening thing.’ And he poured all his fears out.”¹

Lying in bed thinking, unable to express the fears and anxieties that bubble inside because there appears to be no one who would understand — many of the rest home residents with whom I have spoken echo the emotion, or share the experience of sleepless nights, that Steve Nolan’s example describes.

As the realisation that life is nearing its end, that death is a reality that cannot be avoided and that control of future events is no longer possible, all the certainties of a life-time can dissolve. It is then that people often need someone who will listen to the expression of apprehensions that are beyond words, apprehensions of a spiritual nature that embody a search for meaning in the life that has been lived. The possibilities of what might (or might not) happen after death seem inexpressible except to a trusted confidant.

Over many years of pastoral visiting in rest homes I became aware of the unspoken need of some residents who, nearing the end of life, wished to receive reassurance in regard to the effect past actions might have on whatever, for them, lay beyond the end of life in this world. Such need might only be perceived by unspoken signs that occurred within conversation—a long pause triggered by a passing comment, the dropping of eye contact, tears welling for no particular reason. Noticing these signs I always tried to respond with a comment which might give the resident an opening to say more. In some instances, it took time to build trust and further visits before the resident found the courage to develop a

¹ Steve Nolan, *Spiritual Care at the End of Life* (London and Philadelphia: Jessica Kingsley Publishers, 2012), 106.

conversation focussed on the misgivings or doubts that were at the heart of a disturbed peace of mind. The conversations centred on the spiritual needs of the individual in most cases. My experience with Mrs G is one such example. It was the catalyst for this research into meeting the spiritual needs of the elderly.

I had known Mrs. G all my life but had never ministered to her in the pastoral sense. I received an urgent message to call on her while she was dying of cancer. Having previously visited her as a friend, I wondered at this particular call—it felt different. On arriving in her room I was puzzled by her hesitancy and the body language that indicated nervousness and uncertainty at our meeting.

The conversation began in a general way then broke off suddenly and the reason for her call to me was revealed. Briefly, Mrs. G, a Catholic had married a Protestant and in the teaching of the time had known herself to have committed a grievous, a ‘mortal’, sin. She understood this had put her forever outside the community of her denomination, particularly as her children were brought up as Protestants. Now, in the later years of a long life, the Church’s teaching of her youth had come back to haunt her. What would be her fate after death? Was it too late to be reconciled with her church? The answer was simple—a sympathetic priest of recent years was able to counsel her with assurances of the more compassionate approach that could now be found in the Roman Catholic Church. In ensuing weeks the reconciliation became complete. Mrs. G’s trepidation at her approaching death eased. The spiritual dilemma that arose from her former religious convictions and which had brought anxiety and unhappiness was resolved, apparently quite simply, as a result of having someone whom she trusted to help her articulate her very powerful spiritual need.

Yet, from observations made over the years, I have found the visiting chaplain or trained pastoral visitor was not always the person to whom the resident felt confident to speak. Visits had sometimes been seen as perfunctory and the formation of a trusting relationship remained unrealised. For residents who experienced existential spiritual concerns, yet without a religious background through whose remembered language and ritual these concerns might be expressed, a real dilemma arose. To whom might they speak? Who would listen and not make judgment on their lives? In rest homes in which I have worked

the person to whom the resident was most likely to turn was the caregiver, a person met almost daily, someone who in spite of a heavy workload, had built a caring relationship with the ageing resident. It may have been a nurse from the medical team; it may have been a therapist whose regular attentions built an atmosphere of trust and concern; it may have been the ward maid or the cleaner who had taken a caring interest in the resident. The resident sought a familiar, trusted and sympathetic listening ear. However, at times a response was demanded which, while acknowledging the resident's present dilemma, would offer a way forward that would enable deeper understanding of the spiritual issues being encountered. From all such situations, questions arise about the role of caregivers in recognising and attending to the spiritual needs of ageing persons in their care.

Thesis Focus: Rest Home Residents, Caregivers and Spiritual Needs

This thesis addresses the question: To what extent and in what ways is spiritual care part of the caregiver role in New Zealand rest homes? In developing a response, it examines the role of the caregiver in addressing the spiritual needs of rest home residents through a case study of two rest homes in the Wellington region. The research explores understandings and perceptions of the caregivers' role in attending to the spiritual needs of the residents, as analysed through the eyes of different actors in the rest home world. Hence, the research addresses a key set of related questions that arise from consideration of the rest home milieu: What place do caregivers have in rest homes' overall vision for the care of residents' spiritual needs? How aware are caregivers of the spiritual needs of rest home residents? Are they trained and prepared to respond to residents' spiritual dilemmas? Upon what resources might they draw? In order to address such questions, the thesis examines the rest home context, exploring perceptions of spiritual need and provision of spiritual care through the eyes of residents and caregivers, and in formal institutional policy. This thesis argues that caregivers are a more important part of the matrix of spiritual care in rest homes than has been previously understood or acknowledged.

Rest home care has grown substantially in the post-World War II years. In recent decades there has been a significant transition from care offered in small, privately owned nursing

homes or rest homes established by charitable or religious groups to rest homes established as commercial enterprises. Longer life expectancy has led to a greater number of people having limited physical ability and becoming confined to their family home, retirement/rest homes or villages, or secure residential nursing homes. In these situations many have more time to think about the spiritual values they may or may not have embraced in their lives, especially as life nears its end. It follows that if mental or spiritual doubts, fears or unanswered questions arise, an inner tension is created in the ageing individual and their holistic wellbeing is threatened.

This dynamic is noted in Elizabeth MacKinlay's research into frailty and ageing, which acknowledges that "increasing frailty may act ... as an impetus to further spiritual development and transcendence."² She reasons that such changes take place in part because, as their frailty increases, ageing people move from "doing to being". MacKinlay emphasises that caregivers need to recognise these processes, otherwise spiritual needs may be confused with mental stress.³ MacKinlay's observation echoes research by John Swinton and Australian dementia services director Richard Fleming, which suggests that the role of the caregiver for the aged has shifted, in the medical field, from a focus on medical intervention towards mental health care. This change has been accompanied by a concomitant increase in recognition of the centrality of spiritual support.⁴

Two important premises underpin the analysis in this thesis, and will be developed in much of what follows. The first premise is that entry into the rest home context involves particular changes and dislocations that often generate what are essentially spiritual challenges and questions for ageing persons. The second premise is that while spiritual care is generally recognized as a significant dimension of care for holistic wellbeing, caregivers' roles in relation to spiritual care is not well understood. The literature review that follows highlights

² Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life* (London and Philadelphia: Jessica Kingsley Publishers, 2006), 154.

³ Ibid.

⁴ John Swinton, *Spirituality and Mental Health Care* (London UK: Jessica Kingsley Publishers, 2001), 7-10. Richard Fleming and Diana Fitzgerald, "Large-scale Training in the Essentials of Dementia Care in Australia: Dementia Care Skills for Aged Care Workers Project," *International Psychogeriatrics* 21, 1 (2009): 554.

the limited scope and extent of academic research on rest home caregivers and spirituality. The thesis will also demonstrate, however, that there is growing awareness within the aged care sector, including among industry training organisations, of the spiritual challenges that “the ageing” face. Significantly, an increasing array of resources is becoming available for various groups, in helping to address such spiritual needs. Pastoral caregivers and chaplains from the background of Christian spirituality and other faiths are supported by literature written to sustain or develop their understanding of the aged and their spiritual needs. The British National Health Service publishes a comprehensive list of such literature.⁵ Various resources are also available to help family members understand the spiritual needs of the ageing for whom they care.⁶ Significantly, there is less literature for rest home caregivers, who currently occupy an ambiguous space in the overall provision of spiritual care as a dimension of care for holistic wellbeing.

Examination of the caregiver role is timely for a number of reasons. Socially and politically, there is widespread interest, and concern, about attitudes toward older people and the care offered for them in institutions. For example, in late 2013 journalists from *New Zealand Herald* conducted an extensive two-month exposé-type investigation, published as a series of articles entitled “Inside Our Rest Homes”.⁷ Caregivers’ particular roles have attracted considerable attention. In 2012, the Human Rights Commission produced a substantive report, which examined the extended role of caregivers in rest homes together with reference to the increased demands placed on them.⁸ In the rest home context, the support required from caregivers for residents is commonly being seen as multidimensional. They are increasingly expected to respond not only to the physical or medical needs of the

⁵ Hospital/Health Care Chaplaincy: <http://www.nhs-chaplaincy-spiritualcare.org.uk/recommendbookcareofageing.html> (accessed July 10, 2013).

⁶ Eileen Shamy, *A Guide to the Spiritual Dimension of Care for People with Alzheimer’s Disease and Related Dementias: More than Body, Brain, and Breath* (London: Jessica Kingsley Publishers, 2003); Graham Stokes, *And Still the Music Plays: Stories of People with Dementia* (London: Hawker Publications, 2008); Anne Millar, *Growing in Age: Aging in Today’s Society* (Wellington, New Zealand: Philip Garside Publishing Ltd., 2001).

⁷ Martin Johnston and Simon Collins, “Inside our Rest Homes,” *New Zealand Herald*. http://www.nzherald.co.nz/inside-our-rest-homes/news/headlines.cfm?c_id=1503568 (accessed November 28, 2013).

⁸ New Zealand Human Rights Commission, *Caring Counts, Tautiaki tika* (Wellington, New Zealand, 2012).

incapacitated, ageing population, but also to individual emotional and spiritual needs. In spite of these trends, there has been little examination of the roles that rest home caregivers play in addressing residents' spiritual needs, or perceptions of their role insofar as it impacts on spiritual care. It is to expand understanding of the caregivers' role in these aspects of care that the research in this thesis is directed.

Research into Spirituality and Ageing

Research into issues of spirituality and ageing has increased over the past decade in Australia, Great Britain and North America. While New Zealand research in this area remains limited, local research on aged care and palliative care has nevertheless provided helpful insights into the significance of spirituality as individuals approach the end of life.⁹ Understanding the needs of the aged has progressed in New Zealand from reporting a need for specialised care towards more specific identification of and response to the complex and real spiritual needs of the aged. Charles Waldegrave's recent research, for example, includes reference to the importance to their general wellbeing of ongoing involvement by older people in faith and religious activities.¹⁰

International research, such as that by Carson and Koenig, O'Brien, and Moberg, in North America, and MacKinlay in Australia, has demonstrated that concern for the holistic wellbeing of ageing populations is increasingly apparent in governmental, social, religious and commercial agencies.¹¹ In the medical field, there is a vast and growing literature on the

⁹ Penny Eames, "Spiritual Wellbeing for Older New Zealanders," *Perspectives in Public Health*, 132: 2 (2010): 62-63. Also in notes from seminar by Bruce Rumbold, "Collaborative Spiritual Care: Problems, Possibilities, Programs," Master Class presentation at the Hospice New Zealand 20th Palliative Care Conference, Auckland, (November 13, 2012).

¹⁰ Charles Waldegrave, "Culture and Religion," in *Enhancing Wellbeing in an Ageing Society: 65-84 year old New Zealanders in 2007*, eds. Peggy Koopman-Boyden and Charles Waldegrave (Hamilton: The Population Studies Centre, University of Waikato/ Lower Hutt: The Family Centre Social Policy Research Unit, 2009), 191-206.

¹¹ Verna Benner Carson and Harold G. Koenig, eds, *Spiritual Dimensions of Nursing Practice* (West Conshohocken, Pennsylvania: Templeton Foundation Press, 2008); Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground* (Sudbury, Mass.: Jones & Bartlett, 2008); David O. Moberg, ed. *Ageing and Spirituality: Spiritual Dimensions of Aging Theory, Research, Practice and Policy* (New York: The Haworth

role of religion and spirituality in the provision of health services, including services for the aged. For example, O'Brien and Moberg have explored the relationship between patient spirituality and nursing practice, while others such as MacKinlay, and Schipani and Bueckert, have added dimensions of pastoral care, with particular reference to the task of chaplains and religious workers.¹² Research by Pruchno and Smyer provides an example of research addressing the ethical and social challenges to those responding to the spiritual needs of the aged.¹³

Regardless of the growing international literature on ageing and spirituality, and the role of spirituality in holistic care, the role of the caregiver in the New Zealand rest home context remains relatively uninvestigated. In New Zealand, Richard Egan's research based on Hospice care is indicative of the increased attention currently being given to training to enhance the awareness of medical professionals to the spiritual needs of their patients, especially those concerned with palliative care.¹⁴ Judith Ann Brown's thesis, which examined how four rest home residents viewed spirituality and spiritual care at the end of life, recommended improving the spiritual dimension of care. She particularly noted that further research "should be carried out in different residential care settings, especially in the "for profit" sector." She suggested that "research should also be undertaken to gauge the awareness care staff have of residents' wishes for spiritual care in the perideath period."¹⁵ Nevertheless, New Zealand research into the spiritual needs of the ageing rest home population remains limited.

While international research demonstrates an increasing concern with aged care, Gillian Reid makes the further point that, from 1975 to 2005 at least, little research on ageing and

Pastoral Press, 2001); Elizabeth MacKinlay, *The Spiritual Dimension of Ageing* (London and New York: Jessica Kingsley Publishers, 2001).

¹² Elizabeth MacKinlay, ed. *Spirituality of Later Life: On Humour and Despair* (Binghamton, New York: Haworth Press Inc., 2001); Daniel S. Schipani and Leah Dawn Bueckert, eds. *Interfaith Spiritual Care: Understandings and Practices* (Kitchener, Ontario: Pandora Press, 2009).

¹³ Rachel A. Pruchno and Michael A. Smyer, *Challenges of an Aging Society: Ethical Dilemmas, Political Issues* (Baltimore: The John Hopkins University Press, 2007).

¹⁴ Richard Egan, "Spirituality in New Zealand Hospice Care." PhD Thesis, University of Otago (2009).

¹⁵ Judith Anne Brown, "'Let My Spirit Always Sing': A Descriptive Study of How Four Ageing Rest Home Residents View Spirituality and Spiritual Care at the End of Life," MA thesis, Victoria University of Wellington, (2004), ii.

spirituality addressed cultural issues, for example, in relation to differences between Maori, Pasifika and Pakeha cultures within Aotearoa/New Zealand. This becomes significant when Waldegrave's research is taken into account. He quotes population statistics from 2007, which indicate that Pakeha/Europeans are 87.6%, Maori 4.4%, Pacific 2.0%, Asian 3.2% and Others 0.2% of the 65+ cohort.¹⁶ He draws attention to the fact that ethnic diversity in this older age group is increasing as the Asian and Pasifika population itself ages, indicating a likely increase in residents from these cultures, a factor which supports Reid's concerns.¹⁷

Reid's observation that the nationalities and cultures of caregivers are often different from those receiving care, and that this can create special challenges, is particularly pertinent for this thesis.¹⁸ In my observation, there are often cultural disparities between the predominantly ethnic European rest home residents and migrant caregivers. Reid's observation further highlights the opportunities that exist for future research into issues of spirituality confronting the ageing population and caregiver groups. Her conclusions parallel Brown's recommendations. Egan has attended to Reid's concern that spirituality in New Zealand hospice care should be addressed.¹⁹ In so doing his research has also provided some focus and background to Maori cultural attitudes towards spirituality and dying.²⁰

Beyond these academic fields, reports commissioned by New Zealand government agencies into the health and wellbeing of the ageing over the past 15 years have not generally addressed the spiritual care of the aged. Instead, they have tended to focus on demographic issues, predicting increases in the 'ageing' population and consequent challenges and costs to governments and the community.²¹ Government and social service agencies are concerned with providing the support necessary to enable the aged population to live

¹⁶ Waldegrave, "Culture and Religion," in *Enhancing Wellbeing in an Ageing Society: 65-84 year old New Zealanders in 2007*, 191.

¹⁷ Ibid.

¹⁸ Gillian Reid, *The State of Current Research into Ageing and Spirituality*, http://www.selwyncare.org.nz/Resources/library/Research_on_Ageing_and_Spirituality.pdf (accessed July 10, 2011), 5.

¹⁹ Egan, "Spirituality in New Zealand Hospice Care."

²⁰ Ibid, 241.

²¹ Ruth Dyson, *Health of Older People Strategy: Health Sector Action to 2010 to Support Positive Ageing. Draft for consultation*, (September 2001), 3.

independently. The increased number of commercially run rest homes and secure retirement villages reflects the demands of an ageing population requiring care facilities.

National and international literature consistently indicates that longevity as the result of advanced medical practices has led to an increase in institutional nursing home facilities in order to relieve demand on public hospital care. In 2001, New Zealand MP, the Honourable Ruth Dyson tabled a draft report for consultation addressing a wide range of health, social and cultural issues concerning the aged.²² It included considerations of care strategies, yet still did not include reference to religious or spiritual issues. More recent research edited by Koopman-Boyden and Waldegrave addresses this omission and is indicative of a growing recognition of the significance of spiritual issues in the ageing process.²³

Definitional Issues

A number of significant definitional issues arise in connection with my topic. The following expanded definitions clarify my approach to these issues as they are discussed in the course of this thesis.

Ageing

The following definitional discussion of 'ageing' addresses three aspects, all of which have some relevance for the way the term is used in the context of this thesis: that there is considerable debate about what ageing means; that the 'ageing' of rest home residents is marked by certain characteristics; to clarify the 'ageing' life stage of my respondents.

Adults become rest home residents because physical or mental health deterioration has been detrimental to their ability to care for themselves in their homes, even with the support of family or community care organisations. Because of this, the age of adults in care varies considerably and is not dependent on chronological age. Nevertheless, many

²² Ibid.

²³ Peggy Koopman-Boyden and Charles Waldegrave, eds. *Enhancing Wellbeing in an Ageing Society: 65-84 year old New Zealanders in 2007* (Hamilton: The Population Studies Centre, University of Waikato/ Lower Hutt: The Family Centre Social Policy Research Unit, 2009).

researchers have defined 'ageing' as a chronological marker. Davey, for example, assumes 65+ years as the beginning of 'old age'.²⁴ Koopman-Boyden and Waldegrave, in their demographic study of the ageing population in New Zealand, accept "old age" as 65+ years on the basis of legal eligibility for New Zealand Superannuation.²⁵

As MacKinlay points out, however, chronological age has substantial limitations as a predictor of wellbeing in ageing: some people are 'old' while still in their fifties, others are still 'young' in their eighties.²⁶ Schaie and Willis endorse this perception, stressing distinctions between normal (the ageing to be expected according to the chronological age of a person), pathological (showing earlier signs of ageing caused by an atypical development or disease), and optimal ageing (occurring at a later chronological stage because of the physical and mental wellbeing of a person).²⁷ Consequently, 'old age' is argued to be an inadequate generic term because it does not apply to all people over 65 years of age, and it belies the considerable life stage differences that occur in the ensuing 30 years.²⁸

Cognisant of the work of Suzman and Riley who suggest these years be further divided into three stages, MacKinlay wrote "if the third age is defined as being older and still remaining independent (without specifying a chronological range), then the fourth age [includes] frailty, dependency and being in need of care."²⁹ Residents interviewed for this study are identified as being in the fourth age. Although chronological age offered a recognisable basis for data analysis, loss of physical independence was the defining consideration when ageing was discussed in the research for my thesis. The subjects selected for this study maintain their mental independence.

²⁴ Judith A. Davey, "Positive Ageing? A critical Analysis of New Zealand Policies," presented to the 14th Biennial Meeting of the Association of Gerontology of India, (December 16-18, 2008).
<http://www.victoria.ac.nz/nzira/publications/IAGfullpaperDavey.doc> (accessed July 4, 2011).

²⁵ Peggy Koopman-Boyden and Charles Waldegrave, "Introduction," in *Enhancing Wellbeing in an Ageing Society: 65-84 year old New Zealanders in 2007*, 1.

²⁶ MacKinlay, *The Spiritual Dimension of Ageing*, 13.

²⁷ Warner K. Schaie and Sherry L. Willis, *Adult Development and Aging* (Upper Saddle River, New Jersey: Prentice Hall, 2002), 78.

²⁸ Ibid, 79, quoting R. Suzman and M.W. Riley, "Introducing the 'Oldest Old'," *Milbank Memorial Fund Quarterly: Health and Society*, 63 (1985): 177-185.

²⁹ MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 11.

Religion and Spirituality

Kimble, McFadden, Ellor and Seeber suggest, plausibly, that difficulty in differentiating 'spirituality' and 'religion' has led to the neglect of their role in the lives of the ageing.³⁰ 'Religion' and 'spirituality' involve aspects of life concerned with ultimate reality, with an unseen force or order governing human life, and/or possible life after death. Writers, researchers and informants in this study, use the terms in divergent ways, although some generic distinctions are often made. For example, Field comments on definitional inconsistencies and suggests that "spirituality is generally more broadly defined, often conceived as more personal, individual and subjective than religiosity."³¹ Krause observes that "many people speak of religion and spirituality in the same breath ... the major difference is that religion often takes place within formal institutions while spirituality is not necessarily grounded in the context of a formal organisation."³² Because these terms are used in distinct but overlapping ways, this thesis addresses both dimensions. Nevertheless, some elaboration of these key terms, and the ways they have been employed, is useful.

Religion

Moberg's detailed definition of 'religion' includes reference to belief in a supernatural force or power which is accompanied by efforts to get into and remain in a favourable relationship with it, belief in a set of values thought to transcend immediate social circumstances, systems of beliefs and values that explain the mysterious or unknown (including the social organisations into which these beliefs and values have been

³⁰ Melvin A. Kimble, Susan H. McFadden, James W. Ellor, and James J. Seeber, eds. *Aging, Spirituality, and Religion: A Handbook, Volume 1*. (Minneapolis: Fortress Press, 1995), 7.

³¹ Lucy Field, "Religiosity and Spirituality at the End of Life: Challenges and Opportunities," in *Challenges of an Aging Society: Ethical Dilemmas, Political Issues*, eds. Rachel A. Pruchno and Michael A. Smyer (Baltimore: The John Hopkins University Press, 2007), 76.

³² Neal Krause, "An Introduction to Research on Religion, Aging and Health: Exploring New Prospects and Key Challenges," in *Religious Influences on Health and Well-Being in the Ageing*, eds. K. Warner Schaie, Neal Krause and Alan Booth (New York, NY: Springer Publishing Company Inc., 2004), 15.

incorporated), and the “sacralisation of identity ... through mechanisms of objectification, commitment, ritual and myth.”³³

In contrast, Geertz, a cultural anthropologist, observes that religious systems inevitably comprise a cluster of sacred symbols woven into some sort of ordered whole.³⁴ Religious symbols can be an outward expression of belief in the efficacy of a god to create change or bring comfort, and as such, may bring reassurance to the ageing when physical and mental capacities degenerate.³⁵ In the most substantial Australasian examination of issues concerning spirituality and ageing, MacKinlay adopts a definition from Koenig, McCullough and Larson, stating that “religion is an organised system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and to foster an understanding of one’s relationship to others living together in a community.”³⁶ MacKinlay’s definition is the reference point applied in this study.

Spirituality

Koenig, McCullough and Larson provide a definition of spirituality as: “The personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.”³⁷ MacKinlay also accepts this definition, and utilizes it as the foundation for her hypothesis in her study of spiritual growth and care in the ageing.³⁸ Moberg, similarly, suggests that people’s visible religion (as reflected in religious practices or attendance at religious services) is not the same as their

³³ David Moberg, “The Reality and Centrality of Spirituality,” in *Aging and Spirituality: Spiritual Dimensions of Aging Theory, Research, Practice and Policy*, ed. David Moberg (New York: The Haworth Pastoral Press, 2001), 8.

³⁴ Clifford Geertz, *The Interpretation of Cultures: Selected Essays* (London: Fontana Press, 1993), 129.

³⁵ MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 131-138.

³⁶ *Ibid*, 13.

³⁷ Harold G. Koenig, Michael E. McCullough, David B. Larson, *Handbook of Religion and Health* (Oxford: Oxford University Press, 2001), 18.

³⁸ MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 13.

individual spirituality.³⁹ Reaching the conclusion that every person is/possesses a living soul or spirit and thus has spirituality, he suggests that “spirituality therefore, is usually regarded as a subjective personal phenomenon that is identified with such things as faith commitments, behaviour consistent with beliefs, personal transcendence, supraconscious sensitivity, and meaningfulness.”⁴⁰

A clear distinction between religion and spirituality is not always posited in the literature as each, to a great or lesser extent, may embody elements of the other. The significance of each in the life of the ageing will depend on the individual life experiences of those to whom care is offered. In assessing the role of caregivers in attending to spiritual needs, dimensions of religion and spirituality are both therefore relevant. Understanding the ways in which thoughts of religion and spirituality converge or diverge as ageing brings changes in the lives of those cared for is particularly relevant to my study for I argue that caregivers, exposed to the spiritual needs of rest home residents, need to recognise that it is not always a religious response that is required.

Caregivers may respond to questions of faith or doubt pertaining to the teachings of a particular religion by gaining the resident’s permission to refer the question to the chaplain or representative of that religion. Spirituality is not easily defined or bound by tenets of a faith. Spirituality need not be linked to a defined godhead. The individual spiritual search may lead the resident through questions of existence, of the meaning of life, or of a personal essence of being as it has evolved in their past life. Crucially, entering the rest home brings the resident into a culture which can differ greatly from that which has formerly been the background to their life and may be the stimulus behind this search. The resident is dislocated from the reference points against which, up to this time, the meaning of life has been measured. In the new environment the caregiver may find the resident asking for help in making sense of the life that has been theirs. When spirituality is

³⁹ David O. Moberg, “The Reality and Centrality of Spirituality,” in *Aging and Spirituality: Spiritual Dimensions of Aging Theory, Research, Practice and Policy*, ed. David O. Moberg (New York, London, Oxford: The Haworth Pastoral Press Inc.), 3.

⁴⁰ Ibid, 18.

considered in this way the caregiver may find it difficult to support the resident when questions of spirituality arise.

The Rest Home Caregiver and Caregiver Roles

The physical process of ageing increasingly limits the ability of people to live independently of care or support. Ageing may result in reduced communication skills, loss of mental capacity, hearing, speech, sight or reduced mobility, producing isolation and loneliness even amongst those living in places of institutional care. For some people, these can be trigger factors which open them to a deeper awareness of a spiritual need as they search for meaning in life. It is at this stage of life that people find the need for residential care and enter into the rest home culture in which this care is offered. Richards defines caregivers within institutions as “those who provide material, financial, emotional, and spiritual assistance to elders.”⁴¹ This definition is very broad. It incorporates a range of people and categories of care, including professional and medical caregivers—such as nurses, doctors, chaplains and ancillary staff of rest homes and hospitals for the aged. It may even include family. Caregivers in rest homes form an essential part of this wider network of care.

The work of caregivers is intimate in nature, focussed on assisting the ageing residents to cope with daily personal hygiene, with dressing, with keeping their rooms orderly, with attending to small, personal problems that arise in the course of daily living. Caregivers may be asked to ensure residents attend meal times or group activities and to advise senior staff of any change in the residents’ well-being. They are the people with whom residents interact on a daily basis and, consequently, upon whom they may come to rely.

Arising from such daily intimacy, residents may develop trust in their caregivers and ask them for time to talk, for time to share matters of a personal nature arising from residency in the institution. It is in this context that personal, spiritual concerns may be expressed to the caregiver. ‘Caregivers’ may be recognised in terms of the HRC’s report as members of

⁴¹ Marty Richards, “Caring for the Caregiver,” in *Aging, Spirituality and Religion: A Handbook*, Volume 2, eds. Melvin A. Kimble and Susan H. McFadden (Minneapolis: Fortress Press, 2003), 180.

the paid workforce who provide care for older people in residential care facilities.⁴² Yet, as will be further noted in this thesis, their caring encompasses all or many of the facets mentioned. They are not only part of a wider network of physical and social care but of holistic care (which includes spiritual understanding) in ways that are not always well recognised and understood.

The particular spiritual needs created by the dislocations of rest home life and the holistic character of rest home caregiving provide the critical context for this exploration of the caregiver role in relation to spiritual care in New Zealand rest homes.

Methodology

My research into the role of the caregiver in the spiritual care of rest home residents examined the way in which the caregiver role is understood by the caring institutions, by the residents, and by the caregivers themselves. These three agents provided channels through which an analysis of the role of the caregiver within the world of the rest home was made. They enabled clarification of the nature and extent to which spiritual care is recognized as a part of the caregiving role. Analysis of the institutions proceeded through a study of policy and promotional documents, along with fieldwork observations and interviews with rest home management and administration. Analysis of the residents and caregivers' perceptions was based on content analysis of semi-structured interviews with caregivers and residents conducted in two rest homes in the wider Wellington region.

Research was limited to selected staff and residents at two specific rest homes, which are referred to in the thesis as Rest Home A and Rest Home B. The homes were selected to reflect two distinct trajectories in rest home care in New Zealand. Rest Home A was selected to represent rest homes established by religious organisations. Its controlling management is provided through appointees of its Board of Trustees. The Board itself was appointed by two Christian religious denominations to reflect the faith-based ethos of the facility. Rest Home B was representative of commercial enterprises. It is part of one of twenty-five

⁴² The New Zealand Human Rights Commission, *Caring Counts, Tautiaki tika* (Wellington, New Zealand, 2012), 13.

similar retirement villages situated throughout New Zealand, established by a listed company. The retirement village in which the rest home is situated is administered by a senior management team responsible to its Board of Directors.

Recruitment of Participants

Interviewees were drawn from three groups:

- From *institutional authorities* of each rest home in order to assess the recognition of spiritual needs of residents as expressed in policy statements and in authorised practice;
- Five *caregivers* chosen by the institutional authorities from each of the two rest homes;
- Five *residents* from each of the two selected rest homes, men and women who retained the ability to talk with me about their perceived spiritual needs.

Initial interviews with rest home management sought to clarify the philosophy and policy of each institution in regard to the spiritual wellbeing of its clients. These interviews established the institutions' acceptance or otherwise of accredited chaplains or authorised representatives of particular religions. Management assisted in the recruitment of interviewees; managers helped to identify caregivers and residents who were willing to be interviewed, and who represented a reasonable cross-section of their constituency. Interviews were limited to those still able to communicate rationally which meant no understanding of the needs of the mentally frail elderly could be considered. All volunteers were fully informed of the boundaries within which I intended to work, and consented to their participation (see Appendix A).

In keeping with the conditions of consent, pseudonyms have been employed in the following discussion to ensure confidentiality. The questions put to informants were guided by my basic focus question, as well as three hypotheses that underlay my investigation. These hypotheses were:

- That rest home residents need to express their spiritual questions to caregivers with adequate training to enable them to respond;
- That caregivers are not always aware of the spiritual needs of ageing persons amongst whom they work;
- That caregivers require guidance, training or support in order to respond to the identified spiritual needs of residents.

The full list of the questions used (see Appendix B) was modified as interviews progressed, as will be noted in following chapters.

Thesis Overview

The following chapters focus on the role of the caregiver in the spiritual care of rest home residents, as that role is understood in relation to the three key actors in the rest home world. It examines perceptions of spiritual needs and provision of spiritual care at an institutional level, and through the eyes of residents and caregivers respectively.

Chapter 2, “The Institutions”, examines the provision of spiritual care in the two rest home institutions at the centre of this study. The chapter begins by examining the history and growth of rest home care in New Zealand, before considering the character of the two institutions and their approaches to the spiritual care of residents. It highlights differences between the two institutions in terms of policy and ethos. The chapter argues that the policies established by management at each rest home are based on the broader philosophies undergirding each establishment—philosophies which reflect the ethos of their controlling Boards of Trustees or Directors.

Chapter 3, “Rest Home Residents and Spiritual Care”, focuses on residents’ perception of their spiritual needs, with particular regard to the way in which those spiritual needs are met. It examines literature pertaining to the spiritual dimension of ageing, comparing it to data obtained from interviews with selected rest home residents. The chapter explores residents’ stories, highlighting both the nature of rest home life and the issues it raises for residents, and the residents’ views of spirituality and spiritual need. Crucially, it also

explores their view of the role of the caregiver, particularly with respect to spiritual care. The chapter finds that residents do not always have a well-established vocabulary for talking about spiritual needs. Nevertheless, their stories cohere with what much of the current literature describes about the spiritual needs of ageing persons. While they do not consciously identify caregivers as providers of spiritual care, some residents do warm to caregivers, and appreciate talking and confiding in them.

Chapter 4, “The Caregivers,” examines the vital role of caregivers in maintaining optimal conditions and sustaining vulnerable, ageing residents in the last years of their lives. It notes that the caregiver role is never purely physical. By paying attention to their observed role, and to caregivers’ comments, this chapter examines the connection between rest home caregivers and the spiritual care of residents. It highlights that caregivers are conscious that religion and spirituality are important to residents, and do now receive some training in recognizing spirituality as a dimension of care. In practical terms, caregivers’ understanding of spiritual care is most often framed in relation to matters of culture and ‘religion’.

Overall, this thesis argues that caregivers should be regarded as part of a network of spiritual care. Though spiritual care is not a primary role, and it is not always identified as a significant dimension of caregiver responsibility, it nevertheless forms a part of the holistic care that caregivers provide. Caregivers are exposed to the spiritual needs of rest home residents much more than might have been previously understood.

Chapter 2: The Institutions

In order to understand the caregivers' role in relation to the spiritual needs of rest home residents, it is important to establish the milieu in which they work—the nature of the institutions themselves and their place in the lives of the elderly in New Zealanders today. Workplace policies and culture shape workplace conditions. In the case of caregivers, these are also factors that shape caregivers' awareness of, and response to, spiritual needs.

Caregivers work within institutions that govern their working methods and style of approach to the residents for whom they care. The broader context in which institutions operate is also significant. The historical background to institutional care for the needy elderly highlights a developing partnership between the State and a variety of corporate, benevolent and religious organisations. All of these institutions must work in conjunction with the State's legislated policies in order to qualify for Government subsidies for residents in need of ongoing, live-in care. Consequently, each institution must develop its policies to meet legislated requirements. Government rest home subsidies become available when support, as outlined in the New Zealand Positive Ageing Strategy (2001), is no longer sufficient to meet the well-being requirements of the frail elderly in their own homes and the move is made to institutional care.⁴³

Rest homes and retirement villages provide accommodation and care for individuals who have reached the stage in life when they choose, or are compelled by failing health, to move from fully independent living to a form of retirement accommodation which meets their particular needs. These needs vary. Some elderly people remain socially active, independent and physically able, yet desire the security and facilities offered by retirement village living. For others, declining health and/or physical abilities render them frail and dependent on others to maintain a sustainable lifestyle.

⁴³ New Zealand Positive Ageing Strategy (2001), <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/positive-ageing/index.html> (accessed June 8, 2013).

This chapter examines the provision of spiritual care in the two rest home institutions at the centre of this study. The chapter begins by examining the history and growth of rest home care in New Zealand, before considering the character of the two institutions and their approaches to the spiritual care of residents. It highlights differences between the two institutions in terms of policy and philosophy. The chapter argues that the policies established by management at each rest home are based on the broader philosophies undergirding each establishment—philosophies which reflect the ethos of their controlling Boards of Trustees or Directors. Rest home policies shape the ambience and exemplify the distinctive character of each institution. I found that the rest home established by commercial interests demonstrated a strikingly different character from that which was founded as a pastoral enterprise and where recognition of religion and spiritual values exemplified by the work of caregivers continues to be central to the well-being of residents.

Residential Care for the Aged in New Zealand

Historical Background

The history of rest homes is older than that of retirement villages. In Europe and the United States of America rest homes possibly developed from the almshouses, offering relief and shelter to the impoverished elderly of past centuries.⁴⁴ In New Zealand, almshouses labelled as such, disappeared with the advent of increased government financial support for the elderly.⁴⁵ Almshouses were succeeded by rest homes or nursing homes for the frail elderly. Many of these continue to be managed by religious or charitable groups, founded on the particular religion or philosophy upheld by the group.

In nineteenth-century New Zealand, Maori society remained firmly communal with whanau relationships providing care for their elderly. For Pakeha settlers who were in need of support, help could be found through voluntary organisations based on British or European

⁴⁴ "The History of Nursing Homes," *Foundation Aiding The Elderly (FATE)*, <http://www.4fate.org/history.html>

⁴⁵ 1885 Hospitals and Charitable Institutions Act, <http://paperspast.natlib.govt.nz/cgi-bin/paperspast?a=d&d=TT18851021.2.20> (accessed March 23, 2014).

style charities to which they belonged. Members of Lodges and Friendly Societies could rely on one another for aid. Benevolent societies (often organised by women) offered shelter to distressed women in particular. As Tennant notes, residential care of the aged in the period 1880–1920 was overwhelmingly the concern of public charity as represented by the hospital and charitable aid boards.⁴⁶ Towards the end of the century churches were able to initiate more community-focussed charitable outreach to the destitute or needy within their boundaries, largely as a result of the Hospital and Charitable Institutions Act passed in 1885. The Act enabled separate institutions to incorporate and gain support from public monies.⁴⁷ The Catholic Church, through their religious orders, and the Salvation Army became increasingly involved in social welfare.⁴⁸ In the early years of the twentieth century, both before and after the First World War, provision of food and shelter to impoverished single men was a notable aspect of the work of these groups. More homes, developed by religious or benevolent societies, were provided for the elderly, especially for those suffering from the effects of war service.

As the twentieth century unfolded, through the depression years of the ‘thirties into the Second World War years, the face of charitable work and the provisions it made for the needy elderly in the community changed. The Social Security Act 1938 established the modern welfare state. Elderly people admitted to private and religious hospitals became eligible for a daily patient benefit.⁴⁹ Small pensions for the ‘deserving aged and poor’ which began with the passing of the Old Age Pensions Act of 1898, gradually increased with developing national prosperity.⁵⁰ Through the years of mid-twentieth century, rest homes for the elderly became increasingly attractive. More church-run and small private nursing homes were established after the Second World War. Tennant records that this was largely due to the introduction of government subsidies for the construction of homes for the aged

⁴⁶ Margaret Tennant, “Elderly Indigents and Old Men’s Homes 1880–1920,” *The New Zealand Journal of History*, 17:1 (1983): 3.

⁴⁷ Margaret Tennant, *The Fabric of Welfare: Voluntary Organisations, Government and Welfare in New Zealand, 1840–2005* (Wellington: Bridget William Books, 2007), 31.

⁴⁸ *Ibid*, 44–49.

⁴⁹ *Ibid*, 148.

⁵⁰ A. H. McIntock, ed., *An Encyclopaedia of New Zealand, Vol. 3* (Wellington: Government Printer, 1966), 269.

by religious and voluntary organisations, such subsidies rising from 50 percent in 1950 to 100 percent of establishment cost in 1960.⁵¹ Changes to Ministry of Health policies led to increased demand for rest home institutions. Notably, public hospital wards which for many years had become residences for terminally ill, disabled and destitute persons nearing the end of life were disestablished.⁵² Rehabilitation wards, hospices, hospital facilities in nursing homes and independent care houses for people with physical or mental disabilities were now funded by the Government. Tennant notes further that from the 1970s some voluntary and church providers were also providing services to assist the elderly still living in the community, encouraging and enabling independent living to a later stage in life.⁵³

In her article “Aging in Place” Davey examines the attitudes of the ageing to the New Zealand Positive Ageing Strategy (2001), which was launched by the Ministry of Social Policy. The strategy was established with the aim of encouraging and assisting older people to remain in their own homes in order to enhance their sense of independence and self-reliance.⁵⁴ The vision behind this strategy has been realised in many communities with home caregivers supplying physical help with cleaning and shopping for essential supplies each week. Although home care is not the subject of my research, it does have implications for the rest home environment and rest home care. For example, some of the rest home residents I interviewed appreciated the strategy as it enabled them to remain independent until the deterioration of their health meant that twenty-four hour care was needed and the reluctant move into a rest home had to be made. They therefore came into rest home care with more significant physical limitations. Davey includes comments on the Health of Older People Strategy which also supports older people remaining in their own homes, and reduces the need for institutional care.⁵⁵ Her conclusion suggests that, as the population

⁵¹ Tennant, *Fabric of Welfare*, 147.

⁵² Ibid.

⁵³ Ibid, 149.

⁵⁴ Judith Davey, “Aging in Place: The Views of Older Homeowners on Maintenance, Renovation and Adaptation”, *Social Policy Journal of New Zealand* (27), 128-141. <http://www.msd.govt.nz/about-msd-and-our-work/journals-and-magazines/social-policy-journal/spj27/ageing-in-place-the-views-of-older-homeowners-27-pages128-141.html#top> (accessed June 8, 2013).

⁵⁵ Ibid.

ages, a continuum of housing types and options for older people will need to be developed, each with the appropriate levels and types of service provisions, up to full hospital-level care.⁵⁶

Demand for Rest Home Facilities

The past forty years of growth of the institutions now commonly referred to as rest homes, established either as separate institutions or present within retirement villages, is a response to public demand for alternative housing to meet the perceived needs of old age. One ongoing effect of the emphasis on independent living for the elderly has been that when admission to a rest home becomes necessary, residents are frailer than in the past and require a higher level of care. Tennant suggests this was a factor influencing the growth of private sector institutions in the twenty-first century as church and welfare groups could no longer sustain the costs of upgrading their facilities to comply with the escalating standards on which government contracts were based.⁵⁷ Upgrading frequently includes provision for elderly people suffering from forms of dementia or Alzheimer's disease who cannot be left alone for long periods of time. Consequently, care for the elderly in the form of rest homes or nursing homes which also offer secure hospital facilities, is found in many but not all retirement complexes.

While the New Zealand Positive Ageing Strategy (2001) has slowed the demand for rest home beds until later in the lives of the elder population, societal change has meant care within family homes is no longer available as the norm. Such change includes the increase of two-income based households which has reduced family caregiving options, for the trend for women to be fulltime wage or salary earners removes many caregiving women from the home each day. As the median age of New Zealanders climbs with the post-war 'baby boomers' entering the 65+ age group, the number of institutions offering rest home care is growing exponentially. It has been estimated that the percentage of those aged 65+ will

⁵⁶ Ibid, 8.

⁵⁷ Tennant, *Fabric of Welfare*, 149.

increase from 12% in 2011 to 26% in 2051.⁵⁸ Such growth is not reliant on a previous increase in birth statistics, but reflects the increasing longevity of the New Zealand population. Increased longevity is partly a result of increases in survivorship at younger ages, so that more and more members of each birth cohort reach retirement. It is a result of improved health care at all ages, rather than only at the 65+ stage of life.⁵⁹

Substantial improvement in the life expectancy of Maori in the ten years from 1995/1997 to 2005/2007 is of particular note. At birth, male Maori now have a life expectancy of 70.4 years, although this remains less than that of non-Maori Males at 79 years. Female Maori now have a life expectancy of 75.1 years while female non-Maori are expected to live for 83 years.⁶⁰ Management interviewed have suggested this, coupled with changes in Maori cultural practices which have led to allowing family members to be cared for in rest homes in their declining years, signifies a possible further increase in demand for rest home accommodation. Further research is necessary to prove the actual incidence of this. The increase in ageing residents from the Pacific Islands and Asian countries may put further demands on rest home accommodation, although caring for the elderly within family groups has been the observed cultural practice adhered to up until recent years.

Changing family relationships are yet another factor to be noted when examining the increase in demand for rest home beds. Zodgekar suggests that as life expectancy increases the growing numbers of elderly in the family have produced the 'two generation geriatric family'—that is, children reaching old age while their parents are still alive. As time moves on the 'young elderly' in the 60-64 age group will themselves have diminishing ability to care for the 'old-old', 80+ age group.⁶¹ Kirkman further notes the caregiving provided by families—the informal sector—is predominantly the task of women who provide the

⁵⁸ Koopman-Boyden and Waldegrave, "Introduction," in *Enhancing Wellbeing in an Ageing Society: 65-84 year old New Zealanders in 2007*, 1-7.

⁵⁹ Ian Pool, Ben Amey, Michael P. Cameron, Suzan van der Pas, "Health and Wellbeing among Older New Zealanders" in *Enhancing Wellbeing in an Ageing Society: 65-84 year old New Zealanders in 2007*, 39.

⁶⁰ <http://socialreport.msd.govt.nz/documents/health-social-report-2010.pdf> (accessed 19 June 2013)

⁶¹ Arvind V. Zodgekar, "The 'Greying' of Aotearoa New Zealand: Policy Implications of Demographic Change and Structural Ageing" in *Health and Society in Aotearoa New Zealand* (2nd edition), eds. Kevin Dew & Peter Davis (Oxford, New York: Oxford University Press, 2005), 76.

interface between the family and the state.⁶² As more women returned to the work force from the mid-twentieth century onwards this major source of family care providers and voluntary workers was no longer available.⁶³ The resulting need for elder care is seen in the proliferation of rest homes in the twenty-first century.

The Contemporary Retirement Village and Rest Home Sector

Statistics available online through 'Eldernet' indicate there are over 601 rest home facilities available throughout New Zealand.⁶⁴ Eldernet also lists retirement housing facilities available for purchase in 347 retirement villages (many of which also incorporate facilities for rest home or full hospital care).⁶⁵ In the Hutt Valley in 2013, five new or extended developments of retirement villages are underway to meet the anticipated demand for retirement life-style options. The options offered include independent living accommodation (houses or apartments), assisted living (serviced apartments) and care (rest home or hospital facilities).⁶⁶ The 27 retirement housing complexes currently present in the greater Wellington region, (Hutt Valley, Wellington and Kapiti Coast), provide a variety of these features. Eldernet also lists 42 rest homes, some existing as part of the retirement housing complexes or villages. Statistics such as these are indicative of the response being made to the increasing demand for varied retirement accommodation.

Although the Government has moved away from direct provision of geriatric accommodation, the Ministry of Health continues to set standards which all rest homes and aged residential care facilities are required to meet. All are audited and certified to ensure they meet the defined standards. Audits are carried out every one to four years, although

⁶² Allison Kirkman, "Formal and Informal Care: Caring as Paid and Unpaid Labour," in *Health and Society in Aotearoa New Zealand* (2nd edition), eds. Kevin Dew & Peter Davis (Oxford, New York: Oxford University Press, 2005), 117.

⁶³ Tennant, *Fabric of Welfare*, 126.

⁶⁴ *Eldernet* is a New Zealand website which provides relevant information about services for older people. http://www.eldernet.co.nz/Facilities/Rest_Home/Facilities/Service/Map/STID/10 (accessed June 19, 2013)

⁶⁵ http://www.eldernet.co.nz/Facilities/Retirement_Housing_Purchase/Facilities/Service/Map/STID/90 (accessed June 19, 2013)

⁶⁶ Jason Krupp, "Village Projects to Boost Hutt Area," in *The Dominion Post*, Tuesday April 16, 2013. B6; Nicholas Boyack, "Villages Under Way to Meet Retiree Demand," in *Hutt News* (April 9, 2013), 3.

spot audits may be performed at any time. The standards are set out in the Health and Disability Services (Safety) Act 2001 and current practice is outlined on the Ministry of Health website.⁶⁷ To further assure future residents of the quality of care that will be provided, many retirement villages have joined the Retirement Villages Association. The Retirement Village Association (New Zealand) states its membership represents over 90% of New Zealand retirement villages, representing a total industry investment of over \$7 billion and catering for over 24,000 residents.⁶⁸ Villages may become fully accredited members of the Association after triennial external audits for their compliance with the Code of Practice. Certification confirms the village is being run in compliance with the Retirement Villages Act (2003).⁶⁹ Schedule 5 of the Act requires that the Code of Practice in a retirement village include arrangements for the supervision and ongoing training of staff – a matter pertinent to this study, as will be discussed below.⁷⁰

Residential care is expensive. Most residents cannot meet these costs from private incomes alone, but rely on Government subsidies.⁷¹ The Ministry of Health publishes a free booklet on how older people can access financial support for long-term residential care.⁷² To give an indication of the amount residents are required to pay, in a rest home supported by a church-based charitable trust, rest home care costs \$120.70 per day while for residents requiring hospital care charges are \$206.74 per day. In a rest home operated by a public company rest home care costs \$142.44 per day. Hospital care could not be quoted from the public company facility as hospital care residents come with an extra subsidy already paid by the District Hospital Board (DHB). Individual assessment is required if the rest home

⁶⁷ <http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/residential-care/rest-home-certification-and-audits?icn=resthome-cert-audits> (accessed April 26, 2013)

⁶⁸ Retirement Villages Association. http://www.retirementvillages.org.nz/Site/About_RVA/Default.aspx (accessed June 19, 2013).

⁶⁹ <http://www.legislation.govt.nz/act/public/2003/0112/latest/DLM220373.html> (accessed 26 April 2013)

⁷⁰ http://www.legislation.govt.nz/act/public/2003/0112/latest/DLM221425.html?search=sw_096be8ed80be47f3_staff_25_se&p=1&sr=1 (accessed June 19, 2013)

⁷¹ Comment made by Finance Manager at Rest Home A.

⁷² Ministry of Health, 2012. *Long-term Residential Care for Older People: What you need to know*. Wellington: Ministry of Health (July 2012).

provides DHB-contracted care services. A financial means assessment must follow if the resident wishes to receive a fees subsidy.

The Rest Homes of this Study

In order to make a more comprehensive evaluation of the spiritual needs of rest home residents, and of caregivers' recognition of these needs, the selection of rest homes in which to conduct the research was important. Background information was gathered before two rest homes with differing styles of management and clients were selected. To preserve anonymity, these homes will be referred to as 'Rest Home A' and 'Rest Home B'. Both rest homes were located within the context of larger retirement villages.

Rest Home A

Rest Home A was selected as representing rest homes for the ageing which have been established in lower socio-economic suburbs, and for its representative Christian-based ethos. This latter aspect in particular differentiated it from rest homes established as commercial enterprises. Rest Home A is administered by a Trust Board – a charitable trust developed by two Wellington-based Christian denominations. One of these had the vision to build a facility for ageing adults in a lower socio-economic suburb during the era of Government subsidisation of religious organisations willing to open and operate homes for the aged. Plans for the building were drawn up in the 1960s, but delays caused by changes in Government subsidies threw the project into doubt. In 1970, the decision by the leadership of a second denomination to collaborate on the project enabled planning to become reality and the original home was opened in 1974. The two churches have continued to work closely together in ensuing years to develop and expand the activities of the facility. It now offers rest home, hospital and independent living accommodation. Respite and short term stay care is also available. A Day Care Centre offers activities and social interaction to elderly living in the community, with transport to and from their homes provided in the facility's van.

The well-maintained rest home, while not possessing the up-market facilities of some private sector enterprises, gives an impression of homeliness and care. There are 38 beds in the rest home. Rest home residents are housed in simple, single rooms with personal possessions and small furniture items making each a unique expression of its owner's personality. There are some twin-share rooms. All rooms have a hand basin with hot and cold water and some have en-suite facilities. Showers and toilet facilities are provided within each small block of rooms. A large Chapel/Recreation room was built and opened in 2000, and is where church services are held. At other times the room is used for activities planned and conducted by the recreation staff. There are smaller communal areas where residents may gather and well maintained gardens in which they may walk.

The rest home staff includes nurses, caregivers, and therapists in specialised health fields. A chaplain appointed to the permanent staff works on a part-time basis. He pays weekly extended visits to the home and is available to talk privately with residents when the need arises. He moves around the rest home, getting to recognise and understand the residents through informal discussions with them. Clergy from other denominations are welcome to visit residents and do so on a regular basis. Christian services are regularly conducted with various denominations accepting rostered leadership. In the purpose-built chapel, the chaplain leads the weekly church service (or nominates a visiting church leader of another denomination to do so). A representative of the Catholic Church brings a weekly communion to the Chapel for Catholic residents and a priest celebrates Mass once a month. An Ecumenical Communion is also held once a month. In these ways religious practice is well supported. An integral part of the ethos of the Rest Home A is epitomised in the readiness of staff to have each vacant room blessed after a death and before a new resident moves in. The practice recognises Maori cultural needs as well as the spiritual customs of other religions.

Many residents are drawn from the lower socio-economic groups in the surrounding communities, some of whom have previously experienced the support of Day Care offered by the facility. Comments made by residents indicate that others choose to live in this rest home because of the Christian ethos that undergirds the way of life offered. Continuing to

be part of their local community is also apparently important to residents, who find they are not isolated from former friends and social groups.

Rest Home B

Rest Home B was selected as representative of the many commercial enterprises for retirement living available to the ageing population in New Zealand today. It is the first of three retirement villages developed in the Wellington region by its governing company and was opened in the late twentieth century. The company has subsequently established three similar villages in the greater Wellington region with a fourth due to begin construction in 2014. The company is a public company established in New Zealand and offers a full continuum of care. Nationally, it employs over 3,000 staff and serves 6,000 residents. The company's governance is in the hands of its chairman, six non-executive directors, a managing director, and an operations manager. It has over 12,000 share holders to whom dividends are paid annually.

The rest home was established within the retirement village as an integral part of the original provision for retirement living, and draws its residents from the higher socio-economic communities that populate the region. However, some of the residents interviewed stated that they themselves do not come from this social background and experienced a sense of dislocation on entering the rest home. Management suggested that their places in the home were secured by sons or daughters with professional or business careers that have enabled them to live in the nearby communities. When a parent needed to move into a care facility, this was chosen as being close to family, enabling regular visits to be made without long travel being required. Otherwise, the home presents a population source that contrasts with Rest Home A.

My personal observation of the accommodation provided within Rest Home B suggests that it is of a high standard. Approximately 40 independent rooms are provided; each room has en-suite facilities and is fully serviced. Most residents have personal items of furniture or pictures, the arrangement of which tends to give each room a distinctive personality. Communal areas seem warm and comfortable, providing spaces in which residents may

socialise or meet with others to participate in the many activities provided for their health or entertainment—on my visits to the rest home I observed a small group of residents in the communal area participating in organised board games. The home’s Service Information Booklet outlines the wide range of staff providing service to residents on a daily basis, including qualified nurses, trained caregivers, chefs and housekeepers. Specialist staff members are employed to provide activity programmes, gardening, maintenance, laundry services, and administration and management services.⁷³

In Rest Home B, a Chapel is provided in the adjacent retirement village as a place of retreat and quiet in which residents may sit or attend their chosen religious service. Rest home residents are welcome to use this facility but personal physical limitations make it difficult for many to walk to the Chapel room. The facility does not have a chaplain as a staff member but clergy of various denominations are able to visit their members and conduct scheduled services in the Chapel. A monthly roster is prepared to facilitate this. Representatives of all denominations and faiths are welcome to visit their people. Residents are also assisted to attend religious services of their own choosing, outside of the retirement village. For the purposes of this study, Management gave permission to establish interviews with residents and caregivers and provided background information which defined the policy and procedure adopted by the Company in regard to residents’ spirituality, counselling and chaplaincy.

Rest Home Caregivers and Spiritual Care Policies

Rest home care, and the attention paid to the spiritual needs of residents, is influenced by the policy framework within which they operate. Policies are developed by the governing boards of rest homes and are designed to comply with Governmental requirements. The particular ethos of each of the two rest homes studies demonstrate essential differences in the manner in which Government requirements are addressed in their policy documents.

⁷³ *Rest home and Hospital Care Service Information Booklet.*

Spirituality and Spiritual Care Policies

For both rest homes, as for all retirement villages that include rest homes as an essential part of their institutions, and for stand-alone rest homes/hospitals, auditing by Health Ministry officials at regular intervals is mandatory in order to receive and retain certification. Rest home management is required to develop operational policies to meet the Health and Disability Service (General) Standards established by the Ministry of Health.⁷⁴ As a matter of concern to my research, I found this document contained one single, general and catch-all standard in which mention is made of provision for the religious or spiritual needs of residents. It comes under the definition of “Culture” and states that:

“Culture includes but is not limited to age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; **religious or spiritual belief**; and disability.”⁷⁵

Religious or spiritual beliefs of residents are not given focussed attention in these Government Regulations. However, recognition of cultural mores by caregivers is given significant emphasis in their training and will be further discussed, particularly as it applies to provision for and recognition of religious or spiritual beliefs.

In addition, the Health and Disability Commissioner publishes a pamphlet outlining the Code of Health and Disability Services Consumers’ Rights.⁷⁶ This pamphlet is freely available to all rest home residents and is a comprehensive statement of Consumers’ Rights and Providers’ Duties. Right 1 (3) states that:

“Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural,

⁷² <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-healthcare-services/health-and-disability-services-standards> (accessed June 17, 2013).

⁷⁵ Ibid, *New Zealand Standard 8134.0:2008*, 22.

⁷⁶ Health and Disability Commissioner, Te Toihau Hauora, Hauāatanga, *Code of Health and Disability Services Consumers’ Rights* (July 2009).

religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.”⁷⁷

Cognisant of both Clause and Right, the Rest Home B *Management Resource Manual* states as policy that:

“Residents have access to their chosen spiritual leader/chaplain and are offered the opportunity to attend Church services within [the] Retirement Village. Every attempt is also made to assist residents to attend a spiritual service or meet with a chaplain/counsellor of their preference external to [the] Retirement Village.”⁷⁸

The associated Procedure Notes indicate that in each resident’s care plan there is a process for identifying and recording a resident’s spiritual belief and whether or not they wish to attend spiritual services or wish a chaplain/counsellor or other to visit them.⁷⁹

In the Rest Home B *Service and Information Book* available to prospective clients, reference is made to the Service Philosophy that under girds this procedure:

“We respect your rights and recognise the importance of ensuring that our service is culturally appropriate, and meets your physical, psychological, social, spiritual and recreational needs, whilst maximising your potential to maintain your independence.”⁸⁰

These statements indicate the company’s policy in regard to religion and spirituality is essentially to recognise these as the individual concern of the resident while offering a service which facilitates the resident’s individual rights.

Rest Home A’s approach to the residents’ religious and spiritual needs differs from that of the corporate institution in that its institutional spirituality is established for prospective

⁷⁷ Ibid.

⁷⁸ Rest Home B, *Management Resource Manual*, “Resident’s rights 1.3.4: Spirituality Counselling and Chaplaincy.”

⁷⁹ Ibid.

⁸⁰ Rest Home, *A Service Information Booklet*, 5.

residents. Its information booklet includes statements identifying its religious outlook and identity. For example, in the Values Statement on its Welcome page:

“Our Christian values and loving care ensure you are cared for with respect and dignity”.

In its Mission Statement:

“We provide a warm caring Christian environment, with quality care, and a sense of security. We will encourage you to maintain your independence and at all times be sensitive to your cultural and spiritual beliefs.”

Also, in its list of consumer rights:

[You have a right to] “Continue with your cultural and religious practices and value systems which have determined your life in the past.”⁸¹

The noted policies from the two selected rest homes reflect varying interpretations of the Standards Clause and Consumer Rights. The emphasis placed by Rest Home A on providing a Christian environment establishes for prospective residents an assurance of the particular religious ethos governing its policies and procedures. However, this ethos does not prohibit the recognition and support of residents of differing faiths or those whose spirituality recognises no particular religion. The Christian values approach of the Rest Home A Trust Board contrasts the sensitive but more legalistic approach of the governing board of the corporate institution. The contrast is evident when visiting the two institutions, and is observed in the more communal, spiritual commitment of management and staff to the needs of residents that pervades Rest Home A. Here, “Grace”, a blessing on the meal, is said before eating, an action which exemplifies something of the communal values and importance of religious practices to the institution. Residents’ individuality and their personal concerns are responded to by staff with a sense of loving care which went beyond what might be termed ‘the call of duty’. Though difficult to describe and define, this sense was nevertheless tangible to me. It was a sense of the reality of actions that endorsed the

⁸¹ Statements are quoted from Rest Home A, *Rest Home and Service Information Booklet*.

home's value statement that "Our Christian values and loving care ensure you are cared for with respect and dignity." This raises the question as to the role of caregivers, and caregiver training, in creating the different ambience in Rest Home A.

Staff Training

In order to assess the role of caregivers, the patterns of caregiver training used in the two rest homes were investigated. A most common form of caregiver training is done 'in-service', and follows the pattern established by the National Council for Educational Research (NCER). In 1991 NCER published its final report concerning the curriculum and instructional materials prepared through the National Rest Home Curriculum Project (NRHCP) for presentation to the New Zealand Qualifications Authority (NZQA). The project was stated to be a response to "Concern about the training of those responsible for the care of older people and the provision of residential care in New Zealand".⁸² The report resulted from an extensive overview of the training needs of rest home workers and offered a curriculum plan for all rest home staff.⁸³ It defined carers [caregivers] as those who assist people who require help and support with the activities of daily living and states:

Trained carers will have competency levels to perform a wide range of tasks relating to daily living activities, which will complement, but not include or replace, the skills and expertise of other health care professionals.⁸⁴

The report outlined the strengths found in on-the-job training which allowed for involvement and increased awareness of the needs of the elderly. Amongst the eleven strengths noted were the encouragement of staff confidence and skill focus.⁸⁵ The report's competencies and skills chart noted eight broad areas of competencies for caregivers. It included care for the dying and deceased—this appeared to be the only competency in

⁸² G.A. Wagner, *National Rest Home Curriculum Project: Final Report* (Wellington: New Zealand Council for Educational Research, 1991), 2.

⁸³ Ibid, 3.

⁸⁴ Ibid, 6.

⁸⁵ Ibid, 39.

which the caregiver would be encouraged to ensure the resident's spiritual and cultural needs would be met.⁸⁶

Training programmes for caregivers have moved on from 1991, yet significantly most instruction continues to be 'on-the-job'. Twenty years later the Human Rights Commission reported that:

"In the residential care workforce, 46 percent have no qualifications. While most workplaces offer some in-house induction training and others actively encourage formal qualification programmes, workers are not incentivised to take up training opportunities as providers are unable to reward staff through pay increments as their competency increases."⁸⁷

Courses that meet the NZQA's demands are now offered by organisations such as the Health Education Trust (Producers of the Aged Care Education (ACE) modules), Careerforce, Wellcare, Oceania, and Wintec. All offer programmes which, when successfully completed, offer NZQA approved National Certificates in Core Competencies and Foundation Skills and are accessed by caregivers through in-service training in rest homes or through community work skill providers. ACE programmes are reported to be in use in over 60% of residential care facilities throughout New Zealand.⁸⁸

In both rest homes studied, caregivers receive regular training with a senior staff member organising and supervising sessions, the minimum skill requirement for caregivers being Level 2 of the National Certificate in Health, Disability and Aged Support (Foundation Skills). The assistant manager of Rest Home B explained that training was done under the auspices of a staff coordinator who oversaw the one to two month induction course for caregivers when first appointed. Staff went on to individually study the ACE modules and worked towards achieving recognised national qualifications. A second senior staff member gave assistance, especially to those who spoke English as a second language. Regular times of

⁸⁶ Ibid, 41.

⁸⁷ The New Zealand Human Rights Commission, *Caring Counts, Tautiaki Tika*, 73.

⁸⁸ Health Education Trust New Zealand Inc., "About Health Ed Trust", <http://healthedtrust.org.nz/about-us> (accessed June 19, 2013).

instruction on particular health issues were part of the ongoing training for caregivers in this rest home, the company also supporting staff members who wish to study extra courses outside the facility. In respect to specific training to understand the spiritual needs of residents, the caregivers' in Rest Home B explained it is based on aspects of respect for residents' cultural and religious values as introduced through the ACE modules. This forms the basis of their care and respect for the individual resident's religious and spiritual rights, the emphasis being on cultural values.

Rest home A provides what was termed an orientation programme for new caregivers. A 'buddy system' whereby a new staff member is linked to an existing experienced caregiver for support in understanding the systems operating in the rest home has proved effective. Caregivers' formal instruction in the ACE Modules of Care is at their individual levels of attainment and they are encouraged to work towards higher qualifications. The nurse manager responsible for overseeing on-going training based on the modules demonstrates in her manner towards the caregivers the sympathetic, caring attitude encapsulated in Rest home A's Mission and Values Statements to its residents. This attitude was subsequently reflected in the approach of caregivers to their residents and in their response towards management. It is the significant factor which produces an ambience in the home which differs from that of Rest Home B.

The specifically spiritual component of the ACE modules is further outlined in Chapter 4, in relation to caregivers' perspectives. This foregoing discussion of training procedure, however, reveals that the mechanisms for training do provide opportunities to convey and reinforce the religious and spiritual values embodied in the policy statements of the two homes.

Spirituality and Care of Spiritual Needs

Notions of holistic care have been widely adopted in recent decades. Holistic care for residents' well-being requires attention to spiritual needs, alongside appropriate physical, mental and social care. The idea that spiritual care is a necessary component of holistic care

has been increasingly affirmed in research over the past thirty years, yet MacKinlay suggests it is still not always recognised as an integral component of aged care.⁸⁹

The move into the culture of the rest home can be distressing and a challenge to residents' sense of identity. The individual patterns of their former lives were developed around home and family expectations, work place demands, social, religious or ethnic cultural activities and association with friends. The known pattern of these gave meaning to life. While, within the rest home, cultural social customs and their rituals are noted and treated with respect by caregivers and opportunities for the rituals of religion are provided, the inner spiritual turmoil engendered by the unfamiliar day by day culture of the rest home is often neither recognised nor understood.

Culture has a variety of meanings. At times it is seen as a convenient, all encompassing concept through which traditional responses to the historical practice of individual ethnic groups is channelled. Kanitsaki writes of culture as an inherited 'lens' through which individuals perceive and understand the world they inhabit, and learn to live within.⁹⁰ The familiar culture in which the rest home resident has lived and grown will have nurtured the formation of identity through its expression of values and ritual symbolism. Davies discusses this influence with particular reference to spirituality as a form of cultural wisdom generated from folk-insight into life that sustains a sense of meaning, fosters hope, and finds expression through ritual activity.⁹¹

Conversely, religion, exemplified by its rituals and ways of worship, appears to be more straightforward to discern and describe than spirituality when defining rest home policies. This is so when faiths are characterised by their rituals and worship. From the perspective of psychological health, Pargament suggests that religion is complex and personal, a search for

⁸⁹ MacKinlay, *Spiritual growth and Care in the Fourth Age of Life*, 21.

⁹⁰ O. Kanitsaki "Mental Health, Culture and Spirituality: Implications for the Effective Psychotherapeutic Care of Australia's Ageing Migrant Population," in *Mental Health and Spirituality in Later Life*, ed. E. MacKinlay (New York: Haworth Pastoral Press, 2002), 22.

⁹¹ Douglas J. Davies, "Ritual," in *The Oxford Textbook of Spirituality in Healthcare*, eds. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford, New York: Oxford University Press, 2012), 163.

the significance in ways related to the sacred.⁹² Yet religions also promote significant means of social interaction and ethics, frequently with respect to the well-being of the group. Within a religion, people may find identity in caring for others, in serving the communities in which they live, in sharing common values and of feeling themselves to be valued by others. Religious teaching and knowledge may provide a life map through which a person may be guided to find comfort in encountered life events—births, deaths, relationships, occupation and relaxation. Associated religious ethics build constraints, proscribing particular actions and further delineating the direction in which individual lives might move.

Rest home policies that base plans for spiritual care solely on the resident's past attitudes towards religion are not always adequate. Attitudes may undergo marked changes after people become rest home residents. Some will continue to find strength and comfort in the rituals and worship of past years. For others, however, ageing and its accompanying physical limitations reduce the individual's ability to be involved as a leader or supporter of others which may have been an essential part of their religious commitment in the past. The associated loss of social independence in the confines of a rest home may further erode the sense of self that has built up over a lifetime. Residents' spirituality which helped integrate and make sense of life in the past is challenged by the intrinsic culture of the rest home. It is a cultural challenge that can affect people's sense of who they are and the meaning of their life. For some this leads to loss of direction, to loss of the faith embedded in the particular religion that guided them through their lives. Inner, searching questions arise and well-being may be threatened by the ensuing pain of bewilderment and spiritual uncertainty. Guilt is also a powerful agent of faith destruction for some people. It has been my experience that feelings of guilt left unspoken are responsible for shattering the inner peace and spiritual self worth of the ageing. With fewer opportunities for social or outreach activities and more time spent alone, there is more time in which to reflect on mistakes of the past. Memories of breaches of moral or ethical codes, particularly those codes engendered by religious laws, can cause acute mental distress and seriously destroy a

⁹² Hisham Abu-Raiya and Kenneth I. Pargament, "On the Links between Religion and Health: What has Empirical Research Taught Us?" in *The Oxford Textbook of Spirituality in Healthcare*, eds. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford, New York: Oxford University Press, 2012), 333.

resident's well-being, requiring an understanding response from caregivers. Therefore, spiritual care in rest homes will not provide the support necessary for the wellbeing of residents if it is based solely on the individual's past attitudes. It is important that policies which attend to likely changes in the resident's spiritual journey be developed.

Such specific policies were not, at this present time, identified in the rest homes studied. At present, in the two rest homes observed, the caregivers in Rest Home A appear more likely to be aware of and attend to residents' changing spiritual needs. The policies of the rest home encourage them to build a caring rapport with residents. The warm relationships which develop enable rest home residents, who need to talk with a trusted other, to speak of events that for years have concerned them and remained hidden. At times the conversation itself is sufficient to relieve the resident's stress. Caregivers know however, that senior staff will give them support and direction if the resident appears to require more specialised help. The caregivers are encouraged and able to seek this help whenever necessary. In Rest Home B the caregivers do not appear to have similar depths of rapport with their residents. The philosophy of the home does not put emphasis on caregiving which reflects a particular caring ethos, although caregivers themselves demonstrate an understanding of residents' need to be heard and helped face spiritual dilemmas. The migrant caregivers in this rest home are further restricted by the difficulty in communication engendered by their lack of English. However, in neither of these rest homes do policies state an awareness of the possible changing spiritual awareness of the resident. The development of such policies will also need to take into account the need to educate the caregivers, for, if the caregiver is trusted with spiritual confidences and concerns, that person will need to have the ability to identify the resident's ongoing need for help.

In developing rest home policy it will be important to recognise that spirituality is not the exclusive area of concern of those who adhere to a religion, nor is it only, in Pargament's words, "a search for significance in ways related to the sacred."⁹³ As Moberg suggests, people's visible religion (as reflected in religious practices or attendance at religious

⁹³ Ibid.

services) is not the same as their individual spirituality.⁹⁴ For many, spirituality frequently remains a vague sense of a transcendent power influencing or altering understanding of self and the inhabited world. It can be the force that inspires the artist and finds expression in word or music, in picture, sculpture, dance or craft. In a comment on the association between Manhire's poetry and Hotere's art, O'Brien recently expressed the understanding that both artists in their work infer the spiritual existing within humanity, rather than being beamed down upon it from above.⁹⁵ I believe it is this existence of the spiritual within humanity that is the power that begins to disturb the ageing as their lives draw closer to death and they face the existential question of the meaning and purpose of life as they have known it. In particular it is the change from drawing that meaning against the background established in their former ways of life to the new experience of rest home culture that establishes a spiritual tension in the lives of residents. In the two rest homes studied for this research the cultural, religious and spiritual dimensions of care are not ignored, but it remains open to question how fully the individual spiritual needs of residents are understood by caregivers.

Summary

In this chapter I have discussed the history of aged care institutions in New Zealand and the services they offer today. Comment has been made of the response of Government and its agencies to the needs of the aged sector of the population. More specifically, two rest homes have been discussed as examples of the milieu in which caregivers respond to the residents' needs for holistic care, care which includes responding to observed spiritual needs. Management of the two rest homes selected for this research have established policies to meet residents' cultural, religious and spiritual needs. It is apparent that the different philosophies of spiritual care identified in the policies of these homes become significant when put into practice. It is the staff of the rest homes that become responsible

⁹⁴ David O. Moberg, "The Reality and Centrality of Spirituality," in *Aging and Spirituality: Spiritual Dimensions of Aging Theory, Research, Practice and Policy*, ed. David O. Moberg (New York, London, Oxford: The Haworth Pastoral Press), 3.

⁹⁵ Gregory O'Brien, "A Farewell to Ralph Hotere," *Tui Motu InterIslands* (June 2013): 11.

for their implementation. In particular, the caregiver, in the course of undertaking an intimate, physical, caring role, may be seen by the resident as a one to be trusted with personal doubts and fears, a person who might understand the spiritual bewilderment which is being faced as ageing sets previously unknown limits on living. I argue that because of this it is essential to provide adequate and sensitive training in response to scenarios likely to be encountered. The cumulative result of policy and its mode of implementation is the wellbeing of residents together with the ambience of concerned care which is stimulated in the home.

This research now considers the manner in which the philosophy and related policies of the two rest homes are put into practice. The focus of the ensuing chapter will be on the residents, their spiritual needs and their response to their caregivers. It will be substantially highlighted by data collected in the course of recent interviews.

Chapter 3: Rest Home Residents and Spiritual Care

This chapter focuses on residents' perception of their spiritual needs, with particular regard to the way in which those spiritual needs are met. It examines literature pertaining to the spiritual dimension of ageing, comparing it to data obtained from interviews with selected rest home residents.

Interviews with residents were conducted for a number of reasons: first, to gain a fuller picture of rest home life and spirituality; second, to test the extent to which existing literature on spirituality and ageing was borne out in the context of rest homes studied; finally, to gain an insight into the residents' views of the role of the caregiver in relation to their spiritual needs. The interview process aimed to tease out the existential reality of living in a rest home, the spiritual needs of residents in this stage of life and the role that they perceive the caregivers as fulfilling. Two interviews with each selected resident were conducted. A key theme that emerged from interviews with residents was the connection between loss of relationships and search for spiritual meaning in life. The extent to which spiritual needs become focussed by the move into institutional care away from relationships on which their lives were previously centred was noted, as was the response of caregivers to those needs. I argue that while institutional policies address cultural and religious needs, some residents have spiritual needs unmet by institutional agendas. This chapter addresses the residents' ability or inability to source appropriate help from caregivers to address their spiritual needs.

The Spirituality of Ageing

The spirituality of ageing cannot be separated from human perceptions of what death might mean. The inevitability of death becomes a significant challenge as the individual adjusts to the deteriorating strength of mind or body that accompanies ageing. Many find themselves confronted with the dilemma: is the end of life a vast nothingness, a literal 'end'? Or are there heavens or hells into which personal souls or spirits will enter? Some find a new life of peace and harmony is a far more hopeful proposition than that offered by nothingness and

will turn to a religion that offers a way to that end. As Bowker reasons, “religion offers compensating paradises to those who cannot face the realities of death and oblivion.”⁹⁶

For some, following the teaching and beliefs of a particular religion is the way in which inner peace is established when former ways of life end as physical ageing progresses. Imhoff suggests that, “to be human is to accept and meaningfully endure the tension within us from the beginning—the tension between becoming and being and perishing.”⁹⁷ Given the predictability of death, Imhoff emphasises the necessity to prepare for death as “the art of dying right.”⁹⁸ I suggest that accepting and finding meaning in this inner tension is the essence of the spiritual journey towards bodily death. Spirituality in this sense is a personal and subjective phenomenon; a felt experience of existential being that for many is divorced from adherence to a particular religion. It is from within Imhoff’s argued lifelong tension between becoming and being and perishing that many of the spiritual needs of ageing arise and are accentuated by the physical move into rest home living, a reality observed in the course of this research.

Ageing residents enter the rest home environment constrained by gerontological issues that prevent them leading their former independent lives in the community. Their previous lives are as varied as the communities from which they are drawn. Each comes from a particular educational, financial, social or physical background, which, to a greater extent, is left behind, unwillingly abandoned in some cases, because of disabilities and health concerns associated with ageing. Each person embodies the cultural, social and spiritual mores that have shaped his or her life up to this time, for essentially each remains an individual, a real person who continues to need to be valued as such. This need is emphasised when many of the trappings of individual identity—the lifestyles, dress, activities and relationships that may have accentuated individual personalities in former days—are effectively discarded on entering the restricted lifestyle of rest home living. The essence of each person’s self identity and independence is challenged, particularly if it has relied on appearance or

⁹⁶ J. Bowker, *The Meanings of Death* (Cambridge: Cambridge University Press, 1991), 5.

⁹⁷ A. E. Imhoff, “An *Ars Moriendi* for our Time: To live a Fulfilled Life; to Die a Peaceful Death,” in *Facing Death*, ed. H. M. Spiro, M.G. Curnen McRea, L. Palmer Wandel (New Haven: Yale University Press, 1996), 120.

⁹⁸ *Ibid*, 117.

former abilities. On entering the rest home, individual well-being is passed into the hands of those now assigned to their care.

Residents entering a rest home find themselves caught in a web of new and often unwanted experiences. The move to institutional care may not have been made willingly, even amongst those who acknowledge they can no longer manage to live independently. Institutional care breaks relationships with family, friends, and communities. The individual sense of self, of 'being' built up over time within particular spatial contexts—home, garden, country, or town—is lost. The resident becomes part of a rest home community and now faces the reality of altered physical and cultural surroundings while psychosocial and mental changes in life are brought about in the process of ageing. With limited active pursuits there is now more time to think—to think about the probability of life ending, of what it means to be alive or to become. The resident enters into the spiritual dimension of ageing.

MacKinlay suggests that the spiritual dimension of ageing is part of the spiritual journey that is necessarily a part of being human; it is a search for ultimate meaning in life, which individuals undertake if and when certain spiritual tasks are recognised during the process of ageing. MacKinlay proposes a generic model, which illustrates the interaction of spiritual themes and tasks likely to be addressed by the individual during this final stage in conscious life. She identifies six themes, and related tasks, as key spiritual needs of rest home residents. These themes align with my observations of residents' spiritual needs. The themes and tasks are: ultimate meaning—to identify the source of ultimate meaning; response to ultimate meaning—to find appropriate ways to respond; self-sufficiency/vulnerability—to transcend disabilities, loss; wisdom/final meanings—to search for final meanings; relationship/isolation—to find intimacy with God and/or others; hope/fear—to find hope.⁹⁹

My research highlighted the particular significance of relationships, and the insecurity that often arises from unavoidable changes in relationships. Rumbold expands MacKinlay's theme of altered relationship/isolation, noting the links between spirituality and

⁹⁹ MacKinlay, *The Spiritual Dimension of Ageing*, 223-224, and MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 22-23.

relationships in relation to the individual's connection with places and things (spatial relationships), with self (intra-personal relationships), with others (inter-personal relationships), among people (corporate) and with transcendence ('God' or 'something there').¹⁰⁰ Rumbold argued that the difference between individuals' practice of a particular religion and their spiritual needs requires discernment by those offering residential care. Friedman writes of the sense of anomie arising from the isolation that can accompany residency in a rest home and cites forms of ritual, both religious and non-religious that may be useful tools in addressing the spiritual need for connection with either a god or other people.¹⁰¹ Marcoen notes examples of elderly people experiencing a relationship with something that transcended them and gave them spiritual anchorage in the face of a growing vulnerability in old age, his comments endorsing the spiritual needs theme of self sufficiency/vulnerability established by MacKinlay.¹⁰² These writers' insights provided important gauges to compare my findings against.

Being a Rest Home Resident

This section explores what it means existentially to be a rest home resident. The residents I interviewed were all over a 65+ age group with limited physical abilities. Some showed memory lapses but none were classified as being Alzheimer's or dementia sufferers. The interviews were limited to those still able to communicate rationally, which meant no understanding of the needs of the mentally frail elderly could be considered. All participants were selected by management as able to respond to questions that might be asked in the course of an interview. One resident, on reading my proposal for interview, declined participation. The nine completed interviews lasted between forty-five minutes and one hour.

¹⁰⁰ Bruce Rumbold, notes taken from the seminar, "Collaborative Spiritual Care: Problems, Possibilities, Programs," presented as a Masterclass at the Hospice New Zealand 20th Palliative Care Conference (November 13, 2012).

¹⁰¹ Dayle A. Friedman, "An Anchor amidst Anomie: Ritual and Aging" in *Aging, Spirituality, and Religion: a Handbook*, Volume 2, eds. Melvin A Kimble, Susan H. McFadden (Minneapolis: Fortress Press, 1995), 134-143.

¹⁰² Alfons Marcoen "Religion, Spirituality, and Older People," in *The Cambridge Handbook of Age and Ageing*, ed. Malcolm L. Johnson (Cambridge: Cambridge University Press, 2006), 363.

Spirituality and religion can be private and deeply felt concerns, especially for people in this age group. I did not expect the residents, most of whom were unknown to me before the interviews, to reveal their inner, closely guarded feelings or attitudes at a single meeting. Therefore, some time was spent in advance of our interviews establishing a sense of trust and an assurance of my integrity in receiving their confidences. I interviewed residents in the light of prevailing views concerning the spirituality of ageing. Questions were asked which enabled me to gain a sense of what it was like to be a rest home resident. These gave me the opportunity to test the salience of current theories, to explore the residents' sense of their relationship with caregivers, and the extent to which caregivers were turned to as a source of spiritual support.¹⁰³

Residents were first asked to respond to the question, "What does it mean to be in a rest home?" Responses to this question provided an indication of how residents express their psycho-social needs. The responses highlighted the issue of the effect of the move into institutional care on their lives and relationships. The discussions opened an understanding of the participants' acceptance of the inevitability of the progress of old age. They also provided an opening insight into the temperament of the participant. A variety of answers were forthcoming, most of which accepted the unavoidable loss of independence due to advancing age, a loss treated with resignation by some but antagonism by others.

Residents at Rest Home A

Graham, from the Netherlands was accepting of the need to be in rest home care because of his increasing physical weakness. He migrated to New Zealand over sixty years ago and still spoke English with a strong accent. He had trained as an artist in his homeland but on arrival in New Zealand trained and served for ten years as a Salvation Army Officer. For many years after that he was a secondary school art teacher and artist. His room contained a large bookcase filled with books that reflected these two dimensions of his life. "Oh I've got used to it [being in the rest home]," he said, projecting a sense of resignation to the inevitable. "Yes everything is here."

¹⁰³ Confidentiality agreements and other relevant process documents are presented in Appendix A.

Graham's wife had moved with him into the rest home and he mourned her recent death, another important relationship in his life having been broken. He befriended other residents, an outreach which reflected his lifelong ministry to others through his church and teaching careers. Many, particularly the men, would come to his room to talk with him. He gave the impression that he was living his faith in these penultimate times of his life and was an example of Rumbold's identification of a person who recognised both his need and the needs of others for inter-personal relationships in the rest home environment.

Ngaire was accepting of being part of the rest home community. She had a zany sense of humour, delighting in showing off the items that decorated her room, particularly the witch-doll (gifted by her family) that greeted people as they entered. She had a cheery outlook on life, her only regret being the food restrictions placed on her by her current state of health. Now nearly ninety, Ngaire had been in the rest home for three years after previously living independently in a villa in the rest home complex. "I nearly set fire to the place one day [her villa] so that was my lot—you're coming over here to live now—that was it!" Ngaire regretted the inevitable loss of independence associated with this move but her network of continuing relationships with her large family brought a sense of security to this stage of her life.

Zoe was a widow who had lived on her own for many years. A gentle welcoming lady, she had lived in the rest home for two years, persuaded by her doctor to make the move after a series of falls made it hard for her to live alone. Admitting he was right, she now found it a relief to know help was readily available, especially after suffering a stroke not long after she was admitted. Zoe was able to express her feelings about the changes that had occurred in her life. "Leaving my home was a big thing but I knew it was necessary so I ended up here. More or less in my own territory—I didn't have to go to Wellington or anything like that. I was still in the Hutt Valley and not far from where I lived. I have good friends who come in ... I've made acquaintances [in the rest home] but I wouldn't say I've made real friends. And I've met lots of people. I've enjoyed that. But basically I'm a loner and I can be quite happy being alone." Zoe's appreciation of living in a rest home sited in the same physical community in which most of her life had been spent was important. It enabled her to

maintain relationships with established friends and with her church community, a factor which brought a sense of emotional and spiritual stability to her existence even though her physical wellbeing was changing.

Irene told me from the start that she didn't have much time to talk to me—a friend was taking her out to lunch. The comment was terse and came after I had introduced myself. It set a strained atmosphere. I was told of how, when living on her own in the nearby district, the Anglican Church had let her down for no one from there had ever visited her in her home. The Salvation Army had visited and that was where she belonged now. As we talked she relaxed more, though some of my comments and questions would set off a tense response. Irene had lived in the rest home for nearly four years and described it as “not a united sort of place. You go your own way. Nobody tries to talk to you or anything.... No, it's not what it used to be.” She spoke of never having been given the opportunity to choose where she might live after illness and a time in hospital left her incapable of returning to her own home. Family and doctors had made the decision for her “And I've never been back home.” All that she retained in the small space that was now her home were two chairs, some pictures, her computer and keyboard, and various small ornaments. I sensed bitterness, grief and anger about how her home had been broken up—the control of her life had been taken from her and she resented her physical and emotional dependence on others, expressing it as antagonism towards the people and physical surroundings that now bounded her life. Nolan quotes Watts as identifying such frustration and anger as an example of transference of emotions onto those now responsible for her wellbeing.¹⁰⁴ Yet, when asked if there was anyone to whom she could speak about her feelings Irene responded, “No, not in this home. They're all good to you mind you, as far as that goes. They're all good to you but they're all too busy to have time to spare.”

Mary shared her life and beliefs with everyone. Her door was wide open and all who passed by gave her a wave or stopped to speak. Mary was confined to bed at times now as cancer was drawing her life to an end. Yet she delighted in the people around her. Her sense of selfhood was not challenged by either her confinement in the rest home or by the disease

¹⁰⁴ Nolan, *Spiritual Care at the End of Life*, 42.

which was ending her life. A Catholic Nun (a Mercy Sister) for over sixty years, her vocation had been to help others—from the girls in the schools at which she taught to derelicts she rescued off the streets. She spoke of wanting to share God’s love with them and her desire to continue her ministry of love in the rest home. Caregivers and other staff as well as many of the residents warmed to her caring presence. Her attitude was summed up in her comment, “this place is a lovely tapestry of life.” Mary projected a sense of peace and strength based not only on the rituals of her religious beliefs but firmly anchored in her expressed inner spiritual strength.

Residents at Rest Home B

Friedman has argued that ritual of any kind can act as an anchor and shield against the uncertainties that the ageing process propagates.¹⁰⁵ Ben illustrated the counterpoint that denying such ritual may result in anomie and inner spiritual turmoil. The door of Ben’s room was firmly shut to discourage casual visits by other residents. He was abrupt but ready to talk with me. He related long stories about the illness that forced him to come into care, and about his dead wife—she had been blind for many years, and Ben had cared for her until she died. In spite of his gruffness, I heard many family stories, which he illustrated from the pages of his photo album, stories in which his own sense of identity—of selfhood and self-worth—were based. He arrived at the rest home after a long time in hospital and was bitter about losing his independence and his ability to order his life following the ritualistic pattern he had established in caring for himself—especially his most valued ritual of regular meeting with his mates for a drink and yarn. “So when I finished there [the hospital] they [his daughters] brought me home but went the wrong way. Dad, I’ve got something to tell you—we’re not allowed to take you home—you’re not allowed to be by yourself.... Then they brought me in and put me in this room and I haven’t been out since—except when my daughters come and get me. [So how have you felt about being in here?] Well I don’t like it—I like the sea.”

¹⁰⁵ Friedman, “An Anchor amidst Anomie: Ritual and Aging,” 134-143.

Being confined to the rest home shattered Ben's need for independence. He could no longer join his men friends for a drink at the local pub. The companionship of this regular meeting was important and could not be replaced by the efforts of caregivers to help him form a new social group. He later spoke of being encouraged to join a small group from the rest home on an outing—an event that proved to be disastrous for “they were all women except me and the driver. Never again!”

Marg did not find communal living in her rest home easy. She had lived an active, independent life and now, at nearly ninety, she much preferred her own company to that of other residents. “I don't like it here. Too many people for a start. I don't like being organised. I don't like being told what to do.... There's no privacy really.” Yet she was eager to tell me of her life – both the happy and hard events. She projected a need to get me to understand why she had moved out of her unhappy marriage after her daughters had grown up and left home. This and other memories obviously troubled her. Her comment that she had been unable to speak of these to anyone else highlighted the reason for my research into caregiver roles.

Win's room was impersonal, reflecting her brief residence in the rest home. It had not been decided whether or not she would become a permanent resident. She gave the impression that she was yearning to return to her own home. Home was the place where she could be surrounded by things in which the memories of her life were embedded—once again the stability of spatial relationships being pivotal to wellbeing. The interview gave me the impression that the death of her husband four years previously left life without meaning for her. Win acknowledged that a permanent move into the rest home was inevitable but not welcome. “I don't think my daughter wants me to go back to my little apartment because that would be living totally on my own which I wasn't very happy with because all my life I have had someone to be with me and suddenly I was on my own. I was not sufficiently able to live like that ... It [being in the rest home] means security for [daughter]—she doesn't need to worry about me.” Win was unhappy. She was vulnerable. Unable to transcend the loss of her husband or the thought of being separated from the home and belongings in which her memories of him were kept alive, she appeared to have given up all hope for her

own future. I perceived a sense of fear and helplessness, the isolation brought about by the events of ageing highlighting her need for a spiritual intimacy that was formerly nourished by her caring relationship with her husband.

After four years of residence, Elsa had made the transition to accepting the rest home as her place to be. She talked readily about the routine and care received, about new friends made and lost to death, but her growing difficulty to walk was unsettling her. "I think this [rest home] is lovely—I'm normally a happy person you know ... but now I'm just unhappy with walking. It's horrible." Elsa liked to help people – especially those wandering around seemingly aimlessly. She referred to them as 'the dementias' and was concerned that the number of them in the rest home had grown, thereby reducing the number of people with whom she could talk rationally—she loved to 'chat'. Nevertheless, I was told of how she was able to steer them back to their rooms or activities. Elsa seemed the most spatially secure of all the residents interviewed in Rest Home A. She had settled in and claimed it as her space, the trauma of giving up her former independent life having been overcome. It is significant that she was prepared to make communal spaces her spaces and participate in the activities that were offered daily.

Positive, Negative and Resigned

Responses from the residents gave an opportunity to widen understanding of the residents' attitudes towards rest home life. Negative comments were direct in the expression of fretfulness, yet even the positive comments appeared to imply the need for a conscious effort to show acceptance of the inevitable. Body language shown as the respondent turned away or was uncomfortable with the question indicated a sensitivity that could not be openly expressed. The sense of resignation, of reluctantly accepting the loss of former ways of living and the new dependence on caregivers, is echoed in the findings of other researchers, indicating that this is a typical response from residents who feel confined by the limitations of rest home life. Millar, drawing on her extended experience with older people as a nurse, counsellor and pastoral care worker writes that, "The enormity of the

adjustment that has to be made to communal living cannot be underestimated. The struggle to adapt is an ongoing process which can be very acute.”¹⁰⁶

For the respondents in this study, loss of independence was invariably associated with failing health and physical abilities, the ramifications of which were expressed as fears for the future, the possibility of pain and slow bodily deterioration, the process of dying. Zoe, who otherwise presented as a contented resident said, “I’d really hate to have a stroke again and be incapable of doing most things myself.” Mary, recently diagnosed with a terminal cancer said of this experience, “insecurity is part of it.” Graham, no longer able to pursue his lifelong artistic talent commented sadly, “The skills are going—too shaky now.”

Ben spent a considerable part of our time together giving graphic details of the way in which his health had deteriorated over the years. He explained the tough nature of his life—the many times he had overcome the personal hardship and family tragedy that challenged him. Physical deterioration for him meant a degrading loss of independence and the knowledge that worthwhile life as he knew it was over, there was no way now to overcome future challenges. He wore a silver cross on a fine chain around his neck so it seemed pertinent to ask whether or not he thought God was punishing him. After thinking for a moment his answer was, “Yeah”. When asked if he ever wanted to talk to someone about this his response was “No. It wouldn’t help me would it?”

In these interviews many made references to their former ways of life, particularly to the difficult times, which linked again to the question of damaging or lost relationships and their spiritual effect on the residents (as defined by Rumbold).¹⁰⁷ It is of note that following the formal, recorded discussions, unrecorded comments were made of marital struggles and abuse, of family difficulties and of contrasts between life “then” and “now”. Personal actions taken through the years to preserve individual dignity and self-worth were discussed. Such comments suggest that pain of the past was felt once again. The curtailment of activity brought about by the new physical and social restrictions of ageing

¹⁰⁶ Anne Millar, *Growing in Age: Ageing in Today’s Society* (Wellington, New Zealand: Philip Garside Publishing Ltd., 2001), 103.

¹⁰⁷ Rumbold, “Collaborative Spiritual Care: Problems, Possibilities, Programs.”

gave residents introspective time that was often spent alone in the small room that formed the new boundary of personal life.

Malcolm Johnson has coined the term *biographical pain* to assign to the experience of older people facing death and writes, "Faced with life almost at its end and now beyond reconstruction has been a source of dismay, depression, self-loathing, guilt, and anger for many."¹⁰⁸ Ben's comments illustrated his biographical pain, his frustration, regret and anger at the way events of his life, some of them outside his control, had reduced him to the prison of physical incapacity and the loneliness of rest home life. For others the entry into rest home care is a turning point in life and may establish a spiritual search for answers to questions that evolve from their mental pain. It appears to be part of Imhoff's tension between the sense of being and perishing, the spiritual transition from life to death. Anne Harrington, a senior lecturer in the School of Nursing and Midwifery at Flinders University in Australia writes, similarly, of the spiritual journey that is triggered by despair.¹⁰⁹

Becoming a rest home resident then is a process of being, of working through the often unspoken, hard to identify spiritual challenges of ageing.

Resident Understandings of Religious and Spiritual Needs

With the "spiritual challenges of ageing" in mind, it was appropriate to determine the significance of religion or spirituality in the lives of residents. The primary responses equated religion with the practice of a particular faith. The residents interviewed named as their faith background the religion of their youth, their days when custom frequently entailed being sent to Sunday school or being taken to church services.

When questioned about religion, Ngaire replied, "It means a lot really. For years I had a large family and I couldn't get to church the way I used to. I was christened, confirmed,

¹⁰⁸ Malcolm L. Johnson, "Spirituality, Finitude, and Theories of the Life Span," in *Handbook of Theories of Aging* (2nd Edition), eds. Vern L. Benston, Merrill Silverstein, Norella M. Putney, Daphna Gans (New York: Springer Publishing Company, 2009), 666.

¹⁰⁹ Anne Harrington, "Hope Rising out of Despair: The Spiritual Journey of Patients Admitted to a Hospice," in *Spirituality of Later Life: On Humour and Despair*, ed. Elizabeth MacKinlay (New York: The Haworth Pastoral Press, 2004), 123.

married, all in St Augustine's.... Since I came here I go to Communion." Participating in the formal, familiar ritual of Eucharistic liturgy enabled her to retain her relationship with the religion which she had known and experienced all her life.

Irene had previously spoken warmly about the support she had received from a member of a Salvation Army congregation and now responded, "Well it [religion] means Church. It means service [to the community] and it means love amongst us—do you know what I mean?" For Irene, too, it was the sense of connection to God and relationships with others through particular forms of religious expression that provided a strength she needed at times when rest home living left her angry and bewildered. Staff changes had meant that a caregiver to whom she felt close had moved on and with no one to replace her, Irene felt bereft, expressing her grief in anger against the home authorities.

For Zoe, "Religion means a way of life to me. I've always been a Catholic and that's just part of me." The foundation of her life was the prayer, service and outreach to others expressed through her church and faith in God. Ben, whose upbringing, he said, was Catholic, responded, "Didn't have any time for it [religion] really. I was always working." Yet the symbol of his faith – the silver cross was always worn. Marg equated religion with her harsh upbringing in a convent but enjoyed going to church because she could walk there (a favourite pastime.) Church filled an important gap in later years when personal relationships were breaking down. Regular attendance at worship remains important to her.

Religion for Win was something that she had to do in her growing years. When asked what religion meant in her life Win said, "Not as much as it meant for Gary [her husband], definitely. Religion was simply something you did on Sundays, the thing to do." She felt that the best example of being truly religious was her husband, yet they rarely spoke of it. To Elsa, religion meant going to church on Sunday and helping with church activities on other days. The denomination did not matter to her—finding herself a place where she could be involved in helping with their community outreach activities during the week settled the question of where she would go on Sundays. Being part of a religious community was important. It gave her a sense of belonging, trusted friendships, and the experience of being valued for the physical contribution she was able to make to improve the lives of others.

Religion for many residents was clearly in line with definitions which explain it as being based on established forms of worship and with its associated observances, symbols and communities. Religion supplied their human need to be part of a caring community and to be needed in the service of others. On the other hand, Ben found his sense of community beyond the confines of religion.

Two residents had been particularly involved in leadership in their Christian denominations. Graham was very clear about the place of religion in his life. “When we talk about religion of course that goes with my profession. I was called to be an officer [Salvation Army]—that was my calling ... that didn’t work out—[after ten years] it was as if the Master said, ‘I’ve had enough, I’ve had enough of your time—go back to your art’.” Religion to Graham is simply God, knowing that everything in life is wrapped up in the ‘being’ of God, in the mystery of life. Religion, as he expressed it, was far more than an organised system of beliefs, symbols, rituals and practices. It could not exist without accepting the life mystery, the spirituality at its heart. He continues to live his life in this knowledge, while accepting that his difficulty with the formal ministry of his earlier years was in making this understanding real to others. He continues to gently help any residents who talk to him, who try and understand this God who is so real in his life.

Similarly, Mary’s life is dedicated (in her words) to conveying God’s love to others. A determined, sprightly woman in spite of her advanced illness, she was very clear that ‘religion’ was not in her vocabulary. “The word ‘religion’ is out with me, out with me. It’s not the end and be-all of everything. To me it is love. Love is God.” I again had the impression that it was the spiritual being of God that was the vital force in her life rather than the highly organised religion of her professed faith.

While continuing to practise their faith within their particular denominations the spirituality of Mary and Graham overcame the traditional restraints denominational religion might have put on them. Spirituality for them was an essential, non-negotiable facet of life. Religion and its practices could be questioned but not the spiritual realities on which they saw religion as being founded. The two participants experienced and understood

spirituality, in Moberg's terms, as a subjective, personal phenomenon.¹¹⁰ Further discussion with other participants indicated that they differentiated between religion and spirituality, but that both were part of their lives. Ngairé wasn't sure about the term spirituality but was certain that religion had been with her all her life. "It's inside and you can't do anything about it." She went on to equate it with her internal ailments, citing these too as the good Lord's action within her.

An inner, quiet perception of God was tied to Irene's reluctant acceptance of the events of her life. "What I want will happen, will happen. There's nothing I can do but accept it." Asked if she thought about spiritual things she responded, "Sometimes at night when I go to bed. Mostly then, and sometimes I wake up and lie there thinking—usually on a religious line.... I just believe if I talk to God—what's to worry about?" Asked if this brought reassurance and comfort that God is there brought the rapid, affirmative answer, "I know he's there. Nothing will ever change that. ... Yes. Well it's everything. Yes."

Zoe's response was different but indicated the way in which she interpreted spirituality as being the deep, guiding force in her life. She told a story of how she resolved a small conflict with another resident that had arisen. "I sort of said to God, now what can I do? I don't want to remain angry with this lady, I just want, not 'make it up to her', not that silly sort of thing. I just wanted to give her something, and she was so thrilled. I think God showed me the way. I really do."

Zoe had already told of a lifetime of faith and trust in God. Her response contrasted with that of Ben. For him, religion not spirituality was his point of reference. He recognised the importance of its symbols and rituals as they applied to others and told the story of being happy to wait to close the coffin of his dead Catholic father until his sister had time to buy a crucifix to put in his hands. Yet, when asked if he thought there was a heaven his answer was "No. I talk to my wife every day though." (His wife died some years ago but could be said to be 'spiritually' alive to him still.) Possibly this indicates that beneath the gruff, practical exterior he presents there is a spiritual awareness that he does not admit to.

¹¹⁰ Moberg, "The Reality and Centrality of Spirituality," 3.

“Spirituality was simply part of people” was Marg’s understanding. Her work as a volunteer at the Hospice led her to question “why these things happen?” but she conceded there must be something more to life. “Oh there has to be, there has to be. I’ve been talking to somebody up there for so long there has to be.”

Win’s marriage had been a happy, fulfilling one—her husband’s death has left a great gap in her life. Her husband had a deep faith but one she couldn’t share. “I’d love to believe. I think the security of believing would be lovely. But I just can’t. Spirituality is personal. Something to yourself. Something you are able to think and communicate with. Something that is an other, an extension of concept.” When asked what would typify spirituality for her she answered, “Gary [my husband] was spirituality to me.”

Elsa, after telling how she said her prayers every night and of the way prayer had been answered in her life said, “A spiritual sense to me is embracing everything—Catholic, Baptist, everything that matters. Everyone is as good as me and I just hope that they live like me. I mean I would go to any church for a funeral service, if I knew the person.” She went on to tell me of the ‘lovely’ Moslem friends she had. When asked if she talked to people about her faith her answer was, “I don’t think so—except with you—I don’t think I’ve ever had a discussion about religion.”

The responses to questions of spirituality illustrate the link between spirituality and relationships as proposed by Rumbold. Reflecting his hypothesis, the relationships observed here are predominantly intra-personal, that is the individual’s relationship with self, and transcendence, the individual’s relationship with a god or a higher being, the ‘something there’.¹¹¹ The prayers said, the sense of another ‘being’ were indicative of this. In some cases inter-personal relationships, relationships with others also influenced and were influenced by the individual’s spirituality. Win’s comments particularly highlighted the sense of spirituality as deriving meaning from a significant relationship. This relationship was severed by the death of her husband and has left her searching for meaning in her own life.

¹¹¹ Rumbold, “Collaborative Spiritual Care: Problems, Possibilities, Programs.”

From the comments of rest home residents comes the question of how best to enable them to process a sense of meaning of life, of being and becoming in the face of death, of how to work through the often unspoken, hard to identify spiritual challenges of ageing. These are issues to be addressed if holistic wellbeing is to be attained by residents in the final years of life.

Addressing Spiritual Issues: Residents' Relationships with Caregivers

Rest home residents expressed their views of religion and spirituality. As reported, some were secure in their understanding. Others were not. It follows that if holistic wellbeing is to be attained by rest home residents they will require sensitive support from the people with whom they form trusted relationships. Such people may include the caregivers whose daily care brings them into the personal ambit of residents. Krause addressed the need for older people to receive help in grappling with complex and abstract issues in order to derive a sense of meaning in life. He discussed the uncertainty older adults might have about the conclusions they have reached and the rationale on which they have relied in order to arrive at them. He made the point that it is important to have a 'trusted other' to help them reflect on their deliberations.¹¹² Acknowledging Krause's comment, the next stage of conversation aimed to establish whether or not the participating residents believed they had someone with whom they might talk through their unnamed fears, doubts or spiritual concerns in these later years of their lives. I tried to discern whether or not they would talk with their caregivers as people who may have part in their spiritual care.

I received a variety of responses. Mary has no doubt in believing in God as the power infusing and providing meaning to all life. She acknowledges the unknown 'mystery' of why life events happen as they do, but has a spiritual director/counsellor she talks to regularly so did not require anyone from within the rest home. She in turn talks to her caregivers every day about the reality of her faith and delights when they respond and discuss her comments

¹¹² Neal Krause, "Deriving a Sense of Meaning in Late Life: An Overlooked Forum for the Development of Interdisciplinary Theory," in *Handbook of Theories of Aging* (2nd Edition), eds. Vern L. Bengtson, Daphna Gans, Norella M Putney, Merrill Silverstein (New York: Springer Publishing Company, 2009), 111.

with her. Graham, equally confident in the reality of his relationship with God, similarly shares his spirituality (rather than denominational faith) with others, offering guidance when asked. Irene has an intimate friend outside the home and another, a caregiver from within the home with whom she can talk if the necessity arose. Ngaire commented that the caregivers “get all my moans and groans. I might be able to talk to the Chaplain here now [about spiritual concerns] but I don’t know him very well. Some things you can talk to people about—some things you can’t talk to them about—you know what I mean? Now [a former activities organiser within the home] – you could talk to her about anything.”

Ngaire, in giving the impression that a new relationship would have to be built with the Chaplain before she could confide in him, brought to the fore the importance of trusted relationships between caregivers and residents. When asked to whom she would talk if there was something bothering her, she responded, “I don’t really know. It used to be Betty [a former caregiver] but she’s not here now. I might be able to talk to Ned – he’s the Chaplain here now but I don’t know him very well. Some things you can talk to some people about—some things you can’t talk to them about—you know what I mean? Betty—you could talk to her about anything.”

Zoe would talk with her priest or to one of the two nuns resident in the home. Elsa, after a life spent helping people through her involvement in church activities, continued that habit in the rest home. I was told of her outreach to residents with dementia, other people who were, in her understanding “quite happy because they didn’t know they had a problem”. She loved a “good chat” with those residents whose minds were not affected but when asked if she ever had a need to talk through her own questions about life and its projected outcome replied, “No I don’t really think that for me. I don’t know because I don’t think I’ve ever let things worry me. I’ve sort of found a reason—I’ve got on top of them.”

In contrast, Ben was firm in saying “I don’t talk to anybody—not my sister. I’ve never been one to talk to people. I just keep things to myself. You think about it a lot you know. I wasn’t brought up to talk. My father was at sea. I’m just a loner you know.” Marg was direct in her answer. “Talk about things spiritual? No! There’s a service here on Tuesdays. Win was confident she could talk with her son about practical decisions that affected her future. The

recent experience of being alone without even work colleagues to talk with during the day had overwhelmed her. It was an experience like no other and she worried about returning to that state if she returned to her own home. She did not find it possible to talk with any of her caregivers, finding their lack of English a barrier. She was even more emphatic when asked if she could talk with caregivers about spiritual matters that bothered her. As a very private person, her response was, “I’d never dream of talking to caregivers. I have special friends, I have one very special friend who always helps me—that was after—I don’t think I could have carried on without her.” Win demonstrated a need for close relationships, but this need could only be met by people whose friendship had been tried and tested in the past—people who were now separated from her by circumstances of ageing.

The over-all impression gained from these answers in the interviews was that, as ageing brought participants closer to end of life experiences and death, a confidential relationship with an understanding other person to whom doubts and fears might be expressed was important to their holistic wellbeing. Recognition that this was important was not evident in the majority of residents interviewed. Certainly, although some developed warm relationships with their caregivers, the relationship did not appear to be associated with receiving spiritual support, a role that was identified with religious professionals.

Meeting Spiritual Needs

The interviews with residents gave an unclear response to the question of whether or not they have spiritual needs as they face the last years of their lives. Evidence gathered indicates that it is reasonable to conclude that rest home residents do have spiritual needs, equating with research information sourced from relevant literature. Participants did not always recognise and express their needs as ‘spiritual’. Most residents responded to questions pertinent to spirituality in terms of religious faith. For some the reluctant move into institutional care, often as a result of medical advice or from the decisions of family members, was the catalyst for facing spiritual fears. Loneliness and bewilderment engendered both by the move from known backgrounds and relationships and by the loss of independence caused by increased frailty and diminishing health, triggered introspective

reflection on life and its meaning. Various levels of anger and grief—the biographical pain of which Johnson writes—were perceived from both verbal and non-verbal indications.¹¹³ For some the religious practices of a life time were able to bring assurance and comfort when the pain was recognised. For others this was not so. For all, the changes in relationships (as in Rumbold’s spatial, intra-personal, inter-personal, corporate and transcendent definitions) were linked to an increased need for assurance that might be acknowledged as “spiritual needs”.¹¹⁴

Unsurprisingly, where residents are recognised as coming from a generation when questions of belief or deep inner feelings were not openly discussed, recognising their spiritual needs is a challenge for caregivers. Unless residents themselves recognise the need for individual support and direction in making sense of their lives and personally search for a trusted person with whom the spirituality or meaning of life might be discussed, this help may not be provided. As discussed in the previous chapter, institutional policies indicate an awareness of the spiritual dimension of aged care, but recognition of spiritual needs and implementation of spiritual care appears to be delegated to religious professionals rather than regular staff with whom the residents may build trusting relationships. The importance of the caregivers understanding of the implications of residents’ spiritual needs through appropriate training cannot be underestimated if the care given is to be holistic. A discussion of this follows in the next chapter.

¹¹³ Johnson, “Spirituality, Finitude, and Theories of the Life Span,” 666.

¹¹⁴ Rumbold, “Collaborative Spiritual Care: Problems, Possibilities, Programs.”

Chapter 4: The Caregivers

The focus of this thesis now moves to the caregivers who are responsible for the individual care of ageing rest home residents. Caregivers, or ‘carers’, are members of the paid workforce who provide care for older people in residential facilities.¹¹⁵ The group of such workers is large. In its 2012 report into employment in the aged care sector, *Caring Counts*, the New Zealand Human Rights Commission [HRC] noted that “as many as 48,000 workers in New Zealand, the vast majority of them women, undertake indispensable but largely invisible employment every day. They care for older people either in their homes, in residential aged care facilities, or in hospitals.”¹¹⁶

In the rest home context specifically, caregivers perform a vital role in maintaining optimal conditions and sustaining vulnerable, ageing residents in the last years of their lives. By paying attention to the caregiver role this chapter examines the connection between employed rest home caregivers and the spiritual care of residents. The question arises as to whether the caregiver is adequately trained to recognise and respond to spiritual needs in ways that are appropriate to the individual. Do caregivers understand notions of spirituality and spiritual care as a dimension of their work? This chapter provides a profile of the caregiving constituency before examining the training, attitudes and expectations of caregivers in the two case study rest homes, with respect to spirituality.

Caregiving and the Caregiver Workforce

Caregivers operate within a wider context of care, which incorporates a range of participants. Rest homes draw upon the contribution of various specialists who work as a team to provide holistic care—physical, psychological, emotional, social and spiritual—in support of residents’ well-being. MacKinlay emphasises the importance of the contribution of aged care staff in facilitating well-being, noting that staff attitudes are more important to

¹¹⁵ NZHRC, *Caring Counts*, *Tautiaki Tika*, 13.

¹¹⁶ *Ibid*, 1.

resident morale than the building design and environment of the rest home.¹¹⁷ Within the rest home context caregivers are formally assigned what could be seen as relatively mundane physical tasks associated with cleaning, clothing and hygiene. However, the caregiver role is never purely physical as, “caring for older people requires a unique set of skills, resources and personal relationships”.¹¹⁸ The main purpose of caregiving is illustrated in a sample rest home caregiver job description, which states that the job is: “To provide quality nursing cares within [the rest home] philosophy of care and service objectives, and the Health and Disability Code of Rights; To work under the supervision of a Registered Nurse and be part of an interdisciplinary team to provide nursing cares and treatments; To assist each older person to maintain their independence for as long as possible.”¹¹⁹ This description is comprehensive and describes a need for wide ranging skills in caregivers.

The recent HRC Report of the Inquiry into the Aged Care Workforce gives pertinent information about both the nature of the workforce and the challenges faced by caregivers in the rest home sector. According to the report, the sector is staffed by an ageing and largely female workforce. The ageing of many current caregivers and their probable pending retirement makes recruitment and retention of workers a significant contemporary concern.¹²⁰ While the dominance of female workers was noted, the caregiver sample examined in this research could not be described as “ageing”. The report also notes the desirability of overcoming this gender imbalance of caregivers in rest homes. Statistics indicate that 92% of caregivers are female.¹²¹ Many male residents, however, relate more easily to male caregivers, making the recruitment of more male caregivers desirable. This task is likely to be important if demographic trends indicating increasing male longevity persist, since an increase in male residents is to be expected.¹²² Ageing and gender issues amongst caregivers are important but so too is ethnicity.

¹¹⁷ MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 238.

¹¹⁸ NZHRC, *Caring Counts, Tautiaki tika*, 17.

¹¹⁹ From the job description supplied by Rest Home A.

¹²⁰ NZHRC, *Caring Counts, Tautiaki tika*, 23.

¹²¹ *Ibid*, 97.

¹²² *Ibid*.

The rest home sector workforce in New Zealand is ethnically diverse. This pattern was reflected in the sample of caregivers interviewed in this research, where 50% of the caregivers interviewed were migrant workers. The 2006 Census reports that 25% of caregivers in the aged care sector were born overseas.¹²³ The HRC report points out that some migrant nurses become caregivers if their nursing qualifications are not recognised in this country. Other migrant workers take up long-term care jobs or work at lower levels than their qualifications demand because of their lack of ability with English. For such as these, caregiving may be a transitional job worked at until English requirements are met. For migrants who move to New Zealand in response to the demand for cheap labour, the traditional female task of caring for others offers the opportunity to become established as part of the local workforce.¹²⁴ The pressures created by these social issues result in rest homes with a caregiving workforce which may present residents with unaccustomed cultural challenges.

Cultural Diversity

The culturally diverse labour force in rest homes is not matched to the predominantly Pakeha/European culture of residents. Maori and Pasifika cultural traditions have meant that fewer people in this age group have moved into residential care. Rather, most elderly people in these cultures are cared for within family homes, for example, within the Maori *whanau* or Samoan *aiga* (wider family). There is evidence, however, that these patterns are changing, as family members are themselves either in the paid work force or ageing to the point where they cannot sustain actions of care for the frail elderly. As a consequence rest homes are receiving a small increase in residents from Maori and Pasifika communities, a trend that is predicted to increase in coming years. If this is so, a corresponding, developed understanding of appropriate cultural mores will be required.¹²⁵ Cultural understanding becomes important when issues of residents' spirituality are considered.

¹²³ Ibid, 104.

¹²⁴ Ibid, 103-104.

¹²⁵ Comments gathered from discussion with The Hon. Luamanuvao Winnie Laban and Professor Cindy Kiro (August 15, 2013), reflecting on the Tagata Pasifika television documentary "Elderly Care" (August 1, 2013).

Spirituality is a significant dimension of culture. Eames, quoting from the Universal Declaration of Cultural Diversity, writes that, “culture should be regarded as the set of distinctive spiritual, material, intellectual, and emotional features of society or social group, and ... it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.”¹²⁶ In the course of this research it was evident that migrant caregivers in particular saw both religious and spiritual needs of residents as being ‘cultural’. Challenged daily to understand the cultural background of residents, caregivers found the customs and values through which residents’ identities were formed, differed in significant ways from their own. These cultural differences embody a number of specific issues for care, although not all of these were negative. In discussion, each caregiver drew comparisons between understandings from their own cultures and the largely Pakeha/European or Maori cultural traditions of their ‘cares’.¹²⁷ Interviews with caregivers from six cultural backgrounds showed that their own experiences and training had helped them to be aware of differences in cultural food constraints and death and dying rituals. Understanding these defined differences was important. However, the spiritual implications of culture presented a number of implications for care.

Caregivers Interviewed

The eight female and two male staff caregivers interviewed in this study were nominated by their rest home managers, and interviewed in the two selected rest homes. The variations in the demographic characteristics, the ethnicity and the qualifications of the men and women who participated in the interviews corroborate the HRC report comments in this regard. The diverse ethnic backgrounds of these rest home caregivers were significant as their cultural and language differences influenced the way in which they approached the residents for whom they cared. Caregivers were not asked their age. The number of years

¹²⁶ Penny Eames, “Spiritual Wellbeing for Older New Zealanders” *Perspectives in Public Health*, 130: 2 (2010):62-63. Quoting from: UNESCO, *Universal Declaration on Cultural Diversity*, adopted by the 31st Session of the UNESCO General Conference, Paris (November 2, 2001).

¹²⁷ ‘Cares’ was the noun many caregivers applied to the group of people to whom they were assigned and for whom they ‘cared’. “She’s one of my ‘cares’.”

they had worked in and experienced caregiving in rest homes was noted. The average time of employment of interviewees at Rest Home A was fifteen years, while at Rest Home B the average was six years. The variation is partly explained by the number of years since the two rest homes were established. Rest home A has recruited caregivers for thirty-nine years, the interviewed caregivers' years of service ranging from twenty-five years to six years. In contrast, caregivers interviewed in rest home B, established less than twenty years ago, had a lower average tenure. Regular work was important to these caregivers. There appeared to be no desire to change employment in either rest home.

Caregivers explained their reasons for undertaking this work. This information is included here by way of introducing the caregivers, and to exemplify the concerned approach they showed towards their resident 'cares'.

Rest Home A

Dawn is a senior nurse with management and training responsibilities at the rest home.¹²⁸ A New Zealand Pakeha, she trained as a nurse then worked in a variety of specialised nursing situations before being employed for the past twenty-five years as a caregiver for the elderly. The move to caregiving nursing was made firstly for family reasons –the hours of work, the convenience of a work place close to home—and the challenge of something different. She explained, “So I started at a rest home and I found that I enjoyed it. Coming here I think I blossomed and learned a lot more. When you understand and learn it is even more worthwhile. I just love looking after these people.”

Edna, also Pakeha, has had fifteen years' experience as a caregiver. Before being employed fulltime in her current rest home she had worked in another and also as a caregiver in the community. Edna expressed her satisfaction with her work commenting that she found fulfillment in it because it entailed “Getting to meet people and just getting to talk to them, getting to know them.”

¹²⁸ All names are pseudonyms as anonymity was promised.

Meg, who is Maori, had worked for seven years as a caregiver in the rest home after a brief experience at another. She was happy and enjoyed her work in this rest home “Because the staff here—I found them so marvelous with the patients, a lot of support—that was through management; my training peers were excellent. They never shunned me or said they didn’t have time for me. They were always here to help me so that’s why I settled in very well here.”

Rosie is also Maori. She said, “I’ve worked here about twenty-four years. As soon as my last child started school I started here in the kitchen. I asked my boss—I said I was happy to experience all jobs so I don’t really know how long I have worked as a caregiver—probably about fourteen or fifteen years maybe.”

Tom began working in rest homes as a gardener, rising from under-gardener through promotion to full time work as maintenance man. His job now includes driving the rest home bus and escorting residents on regular outings. Despite his lack of full training as a caregiver, both management and residents recognise his caregiving skills. Speaking of his love of the job and relationship to residents he said, “Oh yes. I spend a lot of time with them—they all know me. I’m the best known one around here.... I do my little tour in the morning when I arrive. I call in and say hello to them all.... They love it. Yes. It’s just a little personal visit.”

Rest Home B

Sunada, a Fijian-Indian Hindu, had five years’ experience as a caregiver in the rest home. Shy and nervous about being interviewed she began to relax as we talked. “Yes. If I stayed at home I would have nothing to do. I can spend my time with elderly people. Take care of them.... I really like them and I want to work for true understanding. This is my first job.”

Sawini, who was also Fijian-Indian, and Hindu, migrated from Fiji having never been employed before. Finding that in New Zealand both husband and wife had to work to provide for their family she worked part-time for a year in another home then, following a short period of part-time employment at the rest home, was accepted as a full-time worker—a total of nine years as a caregiver. She expressed pleasure in her work. “Oh I love

working with these older people. Yes. Care for them, yes everything. For all my day goes to work with them for my fun and work and everything and we learn new things every day.”

Fajr, a senior caregiver (and so permitted to give out medications) had worked there for eleven years. She has Indo-Fijian ethnicity and is Moslem. As she explained her duties it became clear she valued and was serious about the intimate nature of caregiving, gently but briefly commenting, “It’s quite a nice experience to work with aged care people you know.”

Shari, a Hindu Malaysian had worked in the rest home for four years. She was anxious for me to understand that she qualified as a nurse at home saying, “Because I work in nursing in my country so I find this job is very nice you know? This is my life and I can do it better you know? The caregiving ... I am qualified. I enjoy being a caregiver. It is similar to nursing what we are doing you see.”

Similarly, John, a Christian Filipino was a qualified nurse who explained his two years of employment as a caregiver as, “It is nursing. Because I’m a nurse. I just finished nursing training in my own country—and this could be the only way I have a job here.”

Each caregiver presented their distinct personality, as the foregoing quotes demonstrate. In the course of the interviews I was able to build an understanding of their individual attitudes towards the residents for whom they cared. Each resident was seen and cared for by these caregivers as a person, rather than as a task to be faced each day. The caregivers’ attitudes reflect Hudson’s view of the significance of individual personhood to holistic healthcare. Hudson argues that such recognition is integral to the well-being of those who are cared for, arguing that, “personhood can be reduced to ‘thinghood’, particularly when a person is reduced to component parts, rather than treated as an indivisible unity of body, mind, and spirit.”¹²⁹ She further concludes that “personhood is prompted by persons in relation, where even the seemingly remote ‘other’ finds a place.”¹³⁰ The caregivers that I interviewed were evidently building such individual relationships with their ‘cares’. The significance of these relationships was apparent in Rest Home A where staff had changed

¹²⁹ Rosalie Hudson, “Personhood,” in *The Oxford Textbook of Spirituality in Healthcare*, ed. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford: Oxford University Press, 2012), 105.

¹³⁰ Ibid, 110.

and two residents expressed their individual needs to find someone trustworthy with whom “things could be talked over”.

Language Difficulties

Building personal relationships requires overcoming one particular difficulty—the language barrier. Effective communication between resident and caregiver is vital to the establishment of quality care. MacKinlay writes, “The onus is always on the staff to effectively communicate with residents, never the other way, as these elderly people may often have impaired communication abilities, and need sensitive support from the staff.”¹³¹

Ageing residents are likely to suffer sight or hearing loss, times of forgetfulness, hesitancy or reluctance to express personal needs. Overcoming communication barriers is important to the holistic well-being of residents, and this is not made easy when the caregivers are themselves speakers of English as a second language. Interpretation of idiom or unusual words can lead to misunderstandings between resident and caregiver. Heavily accented speech is often not understood by the resident.

In one rest home, facility with communicating in English was a major difficulty acknowledged by the five interviewed caregivers, and also mentioned as a factor by some of the residents for whom they cared. The limited command of English or strongly accented English exhibited by these five caregivers inhibited easy communication with residents. The caregivers were alert and bright as they addressed the residents, but it was apparent that their comments or questions were not always understood. Win, a resident, spoke of being at the mercy of the caregivers (an emotive statement), although “all the women who work here are very pleasant and kind”. However she felt unable to talk with them because, “They’re mostly Islanders, Fijians or possibly Filipinos—I think two of them—I might be wrong –that’s my wild guess. They’re the males. There are three males [Filipino].... They’re different races from the women [Indo-Fijian caregivers].”

¹³¹ MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 238.

A caregiver, John, commented about difficulties he faced in his conversations with residents, “Sometimes you don’t have any knowledge—you don’t know. This is my second language. But I’m still learning.”

As a researcher, I too found that the heavily accented English and lack of vocabulary of the migrant caregivers made it difficult to understand their responses to my questions at times. As Shari, a Malaysian Hindu caregiver enquired at the end of our interview, “Do you know what I am saying? My English is not very good at times. I hope you understand.” Indeed her English had been difficult and it was an effort at times to find the defining concepts behind her words. Shari and other migrant workers were struggling to develop their understanding of and use of the English language. While their capacity to understand all comments made by residents was limited, their caring attitude towards the residents was not diminished. Yet their ethnicity and language difficulties formed a barrier that isolated them from understanding the needs of some residents.

Daily Work with Residents

In the two rest homes studied the staff caregivers’ duties were consistent with the job description referred to earlier in this chapter. Daily each caregiver came into intimate, personal relationships with the ageing residents to whom they were assigned. Caregivers in both homes had a regular order of duties to perform which reflected the needs of residents according to the time of day. Those on the morning shifts had to rouse their ‘cares’ and sit them up for breakfast, clear after breakfast, tidy their rooms, supervise showering and dressing, check and report medical problems to the Registered Nurse, and generally prepare their ‘cares’ for the day ahead. These appeared to be basic duties with slight variations between the two institutions. Caregiver Meg offered one insight into this work saying, “It [the morning shift] is probably the hardest shift of them all. Night shift’s a piece of cake if all the patients are fine. I’m not saying it’s a piece of cake all the time because sometimes it will take just one or two patients to throw the whole night. The afternoon shift’s not too bad either because they’re not showering – just a case of giving them a good wash and making sure their teeth are done.”

While the caregiver role is primarily defined in terms of physical care, the nature of caregiver duties means that the role is never this narrowly understood. The physical limitations of the frail elderly often require the caregiver to support or lift residents to enable them to rise or move from bed each day. Cleaning and hygiene tasks follow routines established to deal with physical surroundings and personal cleanliness—showering or washing, cleaning teeth and hair, cleanliness of clothing—as well as the undignified and unpleasant tasks, such as dealing with results of incontinence. The intimate nature of these tasks necessitates the building of a relationship of trust between caregiver and resident. It also means the caregiver is often the first to notice and report signs of deterioration in a resident's physical or mental state to the registered nurse on duty. These may include increased physical frailty, a developing inability to balance or move independently, a deteriorating skin condition, or a cough or rise in temperature that might require further examination by medical personnel. A resident's increasing bewilderment or inability to respond rationally in conversation with the caregiver would be reported as a sign of mental deterioration, possibly the result of strokes or advancing dementia. Fajr, a senior caregiver explained the work of her junior colleagues, "And then they take care of the residents—like Mr S—he's very sick, coughing—and then they come to me and say "Mr S is very sick, coughing" and then they might say he's got flu symptoms. And then I assess. I go to see him and take his temperature, B.P.[blood pressure] and then I report to the R.N. [registered nurse] saying this is my patient, my side, having these symptoms. She goes to see him and will report to the doctor."

Although rest home residents are more independent than those in hospital facilities, this in itself proves an extra challenge for caregivers. Personal independence is usually defended by residents. Seventy-five or more years of independent living and thinking by them is not easily relinquished to the new demands of daily routine in rest home life, even when the mental and physical limitations of ageing become manifest. Consequently, caregivers are required to display tact and understanding as they undertake their duties, encouraging residents to get out of bed each day, to wash and dress, to choose appropriate clothing and to move away from their rooms to participate in the occupational or social activities

provided by the rest home. As they work with nine or more residents on each shift, the caregivers become very aware of residents' mood swings or emotional crises, and often develop considerable empathy, care and respect in dealing with the variety of challenges their work entails. As one caregiver, Rosie, explained, "I do about four or five showers a day, so you start a shower with one person and then you check on another having a wash. In this sort of work you have to become really friendly with your resident. Ask them nicely to help with the assistance—like start getting dressed for the day—you put out the clean clothes and so on."

Through the very private conversations that arose while care duties were undertaken, Meg found herself the recipient of residents' stories that previously may never have been told. Interviews with other caregivers revealed that listening to experiences of past incidents in the lives of residents was part of their caregiving experience—stories of pain, hardships or regretted actions possibly never before spoken of but now shared with the person who was showing a personal concern for their well-being.

Intimate contact was fostered by the concerned attitude of the caregivers. In the course of my interviews it became obvious that caring was understood as more than a concern for their physical necessities. Caregiver Rosie's comment was indicative of this. "I encourage the residents to do a bit for themselves ... the main thing is to try and maintain independence and feel wanted. Stuff like that—you know." Caregiver Fajr recognised the loneliness that is felt by residents who no longer have partners or families whose presence once formed the nucleus of their lives. "It's a really good experience working with the people—their special needs and all that ... most of them are alone. They have a niece or nephew or something like that but they get lonely, they want to talk."

Rosie and Fajr encapsulate the caregivers' expressed understanding that each resident is recognised as an individual with individual needs to be addressed. The fact that they had little time to talk individually with their 'cares' was a general complaint. The common impression gained in all ten interviews was of a deep and focused sense of loving concern for the ageing residents for whom they had responsibility. As Shari expressed it in her limited English, "I really enjoy this work—it's really helpful for the old people you know? It is

a good thing that we are doing too. It's not just doing for your job it's doing for my heart and inner too—so if there's anything, I can help them you see.”

The depth of caring that was expressed by these caregivers reflects the general commitment of New Zealand nurses and caregivers of the elderly identified in the HRC inquiry into the sector. The report speaks of caregivers being generally fond of the people they cared for and feeling a responsibility for them.¹³² Similar attitudes were evident with caregivers I interviewed. They are central to the trust and mutual affection that may develop between caregiver and resident. It does not happen in every case, but in many instances (as noted in interviews with residents) individual caregivers do become ‘special’ to particular residents and their time on duty becomes anticipated with pleasure. Some caregivers interviewed were aware of the trust and reliance placed on them by particular residents as exemplified by Meg’s comment, “I go home—I’ve got a patient in my wing, she walks around the corridors looking for me (I know because my daughter works here like me). She comes home and says, “Oh, Mum, Mrs. D. is walking about looking for you.” Then I come back and my boss says, “O Meg it’s so good to have you back. Your patients have missed you.” The particular resident in question suffered from early stages of dementia and Meg told of the way she would talk to her, encouraging and guiding her through the challenges that faced the resident each day.

Verbal communication was an important dimension of Meg’s interactions, a factor that highlighted the difficulties faced by migrant caregivers who lacked English language skills. Responses from other caregivers made it clear that caregiving was never done in silence, for they used verbal encouragement to stimulate response in the residents. This proved to be so even when the resident was reluctant or unable to respond (having lost speech from stroke-induced brain damage or because of the loss of a major percentage of hearing). More often than not, responsive verbal communication was the catalyst for stimulating a relationship of mutual understanding between the caregiver and resident. In turn, when time permitted, this led to the caregiver being the recipient of the resident’s expressed

¹³² NZHRC, *Caring Counts, Tautiaki tika*, 18.

anxieties or apprehensions. Such conversations variously revealed psychological, emotional, social, or spiritual concerns. To respond adequately, the caregiver needed to understand something of the holistic needs of the individual that reached well beyond the expected physical care being offered. Edna's observation on these dynamics was particularly pertinent to the focus of this research: "We get to know them a lot—some of them have been here a long time and it's sad for them going [at death] but we know they've got no pain any more ... it's mostly the women I find that talk to you about religion, more than men, though the men do talk to you as well ... and most times that's at night as well. I find they're very appreciative of you listening."

Edna's comment endorses Rumbold's point that spiritual care takes place within genuine human encounters, and requires both skill and humility of its practitioners; it is not something that can be delivered simply as a professional service.¹³³ Whether or not the caregivers recognised and felt able to respond appropriately to the expressed or implied spiritual needs of the residents was of particular concern to me. This key factor will be further discussed in considering the elements included in training programmes established for residential caregivers.

Understanding of Religion, Spirituality and Residents' Spiritual Needs

Recognition of residents' spiritual needs was present in the two institutions featured in this current study. As noted, policies in each made provisions, based on their philosophy, to meet these needs. On admission to either rest home the new resident is interviewed and an individual care plan drawn up, a section of which acknowledges the newcomer's possible cultural, religious or spiritual needs. Responding to the questions involved may centre the resident's thoughts on these matters, which previously might have been disregarded. That the initial entry into the rest home may bring about a spiritual crisis is affirmed by Dawn

¹³³ Bruce Rumbold, "Models of Spiritual Care," in *The Oxford Textbook of Spirituality in Health Care*, eds. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford,: Oxford University Press, 2012), 182.

who explained that her role in admitting residents entailed filling in forms with relevant information from the new resident to enable the staff to recognise his or her spiritually based needs both in the present and at the time of death. She said it is a sensitive role and in the process of asking the necessary questions, the new resident will often confess to a fear of death. She commented that at times this may lead into a spiritual discussion, "Perhaps not at any depth but sometimes it can go on with the new resident saying, 'I'm really frightened about dying'. If someone is frightened about dying I often will say, 'Well, it's just one of those things we can't really do terribly much about'; but sometimes I do say, 'next time the Chaplain is here you might like to talk with him'." As time goes on and the permanence of living in the rest home becomes accepted the resident may seek a trusted person with whom such doubts and fears may be discussed, that person often being the caregiver.

Caregivers bring their individuality and personality to their role as the personal nature of the relationships between caregiver and resident develop. As a consequence, in order to assess the caregiver's role in responding to the spiritual needs of rest home residents, time was spent gaining an understanding of their perception of 'religion' and 'spirituality'. At this point the complexity of the English language became a problem for some of the caregivers. Many introduced comments on the culture of residents. This did not apply solely to the migrant speakers of English as a second language, for spirituality may be seen as an integral facet of both religion and culture. It was therefore not surprising that perceptions of religion, spirituality and culture became intertwined in the interviews with caregivers.

In response to the question, "What does the word 'Religion' mean to you?" some caregivers clearly interpreted religion as an organised approach to their god through prayer, church/faith community attendance or teaching. Edna felt she clearly understood religion. "People have their own religion. It's their right to have whatever they want. They believe in God. Some of them don't. It's just something we go by." John was equally firm in his reply, "Religion? It's a relationship to God. Religion will not save you. Only God will save you." For Sawini, "Religion means like so many different residents here—like all their religions. Like they believe in Moslem—most of them are Christians—that's their religion? So the

Christians, they go to church on Sundays for their prayers, yes?” Yet Sunada found it hard to separate religion and culture and replied with questions, “Religion? Ah—like which culture? Like I am Hindu? They always ask me about my mark [her bindu].” Shari too had difficulty expressing her understanding of religion, identifying it with culture, “I don’t understand. Like Maori religions? Maori culture, Kiwi culture—so many different—I’m still learning you see—so many different.” These comments were similar to those of others and gave the impression that religion and culture were considered synonymous words, especially in the minds of those whose lives were based in cultures differing from those of their ‘cares’.

The degree to which caregivers recognised the spiritual needs of their “cares” varied. When questioned on an understanding of ‘spirituality’ the mental link between the two concepts continued for some. Most reported that the need to be aware of the residents’ spiritual needs was embedded in the training they received at the start of their employment. In discussion, however, it appeared that the focus in this section of the training was on the spiritual values associated with particular cultures that must be respected. As Sawini commented, “Spiritual person—I think it’s like that—we have one of our residents here who doesn’t eat pork.” Meg was emphatic, “We had lectures on different cultures—like the Maori culture, the Jewish culture, and Indian culture as well. One thing I learnt is if the patient talks about their spirituality or their culture openly I learnt not to push my beliefs on them. It took a lot of time for me to understand because I thought I was being helpful but in fact I wasn’t.” Shari said, “Spirituality is like age—you are getting aged—you know, they got nothing to do—like their family. They got their own things—like the spiritual—they have to pray themselves and make themselves strong you see? Their prayers will help them. I tell them if you go to church and pray it will make you happy and then your mind will be happy—talking to their God. They will feel much better.” Fajr too associated spirituality with church attendance. “In [the rest home] we got a chapel—the different ones [clergy from various denominations] they come here. The residents, they go to the chapel services each week.”

I consider such answers to have evolved from the personal spiritual understanding of the caregivers. While three of the caregivers were Hindu devotees, and wanted to go on to talk

about spiritual experiences from their point of view, others expressed Christian understandings. One saw her spirituality deriving from being in touch with the spirituality of her people [Maori]. Another was devoted to her Moslem practices and her conversation demonstrated a life spent in her own tradition, noting the strength she gained from her daily devotions.

Other caregivers expressed understandings that were less obviously shaped by religious orientations. For Meg spirituality was an integral part of her connection to some of the difficult people she cared for—a spiritual connection that could not be explained in any other way. “I don’t know, I just seem to have a connection with people at times, but it’s the difficult ones I seem to take to—the naughty ones—I don’t know why ... I just seem to take to them, to take up the challenge to connect with them. And once I’ve made that connection I know I’ve done my job very well. [Asked, “what is it that keeps the whanau together?”] It’s love and compassion and the spirituality.” Edna too had an instinctive rather than taught understanding of residents’ spirituality. “Spirituality? Would that be like someone didn’t believe in God, but they still believed in something?”

Overall, I found that caregivers’ understanding of culture, spirituality and religion varied widely. A definitive understanding of spirituality in terms of integration of self in a new community, of bringing a sense of meaning to life, of coming to terms with existence and the possibility of death could not be expressed by them. Answers were limited to aspects of death and dying—when asked if the residents ever spoke to them about such matters most responded that spiritual questions revolved around the residents’ wish to die. The caregivers commented that residents expressed their spiritual doubts or concerns at times of suffering or distress—when loneliness, deterioration in health, hopelessness or seeming alienation from loved ones became too much to bear. Tom, reflecting on his daily chats with residents explained his response, “Some of them wonder why they are still here, they don’t know why. I just say to them ‘when your time’s ready he’ll come, he’ll come. But your time’s not up yet’.” Shari said, “I say that everybody have to go one day but if you’re here, enjoy life. Stay in this world because God give you so many things, God will take you when he wants, but until then enjoy your time—and your body must be kept strong so you have to

do an activity every day ... the world is ours to enjoy, God gives everything. Just keep doing things and we will help take care. Be happy.” Sunada attempted to divert residents. “Some of them do say ‘when is it [death] going to happen?’ And I say, ‘no, no, no, you are not going to die’ ... when there is an attack we just tell them something else.” John’s response was interesting, because it raised the question of boundaries that must not be crossed in responding to residents’ comments or questions. “I would just comfort them and tell them. I cannot reassure because you don’t do that. That’s what I learnt from the course.” Rosie was very aware of her limitations and the boundaries she must not cross in responding to spiritual concerns of her ‘cares’. “Some of them are thinking about when they pass on. I say go and talk to Jenny [former Chaplain] or Mary [home manager] or even their family. I’m not the one to talk to.”

Sulmasy endorses this kind of approach, emphasising that caregivers need to be constrained by boundaries when working with their ‘cares’. He notes the danger of proselytizing, of violating the dependent nature of, in this case, the caregiver/frail resident relationship. The caregiver might suggest that confidential issues, which may be shared by a resident, could more appropriately be discussed with the chaplain or counselor. While a resident might ask for simple prayer, he argues that such prayer should not be offered by the caregiver. In summary, he states there is ethical justification for spiritual care but it must be guided by firmly set ethical principles.¹³⁴

In summary, from the interviews it was apparent that caregivers were not easily able to separate concepts of culture, religion and spirituality but recognised the importance of each of these in the lives of the residents. Evidence expressed from their own faith backgrounds indicated that they understood and tried to respond to the elements of religion and spirituality that arose in the lives of their ‘cares’. It was clear that some aspects of spiritual care were recognised as part of the care residents required at times. However, it was equally evident that caregivers were hesitant and uncertain of how to make appropriate

¹³⁴ Daniel P. Sulmasy, “Ethical Principles for Spiritual Care”, in *The Oxford Textbook of Spirituality in Health Care*, eds. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford: Oxford University Press, 2012), 465-470.

responses to this need. For this reason the spiritual component of their training was examined.

The Spiritual Component of the Training of Caregivers

When interviewed, eight of the caregivers indicated that the spiritual component of their training courses was defined by the requirement set by the unit standards in the National Certificate in Health, Disability and Aged Support (Foundation Skills). Two caregivers had not received this training. The ACE programme studied by most of the caregivers meets the Foundation Skills requirements and is delivered in a series of modules. Spiritual components of caregiving are developed as core competencies within this programme, a mode of instruction recognised by Kelly as being one which enables the real learning needs of caregivers to be met, in turn meeting the actual (not assumed) spiritual needs of patients.¹³⁵ Yet, in practice, the course does not appear to have enabled caregivers to make the distinction between the understandably difficult concepts of cultural customs and spirituality.

Spiritual aspects of care are addressed in a number of places within the ACE programme. Module One introduces *Support Work*, which outlines the holistic nature of caregiving and defines the types of information gathered when a resident enters a rest home. Here, basic definitions are given which recognise the difference between cultural customs and spirituality. 'Spiritual Information' is broadly defined to include information "about how people find meaning in life and a sense of connection with people and important things in their life." 'Cultural Information' is defined as being about "a person's culture is what they do and why they do it, what is important to them."¹³⁶ Caregivers may access residents' information as collated by the nurse manager, and entered in the individual resident's care plans.

¹³⁵ Ewan Kelly, "Competences in Spiritual Care and Education Training", in *The Oxford Textbook of Spirituality in Health Care*, 440.

¹³⁶ The ACE Programme, Module 1 (Health Ed Trust New Zealand Inc., 2008), 23.

In Module Two, *The Ageing Process*, caregivers look at the spiritual effects of ageing, together with cultural changes that may arise from life experiences. The training module comments “that as we get older, we may think more about spirituality and what it means to us,” noting that spirituality means different things to different people. In this it includes reference to seeking meaning in life through religion or ideas about life, expressing spirituality in love for other people or love of nature, linking spirituality to special places such as the marae or beach or forest, and spirituality as it involves the idea of the soul which may continue after the death of the body.¹³⁷ Reference is made to culture in relation to the aged, the module noting that “our culture does change as we age. It is always important to find out about the culture of each person you support and be aware that their culture may change.”¹³⁸ It suggests cultural changes are brought about when for medical reasons diets have to change or when daily life experiences of work and relationships change as a result of ageing and the new way of life in the rest home. Recognising and understanding the cultural change engendered by the move into a rest home is of particular importance for caregivers.

Module Four, on *Effective Communication*, attends to the changes in spiritual and cultural awareness in residents brought about by experiences of grief, noting this is a time when religious beliefs or spiritual values may be questioned. It is in the comprehensive treatment of grief-based issues that, in compliance with the rest homes policies and procedures, the caregiver might recognise the resident’s need for more specialised support beyond the boundaries of the caregiver’s own abilities. The module teaches caregiver responses that can be effective in caring for the many ways in which residents grieve for losses endemic in their own ageing process and in the deaths of loved ones. Paramount in the discussions is the instruction “Remember, stay within your role boundaries, your own abilities and the policies and procedures of your organisation when offering support to a grieving person”.¹³⁹

¹³⁷ The ACE Programme, Module 2 (Health Ed Trust New Zealand Inc., 2008), 48.

¹³⁸ Ibid, 50.

¹³⁹ The ACE Programme, Module 4 (Health Ed Trust New Zealand Inc., 2008), 81.

Spirituality is not always an easy concept to express. The spiritual component of the observed caregivers' training is embedded in these particular modules of the ACE programme, but I come back to the question, "does this training help caregivers understand the significant role that spirituality plays in the establishment of wellbeing in the lives of the frail elderly?" Based on the findings of this study I believe it begins to do so. The nature of care offered by the caregivers shows they have some perception of the spiritual needs of their cares implicit in the way they interact with them. Issues of culture and spirituality are distinguished in the ACE modules but, particularly in the difficult context of spiritual awareness, the prescribed ideas are not fully understood in practice. I suggest that these modules help the caregiver progress to a deeper understanding of residents' spiritual needs, but if attention to spiritual care is part of the caregivers' role they may need times of relevant discussion with their mentor, tutor or supervisor to fully understand its significance.

Caregivers' Response to Training Received

Caregivers' acknowledged that that their training courses were important, and had furnished them with new understandings and practical caring skills. However, little mention was made of the spiritual aspects of the courses. In discussing their training caregivers merged spirituality with what they had learned about cultural issues. For example, Meg did not mention training to recognise aspects of spiritual care but highlighted the subject content of a course that included: "Dementia; everyday living cares that they needed; it helped us recognise—jeeppers—it all comes naturally to me now but then I didn't understand. When I started my training here, everything started falling into place." Meg's new-found confidence endorses the comment in the HRC report "that training is itself intrinsically rewarding for those who undertake it, promoting enhanced self esteem and a sense of achievement."

Similar pride in achievement was expressed by three formerly untrained women who were employed as rest home caregivers and who had now received in-house training through the ACE programme modules. Understanding appropriate cultural responses was important to

them yet there was no mention made of spiritual issues. Sawini explained, “We had the orientation and so many programmes—you know, the ACE programmes, they were teaching us and then we got the certificate for that.... It’s all free for the staff—all the training. Yes, so when we do the ACE we know more about old people—what to do. We learnt them all from here.” Rosie recalled how she was encouraged to do the courses. Fajr, after working for eleven years and now a senior caregiver, has completed the National Certificate in Aged Care. She has a good command of English and her years of experience as a caregiver gave me a clearer insight into the training the caregivers at Rest Home B experienced. She outlined her training and added “In a year we get about twenty teaching things about many topics. For example we get one about skin care for residents—about the pressure areas, about abuse or neglect for our cares. We had people coming from outside to talk—we had people coming to talk about Parkinson’s, things like that. About what it means and how you can look after them. How to recognise symptoms for them—you know, how to help them.” Yet, again, focussed training in responding to spiritual issues was unmentioned.

Responding to spiritual needs appeared to be left to the caring instinct of the caregiver. Tom, who did not fit the regular pattern of caregiver (although he was acknowledged as one by management), explained, “Me? I didn’t have training. I had to know what the job entailed and I had to know what the caregiver’s job entailed and I had to know how to respect the rights of residents and all that. I’ve done modules and all that and I’ve done things like—I’m on the health and safety committee here—so I did all that. I learnt about patients’ rights—I had to learn about that you know—have respect for their privacy and all that stuff—they’re real people and that’s the way you’ve got to look at them.... The old people do have feelings and you’ve got to treat them as such.” Tom did not regard himself as a trained caregiver, yet his compassionate approach to the dignity of residents amongst whom he worked drew from them a response of high regard and trust. In befriending them he offered them the sense of self-respect, which contributes to a state of spiritual wellbeing and of emotional strength. Even though, as in Tom’s case, the response was instinctive, it can manifest itself in a resident’s overall ability to cope with the frailty of ageing and the

doubts and fears ageing may engender. Paloutzian, Bufford, and Wildman note that while “spiritual well-being is not synonymous with spirituality it is closely related to it.... Spiritual wellbeing connotes one’s subjective perception of wellbeing in both the religious and/or existential dimensions in accord with whatever is implicitly or explicitly conceived of as a spiritual umbrella for the individual.”¹⁴⁰ Tom’s simple but direct approach to residents gave them positive affirmation of their personhood from within which a spiritual dimension of wellbeing might be nurtured.

Affirming and recognising that each person has the need to be respected and listened to is an important aspect of caregiving. Rest Home A for example incorporates this in the list of duties and tasks of caregivers in order “to foster self-esteem and self-confidence.”¹⁴¹ Such care recognises that a spiritual dimension is embedded in what it means to be human, in affirming the reality of self in relation to the environment. It is a component of caregiving necessary for holistic care of rest home residents. Yet the caregivers either did not seem to understand its importance, or were anxious about overstepping boundaries in their relationship with their cares. Jackie Ellis and Mari Lloyd-Williams describe spiritual care as having “boundaries, roles and expectations” which are blurred between the members of the team offering support to residents.¹⁴² I question the extent to which an understanding of care as providing for a spiritual need is currently developed as part of caregivers’ training. Caregivers affirmed their appreciation of their training but, if spiritual care is to be recognised as part of their role, a change in emphasis towards their understanding of what is meant by the spiritual dimension of holistic care will possibly better guide them.

Summary

The rest home caregiving work force in New Zealand is expanding as is public recognition of the importance of the practical aspects of caregiving for the frail elderly of the nation. The

¹⁴⁰ Raymond F. Paloutzian, Roger K. Bufford, and Ashley J. Wildman, “Spiritual Wellbeing Scale: Mental and Physical Health Relationships”, in *The Oxford Textbook of Spirituality in Health Care*, eds. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford: Oxford University Press, 2012), 353.

¹⁴¹ Rest Home A Job Description, “Duties and Tasks: 4.3”.

¹⁴² Jackie Ellis and Mari Lloyd-Williams, “Palliative Care,” in *The Oxford Textbook of Spirituality in Health Care*, eds. Mark Cobb, Christina M. Puchalski, Bruce Rumbold (Oxford: Oxford University Press, 2012), 261.

demand for holistic care for this sector of the population is being met by the recruitment and training of caregivers from diverse cultural backgrounds. Accompanying this response to the industry's demands lie the difficulties of developing a workforce which can understand the culture and language of those for whom care is offered.

Analysis of the work of the caregivers in the rest homes studied revealed the caregivers' personal involvement in the life and concerns of those for whom they cared. Holistic care is extended to residents through work that is intense and varied by obvious and inherent demands. Migrant workers have a fundamental barrier to overcome until they are able to use the English language proficiently. Language difficulties prevent deeper communication with residents, although on their part, migrant workers at times appeared to instinctively understand the needs of their 'cares'.

Staff training is regarded as important in both studied rest homes and staff members appreciate the way in which content of courses relates to their duties. There is little doubt about the presence of some form of understanding of the spiritual needs of residents being present in the attitudes of the caregivers studied. To these caregivers, spirituality, religion and cultural practices often merge, being understood and appreciated through their own religious and cultural understandings.

The ACE modules which form the basis of ongoing study for caregivers convey the spiritual component of training by focussing on competences arising out of the daily relationships formed between caregivers, residents and management. From within these caring relationships caregivers become the recipients of residents' expressed concerns about their spiritual wellbeing. Yet caregivers seem hesitant in responding in ways that might support their cares. Training to recognise and respond to spiritual needs may require further development to enable caregivers to support residents in the spiritual challenges that face them in the ageing process in a rest home.

Chapter 5: Conclusion

This thesis has addressed the question: To what extent and in what ways is spiritual care part of the caregiver role in New Zealand rest homes? It has shown that caregivers are exposed to the spiritual needs of rest home residents much more than might have been previously recognised within the rest home sector. New rest home residents are drawn into a culture that challenges the source of their self-identity, in that failing health has deprived them of independence and the ability to control the manner in which their lives are led. The milieu against which their lives have previously formed an understanding of 'self' is no longer relevant. The transition from a former way of life to that of the rest home becomes a spiritual challenge, as personal, existential questions of life and 'reason for being' cannot be ignored. Rest home policies and philosophies acknowledge the trauma that a new resident faces. In practice, it is often the caregiver to whom the resident turns for help.

Within the rest home, the intimate, personal nature of caregiving can lead to trusting relationships between resident and caregiver, which, in turn, form the channel through which concerns may be expressed. NZQA-certified training programmes prepare caregivers for competency in performing a wide range of tasks, yet, while caregivers are usually confident in carrying out tasks relating to daily living activities, they seldom communicate the same confidence when faced with the spiritual needs of residents. Caregivers in this research often heard the spiritual concerns expressed by residents, but were unsure of how to respond. Their training introduced them to the concept of addressing spiritual needs, but an extension of training is required to enable caregivers' deeper understanding of those needs. Caregivers must be enabled to respond to issues of a spiritual nature when and where they occur in a workplace setting. They also need to be recognised as part of a larger network of spiritual care providers, and their role more consciously integrated into that wider network of care. Addressing the spiritual needs of residents is necessary if the provision of care in rest homes for the aged population in New Zealand is to be genuinely holistic.

One important dimension of this thesis has been the light shed on the particularity of the spiritual challenges associated with rest home life. Rest home residents face some spiritual challenges common to ageing populations generally, but also face other challenges that are formulated in ways that are specific to their particular context. When becoming residents in a rest home facility, the frail elderly face a major transition from independent living to being dependent on others. They typically experience significant dislocations, relationally as well as in temporal location. They are thrust into new 'communities', and social settings. Existing relationships become circumscribed when the resident is no longer able to meet regularly with those who have been part of daily life. This radical change of lifestyle is a significant factor that may trigger a resident's search for meaning in life as they sense the inevitable progression to death.

In this setting, residents, now faced with an unknown or previously unconsidered spiritual quandary, may require particular kinds of support to express or work through the engendered stress. Some residents find comfort in religious teachings and practices that have previously been part of their lives. Others find that these may not always provide the help needed at this stage of life. Still others may feel hesitant about discussing spiritual questions or doubts with an unfamiliar chaplain or pastoral care worker. A trusted caregiver may become, almost by default, someone to whom the resident turns to try and express the spiritual dilemma being faced.

Caregivers' roles in rest home life are crucial. The caregiver is an integral member of the rest home work force, working at the forefront of daily care for residents. Although institutions make formal provision for religious support for residents, this is not always the help required at this stage of life. Nor is the institution able to foresee when or how a resident's spiritual dilemma will manifest itself. This study has found that there are unexpected times when the caregiver is required to respond to the spiritual outpouring of a resident's expressed needs. The professional pastoral or religious worker is not always available or wanted when residents require such help so it is important for the caregiver to understand how to recognise challenges of a spiritual nature, and to respond adequately when questions of a spiritual nature arise.

Questions of Religion, Culture and Spirituality

A major challenge in this area relates to the difficulties associated with definition, and the interplay between notions of religion, culture and spirituality. The residents interviewed in this thesis were clear about the importance or otherwise of their religious affiliations, and how associated beliefs and ethics have been integrated into or discarded from their lives. These religious dimensions are recognised and attended to through the policies of the rest homes. Residents' religious needs are identified on admission when a care plan is established. Subsequently, ministers or pastoral workers are encouraged to work amongst those who require such contact. Indeed, there was agreement among residents that policies established by the rest homes worked well and enabled their religious needs to be met.

Spirituality, as distinct from religion, is not so easily identified and attended to. Spirituality is arguably a more abstract concept, and concerns questions related to human existence. It relates to an awareness of what comes to be seen as the sacred in life. For some people, spirituality is bound up in their religious values and outlooks. However, life forces experienced apart from religious teachings may have a profound effect on an individual. A spiritual awareness may arise from different contexts for each individual—from an affinity with nature, from observing the wonder of night skies, from music, or from an experience of great love. More importantly, individuals' sense of their own self—what makes them who they are, and the reality and meaning of their own existence—is a fundamental dimension of their spirituality. Through the interviews, I found spiritual awareness, and attention to such matters, deepened and became more important to residents as they aged.

Significantly, the sense of a spiritual dimension to life may differ from previously held religious beliefs. A resident may never have expressed interest in or been part of a particular religion. There are indications, however, that spiritual needs (as distinct from religious needs) become focused by the move into institutional care, away from the important relationships on which their lives were previously centred. MacKinlay posits the spiritual dimension of ageing as part of the essential spiritual journey that is necessarily a part of being human, seeing it as a search for ultimate meaning in life, one individually

undertaken if and when spiritual tasks are recognised during the process of ageing.¹⁴³ My research supports this assertion in that I found residents interviewed demonstrated a connection between loss of relationships that gave meaning to life and a new search for meaning. It is this connection that highlights the need for recognition of the spiritual dilemmas being faced by some residents.

Religious or spiritual understandings frequently underpin various traditions that form the background to an individual resident's life. In the care plan drawn up on admission to the rest home most of these are identified as cultural understandings. Caregivers refer to the care plans and are aware of cultural responses that are appropriate for their 'cares.' Cultural mores are often referred to when religion and spirituality are discussed. However, difficulties in understanding residents' spirituality apart from culture arise with migrant caregivers for whom religious practices and spiritual concepts are embodied in their personal cultural customs, a concept that is projected on to their 'cares'. The predominantly Pakeha residents for whom they care have not developed this same understanding. To them, culture and spirituality are separate issues.

Lack of understanding arose from the cross-purposes of language used in the process of identifying spiritual needs. Residents and caregivers alike found it difficult to separate spirituality from the practices and social activities of their particular religious backgrounds. For the residents, there was an inability to express the existential questions with which they were now faced. Caregivers lacked the ability or depth of understanding to recognise such needs. Yet the salient concerns remained with the residents, highlighting the need for caregivers to develop an increased awareness of them.

Caregiver-Resident Relationships and Spiritual Needs

During the course of my interviews it became obvious that caregiving was understood as more than a concern for residents' physical necessities. Through the concerned attitude of caregivers, many of whom show intuitive recognition of residents' needs, intimate contact

¹⁴³ MacKinlay, *The Spiritual Dimension of Ageing*, 223-224.

with residents was further established. Stories told to caregivers embodied vital questions, the hopes, memories and fears engendered in this fourth stage of residents' lives; stories which contributed to their spiritual struggle to find life-meaning in past events; stories through which existential meaning in present and future events was sought. Whether or not it is recognised by caregivers, such stories expose them to the spiritual needs of their 'cares'. They are exposed to the spiritual needs of rest home residents much more than might have been previously understood, even by caregivers themselves.

The awareness of caregivers of the spiritual needs of rest home residents is demonstrably governed by three factors: their willingness to communicate with residents; their understanding of culture, religion and spirituality; and the training they have received. Regardless of gender or cultural perceptions, during the course of this research it was obvious that the individual caregiver is the person upon whom the resident relies for the most intimate care. Caregivers noted with some sense of pride the ways in which they coped with a heavy daily work load. Their 'cares' were not always cooperative, and caregivers' anecdotes told of ways in which they recognised and empowered residents to retain personal dignity while assigned tasks were accomplished. Yet, in spite of time constraints imposed by heavy workloads, residents were listened to.

Listening is an essential part of the caregiving experience. The caregiver, if present when the resident's need to talk arises, is the person who might be able to identify the resident's need. In times of particular stress for the resident, particularly in the night when sleeplessness, loneliness and pain bring haunting thoughts, it is the caregiver alone to whom some of the residents express their anxieties or tell their stories. One caregiver recognised the loneliness felt by those who no longer have partners or families whose presence once formed the nucleus of their lives, and noted the residents' need to talk with someone. Through the very private conversations that arose while care duties were undertaken, another found herself the recipient of residents' stories that may not previously have been told. Many of the caregivers spoke of hearing stories of individual crises that presented a need to be met directly rather than deferred to a chaplain or pastoral worker who was not immediately available. The stories of pain, hardships or

regretted actions that were heard emphasised the integral role of the caregiver as a member of the rest home staff who provide holistic care.

Caregiver understandings of culture, religion and spirituality are another important factor. There was clear evidence of some understanding of the spiritual needs of residents in the attitudes of caregivers interviewed. For some, spirituality, religion and cultural practices blended, being understood and appreciated through their own religious and cultural backgrounds. For others, understanding was more instinctive. When asked if the residents ever spoke to them about spiritual matters, most caregivers responded that spiritual questions appeared to revolve around the residents' wish to die. They found that residents expressed their recognisable spiritual doubts or concerns at times of suffering or distress—when loneliness, deterioration in health, hopelessness or seeming alienation from loved ones became too much to bear. Caregivers working the night shift were particularly familiar with the dark times, the '3 o'clock in the morning' questions of self worth or identity which are distressing to wakeful or pain-filled residents. Such residents wanted to talk through their doubts and fears right there and then—particularly with this person they trusted, the caregiver who was alert to their distress—and having found the courage to do so, did not want to lose the moment. At present, much of the caregivers' response is intuitive, but it underscores their need to be adequately trained to recognise and understand the indications of a resident's crisis.

Insofar as caregivers have a role to play in spiritual care, their ability to do so is shaped by their preparedness achieved through training. I believe that spiritual care of the elderly could be more effective if training programme content was developed to give greater attention to providing caregivers with more adequate ways of responding to spiritual needs. Training of the interviewed caregivers varied. It was acknowledged as important in the two rest homes studied. This is in contrast to the reported 46% of residential caregivers in New Zealand residential institutions for the aged who are said to have no qualifications of any kind.¹⁴⁴ It is significant that the caregivers in this research were enthusiastic about the

¹⁴⁴ NZHRC, *Caring Counts, Tautiaki tika*, 73.

courses they undertook, and were eager speak of their achievements. It indicates a willingness to learn more of the nature of caregiving and their desire to care for residents' needs in the most effective way. I suggest that they would be eager to extend their understanding of residents' spiritual needs if the opportunity is open to them.

This observation is supported by the caregivers themselves who raised concerns about their ability to respond to residents' spiritual needs. They expressed their lack of understanding of the responses that would best help residents. When questioned about any training they might have received on this aspect of caregiving, most focused on training related to cultural needs. Associated, too, were boundary issues—the caregivers were aware that they should not express their own opinions and values in responding to residents. Clearly, boundaries are necessary. However, if anything, this emphasis in training appeared to erode caregivers' confidence and assurance in engaging with residents' concerns. As a result, the common response of caregivers in this situation was to suggest the resident might talk to the chaplain about their concerns. While this might be helpful to those residents whose religion recognises the chaplain, I believe that more could be done to prepare the caregiver to interact supportively with the resident at the time the need was most pressing. Overall, there appeared to be a desire on the part of the caregiver to understand more deeply the type of response that would prove appropriate to the resident's need. It would be important to include in training programmes, discussions which explore cultural and spiritual dimensions of dying and death that may not correspond with particular religious beliefs. More focused training in this area might provide caregivers with the ability to support the resident through times of spiritual dilemma.

Notwithstanding the real contributions they make, the caregivers' role in spiritual care is nonetheless a limited one. To be clear, not all residents will talk with their caregiver. From the interviews, I found, that some residents' considered it abhorrent that they might treat the caregiver as a person who could be trusted with their sensitive, innermost thoughts, no matter how stressed they became. Some residents regarded the caregiver as a menial worker rather than a person with whom such trusting relationships could be forged. There is a class element to such attitudes. This stance also appears to be particularly associated

with the ethnicity of the caregiver, and their ability to communicate. Residents who regard the caregiver as a servant rather than as a person who cares for and supports them appear unlikely to develop a responsive relationship with them. In such cases, the caregiver must know when not to cross the boundaries established by the resident. Caregivers are challenged and their work is limited by the expressed attitudes of their 'cares'.

The gender and ethnicity disparities between caregivers and residents are two key demographic issues that also have a bearing on these questions. The rest home sector is staffed by an ageing and largely female workforce, many of whom work part time. It is a workforce which embodies a significant gender imbalance, a factor noted in my research. I saw how important it was to male residents to have a male caregiver to whom they could talk 'man talk'. This observation supports an issue highlighted in the 2012 report into employment in the aged care sector which signalled the desirability of overcoming this imbalance as demographic trends indicate that increasing male longevity is likely to result in an increase in male residents.¹⁴⁵

While the gender imbalance is a significant factor regarding caregivers in the rest home sector, so too is the ethnically diverse nature of the workforce which, particularly because of language difficulties, may inhibit communication. MacKinlay, in her seminal work on ageing and spirituality, picked up on this point, noting that, "The onus is always on the staff to effectively communicate with residents, never the other way, as these elderly people may often have impaired communication abilities, and need sensitive support from the staff."¹⁴⁶ Effective communication is a problem evident in the sample of caregivers I interviewed, five of whom had difficulty speaking and understanding English. The diversity amongst caregivers is not matched by the ethnic diversity of residents, and this almost certainly contributes to some residents' inability to treat them as equals who would understand their personal concerns. To these, the migrant caregivers present a cultural and language challenge, which limits effective interaction and communication. I found that migrant caregivers interviewed for this project are alert and bright when they address the

¹⁴⁵ Ibid, 97.

¹⁴⁶ MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, 238.

residents, but it is apparent that their comments or questions are not always understood—an aspect of their caregiving to which, I suggest, rest home management needs to be constantly attentive.

Summary

With demographic statistics predicting a substantial increase in New Zealand residents in the 65+ age group in future years, a corresponding increase in residential care facilities for the frail elderly is anticipated. Wellbeing of the ageing population is being improved with advances in social and medical care, and life expectancy is increasing. Significantly, it is expected that people requiring rest home care will be older and possibly frailer than those being cared for today. As the increasingly diverse migrant population ages, future residents of rest homes are likely to be drawn from a broader range of ethnicities, which will provide further challenges to those responsible for their care. It follows that caregivers will require more developed skills in the total aspects of care they provide for the residents. Such care must include attention to spiritual needs. This current research has shown that being prepared to respond to the spiritual needs of residents must be an essential element of their training, one which will continue to be important in years to come.

The central argument of this thesis has been that caregivers are already exposed to the spiritual needs of rest home residents, much more than might have been previously understood. Caregivers are the most likely staff members in rest homes to hear residents' stories through which spiritual needs might be identified. Their personal involvement in the life and concerns of those for whom they care appears to be a positive factor in promoting the residents' wellbeing. However, it must be acknowledged that while they are intelligent women and men, many caregivers have limited educational backgrounds or skills. This, accompanied by ethnic and language difficulties, places them in a complicated position in regard to finding resources or opportunities to develop skills in understanding or responding to residents' spiritual needs. They have the ability to learn, but their circumstances in life have not enabled them to develop proficiency in finding resources to help deepen their understanding of their role.

Caregivers are staff members who require greater recognition of their likelihood to be exposed to the spiritual needs of rest home residents. Care of spiritual needs is an important though largely unrecognised feature of the caregivers' role. Its importance cannot be underestimated in the provision of holistic care for rest home residents. Further research into this aspect of the caregiving role would be highly desirable in order to advance my findings to a stage where they could be presented as a foundation upon which future policy development and training initiatives might be based. More attention to training caregivers to understand the spiritual needs of residents is a challenge the aged care industry must face in order to provide the truly holistic care they require.

Do Not Go Gentle Into That Good Night

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

Though wise men at their end know dark is right,
Because their words had forked no lightning they
Do not go gentle into that good night.

Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay,
Rage, rage against the dying of the light.

Wild men who caught and sang the sun in flight,
And learn, too late, they grieved it on its way,
Do not go gentle into that good night.

Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light.

And you, my father, there on that sad height,
Curse, bless, me now with your fierce tears, I pray.
Do not go gentle into that good night.
Rage, rage against the dying of the light.

Dylan Thomas¹⁴⁷

¹⁴⁷ Walford Davies and Ralph Maud eds., *Dylan Thomas: Collected Poems, 1934- 1953* (London: J. M. Dent & Sons Ltd., 1988), 148.

Appendix A

VICTORIA UNIVERSITY OF WELLINGTON

Te Whare Wānanga o te Ūpoko o te Ika a Māui

Project Research 2012 – Information to Consenting Managers of Rest Homes.

Topic: A Study of Spiritual Life and Care in New Zealand Rest Homes.

Researcher: Judith Hardie.

I am a post graduate student currently undertaking research into spiritual life and care in New Zealand rest homes. Thank you for volunteering to be interviewed. The purpose of this informed consent document is to give you a clear idea of what the research project is about and to explain how you can help with its development. Your participation in the study is essential for me to gather a broad set of comparative information for the research and subsequent analysis.

The intention of this research is to help develop a deeper understanding of the ways in which spiritual needs are catered to in rest homes in the Wellington region. An aspect of maturity observed in the later years of life appears to be based in altered spiritual awareness. As a consequence some people may have difficulty understanding their new or altered spiritual perceptions and find it hard to express doubts or fears that might arise. Finding a supportive, understanding caregiver to whom such concerns might be expressed is not always easy for the individual.

In turn, the caregiver may not find it easy to recognise a person's need to enter into such a conversation. The caregiver may also have difficulty in responding effectively when faced with the questions of a spiritual nature. The question arises as to whether or not it might be desirable to offer training to help the caregiver respond. Finding a way to understand and address concerns that are identified through the interviews is an aim of this research project.

No particular faith commitment is expected from those interviewed as all comments and perspectives of participants will be of significance for the purposes of this study.

I am aware that you may have sections of your policy documents which address the issue of the individual resident's need for recognition and care when questions of a spiritual nature arise. It would be helpful to me if your Rest Home Policy might be discussed. I am also aware that some people in care may not be physically or mentally able to give consent to this research and ask your guidance in making the request for interview to an appropriate selection of your residents. Similarly, I seek your guidance in identifying Caregivers for whom participation in this research would be acceptable.

If you agree to being interviewed you will find the interviews will finish within 40 to 60 minutes. The interviews will be fairly informal and I will encourage you to speak freely about your thoughts and feelings. I will make notes of comments made and, if you permit,

will make an audio recording of our conversation. This will later be transcribed and kept with the records of your interview for later analysis. These records will be secure and confidential with only my supervisor having access to them without your consent. You will receive a copy of the transcription of the interview and be able to make any changes, additions or deletions that you wish at that point.

If you decide to take part in this research you will be given a copy of this information sheet to keep and be asked to sign a consent form.

You may withdraw from an interview at any point, for any reason. You may also withdraw from participation in the project as a whole before the 30th November, 2012. If you feel the need to withdraw for any reason at this stage, the information you have provided will be destroyed. All the information you supply will be treated in strict confidence and you will not be identifiable in any report of the research.

Victoria University requires ethical approval to be obtained for research and this has been granted.

If at any time you wish to contact me about this research please do so. I will be happy to receive any questions or further comments. My contact details are: Telephone 04 5651947; email: judy.hardie@vuw.ac.nz

My supervisor's details are included at the end of this information sheet. Please feel free to contact him should you need to do so.

Thank you,
Judith Hardie, Victoria University of Wellington.

Supervisor:

Dr Geoff Troughton

Lecturer in Religious Studies

Victoria University of Wellington

PO Box 600, Wellington 6140, NZ

Email: geoff.troughton@vuw.ac.nz

VICTORIA UNIVERSITY OF WELLINGTON

Te Whare Wānanga o te Ūpoko o te Ika a Māui

Project Research 2012 – Information to Consenting Caregiver Participants.

Topic: A Study of Spiritual Life and Care in New Zealand Rest Homes.

Researcher: Judith Hardie

I am a post graduate student currently undertaking research into spiritual life and care in New Zealand rest homes. Thank you for volunteering to be interviewed.

The purpose of this informed consent document is to give you a clear idea of what the research project is about and to explain how you can help with its development. Your participation in the study is essential for me to gather a broad set of comparative information for the research and subsequent analysis.

The intention of this research is to help develop a deeper understanding of the ways in which spiritual needs are catered to in rest homes in the Wellington region. An aspect of maturity observed in the later years of life appears to be based in altered spiritual awareness. As a consequence some people may have difficulty understanding their new or altered spiritual perceptions and find it hard to express doubts or fears that might arise. Finding a supportive, understanding caregiver to whom such concerns might be expressed is not always easy for the individual.

In turn, you as a caregiver may not find it easy to recognise a person's need to enter into such a conversation. As a caregiver you may also have difficulty in responding effectively when faced with the questions of a spiritual nature. The question arises as to whether or not it might be desirable to offer training to help the caregiver respond. Finding a way to understand and address concerns that are identified through the interviews is an aim of this research project.

No particular faith commitment is expected from those interviewed as all comments and perspectives of participants will be of significance for the purposes of this study.

If you agree to being interviewed you will find the interviews will finish within 40 to 60 minutes. The interviews will be fairly informal and I will encourage you to speak freely about your thoughts and feelings. I will make notes of comments made and, if you permit, will make an audio recording of our conversation. This will later be transcribed and kept with the records of your interview for later analysis. These records will be secure and confidential with only my supervisor having access to them without your consent. You will

receive a copy of the transcription of the interview and be able to make any changes, additions or deletions that you wish at that point.

If you decide to take part in this research you will be given a copy of this information sheet to keep and be asked to sign a consent form.

You may withdraw from an interview at any point, for any reason. You may also withdraw from participation in the project as a whole before the 30th November, 2012. If you feel the need to withdraw for any reason at this stage, the information you have provided will be destroyed. All the information you supply will be treated in strict confidence and you will not be identifiable in any report of the research.

Victoria University requires ethical approval to be obtained for research and this has been granted.

If at any time you wish to contact me about this research please do so. I will be happy to receive any questions or further comments. My contact details are: Telephone 04 5651947; email: judy.hardie@vuw.ac.nz

My supervisor's details are included at the end of this information sheet. Please feel free to contact him should you need to do so.

Thank you,

Judith Hardie

Victoria University of Wellington

Supervisor:

Dr Geoff Troughton

Lecturer in Religious Studies

Victoria University of Wellington

PO Box 600, Wellington 6140, NZ

Email: geoff.troughton@vuw.ac.nz

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wānanga o te Ūpoko o te Ika a Māui

Project Research 2012 – Information to Consenting Rest Home Residents.

Topic: A Study of Spiritual Life and Care in New Zealand Rest Homes.

Researcher: Judith Hardie

I am a post graduate student currently undertaking research into spiritual life and care in New Zealand rest homes. Thank you for volunteering to be interviewed.

The purpose of this informed consent document is to give you a clear idea of what the research project is about and to explain how you can help with its development. Your participation in the study is essential for me to gather a broad set of comparative information for the research and subsequent analysis.

The intention of this research is to help develop a deeper understanding of the ways in which spiritual needs are catered to in rest homes in the Wellington region. An aspect of maturity observed in the later years of life appears to be based in altered spiritual awareness. As a consequence some people may have difficulty understanding their new or altered spiritual perceptions and find it hard to express doubts or fears that might arise. Finding a supportive, understanding caregiver to whom such concerns might be expressed is not always easy for the individual.

In turn, the caregiver may not find it easy to recognise a person's need to enter into such a conversation. The caregiver may also have difficulty in responding effectively when faced with the questions of a spiritual nature. The question arises as to whether or not it might be desirable to offer training to help the caregiver respond. Finding a way to understand and address concerns that are identified through the interviews is an aim of this research project.

No particular faith commitment is expected from those interviewed as all comments and perspectives of participants will be of significance for the purposes of this study.

If you agree to being interviewed you will find the interviews will finish within 40 to 60 minutes. The interviews will be fairly informal and I will encourage you to speak freely about your thoughts and feelings. I will make notes of comments made and, if you permit, will make an audio recording of our conversation. This will later be transcribed and kept with the records of your interview for later analysis. These records will be secure and confidential with only my supervisor having access to them without your consent. You will

receive a copy of the transcription of the interview and be able to make any changes, additions or deletions that you wish at that point.

If you decide to take part in this research you will be given a copy of this information sheet to keep and be asked to sign a consent form.

You may withdraw from an interview at any point, for any reason. You may also withdraw from participation in the project as a whole before 30th November, 2012. If you feel the need to withdraw for any reason at this stage, all the information you have provided will be destroyed. All the information you supply will be treated in strict confidence and you will not be identifiable in any report of the research.

Victoria University requires ethical approval to be obtained for research and this has been granted.

If at any time you wish to contact me about this research please do so. I will be happy to receive any questions or further comments. My contact details are: Telephone 04 5651947; email: judy.hardie@vuw.ac.nz

My supervisor's details are included at the end of this information sheet. Please feel free to contact him should you need to do so.

Thank you,

Judith Hardie

Victoria University of Wellington

Supervisor:

Dr Geoff Troughton

Lecturer in Religious Studies

Victoria University of Wellington

PO Box 600, Wellington 6140, NZ

Email: geoff.troughton@vuw.ac.nz

CONSENT TO PARTICIPATION IN RESEARCH

Research Project: A Study of Spiritual Life and Care in New Zealand Rest Homes

Researcher: Judith Hardie

I have read the participant information sheet and agree to take part in this research investigating spiritual life and care in New Zealand Rest Homes.

I accept that I will be interviewed, notes taken and that the interview may be recorded and transcribed to be used as a basis for conclusions published in a Master's Thesis. I understand I will have the opportunity to read the transcription of the interview and make changes to it.

I accept that any comments will be recorded confidentially and a pseudonym will be used as a reference to my comments in any documented conclusions.

I understand that I may withdraw from an interview at any point, for any reason, and from participation in the project as a whole before the 30th November 2012. I accept that any records of my comments will then be destroyed.

I am satisfied that all information supplied to the researcher will be treated in the strictest confidence.

Tick if applicable

I agree that the interview may be recorded ☐

Name of Participant _____

Signature

Date: _____

Appendix B: Questions to be addressed

The following were a preliminary but indicative sample of the kinds of issues I proposed to ask of the various parties:

To the Institution:

1. What is the philosophy of this institution regarding the spiritual needs of the clients?
2. How does this translate into practice?
3. Is there a designated place for responding to spiritual needs (Quiet Room, Chapel)?
4. How do you translate the rest home philosophy into guidelines for all staff?

To caregivers:

1. What do the words 'religion' and 'spirituality' mean to you?
2. What guidelines are you given on how to respond to clients spiritual needs?
3. How do you feel about entering into faith based discussion with clients?
4. Has working in this place influenced your spiritual understandings?
5. How do you respond if a client talks with you about a religious or spiritual concern?
6. Would you like to be given more help in responding to the spiritual needs of clients?

To residents:

1. As you grow older do questions of what might have been or what will be bother you?
2. Have you ever been able or wanted to talk with someone about your life and its feelings?
3. If 'yes', who did you choose to talk to?
4. If 'no' what stopped you from speaking to someone?
5. Are you aware of the possibilities which are offered in this home to enable you to talk through things that are worrying you?

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