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Research paper

"To a better place": The role of religious belief for staff in residential aged care in coping with resident deaths

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ABSTRACT

Introduction: Staff in residential aged care (RAC) face increasing exposure to death and dying provoking coping-related responses. This study reports on research exploring the role of religious/spiritual belief in staff coping with death and dying in RAC homes.

Method: Utilising a mixed methods, concurrent triangulation design, data from interviews and questionnaires with 113 RAC staff were analysed to explore the relationship between staff members' religious/spiritual beliefs and coping with resident deaths within the context of 50 RAC facilities.

Results: Participants appeared to have distinctly different experiences of the role of religious/spiritual beliefs in their attitudes toward death and dying – as reflected linguistically in how they described it. Strong religious/spiritual influence and religious affiliation were associated with lower scores for burnout. Level of religious/spiritual influence does make a difference in the strategies employed by staff in coping with death and dying.

Conclusion: Given the potential benefits associated with religious/spiritual beliefs, RAC facility management would be well advised to foster a workplace culture that supports and encourages spiritual/religious expression among facility staff. Greater understanding of the role of religious/spiritual beliefs in helping staff to make sense of the end-of-life experience can provide the basis for the development of staff supports enabling both improved staff well-being and resident end-of-life care.

1. Background

As world populations, age [1,2] staff working in residential aged care (RAC) are subjected to increasing occupational stress and report high levels of burnout [2]. As defined by Maslach and Jackson [3] 'burnout' is an "a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do people work of some kind" (p. 1). Stressors within RAC include high workloads, low staffing levels as well as exposure to the declining health and deaths of residents [4]. Previous studies examining staff responses to patients' deaths [5–7] suggest that staff can be negatively affected by resident deaths and may experience symptoms of grief [8] which can contribute to burnout [4]. Given the potentially damaging effects of stress and burnout experienced by healthcare staff in aged care [12], a greater understanding of the factors that might alleviate or prevent it from occurring is needed.

"Meaning systems" represent internal cognitive structures utilised by individuals to make sense of the world. These core beliefs inform an individual's understanding of reality [9]. As stated by Clifford Geertz [10], "man is an animal suspended in webs of significance he himself has spun." Language (linguistic symbols) and meaning systems are interconnected. From the perspective of the symbolic interactionists and social constructionists, humans can be understood as symbol manipulators [11–13]. Linguistic symbols are stored by persons in ways comparable to internalised maps (meaning systems) representing their external reality [14–16]. Meaning systems shape the strategies utilised to cope with the particular challenges of a situation [13,14]. Coping involves both cognitive and behavioural methods of managing both external and emotional demands [15]. Distress can arise when the understanding of a particular event (appraised meaning) by an individual, challenges or contradicts their meaning system [16]. Systematic investigation of the organisation of the linguistic symbols utilised by staff and the shared meaning they represent may provide insight into the construction of staff religious/spiritual beliefs and the

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role of these beliefs in coping with death and dying in RAC.

Healthcare professionals may be more successful in coping with repeated exposure to trauma and death-related situations if they can understand and consolidate these experiences under broader meaning systems [17]. These meaning systems may be constructed on the basis of religious or spiritual beliefs, (although not always) [18]. In this paper, we utilise a broad definition of religious belief which incorporates spirituality [19] and recognise the lack of agreement within our pluralistic society regarding what constitutes religious/spiritual belief [20]. Within the context of the study, we are reporting, religious/spiritual belief was defined as a search for "meaning and purpose in life which may or may not be related to religion" [21].

Religious/spiritual belief has been associated with mental health benefits. Research indicates that religious and spiritual beliefs can assist care workers in coping with death in RAC [22,23]. Strength of conviction has also been implicated in improved mental health. For example, Ross [24] in a study of religious practice and psychological distress in a diverse urban population, found the highest levels of distress in the weakly religious (people who were unsure what to believe); those with strong religious conviction (spiritual/religious views worldview) as well as the non-religious conviction (secular worldview) were the least distressed. This suggests that psychological benefit may in part be based on the strength of conviction rather than the category under which an individual falls (religious/spiritual or non-religious/non-spiritual) [25–27].

2. Research question and objectives

The research sought to explore the following question: What is the association between the religious/spiritual belief influence of staffing working in RAC settings and their attitudes toward death?

The objectives of the study were: 1) to describe the extent to which participants considered their religious/spiritual beliefs influenced their attitudes toward death and dying; 2) to quantitatively examine the association between religious/spiritual belief influence and participant burnout; 3) to provide a visual representation in metric space of the language (linguistic symbols) representative of these religious/spiritual belief influence types and 4) to qualitatively examine the association between these religious/spiritual belief influence and differences in self-reported coping with death and dying.

3. Methods

A concurrent triangulation design [28] was adopted from data collected as part of a larger study providing evidence about the nature of dying from dementia in 61 RAC facilities in New Zealand. This mixed methods design was selected in order to capture a more complete, holistic, and contextual portrayal of the relationship between religious/spiritual belief influence and attitudes toward death. As a mixed methods design, equal emphasis was given to the results of both the quantitative and qualitative data analyses with initial data analyses conducted simultaneously by DB (qualitative) and RF (quantitative). The goal was to achieve convergence in the results across the different methods which according to Bouchard [29] "enhances our belief that the results are valid and not a methodological artefact (p. 268)."

3.1. Sample

A purposive sample of 113 staff members (Registered Nurses-RNs, Enrolled Nurses-ENs, and Health Care Assistants-HCAs) were recruited from 50 facilities where resident deaths had been reported over a three month period (beginning in January 2016 and ending in February 2017) Staff were recruited to participate based on their direct involvement in an identified decedent resident's care 14 days prior to death.

3.2. Procedure

Objective One –Level of influence of religious/spiritual belief on attitudes toward death and *Objective Two-Relationship between religious/spiritual belief influence and burnout* were addressed through data collected in a brief questionnaire administered to the 113 staff members (see Appendix A (Supplementary File)). The questionnaire included socio-demographic characteristics (e.g. gender, age, ethnicity, role, time in aged care etc.) and items regarding the influence (strong/minor/none) of religious/spiritual beliefs on staff attitude toward death [30] and cultural influences on attitudes toward death (strong/minor/no influence) [30]. These two items, each measured on a scale from 1 'strong influence' to 3 'no influence', were developed by Frommelt [31] as part of a study designed to assess the relationship between demographic factors including previous education and religious and cultural beliefs and nurses' attitudes toward caring for individuals with life-limiting illnesses [31]. A measure of burnout [32], the 10 item Burnout Measure short version (evaluated on a 7-point scale) which is a widely used self-report measure of burnout [32], was also included. A score between 2.5 and 3.4 indicates danger signs of burnout and scores of 3.5 and over on the measure indicate burnout [32]. Internal consistency as reported by the authors has ranged between 0.87 and 0.92 with two national samples and three occupation-specific samples [32]. Test-retest reliability was reported as 0.74 in a study of Masters of Business Administration students [32]. In the current study, a Cronbach's alpha of 0.83 was recorded which indicated a high level of internal consistency for the scale with this specific sample.

Data to address *Objectives Three- Visual representation of religious/spiritual belief influence types* and *Four-Interpretive analysis of religious/spiritual coping* were collected from semi-structured interviews with the 113 staff member participants most involved in the resident's care in the 14 days prior to death. These staff members were first asked to participate by facility managers and then upon consent contacted by the researchers to set up a convenient time for the interview at the RAC facility. Informed consent was gained from the interviews which were approximately forty minutes in length. Interviews were audio-recorded with participant permission prior to being transcribed in full by an external agency. Questions related to staff experiences of the residents' end of life care and dying journeys (see Appendix B (Supplementary File)) and were developed from a review of the literature. Resident identification information was not divulged to researchers. Ethical approval was secured from the University of Ethics Committee. All participants were given the opportunity to consider their participation and choose whether to opt in.

3.3. Analysis

Data analysis was conducted by DB and RF, and the process is outlined below in relation to the objective addressed:

Objective One –Level of influence of religious/spiritual belief on death attitudes and *Objective Two- Relationship between religious/spiritual belief influence and burnout* – Quantitative data from the demographic questionnaire was imported into SPSS version 21 for analyses. Both descriptive (frequencies, mean, SD) and inferential statistics (chi-square, *t*-tests, ANOVA) appropriate to the level of measurement were utilised.

Objective Three –Visual representation of religious/spiritual belief influence types- Interview transcripts were initially sorted into three composite text files based on self-reported religious/spiritual belief influence. A content analysis of the compiled text material (strong influence/minor influence/no influence) was then conducted with the HAMLET II 3.0 [33,34] which was used to generate three separate lists (one for each meaning type) of words related to religious/spiritual belief influence, based on the counts of word frequencies within the three composite texts files. HAMLET [33] is a programme devised to provide linguistic content mapping. It "quantifies and visually portrays