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Abstract
Spirituality is a contested concept with a wide taxonomy of meaning discussed in the literature. Within the domain of health care, there has been increasing interest in the importance of understanding and valuing patients' individual spirituality as a function of providing appropriate support, particularly as part of nursing practice. This article reports on an ethnographic participant observation study that explored the cancer day care provision of a community hospice trust located in Southern England. The aims of the study were to explore why users of day care came to the sessions and the perceived benefits of attending. Secondary analysis of the data undertaken after initial reporting on the findings has revealed the ways in which participants construct their core life meaning as personal spirituality. Drawing on literature that discusses the multi-faceted concept of spirituality, the data suggest that relationships and citizenship work are key spiritual components in the lives of these participants, with both these elements significantly contributing to the maintenance of a congruent 'self'. 'Doing' rather than 'being' is at the core of spiritual essence for those undertaking citizenship work, with this engagement with the world as one form of transcendence.

Introduction

Interest in and recognition of the function of religious and spiritual coping in adjustment to serious illness, including cancer, has been growing. New ways to both assess and address spiritual concerns as part of overall well-being are being developed by health care practitioners as part of a package of support for people with critical and terminal illness (Randall and Downie, 2006; Watts, 2008). For this support to be meaningful, however, it is necessary to determine which dimensions of spirituality are relevant and the ways in which the human spirit can be celebrated in the face of life-threatening illness (Cobb and Legood, 2008). The ultimate value of such exploration is to make it possible for us to die the way we live (Hockey, 2002). For older people (who form the majority of participants in this study), a sense of identity and understanding of a person's place and status in the world appear to constitute key components of spirituality (Thompson, 2007).

This article discusses the concept and meaning of spirituality in the lives of people suffering from cancer and for those who have been bereaved to cancer. It draws on ethnographic research conducted at a community cancer drop-in facility run by a hospice trust in southern England and highlights a range of 'spiritualities' in the lives of participants. The objectives of this small-scale study were to explore what motivates users of the drop-in sessions to attend and what they find to be the principal benefits. The key findings point to the sessions reducing the sense of social isolation many experience as cancer sufferers and also to the ways in which managing to get to the sessions acts to confirm hope for continued survival. These findings are fully reported in other work (see, Watts, 2009) and are not the subject of the present article. The large amount of data gathered for the study included material concerned with different elements of core-life meaning and this prompted a secondary analysis of the data focusing on personal spiritualities as presented in the literature. This article focuses on two aspects of spirituality present in the data: relationships and citizenship and adds to understandings of secular meanings of spirituality.

The first section of the article considers a broad literature that seeks to uncover what the term spirituality means and reveals that there is no consensus on its

conceptual clarity. The relationship between spirituality and health comprises the next discussion topic and this is followed by an account of the study's methodology that describes the setting for the research and provides brief details of the participant observation methods used. The themes of relationships and citizenship as biographical continuity, both being significant components of spiritual meaning for this small research population, constitute the two topics that comprise the results section. The closing section of the article draws together the discussion supporting the general assertion by Glendinning and Bruce (2006) that religion is gradually giving way to spirituality.

The term 'spirituality' is characterised by its complexity and a conceptual range that includes its distinction from religion (Rumbold, 2002) and its place at the core of individual lived experience as an underpinning feature of personhood (Moore and Purton, 2006), so that spirituality may be expressed *both* religiously *and* humanistically (Wright, 2004). The concept of spirituality is present in all cultures encompassing experiential aspects, whether related to membership of a religious group or to acknowledging a wider sense of peace, transcendence and connectedness. Individuals may thus consider themselves as spiritual and religious, highly valuing religious faith with this as the lens through which to understand the meaning of life. Others may regard themselves as spiritual but not religious, highly valuing spiritual well-being but not as part of a religious path with this latter category reflecting the shift from sacralisation to secularisation within a post-modern post-industrial context. Whether as part of religious or secular traditions, the spiritual domain acknowledges the importance of the big questions of life and death, in relation to self, others and the 'cosmos' (Wright, 2004).

Discussion that follows will consider spirituality from a number of perspectives that includes spirituality as religious belief and practice, as existential meaning and as self-worth based on Giddens' (1991: 57) concept of ontological security. The relationship between spirituality and health, particularly in the context of life-threatening illness, will be a focus of this introductory discussion, drawing principally on ideas presented in the nursing literature that explores the topic mainly as a vehicle for developing professional health care practice.

Across time and cultures spirituality has been allied to religion, particularly formal institutionalised religion with its emphasis on theist and doctrinal principles that can be understood as orthodoxy (Cobb, 2001). Religion is highly culturally and socially determined with Robinson (2008: 50) defining religion as 'a system of faith and practice expressing a particular spirituality'; this system, he argues, is predicated on the features of community and corporate awareness of the ultimate *other* or God. Because of its group structures, religion tends to be prescriptive maintaining collective congruence and sense of spiritual belonging that transcends everyday material or sensory experience. Acts of meditation or worship are spiritual practices that 'bind' members of faith communities where the position of 'self' is less important than the cohesion of the group.

In recent years, with the widespread decline in adherence to formal religion, alternative, mainly secular meanings of spirituality have found prominence in the literature. Rumbold (2002: 9) points to the increasing authority of the self, rather than the collective, as one explanation for the renewed public interest in non-religious spirituality. The authority of a specific, often religious tradition, now increasingly gives way to the authority of the individual *over* those traditions. The intersection of micro and macro values makes possible new forms of creativity in the search for understanding of who we are and why we are here. Cobb (2001) characterises these

concerns about the essential questions of life meaning as 'ultimate values', claiming that these are at the core of spirituality because it is these values that are fundamental in framing the world of the individual.

Transcendence, as reaching out to the other through empathy that takes us beyond ourselves, has always been present in writings on spirituality. Robinson (2008: 104) argues that 'transcendence is not about a separation from the world but rather is an engagement with it'. This interpretation points to transcendence not as an escape from earthly concerns to a divine realm but as an experience of personal growth and development that enables a person to go beyond limitations of the self and circumstance. Parry (1988) suggests that transcendence as 'virtue' is concerned with individuals reaching their highest potential which is achieved through testing limitations.

A life-threatening illness can give rise to a range of limitations that may include the prospect of being disconnected from the embodied self previously recognised as 'me' (Holstein and Gubrium, 2000). Giddens' (1991) concept of ontological security, that describes this fear, is relevant here and contributes to existential understandings of spirituality. Ontological security derives from a sense of continuity with regard to an individual's life events. To be ontologically secure is to possess understanding of one's place in the world and is a pre-requisite for the competence of self-worth and self-identity that Giddens argues is not simply given, but must be routinely created and renewed and sustained in the activities of the individual. In the context of those facing life-threatening illness these core values, that constitute ontological security, can be undermined to produce what Bury (1982) terms a 'biographical disruption'.

In recent years some writers have directed their attention to the ways in which the search for universal meaning can be conceptualised as applied spirituality, particularly within education and health care (Robinson, 2008). The nursing canon has been particularly influential in its contribution to understandings of spirituality in the context of health. For example, McSherry and Cash (2004), writing in the nursing tradition, present a taxonomy of meaning of spirituality across a continuum with religious and theist ideals at one extreme, and secular, humanistic and existential elements at the other. Writing in the Scandinavian nursing context, Christensen (2008) argues that spirituality is essentially an intimate private matter and one that may lie beyond the nursing function. Merja's (2002) study of provision of spiritual support to families of cancer patients by nursing staff broadly supports this view. Other writing from Scandinavian health researchers directs attention to the ways in which spirituality is expressed by patients. Raholm (2002), for example, conceptualises spirituality as an inner strength developed through suffering that results in a new appreciation of life and health, whilst Kvale (2001), in the case of cancer patients, points to the importance of them finding meaning by living in the present that is centred on talking about 'normal' life (families and hobbies) with spirituality characterised by the 'every day'. Koslander's (2008) work argues that patients' spiritual needs should be defined by them and are likely to be highly individual.

Setting and participants

The empirical research, on which this article draws, was based in a community hospice trust that is housed within a local community centre in an urban area located in Southern England. The aims of the research were to explore how both cancer sufferers and cancer survivors (included in this category are those who have been bereaved through cancer) make use of a community hospice drop-in day care facility.

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The research questions focused on the reasons why people come to the centre and how they make sense of the professional, voluntary and peer support they receive, particularly in relation to ongoing treatment. The trust has been constituted as a non-clinical service, aimed at providing informational, social and therapeutic support to cancer sufferers. It has no medical facility; no in-patient unit and no employed clinical staff, which makes it 'feel' more like a social, than a clinical space. The trust operates twice-weekly afternoon cancer 'drop-in' sessions with variable numbers attending, with an average of twenty to thirty at each session.

There is a very wide age range represented amongst users of the facility with the youngest currently being thirty-two and the oldest, eight-eight. Proportionately there are more women than men who use the service and nearly all the volunteers are women. Participants included those with active disease, some in remission and others who had been bereaved to cancer with several in this group having become volunteers at the drop-in. There is a core group of approximately ten regular attendees and a major proportion of the data collected draws on the sickness stories of this group who I got to know very well. The trust has a manager and fundraiser with informational and practical support provided by a team of dedicated volunteers, a now well-documented and familiar feature of the cancer narrative (Lawton, 2000; Armstrong-Coster, 2004). The voluntary efforts of a range of health and therapy practitioners contribute to a portfolio of different treatments available to users of the drop-in; reflexology, Indian head massage and aromatherapy being the most popular.

Methods

My researcher role was preceded by a short period as an occasional volunteer at the sessions during which time I was able to get to know some of the other volunteers and regular users of the service. The research, conducted over a fifteen-month period, adopted an ethnographic approach (Hammersley and Atkinson, 1995) with participant observation as the principal data-gathering tool. Because of the opportunity for immersion in the research context, ethnography is often represented as the method best suited to reduce the gap between experience and the objectification of subjects. Wilkinson (2005) argues that this is especially so in the case of researching personal suffering that resists articulation because it goes beyond that which we can say or understand.

During the fifteen months of the study my role was one of both researcher and volunteer with my time taken up with making tea, setting up board games, tidying up and generally chatting to those attending the sessions that run for three to four hours in the afternoon. These conversations were a rich source of data that enhanced the main data set drawn from listening to talk between group members and from observing their non-verbal behaviours. These observational elements of the research have been illuminating and this confirms Jones and Somekh's (2005) claim that observation is an important, but often under-rated, method of data collection. The making of detailed handwritten notes in the form of a research journal (Rager, 2005) constitutes the documentary data and a thematic approach to data analysis, following a broadly grounded theory paradigm (Glaser and Strauss, 1967), was ongoing throughout the data collection which ceased at the point when data saturation had been achieved.

The recording of observations and verbatim comments of participants was often a fraught activity with me quietly slipping away to quickly jot down details of interactions and conversations in a way that was not seen as disruptive of the group dynamic. One strategy I frequently used to legitimate this 'slipping away' was the gathering up of tea and coffee mugs for washing up, disappearing into the kitchen for

a few minutes. This demonstrable purpose for removing myself from the group that also gave me the opportunity to write in my journal, made the 'slipping away' less uncomfortable. This and other practical challenges within the conduct of this research have been discussed in other writing (see Watts, 2008b) and are a function of the pre-eminence for participants of my volunteer role in the day care setting. Despite being informed about the research, they showed little interest in it making clear their primary expectation was that I would join in with whatever activities were taking place in the same way as other volunteers.

Ethical concerns

Elsewhere I have written in some detail about the ethical dilemmas presented by the research (see Watts, 2008b) which had been sanctioned by the trust's management committee so here would make the brief point that the conduct of the research involved ongoing ethical reflexivity to ensure confidentiality and appropriate boundaries in relationships. In particular the issue of informed consent presented challenges because asking participants to sign consent forms did not seem meaningful in this context. They were not being interviewed or asked to be part of a focus group, neither were sessions being filmed or audio-recorded so a brief outline statement explaining the study's aims seemed a more appropriate ethical research instrument. The research statement was made available to all those attending the sessions, with both the manager and myself careful to refer participants to the dual aspects of my presence. Reassurances that confidentiality would be maintained and the names of participants changed in any reporting were made, and this was one of my first tasks when introducing myself and the study to new attendees.

Results

The introductory discussion revealed that contemporary spirituality is emerging largely as an instrument to enhance personal well-being and a tool with which to improve or maintain health and quality of life (Sinclair et al, 2006). The fluidity of the spiritual domain with a resulting 'deregulated' spirituality that can include dimensions of self, others, higher beings and the cosmos as well as the activities of being, finding meaning, connecting and transcending points to both its inherent plurality and subjectivity. For this small research population it is the activity of connecting in terms of relationships with family and friends and in terms of wider social networks in the form of civic deeds that are the key properties of spirituality.

Relationships

As indicated above, the research did not specifically set out to explore with participants their understanding of spirituality. A secondary reading of the data, however, reveals that a number of meanings of spirituality was evident in participants' stories, most of which were narratives of woundedness (Frank, 1995). In most cases these narratives revealed how anxiety about their health, uncertainty about the future and the multidimensional experience of pain, had all contributed to suffering in their lives. For some, their 'self-stories' had been temporarily silenced by the trauma of illness and receiving a cancer diagnosis, but they gradually emerged through the comfortable dynamics of the group setting. Two spiritual themes were evident: the first focuses on the importance of relationships in giving meaning and purpose to their lives (Zohar and Marshall, 2001). The second concerns aspects of citizenship that serve to reinforce ontological security (Giddens, 1991) that was, for some, a powerful spiritual component.

During the fifteen months of the research only two participants made any reference to their adherence to a religious faith and formal religious practice appeared to hold little relevance in the lives of a majority of those attending the drop-in. Whilst

the topic of religious faith was notably absent from the talk at the drop-in, a myriad of connections to others through family and friendship, was a dominant theme at the sessions. This was particularly the case for those with active disease, some of who were very fearful about the future. Being able to voice and share the details of their family life seemed to confirm biographical continuity and sustain them despite physical and emotional difficulties caused by their cancer experience. Rita, in her early seventies with progressive disease explained how important her family was:

> "Bill (her husband) and the boys keep me going. Even though they live away we still do a lot together as a family. They are my rock and as long as I've got them, I'll be OK".

Maureen, in her early forties and suffering from terminal breast cancer, described to me on several occasions how she had to prioritise tending to the needs of her disabled father, with whom she lived. Her mother had died some years earlier, leaving her in the role of 'home care-taker'. She explained:

> "You see it's just me and dad and he don't want to know about my cancer and the treatment. I do my best to look after him but I get so tired. I don't know what he's going to do when I am gone".

Notes in my journal made a few weeks after the time of Maureen's comments above show that she was very committed to her father and, despite her rapidly waning physical health, managed to organise life around him. She told me how focusing on his needs acted as a motivation in her life. "I am not good in the morning but getting up to be with dad, I suppose, helps me get going. He don't say much but he smiles a lot".

For Molly, it was her relationship with both family members and a wide group of friends that appeared to be the driving force providing meaning in her life. At seventy-nine, she had been widowed to cancer and had experienced recurring cancer episodes that had had the effect of making her stoic but careful to actively value close relationships. One of her grandchildren was seriously ill drawing from Molly these comments:

> "I want to give her (the grand daughter) my strength. I like to get down there as often as I can so that my son hasn't got it all on his shoulders. He's a strong boy (he is over fifty!) but I've got to help him all I can. That's what mothers are for".

In a few cases the strength of relationships appeared to be connected to regularity and frequency of contact with 'neighbourliness' a significant feature in some participants' stories. Contributing to the material well-being of others, who themselves had difficulties, signified a particular form of connectedness based, in part, on the potential for reciprocity. Reg, an older man newly diagnosed with cancer, usually preferred to quietly socially isolate himself at the drop-in sessions, often sitting alone drinking his tea. He rarely spent time chatting but on one occasion he told me about his neighbour who had lived next door for many years and now, suffering from a heart condition, was finding it difficult to get out. Reg spoke about how this longstanding relationship meant a lot to him:

> "Jack's been next door for years and years and we have seen the kids grow up and go. He's got boys like me. I try and get his shopping and of an evening I go in sometimes. You do get lonely. I suppose we can help each other a bit. Not everyone has good neighbours do they that they can depend on?"

Joyce, a volunteer at the sessions whose husband had died from cancer, spoke similarly about one of her neighbours who she regularly brought to the drop-in. Speaking of her neighbour she said: "She's been good to me and saw me all through it. Somehow she seemed to understand and now she's got it (cancer) so I've got to help her get through it". Joyce's words encapsulate a 'helping' narrative that is underpinned by reciprocity within relationships with Joyce positioned as an authentic cancer survivor. The capacity to 'help' enables Joyce to define herself in a relation of care to others. Her kindnesses, not just to her neighbour but also to others using the centre, appeared to give purpose to her life beyond self-interest and materiality.

Citizenship

A number of participants were active in their local community and, despite unpredictable and fluctuating health, continued to undertake different forms of voluntary work as part of a model of active citizenship. I use the term 'citizenship' in this context to refer to perceived duties or obligations rather than rights, as part of a civic tradition of participation (Lister, 1997). These obligations that could be seen as contributing to what Roche (1992) terms as a 'duties discourse', were spoken of in ways that positioned these voluntary efforts as a form of productive social presence. Molly, Pat and Joan were involved in different community roles – Molly at a local girls school where she helped with reading and pastoral matters, Pat as a volunteer at the Citizens Advice Bureau (CAB) and Joan at her church where she was one of the leaders of a weekly Bible study group. Doris, in her late seventies, worked regularly at a local charity shop and also was a governor at a local school. My research journal records how they told me about these various obligations.

> "I have been going up to the school for years. The girls are lovely and from so many different countries. What they need is time and that is something I've got. You have to be so patient; it takes a lot of patience". (Molly)

> "I am up at the CAB two afternoons a week and I love it. I went through the training but I have to keep updated about policy and legislation. So many people need help about all sorts of things, benefits, rents, employment issues. Another big thing is immigration and asylum rights. I try and make a difference. I don't know if I do but I try". (Pat)

> "I have been leading the Tuesday bible study group for a while now and getting ready for it gives me something to focus on and work towards. After the op I couldn't go for a while and I missed it. Also that very cold spell we had kept me indoors". (Joan)

> "I really enjoy it at the shop. The others are nice and we have a bit of a laugh. I can't stand the thought of not being out in the world and not taking part somehow. The day I am not doing something for people is the day I am finished". (Doris)

I observed how voicing their continued involvement in these undertakings was important for them in confirming self-worth and contributing to a sense of achievement in their lives. An essential attribute of 'being' for this group was 'doing' and mainly 'doing' *for* others. Being able to see themselves as active citizens in roles unrelated to their illness was an important component of achievement. It also gave

them a sense of purpose and, because these were all longstanding commitments, it was one way of maintaining biographical continuity.

Although continuity in these roles was maintained, discussion amongst participants did differentiate between 'then' and 'now', particularly in relation to difficulties around reliability caused by the need for them to attend hospital appointments and by adverse reactions to treatment and sometimes, as Doris put it, by generally "not feeling up to much". At one session Molly explained about the problems she was having with the school furniture:

> "The chairs are a bit low, they make my back ache, especially since the last lot of treatment. I've mentioned it to – but I can't expect them to get special chairs in for me can I?"

Some were finding that these roles were placing heavy demands on their depleted energy resources, giving rise to anxieties about how long they could sustain these regular commitments. There were other anxieties associated with these roles, not least of which, was the expectation by others that they could be relied upon. In the case of Joan, for example, I could see that this was experienced by her as stressful and as pressure to carry on as normal when, in fact, 'normal' had been replaced by the 'extraordinary'. Remarkably, despite her increasing frailty, her gritty determination resulted in her missing very few of her Tuesdays (as she referred to the weekly bible study group she led) and I could see that this was a source of considerable personal pride, enabling her to continue to see herself as a 'giver' as well as a 'taker'.

Discussion and conclusion

Data from this study suggest that one important component of spirituality for those living with cancer, is the maintenance of a consistent or congruent 'self'. For a majority of participants this congruence involved the maintenance of an active *social* as well as an *individual* self, with secular and humanistic spiritualities common amongst them (the case of Joan being the only exception). A 'religion-free' (Wright, 2004:219) spirituality, rooted in their faith in themselves as worthwhile human beings, living independent lives, emerged as an important spiritual biographical resource. This relational, ontologically based spirituality seemed to act as a defence against the incremental dismantling of personhood (Rose, 1996) that cancer can bring about with its often physically and psychologically ravaging effects.

As reported by other writers, a focus of this group was on the importance of relationships in framing their quality of life and this was a dominant theme. The spiritual dimension of their lives found expression in the pleasure and joy they experienced in their families and friendships. These interactions formed the basis of how they saw themselves and their achievements. The centrality of relationships in sustaining ontological security (Giddens, 1991) amongst this group was also a powerful theme, with friends and neighbours, as well as family instrumental in confirming biographical continuity that itself positively impacts on spiritual well-being.

These consistent relationships gave meaning and continuity to participants' lives and acted as a spiritual bridge connecting former 'well lives' with current troubled ones. The practical and emotional disorder created by cancer appeared to be ameliorated by relationships shaped by kinship, shared instrumental interests and by locality. The potential of these relationships to positively affect the inner well-being of these cancer sufferers was a mark of certainty in lives transformed by cancer and now characterised by doubt and fear. In the case of 'neighbourliness', I was reminded of Mark Granovetter's (1973) thesis of the strength of weak ties, with notions of

'strength' characterised by a combination of the amount of contact time, the emotional intensity, the intimacy (mutual confiding) and opportunity for reciprocity. The issues of access and geography, it seems, are instrumental in determining how relationships are enacted. With families often dispersed, the importance of neighbours and others from the local community should not be underestimated in terms of people experiencing inter-connectedness (Thorne, 2005).

In respect of citizenship activity, what seemed to be important was the requirement on the part of informants to keep their cancer identity at bay and within boundaried limits to ensure that it did not encroach on other 'non-cancer' aspects of their lives. They were concerned to protect their status as contributing members of the community and mutual encouragement to this end featured in their conversations. For example, when Joan explained that she was finding it difficult to muster the energy to, as she put it, '*go to group*', Molly offered encouragement explaining that she only temporarily stopped helping at the school when she was at her worst and, even then, managed to accompany her friend out shopping to give the friend confidence following the sudden death of her husband. Doris added: "if you start dropping things what will you have left to live for?"*, indicating that continuing to be fully themselves, as much and as long as possible, was significant as one expression of their spirituality. This form of spiritual expression that draws on opportunities for belonging has been found by other writers to be significant and Erricker and Erricker (2001), for example, develop this theme to suggest that the spiritual life is a community life.

Although the undertaking of citizenship activities was found to be increasingly stressful due to high levels of fatigue and physical discomfort, these were identified as being critical in maintaining a sense of self-worth. Participants engaged in community endeavours were very reluctant to either reduce their commitment to these activities or abandon them altogether. Community participation seemed to mediate the effects of the ontological transition from wellness to illness acting as a spiritual buffer against the realties presented by an uncertain cancer trajectory. I observed that those who characterised this participation as a form of work (such as Doris, for example) were particularly resistant to any suggestion that there may be other more relaxing or rewarding ways of spending their time. Generally such suggestions were dismissed out of hand and this led me to consider that, in these cases, what I was observing was the spiritual value accorded to 'doing' (particularly socially recognised 'doing') rather than 'being', as a vehicle through which selfhood could be preserved and nourished (Moore and Purton, 2006) and personal integrity and well-being maintained. The ambivalence in some accounts about continuing with these activities against a background of deteriorating health was resolved by participants carrying on with their work as the unfinalised process of living with boundary and role tensions.

The conceptual claim of citizenship as a form of spirituality does not have currency in the literature which stresses 'being' over 'doing', as spiritual essence. The emphasis on 'doing' over 'being' was, however, a clear feature of the spiritual orientation of some participants in this research who, as purposive actors capable of choice were determined to contribute to the community as part of a process of ongoing self-definition. Living with a life-limiting condition and less than well bodies, as 'temporary' cancer survivors, was not the measure of their lives but actions that serve and support others were at the core of their spiritual resilience. Commitment to people both in kinship and community relations, as a way of valuing connectedness, was central in influencing the spiritual well-being of participants. Thus, although citizenship work was very much an individual choice, it was relation-

rather than individual-centred. At its core this spirituality is based on awareness of the other that Robinson (2008) argues is transcendence.

As final reflection, at no point in the study did any of the participants explicitly refer to 'spirituality' or to spiritual matters and in that sense they did not cognizantly 'own' either their relationships or citizenship activities as spiritual essence. However, because these elements were so prominent in participants' stories, in shaping their identity, hopes for the future and every day routines – in sum making them who they are, the claim made through my interpretive lens that these are spiritually significant, is supported by the literature.

Although this article draws on a small data set, the findings discussed contribute to the current debate about contemporary meanings of spirituality in the lives of those suffering with cancer. It particularly draws out the spiritual relevance of citizenship activities in confirming individual personhood and life-meaning and helps develop understanding of secular forms of spirituality.

The names of participants have been changed to protect confidentiality

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