CE Ethics Series

1.5 ANCC Contact Hours

Silent Illumination

A Case Study Exploring the Spiritual Needs of a Transgender-Identified Elder Receiving Hospice Care

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With a growing population of transgender-identified elders in the United States, their unique spiritual end-of-life needs are coming to light. This article presents a case study of a hospice volunteer who used skillful means as an artist to help a transgender-identified woman express her spirituality in the last 6 months of her life. After data analysis, 4 themes emerged related to the expression of spirituality by lesbian, gay, bisexual, transgender, and queer (LGBTQ) elders at end of life. The themes that emerged included (1) the human element in advocacy for spiritual care, (2) the importance of safe spaces for reflection and meditation, (3) the importance of skillful means to work with LGBTQ people, and (4) acknowledgement of gender identity as a spiritual need. This case study serves as a springboard to advance research into the end-of-life needs of LGBTQ elders and the ways in which members of the hospice team can support spiritual care and alleviate suffering for this population.

KEY WORDS

elder, hospice care, LGBTQ, transgender

Approximately 1.4 million Americans identify as transgender. Of the people who identify as transgender, approximately 967 000 are 25 to 64 years of age, and 217 000 are older than 65 years.[1] For the first time in history, there is a visible cohort of transgender-identified (TI) older adults.[2] Approximately 95% of people using hospice in 2016 were older than 65 years.[3] Therefore, it is more likely to encounter TI older patients in hospice. However, few data exist on the intersectionality of gender identity, aging, and needs for care at end of life (EOL).[2,4]

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BACKGROUND AND SIGNIFICANCE

The Institute of Medicine[5] report "Dying in America" was presented in September 2014. The report's key findings suggest that current models of palliative care are not adequately addressing the needs of people who are nearing the EOL and their care partners.[5] Although there are increasing numbers of TI people across the life span, transgender elders older than 60 years are members of a cohort that has been called "Generation Silent," a name given to the almost invisible cohort of aging lesbian, gay, bisexual, transgender, and queer (LGBTQ) people.[6]

Key Terms

Any discussion on the health and well-being of TI individuals should begin with some key terms. For clarity, some terms will be defined in the way they will be used in this article. Witten[4] wrote, "New linguistic descriptors are emerging as younger TI people create new terms to self-describe their gender identity." We are using terms as they are currently being used at this time. See the Figure for a list of key terms. A key term that will be discussed in greater detail below is *transitioning*.

A component of the life journey of a TI person is the process of *transitioning*, defined as the developmental milestones of affirming a gender identity that is different from the one assigned at birth.[7] Of those 65 years or older, 97% transitioned at 55 years of age or later.[8] The transition process may include a social transition, the use of hormones, or gender-confirming surgery or some combination of these 3 components.[9] The social transition may include "coming out," selecting gender expression consistent with the new gender identity, choosing a new name, modifying the original birth certificate, and getting new identification (driver's license or passport).[2] For many TI people, the transition may only be a social one because of personal choice, lack of financial means to pay for hormonal supplementation or gender-affirming surgery, or fear of the challenges (physically, emotionally, and spiritually) of transitioning. During the lifetimes of some TI elders, self-disclosure of their gender identity has made them or other members of their community the targets of verbal abuse, physical attacks, and death.[10,11]

Chosen family (family of choice) significant people in their support system of the LGBTQ elder. Care partners could include, but are not limited to, family related by blood, civil partnerships, spouses, adult children, siblings, parents, friends, or any other constellation of people.[19]

Cisgender is a term used to describe people who, for the most part, identify as the gender they were assigned at birth. For example, if a doctor said "it's a girl!" when you were born, and you identify as a girl, then you could be described as cisgender.[37]

Gender identity is an individual's internal sense of being a man, a woman, both, neither, two-spirit, multi-gender, bi-gender, or another configuration of gender. Since gender identity is internal, one's gender identity is not necessarily visible to others.[19]

Queer An umbrella term sometimes used by LGBTQA people to refer to the entire LGBT community. It is important to note that the word queer is an in-group term, and a word that can be considered offensive to some people, depending on their generation, geographic location, and relationship with the word.

Trans/transgender: A simple definition is someone whose gender differs from the one they were assigned at birth. Trans people may identify as male or female, or they may feel that neither label fits them.[19]

Transgender-identified/transgender identifying person (TI) is a person whose gender identity differs from the one they were assigned at birth (natal body). Transgender can be an umbrella term/descriptor for individuals who identify as transgender, gender blending, gender-nonconforming, or nonbinary gender identity.[2]

Transitioning the processes of affirming a gender identity that is different from the one assigned at birth.[7] The transition may occur socially with a name change, pronoun change or a change in the style of gender expression.[2] Transitioning may also include seeking medical intervention with hormones or a variety of surgical procedures, including gender reassignment surgery.[9]

Sexual orientation: The type of sexual, romantic, and/or physical attraction someone feels toward others. Often labeled based on the gender identity or gender expression of the person and who the person is attracted towards. Common labels: lesbian, gay, bisexual, pansexual, etc.[38]

FIGURE. Definitions of selected terms related to gender identity and sexual orientation.

Spirituality at the End of Life

Spirituality is defined as the aspect of humanity that refers to 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.[12] Additionally, Western Zen Buddhist philosophy has a word *Upaya*,[13] defined as "being skillful in means" to evoke the spiritual nature in another by statements or actions adjusted to their needs and adapted to their capacity for comprehension. Spiritual care has been one of the key components of palliative care since the modern hospice era began in the late 1960s at St Christopher's Hospice, founded by Dame Cicely Saunders.

On the interdisciplinary hospice team, each member, including patient/family volunteers, provides care for the human spirit.[14] Within the domain of nursing practice internationally, spiritual care interventions include facilitating the expression of spiritualty, creating space and time for spiritual care practices, providing a compassionate presence, listening deeply, and bearing witness.[15,16]

During an advanced illness, these elders have spiritual needs; however, because of their gender identity, TI persons may be isolated or severed from the faith community by choice, social pressure, or by order of the religious authority.[17]

What is known from research on the needs of TI people and their caregivers at EOL suggests that they, too, are facing challenges receiving high-quality spiritual care.[2,17]

Safety as a Spiritual Need

Emotional and physical safety is an essential component of the spiritual well-being of TI people. However, in the life history of TI adults, emotional and physical safety has not always been taken for granted during interactions with the general public and with the health care system and in seeking spiritual care. As to interactions in the general public, many TI people reported violations of their personal safety. For example, the 2015 US Transgender Survey found that nearly half (46%) of respondents were verbally harassed in the past year, 39% of respondents experienced

serious psychological distress in the month before completing the survey, and nearly 1 in 10 respondents (9%) were physically attacked in the past year.[18]

Concerns about emotional and spiritual safety extend to encounters with the health care system. Currently, this generation of TI elders is not always welcomed into the health care system with compassionate, loving care by the interdisciplinary team, including spiritual care providers within the health care system.[19] When considering seeking care from hospice and palliative care providers, 2 of the greatest fears of TI elders when they reveal their gender identity ("come out" or "come out of the closet") are that, first, health care providers (HCPs) will not provide services at all, and second, if services have been started, HCPs will abandon the patient and their support network, especially in the last days and weeks of life when care and support are most needed.[10]

For many people, spirituality is expressed within a religious community of faith. However, a community of faith or a spiritual care provider may not provide a safe, welcoming presence. Over the life span of TI elders who are now living with a life-limiting illness, the spiritual and religious language of their faith traditions has often been used to demonize variations on gender identity and gender expression that exist outside a female/male gender duality.[17] Transgender-identified people may not be welcomed in a community of faith, or requests for spiritual care may be denied. And thus, emotional, physical, and spiritual safety may become an unmet spiritual need for TI people and their allies.[18]

Significance

In the last 5 years, the number of research studies and publications related to spirituality at EOL has increased, especially addressing the role of chaplains and other direct spiritual care providers.[12,20,21] However, research about interventions for the spiritual care needs of TI people has been neglected.

Purpose

In response to this gap in the literature, the overarching aim of the case study was to explore spiritual care for transidentified people at the end life. This case study was developed for 3 reasons: first, because we have few descriptions of the lives of transidentified elders at EOL; second, although caring for the human spirit is a key component of role of the hospice volunteer, we rarely discuss the role of the volunteer as provider of generalist spiritual care; and lastly, we wanted to highlight spiritual care interventions that address spiritual care needs at EOL using the powerful media of narrative, art, and poetry. Therefore, the purposes of the case study were to (1) identify the spiritual needs of a TI woman in the last 6 months of life and (2) describe how a patient-family volunteer met those needs using narrative, art, and poetry.

METHODS

Setting. An inpatient residential unit of a hospice program in the mid-Atlantic region of the United States.

A case study is an intensive, systematic investigation of an individual conducted when little is known about a phenomenon.[22] Given the dearth of scholarly inquiry on the experience of transgender elders at EOL, the case study method enables a researcher to enter within a specific context, to develop a rich description, and to consider how the complex phenomena can be integrated into a meaningful whole as a portal to begin a scholarly inquiry to inform clinical practice and research.

Case description. The case study describes the journey of a transgender woman, C.S., in the last 6 months of her life. C.S. was a 59-year-old transgender woman admitted to a hospice program with the diagnosis of advanced head and neck cancer. In this case study, the narratives of C.S. are interwoven with those of L.C., a young woman in her late 20s who was assigned as C.S.'s hospice volunteer. C.S. received care in a hospice facility in central Virginia in the fall of 2015 and the early winter of 2016. Care was provided by an interprofessional, physician-led team, composed of nurses, social workers, chaplain, and specially trained volunteers.

C.S.'s gender identity given at birth was male. She was born in a small conservative community near the Blue Ridge Mountains. C.S. graduated from college still living and presenting herself socially as a male. An excerpt from one of C.S.'s stories called "Hide and Seek" illuminates her struggles with transgender identity:

> I would go places and get my nails done… but then I would be scared that someone would see it, so I'd go somewhere else and get them undone. It was a lot of hide and seek.

In her book *Little Star*,[23] C.S. talks about going to San Francisco when she was 21 to 22 years of age in an attempt to get a gender change operation. With little money and no friends, she initially lived on the streets and eventually in a pensioner motel. During her time in San Francisco, Harvey Milk, activist and the first openly gay San Francisco City supervisor, was killed. She also experienced the loss of other friends to violence at that time.

As a part of her social transition, C.S. changed her name to be consistent with her transgender identity. Her obituary described her "as an artist, poet, music lover, and a writer." Her love of music inspired her name change. According to an entry in her blog, when she changed her name, the middle name chosen was inspired by the title of a favorite Leonard Cohen song.

Data Sources

Two primary data sources for the case study included a telephone interview with hospice volunteer L.C. (approximately

9 months after C.S.'s death) and a book, *Little Star*, created by C.S. and L.C. that contained a collection of C.S.'s poetry, narratives, sketches in black ink, and color drawings.[23] Excerpts from the book will be included in the case study.

Additional sources of data were blog postings, C.S.'s obituary, field notes from a visit with the hospice chaplain, publicly available materials that describe the hospice program, and observations of the setting from volunteer work in the same facility.

Trustworthiness of Data Sources

One of the primary sources for the case study was the book, *Little Star*, which was the project that was started while the patient was in hospice in collaboration with the hospice volunteer. The book was published posthumously in March 2017. The patient volunteer did help C.S. with curation of the content for this primary source, *Little Star*[23]; however, the patient herself selected the poetry, narratives, and the art work that were to be used in the book. The blog entries that we used were from patient's own blog that was publicly available. Her obituary included the date and location of her death. We did not attempt to specifically verify this information. However, it is readily available by request from the family.

Authenticity

Traditionally, member checking has been identified as a method used to verify the accuracy of the research participant's words.[24] In hospice research, it has been a challenge because given the short lengths of stay of people in hospice, cognitive changes, or physical decline, they may not be available or able to participate in a member checking process. In our case, the patient was deceased at the time we wrote the case. The patient's family was invited to review the case late November and early December 2018 prior to submission of the first version to the journal. After review, they requested 1 factual change, the religion of the family of origin. We had listed it as Catholic in an earlier draft. As requested, we changed it to Episcopalian (see page 12). Her obituary included the date and location of her death. Although this information can be searched in publicly available databases, we did not confirm this specific data point.

Data Analysis

Thematic analyses as described by Miles and Huberman[25] and Braun and Clarke[26] were the method used to analyze the data sources. During the first stage, initial themes were identified; in the second phase, the initial themes were reviewed again; in the third stage, themes were retrieved and grouped for interpretation, and lastly 4 major themes were defined and named.[25] After 4 major themes were defined and named, a second reader, L.C., reviewed the themes and concurred with the themes.

RESULTS

Little Star: A Spiritual Care Intervention

In the psychosocial assessment, the hospice social worker learned that as a younger person C.S. was a visual artist and poet. In her own words, C.S. said, "I have been writing all the time, at least since I was 11 or 12, more like 8 or 9, I think." She used her art as a way to cope with the challenges of discovering, embracing, and disclosing her gender identity.

L.C. and C.S. began to talk about writing down C.S.'s experiences in a book. L.C. is also a multimedia artist working with painting, sketching, and writing. Upon reflection, L.C. recalls that C.S. stated that she had always wanted to make a book of her life experiences, and gradually the book began to emerge as they met weekly over the last few months of C.S.'s life.

The book started as a series of audio files on a smartphone. C.S. would audiotape their conversations about her life, and L.C. would transcribe the notes. C.S. also included her own poetry and artwork. The book that L.C. and C.S. worked on together was an important spiritual care intervention during the last months of C.S.'s life. L.C. related, "This [creating the book] was a way for C.S. to contribute and send a message to inspire others… and to make up for the times when she was rejected as a volunteer and not allowed to contribute because of her gender identity." According to L.C., the process of putting the book together deepened not only the connection between L.C. and C.S., but also the connections with C.S. and the other people in her life.

Spiritual Needs

While C.S. was on hospice, she maintained a strong connection to the Episcopalian faith of her upbringing but was also influenced by the teachings of Thich Nhat Hahn, the Zen Buddhist monk, poet, and teacher.[27] In L.C.'s words, "C.S. was seeking a closer relationship to God." C.S. actively sought out and received regular visits from the hospice chaplain and the local priest. Some of her spiritual goals in the last days of her life were for forgiveness, love, acceptance, and reconnection with her biological family.

During her interview L.C. was asked to talk about the how the spiritual needs of TI patients at EOL may differ from those of other patients. In her experience, there were differences in 3 areas: spiritual needs for safety because of the history of abuse or discrimination, a need for reconnection with biological family/family of origin, and bereavement support for biological and chosen family. As to the spiritual need for safety, many LGBTQ individuals have a history of abuse or discrimination from HCPs or rejection from church, and therefore, L.C. says, "There is a greater need to consider their spiritual needs

[for safety]." Regarding the need for reconnection and reconciliation, estrangement from biological family is commonly part of the social history for TI people. However, many people have a strong constellation of care from nonbiological supports. Lastly, bereavement support is needed not only for the biological family, but also for the partners or chosen family because they are also grieving. The chosen family may not get as much attention as the biological family because their grief needs may be disenfranchised because the relationship may not be known to others, socially sanctioned, or legally recognized.[28]

Meeting Spiritual Needs

The Role of Volunteer

L.C. volunteered 3 years at the hospice house and found that, in general, all patients have spiritual needs such as connection, reconnection, or maintaining connection to spirituality. During the interview, L.C. was asked to describe her own definition of spirituality. To her spirituality was "faith and a sense of connection to a higher power that she called 'God.'" She went on to flesh out her definition by saying spirituality is "a unifying force, life force, sense of connection to self, and connection to others." In her role as a volunteer, L.C. met the spiritual needs of individuals receiving hospice care by alerting staff to a need for a referral to spiritual care, reading the Bible (or other spiritual literature) to patients, and providing a spiritual presence. L.C. stated, "Listening can be a great gift."

Care for the Spirit

L.C. strongly believes that hospice does a wonderful job of addressing the needs of every aspect of the person. She emphatically stated, "Care for the spirit is equal to all other aspects of care (medical, social, financial)." She spoke very passionately that "hospice treats the whole person." Spiritual care is "upheld and supported by the environment and the people." When asked what hospice could do to improve care for LGBTQ patients and families (biological and chosen), L.C. made 5 recommendations to care for the human spirit of TI people: (1) train staff and volunteers about special needs related to history of abuse and neglect related to gender identity, (2) recruit more LGBTQ staff and volunteers, (3) consistently assess and evaluate spiritual needs throughout the period of hospice enrollment, (4) include the needs of chosen family in spiritual plan of care, and (5) address fears about dying alone without support.

A Spiritual Transformation

C.S. died while on hospice. Survived by her parents, 3 siblings, what she described as her spiritual family, uncles, nephews, and her cat, she was buried in the family's plot in her hometown. After she died, the book was available to her family and friends. L.C. observed a transformation in C.S. during the writing of the book. L.C. stated, "She made a transformation. It brought in new life… a renewal of her life." The project, which started as a poem recorded on a smartphone, became an instrument for the patient to reconnect with her father and siblings, to acknowledge her own unique divinity, to connect with her inner wisdom, and most importantly to her to leave a legacy "for others who had suffered."

DISCUSSION

Data analysis identified 4 major themes related to the expression of spiritual needs of TI elder in the study: (1) the human element in advocacy for spiritual care, (2) the importance of safe spaces for reflection and meditation, (3) the importance of skillful means to work with LGBTQ people, and (4) affirmation of gender identity as a spiritual need. The themes identified in the case study were compared to what is known in the literature about the expression of spirituality at EOL for LGBTQ elders.

The Human Element in Advocacy for Spiritual Care: Coming Alongside

The case study was a powerful description of the volunteer working with her client, C.S., a transgender woman, to help with the audio recording, transcription, and collection of personal narratives, poetry, paintings, and pen sketches. The collection was also an important vehicle to support C.S.'s life review in the last months of her life. Readers of the book bear witness to the suffering on her journey to gender identity, disconnection from family and friends, and physical and emotional trauma in her life.[23] Through the writing of the book, C.S. was able to transform suffering and to reconnect with her friends, family (biological and chosen), pet companion, and her own spirit. The book was her legacy project. After C.S.'s death, the book was a gift that connected her to family and friends, and most importantly, for C.S., it was a way to leave a legacy to help others. In this case, the hospice volunteer served as an advocate for spiritual expression and connection for the TI patient.

The presence of a spiritual care advocate was integral to the provision of spiritual care in the case study. However, without the hospice's organizational commitment, paid spiritual care staff, dedicated volunteers, and connections with other faith communities, access to spiritual care would be difficult for a member of the LGBTQ community.[10,17,19] In some communities, clergy from faith communities are rare visitors to LGBTQ people who are open about their sexual orientation or gender identity.[17,19] Lesbian, gay, bisexual, transgender, and queer people have had their lives and ways of loving demonized by spiritual care providers in many faith traditions.[17,19] The case study highlighted a

method to address this gap in spiritual care through the role of volunteer as advocate. Improvements in spiritual care for TI elders at EOL would rely on the identification of an advocate(s) within the organization providing care or within the patient's faith community. The advocate would use skillful means in relation to the patient to help evoke his/her spirituality and meaningful connection to others.

Safe Spaces for Care, Reflection, and Meditation

Physical and emotional safety is an important spiritual need for TI elders.[17,29] "Safe space" within this context includes not only the therapeutic/healing space (actual setting of care),[14] but also considerations for cultivating safety within a person's interior spaces (mind, spirit, heart space). Disclosure of sexual orientation and gender identity is unique to the experience of LGBTQ people. The first important guidepost during receipt of care is the decision to "come out," that is, to reveal sexual orientation and gender identity. A safe environment for disclosure must be created.[30]

In the case study, while there was not a designated space for meditation and reflection, each room was private, and there were many rooms within the facility and spaces on the grounds that could be used for meditation, reflection, or quiet contemplation. Walker and Breitsameter[31] wrote about the challenges hospices face in maintaining spaces that are open to all expressions of spirituality, not only those based on a specific faith tradition. To promote the spiritual expression of TI elders on hospice, organizations must overcome these challenges to accommodate their TI patients' spiritual need for safety in the care environment.

The case study also illuminated the creation of a safe internal space for reflection, contemplation, and spiritual exploration. L.C. was able to tap into C.S.'s love of narrative, art, and music to encourage C.S.'s openness to sharing her life stories and thoughts on her spirituality. These familiar modes of expression, in addition to L.C.'s skillful means of active listening and acceptance, cultivated an internal sense of safety for C.S. to share her stories. Going forward, care organizations, in addition to providing safe physical spaces for spiritual expression, can ensure that personnel are trained in skillful means to create safe psychological space for spiritual expression.

Skillful Means: Need for Education

Skillful means offered by the volunteer were essential for facilitating C.S.'s spiritual expression in the case study. At the most basic level, the volunteer provided active listening, unconditional acceptance, and commitment to offering spiritual care to C.S., acknowledging her difficult upbringing and struggles throughout her life to find peace with her gender identity. These are skillful means that can be integrated into educational efforts to train hospice personnel in the provision of spiritual care for TI elders. Taking it a step further, the volunteer in this case used her knowledge of art making to open up lines of communication with C.S. and consequently provide a vehicle for spiritual expression and connection. In this case, L.C. used skillful means to elicit C.S.'s spirituality by identifying her strengths and preferred modes of expression. With education on the unique needs of TI elders, hospice personnel would also be able to develop the skillful means to provide spiritual care to their LGBTQ patients.

While C.S. received strong spiritual care, the volunteer still felt that more education was needed to train volunteers and paid staff about the lived experiences of LGBTQ people. For example, staff and volunteers should be aware that violence and threats of abuse are often part of the life journey of TI elders.[32] The simple act of acknowledging their gender identity and significant committed relationship(s) has placed them at risk for physical, emotional, and spiritual violence; stigma; loss of custody of minor children; rejection by family; and abandonment by faith community. With an awareness of these risks, volunteers and paid staff can promote acceptance, understanding, and spiritual validation of TI elders at EOL.

Affirmation of Gender Identity

Affirmation of gender identity is a spiritual need. In the case study, C.S.'s gender identity was fully accepted by the volunteer and other hospice personnel, and in turn, this allowed her to feel safe to express her spirituality. The first place to start in facilitating safe space is to demonstrate respect for gender-appropriate pronouns and language the patient uses to describe himself/herself/themselves. A sign of disrespect is to misgender someone, that is, to refer to someone, especially a transgender person, using a word, in particular a pronoun or form of address that does not correctly reflect the gender with which he/she identifies (Oxford Dictionary Online, https://en.oxforddictionaries.com/definition/misgender, accessed February 14, 2017).[33]

An extension of misgendering is a lack or respect or appreciation for different definitions or configurations of family.[34] It is important to include identification of the role of chosen and biological family[32] in the spiritual history and development of the plan of care.[10,35] As a component of advance care planning and the spiritual history, while it might be helpful to identify key people who will be participating in the care or visiting at the facility, identification of people who are in the circle of care should not become an interrogation. In the case study, C.S. connected to both her biological and chosen family by virtue of the policies and skillful means of staff members at the hospice as well as through the creation and distribution of the book. Respect by volunteers and paid staff for her configuration of family allowed C.S. to reconnect with her biological family and forge stronger connections with her chosen family.

Implications for Education and Research

As mentioned, the 4 themes related to spiritual expression identified in the case study have several implications for advancing education of EOL caregivers in the unique spiritual needs of TI elders. Training for hospice volunteers and paid staff would include information regarding acceptance and sensitivity to individuals with a history of discrimination and misunderstanding, skillful means to elicit spiritual expression in persons whose spirituality may have been rejected by traditional faith communities, creation of safe spaces for spiritual expression, and acknowledgement of the patient's gender identity and family configuration. These trainings would emphasize the importance of spiritual expression for all patients at EOL,[14] but especially for TI elders who may have experienced spiritual turmoil over their lifetimes because of their gender identity.[19]

Regarding implications for future research, because of the gap in the literature with respect to EOL care for TI elders, this case study has the potential to guide research in the following directions: identification and enumeration of the unique spiritual needs of TI elders at EOL, exploration of the ways in which members of the interdisciplinary team can meet the spiritual needs of TI elders, and the use of creative modalities in the spiritual expression of LGBTQ elders.

CONCLUSION

A hospice volunteer used skillful means as an artist to help her TI patient express her spirituality in the last 6 months of her life. This case reveals how the volunteer as a hospice team member can provide care for the human spirit. While spiritual care is typically provided by chaplains or other designated spiritual care providers, nurses may provide generalist spiritual care (ie, presence, providing privacy for spiritual expression, meditation or reflection, playing music, therapeutic use of self).[17,36] Hospice team members can support spiritual expression for TI individuals and break down the barriers of stigma, lack of understanding, and complex family dynamics. With the emergence of a growing population of TI elders, attention to their spiritual needs, especially at EOL, is imperative to promote their quality of life and relationships to self and others. Thus, future education and research efforts will be vitally important to enable members of "Generation Silent"[6] to effectively express their spirituality and spiritual identities.

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