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GCM® National Association of Professional Geriatric Care Managers

Guest Editor's Message

By Leonie Nowitz, MSW, LCSW, BCD

I am delighted to be Guest Editor for this issue on Religion and Spirituality. When I was studying for my social work degree over 30 years ago, the topic of Religion and Spirituality was not in the curriculum. Neither was this subject in the curriculum for nurses, counselors, and doctors until the mid-to-late 1990s.

Fortunately there has been a growing interest in this area over the last decade for all human service professionals as the health and personal benefits of exploring and utilizing the resources that Religion and Spirituality offer is being demonstrated with people who are older and those who are ill.

There are many ways of defining Religion and Spirituality which will be reflected in the articles that follow. A spiritual and religious perspective enables the PGCM to help clients find sources of meaning when facing multiple losses. These sources of meaning may derive from each person's values, beliefs, and spiritual or religious resources. There may be other aspects of their lives that provide meaning. We need to be cautious and aware, when assessing and intervening in our clients lives, always respectful of the views and values of who we serve, even when they may differ from our own.

There are many ways of defining Religion and Spirituality which will be reflected in the articles that follow. A spiritual and religious perspective enables the PGCM to help their clients find sources of meaning when they are facing multiple losses.

The four articles in this issue cover a range of topics from assessment and intervention with our clients, to learning to use our inner awareness of our own spirituality in our work with consumers of our services. We are encouraged to be open to our clients' diverse spiritual and cultural backgrounds. Engaging the spirit of those we serve allows them to feel our authentic care and connection.

Dr. James Ellor's article on *Spiritual Assessment for PGCMs* provides a framework for integrating the spiritual, physical, social, and emotional aspects of each client. These aspects need to be included in the client's overall assessment. Dr. Ellor differentiates between Religion and Spirituality with each having its place with the other. He encourages the PGCM to talk with each client about his or her spiritual joys and concerns, building a way to get to know each person and respond based on the client's concerns and needs. Dr. Ellor provides several examples to discern the meaning of each person's spiritual and/or religious crises and invites us to understand the unique faith or spiritual tradition of each client and the meaning of their symbols of faith. This provides an avenue for the PGCM to respond with a greater understanding of each client's specific dilemma which can differ between clients in different faith traditions and different traditions within the same faith. It also allows for the PGCM to provide both concrete and relational resources that that can help their clients find meaning for themselves. Dr. Ellor's article offers us a broader perspective in helping our clients find meaning in their struggles and fulfillment in their lives.

Dr. Holly Nelson Becker's article on *Integrating Spirituality in Practice* engages us in reflecting on our own spiritual paths and increases our awareness and openness to our clients' perspectives. Dr. Nelson invites us to cultivate self observation and self reflection, and to listen to the client on many levels to in order to find sources of meaning.

She notes that it is important to reflect on our own aging process and our reluctance to speak about sacred sources of meaning. Central to the work with clients is having a client centered focus, to incorporate respect and inclusivity. Dr. Nelson offers several examples that demonstrate good practice when client and practitioner views of their spirituality and religion may differ.

Marita Gruzden's article on *Cultural and Spiritual Diversity* offers us the opportunity to become more aware of our own beliefs and values, as well as our biases and prejudices as we work with clients whose backgrounds are different from our own. Ms. Grudzen recommends that we assess each client's history, psycho-social stressors, and culture, as well as the cultural relationship between the client and the PGCM

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and other agencies they work with. In addition we need to understand the perspectives clients have regarding their illness and how to heal themselves. Being sensitive to each person's cultural and religious resources, will allow the PGCM to encourage those practices that can provide comfort. Ms. Grudzen offers us the opportunity to view differences in people as an opportunity to expand our understanding and our responses to the increasing diverse clients we will work with.

Rabbi Kozberg's article, *As the Spirit Moves*, describes his interactions with residents of an extended care facility. He provides an alternative viewpoint on dementia in that the illness may "steal people's minds, but it cannot steal their hearts, their souls, and their spirits." In contrast to the viewpoints of our hyper-cognitive society, Rabbi Kozberg offers the belief affirmed by the Abrahamic faiths that every human being, no matter how capable or compromised is created in the image of God, and is entitled to respect and dignity. He shares his experiences with the residents he works with who are cognitively impaired and spiritually aware, and who offer profound answers about their lives and the world. The definition of spiritual well-being affirms life in relationship to self, God, and others. People with dementia have need for affirmation, and relationships to others to share love, joy, and a sense of compassion and productivity. Because they are disconnected from themselves and others, Rabbi Kozberg believes that it is the professional's job to affirm their personhood and their ability to stay connected. He encourages us in our role as professional caregivers, to be truly present to each person, to listen to their "melody," and demonstrate our genuine care. This offers our clients the possibility of sanctifying their lives and helping them remain connected to themselves and those who care for them.

I hope these articles stimulate your interest, and encourage you to consider ways of using these perspectives in your work.with your clients. I invite you to enter this conversation by sharing your ideas, experiences and perspectives as we strive to bring a spiritual consciousness into the work with our clients and the families we serve.

Leonie Nowitz, is a founding member of NAPGCM, She is a social worker and care manager in New York City. Ms. Nowitz has taught locally and nationally, and has published articles on care management issues, working with families and accessing spiritual resources for older people and their caregivers. Her most recent article: "Geriatric Care Management, Spiritual Challenges" appeared in the Journal of Gerontological Social Work, *September 2005. Her email address is: leonien1@aol.com.*

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Spiritual Assessment for Professional Geriatric Care Managers

by Rev. James W. Ellor, Ph.D., D. Min., LCSW, ACSW, BCD, DCSW, CGP, CSW-G

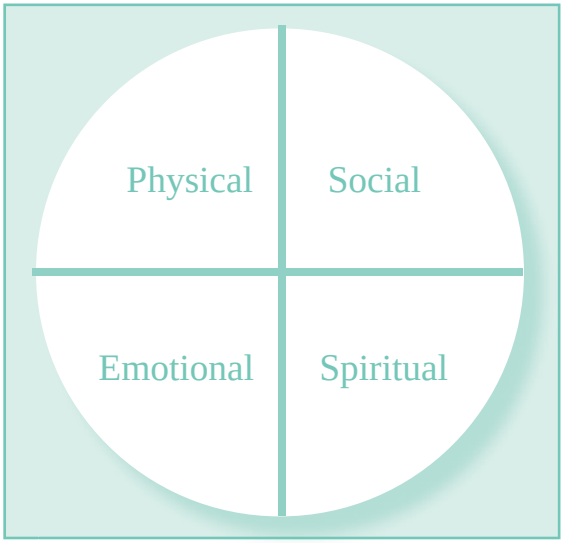
Geriatric care management encounters the religious and spiritual needs of clients in the vocabulary of the client, in the way clients cope with stress, in the community resources that are available to them, and in our own counter transference to the client's religious or spiritual concerns. After decades of treating religion as if it were either pathological or ignoring it all together, in the last decade of the twentieth century, counsellors and care managers began to realize that in fact religion might be an appropriate topic for concern within counselling. With the openness to this topic now comes the need to understand how to include it into our assessment procedures.

Assessments offer the natural nexus between theory and practice. The definitions of what is happening with any given client often reflect our theoretical base. For example, depression can be identified as *anger turned inward, a learned condition,* or *even a lack of meaning in the person's life.* Each definition calls upon the therapist to do different things to help resolve the condition. In an effort to develop spiritual assessment, definitions of what is meant by either religion or spirituality must be a part of the consideration. This creates several challenges as there are so many different possible perspectives.

In this article the author will start by identifying the challenges of defining the religious and spiritual aspects of the person. He will then offer one approach to thinking about this that avoids many of the challenges. Once a definition is developed he will then discuss the various aspects of developing a spiritual assessment that can be effective.

Theoretical Issues

Spiritual assessment is defined as the process of understanding and integrating the religious and spiritual needs of clients into the assessment process. The most desirable approach to spiritual assessment is to integrate the spiritual needs into the total picture of the client based on all of the assessments obtained. This involves the use of a wholistic approach to client assessment and intervention. Alfred Adler first talked about a holistic perspective on human nature. In contrast to the work of Sigmund Freud whose psychodynamic approach attempted to isolate the emotional problem, Adler believed that the physical, social, and emotional aspects of the person were all interconnected. Granger Westburg subsequently taught that this "holistic" perspective needed to be renamed a "wholistic" approach in order to indicate the difference when the spiritual dimension is added to the physical, social, and emotional aspects noted by Adler (Tubesing, 1979).



It is easy enough to talk about the whole person and even to add the fourth dimension of religion (Renetzkym, 1977). The real challenge of wholism is not in the dimensions themselves but rather in the developing an understanding as to how the four dimensions; physical, social, emotional, and spiritual all come together. As with any concept of integration it is an individual process and, to some extent it will depend on the nature of one's approach or paradigm. Both health and religion or spirituality often suffer from this same lack of integration. They may reside on an assessment form, but on different pages under different headings. Health care and its divisions of labour have clearly taught that professionals stay within their areas of competence. This is clearly true in Social Work as well, as it is one of our core values (NASW, 1999). The concept of wholism does not in any way contradict the value of competence. Rather, it suggests a perspective that works to understand that physical, social, emotional, and spiritual matters impact one another and thus are a part of the whole person. When working with an amputee, the physical loss of a limb clearly has emotional implications.

When conceptualizing wholistic assessment, it is important to

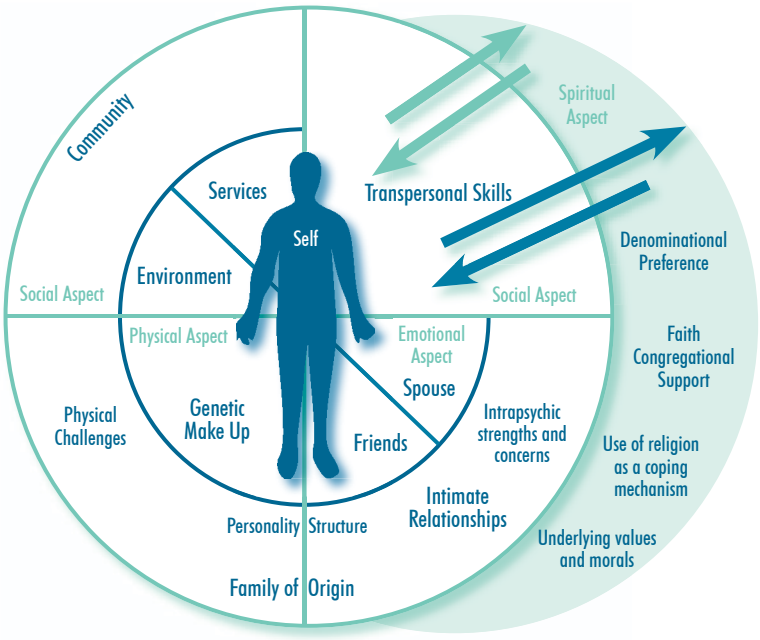
understand that it is clearer to talk about distinct dimensions between the physical and all others than it is to talk about the spiritual as a separate aspect of dimension. As seen in this diagram, a wholistic perspective of the person the spiritual dimension actually permeates or relates to all of the other dimensions. In this illustration, the spiritual is a layer beneath the entire person rather than the earlier model that suggests that it is a distinctly fourth dimension of the person. From the perspective of most of the world's religious traditions, the spiritual aspect of the person relates heavily through transcendence. Transcendence is the capacity to relate within oneself, with others and to one's environment as well as to God. This is certainly not the only way that the spiritual relates to the other aspects of the person, but it is a key aspect of this relationship.

Defining Religion and Spirituality

"Spiritual assessment" became a popular term in the late twentieth century as the counseling disciplines returned to a modest willingness to listen to the voices of spiritual concern. Yet this new openness exposed the continued failure to develop adequate definitions for the spiritual dimension. Reflection on the work of the Lutheran theologian Paul Tillich (*see* Tillich, 1967) suggests that this failure echoes the use by psychology of social scientific definitions for a dimension that cannot be defined by the tools of these disciplines. For Tillich, where psychology is concerned with human existence, theology is concerned with ultimate or essential being (Tillich, 1967). Only with adequate wholistic tools can conceptual insight be developed to support care managers to fully understand the spiritual dimension.

For centuries in Western Europe the accepted view of human nature was drawn from the Christian Church. Only in the last one hundred and fifty years has there been the ability to offer new theories of explanation. Most prominently, the theories of Sigmund Freud led to alternative explanations. More recently scientific theories have become influential.

Wholistic Assessment with Older Adults



By bringing some understanding of the spiritual back into this theory of explanation, counselors are not taking a step backward. Rather, they are acknowledging the needs, concerns, and explanations of their clients. There is a new awakening on the part of the counseling professions to the spiritual needs of clients. Wallis notes, "twenty years ago, no self-respecting M.D. would have dared to propose a double-blind, controlled study of something as intangible as prayer. Western medicine has spent the past 100 years trying to rid itself of the remnants of mysticism" (Wallis, 1996, p. 68). Paul Tillich in dialogue with Carl Rogers in 1965 notes, "if this word were not forbidden in the university today, I would call it something in our *soul* but you know it as a psychologist, as somebody who deals with the soul, that the word 'soul' is forbidden in academic contexts" (Tillich and Rogers, 1984, p. 201).

Prior to the nineteenth century, much of what could be called psychology was developed from a philosophical base that was consistent with the Christian tradition. Today, the counseling professions operate from the humanistic philosophies with little or no acknowledgment of theology. This transition in the basic theory of interpretation means that religious and spiritual issues must conform to the expectations and professional norms of psychology. It also offers the basis for removing any ecstasy and/or mysticism from the spiritual by placing the entire emphasis on a reality that is measured by the experiences of the here and now. Thus, an ever-growing body of literature utilizing the term "Wholism" has emerged where the nature of the person is understood to include physical, social, emotional or psychological, and spiritual aspects (or essences). The challenge that this approach elicits reflects the integration or combination of these elements. Are they separable? Is one superior or more powerful than the other? These questions are often unanswered.

For most care managers today, the challenge is not in recognizing the potential benefit of bringing them

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together, it is in developing a coherent approach. The behavioral sciences see humanity as the focus for their theories of explanation. Relationships conceived by the social and behavioral sciences to that which is beyond human comprehension beg questions as to the basis for understanding. Both behavioral science and religious professionals are searching for approaches which can offer bridges between the various theories to enhance understanding.

Each person who develops a spiritual assessment tool needs to struggle with how to employ it as a part of the theory of explanation for his or her theoretical paradigm. For many seniors, religion and spirituality play an important role in the individual and community quest for meaning in human existence as well as in the quest for ultimate meaning. The term "religion," as defined by Koenig, McCullough, and Larson refers to "an organized system of beliefs, practices, rituals, and symbols, designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community" (Koenig et. al., 2001, p. 18). Organized religions first emerged over six thousand years ago. As such, religion reflects both the nature of the organization as well as the beliefs that are orchestrated by these groups. Care managers should remember that while Christianity is dominant in the United States, there are many other religious traditions, some of whom are dominant in other countries, which need to be understood and addressed by any assessment system that is developed.

Historically, most spiritual assessment tools actually reflect questions of religiosity rather than spirituality as a broader concept. Religiosity and the elements that construct the tools reflecting the approach date back to the turn of the twentieth century. The work of Starbuck (Starbuck, 1911) and others have offered the interpretation of religious phenomena through what has been called "religiosity" for over 80 years. These measures have all struggled to identify the key elements of religion or spirituality that would be acceptable to therapists and researchers. Many assessment instruments include questions like, "How often do you attend church, synagogue, or temple?" or "How often do you pray?" or even "How important is your faith to you?" These questions are important. However, they address the behaviors of religion. They should not be understood as interchangeable with the fullest understanding of the spiritual needs of older adults.

Spirituality is generally understood to be more unique to each individual. Koenig, McCullough, and Larson define 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." (Koenig et. al., 1994, p. 18) Religion and spirituality are not mutually exclusive terms. Rather, each has its place with the other. It is generally thought, however, that an individual can be spiritual without being religious, but one cannot be religious without being spiritual.

The old adage, *the devil is in the details*, may be appropriate here. It is easy enough to conceptualize religion or spirituality in the broadest of terms. For example to ask a person about his or her *beliefs in God* would be logical, until one encounters a persons who is recovering on the 12 step approach to addictions recovery who would rather talk about a *higher power.* Among Christian traditions, some are Trinitarian and would rather talk about the *Father, Son, and Holy Spirit,* where others have a high Christology and would pray only in the name of Jesus Christ. A conversation in 2001 with the then director of the Center for Faith–based Initiatives in the U.S. Department of Health and Human Services suggested that the term faith-based initiatives was employed by the White House because it was universal to all of the faiths groups in the United States. This writer had to point out that the concept of faith assumes a subject and an object, a God and a person. Thus such traditions as Buddhism and even persons who see their spirituality more in terms of their environment than a single God, would not embrace this assumed universality (Netting and Ellor, 2004).

The Assessment Process

As noted earlier, spiritual assessment should not be done in isolation, but rather as a part of a wholistic assessment. This means that the person developing the assessment tool will need to be able to understand his or her results in light of the physical, social, emotional, and spiritual needs of the senior. Particularly critical to this process is the insight as to how these three impact each other.

Possibly the most reliable spiritual assessment tool is a focused interview with a single case design. In other words, talking with each client about her or his spiritual joys and concerns and capturing them in the client's own words is the most effective way to get to know that person. Particularly if the spiritual is a more personal aspect of the person, then it goes without saying that the spiritual will be unique to each person. This does not, however, facilitate integration with the other aspects of the person.

In an effort to integrate whatever tool is to be developed, the initial or pre-step is much like deciding to bake a cake or build a bird house. One generally gets the tools and ingredients out and spreads them on the table. The work of integrating then comes in conceptualizing the connections between the questions that need to be asked and the treatments or solutions available. If the person doing the assessment is restricted to providing services and referrals, then questions about the behaviors of religions and activities of their faith would be most appropriate as these behaviors often

involve rituals or activities that may require such things as transportation, or other believers to share them with. If the services available can also include counseling, then such things as coping mechanisms and sources of hope and meaning would also be important. In some cases, beliefs in an after life may also be important conversations to have with the client.

Developing a Tool

Three key questions must be asked next: Who will do the assessment? What will be assessed? What will the information be used for? These questions help to guide in development of the proper tool for the individual situation. The "who will do the assessment" question will shape both the perception of the senior being interviewed as well as significantly contribute to how the questions are interpreted. It has long been understood that clergy are seen in a different light from other helping professions. By some seniors, clergy are associated with a "magic" that comes from their relationship with God. For these clients, if the person doing the assessment is a priest or other clergy person, answering the questions is like talking to God, or at least God's representative. Other helping professions are generally not given this type of vocation by seniors. Thus a care manager doing the assessment may not invoke these images and may alter the answers given. While many clergy have a broader education upon which to base an understanding of the answers to spiritual questions, care managers can encourage their clients to share their beliefs and concerns if they are open and respectful and empathic in response to the client's concerns. If the care manager feels a lack of knowledge of the client's spiritual concerns, they may need to gain more knowledge of spiritual matters in order to interpret the information given.. Care mangers can also ask their client if they may invite the appropriate religious/and or spiritual professional to be of assistance to them.

The question "what will be assessed?" is a key to the interface of the spiritual questions to the other aspects of the wholistic assessment. If the activity team needs to know what types of worship services should be sought for their community, then the questions about the history of the faith traditions of the senior become relevant. If the care manager needs to understand the influence of religion on the coping patterns of the senior, then these types of questions should be asked. An important point here is that unless this tool is to be used for pure research; questions that are solely for the interest of the counselor or his/her agency would not be appropriate to ask. All questions should be based upon the clients' situation.

Finally, for what will the information be used? This is like the question "what will be assessed" in that it queries the context for the use of the information. It may be used in counseling, program development or even end of life care. Understanding the spiritual needs of seniors can help focus a Bible Study as easily as they can help a counselor interpret feelings. However, in every case there is a context. As noted above, questions should not be asked out of pure interest, but rather to meet individual needs in specific contexts.

Three key questions must be asked next: Who will do the assessment? What will be assessed? What will the information be used for? These questions help to guide in development of the proper tool for the individual situation.

Common Elements

It is important that two groups of questions be developed. The first group are demographic questions. For example, "What is your faith tradition?" and "What rituals or activities of your religion are important?" provide critical information about the person. This group could even include the question, "How important is religion in your life?" Clearly these questions need to be guided by the needs of the common religious traditions in the community where the assessment tool will be used. If there are only Christians in the community, then the question need only be, "What church do you attend?" rather than, "What church, synagogue, or temple do you attend?" On the other hand, where the world traditions are present, a consultant may need to be engaged to be sure that questions are appropriate for all of the traditions that may be engaged by this approach.

The harder group of questions to develop is the second group. These are the questions that reflect spirituality and meaning. They need to directly reflect the theory of explanation operative by the person developing the instrument. Doug Olson and Rosalie Kane (Olson and Kane, 2000, p. 306-307) did a study of the common variables used in spiritual assessment. They found that the most common demographic variables were: relationship with God, religious history, questions about organizational practice, and the degree of commitment.

Olson and Kane found that the most common questions at the heart of the spiritual domain reflected themes of private daily experience, value systems, beliefs, and spiritual development. For counselors, questions about religious coping would also be helpful following the pattern of those asked by Ken Pargament (Pargament, 1997) or Harold Koenig (Koenig, 1994).

The final aspect of spiritual assessment is to understand the format

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for information collection. Will it be done in an initial clinical assessment format or in ongoing meetings with clients? Will it be done on a computer, with paper and pencil? Will it be a kind of test given to the senior to complete and present to the care manager counselor? Some older people reflect on their spiritual and religious interests as part of a group discussion. How will the information be gathered? This is often a very pragmatic question. It depends in part on the resources of the persons collecting the information.

An alternative approach

The constant challenge in spiritual assessment is to find definitions of religious and spiritual content that do not try to inflict a specific theology or position on the client, while still providing consistent data to be used in the clinical process. One system for this was developed by Thibault, Ellor, and Netting (1991). This approach takes the position that humanity is not able to fully understand the mind of God, however he is understood. Therefore it is more effective to start from the human perception or ability to perceive the divine, rather than trying to call the divine by name. This is referred to as Anthrocentric Theology rather than Theocentric Theology. Theocentric theory is much more common and encompasses the writings of most of the founders of the major world traditions. Alternatively, a theologian like Paul Tillich is an Anthrocentric theologian as he presumes that humanity can not fully grasp the nature of God, but can find insights into the way we view God.

From this perspective, rather than ask in clinical assessment about the nature of God, why not ask questions about how the person knows God. Thibault, Ellor, and Netting (1991) suggest that there are three ways humanity experiences God, through our affective relationships, our intellectual understanding, and our actions or behaviors toward God. It is hypothesized by these authors that each person will develop a personal balance between these three that may not look like another person's balance, but spiritual crises occurs when the three are out of balance. For example, a person who may be a devout believer and Roman Catholic, is knowledgeable in Cannon Law as well as the Bible, is a member of the Rosary Society and many other clubs at church as well as a faithful attendee at mass, may yet present as not feeling close to God. In this case the person's knowledge and behavioral areas are strong, but their affective area has changed in some way. Generally speaking when this happens, it is because the person has had a tragedy in her or his life that has led them to question God. Some clients may say."God has abandoned me." By isolating the affective domain, the care worker can support the person through this question of divine abandonment with the hope of some resolution.

Case Examples

Some examples of the challenges of understanding and integrating faith may help illustrate this process. Joanna is a practicing Jew. She attends services on Friday nights and keeps a kosher household. She is also a member of the women's society and provides numerous other informal services in her congregation. However, her congregation has been dwindling in number due to the fact that her neighborhood is changing and she is less able to leave her home due to physical illnesses. She is deeply saddened by these events and often found crying in her bed. How is she to keep kosher now that the last butcher has left her area? How can she feel like she is a part of her congregation if she can not go there? She feels un-attached, isolated, and alone. In this case, alternative behaviors may need to be developed. Referred to as functional equivalents in religious practice, this refers to alternative behaviors such as purchasing kosher products at the grocery store rather than going to the butcher and it may mean receiving audio or video taped copies of services. For the care manager who has counseling and concrete services to offer, spiritual assessment will involve questions that help to understand the behaviors of faith that are important to Joanna, and then problem solving with her to find solutions that are appropriate within her faith tradition to address the concerns.

In another example, the loss or reduction in intellectual resources of one's faith can be best observed using cognitive therapeutic tools. Frequently, a believer will get lost in an intellectual loop. Employing universal statements like "all" and "every" to God can lead the person into either false belief or self destructive behavior. Such notorious cultic group leaders as Jimmy Jones and David Koresh facilitated such thinking, often to the end that they were thought to be especially close to God and were even God-led in guiding their followers to their deaths. In more average cases, an individual can convince themselves that God is mad at them, or God has allowed something to happen to them as a direct result of a particular action. The use of cognitive tools can help alleviate this concern. Clearly a different kind of cognitive irrationality comes with persons who are in early stage dementia. However, in such a case, there are often other tools to help discern this.

Maria, a 78-year-old female, has told her hospice worker that she no longer needs her pain medications because the Virgin Mary is always taking care of her. She is a person with incredible faith, yet racked with cancer. Staff can't see how or even why she should try to live without the pain medications. Maria's faith suggests the emotional importance of the Virgin Mary in terms of taking care of her. Other therapists might point to this as relating to one of her parents or a husband, but at the moment the important thing is to listen to her relationship with the Virgin. For Roman Catholics, the Virgin Mary is an intercessor, an advocate for Maria with God. However, it is understood that God is the one who will heal Maria, not actually the Virgin Mary. Spiritual assessment in this case involves understanding Maria's understanding of who the Virgin Mary is, why she is so important, and assessing the cognitive loop that the Virgin Mary will "always" intervene. One mistake that is easily

made would be to tell Maria that the Virgin Mary might not intervene or heal her. This simply suggests that the care worker is not a true believer in Maria's faith and is generally dismissed. Thus intervening with the loop should start by understanding from Maria the nature of what she expects from the Virgin Mary and indeed from God. Some aspect of the intercessor relationship with God may be helpful in finding a positive way of helping Maria to find the best answer to whether or not to take her pain medications.

The third approach addresses questions about how the client feels about God, what they do for their faith, or what they know about their faith (which may be religiosity questions, This process can expose an imbalance and can help diagnose problems or issues that can contribute to depression or other emotional problems. Maggie is 104-years-old. She has had a stroke which does not seem to impair the clarity of her thinking, but has made it very challenging for her to get out of bed and do things for others the way she always did in the past. When anyone goes into her room, the first thing she will ask them is, "Why won't God let me die?" Like the Maria's question, the first thing to understand about this question is that the common answer is to say, "God has a plan for you and what you need to do is to seek God's plan." Most people like Maggie have already thought of or been told this. They have agonized over what to do to learn God's plan and have not found it. By assessing the person's need to feeling about their faith generally suggest that they want to feel close to nature or to God. When something arises that seems to inhabit that feeling, the person is in spiritual crisis. Frequently this person is struggling with what is known as the theodicy question, or "why do bad things happen to good people?" Something has happened to this meaningful relationship in their lives. As with other questions of meaning, frequently the best way to understand it is to see Maggie as saying that she is experiencing a lack of meaning or feelings of closeness toward God. Viktor Frankl defines this as an existential vacuum, or the experience of the loss of meaning. The treatment for this follows the lines of Frankl's logo therapy to support the client in discovering their own meaning (Frankl, 1988).

Maria, a 78-year-old female, has told her hospice worker that she no longer needs her pain medications because the Virgin Mary is always taking care of her. She is a person with incredible faith, yet racked with cancer.

The point of integration of these three aspects is reflected in the role of transcendence. Many of Joanna's challenges can be facilitated through the work of her faith community and even her own ability to call on family and friends through interpersonal transcendence to help her out. Maria's cognitive loop with the Virgin Mary can be reframed to include her relationship with God and the Virgin Mary in an effort to draw on God's help in making a good decision about her pain medications. Maggie's challenge is to finding meaning in her life. According to Frankl, in order to find meaning, one must first find their transcendence. In other words, helping her to experience feeling needed by someone else and then to better understand her own dependence is the first step toward finding meaning. To find transcendence with God, self transcendence with other persons and all aspects of the person that is supported by our spiritual nature.

A spiritual assessment tool that examines these three aspects would systematically ask questions in each of these three areas, keeping in mind the differences between the various religious traditions. For example, a Baptist may have greater affective involvement with their faith than say, a Presbyterian, but a Presbyterian may be more intellectually involved than the Baptist or a Methodist. Some of this analysis reflects denominational stereotypes; however, the use of these three domains point out the differences between clients, the various faiths, even different congregations within the same faith. It is suggested by the developers of this concept that a balance between the three aspects of the person is ultimately the key to meaningful living (Thibault, Ellor, and Netting, 1991).

Conclusion

Religious and spiritual concerns are commonly raised among older adults. The various counseling professions can ignore the spiritual but may help the client. Yet, there is so much more to older people's needs. The PGCM can offer more with a wholistic approach that gathers together all of the otherwise hidden aspects of the life of the client, affording a clear and more complete picture. There are many theoretical ways to approach this. However, bridging psychology and theology needs to be at the heart of the approach. Together psychology and theology can seek to draw together an explanation for the nature of the person. Spiritual assessment allows the case manager a fuller walk with the client and the greater potential to find meaning in his or her struggles and fulfillment in life.

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Integrating Spirituality in Practice: From Inner Journey to Outer Engagement

By Holly B. Nelson-Becker, Ph.D., LCSW

We are not human beings having a spiritual experience; we are spiritual beings having a human experience.
—attributed to Teilhard De Chardin

Spiritual Questing in the Midst of Living

Many of us who work professionally with older adults—as Professional Geriatric Care Managers (PGCM), social workers, case managers, counselors, or other mental health professionals—have witnessed the power of spiritual questions that can distress, anguish, or assist our clients in managing life transitions. It is not only our client's lives that are touched so strongly by spiritual and religious doubt or help, but also our own. As we, too, develop over the life course, we encounter moments of challenge and reward in daily life. Our own journey—our trajectory of highs and low points—may mirror that of our client, although our professional training and experience may orient us in a somewhat different direction. In this way we can draw on our own wisdom to assist clients to have confidence in theirs.

As we learn to manage life difficulties, our self-concept is formed in part as a product of imaging how we appear to others as well as imagining the judgments others have about us as illustrated in Cooley's theory of the "looking glass self" (Robbins, Chatterjee, and Canda, 2006). We take control of this process by acknowledging that other factors also affect us. Our choices, our histories, our thoughts, and our feelings all combine to give us power to be creative agents instead of reactive ones. While our sense of self is formed in a social context, we can distinguish parts of ourselves that require no outside affirmation. Walking the spiritual path can help us identify aspects of our self-identity that may precede societal recognition, the affirmation from others of who we are and what we are about. These are aspects that we innately sense are important to our own well-being, such as pursuing a unique hobby or a friendship with someone whose views may have been largely rejected by others, perhaps partly because of the social position they hold. Activities such as solo or group meditation, yoga, or other exercise, sports, making music, reading, or participating in volunteer organizations all help shape our being. Our own views may not yet be understood or accepted in the larger social group where we have a home, or they may by contrast closely reflect a particular religious or spiritual faith community with which we affiliate. Whether or not the latter is the case, our spiritual journey becomes the context through which we filter our understanding of clients and the stories they share.

In discussing how the PGCM can integrate her/his own spiritual journey with his/her professional work, it is important to first define spirituality and religion. Spirituality leads one to connect with whatever is perceived to be sacred, whether that is nature, a Divine Presence, a relationship with a friend, or the deepest core of being. It is whatever raises the act

of living to another level and gives it dimension and significance (Canda and Furman, 1999; James, 1902/1961; Joseph, 1988; Nelson-Becker, 2003, 2005; Pargament, 1997). Religion, by contrast, generally is understood in social work to be one aspect of spiritual expression. It refers to the history, beliefs, rituals, moral code, and practices of a particular faith community (Canda and Furman, 1999; Nelson-Becker, 2004). This includes understanding that each of the preceding parts combines to confer a particular holistic identity (one or more) accepted by members of the religious organization.

It should be recognized that other disciplines may perceive these two domains in an alternate way, with religion encompassing the wider circle and spirituality a smaller subset within. This is especially true in theology and religious studies. In social work, spirituality is the language of choice, however, this may to a certain extent be a factor of demographics. The average age of social workers in 2004 was 49 and for nurses was 45 (NASW, 2006). Older adults, by contrast, tend to be more religiously oriented than the younger professionals who assist them (Newport, 2004). This "religiousness gap" with clients can lead to frustration or represent an opportunity to acquire greater wisdom. The metaphor of life as a journey emphasizes movement through time and space, with inherent challenges and benefits, all leading to learning.

The Professional Geriatric Care Manager's Spiritual and Professional Journey

A Professional Geriatric Care Manager chooses to work with older adults because he/she is called to it in some way. There are many professional helpers that eschew work with this population; we know this to be true because of the generally small sizes of university aging classes (Gordon, Nelson-Becker, Chapin, and Landry, 2007). This is challenging work, not for the faint-hearted. The values of a geriatric care manager are tested in the ethical dilemmas of balancing client self-determination with safety and health needs and desires. Is the PGCM comfortable with her own aging process? If not, then seeing her clients become more disabled and frail over time can invalidate her imagined view of how easy her own aging will be. If a PGCM is a younger twenty-something, then it may be easier to differentiate the aging he witnesses as distant and unlike his own. Conversely, if the PGCM is in her late 40s or early 50s, the journey of her client may be viewed as either a welcome or unwanted model for her own aging experience. The particular personal frame one brings to one's work can alter specific outcomes, though perhaps not the more generalized outcomes contingent on the foundational ability to build a therapeutic relationship (Miller, 2007).

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Creating Ethical Contexts in Spiritual Discussions

Incorporating a professional ethical value base grounds a PGCM in his/her work with clients (Nelson-Becker, Nakashima, and Canda, 2006). Just because one asks questions about religion or spirituality in a client interview does not necessarily imply adherence to professional ethical standards, though competent practice does suggest that religious and spiritual assessment are vital. Individual religious and spiritual codes, while similar, may or may not always concur with professional ethics. Religion and spirituality are areas in which we and our clients may hold strong beliefs both in favor and against. The power of those beliefs may tempt us to act from those firmly held positions rather than explore fully the beliefs of our clients. That can be a danger when a professional geriatric care manager with liberal political views works with a conservative client or vice versa.

Respect, client-centeredness, and inclusivity are three primary values that should be considered. Respect includes recognition of the nurturance that both informal and formal support systems provide, while understanding that the decision of the client has priority if he/she has decisional capacity. At times family members may prefer that the client live in a more restrictive environment for safety reasons. Their views should be heard, but the self-determination of the client matters most.

Client-centeredness places the older adult in the middle of all efforts on his/her behalf. It means facilitating access to a religious or spiritual group that a client requests, even if the care manger inwardly disapproves of the faith's tenets. The outcomes of group participation for a particular client, especially in terms of such benefits as social support, may foster health.

Inclusiveness, the third value highlighted here, indicates that a case/care manager should set aside personal views to respect the spiritual diversity expressed by a client. That can be particularly complex if, for example, the care manager finds a religious symbol worn by a client to be personally offensive or unwholesome. One response might be to discuss the meaning of the symbol with the client. The PGCM could be surprised to learn the significance for the client is quite different than his/her own meaning system suggests.

Setting and maintaining clear boundaries is another strategy that

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helps care managers assist their clients without becoming offended or losing their ability work effectively with and for the client. This is especially useful when the older adult is more religious or spiritual than the care manger, as is often the case (Richards, 2005). The care manager need not agree with all of the decisions the older adult chooses to make, while still valuing and nurturing the relationship.

Self-observation and Self-reflection: Inner Awareness

It is life itself that teaches how to live it. Observing our "mistakes" and our "successes" can both teach us, though our mistakes probably teach us more. If the life frame of a PGCM is a spiritual one she/he will notice and reflect on events in a nuanced way, perhaps seeking to understand several levels of meaning. He/she may face the conundrum of embodied spirituality, or how two individuals who each claim to be "spiritual" have such opposing ideas about how to proceed in a dispute. Embodied spirituality is the spiritual eye, or eye of the spirit (Wilbur, 1997). In embodied spirituality, the body is seen as a reliable source of spiritual insight along with the heart, mind, and other consciousness forms (Ferrer, n. d.). Ferrer notes that all human dimensions of an individual can participate freely in life as it unfolds. This approach seeks to integrate transcendent with immanent aspects of spirituality, drawing both together in a grounded and earth-centered way. This type of integration acknowledges the power and energy we receive from our environments, which can be health-inducing or health-diminishing at times, but ultimately sustains us.

Embodied spirituality is a source of renewal outside of human interaction. When we walk in a forest, allowing all our senses to be pervaded by beauty, when we sit by an ocean, listening to the waves lap the shore, we observe the world and perceive our place in it. Steady observation helps us ask the questions we need to ask to understand better: how to relate to ourselves and our clients. This is not about harsh self-criticism when a session did not go "right." *Rather it is a gentle awakening to self that brings us into new awareness and helps us glimpse previously unrecognized strengths.* This "reflective self" then also has the capability to insulate us from the inexorable stress we sometimes feel when we become weary with our client's stories. If we permit it, this part of our "self" can insulate us from the compassion fatigue common with seeing human foibles in an unrelenting stream. The observant self says to us, "This is what happened." The reflective self asks, "Why did it happen? How did it come about? What can be done now?" What can I do to help?"

Opening Outer Awareness

An important aspect to the spiritual journey then is developing the inner vision or the spiritual eye as discussed above. An equal aspect in the spiritual journey of the PGCM is learning how to increase outer awareness. *This is taking the inner vision and giving it the freedom to move beyond the boundaries of the self to co-create healing environments with the client,* consistent with principles of transpersonal theory. One caution *in doing any kind of counseling or therapy, particularly when one is trying to follow a personal spiritual path, is that* this shouldn't be done without occasional consultation or checking with both clients and mentors. It is far too easy to move off the spiritual path and fall into bizarre projections of what clients want or need. Many wise individuals have gone there ahead of us and have written about these dangers, perhaps not with clients, but in human relationships (e.g. Theresa of Avila, Catherine of Genoa, St. John of the Cross, Thich Nat Hanh, etc.)

How can we learn to open our outer awareness in service to helping clients? One of the reasons the spiritual journey can be so difficult is that there are many avenues that can expand understanding, and equally many that darken or cloud it. Ultimately, each professional helper can discover the methods that seem to resonate best with her. One exercise I have found helpful over the years is something I call a "white light" exercise. I have often used this in times of feeling stuck or unsure. In this situation, I visualize the client surrounded by a "white light." I imagine this to represent Goodness, Spirit, the Cosmic Force, and Divine Power. I ask this light to help give the client what he needs, with his permission. Then I also imagine the light touching me so that I can be "enlightened" about what is in my power to give. Another practice I have used is deep breathing to center myself if I feel troubled before I meet with a client. Meditation, visualization, sound vibration through such instruments as Tibetan singing bowls, sacred music, or other sacred sources of meaning can help refresh and renew the PGCM. Due to individual difference, not everyone will benefit equally from every exercise aimed at calming/centering the self and opening up awareness. However, testing several methods will assist in finding a few to add to one's traveling knapsack.

How can we learn to open our outer awareness in service to helping clients? One of the reasons the spiritual journey can be so difficult is that there are many avenues that can expand understanding, and equally many that darken or cloud it.

Engaging Outer Awareness Inside a Client Meeting

When we sit down with clients, we may not know ahead of time what worries, concerns, or moments of elation may surface. A large part of the challenge in client work is *holding a stance of readiness*, ready to move artfully to the right, left, forward, or backward in a classical fencing duel, where the object at play is the current mental health status of our client. We do not play well, when we fail to listen carefully. *If we fail to attend to what is said and unsaid, verbal and nonverbal expression, we may miss the clear moment of enlightenment, when the client reveals the truth they most need to acknowledge.* When we practice our skill of attending carefully, we can also attune to other ways of knowing: the intuition, spirit, artfulness that may help a client shift to a new perspective. We do this well where we can learn to engage multi-channel listening. Multi-channel listening is listening to the content of what is said, the emotion and manner in which it is said, being aware of the intended audience, and the context of the situation. From an anthropological lens, we understand that stories are shaped for the audience (receiver) in a hermeneutic fashion where the storyteller and the audience together form the landscape of memory and meaning (Gadamer, 1971). For older adults, memory has the power to extend the story back in time and reshape it repeatedly as the story moves forward with the aging of the storyteller.

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Starting the Spiritual Conversation

Where spirituality and/or religion are identified factors in a client's immediate problems, implicit permission is usually granted to discuss them as the client seeks greater understanding of either what he/she is able to change or what she cannot. However, if the client does not first address the topic, from our professional stance we often feel reluctance to probe or to generate a discussion about it. In our postmodern age, we haven't yet quite decided how to approach the topics of spirituality and religion. Puzzlement and confusion often lead us to swing in favor of abandoning the topic altogether. In some ways, while we are moving toward greater acceptance and concomitant visibility of GLBT individuals, we still cannot speak about religion, spirituality, and the compelling ways we may interface with them. *The relationship we hold with spirituality and/or religion remains relegated to a private place within ourselves.* We touch this place only when we speak with longtime friends—or if we hold a spiritual/religious affiliation, perhaps we speak with fellow congregants or parishioners or sangha members about our spiritual longings and experiences. Even then, those conversations may not be frequent. *How do we learn to speak about sacred sources of meaning with other individuals, when we so often deny, defer, or delay accessing and reflecting on our own inner journey?* The failure to integrate our sense of the spiritual with what emerges in daily life impedes progress to wholeness and keeps from our clients the best that we could offer. We see our journeys as only our own, completely separate from therapeutic space we share with clients. In fact, our journeys are influenced by our connection to the outside world, our view of late life, our personal sense of purpose or life mission.

I-Thou Relating

Individuals respond in an open fashion when the person with whom they interact creates a zone of comfort. When an older adult is treated as a subject and author of their life, rather than an object who is controlled by outside forces, the relationship has the possibility of being an authentic one. Sometimes older adults will throw up screens to distance others and keep their inner fears from being known. It is important to acknowledge that it may take courage on both sides of the professional-client relationship to learn how religion and spirituality may be valued or despised. What is the professional likely to uncover in starting the conversation about the role of religion and/or spirituality? What will the reference point be? Three primary scenarios may unfold though there may be many nuances in juxtaposition of spectrums of conservative and liberal religious/spiritual traditions: 1) the older adult may be less spiritual or religious than the PGCM; 2) the older adult may be more religious or spiritual than the PGCM or spiritual in different ways; or 3) the older adult may have no interest in engaging in a religious or spiritual conversation.

Older Adults Less Spiritual than the PGCM

Beulah Pierce was an American Indian older woman who was raised in a Catholic boarding school off the reservation from a young age. Although she had been forced to leave the reservation, over time she had developed strong relationships with older "brothers" and "sisters"

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who helped take the role of her parents whom she could visit only once or twice a year. In her young adult years, religious ceremonies she attended on the reservation seemed strange to her, but she did continue to attend Catholic services. She now lives in HUD housing in an urban area. Church-going had been a habit for her, but mainly because of the friends she could visit with weekly. She enjoyed the music, but only rarely enjoyed the priests' homily as much. Church had a role in her life, but it was not a major one. When she could not attend church due to illness or lack of transportation, she never felt guilty or sad.

The PGCM, Karen Davis, was puzzled about the role of church for Ms Pierce. Assumptions about the religiousness and worldview of American Indians led the PGCM to focus strongly on the role of spirituality for Ms. Pierce at first. Karen valued her own connection to spirituality more than religion and tried to search for a similar valuing on the part of her client. When her questions didn't seem to move discussion forward, and Ms. Pierce appeared pressured, Karen, having opened the subject, decided to let it remain there for Ms. Pierce to pick up again or not, as Ms. Pierce might direct. Karen took cues from Ms. Pierce about the role she preferred to give religion in her life now. Karen also was open to spiritual sources not defined by religion such as nature, other sources of community support, or inner strengths that guided Ms. Pierce in her life.

Older Adult More Spiritual than PGCM

Pearl Johnson was a 78-year-old woman who was caregiver to her spouse of 52 years, now bed-bound due to multiple sclerosis. The relationship had been a physically abusive one in previous years, but now was emotionally abusive. Her daughter had been urging Ms. Johnson to leave the marriage, but Pearl replied that Biblical injunctions directed her to stay. Her one solace was her church and the support of her minister who suggested that salvation would be hers in the next life for her good work in this one. When the PGCM visited, Ms Johnson was playing a hymn on the piano. She asked the PGCM to pray with her to give her strength to face demands and disparagement by Mr. Johnson.

The PGCM, Kate Roberts, would sometimes visit the local Buddhist temple and meditate with a sangha, a group who practiced meditation together. Although raised as a Christian, she no longer affiliated with any Christian tradition. She was very uncomfortable with what she saw as Mrs. Johnson's conservative religious outlook and the message Mrs. Johnson received from her minister. She also was unsure what to do when Mrs. Johnson asked her to pray with her. How could she help? In consultation with her supervisor, Kate learned that it was alright for her to support Mrs. Johnson's religious conviction, but also to respond authentically. While she wouldn't suggest Mrs. Johnson leave the marriage, she could explore several alternatives that could help Mrs. Johnson to make that decision herself, or if not decide to leave, at least to give her more power in the relationship.

Dennis Schwartz was an 88-year-old man whose parents had no use for religion. As a result he never entered a synagogue or church until he attended a wedding in his 20s. While he had many friends who hold church memberships, he could never see the point.

Older Adult with no Religious or Spiritual Interest

It is important to recognize that although older adults have a faith affiliation (PRCC, 2001), not all older adults do. Dennis Schwartz was an 88-year-old man whose parents had no use for religion. As a result he never entered a synagogue or church until he attended a wedding in his 20s. While he had many friends who hold church memberships, he could never see the point. "All they do is ask for money, and I've got little enough as it is," was his comment to the PGCM who visited him. The PGCM, Devin Carouthers, had grown up in a Methodist church and, with two sons, was active in leading the local youth group. While he disagreed with Mr. Schwartz's characterization of churches, he understood that his own background and experience was quite different from the experience of Mr. Schwartz. As a result, he knew that while for him religious involvement brought a sense of fulfillment, Mr. Schwartz interpreted some of the aspects of a faith community as negative. Devin thought it was useful to learn Mr. Schwartz's position. He realized that in trying to build greater social support for Mr. Schwartz, a religious community would not be a resource. Devin also realized that he need not feel his own beliefs were being attacked. He could be secure in his own assessment of what religion accomplished for him and his family without needing to convince Mr. Schwartz.

These three scenarios detailed above, while not exhaustive, give some hint of the kinds of practice dilemmas a PGCM may face in integrating his/her own religious or spiritual view with that of a client. While the solutions provided are also only partial, they provide a beginning exploration of how a PGCM could

respond. A more complete exploration would be beyond the scope of this paper, but this brief view provides a sense of the disparities a PGCM might encounter when trying to integrate her own spiritual understandings in her work context.

Conclusion

If we consider ourselves to be spiritual beings in search of what it means to be human, that concept can change us. It can change how we engage and work with our clients. We can always expect to bump into our own "stuff": our discomfort, our areas of darkness or rigidity, our fear, but also a growing recognition of our skills. This seems to be a law of life we can expect to happen. If we are willing, it can urge us into new forms of learning.

Holding a stance of curiosity about our own lives as well as the lives of our clients can open up new kinds of space for both. We stay connected, but let go. We participate in the interaction, but de-center (de-invest the ego) from it. When we can appreciate paradox in ourselves, we can also learn to understand it in clients. Integrating our own spiritual journey in our practice in a conscious way, even if we do it only by holding it in our awareness, can help us understand wholeness in ways that will benefit our clients and everyone with whom we connect. Our own search for wisdom will only enhance our professional work, if we let it thread through all aspects of our life.

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Cultural and Spiritual Diversity: Improving Our Communication and Understanding

Marita Grudzen, MHS

Introduction and overview

This article is based on the philosophy and practice of a multicultural framework for working with the diverse elders living in the United States. Beginning with an analysis of the cultural differences present in the client and case manager encounter, we identify skills and competencies for self awareness improving cross cultural communication, deepening understanding, and negotiating positive outcomes. Central to this process are the sources of meaning found in spirituality, religion, and culture. As we will see, these entities vary from being more or less distinct in some cultures, to being almost indistinguishable in some Asian cultures.

The graph below shows the overlay of the cultural beliefs and values in any clinical encounter with a Professional Geriatric Care Manager. The "agency culture" represents the culture of the Professional Geriatric Care Manager's employer.

Cultural Assessment Tools for Client Encounter and Negotiation

To facilitate trustworthy communication, we each need to initiate and continue to deepen a process of self awareness that assists us to identify our beliefs and values as well as our biases, prejudices, and subtle racism present in our systems.

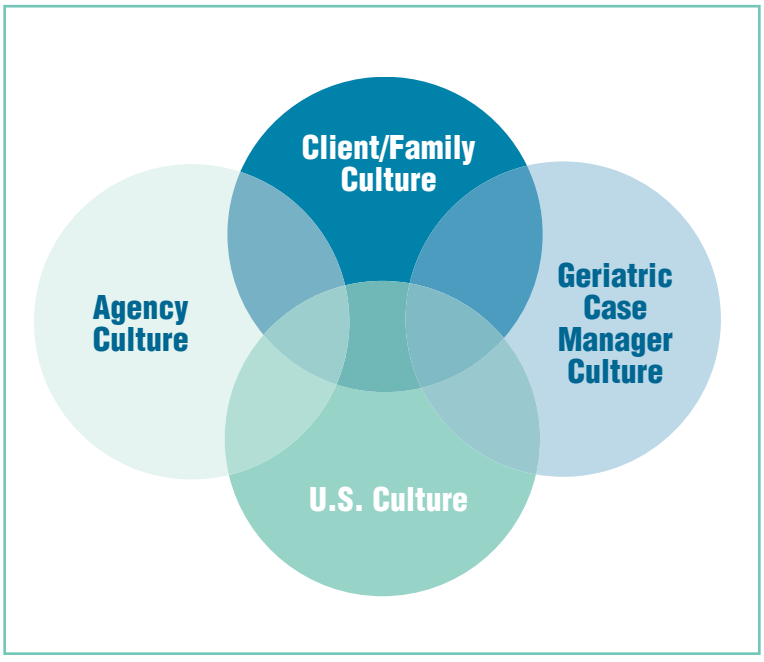
Norma del Rio has identified four essential components of a cultural assessment. First, we need to *elicit how the person identifies her/himself, whether the person is an immigrant, and if so, their level of acculturation, language preferences, writing, and reading ability.*

Second, the *psychosocial elements* of the client's situation. These include internal and external stressors—such as economics, family stressors, social support systems, eating patterns, and alternative health practices.

Third, the *cultural aspects of the relationship between the client and the Professional Geriatric Care Manager*. This includes any power and status imbalance as well as the different values and beliefs and the way all of these are interacting within any encounter.

Fourth, the *explanatory models of the client's illness and/or situation* (del Rio, 2002). Explanatory model is a concept developed by psychiatrist and medical anthropologist Arthus Kleinman. These are the notions that patients, families, and practitioners have about an illness episode (Kleinman, 1988). They often are rooted in very different world views.

Cultural beliefs related to the health needs of the client may be may not be addressed by Western medicine. Sometimes they are even in direct conflict when a Cultural healer recommends treatments which could replace the prescriptions of the medical provider. That is not ordinarily the case. Usually the other world view can be accommodated in a parallel treatment. An example of this when a Latino woman says she is suffering from a "hoax" put on her by her former husband's brother. She fears this may cause her death unless a healer is found who can remove this hoax from her. Realizing the fear and fate plaguing this woman, a healer is sought and identified to perform a ceremony to rid this Latina of her "hoax."



The LEARN model, developed by Berlin (1983), provides a tool for communicating and agreeing on a plan of action.

L Listen with sympathy and understanding to the patient's (and/or family's) perception of the problem.

E Explain your perceptions of the problem

A Acknowledge and discuss the differences and similarities

R Recommend treatment (or intervention) based on mutually agreed on interventions which the geriatric health provider client and family can accept. The client and family may identify the illness is due to an imbalance between "yin" and "yang" foods prepared by the caregiver. Even though the client is taking the medicine ordered by the physician, he insists that he will not recover without the proper foods. The caregiver may not like preparing these foods.

N Negotiate treatment (or intervention). In the above case the Professional Geriatric Care Manager may identify a proper balance of "Yin" and "Yang" foods that the caregiver is more willing to prepare.

Tools for Taking a Spiritual History of Diverse Elders

"Spirituality is the way you find meaning, hope, comfort, and inner peace in one's life. Many people find spirituality through religion. Some find it through music, art, or a connection with nature. Others find it in their values and principles" (AAFP, 2001). Religion is represented by a historical tradition with dogma, beliefs, and rituals practiced by a community of believers.

As we enter into this process, we need to be aware not only of our own cultural but also our spiritual beliefs and how they affect our attitude and practice. Below are two models to use.

FICA (an acronym for the Spiritual History Tool illustrated below)—The FiCA tool is taught in medical and nursing schools and in many schools of gerontology.

HOPE (an acronym for another Spiritual History Tool) The HOPE tool explores patients' sources of hope, strength, and meaning, including spirituality and religion. This tool is described in Anandarajah, G & Hight, E. (2001). At Stanford University School of Medicine recommend combining them—FICA and HOPE—in the following way:

OPENING PHRASE: (choose one of the following)

"For some people, their spiritual or religious beliefs are an important source of comfort and strength in dealing with illness and suffering. Is this true for you?"

"We know that one's spiritual and religious beliefs can affect one's health

"What has given you strength during difficult times in the past?"

F Faith/ Beliefs:

Do you consider yourself spiritual or religious?

What is your faith or belief?

What things do you believe in that gives meaning *to your life?*

I Importance/Influence:

How have your beliefs influenced your behaviors during this illness?

What role do your beliefs play in regaining your health?

C Community:

Are you a part of a spiritual or religious community?

Is there a person or group of people you really love or who are really important to you?

A Address:

How would you like me as your physician (other health care provider) to address these issues in your care and in this setting?

(Anandarajah, 2001); (Pulchalski & Romer, 2003).

Range of Interfaces of Culture, Religion and Spirituality

Observe that this interface will vary with individuals and cultures.

Interface of Culture, Religion and Spirituality

In the above examples, we see a significant difference between the amount of shared overlap in the areas of culture, religion, and spirituality characterized in the two diagrams above.

Diagram 1A represents people who have some but not a great deal of overlap in their lives between their cultural and religious background and their spirituality. An example could (but not always) be an Irish American Catholic feminist. In this instance, she might acknowledge her Irish Catholic roots, ascribe to feminist values regarding contraception, abortion,

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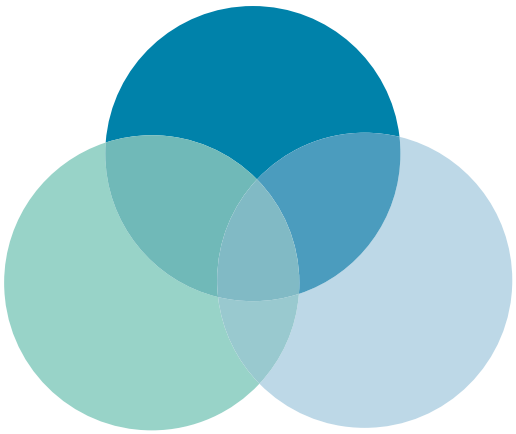
Interface of Culture, Religion, and Spirituality

DIAGRAM 1A



Cultural and Spiritual Diversity: Improving Our Communication and Understanding

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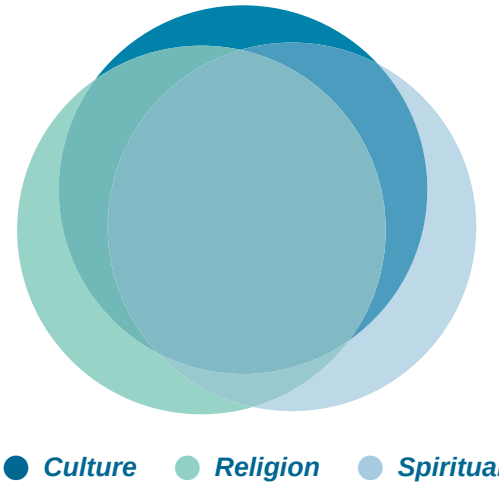
and women's right to be priests, as well as have a strong spirituality which draws some from Catholic mysticism. Being a 4th generation immigrant, she is well acculturated to our secular society.

Diagram 1B represents persons who have a very near overlap between their cultural, religion (or Philosophy), and spirituality. An example could be a Chinese American elder who followed his children to the United States. A recent immigrant, his values have not changed since his arrival from rural China where the culture is imbued with Confucian and Daoist philosophy and way of life. He does not ascribe orthodox Daoism. For this elder, his philosophy and spirituality would be very "Chinese." If you were to inquire about his spirituality or even his religion, he might be hard pressed to respond.

Interface of Culture, Religion, and Spirituality

DIAGRAM 1B



The Confucian values of hierarchy and filial piety are embodied in the society and everyday relationships.

Signs of Spiritual Distress

Whenever we are taking a spiritual history it is important to become aware of any expression of distress in this area. Our reason for taking a spiritual history is, on the one hand to be aware and honor any beliefs or restrictions that relate to our provision of care. We also want to affirm any religious or spiritual resources of the client. During this conversation, we may become aware of a client's sense of hopelessness, or a feeling of being abandoned by God, or outright anger at God. Then again the client may be withdrawn, experiencing isolation and/or a sense of disconnection from their deeper self and others. When we hear a client say: "Why is this happening to me?" Inquire of client whether a pastoral or spiritual resource would be useful. Sometimes the Professional Geriatric Care Manager is able to engage in a search for meaning in such a situation. Additional spiritual resources may still be helpful.

Professional Geriatric Care Managers often have clients whose paid caregivers have different cultural and religious backgrounds. The cultural and religious values of caregivers are often at the heart of their dedication to care giving.

Diverse Cultural and Spiritual Resources for Inclusion in Elder Care

Professional Geriatric Care Managers have many issues to address in working with their clients and families. Having included cultural and spiritual assessments can heighten the case manager's awareness of bridges to comfort and pleasure. Advocating with personal care givers for ethnic meals, exposure to nature, religious music (Negro spirituals, Buddhist chanting), having photos of family in view, or sacred objects at hand offers holistic care. Radio, films, or television programs in the language of the client provide daily contact with the client's mother tongue. Needs vary, based on the setting and involvement of the family, as well as individual preferences.

Professional Geriatric Care Managers often have clients whose paid caregivers have different cultural and religious backgrounds. The cultural and religious values of caregivers are often at the heart of their dedication to care giving. This makes it even more important to respect these values and engage them in the caregiver/client relationship in a positive way. When there are different cultural and religious backgrounds, it is important for the care manager to evaluate the dynamic interplay of theses differences. This needs to occur in a respectful and non-threatening manner. An example of a cultural trait which may cause tension in the relationship between the client

and the caregiver is a different value and perspective on "time." In some cultures, it is not "clock time" but "relational time" that is valued. If a caregiver is also caring for others (family or other clients), the caregiver may choose to respond to a need that emerges for another client, despite the fact that it will result in their arriving later that your client expects. For the caregiver, leaving another person in need, in order to arrive "on time" could pose a threat to their sense of integrity. Regarding time, some cultures simply do not value "clock time." Here it is important that the care manager not immediately presume that the caregiver is being negligent in arriving late. It is important to evaluate the expectations and values on both sides and negotiate in a spirit of mutual respect "timing" that is acceptable for both parties.

Food preparation and language can be other areas that require negotiation on the part of the case manager. Religious or spiritual beliefs can be a source of conflict. It can be very difficult for a caregiver who is deeply religious to withhold their beliefs in interacting with the client. This is especially true when the client is agnostic or a 'non-believer." The Professional Geriatric Care Manager while respecting the religious tradition of the caregiver needs to make sure that the client is free of proselytizing as well as any unwanted conversation or material about religion or spirituality. I have experienced how difficult this can be for a caregiver, and have recommended and led support groups for agency caregivers to process their personal feelings and issues in a group context. This provides a safe place for the staff to process what they may feel as unfinished business with a client they have cared for. This is particularly helpful to caregivers providing for those who are dying.

Conclusion

Difference is so often viewed negatively, occasioning discomfort, strain in relations, and distaste for the unfamiliar (e.g., language, food). Another dimension of the experience is the opportunity it affords us to expand our world, our understanding, our tastes, our language, our sensibilities and ways of doing things—all without leaving our everyday surroundings. The material in this article is intended to help you respond with more awareness to the increasingly diverse populations that you serve?

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Recent publications include Vital Connections in Long term Care (2004 with Barton, J. and Zielske, R.) and "Discerning the Spirit in the Rhythms of Time" (chapter in Aging and the Meaning of Time., 2001.with Oberle, J.). Ms. Grudzen served as religious editor for Vol. III of Doorway Thoughts, Religious and Spiritual Issues in Cross Cultural Care of the Older Adult *(in press).*

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As the Spirit Moves…

By Rabbi Cary Kozberg

Recently, my rock band (I'm the drummer) played at a weekly Sunday afternoon program for the residents of Wexner Heritage Village, the senior adult center where I serve as Director of Religious Life. WHV consists of a long-term care center, assisted living, and independent housing. Residents from all the buildings came to hear "the Rabbi's band," and most seemed to have a great time.

One resident from our "cognitively-impaired" neighborhood—whom I shall name Mary—really enjoyed herself. Mary is a 93-year-old African-American lady, who walks with a walker. Having suffered a stroke and now coping with dementia and other health challenges, her gait is very measured, as is her speech. But that afternoon, to the sounds of "Johnny B Goode," "Heartbreak Hotel," and other hits of the '60s and '70s, Mary walked up to the bandstand and started dancing with incredible energy and poise.

Looking at her face and marveling at her (it was hard to concentrate on drumming), I could tell that she was totally focused on making her body move the way she wanted it to—as it had once done effortlessly. Of course, the rest of the audience-residents, staff, and family members applauded her. After the program, as she walked back home, I said to her, "Mary, you sure were boogying' out there… ""Well, *Raaabbi* (sic)," she drawled, "as long as the good Lord lets me, and as long as the spirit moves, I'm gonna DANCE…"

Thank G-d[1] for folks like Mary. Lots of people like Mary are coping with dementia—a condition brought on by any number of different causes, and resulting in the impairment and/or loss of mental activity, thus affecting their understanding, judgment, memory, mood, and behavior. In this country, the leading cause of dementia is Alzheimer's Disease, which brings on severe cognitive impairment, leading to constant care and assistance in performing the most basic everyday tasks. But for those of us who work with people like Mary on a daily basis, we see that while dementia may "steal" their minds, it cannot steal their hearts, their souls, and their spirits. In so many different ways—through music, painting, the enjoyment of nature, scripture reading, or worship—"the Spirit" continues to move. It animates and defines people like Mary, individuals who are still vital and because they still have much to offer are inspirations to those around them.

To be sure, not everyone shares this perspective. It has been said that we live in a "hyper cognitive" culture—a culture in which people are valued based on "mental capacity": how much they know and how smart/shrewd/sharp they are. As Stephen Post has written, "we live in a culture that is the child of rationalism and capitalism, so clarity of mind and economic productivity determine the value of human life."[2] In such a culture, when mental capacity decreases or disappears, a person's worth and dignity are often devalued. It is as if there were a second part to Descartes' declaration "I think, therefore I am"; If I no longer can think, I no longer am. Such an ethos often concludes that people coping with dementia no longer have spiritual needs because they can no longer clearly think and reflect on matters of spirituality. Thus, matters of the spirit need not be addressed.

To be sure, this is quite a different belief from the one with which, I dare say, most of us were raised the belief especially (but not exclusively) affirmed by the Abrahamic faiths (Judaism, Christianity, Islam) that every human being, no matter how capable or compromised, is created in the image of G-d.[3] Such a belief is the grounding for creating or maintaining spiritual connections with cognitively-impaired persons, for it presumes that such individuals are entitled to respect and dignity no matter how compromised they might be. Indeed, many who have worked with cognitively-impaired individuals affirm that cognitive impairment is not the same as, nor does it necessarily imply, spiritual impairment. And they will also affirm that cognitively impaired individuals are often much more "spiritually attuned" than persons whose cognitive abilities may be well developed, but whose spiritual development remains "reptilian."

In many circles we hear about "strengths-based" approaches to working with older adults—focusing not on deficits and disabilities, but on the strengths and abilities that still abide. Perhaps this is what the ancient Rabbis had in mind when they taught that when G-d spoke the Ten Commandments to the children of Israel, every person present heard the Divine voice *according to his/her own abilities:* the wise heard it in their way, the simple in their way; men heard it in their way, women heard it in their way; the young heard it in their way, the old in their way.[4] Everyone heard it uniquely, because the Voice was not just heard by the Mind, but also by the Soul.

For me, this teaching is a touchstone. And it raises the question: **How do we help persons with decreased cognitive ability and self awareness to stay spiritually connected?** How do we help them to continue to hear "the Voice," each according to his/her own capacity? How do we provide "meaningful" and edifying religious and/or spiritual experiences even when they can no longer really "understand?"

These are key questions, because while "understanding" and cogent articulation of spiritual needs may no longer be possible, nevertheless many individuals with dementia are still able to express in various ways a spirituality that is quite alive and vital even when—especially when—their cognitive "filter" weakens or disappears completely.

Among the many individuals who have taught me this, the following people come to mind:

- Stanley, a profoundly demented resident from a very observant Jewish background, who, as we began our weekly welcoming-the-Sabbath service, would ALWAYS greet me with the words, "Rabbi, it's time to talk to the Boss!"
- Ruth, who responded to a prayer she heard in a worship service with an enthusiastic "I pray that the whole world will be brand new!" Startled by her sincere, succinct, and beautiful response, staff just looked at her in awe—to which she replied, "What's the matter? Didn't you think I could say something like that?"
- Thurlow, who in his last days, was not only demented but also critically ill. When the chaplain came to pray with him, he looked at her and said, "I've always tried to be an honest man. I wanted to be a good man and to be a good friend to those I worked with."[5] Given how physically and cognitively compromised he was, such heartfelt words could have only come from his soul.
- Margaret, who when offered some grape juice for Holy Communion, asked what was in the cup. "It's grape juice, Margaret," the chaplain replied. "It's for Holy Communion." With a big smile on her face, Margaret raised the cup and said "Well, here's to you and me!"[6] At some level Margaret still "knew" the meaning of Holy Communion.

As did Ida, who usually only spoke "gibberish." Once, during Communion, the chaplain was unsure if she could take the grape juice. To the chaplain's surprise Ida accepted the cup and said, "The Lord is my portion and my cup, and I have always been faithful to Him."[7]

Thinking that this might be the last Christmas their cognitively-impaired mother would be able to enjoy with any shred of understanding, her family took her to a Christmas Eve program at their church.

And then there is this amazing (and true) example, as shared by Juliana Goldenberg some years ago: Thinking that this might be the last Christmas their cognitively-impaired mother would be able to enjoy with any shred of understanding, her family took her to a Christmas Eve program at their church. They managed to get seats in front, as to minimize any distractions. The program was a Nativity play and "Mom" was totally focused on the presentation, her eyes sparkling and her face aglow with anticipation.

In the scene when the shepherds came to the stable to see the child in the manger, one of them asked with great excitement: "Is this infant the Messiah? Could it be that this little baby is truly the one promised by G-d?" At which point "Mom" shouted out in a mixture of excitement and annoyance, "OF COURSE HE IS! ANY DUMB SONOFABITCH KNOWS THAT!!"[8]

The "salty" language notwithstanding, this is a "classic" example of "staying connected." But as often as I have personally experienced, or heard about, such heart-warming (and very authentic) accounts of such people "still hearing the Voice," I was not prepared for what I heard during this past High Holiday season—nor were any of the other staff who heard what follows.

In Jewish Tradition, the High Holidays—the ten days beginning with Rosh Hashanah (the Jewish New Year) and concluding with Yom Kippur (the Day of Atonement) are a time to, take "spiritual inventory" and engage in serious self-reflection, in order to try to improve one's self in the coming year. With this in mind as the New Year approached, I asked the following questions to residents in group meeting, living on our "dementia-focused" neighborhood (some of Mary's neighbors), hoping that they might better connect with the sacred season. These were the questions and some of the answers. Some of them were a bit "predictable," but certainly no less heartfelt. Others were not only surprising but truly inspiring:

Before you leave this world what do you want others to know?

"It is important to make life easier for those around you."

"Live life as if today was your last day."

"Be kind and considerate and help others even in a small way."

"That I was a good person…and a good singer."

What do you hope for?

"A better tomorrow for ourselves and our loved ones."

"That pain and suffering will end."

"That I will have the strength to better bear the burdens I have."

"That I will be remembered by those I love."

"That my family will continue to laugh."

"That my children will understand me better, and I will understand them better."

What are you most proud of?

"My children and their accomplishments."

"Raising my family."

"That I'm as old as I am."

"The ability to learn new things at my age—like using the computer."

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As the Spirit Moves...

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"Accepting G-d's invitation to live a better life."

What do you wish you could change?

"I'd like my memory to be better."

"I wish I would have spent more time with my children"

"I wish I could make my husband healthier."

"I wish I would not have spent so much time dwelling on disappointments and would have been able to let go of things that upset me."

"I wish I could have been able to accept what came with more grace and have no regrets."

These responses were from people who are supposed to be "out of it." Perhaps it should be noted that, although the examples and stories offered here took place in various "religious" contexts, and although the words "religious" and "spiritual" are often used synonymously, spiritual needs are not necessarily the same as "religious" needs. It is erroneous to assume that if a person is not a member of congregation/ church or does not profess a certain religious faith, that he/she does not have spiritual needs to be addressed. A particular religion's beliefs and rituals may express the spirituality of some, while others may have an internal spirit that directs their values, even though they do not identify with any particular religious faith. And while "religion" usually refers to a particular set of beliefs and rituals that symbolically express those beliefs, spirituality is usually understood in broader, less-defined terms. Among the definitions/ descriptions of "spirituality" that have been offered are:

- "that which brings meaning to life and that which forms values for an individual.
- "how we live out the relationship we have with a higher being or what we claim to be meaningful in life.
- "the internal sense of wellness, the sense of commonality among all people. (In religious terms, it is that aspect of a person that is created in G-d's image…the process of connecting to our sense of meaning, value, and purpose to create a sense of identity."[9])

Defining "spiritual well-being," the National Interfaith Coalition on Aging said it is "the affirmation of life...a relationship with G-d, self, community, and environment…that nurtures and celebrates wholeness."[10]

Indeed, there are probably as many definitions/descriptions of "spirituality" as there are people. But what all of these definitions seem to profess—whether explicitly or implicitly—is that spirituality and spiritual well-being focus on *affirmation* and *relationship*. They affirm that persons with dementia are still "persons," still created in the Divine image, unconditionally sacred, each with their own personalities. Thus, "when you've seen one person with dementia, you've seen only one person with dementia." [11]

And in their sacred uniqueness, people with dementia still need to *relate* to their surroundings and to other people. They continue to be able to give and receive love and attention. They can still feel compassion and concern. They have senses of humor, they feel sad and happy, and often still have social graces. As Reverend Elbert Cole, a pioneer in the field of spiritual care and dementia, reminds us, people with dementia have the same needs as all people. They need to:

- Love and be loved, respected and appreciated.
- Express compassion and share of themselves.
- Feel productive, stimulated, and secure.
- Celebrate the joy of living.

Often feeling overwhelmingly disconnected—from their surroundings, from other people, and from themselves—they may have a more compelling need to feel connected, even more than those of us who are "with it".[12] In affirming their "personhood," we also affirm their entitlement to *staying* "connected."

But this is often easier said than done. Because of their limited repertoire of responses, working with cognitively-impaired individuals can be more challenging from a clinical perspective. Whereas "normal" responses depend on memory, reason, cognitive integration (the ability to process and organize), some or all of these are usually weaker or altogether lacking in persons with cognitive impairment.

Nevertheless, as the late Father Henri Nouwen taught, one can still offer "a ministry of presence,"[13] which is just about "being there"; being fully present to, and for the other person—focusing on the person, rather than the problem. When words no longer make sense, it is about "listening more to the melody (tone of voice) than to the lyrics. As one anonymous but very wise person observed, "When all is said and done, it is about loving them. And to love someone is to learn the song that is in a person's heart and sing it to her after she has forgotten it." It is such a teaching that informs the following strategies/techniques for being "fully present" to a person with dementia. Here are some other suggestions.

- Pay attention to facial expressions and body language.
- Approach people with dementia from the front. Introduce yourself and say why you are there. DON'T ask "Do you remember me?" If the person doesn't remember, he/she may feel badly.
- Call the person by name, especially by his/her first name. Calling someone by his/her first name communicates a stronger desire to connect.
- When speaking, use a calm tone of voice; speak in short, simple sentences.
- Be aware of cultural differences when it comes to touching or establishing eye contact.

In our Western culture, touching is more acceptable, as is making eye contact. In other cultures, such gestures indicating closeness may not be appropriate.

- Make sure adaptive devices (glasses, hearing aids, etc.) are in place.
- Whatever the person says, accept or validate it (melody is more important than lyrics).
- Be prepared to repeat yourself over and over and over and over...[14]

In a word, it is about communicating *safety* and *acceptance*: "I am here for you and I care about you." However, while techniques are important, they work when they communicate *authentic and genuine care*. And people with dementia intuitively know the difference between someone who genuinely cares about them, and someone who doesn't. It is that authenticity that ultimately creates connections which are "soul to soul."[15]

In the Talmud it is taught, "Be careful with an old person who has lost his memory, for it is said that the holy tablets of the Ten Commandments and the fragmented tablets which Moses shattered, were both housed together in the Holy Ark."[16] In other words, just as the broken tablets of the Ten Commandments retained their sanctity, so too a human being who is somehow "broken" nevertheless retains his/her sanctity and radical equality. We, who believe this to be true and axiomatic to our work, face a double challenge: a culture that denies this truth, and those individuals who may be so easily lost and disconnected without our efforts.

May our own efforts to create and maintain spiritual connections with cognitively impaired persons help us to help them continue to move in right direction—so that the Spirit continues to move them.

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Rabbi Kozberg is the Immediate Past Chair of the Forum on Religion Spirituality and Aging, a constituency group within the American Society on Aging. He has served as Editor of FORSA's Newsletter, and has written and lectured extensively on the spiritual challenges that face older adults and their families, including the booklet Honoring Broken Tablets: A Jewish Approach to Dementia *(Jewish Lights Publishing).*

He plays drums in a rock band, has four children, and is married to his wife, Sheryl.

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Endnotes

1 The name of God has been replaced by "G-d." In Judaism, a person does not casually write the name of God in order to prevent the erasing or defacing of a name of God. Instead, observant Jews avoid writing the name by substituting the letter "o" with a dash.

2 Stephen Post, *The Moral Challenge of Alzheimer Disease*, p.3.

3 Ibid. p. 33

4 *The Book of Legends: Legend from the Talmud and Midrash*, edited by H.N. Bialik and Y.H. Ravnitzky (translated by William Braude), p. 80.

5 Related to me by Chaplain Nancy Hardin.

6 Related to me by Marty Richards.

7 Related to me by Chaplain Nancy Hardin.

8 Presentation at 1992 ASA National Conference Atlanta, GA.

9 Ibid. , quoting Rabbi Sam Seicol.

10 Ibid.

11 Ibid. p. 78.

12 Cf. Cary Kozberg, *A Jewish Response to Dementia: Honoring Broken Tablets: A Jewish Response to Dementia*, 2005: Woodstock: Jewish Lights Publishing, p.4-5.

13 Henri J.M. Nouwen, *The Wounded Healer*, 1972, Garden City: Doubleday, p.65 ff.

14 Marty Richards, "Spiritual Care for the Cognitively Impaired," presentation at ASA Conference, March 13, 1992.

15 Marty Richards, "Communicating 'Soul to Soul'—Challenges for Care Providers," *The Southwest Journal on Aging*, Vol. 1[2]/16[1], Spring 2000.

16 Babylonian Talmud, Tractate Menahot 99a.

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