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DEPARTMENT OF HEALTH POLICY AND ADMINISTRATION

RESIDENT PERSPECTIVES OF RELIGIOUS AND SPIRITUAL CARE PREFERENCES IN NURSING HOMES: A MIXED-METHODS APPROACH

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ABSTRACT

This thesis study uses a mixed-methods approach to seek a deeper understanding of the religious and spiritual care preferences of nursing home residents. The study uses a religious preference stem (how important is it to you *to participate in religious services or practices*) and a spiritual preference stem (how important is it to you to *talk about spiritual matters*). A quantitative Phase 1 analyzed a sample of 255 residents from 35 nursing homes. The religious stem was important to 77.56 percent of residents and was significantly related to gender ($p = .0057$) and religious affiliation ($p = .0001$). A qualitative Phase 2 examined cognitive interviews of 39 residents from 7 nursing homes. The religious and the spiritual preference stems were both evaluated. 8 topical categories emerged, including language confusion and definitional wordage differences. Both phases assured that clinical and research arenas need terminology clarity to eliminate these disparities. This study recommends more, diverse religious and spiritual preference stems to ensure clear, accurate, and actionable assessments.

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Chapter 1: Introduction

Person-Centered Care

The past 40 years are marked by distinct changes in nursing home (NH) care philosophy. This shift, known as culture change, represents NHs transitioning away from health care institutions and toward person-centered homes (Koren, 2010). This evolution began in the 1980s with strong advocacy from groups such as the National Citizens' Coalition for Nursing Home Reform, the Robert Wood Johnson Foundation, the Health Care Financing Administration, and the American Association for Retired People (Koren, 2010). These groups influenced the 1986 Institute of Medicine (IOM) report, *Improving the Quality of Care in Nursing Homes*, which called on facilities to emphasize the "home" more than the "nursing" (IOM, 1986). The following year, congress passed the Nursing Home Reform Act through the Omnibus Budget Reconciliation Act (OBRA) of 1987, requiring facilities to pursue residents' "highest practicable physical, mental, and psychosocial well-being" (Koren, 2010). Hence, much like hospitals' patient-centered care, lawmakers launched and communicated person-centered care as a priority for NHs.

In 2015, the American Geriatrics Society (AGS) maintained that a person-centered approach is essential for producing flourishing care in NHs. AGS asserted that this model creates an advanced vision of health care success by defining quality and value by dignity, personal choices, and life outcomes achieved instead of mere technical benchmarks (Trucil, 2015). This holistic view captures the broader nuances of quality care and produces more efficacious health care for NH residents.

Preferences

To narrow this broad concept of person-centered care, the AGA partnered with the University of Southern California and received support from the SCAN foundation to better define person-centered care (Trucil, 2015). From this research, the collaborators developed a focus on identifying individual preferences to inspire care. Simply put, collecting personal preferences is essential for helping a person residing in a NH achieve his future well-being and reach his own health goals (Trucil, 2015). Further, as everyday aspects of life influence values and goals, these preferences must be gathered too.

In addition to AGA's expert panel on person-centered care, emphasis on preferences has been displayed elsewhere. For example, the Centers for Medicare and Medicaid Services' (CMS) minimum data set (MDS) comprehensively assesses NH residents. The most recent, MDS RAI 3.0, includes a Section F specifically dedicated to acquiring resident preferences for customary routines and activities (CMS, 2010). CMS explains that collecting these daily preferences will help in creating appropriate individualized care plans. Similarly, Congress' Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which requires NHs to submit quality data, importantly mandates collecting patient preferences and goals (CMS, 2015). Likewise, the 2015 White House Conference on Aging (WHCOA) sought a future vision for public and private initiatives for healthy aging and care providing. WHCOA declared the promotion of person-centered care and enabling independence and choice as a main theme, specifically focusing on maximizing personal preferences (WHCOA, 2015). These policies continue to promote both the conceptual ideation of person-centered care as well as its practical implementation through collecting individual preferences to influence care.

Religious and Spiritual Care

Foundations of person-centered care and preference implementation have led to the rise of religious and spiritual approaches to health care. Spiritual care is key to quality of life, as each individual has his/her own dynamic approach to spirituality; thus, each patient has a different perception of the meaning of life and the acceptance of death, both of which influence experiences in healthcare (Morey, 2014).

The bulk of research in this field has focused on hospital settings that treat patients with chronic and life-threatening diseases, especially in respect to coping with the end of life (Erichsen & Bussing, 2013). However, less research has examined those living in institutionalized settings such as NHs, especially the day-to-day activities and preferences of these residents' lives. In NHs, spirituality is a significant predictor of hope (Touhy, 2011) and an influence on positive psychological well-being (Scandrett & Mitchell, 2009). Yet spiritual needs of residents often remain unmet (Erichsen & Bussing, 2013), creating an important need for advancement.

A literature review of current research of religious and spiritual care in NHs was completed to identify and describe existing gaps that need to be addressed. In total, nine articles were collected, evaluated, analyzed, and synthesized for this review; a review matrix appears in Appendix A.

Literature Review Search Criteria and Methodology

A Cinahl database search used the key words "nursing home residents" and varying choices among the keywords "religion or religious," "spiritual care," or "spirituality." These

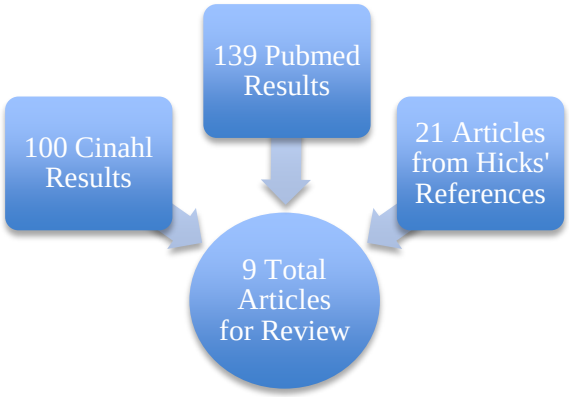
keywords were identified using the Cinahl headings function. Functionally, the search displayed: [(“nursing home patients") AND (("religion and religions") OR ("spiritual care") OR ("spirituality"))] and yielded 100 academic article results.

A similar search in the PubMed database used Medical Subject Headings to search for the keyword “nursing homes” in tandem with “religion” or “spirituality.” In the database, the searched appeared as [(("religion") OR ("spirituality")) AND ("nursing homes")] and produced 139 academic article results.

PubMed was used to narrow results to only those that were literature reviews. Five reviews were identified and one was seen as topically relevant: Hicks, 1999. This article became the first included work for this review, as shown in Appendix A. The articles included in Hick’s reference section (21 total) were added with the 100 results from the Cinahl search and 139 results from the PubMed search in order to be considered for further inclusion; duplicates predictably existed when adding these three sources.

The remaining articles were then put through a manual title search, identifying if any of the previously searched terms were listed or alluded to in each article’s title. This semi-objective evaluation tested if both NHs and spirituality/religiosity were central to the considered article. Literature that specifically targeted questions of end-of-life care and/or dementia was not considered. This criterion narrowed the results to the eight additional works displayed in Appendix A for a total of nine. Figure 1 illustrates this process.

Figure 1. Illustration of Article Selection Process



Literature Review Results

Standardized Terminology

Issues of terminology standardization within NH spiritual and religious care research became evident. Across the literature, large discrepancies exist in *whether* and *how* to differentiate the terms religious, spiritual, and pastoral in regard to caregiving. Some articles did not draw any distinction from these terms and used them interchangeably throughout their works (Morey, 2014; Brandeis & Oates, 2007; Scandrett & Mitchell, 2009; Haugan, 2013). Within these articles, some authors used religious more frequently (Brandeis & Oates, 2007; Scandrett & Mitchell, 2009) while others predominately focused on spirituality (Morey, 2014; Haugan, 2013). However, more confusion arose when these terms were used differently. Uhlman and Steinke (1985) used the terms religious and spiritual interchangeably, while distinguishing pastoral care as a type of care exclusive to the Christian faith. Conversely, Wilkes (2011) used

the term pastoral care as synonymous with spiritual care but noted it to be distinctive from religious care. Other articles that differentiated religious and spiritual care (Hicks, 1999; Touhy, 2011; Erichsen & Bussing, 2013), in general, defined spirituality to be more internal, encompassing, and vague and religiosity to be more external, finite, and behavioral. Overall, these articles did not share consistent, standard definitions.

In lieu of term inconsistencies, research and work is needed to create standard definitions within the discipline. With instability of term usage, comparison and application of scholarly results becomes exceptionally difficult. Authors who clearly define terms within their publications aid in bringing understanding to terminology; yet universal, standardized terminology is still a desired goal (Miller & Thoresen, 2003). Future research must address these issues as they pertain to religious and spiritual care in NHs.

Variation of Methods and Purpose

The literature shows little variation in both methodological design and research purpose. Analysis showed that religious and spiritual care lends itself toward qualitative study design since knowing patients' perspectives is important for understanding emerging questions and problems. However, potentially introducing quantitative study measures through a mixed-methods approach could produce new, unique, and applicable statistical findings for the field. Disciplines, like religious and spiritual care, often need both quantitative and qualitative research to best develop.

Similarly, while the reviewed articles evaluate the benefits of spiritual care (Hicks, 1999; Morey, 2014; Touhy, 2001; Haugan, 2013) and residents' needs for such care (Scandrett &

Mitchell, 2009; Erichsen & Bussing, 2013; Uhlman & Steinke, 1985), most research is focused on end of life care, instead of application to everyday activities and preferences. Further, little is known about barriers to fulfill preferences or about situations in which these preferences may change or depend on alternative factors.

Study Significance

The literature reveals a need for more mixed-methods research focused on religious and spiritual care in NHs. Further, the pertinent need to clarify language and terminology surrounding this field looms. The purpose of this thesis is to address these research gaps through empirical analysis. A quantitative and a qualitative phase will be utilized to provide a thorough and diverse analysis of religious and spiritual care in NHs. Phase 1 (quantitative) and Phase 2 (qualitative) include separate research questions, samples, and methodologies. Quantitative analysis exposes statistical insight into demographic variable relationships and uniquely reveals trends in a large data set. Qualitative analysis inductively uncovers themes from a smaller, interview-based sample. This different approaches will provide rich, detailed data from residents. Thus, both the quantitative and qualitative phases offer novel perspective of religious and spiritual care in NHs. Accordingly, long-term care leaders, regulators, and policy makers may use this research to grow in a deeper understanding of this topic. Hopefully, in effect, such findings will lead to more advanced, future research and applied knowledge that produces better care for NH residents.

Chapter 2: Phase 1—Quantitative

Research Questions

Quantitative analysis of a large data set can provide rich statistical information regarding an examined population and, in the case of this study, its residents' religious and spiritual care preferences. Proper quantitative analysis and conclusive evidence may, in fact, produce results that generalize to reflect greater populations. For Phase 1, three central research questions were developed and pursued:

1) How important is it to residents to participate in religious activities?
2) Does a relationship exist between residents' reported importance of participating in religious activities and other descriptive characteristics such as gender, age group, marital status, race, and religious affiliation?
3) Does a relationship exist between residents' importance of participating in religious activities and their perception of their own health and well-being?

Methodology

Sample

The sample for this project consisted of 255 NH residents from 35 NHs in the greater Philadelphia area and was drawn from the larger PELI project entitled *Assessing Preferences for Everyday Living in the Nursing Home Reliability and Concordance Issues* (Grant No: R21

NR011334-01 PI:Van Haitsma). Selected residents were referred by NH staff if they were English speaking, had been at the NH for at least a week, were expected to remain at the facility for at least another week, and were cleared by a physician as cognitively capable and medically stable (Bangerter, Abbott, Heid, Klumpp, & Van Haitsma, 2015). Participants also needed to surpass a score of 13 on the Mini-Mental State Examination as further screening for cognitive impairment (Bangerter et al., 2015; Folstein, Folstein, & McHugh, 1975). Such a cutoff was chosen due to research showing that individuals with mild to moderate dementia can reliably report their values and preferences (Bangerter et al., 2015; Whitlatch, Piiparinen, & Feinberg, 2009). Informed consent for participation was obtained in person.

PELI

Many tools have been developed in an effort to properly discover and evaluate essential preferences of NH residents; these assessments hope to influence policy and practice in long-term care (Bangerter, Van Haitsma, Heid, & Abbott 2015). Using 500 community-dwelling older adults, The Preferences for Everyday Living Inventory (PELI) was created to be a comprehensive questionnaire about individual preferences for everyday living (Curyto, Van Haitsma, & Towsley, 2015). It includes personal preferences identified as important by older adults in the community and incorporates two items related to religion and spirituality (Curyto et al., 2015).

The content validity of the PELI was initially examined through a panel of 16 experts in long-term care. Eight participants had research expertise and eight others had clinical experience in varied areas of care (Curyto et al., 2015). The panel rated 67 PELI items on a 4-option rating scale that ranged from ‘not relevant’ to ‘relevant’ for long-term care. Eleven expert researchers

(n = 6) and clinicians (n = 5) completed the survey, meeting the maximum recommended number of content validity judges described by Lynn (1986) (Curyto et al., 2015). Nine of eleven judges were required to agree of the items' validity via the standard error of proportion to reach the 0.05 level of significance (Lynn, 1986; Curyto et al., 2015).

Procedures and Results

Statistical procedures were completed and then analyzed through SAS in order to answer the research questions posited. In sum, eight variables were viewed and processed; examples of residents' observations of these variables can be seen in Table 1.

In order to understand how important participating in religious activities was to this sample of NH residents (research question 1), a procedure was done to look at the frequencies within resident responses to the question "How important is it to you to *participate in religious services or practices*?". Responses included, 'Very Important,' 'Somewhat Important,' 'Not Very Important,' and 'Not Important at All'. A table of these frequencies is shown in Figure 2. A pie chart and bar graph of these frequencies are provided as well in Figures 3 and 4, respectively. Results indicated that *participating in religious services or practices* is quite important (77.56% answered either 'Very Important' or 'Somewhat Important') to this sample of NH residents.

To answer the second research question regarding the relationship between residents' importance of *participating in religious services or practices* and other demographic characteristics, cross-tabulations with Chi-square tests were run. Chi-square tests are best for analyzing the relationships of categorical variables, such as gender, age group, marital status, race, and religious affiliation. Each of these demographic variables was crossed with the religious participation importance variable, and results are shown in Figures 9-13, respectively,

in Appendix B. An analysis (using a $p < .05$ cut off) of the p-values produced by the Chi-square tests found that gender ($p = .0057$) and religious affiliation ($p = .0001$) are both significantly related to importance. Conversely, no significant relationship appears to exist between importance of religious participation and age group ($p = .54$), marital status ($p = .33$), or race ($p = .08$).

As demonstrated in Figure 13, the statistically significant ($p = .0001$) relationship between religious importance and religious affiliation was intriguing. 225 NH residents (88%) from the sample indicated a religious affiliation, while 30 residents (12%) abstained. Of the 225, 87 residents (38.67%) identified as Protestant, 82 (36.44%) identified as Catholic, and 56 (24.89%) identified as Jewish. The most significant distinction in this data was among the 121 individuals (53.78%) who rated *participating in religious services or practices* as 'Very Important'. 50 (41.32%) of these residents were Protestant, 56 (46.28%) were Catholic, and only 15 (12.40%) were Jewish. In fact, while 57.47 percent of reporting Protestants and 68.29 percent of reporting Catholics labeled religious participation as 'Very Important', only 26.78 percent of reporting Jewish individuals did the same.

Table 1. Examples of Observations

Examples of Observations

Obs	Gender	ResAge	ResAgeOrd	MaritalStat	ResRace	ResRel	PartRel	CompGenHlth
1	Male	75	Middle-Old	.	Black	Protestant	Very Important	50
2	Female	84	Middle-Old	Married	White	Protestant	Not Very Important	40
3	Female	98	Oldest-Old	Widowed	White	Catholic	Not Very Important	60
4	Male	88	Oldest-Old	Never Married	White	Catholic	Very Important	50
5	Male	60	Middle-Adult	Divorced	White	Jewish	Not Important At All	30
6	Male	104	Oldest-Old	Widowed	Black	.	Somewhat Important	60
7	Male	77	Middle-Old	Divorced	White	Jewish	Very Important	50
8	Female	67	Young-Old	Divorced	White	Jewish	Very Important	60
9	Female	86	Oldest-Old	Widowed	White	Jewish	Very Important	65
10	Female	81	Middle-Old	Widowed	White	Jewish	Very Important	60
11	Male	75	Middle-Old	Widowed	White	Jewish	Somewhat Important	60
12	Female	90	Oldest-Old	Widowed	Black	Protestant	Very Important	60
13	Female	77	Middle-Old	Divorced	White	Jewish	Not Important At All	55
14	Male	91	Oldest-Old	Widowed	White	Jewish	Not Very Important	70
15	Male	94	Oldest-Old	Widowed	White	Jewish	Very Important	80
16	Male	99	Oldest-Old	Married	White	Jewish	Somewhat Important	65
17	Female	76	Middle-Old	Widowed	White	Protestant	Somewhat Important	70
18	Male	100	Oldest-Old	Widowed	White	Jewish	Very Important	50
19	Male	81	Middle-Old	Widowed	White	Catholic	Very Important	65
20	Female	87	Oldest-Old	Divorced	White	Catholic	Very Important	75
21	Male	75	Middle-Old	Widowed	White	Jewish	Not Very Important	35
22	Male	70	Young-Old	Never Married	White	Catholic	Not Important At All	60
23	Female	95	Oldest-Old	Widowed	White	Jewish	Very Important	30
24	Female	90	Oldest-Old	Widowed	White	Jewish	Somewhat Important	60
25	Female	88	Oldest-Old	Widowed	Black	Protestant	Very Important	55

Figure 2. Frequencies of Importance of Religious Participation

Frequencies of Importance of Religious Participation

Importance of Religious Participation				
PartRel	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Very Important	135	53.15	135	53.15
Somewhat Important	62	24.41	197	77.56
Not Very Important	29	11.42	226	88.98
Not Important At All	28	11.02	254	100.00
Frequency Missing = 1				

Figure 3. Importance of Religious Participation Pie Chart

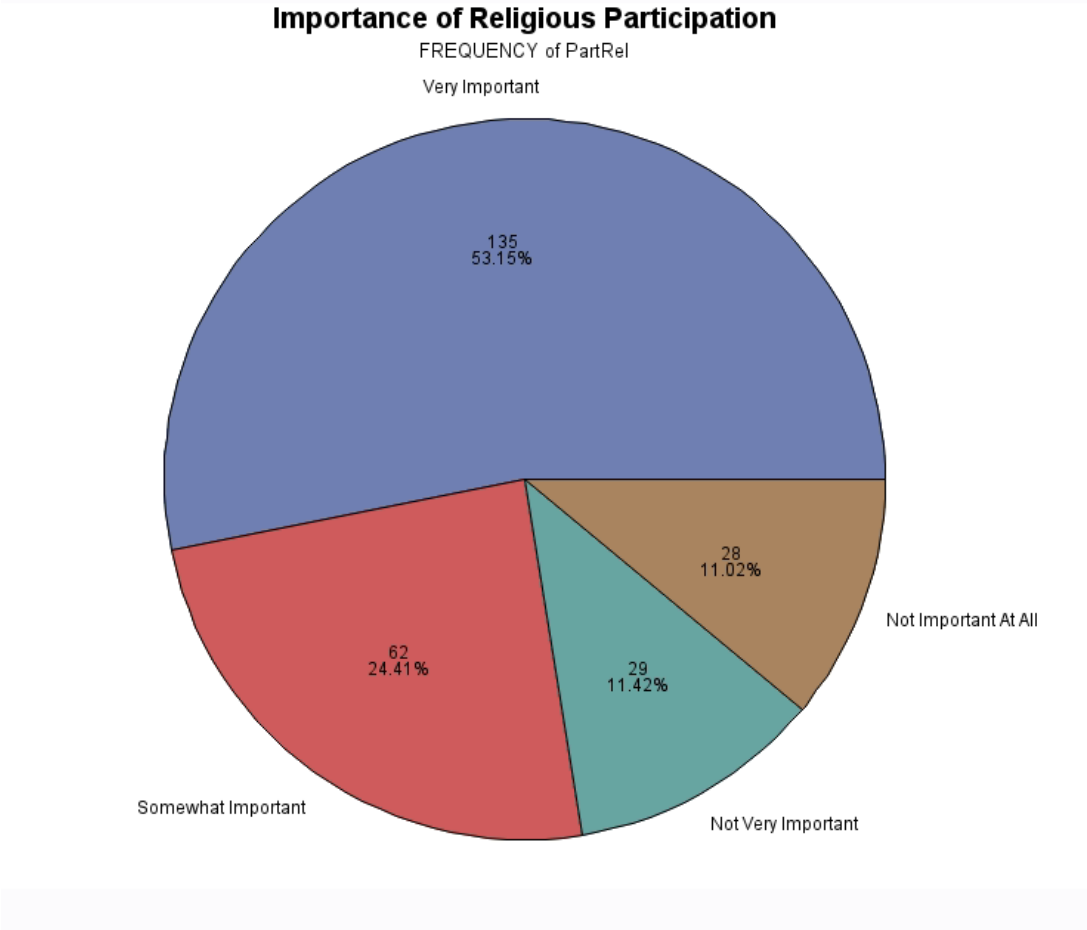
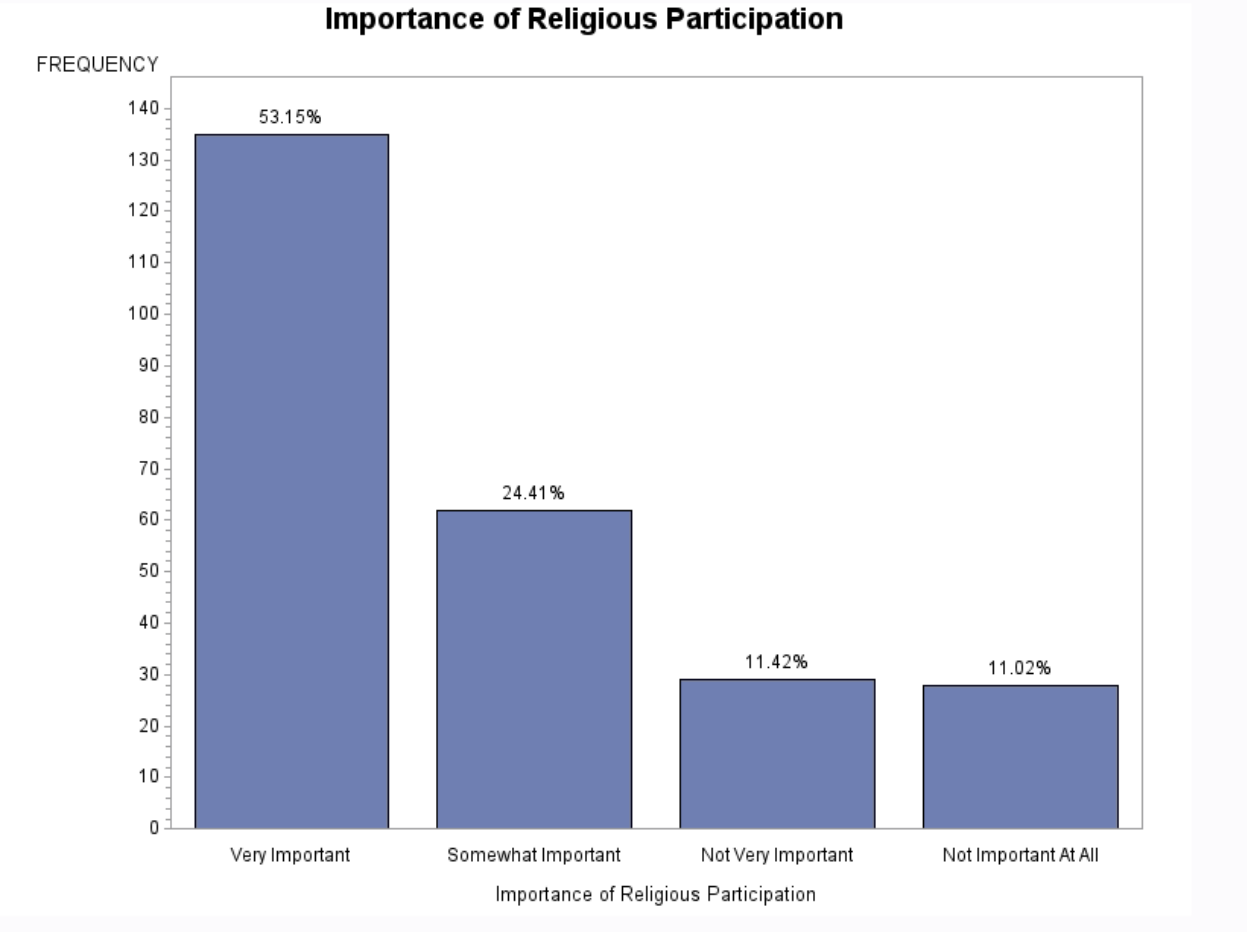


Figure 4. Importance of Religious Participation Bar Graph



Finally, the composite general health variable was analyzed to understand whether a relationship existed between residents' self-reported importance of *participating in religious services or practices* and their perception of their own health and well-being. The composite general health variable is a composite score of five self-rated health items pulled from the SF-36 questionnaire. The SF-36 allows participants to rate their health, particularly in comparison to others they know of the same age (Ware & Sherbourne, 1992). Within this sample, one item asked residents to rate their general health on a scale of 1 (excellent) to 5 (poor), while the 4 other items asked about health compared to others on a scale of 1 (definitely true) to 5 (definitely false). Thus, lower scores convey a healthier perception of oneself. The five items used to create

the composite general health variable can be viewed in Appendix C. The characteristics of the composite general health variable are shown in Figures 5-7. Notably, the variable appears to be quite normally distributed within the sample, making it optimal for statistical testing.

Figure 5. Descriptive Statistics of Composite General Health

Descriptive Statistics of Composite General Health

Variable: CompGenHlth (Composite General Health Score)

Moments			
N	255	Sum Weights	255
Mean	51.0196078	Sum Observations	13010
Std Deviation	13.9367104	Variance	194.231897
Skewness	-0.1549123	Kurtosis	-0.0451776
Uncorrected SS	713100	Corrected SS	49334.902
Coeff Variation	27.3163809	Std Error Mean	0.87275066

Basic Statistical Measures			
Location		Variability	
Mean	51.01961	Std Deviation	13.93671
Median	50.00000	Variance	194.23190
Mode	50.00000	Range	80.00000
		Interquartile Range	20.00000

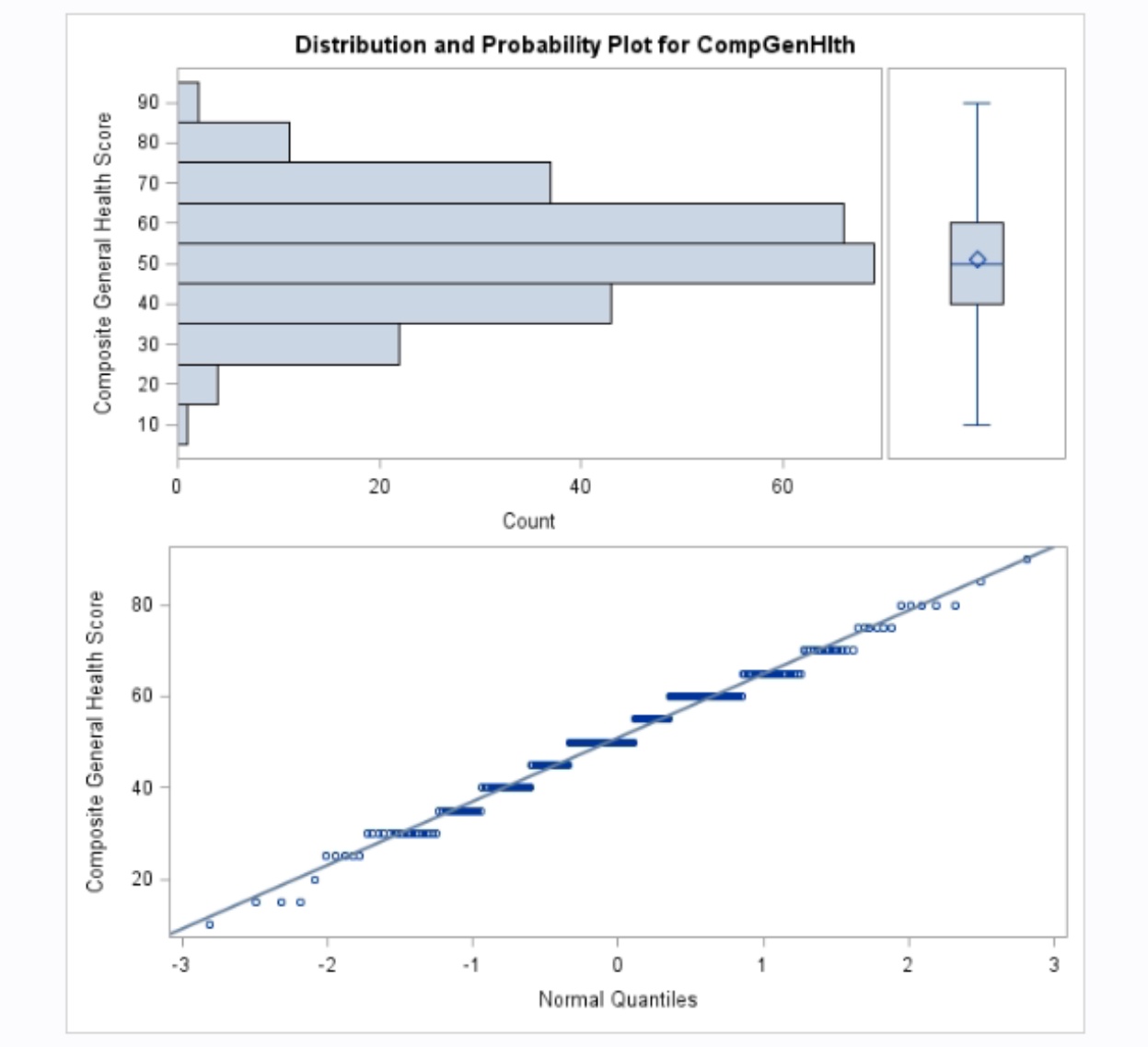
Tests for Location: Mu0=0				
Test	Statistic		p Value	
Student's t	t	58.4584	Pr > |t|	<.0001
Sign	M	127.5	Pr >= |M|	<.0001
Signed Rank	S	16320	Pr >= |S|	<.0001

Figure 6. Quantiles and Extreme Observations for Composite General Health

Quantiles (Definition 5)	
Level	Quantile
100% Max	90
99%	80
95%	75
90%	70
75% Q3	60
50% Median	50
25% Q1	40
10%	30
5%	30
1%	15
0% Min	10

Extreme Observations			
Lowest		Highest	
Value	Obs	Value	Obs
10	217	80	142
15	238	80	230
15	174	80	244
15	97	85	210
20	222	90	148

Figure 7. Distribution and Probability Plot for Composite General Health



An ANOVA test was run to examine the relationship between composite general health and religious participation importance. This procedure tests whether composite general health means differ across the four categories of religious participation importance: 'Very Important,' 'Somewhat Important,' 'Not Very Important,' and 'Not Important at All'. The results of this test are shown in Figure 8 and convey the unlikelihood that any such relationship exists ($p = .73$).

Figure 8. ANOVA of Composite General Health and Religious Participation Importance

Composite General Health as predicted by Religious Participation Importance

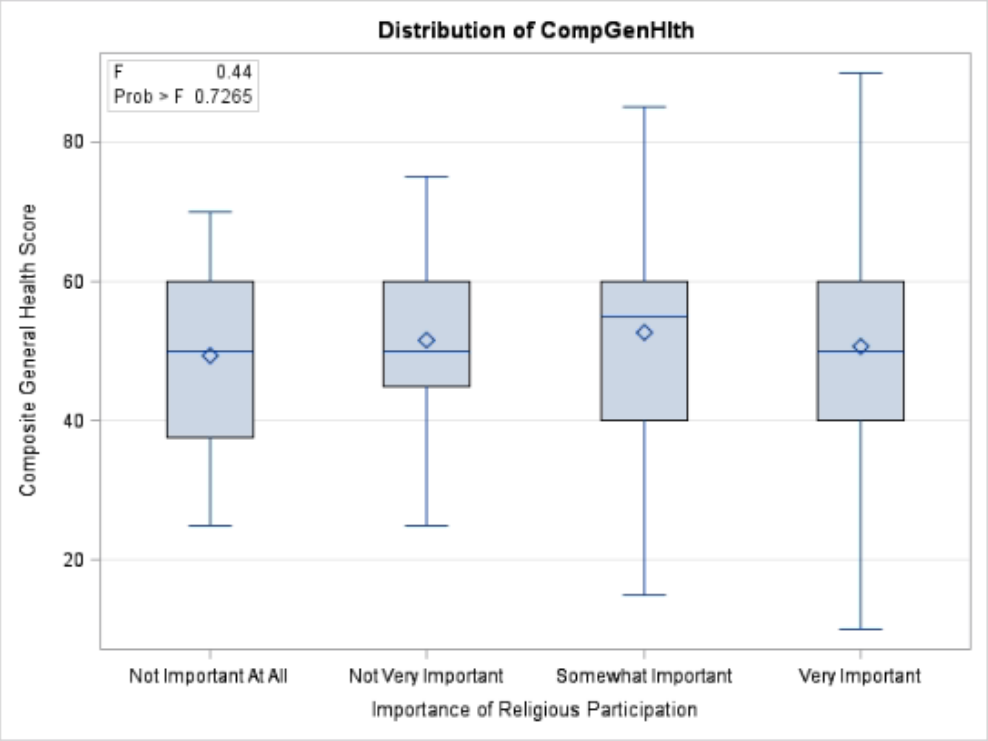
Dependent Variable: CompGenHlth Composite General Health Score

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	3	255.20696	85.06899	0.44	0.7265
Error	250	48636.13162	194.54453		
Corrected Total	253	48891.33858			

R-Square	Coeff Var	Root MSE	CompGenHlth Mean
0.005220	27.29408	13.94792	51.10236

Source	DF	Type I SS	Mean Square	F Value	Pr > F
PartRel	3	255.2069608	85.0689869	0.44	0.7265

Source	DF	Type III SS	Mean Square	F Value	Pr > F
PartRel	3	255.2069608	85.0689869	0.44	0.7265



Chapter 3: Phase 2—Qualitative

Research Questions

Qualitative analysis seeks to inductively discover themes and information through a deep, thorough examination and analysis of a smaller sample. A holistic account of participants' perspectives is desired over merely measurable data and statistics so that a topic may be understood in greatest detail (Creswell, 2014). For this phase, NH residents' perceptions of religious and spiritual care were sought through gathering and analyzing interview responses. Due to Phase 2's inductive nature, no specific research questions were developed; rather, questions, discrepancies, patterns, and meaningful data was allowed to emerge organically.

Methodology

Sample

This phase used a convenience sample of 39 non-veteran, older adults living in seven NHs in the greater Philadelphia region. Table 2 showcases the characteristics on the 39 participating individuals, and Table 3 includes the facility characteristics. Both of these tables are adapted from Heid, Eshraghi, Duntzee, Abbott, Curyto, and Van Haitsma (2014). Social workers at the NHs identified potential participants. These individuals were screened for cognitive ability, ensuring that they scored at least a 22 on the widely used and accepted Mini-Mental State Examination (Heid, 2014; Crum et al., 1993). Further, interviewed residents were English speakers, had been at their NHs for at least one week, were expected to remain at that facility for

at least one more week, and were cleared by their physician for capacity to consent and for mental stability (Heid et al., 2014).

Table 2: Sample Characteristics of Cognitive Interviewing Sample

Variable	N	$\bar{x}$	Frequency	%n
Age (years)	39	78.6	—	—
Gender	39		10	25.6
Race	39			
Caucasian			30	76.9
African American			9	23.1
Marital Status	36			
Married			3	8.3
Divorced/Separated			2	5.6
Widowed			23	63.9
Never Married			8	22.2
Religion	35			
Protestant			6	17.1
Catholic			13	37.1
Jewish			14	40.0
Eastern Orthodox			0	0.0
Muslim			0	0.0
Other			1	2.9
None			1	2.9
MMSE Total Score (0-30)	39	26.4	—	—
Length of stay (days)	39	646.1	—	—

Table 3: Facility Characteristics

Facility	% of Sample (N)	Number of Beds	Star Rating	Ownership
1	33.3 (13)	324	5	Nonprofit- Corporation
2	12.8 (5)	180	3	For profit- Corporation
3	12.8 (5)	180	3	Nonprofit- Corporation
4	12.8 (5)	226	4	Nonprofit- Other
5	10.3 (4)	296	5	Nonprofit- Corporation
6	10.3 (4)	170	5	Nonprofit- Corporation
7	7.7 (3)	120	3	Nonprofit- Corporation

Cognitive Interviewing Procedure

The PELI was designed to use language most important to NH residents when assessing preferences, which are viewed as idiosyncratic representations of the way individuals like to meet psychological needs (Curyto et al., 2015). A technique known as Cognitive Interviewing was used to examine the language, content, and meaning of preferences items in the PELI (Curyto et al., 2015).

Cognitive Interviewing helps adapt measurement tools, like the PELI, to reflect language used by NH residents to describe preferences important to them (Curyto et al., 2015; Sullivan et al., 2013; Willis, 2005). Interviewers were trained in the cognitive interviewing process following methods outlined by Beck, Towsley, Berry, Brant, & Smith (2010) and Housen et al (2008) (Curyto et al., 2015). Interviewers asked residents each preference question with the stem, "How important is it to you to...?" (Curyto et al., 2015). This phase specifically looks at the two preference stems related to religious and spiritual care, namely, "How important is it to you to *participate in religious services or practices*" and "How important is it to you to *talk about spiritual matters*." Items were rated on a 4-point Likert scale (shown to participants in large, size = 48, type font) with responses ranging from 1 = 'Very Important', 2 = 'Somewhat Important', 3 = 'Not Important', and 4 = 'Not Important At All'. After each response, interviewers immediately asked scripted questions, followed by additional prompts to assess the resident's understanding and reason for response (Curyto et al., 2015). Cognitive interviews were audio recorded and behavior observations were noted by the interviewer. Weekly research team meetings addressed questions and concerns about process and technique (Curyto et al., 2015).

The interviewer guided the resident through questions related to importance, choice, and preference fulfillment, asking why the residents answered as they did and/or what came to mind

as they answered. Appendix D contains a blank form example of the cognitive interview template used in this process to collect data.

Due to the large number of tested PELI items and foreseen interview burden, each stem item was only asked of five residents. Therefore, five individuals were interviewed about how important it is for them to *participate in religious services or practices* (individual characteristics in Table 4) and five different individuals were interviewed about how important it is for them to *talk about spiritual matters* (individual characteristics in Table 5).

Table 4: Sample Characteristics—Participating in Religious Services or Practices

Variable	N	$\bar{x}$	Frequency	%n
Age (years)	5	75.6	—	—
Gender (male)	5			
Male			3	60%
Female			2	40%
Race	5			
Caucasian			5	100%
African American			0	
Marital Status	5			
Divorced/Separated			1	20%
Widowed			3	60%
Never Married			1	20%
Religion	5			
Protestant			0	
Catholic			0	
Jewish			5	100%
None			0	
MMSE Total Score (0-30)	5	26.6	—	—

Table 5: Sample Characteristics—Talking about Spiritual Matters

Variable	N	$\bar{x}$	Frequency	%n
Age (years)	5	78.4	—	—
Gender	5			
Male			1	20%
Female			4	80%
Race	5			
Caucasian			2	40%
African American			3	60%
Marital Status	5			
Divorced/Separated			1	20%
Widowed			3	60%
Never Married			1	20%
Religion	5			
Protestant			2	40%
Catholic			1	20%
Jewish			1	20%
None			1	20%
MMSE Total Score (0-30)	5	27	—	—

Content Analysis Procedure

Similar to work done by Bangerter, Van Haitsma, Heid, and Abbott (2015), this study sought to analyze how residents define and explain preferences from a qualitative perspective from cognitive interviewing as well as the importance, choice, and preference fulfillment rates associated with NH residents' responses.

The qualitative content analysis procedures of Graneheim and Lundman (2004) as modeled by Bangerter, Van Haitsma, Heid, and Abbott (2015) were used for the content analysis of the importance of *participating in religious services or practices* and *talking about spiritual matters* items. The thesis author (NPA) conducted an initial reading of the data commentary to create an understanding of the responses and to form preliminarily emerging categories. Resident

responses from the religious item were read and analyzed separately from the spiritual item in order to avoid prematurely comparing the data. The inductive approach of allowing organic thematic categories to emerge, as opposed to fitting responses into preconceived categories or expectations, was essential to the qualitative analysis process.

In the second stage of analysis, more precise categories formed, as well as sub-categories, which grouped similar words and phrases based off of the text and/or context of the responses. The number of sub-categories varied on the depth and variety of content for that concept. Coding notes documented the reasons for grouping similar preferences. These notes helped form categories by interpreting various themes and patterns contained in the response text (Hsieh & Shannon, 2005; Bangerter et al., 2015).

To enhance representativeness, clarity, proper data handing, and reliability, each category was consulted and discussed with researcher and thesis adviser Dr. Kimberly Van Haitsma. Multiple meetings per month were held to deliberate the formation and explanation of coded categories and sub-categories, additionally bringing more individual perspective into the content analysis process. The research duo collaborated to reach complete consensus on the definition of categories and the placement of items into them. Saturation was not reached before all of the data responses were analyzed and coded from the sample (Glaser & Strauss, 1967). Averages of importance means, choice means, and satisfaction means were included and analyzed when appropriate (Bangerter et al., 2015).

Results

The described methodological procedure for content analysis was followed for the two studied preference stems: How Important it is to *Participate in Religious Services or Practices* and How Important it is to *Talk about Spiritual Matters*. From this analysis, eight prominent themes emerged from the data. These included: 1) Language Confusion; 2) Definitional Wordage; 3) Origin of Belief; 4) Level of Involvement; 5) Valence; 6) Time of Importance; 7) Choice; and 8) Satisfaction. These themes are discussed below along with descriptive commentary from the data set. Tables 6-21 encompass these results, and contain information on the quantities of observations as well as the importance means of those offering commentary.

Language Confusion

The theme labeled language confusion observed comments that indicated that individuals were confused about questions they were being asked related to this preference. Comments indicating confusion with describing preferences were looked at, as well as those that thought language was clear and understandable. Table 6 highlights observations from the importance of *participating in religious services or practices* stem, whereas table 7 shows the importance of *talking about spiritual matters* stem.

Only two total comments related to wording confusion were made in interviews for the importance of *participating in religious services or practices* stem. Both comments were made by a resident with a 4.00 importance score (e.g. not important at all). Five total comments from each of the four other interviewed individuals (80%) referenced the language not to be

confusing, claiming that questions were “very clear” pertaining to this item and meant “exactly what it says” (108). These commenting individuals had an importance mean of 2.50 in contrast to the 4.00 of the more confused individual.

Table 6: Language Confusion—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$
Presence of Confusion	*2*	*20%*	*4.00*
Ambiguous	1		
Illegitimate Question	1		
Lack of Confusion	*5*	*80%*	*2.50*
Clear	3		
Worded Well	2		

For the spiritual stem, only two total comments were made communicating a lack of confusion, and there was no difference in importance means between those indicating the presence or lack of confusion. A total of 15 comments from all five interviewed residents expressed confusion over the meaning of spiritual care and questions asked about this preference. One resident blatantly asked: “What do you mean by spiritual? (160). And expressed doubts of arriving at appropriate conclusions on the term: “I'm thinking about the wrong thing; I know I am” (160). Another resident expressed “I'm not quite sure what you are driving at” and “Talking about spiritual matters’ is just a wee bit overthought” (154). Such confusion made this resident worry “that answer might be misconstrued” and lead to conclusions that “would not be true” (154). A different resident showed difficulty answering questions about levels of choice in this preference stating “I'd have to know what you were asking me first” (157).

Others articulated how their preferences depend on the meanings of the language used. When asked what thoughts came to mind when asked about *talking about spiritual matters*, one

individual expressed that would be “Depending what spiritual matters means to me” (117). When considering importance, the resident insisted, “It depends upon what we are talking about whether or not it is important to me or not. It depends upon the subject” (160).

Table 7: Language Confusion—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$
Presence of Confusion	*15*	*100%*	*2.40*
Depends	4		
Not clear	2		
Other	9		
Lack of Confusion	*2*	*40%*	*2.50*
Clear	1		
Understood	1		

While *the participating in religious services or practices* stem produced two comments indicating a presence of confusion and five comments suggesting a lack of confusion, the *talking about spiritual matters* stem generated 15 confusion based comments and two lack of confusion sentiments. These results ($p = 0.0035$) are statistically significant and draw predominate consideration from this project.

Notably, statistical clarity of this issue was not merely seen in the number of comments made. In fact, all five residents interviewed (100%) about the spiritual stem made confusion based comments, and four of the five residents (80%) interviewed about the religious stem made lack of confusion statements.

Definitional Wordage

Definitional Wordage encompasses what terminology residents used when discussing the two studied preference stems. These terms were gathered into higher-order categories for both stems. Resultantly, six sub-categories emerged: *conversing, faith-based practices, locations, clergy, religious affiliation,* and *beliefs*. Table 8 portrays results from the importance of *participating in religious services or practices* item, and Table 9 shows those from the importance of t*alking about spiritual matters* stem.

There were no comments from the *participating in religious services or practices* stem related to conversing or beliefs. Rather, all definitional comments filtered into *faith-based practices, location, clergy,* and *religious affiliation* sub-categories. Importance means varied slightly but were close to one another and appear to be insignificant.

A total of 80% of the residents used 12 terms to define *participating in religious services or practices* as a faith-based activity. This included references to holidays, services, Bar Mitzvahs, or engaging with one's preference. Specifically, the word "services" was used 7 times (more than any other specific definitional word). Notably, this word already appears in the religious preference stem.

Religious affiliation was referred to the second highest number of times (eight) by 60 percent of those interviewed. One's "religion" was used six times, whereas "Jewish" was used twice. 40 percent of residents referenced a location as a part of this preference; specifically, synagogue was referenced four times. Rabbi's (clergy) were referenced four total times by 60 percent of residents interviewed. Thus, residents' preferences for *participating in religious services or practices* appear to be mostly perceived as alluding to faith-based activities and/or

religious affiliation. The lack of the conversing or beliefs language shows the lack of these words in the vernacular of individuals discussing this religious preference stem.

Table 8: Definitional Wordage—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$
Conversing	*0*	*0%*	—
—			
Faith-based Practices	*12*	*80%*	*2.75*
Service	7		
Holidays	2		
Bar Mitzvah	1		
Sabbath	1		
Keeping up	1		
Location	*4*	*40%*	*2.50*
Synagogue	4		
Clergy	*4*	*60%*	*2.67*
Rabbi	4		
Religious Affiliation	*8*	*60%*	*3.00*
Religion	6		
Jewish	2		
Beliefs	*0*	*0%*	—
—			

With the spiritual preference stem, many more and varied definitional terms were used. In fact, 100 percent of the residents explained *talking about spiritual matters* as related to conversing activities or behaviors. In total, they amassed 16 total usages ranging from words like “talking” or “discussing” to engaging in a “roundtable”. Three of the interviewed residents (60%) defined *talking about spiritual matters* with a variety of language related to beliefs. This included talking about what they believe, what matters to them, faith, ethics, and the question of the existence of God. These high quantities of conversing and beliefs comments strongly contrast with their absence in the importance of *participating in religious services or practices* stem.

Comments also contained significantly more items in the *faith-based practices, locations, clergy,* and *religious affiliation* sub-categories. For example, mentions of clergy where not solely about rabbis, but included comments about pastors, chaplains, ministers, assigned persons, and pastoral care. Within religious affiliation, mention was given to religion, Jewish, Catholic, Buddhist, Hindi, and Christian terms. In sum, terminology used to define *talking about spiritual matters* was extremely diverse, even with only five interviewed residents. Clearly, there is not consensus on what this preference specifically means.

Table 9: Definitional Wordage—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$
Conversing	*16*	*100%*	*2.40*
Talking	12	60	
Discussing	3	20	
Roundtable	1	20	
Faith-based Practices	*12*	*40%*	*1.50*
Service	4	20	
Bible/Bible Study	3	20	
Bat Mitzvah	2	20	
Meetings	3	20	
Location	*6*	*60%*	*2.00*
Synagogue	1	20	
Church	5	40	
Clergy	*10*	*60%*	*2.33*
Rabbi	2	40	
Pastor	1	20	
Chaplain	1	20	
Minister	2	40	
Assigned Person	1	20	
Pastoral Care	3	20	
Religious Affiliation	*14*	*40%*	*2.50*
Religion	3	20	
Jewish	1	20	
Catholic	5	20	
Buddhist	1	20	
Hindi	1	20	
Christian	2	20	
Beliefs	*23*	*60%*	*3.00*
Beliefs	7	40	
Existence of God	4	60	
Ethics	1	20	
Faith	6	60	
What matters to me	5	20	

Origin of Belief

Comments related to the origin of one's belief surfaced in the importance to *participate in religious services or practices* stem. These comments categorically broke up into references to external and internal origins. An external origin notes a religious or spiritual preference or orientation starting from outside of oneself. An internal origin relates to a personally sourced belief. External and internal comments varied with residents commenting about the importance of *participating in religious services or practices* (Table 10) and *talking about spiritual matters* (Table 11).

For the religious preference stem, family and upbringing were particularly noted as an external source of belief. In total, three of five interviewed residents (60%) commented about family as an origin of belief. One resident stated, "I never thought about it much. It's automatic. If your mother and father do it, it's a family thing" (104). Another said, "I was raised right, but I don't go here." (108). The third resident quoted, "I guess it was more important when I was home. And it's still very important, but not as important cause I don't have my family here with me" (111). Each of these residents captures the idea of an external origin of belief and show that one's upbringing and family life influence their understanding of religious services and practices as well as his/her importance of the preference.

Two of the five (40%) residents interviewed about the importance of *participating in religious services or practices* commented with references to an internal view of the origin of belief. These comments were less robust, detailed, and clear but noted a personal quality. One resident said, "It's a personal thing" (104), and another, "Well religion is your religion" (109).

An importance mean of 2.00 for those who commented about the internal origin of belief construct versus a 3.00 importance mean for those who noted an external origin of belief may be meaningful.

Table 10: Origin of Belief—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$
External	*3*	*60%*	*3.00*
Family	2		
Raised Right	1		
Internal	*3*	*40%*	*2.00*
Individual	3		

Comments about internal and external origins of belief were less prevalent in the *talking about spiritual matters* preference. In total, one external comment and one internal comment were made about the preference. With an external perspective, one resident commented, “No, I am not a fallen away anything. I was sent to Catholic school, but I don't consider myself to be a fallen away Catholic (154). The internal comment appealed to common sense as a source: “I didn't decide; it is just basic common sense” (160) With an exceptionally small sample size, the same trend in importance mean is seen— an internal framework (2.00) correlating with a lower importance mean than the external framework (4.00).

Table 11: Origin of Belief—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$
External	*1*	*20%*	*4.00*
Not Fallen Away	1		
Internal	*1*	*20%*	*2.00*
Common Sense	1		

Level of Involvement

The level of involvement theme surfaced as different individuals spoke of *participating in religious services or practices* and *talking about spiritual matters* with varying degrees. These comments separated into three sub-categories: active involvement, passive involvement, and no involvement**.** Active comments encompassed being committed, engaged, and participative in religion or spirituality. Passive involvement comments were characterized by inconsistent attendance or going without participating. No involvement labeled comments where a person did not become involved with these activities at all. Results are shown in Tables 12 and 13.

Levels of importance were talked about significantly more through spontaneous comments of the *participating in religious services or practices* preference stem. This included 21 total comments across the three categories, compared to only ten comments made on the preference of *talking about spiritual matters*.

Seven active comments were made by four of the five (80%) interviewed residents. In reference to committing to religious practices or services, one resident observed, “Every Saturday there's a service. They go they never miss it” (108). Another resident showed the distinction of not only committing to attending but to also participating by stating, “I have been in the Synagogue and I have participated” (113). Similarly, one said “You want to go and want to participate by doing what the sermon requires” (113). Another resident summarized this active perspective by vocalizing, “Well, religion is your religion. You should be involved” (109)

Another eight comments made by four of the five interviewed residents (80%) held a passive perspective of involvement in religious practices or services. These residents used phrasing like “I've gone a couple times and I haven't gone” (113) or “One time I didn't feel like going, so I didn't (111).

Six total comments noted not going, not participating, or not being religious at all. Three of the five interviewed residents (60%) made reference to not being involved in these practices or services.

Interestingly, a balanced number of active and passive comments shows division among perspectives of involvement in religious services or practices. Further, residents who mentioned active involvement and those who mentioned passive involvement both have an average importance mean of 2.50. Predictably, those who personally mentioned not participating passively or actively had a high importance mean of 3.50—showing a lack of importance of this preference to those individuals.

Table 12: Level of Involvement—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$
Active	*7*	*80%*	*2.50*
Participate	4		
Commit	1		
Keep up	1		
Involved	1		
Passive	*8*	*80%*	*2.50*
Go When Feel Like	5		
Open	1		
Stay outside	1		
Other	1		
None	*6*	*40%*	*3.50*
Don’t Participate	2		
Don’t Go	3		
Not Religious	1		

Three comments made by 40% of those interviewed indicated active involvement in *talking about spiritual matters*. For example, one resident mentioned the importance of keeping

up with reading and engaging in conversation saying, “She gives me scripts out of the Bible and I read them. I talk to her a lot” (155).

Twice as many comments (six) were made by 60% of residents referencing a passive perspective of involvement. For instance, one resident spoke conditionally saying, “If I see the Rabbi we talk” (117). Another person referenced only going periodically and having people passively come to him: “If I don't go to it they come and see why” (155).

Only one person (20%) noted a lack of passive or active involvement saying, “Because when a pastor or a chaplain or a rabbi walks into the room and asks if I wish to talk to them I say, ‘No’ and they leave” (154).

A steady emerging trend can be seen in the importance means between those who made comments with these perspectives. The active, passive, and none categories had mean importance ratings of 2.00, 2.33, and 4.00 respectively. Potentially, those who view *talking about spiritual matters* as an actively involved activity correlate with those who view it as more important in their lives.

Table 13: Level of Involvement—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$
Active	*3*	*40%*	*2.00*
Act to Keep Church Up	1		
Read	1		
Offer Opinion	1		
Passive	*6*	*60%*	*2.33*
Go When I Feel Like	2		
People Come to Me	3		
Listening	1		
None	*1*	*20%*	*4.00*
Don’t Want to Talk	1		

Valence

Resident comments also made reference to the valence of *participating in religious services or practices* and *talking about spiritual matters*. Valence is a psychological term that refers to how attractive or aversive an item is. In the case of these samples, it refers to how attractive or aversive religious and spiritual activities were to residents. Positive valence refers to attractiveness, whereas negative valence refers to the preference's level of aversiveness. Tables 14 and 15 show results.

Five total valence comments were made when residents were asked about *participating in religious services or practices.* Two total comments were made about attractiveness by two of the five residents (40%). One resident said, "Some people get a warm spot in their heart to talk or pray to God" (113), and another said, "They find out that it is important… And they think it's important and they go" (109). In these instances, developing a desirable feeling or a perceived importance lead one to pursue these preferences more.

Three negative valence comments were made by three of the five interviewed residents (60%). These comments included references to negative experiences with religion, exposure to hypocrites, and antsy feelings (104, 108, 113). The importance mean for those making positive valence comments was 2.50 as opposed to 3.33 for those who made negative valence comments. This trend, though in a small sample size, corresponds with expected trends. Those who may view religious services or practices as attractive view them as important; vice versa, those who may view religious services or practices as aversive see them as unimportant.

Table 14: Valence—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$
Positive (Attractiveness)	*2*	*40%*	*2.50*
Warm	1		
Discover Importance	1		
Negative (Aversive)	*3*	*60%*	*3.33*
Hypocrites	1		
Bad Experience	1		
Antsy	1		

More comments relating to valence where made by residents who were asked about their importance of *talking about spiritual matters*. In total, three of the five interviewed residents (60%) made five positively valenced comments, whereas one of the interviewed residents (20%) made six negatively valenced comments. Positive valence comments centered on things transpiring or having a wake-up call, which lead to talking about spiritual matters. Similarly, comments referred to seeking spiritual matters when fear or interest is peaked.

One resident commented about the negative valence of *talking about spiritual matters* with strong language saying, “I just don't like an assigned person of the cloth trotting in with their little smile asking if they can talk with me” and “I hold very little patience with most religions” (154). Evidently, negative and positive valence are a continuum. Some individuals find *talking about spiritual matters* to be very attractive, some find it very aversive, and many fall elsewhere in between. The importance mean may begin to measure this valence characteristic. The importance mean of those with positive valence comments was 2.66, and the importance mean of the individual stating negative valence was 4.00 (not important at all).

Table 15: Valence—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$
Positive (Attractiveness)	*5*	*60%*	*2.66*
Seek in Fear	1		
Wake-up Call	1		
Something Transpired	1		
Interesting	1		
New Roundtable Event	1		
Negative (Aversive)	*6*	*20%*	*4.00*
Undesired	2		
Disappointment	1		
Reject in Depression	1		
Little Patience	1		
Person Trotting in	1		

Time of Importance

Some residents referenced the time when *participating in religious services or practices* (Table 16) or *talking about spiritual matters* (Table 17) was most important to them. A question imbedded in the cognitive interview prompted these comments. A few residents noted its significance and responded accordingly.

Four total time of importance comments were made about the *participating in religious services or practices* stem. These came from three of the five interviewed individuals (60%). One resident noted that this preference is currently most important to him saying, “I think it's more important to me now than ever,” specifically because of increased age: “when you are older it becomes more important. You realize it more” (109). Alternatively, two residents noted the preference being more important before coming to their current facility. One said, “I guess it was more important when I was home. And it's still very important, but not as important cause I don't have my family here with me” (111). Another simply said *participating in religious services or*

practices was more important “When I was younger” (108). Whether due to age or environment, variability exists in when *participating in religious services or practices* may be more important in a resident’s life.

Table 16: Time of Importance—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$
Current	*2*	*20%*	*2.00*
Now	1		
Realize When Older	1		
Past	*2*	*40%*	*2.50*
When Younger	1		
When Home	1		

Interestingly, no comments emerged from the *talking about spiritual matters* preference. Individuals either did not indicate a time when *talking about spiritual matters* was more important to them, or the question had no response listed. This juxtaposed the frequency of comments made about the importance of *participating in religious services or practices* preference stem.

Table 17: Time of Importance—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$
Current	*0*	*0%*	—
—			
Past	*0*	*0%*	—
—			

Choice

Residents surveyed on both preferences were asked how much choice they feel they have in fulfilling the preference. Residents could respond with ‘free choice’, ‘some choice’, or ‘no choice’ (coded as 1.0, 2.0, and 3.0 respectively). Residents could also provide spontaneous commentary as to why they chose this rating. In response, comments related to free choice dominated the interviews of both preferences, as portrayed in tables 18 and 19.

Six total comments from every interviewed resident (100%) surfaced about free choice in *participating in religious services or practices*. Expectantly, this resulted in a 1.00 choice mean average. Comments from residents included: “Anyone can go to services here, visitors can go. It's open. I think it's wonderful” (108); “On my terms, yes. Cause I don't go, I don't go. Nobody objects.” (108); “Well if it's open and there's something going on I go right in” (109). Whether residents were actively, passively, or not involved, these consensus comments show that free choice can be offered to residents. This free choice is responded to positively.

Table 18: Choice—Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$	Choice $\bar{x}$
Free Choice	*6*	*100%*	*2.8*	*1.00*
Nobody Forces	1			
Nobody Objects	1			
It’s Open	2			
My Choice	1			
My terms	1			
Some Choice	*0*	*0%*	—	—
—				
No Choice	*0*	*0%*	—	—
—				

With the *talking about spiritual matters* preference, similar trends were seen. Four residents (80%) commented about free choice, and one resident (20%) referenced some choice. Similar to *the participating in religious services or practices* preference, residents said they had free choice, “Because nobody's stopping you here from talking about anything (117) and “Everybody treats me nice and I can say what I want to say. Naturally they have rules and regulations and they are not hard. (160). Even with boundaries or limitations, choice could be maximized according to this comment. The only individual who claimed there to be some choice said that there were not really many opportunities and suggested a roundtable discussion as an addition to the NH.

Table 19: Choice—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$	Choice $\bar{x}$
Free Choice	*4*	*80%*	*2.25*	*1.00*
Nobody stopping you	1			
No one hoists themselves on you	1			
They will listen	1			
I can say what I want	1			
Some Choice	*1*	*20%*	*3.00*	*2.00*
Not really opportunities	1			
No Choice	*0*	*0%*	—	—
—				

Satisfaction

Similar to the choice item, residents were asked how they felt each preference was fulfilled in the last month. Residents had the opportunity to respond with “mostly or completely,” “little or somewhat,” or “not at all” (coded as 1.0, 2.0, and 3.0 respectively). Like the choice measure, spontaneous commentary justifying responses could be offered. Table 20 contains

results for the importance of *participating in religious services or practices* item, while Table 21 contains those for the *talking about spiritual matters* preference.

All five residents (100%) commented about having their *participating in religious services or practices* preference mostly or completely met. Correspondingly, all five reported a 1.00 satisfaction mean by choosing “mostly or completely satisfied.” Commentary included: “I don't participate. I'm satisfied” (104); “Because I enjoy it” (109); and “Because like one time I didn't feel like going, so I didn't. And the rest of the time I participate in the service and I like that” (111).

Table 20: Satisfaction— Participating in Religious Services or Practices

Category	Frequency	%n	Importance $\bar{x}$	Satisfaction $\bar{x}$
Mostly or Completely	*5*	*100%*	*2.8*	*1.00*
Satisfied	1			
Because of choice	1			
Enjoy	1			
Like to Participate	1			
Okay with not going	1			
Little or Somewhat —	*0*	*0%*	—	—
Not at all —	*0*	*0%*	—	—

For the *talking about spiritual matters* preference, responses parallel to the choice results. Four residents (80%) noted being mostly or completely satisfied and one resident (20%) selected being a little or ‘somewhat’ satisfied. Those who felt their preference mostly or completely fulfilled noted, “I'm completely satisfied with everything that has gone on” (117) and “I feel they've given me what they felt in the service and they gave it back to me so I feel very satisfied about that” (155). The individual who recorded only being little or somewhat satisfied alleged a

lack of announcements for activities related to *talking about spiritual matters*: “If they announced it or let it be known, then I would go” (157)

Table 21: Satisfaction—Talking about Spiritual Matters

Category	Frequency	%n	Importance $\bar{x}$	Satisfaction $\bar{x}$
Mostly or Completely	*4*	*80%*	*2.25*	*1*
Satisfied with everything	1			
Give me what they feel	1			
Respect	1			
No problems	1			
Little or Somewhat	*1*	*20%*	*3*	*2*
Need Announcements	1			
Not at all	*0*	*0%*	—	—
—				

Chapter 4: Discussion

Phase 1

Quantitative analysis in Phase 1 revealed that 77.56 percent (53.15% 'Very Important', 24.41% 'Somewhat Important') of residents reported *participating in religious practices or services* to be important to them. These results are in accordance with literature showing that religion is important to a majority of older adults in NHs. Koenig and colleagues determined that almost 60 percent of NH residents use religion when coping with their problems, with 34 percent of residents listing it as their most important coping factor (Koenig et. al, 1997). As cohorts age and preferences may change, researchers must continue to analyze this trend. Yet this large sample (255 residents) maintains that religious preferences are important to a majority of NH residents and establishes them as important indicators for study. This quantitative research phase showed how religious importance measures differed across various demographic variables. Specifically, Phase 1's results showed interesting relationships between religious importance and gender, health, and affiliation.

Gender

A significant relationship between religious importance and gender ($p = .0057$) was consistent with numerous studies that found a correlation between these variables in the older adult population (Argyle and Beit-Hallahmi, 1975; Bengtson, Kasschau, and Ragan, 1977; Sloane and Potvin, 1983; Markides and Machalek, 1984; Koenig, Kvale, and Ferrel, 1988; Chatters and Taylor, 1989; Cornwall, 1989; Thompson, 1991; Levin, Taylor, and Chatters, 1992; Levin and Taylor, 1993; Levin and Chatters, 1998; Pudrovska, T. 2015). This relationship is well

established and the results of the quantitative phase lend support to it. Specifically, these results support a significant statistical relationship between gender and religious importance in the NH population. Interestingly, many of the above studies also identified a significant relationship between religious involvement/importance and race; however, race did not show a statistically significant relationship ($p = .08$) in this project. This sample may not have been racially representative and thus, may not have produced representative results. With 77.08 percent of residents identifying as Caucasian, 22.92 percent as black, and 0 percent as other races, the population lacks some racial diversity.

Health

Phase 1's study of composite general health and religious participation found no significant relationship between these constructs. This phase's analysis, combined with existing literature on religious and spiritual care for NH residents, illustrates the topic's complex nature.

The composite general health variable has not been specifically applied to the study of religious and spiritual health. The variable, which is made up of responses to 5 questions (displayed in Appendix C), is meant to be general. The questions, taken from the SF-36, simply refer to "health" without defining the term in physical, mental, emotional, or spiritual terms. Participants are asked about their own health as well as their health relative to others. It is difficult to determine or assume how participants interpret "health" or what they include in their response.

Other studies examining the relationship between health and religiosity and spirituality in NH residents have defined health differently. For example, religiosity or spirituality within NHs have shown to be a significant predictor of hope (Trouhy, 2011), an influence on positive

psychological well-being (Scandrett & Mitchell, 2009), a productive coping strategy (Koenig, 1997), and a beneficial social support system (Commerford and Reznikoff, 1996). However, the composite general health variable does not assess hope, psychological well-being, positive coping, and/or social support. Perhaps the composite general health is not an appropriate variable to examine the relationship between religious activity, preference, and importance. Therefore, this study cannot contribute to the discussion around the positive effects that religious and spiritual care may have on NH residents' health. Further research is needed to understand how to optimally measure health outcomes as they pertain to religiosity and spirituality in NHs.

Affiliation

An interesting finding of this quantitative phase was the statistically significant (p=.0001) relationship between NH residents' importance of *participating in religious services or practices* and their religious affiliation. Scarce research examines whether different religious affiliations correlate with differences in religious involvement preferences. Therefore, this study's finding of a significant relationship (p=.0001) between religious affiliation and religious practice preference indicates a need to investigate the relationship further in the NH population.

These findings raise interpretive questions as to why Protestants and Catholics in this sample report high importance of religious participation, while Jewish residents do not. Perhaps residents of these different religious affiliations interpret the stem, *participating in religious services or practices,* differently (Pargament et al., 1995; Zinnbauer et. al, 1997; Zinnbauer, Pargament, & Scott, 1999). Perhaps religious practices and services hold different importance to the Jewish faith than to the Christian denominations (Iannaccone, 1990; Cohen, Siegal, & Rozin, 2003). Perhaps Protestantism and Catholicism are seen as more actively practicing religions

whereas Judaism is a religious identity, descriptor, or cultural characteristic for individuals (Smolicz, 1981; Cohen & Hill, 2007; Cohen, 2009). The analytical scope of this study is not to verge into historical, sociological, metaphysical, or philosophical interpretations; yet these results indicate a need for continued research with larger, statistically representative samples and keenly designed methodology. Such research could more rigorously analyze this correlational trend and begin to empirically question its origins.

Limitations

While results for each Phase 1 research question emerged, limitations exist to drawing conclusions. Quantitative analysis of how important it is to residents to *participate in religious services or practices* hinges upon an intended, shared, and clear understanding of what *participating in religious practices or services* means. Disparities in defining these terms (as demonstrated in Phase 2) questions whether a ubiquitous understanding has been reached. Further, this preference stem does not allow for the context of differences in religious affiliation. Differences may exist, affecting definitions of religious practices or service and impacting self-reported data. Similarly, the survey did not use a question to inquire about the importance of residents' spiritual preferences. If individuals hold conceptual frameworks that differentiate religiosity and spirituality, the survey stem used (how important is it for you to *participate in religious services or practices*) may not accurately capture their preferences.

Statistical analysis of the results was also quite basic. Researchers must use more in-depth statistical modeling to draw conclusive results. Gender, religious affiliation, race, and health relationships to religious participation must be studied more rigorously. Further, a small sample size may have affected the accuracy of the Chi-square test results; for example, the 30

individuals (11.76%) in this 255-person sample who did not indicate a religious affiliation pose a barrier to analysis.

The sample used in this study may present a representative view of NH residents in Pennsylvania, but a more nationally representative sample is needed to generalize the results of this project. Further research projects much use these results to formulate research questions, samples, and methodology to grow the quantitative research base of religious and spiritual care preferences in NHs.

Phase 2

To date, there is no qualitative research that comparatively analyzes NH residents' perceptions of *participating in religious services or practices* and *talking about spiritual matters*. While no literature exists to which to compare results and findings, this study may serve as an innovative base for future research and analysis. Clarity is needed in the research between care providers and among NH residents. This phase uncovered three qualitative themes labeled language confusion, preference stem differences, and choice/satisfaction factors. These themes will be discussed in turn.

Language Confusion and Definitional Wordage

One of the clearest finding in Phase 2 revolved around language confusion between religious and spiritual preference stems. *Language Confusion* describes how unsure or confused residents were about their definitions of the religious and spiritual preference stems. From the results, it appears this sample of NH residents was confident in their definitions of *participating*

in religious services or practices, while they were confused about the *talking about spiritual matters* stem. Perhaps *participating in religious services or practices* is more familiar to the NH generational cohort. Alternatively, the religious preference stem may simply be more intuitive in its wording than *talking about spiritual matters*.

The interviewed residents even raised concern over the implications of the language confusion. While struggling to answer questions about levels of choice in *talking about spiritual matters*, one resident acknowledged, "I'd have to know what you were asking me first" (157). Others articulated how their preferences depend on the meanings of the language used. When asked what thoughts came to mind with *talking about spiritual matters*, a resident stated "Depending what spiritual matters means to me" (117). A different resident, when considering her importance of the spiritual stem insisted, "It depends upon what we are talking about whether or not it is important to me or not. It depends upon the subject … It depends on what it is in terms of whether it is important to me" (160).

If residents are worried about the misinterpretation of their responses, concern should rise for researchers, administrators, and care providers as well. How can desired religious and spiritual care be provided to NH residents if accurate care preferences cannot be collected, interpreted, or understood? How can conversations among researchers, policy makers, and care-givers take place without mutual understanding in terminology?

These concerns were augmented by results related to *Definitional Wordage*, which reflected the terms residents used while attempting to define these preferences. The definitions that residents associated with the preference stems likely increased confusion. The terminology used for the *talking about spiritual matters* presence stem was significantly more inclusive and diverse than for the *participating in religious practices or services* stem.

Perhaps the terminology related to *talking about spiritual matters* is not merely more confusing and less ubiquitous, but is actually meant to be more inclusive, personalized, and subject to interpretation and individual differences. Experts within the fields of long-term services and supports and religious and spiritual care should seek to create and refine objective definitions for these care preferences. The barriers to communicating about religious and spiritual care preferences in NHs cannot be ignored. Clarity would support the accurate, holistic, and person-centered assessment of these preferences. Understanding *origin of belief, levels of involvement, valence, time of importance, choice,* and *satisfaction* hinge on a basis of clear communication and unity in terminology.

The consequences of confused preference language may be best understood through a simple example. Instead of religious and spiritual preference stems, imagine that interviewed residents are asked "How important is it to you to take care of your mouth?" Two residents may both indicate that this matter is very important to them, yet simple conclusions and assumptions cannot be made from that information alone. This is because one resident may explain that brushing his teeth twice a day is an important hygiene principle, while another describes an adversity to swearing or using inappropriate language. In short, *language confusion* and *definitional wordage* must be addressed to properly fulfil NH resident preferences and provide religious and spiritual care.

Preference Stem Differences

Qualitative analysis in Phase 2 revealed several differences between responses to the *participating religious services or practices* stem and the *talking about spiritual matters* stem. First, within the *Origin of Belief* category, results question why external and internal comments

emerged more in the *participating in religious services or services* stem than the *talking about spiritual matters* stem. Perhaps *talking about spiritual matters* is seen more as a future event, rather than a measure of one's spiritual interest. Alternatively, spirituality may be seen as something that does not have an objective beginning. The religious stem's definition of religious practices or service may be more objectively placed in a developmental context. The number of comments in this category are small and may not be worthy of drawing conclusions upon. Nevertheless, this preliminary trend in the data warrants attention in future research and study.

Comments related to active, passive, and no *Levels of Involvement* for the preference stems show differences. More comments about involvement levels were made for the religious stem than the spiritual stem. These comments were also more evenly split among the three described levels (active, passive, none) in the religious stem than in spiritual stem, which showed an influx in passive commentary. How active one views his involvement in religious or spiritual preferences may affect how these preferences are fulfilled in NHs. Similar to results within the *Origin of Belief* category, these emerging trends in the data should not lead to confidence in these conclusions but, rather, should spur further investigation into the implications they may have for NH residents.

Qualitative results showed that *talking about spiritual matters* led to more *Valence* commentary from interviewees (both attractive and averse). Religious and spiritual preferences appear to be divisive; individuals identified circumstances that would lead them toward or away from religion and/or spirituality. With this in mind, religious and spiritual care preferences require consideration in coping strategies and care planning, yet attention to the opinions of individuals must be recognized and honored. These matters must be understood in the context of

caregiving settings and future research. The reason why *talking about spiritual matters* warranted more *Valence* commentary should be examined.

Lastly, it is noteworthy to consider that some residents viewed *participating in religious services or practices* as being more important in one's life currently or at a previous time whereas no residents made similar references to the *talking about spiritual matters* stem. The reason why the *participating in religious services or practices* stem generated more *Time of Importance* comments is worthy of consideration in future research.

Choice and Satisfaction

Residents interviewed about *participating in religious services or practices* and *talking about spiritual matters* both indicated that they had a significant amount of choice in the fulfillment of these preferences and were satisfied with the fulfilment of these preferences. This raises questions as to whether *Choice* and *Satisfaction* are more facility (environmentally) dependent or a result of the preferences themselves. Similarly, what implication may culture of choice have on caregiving and optimizing person-centered care? With a larger sample size, would correlations between *Choice* and *Satisfaction* continue among residents? Such questions emerge from the data conclusively, even in a small sample. High reporting of free choice and high satisfaction are encouraging as they supersede whether residents view religious or spiritual preferences as important.

Limitations

Limitations of Phase 2 are significant. Primarily, the small sample size of 5 interviewees per preference stem makes it exceptionally difficult to generalize results. Statistical relevance cannot be achieved through such a small sample, yet trends begin in the data. Furthermore, different residents were interviewed for the *participating in religious services or practices* than were for the *talking about spiritual matters* item. This creates issues with consistency and reliability in the data as it negates some conclusions comparing the results between the two stems.

This design was not meant for comparison between the preference stem, and interviewee differences could strongly influence qualitative results. For example, the different residents may simply speak more or offer additional spontaneous commentary. This could skew the number of comments about different stems and the analysis drawn upon them. Similarly, the questions in Phase 2's cognitive interviewing were not designed for specifically measuring religious and spiritual care preferences. The cognitive interview structure influenced the development of categories in the qualitative analysis, potentially preventing depth in the results.

Qualitative analysis is also influenced by author interpretation, as it is inherently more subjective, even with proper methodology and checks in place. Only two individuals in total were consulted in the process of interpreting the data, and thus, comments could have been counted falsely or categorized inappropriately. Personal biases and conceptual frameworks, though designed to be avoided, may unconsciously influence interpreting results. These biases and frameworks cannot be ignored and must be considered as potential limitations of the study.

Implications for Research and Practice

Results of this study most strongly support the need for clearer language and terminology for the religious and spiritual care preferences of NH residents. Integrated analysis of the quantitative Phase 1 and the qualitative Phase 2 both support these conclusions. Phase 1 revealed religion's importance to NH residents and demographic relationships to this importance. However, the phase offered limited analysis, because of potential language confusion and varied participant interpretations. Phase 2's qualitative study more robustly exposed how diverse resident definitions of religious and spiritual preferences are and how much confusion exists. Effectively, these analyses combine to illustrate how undefined these preferences are and how a lack of mutual understanding can negatively affect assessment and person-centered care in NHs.

The main implications of this mixed-methods study are related to care preference assessment, which can occur in both the research and clinical arenas. While some NHs have unique assessment tools, all NHs use the MDS to collect information from their residents. Section F of the MDS uses the same religious stem that was used in this study: how important is it to you to *participate in religious services or practices*? This study has uncovered interpretation inconsistencies within this stem as well as within the spiritual stem: how important is it to you to *talk about spiritual matters?* If care providers are to properly assess the religious and spiritual preferences of their residents, language confusion and definitional wordage must be resolved. The qualitative analysis of this project urges that more, diverse categories within religious and spiritual matters be developed to collect accurate and actionable information from residents.

Residents asked about *participating in religious services* or *practices and talking about spiritual matters* used wordage related to six major categories.

1) *Conversing*: Talking about or discussing religious or spiritual topics through one-on-one relationships or small groups.
2) *Faith-based practices*: Activities related to a resident's religion or spiritual beliefs. E.g. Services, bible studies, ceremonies, meetings.
3) *Locations:* The places one could visit, attend, or engage in activities. E.g. Synagogue, church.
4) *Clergy:* People who represent a religion formally and could visit, talk with residents, or provide support. E.g. rabbi, pastor, chaplain.
5) *Religious Affiliation:* Religion itself or religious descriptors with which residents identify. E.g. Jewish, Catholic, Christian.
6) *Beliefs:* A broad category encompassing what a resident believes to be religiously or spiritually true. E.g. Faith, existence, ethics.

Simply, the breadth of these preferences cannot be contained in the two stems used in this study, or, in the case of the MDS, the one religious stem used. Instead, a higher number of more accurate preference stems should be formed for more accurate assessment. This project data suggests creating question stems from the six subcategories that emerged from qualitative analysis of resident cognitive interviews. Potential stems that flow from this study's findings could include:

1) How important is it for you to *discuss religious or spiritual topics*?
2) How important is it for you to *participate in religious or spiritual activities*?
3) How important is it for you to *go to religious or spiritual locations*?
4) How important is it for you to *visit with religious or spiritual clergy*?
5) How important is it for you to *identify as a Christian, Jew, Muslim, etc.*?

6) How important is it for you to *express your religious or spiritual beliefs?*

Creating optimally worded preference stems is difficult; the procedure takes time and careful word selection. However, this study as well as research done by Curyto and colleagues (2015), Willis (2005), and Sullivan and colleagues (2013) show that cognitive interviewing is a very effective methodology. If further research progresses in creating more and better religious and spiritual preference stems, cognitive interviewing should be used to refine these stems. These procedures would produce improved stems for care providers and researchers alike. These stems could be added to unique provider assessments or to section F of the MDS. Such intervention would hypothetically reduce language confusion and lead to more accurate intake; with more accurate information, care providers can tailor care plans and provide higher quality care. Improved stems would aid researchers in collecting more accurate data as well. In lieu of using ineffective and limited questions, a new set of stems may get to the heart of what residents think, feel, and believe. Clinical and research advancement could bring NH residents the studied benefits of religious and spiritual care and result in higher quality of life.

Appendix A: Matrix of Reviewed Literature Articles

Author (Date)	Title	Journal	Purpose	Method and Sample Size	Location	Terminology	Main Findings
Hicks, T.J. (1999)	Spirituality and the Elderly: Nursing implications with Nursing Home Residents	Geriatric Nursing	To provide an overview of spiritual care with NH residents.	Review article of 21 articles	U.S. and International	Different definitions for religion (behavioral) and spirituality (internal).	Four distinct dynamic phases of providing spiritual nursing care exist. Nurses play a key role in delivering effective care.
Morey, John (2014)	The God Card Spirituality in the Nursing Home	JAMDA	To present research that has shown spirituality's presence and effects in NH	Topical article referencing 55 articles	U.S. and International	Religion and spirituality are used synonymously with spirituality used more.	Spiritual care is a key to the quality of life of NH residents. Very important to study, discuss, and implement.
Touhy, T.A. (2001)	Nurturing Hope and Spirituality in the Nursing Home	Holistic Nursing Practice	To examine how hope and spirituality are related in NH residents.	Descriptive correlational design study, interview questionnaire with 69 NH residents	Florida, U.S.	Religion as behavioral and external. Spiritual as broader and internal.	Through regression analysis, spirituality emerged as the only significant predictor of hope for those in long-term care.

Brandeis and Oates (2007)	The Judaic-Christian Origin of Nursing Homes	JAMDA	To show how NH originated out of Judaic Christian roots.	Topical article referencing and citing 20 articles in its construction	U.S.	Religious and spiritual are used synonymously with larger focus on religion.	NHs began out of Judaic Christian roots but for different reasons. These roots still influence facilities today.
Scandrett and Mitchell (2009)	Religiousness, Religious Coping, and Psychological Well-being in Nursing Home Residents	JAMDA	To measure the importance of religion among NH residents, describe their use of religious coping strategies, and examine the effect on psychological well-being	Cross sectional study of 141 cognitively intact residents in 2 NHs with standardized questionnaires -the SpNQ, BMLSS, FLQM, and a mood states scale: the ASTS	Boston, U.S.	Religion and spirituality used synonymously with a larger focus of religiosity.	Religion was important to most subjects studied. Residents for whom religion was somewhat or very important and who did not use negative religious coping strategies are more likely to have better psychological well-being
Erichsen and Bussing (2013)	Spiritual Needs of Elderly Living in Residential/ Nursing Homes	Evidence-Based Complementary and Alternative Medicine	To analyze the psychosocial and spiritual needs reported by NH residents and how these needs are connected with life satisfaction and mood states	Cross sectional study of 100 residents of 12 NHs with created survey, 14-item brief RCOPE, and Bradburn Affect Balance Scale;	Northern Germany	Differentiates religious and spiritual without providing clear definitions. Focus is on spirituality.	Elderly living in NH have specific psychosocial and spiritual needs, which are in most cases not recognized and cannot be addressed. Greatest needs are for generativity.

Uhlman and Steinke (1985)	Pastoral Care for the Institutionalized Elderly: Determining and Responding to	Journal of Pastoral Care and Counseling	To gather empirical information from residents about their own perception of pastoral care needs.	Cross sectional study with 32-item created questionnaire for 120 NH residents	Across the United States (sampled different regions)	Pastoral care is defined as religious or spiritual care exclusive to the Christian faith	Those with illness had highest desire for pastoral care. High preference for inspirational approaches to care over those with a punitive focus
Wilkes (2011)	Defining pastoral care for older people in residential care	Contemporary Nurse: A Journal for the Australian Nursing Profession	To define characteristics and meaning of pastoral care from the perspective of older recipients, family members, and pastoral care workers.	Qualitative descriptive analysis of interviews with 18 pastoral care workers and 11 older adults in residential care	Australia	Pastoral care is used as synonymous with spiritual care that is broader and more encompassing than religious care.	The defining characteristics of pastoral care were a trusting relationship, spiritual support, emotional support, and practical support. Pastoral care worker is a spiritual guide, confidante, and supporter
Haugan (2013)	The relationships between self-transcendence and spiritual well-being in cognitively intact nursing home patients	International Journal of Older People Nursing	To identify the relationships between self-transcendence and spiritual well-being in cognitively intact NH patients.	Cross sectional study with Facit-Sp spiritual well-being questionnaire for 202 cognitively intact NH residents from 44 NHs.	Mid-Norway	Spirituality and religion are both discussed and not noted as different. Religiosity is used in methods to determine spirituality.	Self-transcendence (both inter- and intrapersonal) is significantly related to NH patients' spiritual well-being

Appendix B: Chi-Square Crosses

Figure 9. Religious Participation Importance and Gender

Chi-Square Cross of Religious Participation Importance and Gender

Frequency
Percent
Row Pct
Col Pct

Table of PartRel by Gender			
PartRel(Importance of Religious Participation)	Gender(Gender)		
	Male	Female	Total
Very Important	32 12.60 23.70 39.51	103 40.55 76.30 59.54	135 53.15
Somewhat Important	21 8.27 33.87 25.93	41 16.14 66.13 23.70	62 24.41
Not Very Important	13 5.12 44.83 16.05	16 6.30 55.17 9.25	29 11.42
Not Important At All	15 5.91 53.57 18.52	13 5.12 46.43 7.51	28 11.02
Total	81 31.89	173 68.11	254 100.00
Frequency Missing = 1			

Statistics for Table of PartRel by Gender

Statistic	DF	Value	Prob
Chi-Square	3	12.5721	0.0057

Figure 10. Religious Participation Importance and Age Group

Chi-Square Cross of Religious Participation Importance and Age Group

Frequency
Percent
Row Pct
Col Pct

Table of PartRel by ResAgeOrd

PartRel(Importance of Religious Participation)	ResAgeOrd(Resident Age Group)				
	Middle-Adult	Young-Old	Middle-Old	Oldest-Old	Total
Very Important	8 3.31 6.30 36.36	26 10.74 20.47 57.78	38 15.70 29.92 54.29	55 22.73 43.31 52.38	127 52.48
Somewhat Important	8 3.31 13.11 36.36	9 3.72 14.75 20.00	17 7.02 27.87 24.29	27 11.16 44.26 25.71	61 25.21
Not Very Important	1 0.41 3.85 4.55	4 1.65 15.38 8.89	7 2.89 26.92 10.00	14 5.79 53.85 13.33	26 10.74
Not Important At All	5 2.07 17.86 22.73	6 2.48 21.43 13.33	8 3.31 28.57 11.43	9 3.72 32.14 8.57	28 11.57
Total	22 9.09	45 18.60	70 28.93	105 43.39	242 100.00

Frequency Missing = 13

Statistics for Table of PartRel by ResAgeOrd

Statistic	DF	Value	Prob
Chi-Square	9	7.9052	0.5437

Figure 11. Religious Participation Importance and Marital Status

Chi-Square Cross of Religious Participation Importance and Marital Status

Frequency
Percent
Row Pct
Col Pct

Table of PartRel by MaritalStat

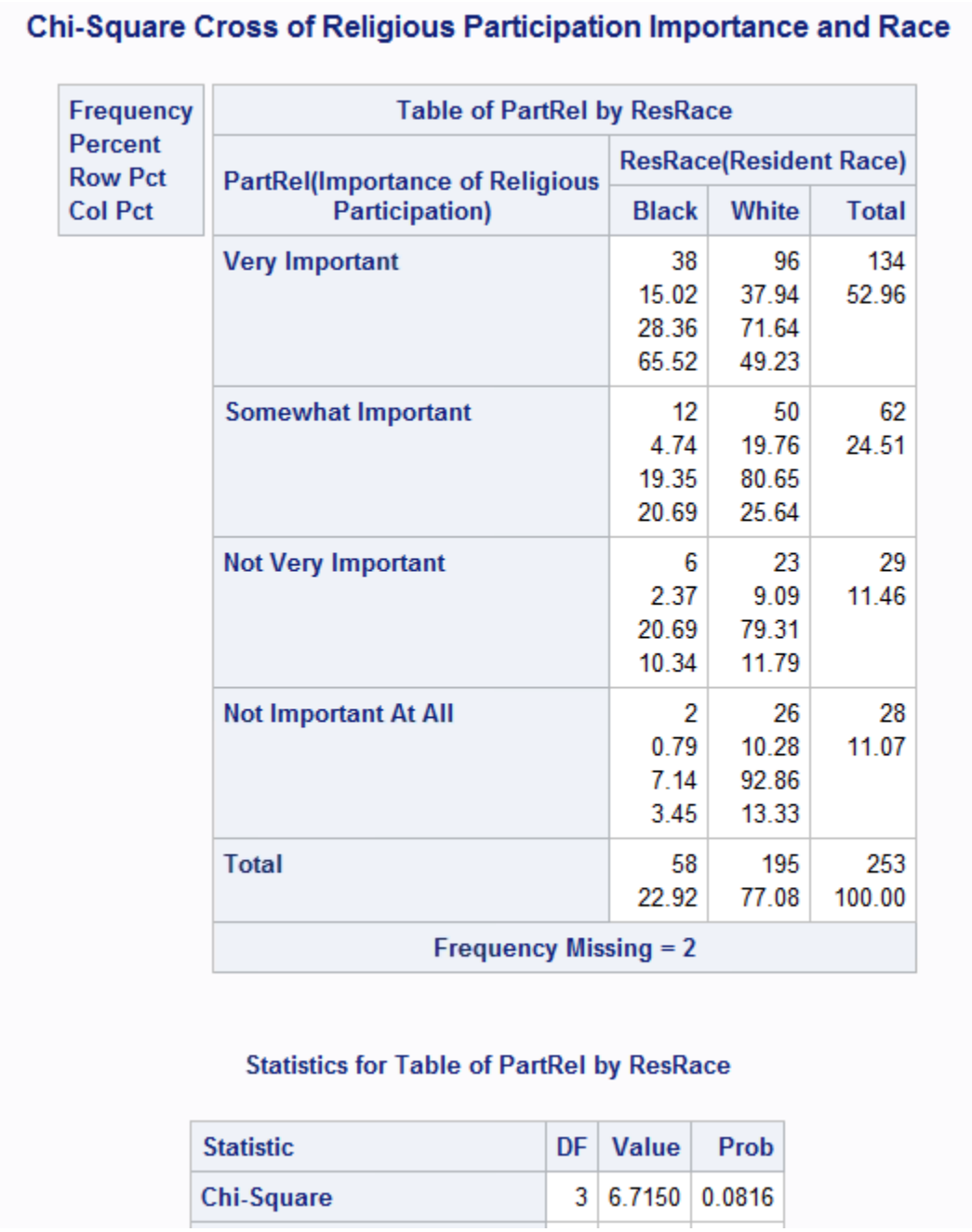
PartRel(Importance of Religious Participation)	MaritalStat(Martital status)				
	Never Married	Married	Widowed	Divorced	Total
Very Important	34 13.55 25.76 54.84	24 9.56 18.18 54.55	61 24.30 46.21 54.46	13 5.18 9.85 39.39	132 52.59
Somewhat Important	15 5.98 24.19 24.19	11 4.38 17.74 25.00	30 11.95 48.39 26.79	6 2.39 9.68 18.18	62 24.70
Not Very Important	5 1.99 17.24 8.06	6 2.39 20.69 13.64	11 4.38 37.93 9.82	7 2.79 24.14 21.21	29 11.55
Not Important At All	8 3.19 28.57 12.90	3 1.20 10.71 6.82	10 3.98 35.71 8.93	7 2.79 25.00 21.21	28 11.16
Total	62 24.70	44 17.53	112 44.62	33 13.15	251 100.00

Frequency Missing = 4

Statistics for Table of PartRel by MaritalStat

Statistic	DF	Value	Prob
Chi-Square	9	10.2073	0.3340

Figure 12. Religious Participation Importance and Race



Chi-Square Cross of Religious Participation Importance and Race

Frequency Percent Row Pct Col Pct	Table of PartRel by ResRace		
PartRel(Importance of Religious Participation)	ResRace(Resident Race)		
	Black	White	Total
Very Important	38 15.02 28.36 65.52	96 37.94 71.64 49.23	134 52.96
Somewhat Important	12 4.74 19.35 20.69	50 19.76 80.65 25.64	62 24.51
Not Very Important	6 2.37 20.69 10.34	23 9.09 79.31 11.79	29 11.46
Not Important At All	2 0.79 7.14 3.45	26 10.28 92.86 13.33	28 11.07
Total	58 22.92	195 77.08	253 100.00
Frequency Missing = 2			

Statistics for Table of PartRel by ResRace

Statistic	DF	Value	Prob
Chi-Square	3	6.7150	0.0816

Figure 13. Religious Participation Importance and Religious Affiliation

Chi-Square Cross of Religious Participation Importance and Religious Affiliation

Frequency Percent Row Pct Col Pct	Table of PartRel by ResRel			
PartRel(Importance of Religious Participation)	ResRel(Resident Religion)			
	Protestant	Catholic	Jewish	Total
Very Important	50 22.22 41.32 57.47	56 24.89 46.28 68.29	15 6.67 12.40 26.79	121 53.78
Somewhat Important	22 9.78 40.74 25.29	12 5.33 22.22 14.63	20 8.89 37.04 35.71	54 24.00
Not Very Important	11 4.89 39.29 12.64	7 3.11 25.00 8.54	10 4.44 35.71 17.86	28 12.44
Not Important At All	4 1.78 18.18 4.60	7 3.11 31.82 8.54	11 4.89 50.00 19.64	22 9.78
Total	87 38.67	82 36.44	56 24.89	225 100.00
Frequency Missing = 30				

Statistics for Table of PartRel by ResRel

Statistic	DF	Value	Prob
Chi-Square	6	27.6969	0.0001

Appendix C: Composite General Health Form

SF-36 QUESTIONNAIRE

Name:_____ **Ref. Dr:**_____ **Date:** _____

ID#: _____ **Age:** _____ **Gender: M / F**

Please answer the 36 questions of the **Health Survey** completely, honestly, and without interruptions.

GENERAL HEALTH:
In general, would you say your health is:

Excellent | Very Good | Good | Fair | Poor

GENERAL HEALTH:
How true or false is each of the following statements for you?

I seem to get sick a little easier than other people

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

I am as healthy as anybody I know

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

I expect my health to get worse

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

My health is excellent

Definitely true | Mostly true | Don't know | Mostly false | Definitely false

Appendix D: Cognitive Interview Black Form

Respondent ID: _____ Date of Interview: _____ Interviewer: _____

PELI IMPORTANCE QUESTIONS

Q__ How important is it to you to [insert italicized stem]:	**Very Important**	**Somewhat Important**	**Not Very Important**	**Not Important at All**	**Non-response**
	1	2	3	4	9
	Barriers related to the Person		**Barriers related to the Environment**		
If resident responds that "it is important, but can't do" (1) First ask, "*why do you feel you can't do it*?" [After recording the person's response, circle the barrier that best exemplifies their answer] (2) Next ask, "*if you <u>could</u> do that preference, how important would it be to you*?" [Record response on the Likert scale above] ***Now I want to ask you some questions about how you think about this topic.***	1 Functional Impairment	2 Sensory Impairment	3 Lack of Opportunity	4 Lack of Resources	5 Quality of Program
	Record resident response to "important, but can't do":				

A. "What were your thoughts as you gave your answer? What came to mind as I asked you this question? What did you think about?
B. "Can you give me an example of the [*insert italicized stem*] you were thinking of when you gave your answer?"
C. "What does the phrase [*insert italicized stem*] mean to you?
D. [For participants who responded not important or only somewhat important, restate the question] "Has this ever been more important to you?'' [If respondent seems uncertain of response option, ask about source of uncertainty]
E. How did you decide that (insert italicized stem) is ____ to you?
F. Tell me in your own words what this question is asking? Is there a different way we could ask this question? In a nutshell, what is this question asking?

LATITUDE OF CHOICE QUESTIONS

How much choice do you feel you have in [insert italicized stem]?	**Free Choice**	**Some Choice**	**No Choice**
	1	**2**	**3**
A. If free choice, why do you feel you have free choice?			
B. If some choice, why do you feel you have some choice?			
C. If no choice, why don't you feel you have any choice?			

PREFERENCE FULFILLMENT QUESTIONS

How well do you feel the preference [insert italicized stem] has been satisfied in the last month?	**Mostly or completely satisfied**	**A little or somewhat satisfied**	**Not satisfied at all**
	1	**2**	**3**
A. If mostly or completely satisfied, why are you satisfied with your preference being fulfilled?			
B. If a little or somewhat satisfied, what would make you feel more satisfied with your preference being fulfilled?			
C. If not satisfied at all, what are the reasons you have not been satisfied with your preference being fulfilled?			

"Changing One's Mind" QUESTION

In your opinion, what would make a person change their mind about how important [insert italicized stem] is to them? (For example one week saying the preference is important and the next week saying it is not important) Record verbatim response:

BIBLIOGRAPHY

Applebaum, R., Straker, J., & Geron, S. (2000). *Assessing satisfaction in health and long-term care: Practical approaches to hearing the voices of consumers*. New York, NY: Springer.

Argyle, Michael and Benjamin Beit-Hallahmi. 1975. The Social Psychology of Religion. Boston: Routledge and Kegan Paul.

Bangerter, L. R., Abbott, K., Heid, A. R., Klumpp, R. E., & Van Haitsma, K. (2015). Health Care Preferences Among Nursing Home Residents: Perceived Barriers and Situational Dependencies to Person-Centered Care. *Journal of Gerontological Nursing, 42*(2), 11-16.

Bangerter, L. R., Van Haitsma, K., Heid, A. R., & Abbott, K. (2015). "Make Me Feel at Ease and at Home": Differential Care Preferences of Nursing Home Residents. The Gerontologist, gnv026.

Beck S.L., & Towsley G.L., & Berry P.H., & Brant J.M., & Smith E.L. (2010). Measuring the quality of care related to pain management: A multiple method approach to instrument development. Nursing Research, 59, 85 - 92. 10.1097/NNR.0b013e3181d1a732

Bengtson, VernL., P.L. Kasschau, andP.K. Ragan. 1977. "The Impact of Social Structure on Aging Individuals." In James E. Birren and K. Warner Schaie (Eds.), Handbook of the Psychology of Aging. New York: Van Nostrand Reinhold

Brandeis, G. H., & Oates, D. J. (2007). The Judaic-Christian origin of nursing homes. *Journal of the American Medical Directors Association, 8*(5), 279-283.

Centers for Medicare & Medicaid Services (2010, May 10). MDS 3.0 RAI Manual: Section F. *American Health Care Association*. Retrieved from: http://www.ahcancal.org/

facility_operations/Documents/RAI_3.0/MDS%203.0%20Chapter%203%20Section%20F%20V1.02%20June%203,%202010.pdf

Centers for Medicare & Medicaid Services (2014, October 28). IMPACT act of 2014 & cross setting measures. *Centers for Medicare & Medicaid Services.* Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html

Chatters, Linda M. and Robert Joseph Taylor. 1989. "Age Differences in Religious Participation Among Black Adults." Journal of Gerontology: Social Sciences 44:S 183-S189.

Cohen, A. B. (2009). Many forms of culture. American psychologist, 64(3), 194.

Cohen, A. B., & Hill, P. C. (2007). Religion as culture: Religious individualism and collectivism among American Catholics, Jews, and Protestants. *Journal of Personality*, *75*(4), 709-742.

Cohen, A. B., Siegel, J. I., & Rozin, P. (2003). Faith versus practice: Different bases for religiosity judgments by Jews and Protestants. *European journal of social psychology*, *33*(2), 287-295.

Commerford, M. C., & Reznikoff, M. (1996). Relationship of religion and perceived social support to self-esteem and depression in nursing home residents. *The Journal of psychology*, *130*(1), 35-50. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/00223980.1996.9914986

Cornwall, Marie. 1989. "The Determinants of Religious Behavior: A Theoretical Model and Empirical Test." Social Forces 68:572-592

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Crum, R. M., Anthony, J. C. Bassett, S. S., & Folstein, M. F. (1993). Population-based norms for the Mini-Mental State Examination by age and education level. *Journal of the American Medical Association*, 269, 2389-2391.

Curyto, K., Van Haitsma, K. S., & Towsley, G. L. (2015). Cognitive Interviewing: Revising the Preferences for Everyday Living Inventory for Use In the Nursing Home. Research in gerontological nursing, 1-11.

Erichsen, N. B., & Büssing, A. (2013). Spiritual needs of elderly living in residential/nursing homes. *Evidence-Based Complementary and Alternative Medicine*, *2013*.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189-198.

Gerdner, L. (2000). Effects of individualized versus classical “relaxation” music on the frequency of agitation in elderly persons with Alzheimer’s disease and related disorders. *International Psychogeriatrics*, 12, 49-65.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine De Gruyter.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today, 24(2), 105-112.

Haugan, G., Rannestad, T., Hammervold, R., Garåsen, H., & Espnes, G. A. (2014). The relationships between self-transcendence and spiritual well-being in cognitively intact nursing home patients. *International journal of older people nursing*, *9*(1), 65-78.

Heid, A. R., Eshraghi, K., Duntzee, C. I., Abbott, K., Curyto, K., & Van Haitsma, K. (2014). “It depends”: Reasons why nursing home residents change their minds about care preferences. *The Gerontologist*, gnu040.

Hicks, T. J. (1999). Spirituality and the elderly: nursing implications with nursing home residents. *Geriatric Nursing*, *20*(3), 144-146.

Housen P., & Shannon G., & Simon B., & Edelen M.O., & Cadogan M., & Sohn L., & Saliba D. (2008). What the resident meant to say: Use of cognitive interviewing techniques to develop questionnaires for NH residents. The Gerontologist, 48, 158 - 169. 10.1093/geront/48.2.158

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualita- tive content analysis. Qualitative Health Research, 15, 1277– 1288. doi:10.1177/1049732305276687

Iannaccone, L. R. (1990). Religious practice: A human capital approach.*Journal for the scientific study of religion*, 297-314.

Kane, R.A., Kling, K.C., Bershadsky, B., Kare, R.L., Giles, K., Degenholtz, H.B.,… Cutler, L.J. (2003). Quality of life measures for nursing home residents. *Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, 58, M240-M248.

Katz et al. (1986). Improving the quality of care in nursing homes. *Institute of Medicine. Committee of Nursing Regulation.* Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/read/646/chapter/1

Koenig, Harold G., James N. Kvale, and Carolyn Ferrel. 1988. "Religion and Well-Being in Later Life." The Gerontologist 28:18-28.

Koenig, H. G., Weiner, D. K., Peterson, B. L., Meador, K. G., & Keefe, F. J. (1997). Religious coping in the nursing home: a biopsychosocial model. *The International Journal of Psychiatry in Medicine*, *27*(4), 365-376. Retrieved from http://ijp.sagepub.com/content/27/4/365.short

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, *29*(2), 312-317.

Lawton, M.P., Van Haitsma, K., Klapper, J., Kleban, M., Katz, I., & Corn, J. (1998). A stimulation-retreat special care unit for elders with dementing illness. *International Psychogeriatrics*, 10, 379-295.

Levin, Jeffrey S. and Robert Joseph Taylor. 1993. "Gender Differences in Religiosity Over the Life Cycle Among Black Americans." The Gerontologist 33:16-23

Levin, J. S., Taylor, R. J., & Chatters, L. M. (1994). Race and gender differences in religiosity among older adults: Findings from four national surveys. *Journal of Gerontology*, *49*(3), S137-S145. Retrieved from http://geronj.oxfordjournals.org/content/49/3/S137.full.pdf

Levin, J. S., & Chatters, L. M. (1998). Religion, health, and psychological well-being in older adults findings from three national surveys. *Journal of Aging and Health*, *10*(4), 504-531. Retrieved from http://jah.sagepub.com/content/10/4/504.short

Lynn M.R. (1986). Determination and quantification of content validity. Nursing Research, 35, 382 - 385. 10.1097/00006199-198611000-00017

Markides, Kyriakos S. and Richard Machalek. 1984. "Selective Survival, Aging, and Society." Archives of Gerontology and Geriatrics 3:207- 222.

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American psychologist*, *58*(1), 24.

Morley, J. E., & Sanford, A. M. (2014). The God Card: Spirituality in the nursing home. *Journal of the American Medical Directors Association*, *15*(8), 533-535.

Pargament, K. I., Sullivan, M. S., Balzer, W. K., Haitsma, K. S., & Raymark, P. H. (1995). The Many Meanings of Religiousness: A Policy-Capturing Approach. *Journal of Personality*, *63*(4), 953-983.

Pudrovska, T. (2015). Gender and health control beliefs among middle-aged and older adults. *Journal of aging and health*, *27*(2), 284-303.

Scandrett, K. G., & Mitchell, S. L. (2009). Religiousness, religious coping, and psychological well-being in nursing home residents. *Journal of the American Medical Directors Association*, *10*(8), 581-586.

Schneck, L., Meyer, R., Behr, A., Kuhlmey, A., & Holzhausen, M. (2013). Quality of Life in Nursing Homes: Results of a qualitative resident survey. *Quality of Life Research*, 1-10. Doi: 10.1007/s11136-013-0400-2

Sloane, Douglas H. and Raymond H. Potvin. 1983. "Age Differences in Adolescent Religiousness." Review of Religious Research 25:142—154

Smolicz, J. (1981). Core values and cultural identity. *Ethnic and racial studies*, *4*(1), 75-90.

Sullivan J.L., & Meterko M., & Baker E., & Stolzmann K., & Adjognon O., & Ballah K., & Parker V.A. (2013). Reliability and validity of a person-centered care staff survey in Veterans health administration community living centers. The Gerontologist, 53, 596 - 607. 10.1093/geront/gns140

Thompson, Edward H., Jr. 1991. "Beneath the Status Characteristic: Gender Variations in Religiousness." Journal for the Scientific Study of Religion 30:381-394.

Touhy, T. A. (2001). Nurturing hope and spirituality in the nursing home. *Holistic nursing practice*, *15*(4), 45-56.

Trucil, Dan (2015, December 3). Putting people at the heart of health care, research from AGS advances definition of person-centered care. *American Geriatrics Society*, Press Release. Retrieved from http://www.americangeriatrics.org/press/news_press_releases/id:6007

Uhlman, J., & Steinke, P. D. (1985). Pastoral care for the institutionalized elderly: determining and responding to their need. *Journal of Pastoral Care & Counseling*, *39*(1), 22-30.

Van Haitsma, K. *Assessing Preferences for Everyday Living in the Nursing Home Reliability and Concordance Issues*. Grant No: R21 NR011334-01.

Van Haitsma, K., Curyto, K., Spector, A., Towsley, G., Kleban, M., Carpenter, B.,…Koren, M.J. (2013). The Preferences for Everday Living Inventory (PELI): Scale development and description of psychosocial preferences responses in community-dwelling elders. *The Gerontologist*, 53, 582-595. Doi: 10.1093/geront/gns102

White House Conference on Aging (2015). 2015 White House Conference on Aging: Final Report. *White House Conference on Aging.* Retrieved from http://www.whitehouseconferenceonaging.gov/2015-WHCOA-Final-Report.pdf

Whitlatch, C. J., Piiparinen, R., & Feinberg, L. F. (2009). How well do family caregivers know their relatives' care values and preferences?. *Dementia*,*8*(2), 223-243.

Wilkes, L., Cioffi, J., Fleming, A., & LeMiere, J. (2011). Defining pastoral care for older people in residential care. *Contemporary nurse*, *37*(2), 213-221.

Willis G.B. (2005). Cognitive interviewing: A "how to" guide. Retrieved from http://appliedresearch.cancer.gov/archive/cognitive/interview.pdf

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., ... & Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the scientific study of religion*, 549-564.

Zinnbauer, B. J., Pargament, K. I., & Scott, A. B. (1999). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of personality*, *67*(6), 889-919.

Academic Vita

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Education

The Pennsylvania State University
The Schreyer Honors College
Bachelor of Science in Health Policy and Administration
Minor in Gerontology
Minor in Human Development and Family Studies

Honors

The Health and Human Development Honor Society
The President's Freshman Award
The President's Sparks Award
The Evan Pugh Scholar Award
College of Health of Human Development Graduation Student Marshall

Experience

Foxdale Village, Continuing Care Retirement Community
Friends Services for the Aging Intern; Health Services Assistant
- Developed orientation presentation of organizational functions and values
- Formulated checklist of skills, tasks, and competencies for new nursing staff
- Assisted in PointClickCare electronic health records implementation

Research

Presbyterian Senior Living
- Analyzed potential Accountable Care Organization partnerships for 32 managed campuses with 50 surrounding hospitals
- Created a multi-layer, interactive map to visually portray data results

Leadership

Cru (formerly Campus Crusade for Christ)
President, Executive Board Member, Emcee, Bible Study Leader, Mentor
- Facilitated weekly meeting for an average attendance of 130 people
- Planned teachings and guided discussion for 10 men in a weekly bible study
- Mentored 4 men weekly to transfer biblical application lessons
- Managed the prayer and weekly meeting teams by setting initiatives and coordinating events, while operating a $200 budget

American College of Health Care Administrators PSU Student Chapter
President, Executive Member, Pennsylvania Chapter Liaison
- Designed recruitment strategies to grow membership by 300%
- Organized meetings for students to discuss and network with professionals in Long Term Services and Supports Management
- Worked with Pennsylvania Chapter President to strengthen partnership

Health and Human Development: Trends in Longevity Research
Developer, Course Assistant
- Created a popular honors course to increase interest in longevity research
- Consulted with 3 faculty professionals to organize and implement class

Service

Volunteer: Centre County Senior Center
Participant and appointed Student Director: Cru Hampton Beach, New Hampshire 10-week 2014 Summer Mission
Participant: Cru North Africa 2-week 2015 Summer Mission