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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

shared meanings, so that they can be more easily grasped and interpreted by the analyst." [35] HAMLET utilises non-metric multidimensional scaling, which belongs to a group of techniques allowing for graphical representations of shared understandings [35–38]. Frequency of use was utilised as a rough measure of the salience of a word to each of the three categories. The 21 most frequently repeated words and their derivatives and inflections (excluding articles, conjunctions, and some auxiliary verbs) were extracted from the total generated word frequency lists from the three composite text files. This was accomplished utilising the 'compare vocabularies' function of HAMLET, [29] which identifies similarities in vocabulary usage across the composite texts by generating the percentage of overlaps of words present in the transcript files. Word usage for each participant type was then reported as a percentage of the total words in this 21-word sample (to normalise across the three subsamples, which had different total word counts) [39]. Utilising the HAMLET II 3.0 programme [36], word co-occurrences and proximities in each composite text file were determined and then summarised in three cognitive maps utilising multidimensional scaling (MDS).

Multidimensional scaling (MDS) was used to determine if the patterns of belief influence–related linguistic behaviour (word-use frequencies and collocations in the transcripts) could be sorted into three distinct clusters that bear a resemblance to the religious/spiritual belief influence categories reported by staff in the questionnaires. MDS can be viewed as a 'pattern recognition' tool to both explore and visualise structured patterns within complex numeric and textual observations in relation to human cognition, perception and contextualised 'meaning.' MDS iteratively adjusts distances between points in the Euclidean space (the model) to match the matrix of dis/similarities (the data) as closely as possible [31]. Frequently co-occurring keywords within the composite text files appear nearby in the mapped Euclidean space, whereas words that are rarely used in the same context appear distant from each other on the map, resulting in a "clustering of perceived similar meanings" [32] effect that is helpful in describing the three religious belief influence types. Underpinned by personal construct theory [33], cognitive mapping techniques (also known as concept mapping) have been previously utilised in health research [32,34,35].

To provide further evidence to support the three religious/spiritual groups, MDS was used to compute an individual differences scaling (INDSCAL) model [40]. INDSCAL was utilised to determine if the MDS solutions derived from the three composite text files could be sorted into three well-defined groups that reflect the religious/spiritual belief categories reported by the participants. INDSCAL fits the matrices for the three composite text files into one shared space, with jointly estimated weight parameters for each composite file. Kruskal's stress was used as a measure of "goodness of fit" [41] for both the MDS and INDSCAL matrices. Stress ranges between 0 and 1, with values near 0 indicating better fit [41].

Objective Four – Interpretive analysis of religious/spiritual coping. Analysis of the complete qualitative interview data adopted a grounded theory approach [42]. Initial line-by-line open coding of the interview transcript data into broad themes [43] was undertaken by DB using NVivo. This analysis occurred simultaneously with the on-going collection of further interview data until conceptual saturation of themes was achieved. Peer review and debriefing strategies (with SF, RF, and MB) were used to support trustworthiness. A religious/spiritual attitude toward death was a theme strongly evident in the data. Properties, or sub-themes, relating to the centrality of religious/spiritual attitudes and beliefs in coping with death had striking contrasts. Findings by RF of significant differences in burnout in relation to participants 'self-reported religious/spiritual belief influence as well as the individual differences scaling results added a potential logic to these contrasts evident in the qualitative data and precipitated further categorisation of the interview texts. Participants' interview transcripts were then sorted into the three self-reported religious/spiritual belief influence categories (strong influence/minor influence/no influence) and analysed separately Close, repetitive reading then ensued to determine the relationship between religious/spiritual belief influence and self-reported coping with death and dying. Quotations were selected to illustrate the sub-themes raised by participants, in the three religious/spiritual belief influence categories. The text excerpts were then checked against the 21-word sample derived from the content analysis outlined above as a form of triangulation. Only limited participant information has been associated with supporting quotes reported in the results in order to maintain participant anonymity.

4. Results

Participants (n = 113) were most often female (93.8%). They most frequently worked as nurses (30.1%) or Healthcare assistants (30.1%) and reported English as their first language (49.6%). Staff predominantly listed NZ European (45.1%) or 'Filipino' (20.4%) as their ethnicity. Participants most often identified Christian (63.7%) as their religion, while 25.7% listed "no religion. Fifty-nine participants (52.2%) reported Registered Nurse (RN) as their professional qualification, while twenty-five (22.1%) reported an Healthcare Assistant education (ACE) programme certification (accredited through New Zealand Qualifications Authority). Participants averaged 12.3 years' experience in aged residential care (range 0.25–42 years) (Table 1).

The presentation of results is structured around the objective addressed as follows:

Objective One – Level of influence of religious/spiritual belief on attitudes toward death. Of the 111 respondents who answered the question, 51.4% reported religion/spiritual beliefs as a strong influence on their attitudes toward death and dying, 22.5% indicated a minor influence and 26.1% reported no influence (Table 2). The majority of participants who reported a religious affiliation also reported a strong influence of religious influence on their attitudes toward death (61.7%), while 21% reported minor influence and 17.3% no influence. Of those participants listing no religious affiliation, 14 participants (48.2%) stated that their religious/spiritual beliefs were either a strong (7) or minor (7) influence on their attitudes toward death, while 15 (51.7%) reported no influence. Likewise, participants (52.2%) reported cultural beliefs as a strong influence on their attitudes toward death and dying, while 19.5% reported a minor influence and 28.3% reported no cultural influence.

Religious/spiritual beliefs and demographic factors. Chi-square analyses indicated no significant relationship ($p > .05$) between religious/spiritual belief influence on attitude toward death and gender, age, job title or job type (full time/part time) or years of experience in aged care. There was a significant relationship between home language (English/non-English) and religious/spiritual influence $X^2(1, N = 111) = 21.19$, $p = .000$. Non-English language native speakers more often reported a strong influence of religious/spiritual beliefs than would have been expected by chance. There was also a significant relationship ($p < .05$) between cultural influence on attitudes toward death (influence/no influence) and religious/spiritual belief influence on attitudes toward death X^2 $(1, N = 111) = 55.64$, $p = .000$. Participants who stated that cultural beliefs influenced attitudes toward death also were more likely to report that religious/spiritual beliefs influenced those attitudes. There was also a significant relationship between religious affiliation (yes/no) and religious/spiritual influence on attitude toward death $X^2(1, N = 110) = 13.04$, $p = .000$.

Objective Two-Relationship between religious/spiritual belief influence, religious affiliation, and burnout

A 2 × 3 (religious affiliation x religious influence) factorial analysis of variance tested the effects of the religious/spiritual influence and religious affiliation (yes/no) on burnout. Results indicated a significant main effect for the religious/spiritual influence, $F(2,73) = 4.55$, $p = .014$. Participants who reported minor influence of religious/spiritual beliefs had a significantly higher mean burnout score ($\bar{x} = 2.67$, $SD = 0.77$) compared to those who had reported strong

Table 1
Participant characteristics frequency and percent (n = 113).
[b]Registered Comprehensive Nurse.
[c]Enrolled Nurse.
[d]Healthcare Assistant training programme (ACE).

Variable	Frequency	Percent
Gender		
Male	7	6.2
Female	106	93.8
Age		
< 20	1	0.9
20–29	12	10.6
30–39	26	23.0
40–49	24	21.2
50–59	35	31.0
60–69	10	8.8
70–79	2	1.8
Ethnicity		
NZ European	51	45.1
Maori	4	3.5
Pacific	9	8.0
Filipino	23	20.4
Asian	3	2.7
Indian	6	13.3
Other European	2	1.8
Other	6	5.3
ESOL		
Yes	57	50.4
No	56	49.6
Religion		
Christian	72	63.7
Muslim	1	0.9
Hindu	6	5.3
Buddhist	1	0.9
No religion	29	25.7
Other	3	2.7
Role		
Facility Manager	15	13.3
Clinical Manager	14	12.4
Registered Nurse	34	30.1
Enrolled Nurse	8	7.1
Health Care Assistant	34	30.1
Other	8	7.1
Professional Qualifications		
RGN[a]	47	41.6
RCN[b]	12	10.6
EN[c]	11	9.7
ACE Training[d]	25	22.1
ACE Dementia Training[d]	7	6.2
Other	5	4.4
Time in Aged Care		
1–6 years	31	27.4
7–13 years	29	25.7
14 years and over	44	38.9
Type		
Part Time	11	9.7
Full Time	101	89.4

[a]Registered General Nurse.
[b]Registered Comprehensive Nurse.
[c]Enrolled Nurse.
[d]Healthcare Assistant training programme (ACE).

influence of religious/spiritual beliefs ($\bar{x}$ = 2.14, SD = 0.70). There was no significant difference in mean burnout scores between the minor influence and no influence groups ($\bar{x}$ = 2.25, SD = 0.60) ($p > .05$). Likewise there was no significant difference in mean burnout scores between strong influence and no influence groups ($p > .05$). There was a significant main effect for religious affiliation (yes/no), $F(1, 73) = 16.00$, $p < .01$. Participants who reported no religious affiliation reported a significantly higher mean burnout score ($\bar{x}$ = 2.59, SD = 0.82) in comparison to participants who reported a religious affiliation ($\bar{x}$ = 2.18, SD = 0.66) (Table 3). Regarding the interaction between religious affiliation and religious/spiritual belief influence, the effect size for the interaction was larger than the main effects, thereby suggesting that there truly may be an interaction effect; however the result was not statistically significant ($p > .05$). This result may have been due to low statistical power for the interaction and a relatively small sample size.

Following the result of a relationship between cultural influence on death attitudes and religious affiliation, a 2 × 3 (religious affiliation x cultural influence) factorial analysis of variance tested the effects of the cultural influence and religious affiliation (yes/no) on burnout. Results indicated no significant main effect ($p > .05$) of cultural belief influence (strong/minor/none) on burnout. As in the previous analysis, there was a significant main effect for religious affiliation (yes/no), $F(1, 87) = 5.06$, $p < .05$. Participants who reported no religious affiliation reported a significantly higher mean burnout score ($\bar{x}$ = 2.61, SD = 0.15) in comparison to participants who reported a religious affiliation ($\bar{x}$ = 2.19, SD = 0.66). There was no significant interaction effect between religious affiliation and cultural belief influence ($p > .05$). A 3 × 3 (religious influence x cultural influence) factorial analysis of variance produced no significant main effects or interaction effects ($p > .05$). This result may have been due to small sample sizes for some categories of response.

Objective Three – a visual representation of religious/spiritual belief influence types.

Results of the linguistic analyses are presented in Table 4 (word usage by religious belief category) and graphically portrayed in Figs. 1–3. Figs. 1–3 portray MDS (Kruskal-Guttman-Lingoes-Roskam smallest space) representations of the words × three participant-religious belief type matrices in three dimensions using HAMLET [33]. The MDS matrices are particularly instructive in summarizing the relationships between word-usage patterns and the religious/spiritual belief types [34]. The items which are of central concern as reflected in the joint-occurrences of the defined vocabulary items also tend to appear in the centre of the resulting configuration. In this case, 'god' clearly appears closer to central issues related to death and dying in Religious/spiritual –strong influence. In contrast "god" becomes more distant for Religious/spiritual –minor influence and is isolated at a distance from other terms for Religious/spiritual – no influence participants (see the location of 'god' highlighted in Figs. 1–3). Similarly, negative emotions as exemplified by the word "sad" appear closer to the centre of the maps for Religious/spiritual influence –strong and Religious/spiritual influence – minor and at the periphery for Religious/spiritual influence – none indicating a distancing from these feelings. Interestingly, words identifying specific religious affiliations were not found in the 21 most frequently used words derived from the composite text files for the three religious/spiritual influence types.

Results of the INDSCAL analysis are visually portrayed in Fig. 4. The INDSCAL model fits a common group space for the three religious/spiritual influence judgements and a parallel weighted space for the three different judgement groups [44]. In the three-dimensional graph of the coordinates, the religious/spiritual influence ratings (strong/minor/no influence) are represented by symbols (Religious/spiritual –strong influence, Religious/spiritual – minor influence & Religious/spiritual – no influence) and the three participant groups by vectors. Results of the INDSCAL demonstrate that the three groups represent distinct viewpoints in respect to the degree of influence of religious/spiritual beliefs in shaping attitudes toward death and dying.

Objective Four- Interpretive analysis of religious/spiritual coping. What follows is an analysis utilising a grounded theory approach of the predominant themes pertaining the centrality of religious/spiritual attitudes and beliefs in coping with death. These themes are further supported by the frequently-used words as identified in the earlier multidimensional scaling analyses and the results regarding the relationship between burnout and religious/spiritual belief influence. The qualitative data is presented in three clusters, beginning with the strong

Table 2
Religious/spiritual belief influence (Strong/Minor/None) frequency and burnout (mean scores)by socio-demographic variables (n = 113).

Religious/Spiritual Belief Influence	Strong	Minor	None	Total			Burnout				
	n	n	n		X^2	*p*		n	$\bar{x}$ (SD)	F/t (Effect Size)	*p*
Gender					0.57	.752	**Gender**			−0.26 (.109)	.789
Male	4	2	1	7			*Male*	6	2.18(.47)		
Female	53	23	28	104			*Female*	88	2.26(.74)		
Age					3.13	.208	**Age**				
Lowest to 49 years	22	8	5	35			*Lowest to 49 years*	32	2.27(.70)	.02(.013)	.979
50 years and over	29	13	18	60			*50 years and over*	46	2.26(.74)		
ESOL					21.19	.000**	**ESOL**				
Yes	40	9	6	55			*Yes*	48	2.10(.67)	2.14(.453)	.035*
No	17	16	23	56			*No*	46	2.42(.74)		
Role					5.20	.267	**Role**				
Manager (Facility, Clinical)	11	10	8	29			*Manager (Facility, Clinical)*	24	2.35(.70)	1.29(.038)	.280
Nurse(RN, RCN, EN)	24	8	10	42			*Nurse(RN, RCN, EN)*	36	2.39(.73)		
Health Care Assistant	21	5	7	33			*Health Care Assistant*	28	2.02(.72)		
Type					1.19	.551	**Type**			−1.32(.440)	.188
Full-Time	53	21	25	99			*Full-Time*	88	2.29(.74)		
Part-Time	4	3	4	11			*Part-Time*	10	1.97(.58)		
Years in Aged Care					6.69	.153	**Years in Aged Care**				
1–6	21	18	18	57			*1–6*	26	2.34(.77)		
7–13	10	2	13	25			*7–13*	24	2.11(.75)		
14 and over	8	8	13	29			*14 and over*	35	2.30(.72)		
Religious Affiliation					15.52	.000**	**Religious Affiliation**			2.24(.481)	.027*
Yes	50	17	14	81			*Yes*	67	2.16 (.66)		
No	7	7	15	29			*No*	25	2.50(.82)		
Cultural Influence							**Cultural Influence**				
Yes	53	21	5	79	56.32	.000**	*Yes*	70	2.22(.69)	−.89(.207)	.375
No	4	4	24	32			*No*	24	2.37(.81)		

* $p < .05$.
** $p < .001$.

religious/spiritual influence participants before proceeding to clusters representing both minor and no influence of religious beliefs. The focus is on the interaction between the subject's religious/spiritual influence and coping with death and dying, not on all aspects of their coping resources.

4.1. Strong religious/spiritual influence

The following quote illustrates how the RN has utilised both her religious beliefs and experience to cope with the death of a resident. Spiritual and professional roles within this view are merged with the consequence that the deceased is "in good hands now."

> I learned how to cope, like this is part of the life and if you think the positive side like it's better, like, they're in good hands now.

Prayer was also seen as an integral component of a good death as illustrated by this quote from an HCA:

> **What's the best thing that can happen to people who are dying**?
>
> I think in the last stage of life if they can still talk, if they can still drink water it would be really good. If they can breathe for themselves, they can pray to God for themselves for the good soul.
>
> **So do you pray for the people?**
>
> Yeah, of course, of course. (HCA)

Prayer was used by another HCA to manage her fear of being alone with the dead body and thus the deceased spirit. Prayer provided both comfort and a sense of being 'present' with the dying resident.

> I'm not afraid of her body, but her spirit…when I'm cleaning her, one of my colleagues left me all alone in the room and then I'm praying for her, and I just felt her hand move, oh my God⋯I don't want her room open; I just don't want to pass by near her room… just the spirits you know, I don't know, it's my feeling…maybe my culture.
>
> I'm a religious person I⋯you just pray to [sic] them and then. . That's the way I do, just comfort cares.

4.2. Minor religious/spiritual influence

Participants within the minor influence group demonstrated a tension between the personal and professional realms – unsure of the boundary between the two. An RN reports one particular incident after a resident's death:

> I should've just acted as what I can see from him. Probably I just got too emotional as well with what's going on….Cos when the other son arrived, he saw dad's dead body and the following day he came to get the things off dad, and he just told me, just didn't quite sleep because I can still see his face, because of, yeah, the remains. And I was just thinking, oh I should have just covered the face.

Another expressed the tension between their own expectations of what a good death is and the realities and responsibilities of the job.

> The HCAs' time, the nurses' time, quite limited with what we can offer our dying residents…we don't have that capacity of giving them one on one care… which is quite sad, you know? That would be good if there was someone that can stay with them bedside, and, you know, just be there, you know, with them.

A relativist approach [45] to religion was utilised as a form of caring:

Table 3
Factorial ANOVA's of burnout mean scores by religious/spiritual belief influence (strong, minor, none) religious affiliation (yes/no) and cultural influence (strong, minor, none).

Burnout	n	$\bar{x}$ (SD)	F(Effect Size)	p
Religious/Spiritual Belief Influence			4.55(.111)	.014*
Religious Affiliation			4.04(.052)	.048*
Religious/Spiritual Belief Influence x Religious Affiliation			2.34(.060)	.103
Strong	**46**	**2.14(.70)**		
Religious Affiliation Yes	41	2.14(.69)		
Religious Affiliation No	5	2.14(.86)		
Minor	**17**	**2.67(.77)**		
Religious Affiliation Yes	11	2.32(.57)		
Religious Affiliation No	6	3.30(.73)		
None	**16**	**2.25(.60)**		
Religious Affiliation Yes	8	2.18(.66)		
Religious Affiliation No	8	2.59(.82)		
Cultural Influence			1.40(.037)	.252
Religious Affiliation			6.36(.079)	.014*
Cultural Influence x Religious Affiliation			1.28(.034)	.283
Strong	**47**	**2.19(.72)**		
Religious Affiliation Yes	38	2.16(.71)		
Religious Affiliation No	9	2.31(.80)		
Minor	**16**	**2.39(.67)**		
Religious Affiliation Yes	12	2.16(.46)		
Religious Affiliation No	4	3.07(.82)		
None	**17**	**2.40(.73)**		
Religious Affiliation Yes	11	2.23(.67)		
Religious Affiliation No	6	2.70(.81)		
Cultural Influence			.30(.007)	.735
Religious/Spiritual Influence			1.30(.030)	.276
Cultural Influence x Religious/Spiritual Influence			.77(.036)	.545
Strong	**52**	**2.15(.70)**		
Religious/Spiritual/Strong	45	2.10(.71)		
Religious/Spiritual/Minor	4	2.75(.60)		
Religious/Spiritual/None	3	2.16(.40)		
Minor	**17**	**2.42(.66)**		
Religious/Spiritual/Strong	2	2.10(.00)		
Religious/Spiritual/Minor	13	2.43(.71)		
Religious/Spiritual/None	2	2.75(.63)		
None	**24**	**2.37(.81)**		
Religious/Spiritual/Strong	4	2.13(.71)		
Religious/Spiritual/Minor	4	2.57(.76)		
Religious/Spiritual/None	16	2.25(.68)		

> Sometimes in there, I pretend because we do have a Catholic service every Tuesday within the unit, and there's a lady in there, and it's really, really important to her. And I'm her key worker, and so I pretend that is my faith, you know. And that makes us very close.

4.3. No religious/spiritual influence

The quote from an RN illustrates a 'matter-of-fact' approach to meaning-making in death as well as an attempt to treat the professional and personal as separate spheres as a means of coping.

Table 4
Word usage in discussing the influence of religious beliefs on attitudes toward death among the three religious belief influence types: composite texts from participants in 50 New Zealand RAC facilities (expressed as percentages of total keyword frequency).

Keyword	Type1 (strong influence)	Type 2 (minor influence)	Type 3 (no influence)
always	7.97	7.13	8.25
care*	12.19	11.95	13.51
comfort*	5.83	4.43	4.67
die	1.57	1.68	1.78
duty	0.48	0.33	0.4
famil*	20.23	20.77	17.14
feel*	6.81	4.71	4.38
funeral	1.36	2.75	1.73
God*	0.34	0.9	0.46
good	9.12	11.06	8.94
help*	3.8	1.91	3.06
need*	7.86	8.98	8.6
normal*	1.85	0.79	2.65
over	2.93	4.38	3.46
pain*	3.56	3.14	5.48
peace*	0.62	0.62	1.15
real	0.27	0.62	0.98
relief*	0.69	0.17	0.69
sad*	1.32	2.13	0.92
sometimes	6.92	5.67	6.35
sure	4.37	5.83	5.36

a* Indicates that variants on a word were allowed, e.g., "famil*" would include "family" and "families".

> No, we were sad at losing her – happy that she's now out of her misery and all the rest of it···I'm not religious. I don't believe in God and all the rest that goes with that stuff… I might be a bit old-fashioned, but that's where I think we are, we're not family. We are the professionals, and therefore I think we need to remember that.

5. Discussion

The effect of death on professional care staff is a neglected area. To our knowledge, this is the first study utilising multiple methods to examine both the relationship between religious/spiritual belief influence and burnout as well as the use of those religious/spiritual beliefs (or lack thereof) in staff coping with death and dying. Results of all three methods provide evidence to support the view that staff within RAC utilise religious/spiritual beliefs to varying degrees in their attempt to deal with the frequently occurring deaths within the facilities. In the current study, 51.4% reported religious/spiritual beliefs as a strong influence on their attitudes toward death and dying (e.g., a positive approach- "they're in good hands now") while 22.5% indicated a minor influence (e.g., a relativist approach – I pretend that is my faith, and that makes us close) and 26.1% reported no influence (e.g., a practical approach "she's out of her misery"). The three cognitive maps (word use patterns) and differential word use frequencies also support the view that participants have distinctly different experiences of the role of religious/spiritual beliefs in attitudes toward death and dying – as reflected linguistically in how they describe it (e.g., the central location of the word 'god' for the strong influence group in comparison to the minor and no influence cognitive maps). The grounded theory analysis of recurrent themes related to the salience of these religious/spiritual beliefs provides further support for these distinct groupings as well as sheds light on how these beliefs influence coping with death and dying.

According to Desbiens and Fillion [46], an individual's capacity to create meaning can reshape stressful situations into positive experiences and can serve as a 'profound motivational force' which improves

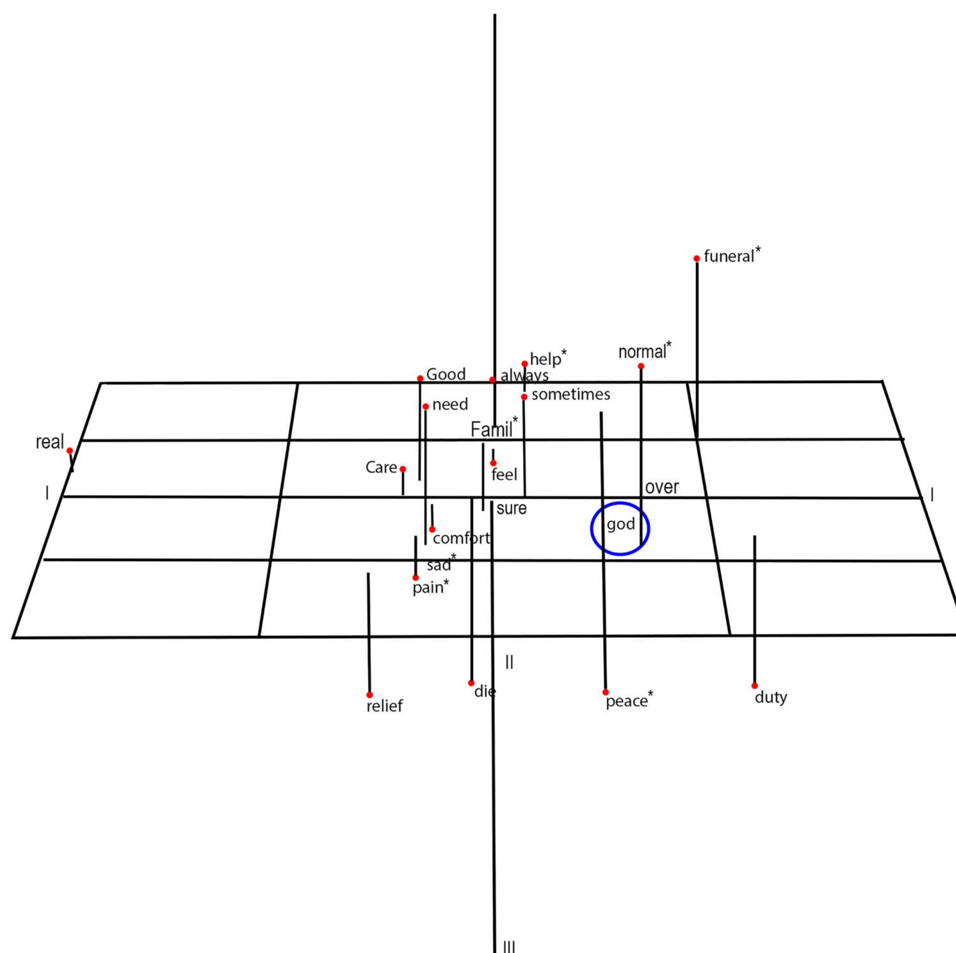

Fig. 1. Religious/Spiritual belief type (strong influence) represented in three dimensions based on a 21-word sample (HAMLET Kruskal-Guttman-Lingoes-Roskam smallest space coordinates) (Kruskal's Stress = 0.08).

quality of life. Moss et al. [47] further stated that aged care staff "need to have a way to make sense out of the death and dying of nursing home residents" (p. S290). Recall the RN who described dying as just a part of life. The findings of the present research also suggest that religious/spiritual belief provides individuals with "a system of values and norms founded on faith" [48] that shapes the appraised meaning of the participant's work in caring for end-of-life residents [49]. As one HCA commented," I'm a religious person…you pray for them…that's the way I do comfort cares."

A meaning system [9] not informed by religious/spiritual belief was also utilised by staff in dealing with end-of-life care (e.g., happy that the deceased resident is now "out of her misery"). Similar to results by Ablett et al. [50], respondents in the "no religious/spiritual influence" group emphasized awareness of maintaining professional boundaries (e.g., "We're not family"). Furthermore, feelings like "sad" appear at the periphery of the cognitive map for the no religious/spiritual influence group indicating a distancing from these feelings. This behaviour may serve a defensive/protective function providing distance for the staff member from the emotional distress of caring for residents and families who are themselves confronting existential issues [50]. Drawing on Pargament's [51] coping theory of the psychology of religion, boundary demarcation was used by some of the participants as a preservation coping strategy. In line with research by Ekedahl and Wengstrom [52] examining the experiences of nurses in cancer care, participants in this group further demonstrated "*Caritas*-oblivion" (a psychological separation from deceased patients) (e.g., "we are the professionals"). The perceived need to maintain boundaries and 'just deal with it" can lead to unresolved grief [5](p. 3).

Lack of professional boundaries has also been identified as a form of dysfunctional coping for nurses leading to ill health [52]. In the present study, participants in the minor influence group did recognise the need for boundaries. However, these participants struggled with where the boundary between the personal and professional realms should sit (e.g., exemplified by the RN's struggles concerning not covering the resident's face after death). Previous research by Gattuso and Beven [53] found high levels of stress in aged care staff related to the conflict between the need to develop a caring relationship and the needs of the professional role. Marcella and Kelley [5] further describe this struggle as "managing emotional attachment and detachment"(p. 7). Members of the minor influence group reflected uncertainty as to the role of personal religious belief in the delivery of end of life care.

Spiritual/religious belief as a form of meaning making may play a role in mitigating burnout in the workplace [18]. The current study findings are in line with research by Babikanga et al. [54] who found that religious values provided a source of meaning in the face of adversity for Ugandan nurses. Intrinsic religiosity (religious values and norms at the core of an individual's approach to life) has also been found to reduced death anxiety [55]. Perhaps unsurprisingly, earlier research [56] also identified a significant relationship between religious affiliation and burnout. However, despite a large effect size in this current study, there was no significant interaction effect identified between religious/spiritual influence and religious affiliation, nor did religious affiliation feature in the MDS or qualitative results. One possible explanation for these results may be found in research by Holland and Neimeyer [17] who proposed that the daily experiential components of spirituality (equivalent to level of influence in the current

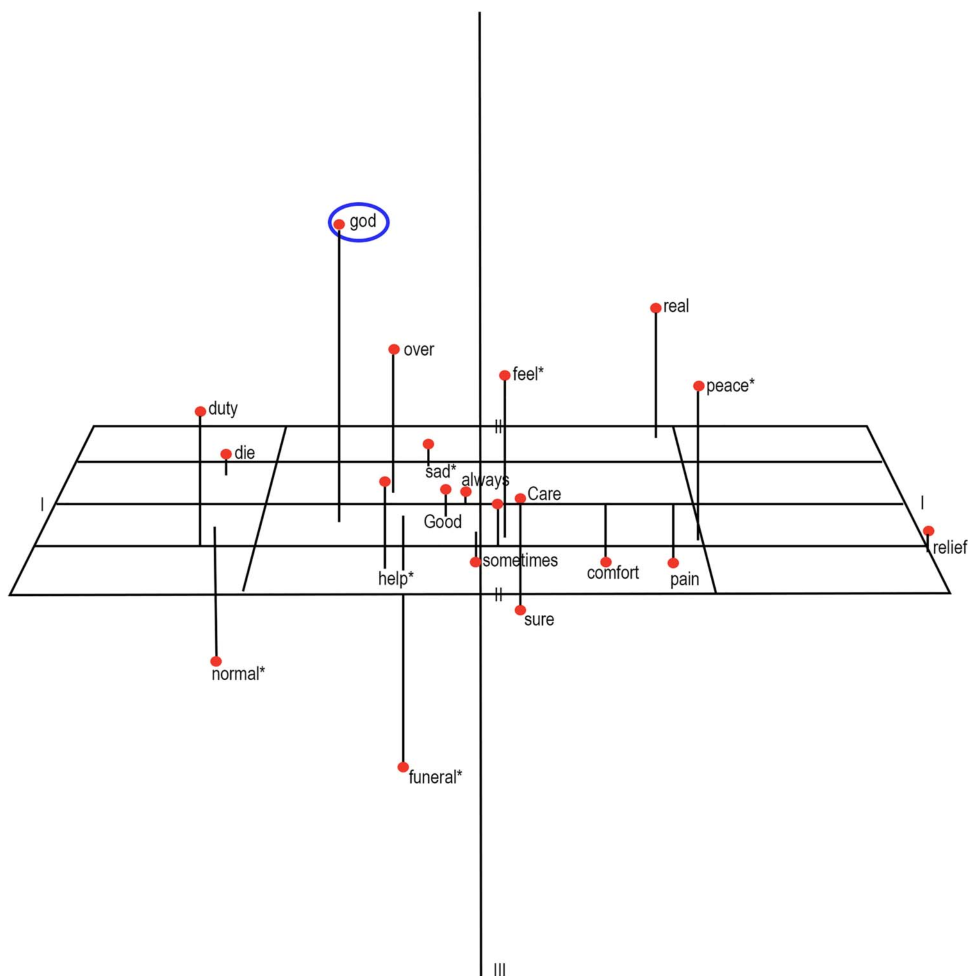

Fig. 2. Religious/Spiritual belief type (minor influence) represented in three dimensions based on a 21-word sample (HAMLET Kruskal-Guttman-Lingoes-Roskam smallest space co-ordinates) (Kruskal's Stress 0.09488).

study) rather than particular religious beliefs or doctrines may be more directly linked to everyday processes (e.g. thoughts and feelings). Supporting this more direct linkage, research by Underwood and Teresi [57] found an inverse relationship between the experiential component of spirituality (e.g., feelings of inner peace, presence, connectedness, etc.) and anxiety, depression and perceived stress. Future research with larger samples is required to explore in greater depth the role of religious affiliation in modifying religious/spiritual belief influence in coping with death.

A relationship was also identified between cultural beliefs and religious/spiritual beliefs toward death although no significant relationship with burnout was identified. These results concur with a review by Peters et al. [58] indicating that culture and religiosity may influence both nurses' death anxiety as well as their attitude toward caring for the dying. The interaction between culture and religious/spiritual influence was reflected in the interview with the HCA who spoke about her prayers for the deceased as well as her cultural fear of being with the deceased resident's body. Within New Zealand, there has been a growing reliance on migrant care workers, particularly from the Philippines [58]. According to the Philippine Statistics Authority 80.58% of the total Filipino population report Roman Catholic as their religious affiliation [59]. The large representation of this ethnic group among the aged care workforce, in comparison to the New Zealand population (1.0%) [60], further emphasises the importance of understanding the role of staff religious/spiritual belief and culture within the RAC sector.

6. Recommendations

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 [18] Memorial services and other rituals that allow for a diversity of religious/spiritual beliefs may also prove beneficial for staff [17]. The variety of cultures represented by RAC staff make this is particularly important due to the disparate meanings are given to death as well as perceptions of death and bereavement [59].

Following on from this point, both time and resources should be provided to staff to enable them to reach out to residents and other staff after a resident death to acknowledge their grief and loss. Research by Marcella and Kelley [5] indicates that such acknowledgement provides both support and a sense of completion which may aid in grief resolution. Perceived lack of organisational support for the sharing of grief by staff has been shown to contribute to staff burnout [60].

Turning to staff education, self-knowledge of one's spiritual or religious belief for RAC staff should be a priority for training. Power and Sharp [61] in a study of hospice nurses highlighted the importance for hospice staff of spiritual belief self-knowledge in order to deal with job stressors associated with meeting the emotional needs of residents. Puchalski, et al. [62], further concluded that healthcare workers were more effective in care delivery when they have "an awareness of their

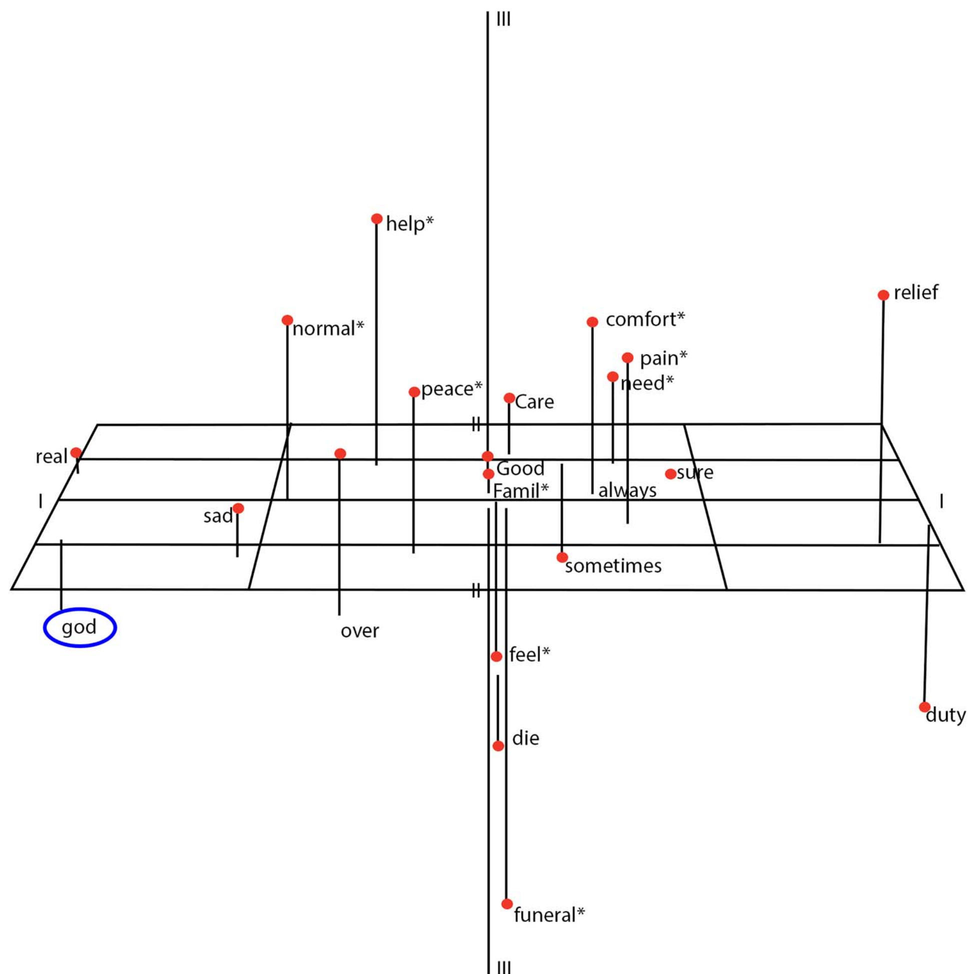

Fig. 3. Religious/Spiritual belief type (no influence) represented in three dimensions based on a 21-word sample (HAMLET Kruskal-Guttman-Lingoes-Roskam smallest space coordinates) (Kruskal's Stress = 0.03).

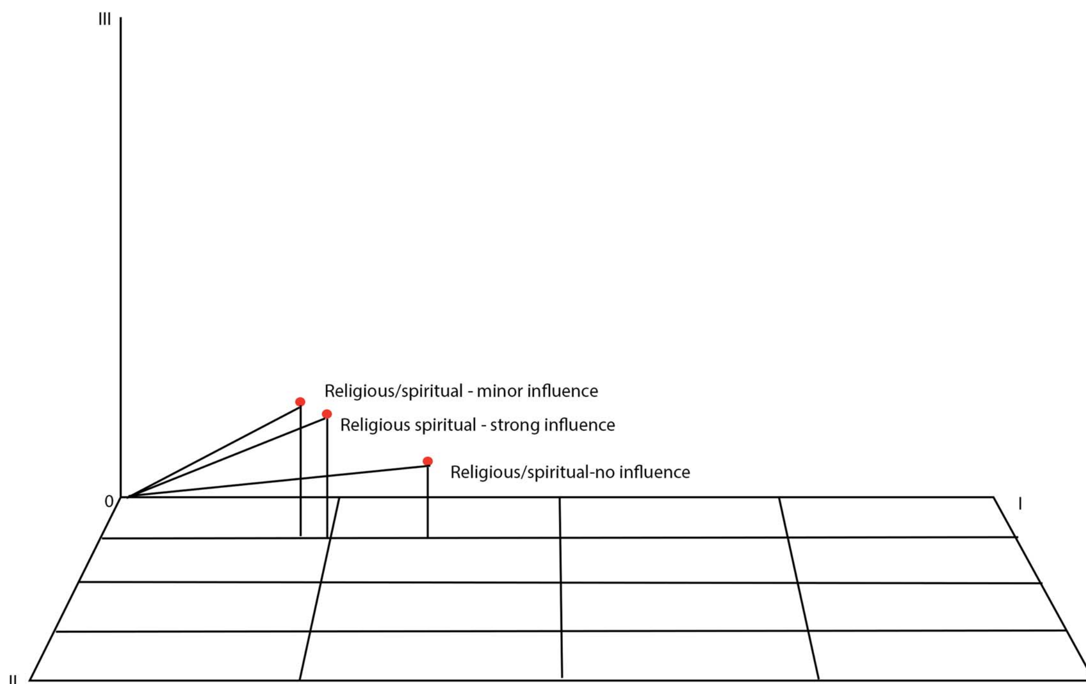

Fig. 4. Distribution of Three Composite Text Files (Religious Spiritual Influence – Strong, Religious Spiritual Influence – Minor, Religious/Spiritual Influence – None) based on Similarities in Word Usage.

own values, beliefs, and attitudes, particularly regarding their own mortality (p. 900).” Use of a diagnostic tool by nurse managers to assist staff with exploring their own belief system may provide self-insights to support the delivery of spiritual care to residents [45].

The results also reinforce the need to implement formal processes for staff (e.g., debriefing opportunities and information on managing grief and loss, opportunities for self-reflection on values and beliefs) as a component of a holistic and inclusive palliative care programme in RAC. This may also contribute to both staff well-being and to improved resident care [63].

7. Strengths and limitations

This study is strengthened by the use of multiple methods providing a greater understanding of this complex topic from the perspective of different types of evidence [64]. Previous studies of religion or spirituality and end of life in RAC have often relied solely on qualitative designs [22,23,65]. Nevertheless, the study has a number of constraints, not least of which is the limited nature of the religious/spirituality influence item [30]. Analysis by Kevern [45] reflects the need for more categories when attempting to classify religious/spiritual belief positions in nurses in order to capture the literal to the symbolic in orthodoxy and relativism. The current study also highlights the relationship between culture and religion in the issues of death and dying, which should be accounted for when designing studies and interpreting results. Finally, given our purposively selected small sample we acknowledge that our participants' views may not be typical of RAC staff across New Zealand, or at the RAC facilities in the study for that matter. Future research involving larger probability sampling and/or longitudinal studies examining the development of religious/spiritual influence over time in staff coping with death and dying in RAC is required.

8. Conclusion

In summary, study results indicate meaning systems [9] informed by religious/spiritual beliefs influence staff's ability to better cope with the experience of end of life care. Furthermore, religious affiliation and culture play a role in modifying religious/spiritual belief influence. As the population ages, staff in RAC will be increasingly called upon to care for dying residents. In the 21st century, with the diversification of religious belief and spirituality beyond the confines of formal orthodoxies such as churches, staff members need to be more prepared to engage in spiritual care for dying residents. Greater clarity and acceptance of what spiritual care looks like, as well as a greater understanding of means utilised by 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.

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Conflict of interests

None.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at https://doi.org/10.1016/j.eujim.2018.03.001.

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