Facilitating gerotranscendence in cognitively intact persons in residential aged care facilities.

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Abstract

Gerotranscendence describes a distinct stage of the life cycle in which the borders, definitions and restrictions of an earlier stage in life are seen as no longer relevant, and an ageing person can find meaning in their current life situation. Some individuals living in residential care facilities may experience loneliness, depression and loss of meaning, while others, who experience this gerotranscendence, move beyond their physical setbacks and altered lifestyle to achieve a state of contentment, and increased life satisfaction. A narrative review of the literature was undertaken to determine what factors in the residential care environment can assist frail and ageing residents to transcend their losses, and experience enhanced life satisfaction, well-being, and peace of mind in approaching death. Eleven articles were reviewed for common themes; five emergent themes were identified, namely the need for individual rather than group interventions in spiritual care of residents, staff attitudes and manner of interaction determine the quality of the spiritual care they provide, staff need to have the time to provide quality interactions, staff require specific training to deliver appropriate spiritual care, and meaningful social interactions are also necessary for residents to facilitate development towards gerotranscendence. To enable the growing numbers of institutionalised elders to receive quality individual spiritual care, and to achieve gerotranscendence, residential care facilities should be structured and funded to allow these identified factors to be routinely implemented.

Introduction

As of 30th June 2014, there were 176,816 people in residential care across Australia. The average age of residents was 84.5 years, with 96% aged 65 years and over, and 18% having come from culturally and linguistically diverse (CALD) backgrounds (Department of Social Services, 2013a); Howe, Robinson & Andrews-Hall, 2007). The post-World War Two "baby boomer" generation is now approaching and passing 65 years of age, and may have a higher level of disability than previous generations. This is because in general, people are living longer, in part owing to increased survival after medical events such as heart attack and stroke (Department of Social Services, 2013b). The ageing of the baby boomer generation will result in the number of older people in Australia increasing 84.8% from 3.1 million to 5.7 million between 2011 and 2031. Because admissions to residential care facilities are characterised by people of increasing age and higher dependency who remain there until they die, there will be a significant increase in the numbers of elderly in residential care, with estimates indicating this may require a doubling in the aged care workforce in the next two decades (Department Social Services, 2013c); Howe et al., 2007).

Ageing can involve a decrease in well-being, as a person may feel increasingly defined by the failing of the body and the finitude of life (Fooken, 1982). Many, if not most, of the people in residential care have experienced compounded losses, including deterioration in physical health and mobility, loss of independence, possessions, home and privacy, and deaths of significant others. On entering residential care, people may experience disappointment, sadness, loneliness and depression, decreased quality of life, loss of meaning, despair, and existential dread at the approach of death (Frankl, 2000, pp.93, 129, 133-134; Haugan & Moksnes, 2013; Hood-Morris, 1996; Konnert, Dobson & Stelmach, 2009).

Despite having significant losses and functional impairments, a proportion of elderly people demonstrate “paradoxical” well-being and growth-oriented developmental change (Fooken, 1982). Schneider et al. (2006), attributed high subjective well-being in ageing people to a “sense of coherence”, a phenomenon thought to be constant from an early age, and manifesting as resilience in coping successfully with innumerable and complex stresses (Antonovsky 2000, cited in Schneider et al., 2006). However, Jung (cited in O’Connor 1985, p.95) proposed that the second half of life can be a time of significant personal growth, when people mature in their psychological functioning, in understanding themselves and others, and in growing towards a state of contentment and wisdom as they approach old age.

Tornstam (1997) introduced the term *gerotranscendence* to describe progression of the life cycle into a contemplative dimension of ageing, in which the borders, definitions and restrictions of an earlier stage in life are no longer applicable. With the development of gerotranscendence there is a shift in meta-perspective from a materialistic and pragmatic view of the world to a more cosmic and transcendent one, which is accompanied by an increase in life satisfaction. Gerotranscendence results in the development of peace of mind, a new feeling of communion with the spirit of the universe, and a redefinition of time, space, life and death (Patton, 2006). Interestingly, Braam et al. (2006), found cosmic transcendence (involving a redefinition of time, space and generations, and a sense of unity with the universe) to be related more to a framework of meaning in life than to religiousness (or religiosity). This is a stage reached through a process of deep reflection, transformation of life views and self-transcendence (Tornstom, 1996). A similar conclusion was reached by Frankl (Colledge, 2002), who stated that the search for meaning is the fundamental motivational force in human beings, and that fulfilment of each person’s individual meaning can only be achieved through self-transcendence. Thus, the spiritual dimension is the basis for the potential of self-transcendence.

Despite a lack of conceptual clarity about the nature of spirituality, internationally accepted definitions of spirituality include the dimensions of meaning, connectedness and transcendence (Hilbers et al., 2010; Reid, 2012; Lavretsky, 2010; Vermandere et al., 2012; Vivat, 2008). Spirituality can be described as the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred (Puchalski, cited in Balboni, Puchalski & Peteet, 2014;). Reed (1992) defined spirituality as the propensity to make meaning through a sense of relatedness, which may be experienced intra-personally (as a connectedness within self), inter-personally (in the context of others and the natural environment) and trans-personally (referring to a sense of relatedness to the unseen, God, or power greater than the self and ordinary sources). Similarly, Tornstam (1989, cited in Wang, 2011) posited three dimensions of gerotranscendence, in which the individual transcends, or moves beyond, a former stage of life, as they grow towards maturation and wisdom in old age. According to Tornstam, the three dimensions of gerotranscendence are the solitude transcendence (self), the coherence transcendence (social and personal relationships), and the cosmic transcendence (communion with the spirit of the universe or higher power). The concepts of intra-personal, inter-personal, and trans-personal self-transcendence in ageing people can, thus, be summarised in the term gerotranscendence.

Spirituality is seen as unique to the individual, and spiritual care is seen as integral to quality of life and well-being (Balboni et al., 2014; Gijsberts et al. 2013; Hood-Morris, 1996). Care of the whole person is emphasised in the bio-psycho-social-spiritual inter-professional model of healthcare, in which equal attention is paid to the spiritual dimension when working with patients /residents and families (Balboni et al., 2014; Hilbers et al., 2010; Puchalski et al., 2014; Sulmasi, 2002; Ustun & Jakob, 2005). Accordingly, spiritual care has become

increasingly integrated into the functions of the multi-disciplinary team in modern healthcare (Edwards et al., 2010, Puchalski et al., 2014).

The development of palliative care has established the importance of the multi-disciplinary team approach, in caring for the whole person (Doyle et al, 1996, p. 3.; Meaningful Ageing Australia, 2016, pp. 6, 19, 21, 23; Milligan, 2011; Puchalski et al., 2014). However, despite advances in whole person care, spiritual growth of persons in residential care may be hindered by our society's failure to recognise the potential of ageing persons to mature into wholeness in later life (Patton, 2006; Tornstam 1996), the ongoing dominant dysfunctional perspective seen in the healthcare system (Nygren et al., 2005), and by factors in the care environment itself (Wadensten, 2007).

There is strong evidence in the literature of the benefits of multi-disciplinary palliative care for the terminally ill and dying (Edwards et al., 2010; Puchalski et al., 2014; Vermandere et al., 2013). However, there is little clarity around the interaction of factors which enhance well-being, and which could facilitate transcendence, in non-terminally ill people in residential care. It appears that both trauma and normal life events can trigger post-traumatic growth or progress towards transcendence of the ordinary boundaries of the individual self (Coward & Reed, 1992, 1995; Frankl, 2006, p. 66 ; Weiss, 2014). Therefore, is it possible for more people in residential care to be assisted to do the same, as they approach the end of life?

A narrative review of the literature was undertaken to determine whether factors in the residential care environment can assist residents to transcend their losses, experience enhanced life satisfaction and well-being, and develop towards gerotranscendence. Findings are discussed, and recommendations are made for residential care staff, program managers, organisations, training and funding bodies. Central to this discussion will be the premise that ageing and old age should be regarded as a distinct stage of life in which former life

parameters have changed, and in which individuals can mature into wisdom and peace of mind in old age, and in approaching death.

Method

A narrative review of the literature was undertaken. Literature was derived from two searches of the PsycINFO and Pubmed databases. The searches were based on the following BOOLEAN search terms:

Search No. 1: (spiritual* OR transcend*) AND (contemplative care OR spiritual care) AND (nursing home OR institution* OR residential care) AND (aged care OR frail) NOT (palliative OR hospice OR dying OR dementia)

Search No. 2: gerotranscendence

The inclusion criteria were articles discussing gerotranscendence that were in English language, peer reviewed, journals, and that had populations in residential (aged) care facilities /institutions or nursing homes.

Articles were excluded if populations had diagnoses of dementia, or populations that were in hospitals, prisons, mental health facilities, palliative care, hospice, dying care, or terminal care. The reason for these exclusions was to limit the search of the literature to frail (aged) or chronically (but not terminally) ill, functionally impaired, cognitively intact persons in residential care facilities.

Results

Search No.1 resulted in finding a total of 67 relevant articles in PsycINFO, and 115 articles in PubMed databases. Search No. 2 resulted in finding a total of 72 articles in PsycINFO, and 36 articles in PubMed databases. Articles focusing on transcendence in residents with terminal illness or in palliative care settings were excluded, on the basis that diagnosis and treatment of a terminal illness could change the residents' perspective on living and dying.

From these articles, eleven articles were selected as the basis for the narrative review. Table 1 shows details and demographic characteristics of the 11 extracted studies, including information on populations, site /location of study, and length of occupancy in the residential care facility.

Table 1. Study details/particulars

Paper	Study Type	Country of Participants	Site of study	N	% Female	Age Range	Mean Age	Length of Occupancy
Haugan (2014)	Cross-Sectional	Norway	44 Nursing Homes	202 cognitively intact	72.3	65-104	86	Min. 6 months Mean 2.6 years
Haugan et al (2012a)	Cross-sectional	Norway	44 Nursing Homes	202 cognitively intact	72.3	65-104	86	Min. 6 months Mean 2.6 years
Haugan et al (2012b)	Cross-sectional	Norway	44 Nursing Homes	202 cognitively intact	72.3	65-104	86	Min. 6 months Mean 2.6 years
Haugan et al (2012c)	Cross-sectional	Norway	44 Nursing Homes	202 cognitively intact	72.3	65-104	86	Min. 6 months Mean 2.6 years
Jeong, McMillan & Higgins (2012)	Case Study	Australia	3 Nursing Homes	3 Residents 11 Family members 13 RNs	2/3 50 100	68-94	81	Not stated
Wang (2011)	Structured interviews	Taiwan	2 Nursing Homes 3 Assisted living facilities 1 Veteran's care home	195 residents	51.8	65-98	79.7	Not stated
Wang, Lin & Hsieh (2011)	Randomised Control Trial	Taiwan	2 Assisted living facilities & 1 Nursing Home	35 residents in experimental group 41 residents in control group	60 63.4	65-95	80.5	5.43 years
Wadensten (2010)	Interviews	Sweden	1 Nursing Home	6 Residents	63.4	68-96	Not stated	Min. 16 months
Wallace & O'Shea (2007)	Quantitative descriptive study	USA	1 Catholic Nursing Home & 1 Jewish Nursing Home	26	73	65-100	No mean age stated but 30% aged 86-90	92% 1 year

Bickerstaff et al (2003)	Content analysis of interviews	USA	6 Long Term Facilities in two cities	180	73.7	65-103	82	Min. 3 months Mean 3 years
Reker (1997)	Correlational	Canada	Community-living and several Institutions	87institutionalised 99 community-residing	68	65-94	77.8	Not stated

As seen in Table 1, the selected research articles originated from Norway and Sweden, Taiwan, Australia, USA and Canada, reflecting an international research base to the issues under question. The demographics demonstrated a similar age range of participants between 65-100 years, with a mean age of around 83 years. The study populations also demonstrated the high proportion of females (mean percentage of females in sample was 67%) in (non-veteran) residential care facilities. Diverse methodological approaches were apparent, including both quantitative and qualitative studies, and one randomised control trial.

Limitations of the studies included omission of information about length of occupancy in some of the residential care facilities; responses to questionnaires possibly affected by frail residents fatiguing, and non-random sampling; limitations of cross-sectional designs with respect to causality; and difficulty generalising to larger or more diverse populations in other residential care facilities.

Table 2 presents the primary outcome measures, analysis and key findings in the quantitative studies, and Table 3 presents those of the qualitative studies.

Table 2. Key Study Findings – *Quantitative* Studies

Study	***Primary Outcome Measures***	***Analysis***	***Key Findings***
Haugan (2014)	Herth Hope Index Purpose-in-Life Test Self-Transcendence Scale Nurse-Patient Interaction Scale	Structural Equation Modeling	- Nurse-patient interaction influences hope, meaning in life and self-transcendence in cognitively intact nursing home patients. - Finding ways to enhance Nursing Home caregivers' ways of interacting and communicating with Nursing Home patients might significantly influence patients' hope, self-transcendence and meaning in life. - Hence Nursing Home staff (nurses) should be given more time for interacting with their patients. Continuity of care and mutuality in the caring relationships are also important.
Haugan et al (2012a)	Self-Transcendence Scale; Nurse-Patient Interaction Scale; Functional Assessment of Cancer Therapy – General (QoL) Scale; Functional Assessment of Chronic Illness Therapy – Spiritual Well-being Scale.	Independent sample t-tests Correlation analysis Multiple linear regression analysis	- This study utilised a two-factor construct of self-transcendence, consisting of inter- and intra-personal aspects: - Inter-personal self-transcendence (having hobbies or interests, being involved, sharing wisdom, helping others in some way, having ongoing interest in learning) was positively related to social, functional and spiritual well-being. - Intra-personal self-transcendence (accepting myself, adjusting well to present situation, adjusting well to physical abilities, finding meaning in past experience, able to move beyond things that once seemed important) was significantly related to emotional, social, functional and spiritual well-being. - Nurse-patient interaction related significantly to physical/emotional/functional well-being. Hence, nurse-patient interaction facilitating Nursing Home patients' self-acceptance & adjustment significantly would increase well-being among these individuals. - Age and gender were not significant predictors of multidimensional well-being. However, regarding functional and spiritual well-being, gender was significant (Female >Male).
Haugan et al (2012b)	Self-Transcendence Scale Nurse-Patient Interaction Scale	Correlational statistics Exploratory Factor Analysis	- Nurse-patient interaction significantly influenced intra-personal self-transcendence items 'accepting myself', 'adjusting well to present situation', & 'finding meaning in past experiences'. - Nurse-patient interaction had an indirect mediated influence on inter-personal self-transcendence items 'having hobbies & interests I enjoy', 'helping others in some way', 'having ongoing interest in learning', and 'able to move beyond things that once seemed so important'. - Nurse interactional qualities such as being present, listening, empathic understanding, respecting, accepting and acknowledging the resident as a person to be taken seriously can contribute to self-transcendence and thereby increased well-being in cognitively intact residents in long term care.

Haugan et al (2012c)	Self-Transcendence Scale Functional Assessment of Cancer Therapy General (FACT-G) Quality of Life	Structural Equation Model Analysis (LISREL 8.8) Chi-square analysis	- Self-transcendence relates to functional, emotional and social well-being and indirectly influences physical well-being (mediated by functional and emotional). - Nursing interventions that facilitate interpersonal and intra-personal self-transcendence are a potential resource for multi-dimensional well-being, through supporting patients' self-acceptance and adjustment.
Wang (2011)	Gerotranscendence Scale; Barthel's Index (Activities of Daily Living (ADLs) /physical ability); Geriatric Depression Scale (Short form); Inventory of Socially Supportive Behaviour; Life Meaning Scale; Life Satisfaction Scale.	Chi-square analysis Factor loadings, t-scores Confirmatory factor analysis	- Development towards gerotranscendence (GT) of institutionalised older people is associated with social and spiritual factors (social support, meaning of life, and life satisfaction). - With adequate social support systems, elders show a sense of belongingness, love and connection with others. Within a physically supported environment, elders' physical decline does not impede the development of GT. - Residents with severe depressive symptoms have lower GT.
Wang, Lin & Hsieh (2011)	Gerotranscendence Scale Geriatric Depression Scale (Short Form) Life Satisfaction Scale	Paired t-test Wilcoxin McNemar ANCOVA	- Gerotranscendence (GT) allows elders to recognise change of life perspective, to realise that GT is critical in old age, and can be stimulated to reach GT. - In this study, elders over 80 years received less benefit from the GT program. - GT support group can slightly reduce institutionalised elders' depression. - GT support group significantly increased institutionalised elders' life satisfaction. - Professional caregivers must be educated and trained in the application of GT principles. - The concept of GT should be included in professional health education criteria. - Ongoing GT support groups for residents can promote life satisfaction.
Wallace & O'Shea (2007)	Spirituality & Spiritual Care Rating Scale	Correlational and Factor Analysis	- Residents had moderately positive views of spirituality and the spiritual care they received. - Residents felt positively about many nursing interventions supporting spirituality, E.g. arranging clergy visits, kindness, spending time listening (presence), & showing respect for residents' needs. - Nurses play a significant role in promoting spirituality, multiple dimensions of health and quality of life.

Reker (1997)	1. Zung Self-Rating Depression Scale 2. Life Attitude Profile - Personal Meaning, Will to meaning, Future Meaning & Choice/Responsibilities 3. Future Orientation Scale - Optimism 4. OARS Manual – Social Resources, Physical Health	Means and SDs Bivariate correlation Four-step multiple hierarchical regression analysis	-	For institutional elderly, the existential variables of a sense of personal meaning, choice, and optimism, coupled with meaningful social contacts offer ways of transcending losses and feelings of depression in old age. - In addition to this, logotherapy may be one method of restoring hope by making people aware of their inherent power to stop feeling victimised and take control of their lives.

Table 3. Key Study Findings – *Qualitative* Studies

Study	***Source of Qualitative Data***	***Analysis***	***Key Findings***
Jeong, McMillan & Higgins (2012)	Values Clarification Worksheet Data from observations, interviews & document analysis	Thematic Content Analysis of the phenomenon of Advance Care Planning (ACP) Software Program Nvivo 7	- The Values Clarification Worksheet tool examined the person's beliefs about Quality of Life (QoL) and their personal ethical/spiritual beliefs with respect to life-sustaining treatments, in view of their past experience, social relationships, family concerns, how they dealt and coped with crises in life, and how they made decisions. This process enhanced the essence of "who they were and how they lived their life", enabling expression of their spirituality. - ACP can therefore facilitate the older person to continue to realise the "essence of their being", to experience gerotranscendence in end-of-life moments, and to die in a way consistent with their "essence of being", and as they wish. ACP can support the older person and their family to a self-determined life closure.
Wadensten (2010)	Explorative interviews using open-ended questions before and after 15 months of staff intervention based on theory of gerotranscendence.	Qualitative Content analysis Thematic analysis	- Elements in the caring environment can facilitate or impede the development of gerotranscendence. - Supporting older residents towards gerotranscendence included ways to reduce pre-occupation with the body, ideas about conversations that stimulate personal growth and different ways to reminisce. - Some residents performed life reviews and thought about their lives, and this was further stimulated by staff behavior. Certain residents became more reflective and residents were noted to be engaging in more reflective conversations. Residents commented that because of the intervention they now talked about more private matters in social interactions. - The life review process should be seen as part of promoting healthy ageing
Bickerstaff, Grasser, & McCabe (2003)	Analysis of responses of 95 residents (n=180) whose responses demonstrated evidence of self-transcendence	Thematic Content Analysis of cluster categories based on Reed's (1991) Self-Transcendence Theory	- Five main themes emerged in Nursing Home residents who transcended losses – feeling valued by self and others, responding to the needs of others, love and memory of love continue to have meaning, keeping mind, body & spirit active give meaning to life, and a belief in a higher power gives meaning to suffering and loss. - Recommend providing opportunities in long term care for structured reminiscence, offering alternatives to losses such as ways of helping others, and validation of goals & values and of individuals' spirituality, however this may be expressed.

Five emergent themes (Braun & Clarke, 2006; DeSantis & Ugarizza, 2000) were derived from a narrative analysis of the articles used in the review. These were:

(i) the need for individual rather than group interventions in spiritual care

(ii) the quality of spiritual care depends on staff attitudes and the way staff interact with residents

(iii) staff need time to provide quality interactions which can facilitate self-transcendence in residents

(iv) meaningful interpersonal /social interactions are a necessary part of spiritual care, and

(v) staff require specific training to deliver appropriate spiritual care, in order to facilitate transcendence in residents.

Each of these themes and the details of them, is discussed in detail below with reference to the articles discussing these themes.

(i) *Resident /staff member interaction is more beneficial on a one-on-one basis, rather than in a group.* Wadensten (2010) recommended the importance of staff setting an intention to establish a relationship when communicating with each resident, and focusing on the resident as a unique person. Nurse-patient interaction facilitated both intra- and inter-personal self-transcendence in nursing home residents, as well as having a significant impact on residents' physical, emotional, social and functional well-being. Nurse-patient interaction is a resource for connectedness, hope, self-acceptance and adjustment, meaning in life and self-transcendence in nursing home patients (Haugan et al., 2012a, 2012b, 2012c; 2014).

(ii*) The quality of the resident /staff member interactions is enhanced through staff spending time, listening, building a trusting relationship, treating the resident as a unique person, and encouraging life review and in-depth discussion of personal meaning, attitudes, values and beliefs* (Haugan et al., 2012a, 2012b, 2012c; 2014; Wallace & O'Shea, 2007). Detailed Advance Care Planning, in which residents' attitudes, values and beliefs were explored and clarified, facilitated their realisation of the essence of "who they were and how they lived their lives". In this way residents in long term care can be supported to experience gerotranscendence, and to achieve a self-determined life closure, by dying in a way consistent with their "essence of being" (Jeong et al., 2012).

(iii*) Staff need to have the time to be able to provide quality interactions with residents to facilitate intra-personal transcendence***.** Nursing home residents felt positively about nurses' one-on-one interventions which supported their spiritual care, including spending time listening, and showing kindness and respect for their spiritual needs **(**Haugan et al., 2012a, 2012b, 2012c; 2014; Wallace & O'Shea, 2007). Staff can assist residents in keeping mind, body and spirit active, in order to give meaning to life, and by helping them to explore their beliefs (Bickerstaff, Grasser & McCabe, (2003). Elderly institutionalised residents with high scores on the existential variables of personal meaning and optimism, coupled with meaningful social contacts, appeared to have transcended their losses and were less likely to suffer from depression (Reker, 1997).

(iv) *Residents need meaningful social contacts for enhanced well-being.*

Nursing home residents were able to transcend, or move beyond, their own losses and difficulties through focusing on responding to the needs of others (Bickerstaff, Grasser & McCabe (2003). Among institutionalised older adults from a range of elder care facilities, a

higher degree of social support, life satisfaction and meaning in life were related to a higher degree of gerotranscendence. Increase in gerotranscendence was also accompanied by a change in residents' negative view of aging (Wang, Lin & Hsieh, 2011).

(v) *Staff require appropriate training in spirituality, spiritual care and listening skills, and the principles of gerotranscendence.* Nursing home residents were noted to be more reflective, and to engage in more reflective conversations with other residents, when staff were given gerotranscendence guidelines aimed at promoting life review, and encouraging and supporting perceptions of positive ageing (Haugan et al., 2012a, 2012b, 2012c; 2014; Jeong et al., 2012; Wadensten, 2010; Wallace & O'Shea, 2007; Wang, Lin & Hsieh, 2011).

Discussion

The aims of this narrative review were to determine the key factors which can facilitate well-being, quality of life and gerotranscendence in cognitively intact persons in residential care facilities. Five emergent themes were derived from the analysis of the literature, namely the need for one-on-one resident-staff member interaction, the importance of staff engaging in quality interactions, staff need to have the time to build quality relationships with residents, residents need meaningful social interactions, and staff require training in spirituality, spiritual care and gerotranscendence.

Spirituality can be seen as a resource that is potentially always present in the person, and is integral to human development, enhancement of health, and evolution of consciousness (Reed, 1992). More specifically, spirituality can be seen as the propensity of the individual to make meanings through a sense of relatedness or connectedness, described by Frankl as "*the will to meaning*" (Frankl, 1988, pp. 26-27, Reed, 1992).

In the context of residential care facilities, staff member-resident interaction is fundamental to the support of spiritual expression, and, thus, to the encouragement of gerotranscendence (Haugan et al., 2012c, 2014; Hermann, 2007; Wadensten, 2010, Wallace & O'Shea, 2007; Wang, 2011). Hence, staff will require training and sufficient time to participate in quality one-on-one interventions with residents (Chan, 2009; Ronaldson et al., 2012). While in the past spiritual care has been one of the roles of nurses, this may no longer be possible in the residential care environment, where nurses have limited time to spend one-on-one with residents, other than when engaged in clinical interactions. In residential care facilities, it is the personal carers, staff employed to run the "lifestyle" programs (e.g. outings, singing groups, exercise programs, etc), chaplains, pastoral care practitioners and volunteers, who potentially are able to spend time with individual residents, provide continuity of care,

and build the necessary trusting relationships to facilitate the development of gerotranscendence.

This process is best facilitated through one-on-one interactions incorporating both life review and in-depth Advance Care Planning. Life review is based on a therapy approach later developed into Narrative Therapy, whereby people re-structure their past into a positive and integrated story (Geldard & Geldard, 2012, p. 128). Advance Care Planning is based on the core values of personal autonomy, informed decision making, truth telling and control over the dying process (Johnstone & Kanitsaki, 2009). In utilising life review and in-depth Advance Care Planning as tools to determine what is important to each individual, a supportive listener helps the person to reflect on their past, and integrate their beliefs and attitudes into an enhancement of present and future including, but not limited to, goals of medical treatments and end-of-life care (Haugan et al., 2012a; Bickerstaff et al., 2003; Jeong et al., 2012; Wadensten, 2010; Wang, 2011).

Recommendations

The following recommendations are based on the emergent themes from the literature, and are aimed at assisting residents in aged care facilities to transcend chronic illness, ageing and loss, and experience enhanced well-being and quality of life. Additional literature has been used to clarify and support these recommendations.

From the literature, it is clear that the residential care environment provides the background on which spiritual care is provided (Haugan et al., 2012a). Being person-focused and exploring what is of importance to the individual resident is the way to connect with each person and facilitate intra-personal self-transcendence (Haugan et al., 2012a; Touhy et al., 2005). As well, to focus on a person's inner strength is to apply a positive health perspective

that can counterbalance the dominant dysfunctional perspective often taken in the health care system (Nygren et al., 2005).

Staff require access to training to increase their level of comfort with the multi-dimensional concept of spirituality, in order to gain an understanding of their own spirituality, and to learn to function as part of an inter-disciplinary team (Chan, 2009; Vermandere et al., 2013). Training for staff should also include the theory and application of gerotranscendence principles, in order to facilitate staff members' perceptions of positive ageing, their understanding of individual residents, and how to support them in developing towards gerotranscendence (Wang et al., 2011).

Staff can learn to develop interventions based on gerotranscendence principles, by assisting residents to focus less on the (failings of) the body, and spend time reflecting more about their lives, in terms of what they find important and meaningful. A range of activities and interventions based on individual choices and preferences can then be made available to residents, in order to encourage them to find meaning and purpose through relationship and connection. In this way staff can reinforce "*patterns of connectedness*" (Reed, 1992, p.350) within and between residents, thereby facilitating intra- and inter- self-transcendence. This process could be extended through staff leading groups aimed at facilitating residents' participation in reflective social interactions, or gerotranscendence support groups focusing on positive ageing. (Meaningful Ageing Australia, 2016, pp. 17, 18, 20, 21; Tornstam, 1996; Wadensten, 2010, Wang et al., 2011).

Development of the inter-personal dimension of self-transcendence occurs through expansion of personal boundaries and increased generativity (Bickerstaff et al., 2003; Reed, 1991). A person can be assisted to decrease their focus on their physical limitations and suffering, and instead appreciate that they may be able to help others, that their wisdom can be shared with family or friends, and /or they can find support and inspiration through

contributing to meaningful, i.e. reflective social and group interactions (Haugan et al., 2012c; Bickerstaff et al., 2003; Wang, 2011). Facility staff could explore opportunities for residents to expand their personal boundaries by helping others. Development of gerotranscendence can be facilitated by enhancing interpersonal and social connections between residents in this way (Bickerstaff et al., 2003; Wang et al., 2011). While many residents would have difficulty helping others directly, owing to their own disabilities and the need for safety supervision, lifestyle staff may be able to help some residents to find meaningful ways to contribute to others and to life in the facility, such as sitting with someone who is non-verbal and lonely, and participating in group activities such as cutting and arranging flowers together, to beautify indoor spaces.

Program managers require training themselves in gerotranscendence, so as to be aware of the importance of training for other workers, and to facilitate gerotranscendence interventions and groups with residents. Program extension could include psycho-education for residents about positive ageing and transcendence in old age, perhaps through participation in gerotranscendence support groups. As well, staff trained in facilitating relaxation (Davis et al., 2008, pp. 41-46; Reig-Ferrer et al., 2014) and mindfulness groups (Davis et al., 2008, pp. 58-63; Williams et al., 2007, p. 59), could also help residents to socialise, feel less isolated with their own problems, and worry less about the future, by learning to focus with acceptance on the present moment.

Summary

Self-transcendence occurs when a person finds meaning in their life and develops a shift in view to reach beyond him or herself. Spiritual care can facilitate this shift in a resident's life-view beyond him or herself, to develop expansion of personal and temporal

boundaries, and increased well-being and life-satisfaction (Frankl, 2006, p.83; Haugan et al., 2012b, 2014; Tornstam, 1997; Wang, 2011; Wadensten, 2010; Wang et al., 2011).

Spiritual care is facilitated by one-on-one staff /resident interactions aimed at establishing a narrative relationship, affirming each person's individuality and assisting them in meaning-making (Wadensten, 2010). This process is supported by adoption of the palliative care bio-psycho-social-spiritual model, in which chaplains and pastoral care practitioners are included in regular ongoing clinical team meetings and teamwork of the multi-disciplinary team (Doyle et al., 1996; p.18; Puchalski et al., 2014).

A number of barriers to the provision of quality spiritual care stem from the fact that there is a general lack of knowledge about self- and gerotranscendence. This lack of awareness is reflected in insufficient staffing in residential care facilities, lack of time for staff to interact one-on-one with residents, lack of awareness of the importance of integrating pastoral care staff into the clinical team, and lack of training of the staff who spend the most time with residents.

This narrative review has confirmed that staff need to have the training and the time to provide residents with quality one-on-one spiritual care interactions, and to facilitate meaningful social contacts and support groups for residents (Haugan et al., 2012a, 2012b, 2012c, 2014; Wadensten, 2010; Wang, 2011). As the baby boomer generation continues to age, with the projected increase in numbers of older people needing residential care, there will be an increasing need for implementation of quality spiritual care and interventions based on the principles of gerotranscendence. Recommendations of this review include education for healthcare professionals and managers in the principles of gerotranscendence, access to ongoing professional development and training for staff in gerotranscendence and spiritual care, and continued lobbying for improved funding and staffing levels to improve the holistic care of people in residential care facilities.

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