# SPIRITUALITY OF CARETAKERS

# AND

# END OF LIFE CARE

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A Dissertation
Presented to the Faculty of the
California Graduate Institute of
The Chicago School of Professional Psychology

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In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Philosophy
in
Clinical Psychology

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By
Duraiyah Thangathurai
March 2010

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2010

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## Dedication

To my beloved father, mother, siblings, and family members,

To my spiritual Guru Bhagavan Sri Sathya Sai Baba

To my patients, students, residents, professors and teachers

To the Divine and Inspiring spiritual images namely

Durga, Sarasvathy, Luxmy, Kali, Quadleupe, Shiva, and many others sacred images.

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DISSERTATION ABSTRACT

# SPIRITUALITY OF CARETAKERS

# AND

# END OF LIFE CARE

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March 2010

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This dissertation is based on the study of the spirituality of caretakers, mainly physicians and nurses, with regard to its effect on the care of terminally ill patients. Terminally ill patients, in addition to physical symptoms, have many spiritual issues in their final days of life. While historically spiritual care has been available for many centuries it is becoming more and more neglected with the advancement of science and technology. These advances, however, do not significantly alleviate patient suffering related to psychological, spiritual, and social aspects. Now there is a renewed interest in the area of spirituality and people have again become aware of the importance of caring for the dying patients and their families. Numerous studies over the last two decades

support the therapeutic effect of spiritual care, but these studies concentrate more on the perspective of the patient and the family members.

The literature search is based on the historical development of spirituality in various parts of the world. This approach gives a broader perspective on spirituality that goes beyond the limitations of religion and culture. Spirituality is further explored in terms of psychological, philosophical, and sociological contexts. The psychological areas focus on existential themes. The review also incorporates other psychological aspects such as psychodynamic, humanistic, imaginal, and transpersonal principles. Additional areas of the review emphasize and examine the importance of spiritual care relating to elderly patients.

The current dissertation is based on patients in a cancer hospital who were admitted to the intensive care unit (ICU). The spirituality of caretakers was evaluated by interviews, surveys, and case studies. The evaluation was mainly carried out on experienced physicians in an academic setting and on those involved in the care of the patients in the ICU. The results show that spirituality of caretakers has a beneficial effect on the spiritual care provided to the patients.

# INTRODUCTION

I have been taking care of patients for over 30 years. These patients have suffered from a variety of ailments including cancer, traumatic injuries, severe heart or pulmonary disease, and end stage-liver or kidney disease. For those who became terminally ill I was able to participate in their care during their final days of life. Many of these dying patients had spiritual issues they wished to discuss and they hoped that their caretakers would support this need. Thus, it is important for the caretakers working with the terminally ill to understand this expected role. It is a humanistic approach—one with compassion, empathy, and presence—that helps to establish this relationship and to navigate them through their final days. I observed that this type of spiritual care not only improved the quality of life of the terminally ill patients but also allowed physicians to develop skills in nurturing and coping.

I have worked in many different parts of the world and, interestingly enough, I have found that spirituality plays an important role in the care of the terminally ill patient. In places that I have visited, including Australia, Europe, and Asia, spirituality has become part of the care for the terminally ill. In fact, it played as important a role as medications and basic nursing care. In this sense spirituality transcends religion, morals, culture, and geographical boundaries.

When you are inspired by some great
purpose, some extraordinary project,
all your thoughts break their bonds;
your mind transcends limitations,
your consciousness expands in every direction,
and you find yourself in a new, great
and wonderful world.
Dormant forces, faculties and talents
become alive, and you discover yourself
to be a greater person by far
than you ever dreamed yourself to be.
- Patanjali (1st to 3rd century BCE)

Lives of great men all remind us
We can make our lives sublime,
And, departing, leave behind us
Footprints on the sands of time.
- Henry Wadsworth Longfellow (2006)

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# CHAPTER 1

## NATURE OF THE STUDY

"The art of living well and the art of dying well are one." – Epicurus

"In my end is my beginning." – T.S. Eliot

In recent years both the medical community and the public have become increasingly aware of the importance of spirituality in healthcare (Sinclair, Raffin, Pereira, & Guebert, 2006; Astrow, Puchalski & Sulmasy, 2001). Nowhere else in medicine is the importance of spirituality more apparent than in the care of terminally ill patients.

It is well recognized that most patients suffer during their final days of life (Ventafridda, Ripajonti, Tambvurini, Cassileth, & DeConna, 1990). While modern medicine has made great advances in technology, drug therapies, surgical techniques, and other curative and life-prolonging measures, these advances have not made a significant contribution to the spiritual, social, and psychological well-being of terminally ill patients. Ironically, these advanced techniques at times have contributed to the prolongation of the dying process and may have resulted in more pain, anxiety, hopelessness, depression, and suffering (Puchalski, 2002). Dr. Puchalski is a leading physician and authority in palliative care medicine. She stressed the importance of spirituality:

> Our culture and our profession as a whole must look at dying very differently from the way it currently does. We need to see dying not as a medical problem but as natural part of life that can be meaningful and peaceful. We can broaden and perhaps even enhance our lives now by knowing that one day we will die. By thinking about our mortality early in life, we will not be caught off guard and pressured by the dilemmas of choices at the end-of-life. We will have had a chance to think about some of those choices sooner and to come to peace with our mortality. This is where religious organizations can be particularly helpful. They can facilitate our discussions of dying and what that means to us. They can educate their members about the importance of preparing themselves for the choices, both spiritual and medical, that need to be made near the end-of-life. We, the interdisciplinary care team, can jointly assist the dying person in coming to peace in life's last moments (p. 810).

Spiritual care inspires compassion and empathy and provides a sense of dignity and meaning (Cawley, 1997; World Health Organization, 1990). As shown in several studies, spirituality offers a renewed sense of hope and direction to patients and their families (Fetzer Institute, 1999; Gallup, 1994).

Death with dignity is the main spiritual theme addressed by humanists, ethicists, spiritualists, and philosophers (Brant, 1998). Various religions espouse dogmas and rituals that make death easier by promising an afterlife or rebirth (Eliade, 1996). Immeasurable hours are spent pronouncing sermons, homilies, or rituals related to dying, redemption, suffering, and coping with the loss of life. Many prominent spiritual figures such as Augustine, Buddha, Tolstoy, Gandhi, Mother Teresa, and the Dalai Lama have all

expressed their philosophies on the importance of spiritual care and the acceptance of death (Johnson & McGee, 1991; Kramer, 1988; Josephson & Peteet, 2004). Nothing has been more uniformly prevalent throughout history than the notion of spirituality.

There are numerous definitions of spirituality, ranging from a dogmatic view to a broader and all-inclusive perspective. Pargament (1999) defined spirituality as a search for the sacred entity, which refers to a God or a supreme being. His definition of spirituality arises from a religious context, influenced by the values, beliefs, and doctrines of specific religions. Stifoss-Hanssen (1999) offered a definition of spirituality that encompasses humanistic existentialist concepts including holism, authenticity, self, connection with others, community, and the meaning of life. Wheeler's (2002) description related to the world-oriented perspective, which refers to a vital life force that animates and connects us to all the rhythms of the universe, nature, ancestors, and community.

I will focus on a broad, multidimensional definition that integrates spirituality from three different perspectives: God-oriented, which relates to practices involving faith in God or a higher power; humanistic or people-oriented, which focuses on human achievement or potential; and world-oriented, emphasizing the relationship to nature, cosmos, and ecology (Hill et al., 2000). This multidimensional definition fulfills the existential approach to spirituality. The Oxford Dictionary defined existentialism as "a philosophical theory or approach, which emphasizes the existence of the individual person as a free and responsible agent determining their own development through acts of the will" (Blackburn, 2008). Choices and responsibilities are an essential component of spirituality.

Most studies conducted in the area of spiritual care are related to patients and their families. There has been minimal research on the characteristics of caretakers related to spiritual care (Sulmasy, 2006). I hypothesize that the spirituality of caretakers during this critical period is equally important and must be developed and nurtured. The purpose of my research is to conduct a critical analysis regarding the spirituality of physicians and nurses in the care of the elderly and the dying. This analysis will be focused on the perspectives of physicians and nurses as it relates to their knowledge, experience, and implementation of terminally ill care.

## Background to the Problem

In their final days patients struggle with spiritual questions that include the role of a higher power, the reasons for suffering, and wondering what happens after death (Ventafridda, Ripamonti, Tamburini, Cassileth, & DeConna, 1990). These existential questions might not have been previously considered but in the final days of life become imminent, an impending reality of life (Bolen, 1998; Saunders, 2004). Other major issues in the final days of dying are the fear of abandonment, pain, suffering, loneliness, loss of autonomy, and lack of control of bodily functions (Saunders, 2004). Many terminally ill patients go through a protracted course of dying, which includes severe depression, withdrawal from society, and suffering until death. A small proportion of these patients turns to euthanasia or commits suicide. The risk of suicide is highest among the elderly (Koenig, 2007).

Physicians caring for end-of-life patients face unique challenges. They may question their competence because of their inability to cure terminal illness and provide hope to their patients. Often they are reminded of their own vulnerability, mortality, and

unpleasant personal experiences from the paSt. Currently, most physicians and nurses are not trained adequately to deal with end-of-life issues because the majority of their training is focused on scientific methodology (Sulmasy, 2006). Compounding the distress of physicians and nurses, patients and their family members are in the midst of existential and emotional crisis. Many physicians limit their involvement at this stage of care because they have no hope to offer in these situations. Their focus is directed toward the physical symptoms of these patients. Pain is treated with increasingly large doses of opioids, with minimal consideration given to the spiritual, psychological, and social nature of the pain and suffering. Cicely Saunders (1996), a nurse and a physician who was known for her pioneering work in hospice care, stated that physicians and nurses seldom address the spiritual needs of patients.

## Problem Statement

The focus of most studies is on the spiritual needs of the patient and the family. There are a few studies focusing on how the spirituality of hospice workers affects the care of the patient. These studies may not be applicable to physicians and nurses in larger healthcare settings. Does the spirituality of the physicians and nurses improve the quality of care in the terminally ill?

The researcher's belief is that the spirituality of the healthcare providers improves the care of terminally ill patients. If the caretakers do not believe spirituality is important, they may not emphasize this aspect of care. Consequently, the quality of care may be compromised significantly.

## Research Questions

1. What part does spirituality play in the care provided by physicians to terminally ill patients?
2. What part does spirituality play in the care provided by nurses to terminally ill patients?
3. What are the differences between physicians and nurses with respect to the extent that they employ spirituality in providing care to terminally ill patients?
4. In general, to what extent do physicians and nurses believe spirituality is an important part of care for terminally ill patients?

## Application of Results

This study design is intended to reveal that the spirituality of the physician and nurses is pertinent to the care of terminally ill patients. The study may also be helpful in identifying challenging issues associated with the end of life.

End-of-life care providers should consider the spiritual beliefs of their dying patients and families to render better care. The study may provide answers to the following questions regarding spiritual care: What are the practical aspects of spiritual care, and how can spiritual care be assessed?; What kind of communication should providers have with patients regarding their spiritual beliefs?; What should be done when there are conflicting views between physicians and patients?; Should the care team recruit additional experts to provide spiritual care?; Should physicians or nurses provide spiritual care without proper training?; Would an untrained physician or nurse providing spiritual

care negatively affect the patient's care and possibly do more harm?; and, What are the professional boundaries for physicians? (Post, 2000).

Based on the results of the study, one may be able to ascertain whether the spirituality of caretakers meets the patients' spiritual needs. In addition, this study may determine whether spiritual care will transform physicians and nurses into better caretakers. Finally, spirituality may help caretakers cope with loss and the suffering of patients.

## Theoretical Framework

To apply the appropriate theoretical framework applicable to spiritual end-of-life care, caretakers must understand the terms *spirituality* and *spiritual care*. More importantly, they need to have a clear understanding of the spiritual issues facing the dying patient and how spiritual care can be provided to improve the quality of care. The main applicable framework is focused on existential psychology. The other branches of psychology that encompass existentialism in terminally ill patients are incorporated and include: psychoanalytical frameworks of Carl Jung, transpersonal, imaginal, psychosynthesis, humanistic, and positive psychology.

## Definition of Terms

### *Buddhism*

Buddhists emphasize human actions in their focus on karma and reincarnation. Buddhism recognizes four noble truths: (a) life is basically suffering; (b) the origin of suffering lies in attachments and craving pleasures; (c) the cessation of suffering is by

letting go of cravings; and (d) the way to cease craving is to follow the noble path chosen by Buddha. The *Tibetan Book of Death,* an ancient synopsis about the process of dying, outlines these Buddhist concepts.

*Christianity*

The basic Christian message is one of love for humankind. The most distinctive tenets are the trinity, incarnation, and atonement. Suffering is caused by sin, broadly defined as actions that result in estrangement from God. Suffering is relieved by God's grace and the belief in the promise of eternal life.

*Hinduism*

Hinduism is a polytheistic religion with many gods and goddesses. The Hindu karma is the concept in which suffering is payment for the debt of our past actions. The common god images of worship are Vishnu, Shiva, and Sakthy. Hindu scriptures, known as Vedas, address achieving awareness of the eternal self.

*Holistic*

A holistic approach is a synergistic approach that deals with combined physical, mental, emotional, and spiritual aspects of human health and illness.

*Islam*

In Islam, God—Allah—reveals the truth of monotheism, the Ten Commandments, the golden rule, and the five pillars of Islam, which describe the righteous life. Suffering is caused by alienation from the will of Allah and is relieved by

total surrender to his will. Sufism is a branch of Islam, rich in broader spiritual ideas, and has many resemblances to other traditions (Armstrong, 2002).

*Judaism*

Judaism is a monotheistic, Abrahamic religion that views the world as good because it was made by God. Suffering results from disobedience of God's law as it is described in the Torah. Relief of suffering is possible by asking for God's forgiveness and living according to God's will. Generally, suffering is viewed as a necessary part of God's creation and not as a punishment. The focus is on life on earth rather than on what happens after death.

*Spirituality of Native Americans*

Native Americans believe in ancestor worship, which, according to them, serves two purposes in life. It helps them to know the self and to help others. They also believe there is spiritual power in nature, land, and animals. There are many tribes with many diverse rituals and practices, but commonalities exist among them.

*New Age Movement*

The New Age Movement combines aspects of spirituality, practices of many world religions, and environmentalism. It is an eclectic approach to spirituality and a rejection of mainstream dogma. It often is called self-spirituality or new age spirituality. It may also include ideas from modern science, psychology, and ecology. It also has roots in transcendentalism, Swedenborgianism, astrology, alchemy, western occult traditions, and Kabala.

*Quantum Physics*

Quantum physics is a branch of physics that studies energetic characteristics of matter at subatomic levels.

*Reincarnation*

Reincarnation is a philosophy in which the soul has multiple lives in the process of achieving a higher level of spiritual maturation.

*Religion*

Religion is a belief system that provides a framework for understanding one's existence and for responding to universal spiritual questions. Religious rites and rituals may provide specific ways of expressing spirituality. Because religious rituals and observances offer powerful sources of inspiration and comfort to many, the religious beliefs of all terminally ill patients should be supported in every possible way.

*Spiritual Healing*

Spiritual healing is a form of healing that operates on lower physical and ethereal levels but also corrects energetic disturbances and encompasses emotional, mental, and higher spiritual levels.

*Spirituality*

Spirituality is considered a broader, more inclusive category than religion. Spirituality includes love, relationships, caring, presence, empathy, and compassion.

Spirituality goes beyond religion and can be inclusive of religious philosophy (Scott, 2001).

# CHAPTER 2

# REVIEW OF RELATED LITERATURE

## Chapter Overview

The purpose of this chapter is to review the literature about the beneficial aspects of spiritual care and the spirituality of caretakers, mainly physicians and nurses, relating to the quality of care given to terminally ill patients. Historically various ideas, concepts, and theories contributed to the development of spiritual care in the practice of medicine, especially in the area of end-of-life care. During past centuries many traditional systems of medicine have integrated spirituality as part of the care for the sick, elderly, and dying. In the last 100 years, with the advancement of science, technology, and industrialization, spiritual and holistic aspects of care have been ignored. However, recently there is a renewed interest in incorporating spirituality to optimize medical care. What was once known to be compassionate religious care is now evolving into a broader, more all-encompassing total care. There is now an attempt to shift from a biological, medical model to a bio-psychosocial-spiritual model. To achieve optimal patient care, healthcare professionals must incorporate this dimension of care into their practice, particularly in end-of-life care where spiritual issues come to the forefront.

This chapter will focus on the development of spiritual care and its importance by examining various religious, cultural, and traditional beliefs and practices in a historical

sequence. The perspectives of various great thinkers and humanistic figures including theologians, philosophers, saints, sages, physicians, and caretakers who have contribute to various aspects of spiritual healing will be explored (Armstrong, 2006). Spirituality and its relationship to psychology, ethical philosophy, holistic practices, and rituals will also be surveyed. Furthermore, scientific empirical research and qualitative studies relating to spiritual aspects of care in terminally ill patients will also be investigated (Armstrong, 2006; Eliade, Wiesner, & Couliano, 1991).

*Early Spiritual History*

To understand the relationship between spirituality and healthcare and its evolutionary development, one needs to examine traditions, philosophies, practices, belief systems, culture, and mythology (Smith, 1995; Armstrong, 2006). In the past, in every culture spirituality or religiosity was a key component in the care of the sick, elderly, and dying. Priests, shamans, rabbis, monks, sages, and saints were the traditional providers of spiritual care for the elderly and dying (Eliade, 2004). As seen in ancient religious rituals, they also focused on the care of the soul after death. Even now, in some parts of Asia, Africa, Australia, and South America, shamans and medicine men play an important role in providing medical care to the indigenous people. These practices can be traced back to prehistoric times (30,000 years ago) when Neanderthals and Cro-Magnon practiced burial rituals as depicted by cave paintings and artworks (Solomon & Higgins, 1996). The motivation for these spiritual practices reflected a reverence for the preservation of the human dignity of the dying and the care of the soul.

Since the beginning of humanity there has been a preoccupation with death and what transpires after death. Many ancient stories remind us of the transient nature of

one's earthly life, and the futile quest for immortality. This concept appears in several stories including the *Epic of Gilgamesh* in Mesopotamia, and the story of Nachiketas and Yama as narrated in the *Katha Upanishad*. The story of the *Bhagavad Gita,* the Hindu spiritual text, is based on the meaning of life and death dialogues between the warrior Arjuna and the god Krishna (Kramer, 1988; Easwaran, 2000). A majority of Indian spiritualists are influenced by the teachings of the Bhagavad Gita including Gandhi, Ramakrishna, and Vivekananda (Easwaran, 2002).

All religions and belief systems focus on a soul or life force that continues to live after death. In different traditions, this is referred to as Atman, soul, chi, or spirit. This life energy either is believed to return through a process of rebirth or continues to exist in communion with God or higher power or consciousness.

In prehistoric times, as societies first were beginning to develop, religious practices were confined to the worship of nature and natural forces. This period was also known for intense competition among tribal groups, violence, and rituals including animal and human sacrifices. There was a need for social reform or societies would not have been able to survive. This reform was of a spiritual nature and occurred in many areas of the world between 800 BC and 250 AD (Armstrong, 2006).

*Axial Age and Spirituality*

Spiritual reformation became a potent force in uniting society and bringing harmony and peace within the communities. Karl Jasper refers to this period as the Axial Age (800 BC–250 CE). Jasper was a German existentialist who did extensive work on the historical aspect of spiritual development. During this period many spiritual changes took place in diverse regions of the world, including the Middle East, Israel, Persia, India,

and China.  The spiritual foundations were laid contemporaneously and independently throughout the world (Armstrong, 2006; Jasper, 1977).

In ancient Israel, Jeremiah, Elijah, and Isaiah put forth ideas fostering harmony, peace, and love (Bultmann, 1984).  In Israel, a Jewish sect referred to as the Essenes (Larson, 1967) lived in the area of Kumran near the Dead Sea (200 BC–200 CE).  The Essenes were known for their strict spiritual beliefs and practices.  They adhered to spiritual disciplines such as nonviolence, pacifism, vegetarianism, asceticism, equality, and altruism (Solomon & Higgins, 1996; Schoenfield, 1984).  Some authors believe that both John the Baptist and Christ descended from this sect.

In Greece, Heraclites (535–475 BCE) was known for his philosophical ideas reflecting the theme that everything in the world is transient and in a constant state of change (Russell, 1967).  This concept was reflected in his saying, "one cannot step twice into the same river."  His work influenced many Western European existential philosophers including Nietzsche.  Pythagoras, a philosopher and mathematician who lived circa 500 BC, was the first to propose the spiritual concept of a soul and the process of transmigration from one life form to another.  Other Greek philosophers, including Socrates and Plato, were influenced by Pythagoras' teachings (Blackburn, 2008).  His teachings also contributed to Christian philosophy years later.  Plato had strong views with regard to the soul and end-of-life care.  In his final days of life, he preached that everyone should be prepared to accept death and "practice the art of dying."  Stoic philosophers such as Cicero, Xeno, and Marcus Aurelius addressed issues relating to death and dying in detail (Durant, 1991).  Cicero is known for his essays on old age, *Cato Maior Senectude*.  This book was favored by President John Adams and was selected as a

Harvard Classic. Christianity played a major role in the spiritual development of the West (Smith, 1991). Jewish and Greek philosophers and theologians, including Plato, Saint Paul, and Plotinus influenced early Christian beliefs. Saint Paul, who came from Greek Jewish traditions, was instrumental in universalizing the Christian spiritual themes of love and faith (Ehrman, 2004). Many monotheistic sects surfaced in Rome, Israel, Persia, Egypt, Greece, and Asia Minor that had Jesus as a central figure (100–400 CE). These sects included Manicheans, Arians, Gnostics, Ebionites, Donatists, and Marcionists (Clifton, 1992). These sects agreed on many common ideas such as love, nonviolence, compassion, and acceptance of Christ as the central religious figure. Sects disagreed on which gospels should be accepted as cannon, and the nature of God. Several sects claimed to differentiate between the God of the Old Testament and the God of the New Testament. The God of the New Testament was a compassionate, loving, forgiving, and universal God, whereas the God of the Old Testament was punishing, indifferent, and limited exclusively to the Jewish people (Jung & Segal, 1992).

During the Axial Age, St. Anthony from Egypt pioneered the Christian monastic movement (Cornwell & Cornwell, 2009). Other Christian scholars, Clement of Alexandria (150–215 CE) and Origen (185–254 CE), contributed to the early writings on Christianity (Armstrong, 2006). St. Augustine (354–430 CE) from North Africa, then a part of the Roman Empire, greatly expanded on these early Christian writings. His beliefs were influenced greatly by his conversion experiences from the Manichean sect to the Christian faith. St. Augustine also was instrumental in establishing additional concepts of Christian faith including the trinity, salvation, and divine grace. In his book *Confessions,* he wrote of the premature death of a close friend who converted to

Christianity just prior to his death. This experience was instrumental in his search for the true nature of God. He found hope and faith in the Christian religion (de Montaigne, 1993; Yalom, 2005). Augustine stated, “it is only in the face of death that the man’s self is born” (quoted in Yalom, 2005, p. 33).

St. Augustine was instrumental in forming and popularizing mainstream Christianity. He was influential in the conversion of Roman Emperor Constantine (273–337 CE) to Christianity, which became a major state religion replacing other religious sects (Willis, 2005). St. Augustine held a significant position as bishop in the Church of Rome during this time. Emperor Constantine was very active in the formulation of dogmas and rules for mainstream Christians while limiting other practices, philosophies, and opinions. Members of other Christian sects that differed from the church of Constantine were treated as heretics. The Augustinian spiritual views were both popular and widely accepted and continued to influence the Roman Empire for many years (St. Augustine, 2001).

Many sects evolved in ancient Persia from the early Indo-Aryan traditions. Spiritual reformation began with Zoroastrianism, a monotheistic sect started by Zarathustra (628–551 BCE), also known as Zoroaster in the West (Armstrong, 2006). Zoroastrians believed in one universal and transcendental God, namely Ahura Mazda. Ahura Mazda is the beginning and the end, the creator of everything that can and cannot be seen, the Eternal, the Pure, and the only Truth. They believed that he ultimately will prevail over evil Angra Mainyu (Ahriman). Ahura Mazda worship evolved as the counterpart of the rival Indo-Aryan god Indra. Indra worship originated from the earlier ancient Indo-Aryan tradition (Eliade, Wiesner, & Couliano, 1991; Foltz, 1999). Another

cult, Mitra worship, originated in Persia and spread to the West, including Rome, and became a popular sect among the Romans during the pre-Christian era. Many authors believe that Zoroastrian philosophy has influenced other monotheistic religions strongly including Judaism, Christianity, and Islam (Armstrong, 2006). In many aspects, the Zoroastrian teachings, Avesta, parallel Moses' Ten Commandments. The German philosopher Nietzsche was inspired by Zoroaster's teachings and wrote a book titled *Thus Spoke Zarathustra*.

One of the earliest sects of Christianity, known as Manichaeism, was founded in Persia by Mani (c. 216–276 CE) and spread to Rome and other areas in Europe. Manichaeism is a synthesis of Christianity, Zoroastrianism, Gnostic concepts, and Buddhism. During Constantine's empire Manichaeism was suppressed in Rome and Persia, and its founder, Prophet Mani, was executed in Persia (Armstrong, 2006; Meyer, 1999).

The spiritual philosophy in India developed around 1000 BCE to 600 CE, and remains the main basis of current Hindu religious practices. The earliest Indian scriptural teachings had its roots in Indo-Aryan tradition and are referred to as Vedas, which means "sacred knowledge" in Sanskrit. The foundation of Hinduism is based on the metaphysical reality called *Brahman,* which is the absolute, changeless, formless, and eternal (Smith, 2009; Flood, 2003). The following Sanskrit peace mantra from the Vedas is commonly recited in Hindu temples and schools, "*Asato ma sadgamaya tamaso ma jyotirgamaya mrityor mamritam gamaya.*" This mantra reflects the essence of Hindu thoughts of the Upanishads and can be translated into English as "Lead me from falsehood to truth, from darkness to light, from death to immortality."

Fritjof Capra (1999) is a well-known western physicist who also studied Hindu scriptures extensively and explained the universe and God. The Rig Veda explained the universe as *Rita*, which means cosmic one that is intrinsically dynamic. The universe must be grasped dynamically as it moves, vibrates, and dances. Capra stated that eastern mystics see the universe as an inseparable web with dynamic rather than static interconnections. The cosmic web is alive, it moves, grows, and continually changes. Capra further stated that Shiva, the cosmic dancer, is perhaps the perfect perception of the dynamic universe. Through his dance, Shiva sustains manifold phenomena in the world by immersing the universe in his rhythm, a magnificent image of the dynamic unity of the universe (Coomarasamy, 2006).

The Upanishads, another set of philosophical Hindu texts, describe God/Brahman as immortal, formless, timeless, moving, and transcending all forms (Armstrong, 2006). The Upanishad period parallels the axial age during which major spiritual transformation took place in India (Easwaran, 2007).

Patanjali (200 BCE) and Adi Shankara (788–820 CE) were the founders of Vedanta philosophy and emphasized that everything in the universe is a manifestation of god's energy or Brahman, and the human soul (Atman) originates from Brahman (Feuerstein, 1989). Divine energy permeates everything and everyone (Jackson, 1994). The good and bad we experience are dual states of mind and the divine energy is the only reality (Deussen & Johnston, 2007). The Upanishads, in the Chandogya Upanishad, further stress the importance of the immortality of the soul:

> The self which is free from evil, free from old age, free from death, free from grief, free from hunger and thirst, whose desire is the real, whose thought is the real, he should be sought, him one should desire to understand. He who has found

> out and who understands that self, he obtains all worlds and all desires (Solomon, 2002, p. 130).

In this context, the self refers to the soul.

In India, many philosophers, saints, sages, and poets for centuries expressed spiritual existential ideas relating to freedom, authentic living, connection with higher power, soul, meaning of life, nature, and death. These are expressed in the Hindu scriptures: the Vedas, Puranas, and Upanishads. In the first century, saints Valmiki and Vedaviyasar contributed to the scriptures called Ramayanam and Maha Bharatham. In South India, Thiruvalluvar (300 BCE) and Auvaiyar (100 BCE) are two of the spiritual figures who are still honored and respected. In Tamil Nadu, Thiruvalluvar was known for his famous book *Thirukural,* which is a synopsis of many existential themes relating to life (Sundaram, 1990; Pope, Drew, & Lazarus, 2005). Auvaiyar was the first female philosopher and poet who stated the spiritual codes known as *Aathichoodi*, which are similar to the Ten Commandments of the Judeo-Christian traditions (Krishnamurti, 1995). To this day, over 100 million Tamils from South India and other countries study and follow these codes. Other famous saints and sages of South India were Sampanthar, Thiru Navakarasar, Sundarar, Manickavasagar, Patinathar, and several others (Pope, Drew, & Lazarus, 2005; Barnett, 2010; Bharati, 1968).

In India another major spiritual reform took place circa 600 BCE when Buddhism became a powerful spiritual movement (Armstrong, 2006; Smith 1991). It was based on the teaching of Gautama Siddhartha. Buddha means "enlightened one" or "one who has awakened." Buddha attained enlightenment, also referred to as *Nirvana*. He explained the nature of reality and the path of life and introduced the concept of the middle way or path. The middle path seeks moderation and is important in avoiding the extremes of

self-indulgence and self-denial. According to him, we suffer in life due to our desires or attachment to transient things. Liberation from suffering will come from carrying out right actions. He summarized his teachings as the Four Noble Truths: *Dukka* means suffering and is everywhere; *Samudaya* is a cause of suffering that comes from attachment or desire; *Nirodha* is the end of suffering; *Maggo* (*Marga*) means there is a path that leads out of suffering known as the Noble Eightfold Path—right view, right thought, right speech, right conduct, right vocation, right effort, right attention, and right concentration. The theory of karma is based on cause and effect. Every volitional action produces effects or results. Buddhism also has numerous existential themes and teachings, which are compatible with the existential philosophy of the West (Armstrong, 2008; Bodhi, 2005).

Buddhism became a strong force spreading from India to neighboring countries and to Far East countries such as Vietnam, China, and Japan, where it was incorporated with native religious practices including ancestor worship and nature worship. In China, Buddhism was incorporated with the philosophical ideas of Confucianism and Taoism. From China, Buddhism spread to Japan, where it was influenced by the existing religion, Shintoism (Smith, 1991). Shintoism is characterized by worship of nature, ancestors, many gods, and spirits.

King Ashok (304–232 BCE) was the most powerful emperor in Indian history. He was a Hindu who embraced Buddhism following horrible experiences of war, and he was instrumental in organizing and spreading Buddhism in Southeast Asia, Persia, and Afghanistan (Smith, 1991). Nagarjuna (150–250 CE), a south Indian Buddhist monk,

started a new school of Buddhist philosophy known as Mahayana Buddhism (Jaspers, 1974).

Bodi Dharma (4th to 5th century CE), an Indian monk, spread Mahayana Buddhism in China and in the Far East. Zen Buddhism, which originated from Chan Buddhism of China, became popular in Japan. The word *Zen* originated from the Sanskrit term *Dhyana,* which refers to meditation. The aim of Zen Buddhism is to discover the Buddha nature in each person through meditation and mindfulness of daily experiences (Williams, 1989; Edelglass & Gardield, 2009).

The primary focus of Mahayana is Bodhisattva, to strive for enlightenment Buddhahood for the benefit of both oneself and all other sentient beings (William, 1989). Buddhahood is blissful mind completely free from suffering and its causes. The Bodhisattva works tirelessly for the benefit of all living beings. Mahayana Buddhists (large vehicle) believe in universalism, that everyone has the potential to become Buddha and that Buddha's transcendental immanence, Buddha nature, is found in everyone (Borg, 2004). The Dalai Lama can be considered an example of a modern day Bodhisattva. Theravada Buddhism (small vehicle), on the other hand, focuses on personal enlightenment. To achieve personal salvation one must work within oneself. Theravada Buddhists do not believe in the concept of Bodhisattva (Donath, 1971; Rahula, 1974; Eliade, 1985).

Around the same period of Buddhism another spiritual tradition known as Jainism started in India. Mahavira (599–527 BCE), the founder of the Jain sect, emphasized and expanded concepts on the principle of compassion and nonviolence (*ahimsa*) to all forms of life. Many other sages and saints from various Indian traditions also reemphasized the

concept of *ahimsa* and compassion (Crim, 1989; Singh, 2001). In India, Islam was introduced by Moguls and became a major religion in the last thousand years. Emperor Akbar was instrumental in postulating and expanding Islamic spiritual ideas and respecting the beliefs of other faiths (Habib, 1997). In the last 500 years, Sikhism was formed by a spiritual leader, Guru Nanayak, and his followers. It is based on the concept of one Universal God and incorporates both Islamic and Hindu ideas of spirituality (Smith, 1991; Mcleod, 1998).

In China, Lao-Tzu, Mo-Tzu (470–391 BCE), and Confucius (400 BCE), along with several Buddhist monks, contributed to spiritual development during the Axial Age. (Kirkland, 2004). Lao Tzu, a contemporary of Confucius, introduced the philosophy of Taoism. Lao-Tzu's teachings are compiled as the classic Chinese text *Tao Te Ching* or *Dao De Jing,* which continues to be the source of spiritual inspiration to many.

Tao can be defined as a path or road, the way of nature and of ultimate reality. Tao is often described as a force that flows through all life. A happy and virtuous life is one that exists in harmony with the Tao. Tao, nature, and reality are one. According to this philosophy, not revering the Laws of Nature adversely affects people. However, accepting Tao with knowledge and reverence provides balance and harmony. According to author Smith (1991), the Tao that can be told of is not the eternal Tao; the name that can be named is not the eternal name. It manifests plainness, embraces simplicity, reduces selfishness, and is lacking in greed and desire (Kramer, 1988):

> The way (Tao) that can be spoken of
> Is not the constant way (Tao);
> The name that can be named
> Is not the constant name.
> The nameless was the beginning of heaven and earth;
> (Kramer, 1988, p. 82)

Confucius' teachings and philosophy emphasized morality, duty, social relationships, justice, and sincerity (Xinzhong, 2000). Confucianism represents a higher form of moralism involving humaneness (*ren*) and righteousness (*yi*). Confucius introduced a value system based on strong loyalty, which involved family, individual citizens, rulers, and kings. He emphasized respect for elders by their children, and the importance of the family unit as a basis for an ideal government. He expressed the well-known principle, "Do not do to others what you do not want done to yourself," one of the earliest versions of the Golden Rule (Smith, 1995).

Confucius' philosophy of virtue is based on harmony of the citizens, which includes members of the family and society. His teachings emphasize self-cultivation, emulation of moral values, and the attainment of skilled judgment rather than knowledge of rules (Brooks & Brooks, 1998). His teachings may be considered as an eastern form of virtue ethics that is based on absolute duty. In Confucian ideals, filial piety is one of the virtues to be held above all else. Filial piety relates to a respect for parents and engaging in good conduct, which shows courtesy, love, respect, and support. It also involves taking care of the ill, displaying sympathy and concern for the sick and dying, and carrying out rituals after their death to appease their spirits (Solomon, 2002; Smith, 1995).

A disciple of Confucius, Zi-lu, once approached him with existential questions about God, life, and death, as reported in *Analects*:

> Zi-lu asked how to serve the spirits and the gods. Confucius replied, "Not being able to serve other people, how would you be able to serve the spirits?"
> Zi-lu said, "May I ask you about death?" Confucius replied, "Not yet understanding life, how could you understand death?" (Solomon, 2002, p. 8)

Mo Tzu, the other prominent Chinese philosopher, differs from other contemporary philosophers. His teachings emphasized self-reflection and authenticity rather than adherence to rituals. He observed that we often learn about the world through adversities. One attains true self-knowledge by reflecting on one's own successes and failures rather than from performing rituals. He favored a life of asceticism and self-restraint, renouncing material extravagance. Mo Tzu proposed a doctrine of universal love (Solomon & Higgins, 1996). His concept of spirituality was based on love, care, compassion, altruism, service, transcendence, meaning, and nonviolence.

Chuang Tze, also referred to as Zhuangzi, was an existential philosopher who lived in the 4th century BC and often commented on life and death. He espoused the theory that there are limitless things to know in this world, and that it is foolish for a human, who is limited, to pursue the unlimited.

Many eastern philosophers believed death is followed by another level of existence. This way of thinking minimizes the fear of death and helps family members throughout the grieving process. Chuang Tze believed life and death are merely human distinctions of one reality. He wrote:

> Life is the companion of death, death is the beginning of life. Who understands their workings? Man's life is a coming together of breath. If it comes together, there is life; if it scatters, there is death. And if life and death are companions to each other, then what is there for us to be anxious about? (Kramer, 1988, p. 85)

This existential philosophy of Chuang Tze is popular among Chinese wisdom traditions.

Buddhist ideas flourished in other eastern Asian countries including Tibet, Bhutan, Burma, and Nepal. Tibetan Buddhism, called Vajrayana, is becoming a popular movement throughout the world (Powers, 2007). The teachings of the Dalai Lama, Pema Chodron, and Sogyal Rinpoche are based on Tibetan Buddhism concepts. Tibetan

Buddhism is more ritualistic and includes chanting and ritual, which followers claim provide a quicker method of attaining Nirvana or enlightenment (Lama, 2001; Chodron, 2001; Rinpoche, 1994). According to Vajrayana, one needs to have a guru or teacher, also known as lama, to initiate spiritual practice. *The Tibetan Book of Living and Dying* by Sogyal Rinpoche explained the concepts of karma, rebirth, and nature of mind. It explained how to train the mind through meditation, follow a spiritual path, have compassion, and care for the dying. The ancient funerary text known as *Bardo Thodol (Tibetan Book of the Dead)* described in detail the soul's experiences and journey during the final days of dying (Kramer, 1988). The interval between death and the next birth is divided into many stages. These periods are referred to as Bardo.

In Mahayana Buddhism, the feminine form of the Buddha figure is known as Guan Yin and is worshipped in Far East countries such as China, Taiwan, Vietnam, Korea, and Japan. The name Guan Yin refers to the one who hears the cry of the human beings. She can be compared to the Virgin Mary of the Christian tradition. In Sanskrit mythology, Guan Yin originates from Avalokitesvara, who was initially a masculine form of bodhisattva who embodied the compassion of all Buddhas. The Guan Yin image represents compassion, love, kindness, and peace. She is loved rather than feared (Smith, 1991). The equivalent feminine Buddha form in Tibet is referred to as Tara. Recently, Guan Yin worship and meditation are becoming popular in various parts of the western world.

## Spiritual Development in Europe During the Middle Ages, Renaissance, and Enlightenment

Christianity became the major religion in Europe following Roman influence, replacing pagan, shamanistic beliefs. During the Middle Ages, many western spiritual thinkers moved away from the dogmatic views of the Vatican and attempted to incorporate broader spiritual ideas. Many incorporated their own experiences, philosophies, visions, and ideas that were appealing and resonated with their faith. Several of them were condemned and persecuted for their beliefs and actions (Armstrong, 1994).

Hildegard von Bingen (1098–1179 CE), a German nun, was known for her visions from a very young age (Maddock, 2003). She later joined a Benedictine monastery where she became a nun and helped and healed many sick patients. She wrote many hymns about her visions, called *Scivias* (Hildegard of Bingen, 2001). She came from an influential, aristocratic family in Germany and therefore was not persecuted for her spiritual beliefs.

A close contemporary of von Bingen was St. Francis of Assisi (1182–1226 CE), a 13th century mystic and saint. St. Francis lived an ascetic life, with extreme compassion for humans, animals, and nature (Di Monte, 2007). He felt a deep connection with all beings, including flowers, trees, mountains, winds, water, air, and the sun, and demonstrated total openness to the natural world and all living beings, accepting them as brothers and sisters and treating them with love and respect. St. Francis was known for his prayer, which is the most enduring prayer recorded in history (House & Armstrong, 2003). Wayne Dyer, American spiritual philosopher, psychologist, and motivational

speaker, claimed that he was strongly influenced by the teachings and the prayer of St. Francis (Dyer, 1998). The prayer is universally popular among people of various traditions, provides peace, consolation, harmony, healing, and spiritual growth.

St. Francis also was known for his compassion toward animals and his ability to communicate with birds, animals, and even fish. He reached out to all life forms and felt a deep connection with them and with God (Dyer, 1997). All creatures were attracted to him; birds allowed him to hold them, and wolves and other wild animals would listen to his admonishments. His relationship with God was based on cosmic mysticism. He was probably the greatest saint in recorded history even though his views were contradictory to those of the church during his time (Dyer, 2003).

Another well-known spiritualist, St. Clare of Assisi (1194–1253 CE), was a nun who lived during St. Francis' time and was one of his great admirers (Coakley, 2006). Her compassion for the poor was so extreme that she refused to eat and starved herself to death. Her sister, St. Agnes, joined her in helping the poor and the sick (Di Monte, 2007). Another great mystic was St. Peregrine (1260–1345 CE) who healed many patients afflicted with cancer and became the patron saint of cancer.

Meister Eckhart (1260–1328 CE) was a spiritualist, philosopher, and Catholic theologian whose ideas integrated metaphysics and spirituality into traditional Catholic beliefs (Schopenhauer, 1966; Schurmann, 1978). The German philosopher Schopenhauer commented that Buddha and Meister Eckhart had similar views; however, Buddha expressed them openly whereas Eckhart had to camouflage his views within the boundaries of the Catholic Church (Schopenhauer, 1966). The 20th century humanistic psychoanalyst and philosopher Erich Fromm claimed that he was influenced by Eckhart's

writings and integrated his ideas in his own practice. Hammarskjold (1905–1961), a former United Nations Secretary General, was an ardent follower of Eckhart's spiritual philosophy and teachings. He received the Nobel Prize for his peace work. He commented:

> The explanation of how man should live a life of active social service in full harmony with himself as a member of the community of spirit, I found in the writings of the great medieval mystic Meister Eckhart for whom "self-surrender" had been the way to self-realization (Van Dusen, 1967, p. 47).

Today, many psychotherapists and community workers incorporate Eckhart's teachings into their practice of providing spiritual care.

In Spain, Theresa of Avila (1515–1582 CE) and St. John of the Cross (1542–1491 CE) were known for their spiritual care of the poor and sick. Theresa of Avila was a Carmelite nun whose spiritual beliefs and mystical ideas attracted many followers in Spain. At the age of 20, she fell sick and experienced visions of Christ. Along with Saint John of the Cross, she reformed the Carmelite order (Gallick, 2007). She strongly stressed the positive values of love, similar to Mother Theresa. According to Theresa of Avila:

> Whether one is a Hindu or a Muslim or a Christian, how you live your life is proof that you are not fully His. We cannot condemn or judge or pass words that will hurt people. We don't know in what way God is appearing to that soul and what God is drawing that soul to; therefore, who are we to condemn anybody? (Chalika & Le Joly, 1996, p. 91)

Saint John of the Cross was a Spanish mystic and saint known for his writings on the subject of soul. He was persecuted and imprisoned by the Catholic Church for reforming the Carmelite order. While in prison, enduring torture and suffering at the hands of Catholic authorities, he composed a famous collection of spiritual poems entitled *Dark*

*Night of the Soul*. According to him, his suffering helped him attain spiritual closeness to God (Saint John of the Cross, 2002; Moore, 2004).

Baruch Spinoza (1632–1677 CE) was a Dutch Jewish philosopher whose ideas on religion and spirituality were not recognized fully until years after his death. During the 17th century Enlightenment, he laid the groundwork for scientific and spiritual concepts that influenced many scientists, including Einstein (Reed, 2008). Some of his views were contradictory to traditional dogmatic Judeo-Christian concepts. He believed that nature and God are not separate entities. He also opposed Descartes' view of mind-body dualism (Strauss, 1997). The German philosopher Hegel had great admiration for his work. Spinoza contended that everything in nature (everything in the universe) is one reality. He believed that one set of rules governed both God and nature (Bloom, 2006; Garrett, 1995). His pantheistic view of spirituality later was espoused by Einstein and other scientists. Einstein stated, "I believe in Spinoza's God who reveals himself in the orderly harmony of what exists, not in a God who concerns himself with the fates and actions of human beings" (Calaprice, 2000, p. 204). Einstein further stated:

> Spinoza is one of the most profound and pure people that our Jewish race has produced. I am fascinated with Spinoza's pantheism, but admire more his contribution to modern thought because he is the first philosopher to deal with the soul and body as one, and not to separate things (Calaprice, 2000, pp. 100-101).

Another well-known and controversial theologian who influenced many spiritualists was the Swedish scientist, philosopher, and Christian mystic Emanuel Swedenborg (1688 – 1782 CE). At the age of 56, he had a spiritual awakening and experienced dreams and visions. He was considered by some traditional Christians to be a heretic (Sigstedt, 2007; Toksvig, 1948). Swedenborg believed salvation only is possible through the conjunction of faith and charity. He did not believe in the concept

of the trinity and claimed that the Father, Son, and Holy Spirit were different aspects of the one God. One cannot divide divinity into three Persons. He wrote and published numerous theological and spiritual writings (Corbin, 1995). Many famous spiritual thinkers were influenced by him including transcendentalist Ralph Waldo Emerson, writer Henry James, Jr., and his brother, physician and philosopher William James, the Irish poet William Butler Yeats, and psychologist Carl Jung.

Throughout the history of humankind, philosophy and ethics have intertwined with spirituality. Deontology and teleology were two popular ethical theories espoused by western philosophers. Deontology focuses on the act while teleology focuses on the end and is goal directed. The German philosopher Immanuel Kant (1724–1804 CE) was a proponent of deontological ethical concepts. According to him, deontology deals with moral law, wherein one treats humanity as an end in itself rather than (merely) as means to other ends the individual might hold (Kaufmann, 1956). He stated that human concepts are not derived from experience but rather precede experience; these are *a priori*. He disagreed with the Scottish empiricist Humes' concept that knowledge can only be derived from experience (Allison, 1990). He argued that experience merely is subjective and not processed by pure reason. He disagreed with rationalist Descartes and Gottfried Leibniz (1646–1716), who were the influential figures of the rationalist movement. According to him, reasoning without application to experience leads to theoretical illusions. He synthesized a philosophy that has both rationalist and empirical approaches, called transcendental idealism. This is expressed in his book *Critique of Pure Reason* (2008). Kant proposed that one must follow a moral obligation that is absolute and referred to it as Categorical Imperatives (Kant, 2001). Categorical

Imperatives are principles that are intrinsically good and valid and must be obeyed in all situations and circumstances. His books *Critique of Practical Reason* (2002) and *Metaphysics of Morals* (1996) raised many rational arguments to support the existence of God.

Another German philosopher, George Wilhelm Hegel (1770–1831 CE), is known for his concept of universal spirituality. He viewed religion as a manifestation of the consciousness of an absolute being. In Hegel's first book, *Phenomenology of Spirit* (1977), he referred to the spirit as a cosmic soul that encompasses all of us and all of nature as well (Soll, 1969). Hegel referred to the cosmic soul as *weltgeist* and wrote:

> It is not difficult to see that ours is a birth-time and a period of transition to a new era. Spirit has broken with the world it has hitherto inhabited and imagined . . . . It is indeed never at rest but always engaged in moving forward . . . . The frivolity and boredom which unsettle the established order, the vague foreboding of something unknown, these are the heralds of approaching change (Solomon, 2002, p. 3).

Arthur Schopenhauer (1788–1860 CE), a contemporary of Hegel and a leading figure of the Romantic Movement, was a western scholar of Buddhist philosophy (Solomon & Higgins, 1996). Schopenhauer is known for his work called *The World as Will and Representation* (1966). He stated that the world is fundamentally what we recognize in ourselves as our "will." This will can never be fulfilled. To Schopenhauer, the will is a metaphysical existence that controls not only the action but also every phenomenon, which is referred to as the "thing in itself." Will underlies everything and manifests as a natural force, instinct, or intellectually enlightened being. This will is without purpose and, therefore, cannot be satisfied. The term *will* that commonly is used is rational and intentional. Schopenhauer also wrote extensively about aesthetics including beauty and nature.

Schopenhauer's writings influenced many European philosophers including Nietzsche, Wittgenstein, and Freud. Nietzsche and Freud developed their philosophical and psychological perspectives from Schopenhauer's writings. Ludwig Wittgenstein, known for his book *Tractatus* (1998), was influenced deeply by Schopenhauer's metaphysics and the mathematical philosophical ideas of Bertrand Russell (Klagge, 2001). Another contemporary of Schopenhauer was Friedrich Max Müller (1823–1900 CE), a German scholar and philologist at Oxford in England. He was the pioneer in exploring the roots of Indo-European religious traditions and was known for his book *Sacred Books of the East* (Van den Bosch, 2002). He emphasized the parallels between Vedic and Indo-European traditions. Müller was influenced heavily by the teachings of Spinoza (Stone, 2002). Müller was attracted to the Vedanta teachings of Ramakrishna, a well-known saint of India. He also spent several years exploring and researching Indian art, religion, and culture. He was instrumental in introducing Indian philosophy to the western world (Müller, 1962).

Rudolf Otto (1869–1937) was a German Lutheran philosopher and theologian known for his writings on comparative religion and spirituality. He is acclaimed for his famous work *Idea of the Holy*. He was the first to refer to strong spiritual experiences as "numinous experiences." These are nonrational, nonsensory experiences and are called "*mysterium tremendum et fascinans*," meaning mysterious, fascinating, and tremendous all at one time. Numinous experiences make one feel stunned, astonished, and wonderful, and cannot be described adequately because they are not of the ordinary world (Corbett, 2007, p. 12). These experiences are forceful and overpowering, thus making human beings small and powerless. Contact with *numinosum* (i.e., that which produces

numinous experience) provides a sense of oneness with the world and others (Casement & Tacey, 2006).

Prophets, sages, and saints including Moses and St. Paul had numinous experiences. St. Paul saw a flash of light and heard the voice of Jesus saying, "Why do you persecute me?" This numinous experience was the basis of his spiritual transformation into a Christian. In the Bible and other religious texts there are several accounts of numinous experiences. Some of these experiences occurred after seclusion and fasting. Moses fasted for 40 days in the desert before he received the Ten Commandments on Mount Sinai (Exodus 34:28). Jesus also fasted for 40 days in the wilderness before his encounter with Satan (Matthew 41:11). Other religions also have fasting rituals to prepare for spiritual experiences. Numinous experiences also have occurred after a period of illness (Gooch, 2000). Many spiritual and religious figures were transformed by numinous experiences.

During the early 19th century the spiritual movement known as Theosophy was started by Madam Blavatsky (1831–1891 CE) and contemporary spiritualists to integrate universal spiritual values (Ryan, 1975). Madam Blavatsky was born in the Ukraine and founded the Theosophical Society (1875), which had three objectives: to form the nucleus of the Universe of the Brotherhood of Humanity, without distinction to race, creed, sex, caste, or color; to encourage the study of comparative religion, philosophy, and science; and to investigate the unexplained laws of nature and the powers latent in man (Zirkoff, 1980).

Blavatsky influenced Annie Besant (1847–1933), a women's rights activist from London, who became a spiritualist and later the leader of the Theosophical movement

after Blavatsky. Besant and Blavatsky had an extensive knowledge of Christianity, Buddhism, and Hinduism. They spent many years in the east and especially in India (Taylor, 1992). Besant was instrumental in bringing Jiddu Krishnamurti (1895–1986) into the Theosophical movement and introducing him to the West. He remained in California as a spiritual philosopher for the rest of his life.

Rudolf Steiner (1861–1925), a German spiritualist, joined the Theosophical movement. Many years later he started his own movement, which he called anthroposophy. Steiner was also influenced by the writing of Goethe (1749–1832 CE) and Fichte (1762–1814 CE). Anthroposophists focus mainly on the experience of spirituality within themselves and the universe (Steiner, 1999; Wilkinson, 2002). Steiner claimed that every religion is valid and true and has a purpose within the cultural context and time in which it originated. According to him, the historical view of Christianity should be changed and transformed to meet the evolving needs of humanity (Lachman, 2007). He also believed in Gnostic concepts of early Christianity and the eastern principles of karma and reincarnation. Steiner influenced Robert Sardello, a popular depth psychologist who is currently the president of the Spiritual Institute in the United States. Sardello wrote the introduction to Rudolph Steiner's *Psychology of Body, Soul, and Spirit* (1999). Steiner also was the founder of Waldorf education and anthroposophical medicine.

## Spiritual Development in the Middle East and Persia

The spiritual and religious concepts of Islam, Judaism, and Christianity have their origins in the Abrahamic traditions. Islam incorporates many concepts of Judaism and Christianity such as creation, death, and resurrection. The founder of Islam was the

prophet Muhammad (Armstrong, 2007; Eliade, 1988). Many spiritual scholars believe the term *Islam* means surrendering to God and honoring the teachings of the prophet. While others think Islam is related to Sharia law, which may limit spiritual freedom and progress (Armstrong, 2006).

Sufism originated as a spiritual mystical sect of the Islamic tradition, moving away from its strict dogmatic practices (Ernst, 1997). However, there are wide variations in opinion among Sufi followers. In some Islamic countries, the practice of Sufism has been banned by fundamentalists and frowned upon by traditionalists, whereas Sufi scholars consider Sufism a spiritual expansion of Islamic tradition and the teachings of the prophet Muhammad. They view Sufism as a body of thoughts and practices in which the inner spiritual path to God is emphasized over dogmatic external acts (Chittick, 1983; Sells, 1995). Their practices vary from whirling dervishes to more contemplative forms in an attempt to obtain spiritual closeness to God. Many Sufi followers believe that through music, poetry, and dance one may overcome the ego and begin a spiritual journey toward God. Some Sufi saints believe in the quest to be reunited or become one with God. This quest or journey can be facilitated by religious doctrines and individual experiences, but ultimately the search must begin within one's self (Azmayesh, 2002).

Many Sufi teachers emerged in Persia during the period of the 8th to the 12th century, including Al-Kindi, Al-Balkhi, Attar, Rumi, and Al-Ghazzali. They were opposed to any forms of violence and were humanistic and caring. They gave spiritual guidance to others based on connection, love, and caring. Many of them were spiritual healers or physicians who adopted therapeutic interventions to treat the physical, mental, and social aspects of human pain and suffering.

Al-Kindi (800–866 CE) incorporated neo-Platonian philosophy with Islamic ideas. According to him it is difficult for human beings to understand fully the true nature of God. Al-Razi (865–925 CE), another philosopher and physician, was known as Rhazes in the western world. He stressed that mental health is an essential part of total patient care and rejected the concepts of mind-body dichotomy (Fa Adlin, 1990). Rhazes' views on creation and dying were strikingly similar to Neoplatonian views.

Al-Balkhi (850–934 CE), in addition to being a spiritual figure, was a physician, and a psychologist. In his discussions, he referred to the body and soul as being intimately connected, requiring harmony and balance to prevent illness. He was the first to practice cognitive psychology, which addressed both the psychological and physical aspects of illness (Haque, 2004). He differentiated between neurosis and psychosis and classified various types of depression. He stressed:

> Spiritual medicine is a crucial branch of Islamic medicine known, in Islamic medical literature, as al-Tibb al-Ruhani or Tibb al-Qalb. Although Al-Tibb al-Ruhani concerns mainly with spiritual and psychological health, however, spiritual medicine cannot be separated completely with physical medicine (al-tibb al-jismani) since man's construction is from both soul and body (Deuraseh & Talib, 2005).

Al-Hallaj (858–922 CE) was a Persian mystic, poet, and teacher of Sufism. Expressing the unity he felt with God at the peak of his spiritual experience, he claimed that he had become one with God (Keddie, 1978). His statement was considered heresy by the mainstream Islamic authorities and he was tortured and executed. His teachings later influenced many other Sufi philosophers such as Rumi and western spiritual thinkers including Meister Eckhart.

Greek philosophy influenced many Islamic spiritualists, including Al-Farabi, Ibn Sina, and Omar Khayyam (Fakhry, 2002). They preserved and incorporated the

teachings of many Greek philosophers, including Aristotle, Socrates, and Plato. Ibn Sina, also known as Avicenna, was a famous physician comparable to Hippocrates of Greece. He believed God created the world through emanation and all of God's creatures are drawn to God by love (Keddie, 1978).

Omar Khayyam was a Sufi philosopher, a poet, a mathematician, and an astronomer (Fitzegerald, 2009). He also was considered a Sufi mystic, and his philosophy and poetry had a major impact in Persia and the Middle East. His teachings influenced many western scholars, including Thomas Hyde (1636–1703 CE) and Edward Fitzgerald (1809–1883 CE). Khayyam is well known for his classic work *The Rubaiyat:*

> The moving finger writes, and having writ,
> Moves on: nor all your Piety nor Wit
> Shall lure it back to cancel half a Line,
> Nor all thy tears wash out a Word of it (Yogananda, 2000, Quatrain 71).

This quotation has a deep existential meaning that one has to be responsible for one's own actions.

Ibn Rushd, also known as Averroes (1126–1198 CE), was an esteemed physician who was considered the Hippocrates of the Islamic world (Sonneborn, 2006). He was born in Cordoba, Spain. In his teachings he incorporated the philosophy and spiritual views of Aristotle. Averroes accepted the doctrine of the immortality of the soul (Solomon & Higgins, 1996).

In the 12th and 13th centuries there was a profound Sufi influence in the Islamic world (Chittick, 2007). Sufism was a strong spiritual movement that combined mystical aspects of Islam, Zoroastrianism, Judaism, Christianity, and eastern philosophies. They believed Sufi practice was based on love as a divine nature, which was inherent in every human. Sufis led simple, humble, and selfless lives and provided service to society.

Many well-known Sufi philosophers such as Rumi, Attar, and Al-Ghassali felt closeness to God and stressed that death must not be feared because one returns to the original source (Frager, 1999). American transpersonal psychologist Frager is a scholar of Sufism and wrote about the philosophy and practices in his book *Heart, Self, and Soul.*

Attar (1145–1220 CE) was a Persian Sufi poet from Neyshapur, Persia who was a healer and one of the earliest pharmacists. He inspired many famous Sufi poets including Rumi. As a young man Attar traveled to many places including Mecca, Egypt, Damascus, and India. He was well known for his masterpiece, the *Manteq-al-Tayr,* or the *Conference of the Birds.* In this work he described a group of birds (human souls) under the leadership of Hoopoe, the spiritual master determined to search for the legendary god Simurgh. The birds had to confront their own individual limitations and fears while journeying through seven valleys before they ultimately found Simurgh and completed their quest. The birds that completed the quest discovered that they themselves were the Simurgh they sought (Attar, 1984). This mythical story illustrates that the divine is present within us and our spiritual development helps to realize the divine nature of every human. The seven valleys represent various spiritual stages that one goes through (Lewisohn & Shackle, 2007). Attar's philosophical view appears to be similar to that of Vedanta philosophy.

Al-Ghazali (1058–1111 CE) was a philosopher and a Sufi mystic who influenced many western theologians, such as Moses of Maimonides (1135–1204 CE) and Thomas Aquinas (1225–1274 CE) (Keddie, 1978). Ghazali recognized that there are two types of diseases: spiritual and physical. Spiritual diseases are more harmful and result from ignorance and alienation from God (Fa Aldin, 1990; Al-Ghazali, 2000). These spiritual

afflictions include the following: self-centeredness; addiction to wealth, fame, and social status; ignorance; covetousness; lust; deception; and greed. Activities such as pursuit of learning, service, and love for others help one overcome spiritual weaknesses. He also stated that human beings occupy a position between animals and angels. Spiritual practice and knowledge help one rise to the level of angels or, conversely, fall to the level of animals if anger and lust dominate (Griffel, 2009). Al-Ghazali was known for his writings *Alchemy of Happiness.*

Shahab al-Din Suhrawardi (1155–1191 CE) was a Sufi and the father of imaginal psychology (also known as Illuminationist philosophy). He was influenced by Zoroastrianism, Neoplatonianism, and eastern philosophies and formulated the ideas of an independent intermediary world, the imaginal world (*alam al-mithal*). His writings include *Temples of Light, Intimations,* and *Philosophy of Illumination* (Suhrawardi, 2000). He was considered a heretic by Islamic fundamentalists and was executed.

Mulla Sadra (1571–1641 CE), and ardent follower of Suhrawardi, became the most influential of the Illuminationist philosophers and popularized the philosophy (Jambet, 2006). The French psychologist Henry Corbin (1903–1978) was influenced greatly by his writing and introduced imaginal psychology to the western world. Carl Jung incorporated Suhrawardi's teachings in his writings.

Rumi (1207–1273 CE), also known as Jalaladdin, was a Persian Sufi poet and philosopher who influenced many millions of people from different religions (Chittick, 1983). His teachings are popular even among modern-day philosophers, psychologists, and spiritualists. In his early years he encountered his mentor Attar, who recognized

Rumi's spiritual eminence and encouraged his spiritual quest. Rumi traveled to many places, including Baghdad, Damascus, and Anatolia, and shared his ideas and teachings.

Rumi's thoughts have a universal appeal. His spiritual philosophy was focused on personal spiritual experiences, love, the soul, and relationship with God. Oneness with God was a common theme among many Sufi philosophers. Rumi also found creative acts such as music, dancing, and poetry as deep expressions of the soul's love for God (Van de Weyer, 1998; Barks, 2006). This idea of creativity and transcendence of the self is found in many other religious traditions including Zen Buddhism, Vedanta philosophy, and Christian spiritual traditions. Rumi was the inspiration behind the Mevlevi Order, otherwise known as Whirling Dervishes, who express their devotion through music and dance ceremony known as Sema. Rumi's views on spirituality and religious tolerance are illustrated well by the following popular poem:

> Come, come, whoever you are,
> Wanderer, idolator, worshiper of fire,
> Come even though you have broken your vows a thousand times,
> Come, and come yet again.
> Ours is not a caravan of despair (Safransky, 1990, p. 67).

Rumi was well-known for his work, entitled *Masnavi*, in which he described a universal message of love (Naini, 2002):

> Love's nationality is separate from all other religions,
> The lover's religion and nationality is the Beloved (God).
> The lover's cause is separate from all other causes.
> Love is the astrolabe of God's mysteries.

Rumi urged that people with various religions and traditions could live together in peace and harmony. His philosophy of universality is expressed in the following poem:

> I searched for God among the Christians and on the Cross and therein found him not.
> I went into the ancient temples of idolatry; no trace of him was there.

> I entered the mountain cave of Hira and then went as afar as but God I found not.
> With set purpose I fared to the summit of Mount Caucasus and found there only '*anqa's* habitation.
> Then I directed my search to the Kaaba, the resort of old and young; God was not there even.
> Turning to philosophy I inquired about him from the Ibn Sina but found Him not within his range.
> God was not there even in that exalted court.
> Finally, I looked into my own heart and there I saw Him; He was nowhere else (Sharif, 2007).

His spiritual message is directed inward to find the soul.

This poem has deep existential meaning and has similarities to the hymns in the Hindu texts. Rumi's spiritual views of oneness with God were reflected in the following quotation:

> Why should I seek?
> I am the same as he, his essence speaks through me.
> I have been looking for myself (Rumi, 1997, p. xx).

Ibn Abbad al-Rundi (1333–1390 CE) was one of the leading Sufi theologians of his time known for his literary work, *Letters on the Sufi Path* (Ibn Abbad Al- Rundi, 1988). He was born in Ronda, a Spanish province. He immigrated to Morocco at an early age and continued all his life in Morocco in various cities. His approach was different from the poetic approach of Rumi, in that his focus was on daily spiritual practice. He is comparable to St. John of the Cross; both emphasized the ways in which everyday spiritual practices support one's progress on the spiritual journey toward God. His writings included many letters to his followers offering advice on spiritual practices. His philosophy resonates with Hermann Hesse's (2008) as expressed in his novel, *Siddhartha*.

The Baha'i faith, founded by Baha Ullah (1817–1892 CE), originated in Persia. In the Persian language *Baha'i* means glory or splendor (Esslemont, 2006). The Baha'i

tradition incorporates many ideas of Sufism and Islam and emphasizes the spiritual unity of all humankind. The Baha'i faith recognizes many divine messengers, each of whom established religious traditions according to the needs of the societies during the period in which they lived. It recognizes spiritual and religious leaders of all religions, including Abraham, Buddha, Jesus, Muhammad, as well as the recent prophet, Baha Ullah. The three principles of the Baha'i faith include the unity of God, the unity of religion, and the unity of humankind. According to this faith God periodically reveals his will through divine messengers who transform humankind to develop morally and spiritually. Baha'i also emphasizes equality between men and women and elimination of all forms of prejudice. It recognizes world peace, harmony of religion and science, obedience, and elimination of extremes of wealth and poverty. Baha'i teachings may be influenced by Attar's *Seven Valleys,* which emphasized the stages of the soul journey toward God (Esslemont, 2006).

For many years Kabbalah has remained the source of spiritual and mystical traditions among Jews (Matt, 1996). It is a set of esoteric oral teachings passed on for generations. The teachings of Kabbalah have been guarded and concealed for many centuries. Kabbalah teachings explain the nature of the universe, the purpose of human existence, and spiritual realization. The teachings of spiritual leaders such as Abraham, Noah, Moses, King David, and King Solomon are considered the initial sources of Kabbalah. Some scholars believe that Kabbalist teachings reflect eastern, Zoroastrian, Gnostic, Sufi, and ancient Egyptian mystical and spiritual ideas. Other famous Jewish scholars who contributed to Kabbalist literature include Shimon Bar Yochai (1st century), Moses de Leon (1250–1305 CE), and Rabbi Isaac Luria (1534–1572 CE). For many

years Kabbalist teachings were limited only to males over 40 years old. *Zohar* is a popular text in Kabbalah and Rabbi Shimon was credited for its initial writings. Recently Kabbalist knowledge has become open to all those who seek to understand it, whether male or female, regardless of age, and is now incorporating scientific ideas (Mathers, 2008).

## Transcendentalist Movement in the United States

The Transcendentalist Movement in the United States was influenced by German and English romanticism and eastern Upanishads philosophy and originated with Ralph Waldo Emerson, Henry David Thoreau, Margaret Fuller, and Emily Dickinson (Solomon & Higgins, 1996). This movement expanded toward spiritualism by incorporating naturalist concepts such as freedom, self-reliance, intuition, the spiritual nature of the universe, and connection to humanity, and moved away from extreme scientific rationalism and scientific dogmas (Felton, 2006). Emerson and Thoreau are the best-known figures of Transcendentalism.

Emerson was a leading poet of the mid-19th century. He was influenced by many European Romantic poets including Milton, Coleridge, Wordsworth, and Carlisle (Blake, 1996). He was interested in the richness of German Romantic thought and the ethical writings of Indian philosophy and poetry. Emerson emphasized the importance of nature as a source of spiritual sustenance and was in agreement with the ideas of the German philosopher Hegel. He was the leading figure of American romanticism and poetry and believed that humanity was linked by a collective "oversoul" that gives intuitive moral guidance. He emphasized the intuitive part of self as the basis for gaining fulfillment in life and felt self-reliance was the ultimate virtue (Solomon & Higgins, 1996). He wrote

many essays on nature, poetry, the oversoul, experience, and self-reliance. Sir Oliver Wendell Holmes wrote a book dedicated to Emerson. Emerson was called the Sage of Concord because of his poems, essays, and lectures.

Henry David Thoreau was one of Emerson's most celebrated disciples and was known for his masterpiece *Walden*. Thoreau was attracted to nature and had distaste for the excesses of civilized society. He took up residence on a parcel of land by Walden Pond in Massachusetts and led a simple life of individual communion with nature. The transcendentalists were optimistic and convinced of the inherent goodness of humanity. Thoreau's essay on civil disobedience has inspired many spiritual leaders including Gandhi and Martin Luther King (Nishida, 1992; Gandhi, 2008). In addition to emphasizing humanity's union with nature, Thoreau also emphasized the importance of intuitive insight over logical reasoning. Thoreau was considered by many scholars to be an eminent existentialist. The spiritual themes in the writings of several famous American poets and authors were influenced by the transcendentalist movement. The transcendentalist movement influenced poets including Emily Dickinson, Walt Whitman, and Henry Wadsworth Longfellow. The main themes expressed by them were freedom, self-reliance, intuition over rationalism, connectedness to nature, and love for humanity. Whitman's poems expressed human love and the beauty of the human body. Emily Dickinson wrote many poems in which nature and existential themes such as death are addressed. Longfellow was a poet known for his work including *Voices of the Night*. His existential poems are reflected in "Psalm of Life":

> Trust no Future, howe'er pleasant!
> Let the dead Past bury its dead!
> Act,—act in the living present!
> Heart within, and God o'erhead! (Poem 3, Volume: Voices of the Night, 2000)

This poem has similarities to Buddhist concepts.

William James (1842–1910), psychologist and philosopher, was a professor at Harvard and the originator of American experimental psychology (Gerald, 1986). He stated that spiritual experiences are more important than religious teachings, or dogmas. His views were well expressed in the book *Varieties of Religious Experience* (1997). James' work was based on integrating medical science and experiences relating to spirituality. He believed that there are many ways of experiencing God, and that such experiences can be remedies for depression, mental suffering, insecurity, and doubts. James is considered a spiritual existentialist who incorporated scientific thinking.

According to James, spiritual beliefs have genuine consequences in life. He emphasized that there is a contrast between a healthy soul and a sick soul. Healthy souls look for good in everything and look for the best in any situation. Sick souls suffer from negativity and depression. For James, the twice born soul is that sick soul that has been cured by spiritual experience and can therefore be the healthiest of all the souls because it has been born twice.

One of James' students, Kitaro Nishida (1870–1945), a Japanese philosopher and founder of the Kyoto School of Philosophy, adopted James' ideas while incorporating them with Japanese Buddhist concepts. He referred to this as Pure Experience, comparable to Zen meditation, in which the unity of nature, humanity, and all things are experienced (Nishida, 1992). Pure experience transcends individuality when one encounters something that is truly universal, the ultimate reality in which self and universe become one (Ikeda, 1983).

The other important philosopher and teacher who wrote extensively about religion and spirituality was Mircea Eliade (1907–1986). He was interested in eastern religions and American Transcendentalist ideas. He spent many years in India studying eastern philosophy (Eliade, 1981). His writing included topics such as Shamanism, Myth, Symbolism, Dreams, and Yoga (Eliade, 1970). Eliade's book, *The Sacred and the Profane,* explores experiences relating to nature, places, objects, and time. He found broad, cross-cultural parallels and unities among many religions, particularly in religious myths. He coined the term *hierophanies*, which refers to the manifestation of the sacred and is a broader concept than *theophany*, which mainly refers to the manifestation of God. Eliade wrote about dreams and myths in relation to spirituality (Eliade, 1978). In his book, *The Sacred and the Profane: The Nature of Religion,* he stated, "Religious man can live only in a sacred world, because it is only in such a world that he participates in being, that he has a real existence" (Eliade, 1961, p. 64). Eliade moved to the United States from his native Romania and became head of the Department of Religious Studies at the University of Chicago after growing up in Romania and spending many years in the east. Eliade was influenced by other contemporary philosophers including Rudolf Otto and the founders of the Traditionalist School, Rene Guenon and Ananda Coomaraswamy.

## Evolution of Medical Ethics

Universally, spiritual practices guided the moral and ethical duties of physicians and caretakers. Early physicians who were also philosophers, priests, and spiritualists were instrumental in formulating spiritual codes governing the conduct of healers. The Hammurabi codes (1700 BCE) were adopted in Babylon. Oral traditions of the Torah

started with Moses and were later followed by Talmudic laws in Israel. In India, Manu's codes originating from the Vedic and Upanishad traditions (1200–500 BCE) served as the guide. These codes of conduct were referred to as Dharma Sutras (Beauchamp & Childress, 2001) and emphasize the ethical care of the elderly, dying, and the sick. The philosophies of Buddhism and Jainism emphasize compassion and empathy toward the sick. In Persia, the famous physician Rhazes (860–923 CE) formulated ethical principles relating to the care of the sick. He was influenced by the Greek philosophies of Aristotle and Plato. Mogul emperor Akbar integrated Islamic ideas with Hindu concepts to formulate ethical principles.

Ancient Greek philosophy and traditions shaped western medical ethics for many centuries. The Hippocratic Oath has been adopted by physicians and has become a standard in western medical practice. This oath had a polytheistic religious origin dedicated to the Greek gods and goddesses. It was originally sworn to Apollo, the god of medicine, to his son the healer Aesculapius, and daughters Hygeia and Panacea. Hygeia is known as a goddess of preventive medicine and Panacea is known as a goddess who heals ailments. Aesculapius learned the art of medicine from the famous Chiron, a centaur who was the greatest healer in Greek mythology.

The Hippocratic Oath has been revised to reflect montheism and is now widely accepted throughout the world and incorporated with the secular ethical concepts. The main themes of the Hippocratic Oath are beneficence and nonmalfeasance.

Moses Maimonides (1135–1204 CE) was a Jewish philosopher of the Middle Ages known for his spiritual ethical principles (Kraemer, 2010; Davidson, 2005). He was born in Cordoba, Spain and migrated to Cairo because of rising anti-Semitism. There he

worked as a physician, legal scholar, and philosopher. He was responsible for composing the following oath that contains spiritual themes:

> The eternal Providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all time; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children. May I never see in the patient anything but a fellow creature in pain. Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today. Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling (Koenig, 2007, p. 93).

Modern secular ethics comprise four principles: beneficence, nonmalfeasance, autonomy, and justice. In terminally ill patients, virtue ethics are more appropriate than secular ethics because they emphasize the character and quality of the caretaker. Virtue ethics focus on moral duties and includes the physicians' qualities of compassion, sympathy, truthfulness, relationship, and honesty to the patient.

Virtue ethics originate from Aristotle's writings (Beauchamp & Childress, 2001, Taylor, 2002). According to Aristotle virtue principles include *arête* (virtue), *phronesis* (moral wisdom), and *eudemonia* (flourishing) as well as other values such as prudence, justice, fortitude, and temperance (Hardie, 1968). Virtue ethics were developed further by Christian ethicists as early as the Neoplatonian era and later by St. Augustine and Thomas Aquinas (1225–1274 CE). Aquinas stressed the importance of virtue in his writings, *Summa Theologica* (Aquinas, 1948). Later, Emmanuel Kant contributed to virtue ethics by describing moral duty as an absolute, calling it a categorical imperative (Sullivan, 1994). In the last century the concept of virtue ethics was eclipsed by secular

ethics, but it is now resurfacing and gaining greater acceptance in medicine, especially in the area of end-of-life care. Virtue ethics principles are being revived by modern philosophers such as Anscombe and Alasdair Macintyre (Teichmann, 2008; Knight, 2007).

The eastern philosophy of Confucianism also reflects principles of virtue ethics. Confucius emphasized the moral duty of each individual member of the society, whether king, citizen, physician, mother, father, son, daughter, or servant. Confucianism also imposed a higher duty on the children. Confucius described this as filial piety, in which children have the duty to take care of parents with love, respect, and devotion (Solomon & Higgins, 1996).

Martin Heidegger, the existential phenomenologist, placed a strong emphasis on the experiential and relational aspect of care of the sick (Beauchamp & Childress, 2001). Many nursing school curricula adopt his concepts of care, described as "being" or "*dasein*" (Heidegger, 1962), in other words, being fully present.

Carol Gilligan, a modern ethicist and feminist, was a proponent of care ethics and was critical that most current secular ethical theories were male biased. Men often think in terms of justice, rules, rights, and autonomy based on individual rights. Women are more often concerned with the experiential or practical aspects of care and relationship (Oldnall, 1996). Care ethics is becoming a moral equivalent of other theories, including secular ethics (Held, 2005; Slote, 2007).

The underlying themes of all the ethical theories, including secular concepts, have spirituality at their core. However, there is reluctance among many physicians to discuss spiritual or religious issues when addressing medical care. They avoid discussions on

spirituality because they believe the majority of the scientific community may view religion/spirituality as being in contradiction to the scientific practice of medicine (Beauchamp & Childress, 2001).

## Philosophical and Psychological Concepts Relating to Spirituality

Most of the psychological theories were developed in the 19th and 20th centuries. Many philosophers and psychologists focus on the area of spirituality and the care of the dying. The existentialist philosophers focused on issues such as meaning, freedom, choices, responsibility, and dying. In addition, many existentialists who are phenomenologists focus on lived experiences of the temporal being, which Heidegger described as *dasein*.

The analytical psychology of Carl Jung focused on the transformation and individuation process. Erikson described the stages of psychosocial development through old age and death. Humanistic psychologists such as Carl Rogers focused on empathic, genuine relationships. Cognitive-behavioral therapists, Beck and others, focused on maladaptive thoughts and false schema. Several other psychologists focused on transpersonal psychology, psychosynthesis, archetypal psychology, imaginal psychology, and positive psychology. Social psychologists and social scientists such as Baltes from Planck Institute and US researchers including Carstensen, Ardelt, Rowe, and Kahn focused on issues relating to optimal aging of the elderly.

## Existentialism

The term *existentialism* was coined by the Christian French philosopher Gabriel Marcel several decades ago and is applicable to any philosophy that relates to individual existence (1963). Webster's dictionary (2008) defines existentialism as:

> A twentieth century philosophical movement embracing diverse doctrines but centering on analysis of individual existence in an unfathomable universe and the plight of the individual who must assume ultimate responsibility for acts of free will without any certain knowledge of what is right or wrong or good or bad.

Existential themes have been found in the philosophy and literature of many cultures, but Soren Kierkegaard, a Protestant philosopher, is recognized as the father of existentialism in the western world. Martin Heidegger and Carl Jaspers were phenomenologists who focused on existential experiences (Jaspers, 1997). Existential themes are found in the writings of philosophers and poets and in the myths and literature of diverse cultures. Buddha's teachings, Augustine's confessions, Greek and Shakespeare tragedies, Hindu writings of Vedanta and Upanishad, Sufi teachings, and other Hindu literature contain existentialist themes.

Existentialism can be viewed from three different perspectives: existentialist literature, such as poems, hymns, and writings: the work of existential philosophers; and existential psychology. The focus of existentialism is on conditions of human existence, which include the meaning and purpose of life (Marcel, 1963). It further explores emotions, thoughts and actions, suffering, and responsibilities, and other vital questions relating to subjectivity, religiosity, spirituality, freedom, pain, guilt, and choices (Kaufmann, 1956; Solomon, 2005; Marcel, 2002).

Many philosophers, writers, and poets expounded on existential themes such as life, the meaning of human existence, and death. The Greek philosopher Epicurus (341-270 BCE) stated:

> Become accustomed to the belief that death is nothing to us. For all good and evil consists in sensation, but death is deprivation of sensation. And therefore a right understanding that death is nothing to us makes the mortality of life enjoyable, not because it adds to it an infinite span of time, but because it takes away the craving for immortality. For there is nothing terrible in life for the man who has truly comprehended that there is nothing terrible in not living (Stowers, 1986, p. 117).

About suffering, the Roman Stoic philosopher Seneca stated:

> Who is there in all the world who listens to us? Here I am—this is me in my nakedness, with my wounds, my secret grief, my despair, my betrayal, my pain which I can't express, my terror, my abandonment. Oh listen to me for a day, an hour, a moment, lest I expire in my terrible wilderness, my lonely silence. Oh God, is there no one to listen? (Saunders, 1988, p. 29)

Greek playwrights including Aeschylus, Sophocles, and Euripides wrote numerous tragedies, including Sophocles' *Antigone*, that expressed the existential nature of human life.

The founders of Judaism focused on issues of present life, responsibilities, justice, and freedom. The Judeo-Christian Scriptures contain many existential themes and emphasize the transient nature of life: "For what is your life? It is even a vapour, that appeared for a little time, and then vanishes away" (James 4:14).

Shakespeare, the best-known of the English playwrights, also included existentialist themes relating to death and old age in his plays, including, among others, *Hamlet*, *Macbeth*, *King Lear*, and *Measure for Measure* (Kaufman, 1980). Shakespeare's tragic hero, Hamlet, ponders "to be or not to be that is the question." Many of Shakespeare's plays focused on existential issues such as death, responsibilities, and

relationship. In Shakespeare's *Measure for Measure* (Act 3, scene 1) the character Claudio expressed terror at the thought of life's inescapable finitude:

> The weariest and most loathed worldly life
> That age, ache, penury and imprisonment
> Can lay on nature is a paradise
> To what we fear of death

The Spanish writer Miguel Cervantes expressed existentialist ideas in his classic *Man of La Mancha,* in which his character, Don Quixote, seeks freedom and fantasies in the world he creates in his mind. The Russian author Dostoevsky is known for his existential spiritual writings based on Christian concepts including faith, reason, suffering, punishment, and redemption. Dostoevsky's characters face conflicts and dilemmas between faith and reason as exemplified in his novel, *Crime and Punishment*. Dostoevsky's *Notes from the Underground* centers on a man unable to fit into society with the identities he creates for himself. Other popular Dostoevsky novels, including *Idiot* and *Crime and Punishment,* reflect the existential crisis the author himself had experienced within his family and society (Russell, 2009).

Another well-known Russian writer, Leo Tolstoy (1828–1910), was a remarkable spiritual thinker. In his early life, he wrote two famous novels, *War and Peace* and *Anna Karenina*. In his later life, he wrote many spiritual books including *Confession, My Religion,* and *The Kingdom of God is Within You*. His book *Confession* is an autobiographical account of how his philosophical views changed over time from traditional orthodox beliefs into broader spirituality. He was particularly inspired by the Sermon on the Mount in the New Testament:

> As I grew older and sought the meaning of life I came to find all other explanations unsatisfying, so I returned to Christ's words to examine the real meaning, especially his Sermon on the Mount. As a result I came to realize that

> the simple faith of everyday folks should not be rejected merely because it contains some falsehoods. Instead we should focus on the part of that simple faith that we can recognize to be the truth (Russell, 2009, p. 152).

His spiritual books influenced 20th century figures such as Gandhi and Martin Luther King, Jr. His story "The Death of Ivan Ilyich" dealt with issues relating to the final days of human life. The main character was a 45-year-old man, a high court judge of St. Petersburg, who suddenly became terminally ill. He was surrounded by doctors, friends, and family; however, nobody was willing to tell him the true nature of his illness and that he was dying. Instead, they advised him simply to stay calm and follow the doctor's orders:

> What tormented Ivan Ilyich most was the pretence, the lie which for some reason they all kept up, that he was merely ill and not dying, and that he only need stay quiet and carry out the doctor's orders, and then some great change for the better would result. But he knew that whatever they might do nothing would come of it except still more agonizing suffering and death. And the pretence made him wretched: it tormented him that they refused to admit what they knew and he knew to be a fact, but persisted in lying to him concerning his terrible condition, and wanted him and forced him to be a party to the lie. Deceit, this deceit enacted over him up to the very eve of his death: this lying which could only degrade the awful, solemn act of his death to the level of their visitings, their curtains, their sturgeon for dinner… was horribly painful to Ivan Ilyich. And it was a strange thing—many a time when they were playing their farce for his benefit he was within a hair's breadth of shouting at them: 'Stop lying! You know, and I know, that I am dying. So do at least stop lying about it! (Tolstoy, 1960, pp. 142 - 143)

Aleksander Solzhenitsyn (1918–2008), one of the popular Russian writers of the 20th century, speaks of existential crisis relating to cancer and death in his book, *Cancer Ward*. His book reflects the inevitable and ironic nature of the dying process and the need for acceptance of this terminal process.

Other 20th century existentialist writers include Franz Kafka, Samuel Beckett, and Albert Camus. Franz Kafka wrote *Metamorphosis* and *The Trial*, works that bring up existential issues such as uncertainty and the unpredictability of human life. Albert

Camus wrote *Myth of Sisyphus* and *The Stranger*, addressing meaninglessness, absurdity, and hopelessness related to human existence. He was awarded the Nobel Prize in literature for his existentialist writings. Samuel Beckett, an Irish author, wrote *Waiting for Godot,* a play that was voted the most significant English language play of the 20th century. The play emphasized facing up to absurdities and the meaninglessness of human existence (Solomon & Higgins, 1996).

Ken Wilber is a modern American existential writer known for his unique concepts integrating eastern and western spiritual ideas. He extensively studied the *Tibetan Book of the Dead,* and wrote an interesting book based on his own experience of dealing with the death of his beloved wife, Treya, called *Grace and Grit* (Wilber, 2001). This book was his personal love story of life and death and a deeply moving account of the 5-year struggle he and his wife went through. She suffered from cancer for several years before she died. She kept a journal, which is a powerful testimony of wholeness, harmony, suffering, surrender, healing, and dying. It is a journey of spiritual experiences. She integrated orthodox treatment with alternative therapies such as diet, meditation, energy therapy, and psychotherapy. Treya's honesty, vibrancy, and compassion speak through her journal entries. This book is a synthesis of psychology, psychotherapy, mysticism, and worldview and is useful for the caretakers of terminally ill and cancer patients.

According to Wilber, the human personality is a multileveled manifestation or expression of a single consciousness. He explains this in terms of quantum energies (Wilber, 2000). One goes through different energy levels of consciousness during the dying process: the shadow level, ego, biosocial, existential, transpersonal, and finally, the

level of mind (Wilber, 1993). The mind level refers to the spirit level and is baseless, infinite, and timeless, and, therefore, eternal. Prior to attaining the mind level, the self is characterized by duality and illusions.

Mitch Albom's (1997) *Tuesdays with Morrie* is a story about the existential issues relating to terminal illness. In this story, professor Morrie and his former student reestablish their relationship, enriching each other's lives and growing in the final days before Morrie's death. Margaret Edson's (1999) play *Wit* describes a dying patient's struggle with pain and suffering and her conflicts with her physicians. Her physicians were deeply absorbed with the science of cancer and were indifferent to her feelings and suffering. She finds comfort from a compassionate and caring nurse rather than from her physicians.

## Existential Philosophers and Psychologists

Existential philosophy focuses on areas such as freedom, responsibility, meaning, choices, and death. Existential psychology can be integrated with and applied to other branches of psychology. Existential philosophy relates to subjectivity and teaches that the individual perceives the world according to his or her experiences and world views (Solomon & Higgins, 1996). Existentialism focuses on the view that death is a part of human existence and awareness of death makes one live life to the fullest extent; such a life includes living in the present moment and seeking meaning and freedom that must encompass responsibility and choices (Marcel, 1998).

A number of philosophers explored existential ideas in the 19th and 20th centuries. These included Soren Kierkegaard, Friedrich Nietzsche, Martin Heidegger,

Martin Buber, Ludwig Binswanger, and Medard Boss. Twentieth century existential figures are Rollo May, Viktor Frankl, Ernest Becker, Jean Paul Sartre, and Irvin Yalom.

Soren Kierkegaard (1813–1855 CE) is the founder of western existentialism and a Christian spiritualist. He emphasized the concept of "leap of faith," which is a subjective notion of spirituality that should not be dictated by organized institutions or dogma; therefore, it is up to individuals to make their own choices regarding life and spiritual development. He also addressed issues of existential anxiety and uncertainties in life. Many people go through life as sleepwalkers and suddenly are awakened by unexpected, tragic events. Life is one contingency after another beyond the certainty of death. This is by no means a comfortable state but necessary for a spiritual existence (Solomon & Higgins, 1996).

Friedrich Nietzsche (1844–1900) was a controversial German philosopher who had a revolutionary approach to self, ethics, and society. He was influenced by the pre-Socratic philosopher Heraclitus (Jaspers, 1974). Heraclitus was known for his statement that "one never steps into the same river twice" and believed everything in this world is in a continuous state of flux or change and is transient. Nietzsche focused on human subjectivity and was skeptical about the idea that humans are rational beings. To Nietzsche we are far more creatures of will than of intellect. His famous book *Will to Power* stated that we should give up our herd mentality, which will lead to mediocrity. If we release ourselves by giving free reign to our will we will gain potential for creativity, originality, and authenticity (Solomon & Higgins, 1996; Kaufmann, 1956).

The Spanish philosopher Miguel de Unamuno (1864–1936) is well known for his existential writings and his classic, *The Tragic Sense of Life* (1972). This book addresses

the poignant questions about suffering, undeserved misfortune, and death that are addressed by the world's major religions. His emphasis was on personal responsibility and personal commitment. He concluded that whether life has a meaning or not, one has to make meaning by way of one's commitments. Unamuno agrees with Albert Camus that one must face up to the hopelessness and, thereby, preclude it from diminishing the meaning of human life. Camus' writings emphasized that the meaning of life involves facing up to the absurd. Both authors believed rebellion and passion enhanced the meaning of life (Solomon & Higgins, 1996; Unamuno, 1972).

Gabriel Marcel (1889–1973), a Christian existentialist French philosopher, was known for his book *Man Against Mass Society* in which he focused on an individual search for harmony through reflection. He believed that through human interaction one is able to recognize and accept the subjective nature of each individual. Marcel stated that technology and science have minimized human interactions and created problems and false scenarios and, thus, limited understanding of human subjectivity (Marcel, 2008).

Martin Heidegger (1889–1976) was a German phenomenologist and an existentialist. His existential concept of *dasein*—being in the world—included unity of subject and object. He stated that people suffer because they are alienated from their authentic selves and from the natural world. This is the concept of "existential alienation." Heidegger also believed, like Marcel, that technology distances humans from one another (Heidegger, 1962).

Heidegger used three concepts to explain his philosophy: *umwelt*, *mitwelt*, and *eigenwelt*. *Umwelt* refers to nature and environment, drives, birth, and death. *Mitwelt* refers to relationship, or how one relates to the world with respect and love. *Eigenwelt* is

the individual awareness of oneself as a human being. Heidegger disagreed with the Cartesian duality of mind and body. Heidegger wrote about phenomenological existentialism (human experiences). He reminded us that we exist in the world and should not try to look at ourselves as being apart from the world. He admonished us not to fill every day of our lives with superficial conversation and routines and assume that we are going to live forever. He urged us to live an authentic life without anxieties (Heidegger, 1962). Heidegger is known for his classic on existential phenomenology, *Being and Time* (1962).

Jean Paul Sartre (1905–1980) was a French existential philosopher, novelist, and political activist (Kaufmann, 1956). He was awarded the Nobel Prize in literature but refused it. He was convinced that human beings are freer than the other existentialists believed. Our values are what we choose; the failure to acknowledge our freedom and choices causes emotional problems. This freedom is difficult to face up to and we therefore tend to invent various problems (Sartre & Barnes, 1943). Sartre used the term "bad faith" for excuses. Sartre's existential philosophy includes freedom, responsibility, self-deception, and despair. He believed in human freedom and warned about self-deceptive motives by which people often try to elude responsibility. In his famous lecture "Existentialism is Humanism" (Kaufmann, 1956), Sartre stated that freedom entails total responsibility in the face of which we experience anguish, forlornness, and despair. Genuine human dignity can be achieved only in the active acceptance of these emotions.

Simone de Beauvoir (1908–1986) was a existential philosopher, writer, and feminist. She was influenced by Sartre and her existential ideas, which are expressed in

her works including *Ethics of Ambiguity*. She integrated existentialism with feminism and worked closely with Sartre (Madson, 1977).

Paul Tillich (1886–1965) was a Christian existentialist who followed Kierkegaard's teachings. His seminal works were *The Courage to Be* and *Dynamic of Faith.* Tillich believed all statements about God are symbolic, and these symbols are sacred as they reflect God or God's nature (Eliade, 1991). He insisted that anyone who participates in these symbols is empowered by the Power of Being, which overcomes and conquers nonbeing and meaninglessness. Another Christian existentialist was Rudolph Boltzmann (1884–1976) who wrote less of symbols and more of myths, as seen in his essay entitled, *New Testament and Mythology* (Bultmann, 1984).

Edmund Husserl (1859–1938) was a phenomenologist who focused on the intuitive aspects of consciousness. Husserl postulated consciousness in relation to nature consisting of three forms: ego, cogito, and cogitate. Ego is the stream of consciousness in which one acquires meaning from the environment. Cogito includes the acts of consciousness, such as denying, doubting, and affirming. Cogitate are the subjects of thought or consideration (Kaufmann, 1956). Alternatively, Maurice Merleau-Ponty (1908–1961), a French existential phenomenologist, wrote that our experiences are determined by our body perception and its interaction with the environment (Merleau-Ponty, 2002).

Martin Buber (1878–1965) took a less individualistic stand compared to most other existentialists. He stated that humans live in a kind of "betweenness" in which there is never just an "I" but always an "other." The I changes depending on whether the other is an "it" or a "thou." He stressed the importance of "presence," which has three

functions: it enables true I/thou relationships, allows meaning to exist in a situation, and enables an individual to be responsible in the here and now. Buber argued that the therapist and client could not be on the same footing, for it is the latter that comes to the former for help (Corey, 2005; Friedman, 2000).

Ludwig Binswanger (1881–1966) was a Swiss psychiatrist and existential psychologist. He proposed a holistic model of self that addressed the relationship between the person and his or her environment. He used a phenomenological approach to explore significant features of self such as choice, freedom, and caring. Existential analysis emphasizes the subjective and spiritual dimensions of human existence. Originally, Binswanger looked to psychoanalytic theory to shed light on psychosis but later moved toward an existential view of his patients. This perspective enabled him to understand the worldview and immediate experience of his patients as well as the meaning of their behavior, as opposed to superimposing his views as a therapist on their experience and behavior (Corey, 2005; Ghaemi, 2001).

Medard Boss (1903–1996 CE), a Swiss psychiatrist, referred to our ability to reflect on life events and attribute meaning to these events. Humans have the capacity to make choices about numerous events (Corey, 2005). The therapist must enter the client's subjective world without presuppositions that would impede this experiential understanding. Boss was deeply influenced by Freudian psychoanalysis, but even more so by Heidegger. His major professional interest was directed at applying Heidegger's philosophical notions to a therapeutic practice, and he especially was concerned with integrating Freud's methods with Heidegger's concepts, as described in his book *Psychoanalysis and Daseinanalysis* (Boss, 1982).

Viktor Frankl (1905–1997) addressed existential issues and was a pioneer in logotherapy, a form of psychotherapy that focused on finding meaning in life (Frankl, 1959). According to Frankl, striving to find a meaning in life is the primary motivating factor for man. He is well known for his book *Man's Search for Meaning*. Frankl was a victim of the Holocaust and lost many loved ones in Nazi concentration camps. In spite of his great loss and suffering he pursued a meaningful life. Frankl believed neurotic persons lack full awareness of their life's tasks. Therefore, therapeutic goals must be directed to find meaning in life to overcome the neurosis.

Walter Kaufmann (1921–1980) was an existentialist philosopher, Princeton professor, and writer who explored the work of key existentialist philosophers in his book, *Religion from Tolstoy to Camus* (Kaufmann, 1961). He examined Nietzsche's work, reintroduced it, and cleared up many of the false impressions created by the fascist movement. Kaufman also reemphasized and simplified the philosophies of Dostoevsky (1821–1881 CE), Kierkegaard, Kafka, Heidegger, Sartre, and Camus. Kaufmann was skeptical of the benefits of secularism and saw little or no benefit in the quest for certainty (Solomon, 2005).

Rollo May (1909–1994) was an American existential psychologist, who was the first to apply existential phenomenological ideas and philosophy to American psychology. May was influenced by American humanism, and was interested in reconciling existential psychology with other philosophies (May, 1994). He proposed six ontological principles: (a) every person is centered in one's self and lives life through the meanings one places on that center; (b) every person is responsible for mobilizing one's courage to protect the self, to affirm it, and enhance its continued existence; (c) every

person needs other people with whom one can empathize and from whom one can learn; (d) every person is vigilant about potential dangers to one's sense of selfhood; (e) every person has self-consciousness and experience in which one is both subject and object; and (f) anxiety originates, in part, out of one's awareness that one's existence or sense of the meaningful being can end (Monte & Sollod, 2003; May, 1996). May discussed love and will and recognized four kinds of love: (a) *agape* (divine love) or *caritas* (care), which is the love devoted to the welfare of others, and the prototype of God's love for man; (b) sex, or lust (libido); (c) *eros*, the drive to procreate; and (d) *philia*, or brotherly love and friendship (Monte & Sollod, 2003).

Rollo May (1994), in his book *The Courage to Create*, discussed the need for every individual to realize the authentic self. If a person is not true to one's self, one betrays oneself and furthermore betrays society by denying the authentic self. In *Love and Will* (1969) May wrote of the balance of motivations in an individual's life between lower needs, such as food and sex, versus higher needs, such as love. In *Freedom and Destiny* (1999), he explained that freedom is not absolute, and there are limitations put on freedom by external circumstances.

Dr. Irvin Yalom, a modern-day existentialist and psychiatrist from Stanford University, has written many textbooks as well as fiction novels in the area of existentialism. Born to a family of poor Russian Jewish immigrants, he specialized in psychiatry after medical school and held a chief position at Stanford University. Yalom is a pioneer in group therapy in the United States whose existential themes are influenced by Stoic ideas. He discusses life and death issues. Yalom advocates the philosophical teachings of Epicurus, Nietzsche, and Schopenhauer to help patients come to terms with

their mortality and cultivate the ability to create a fate they can love. He is very open about his clinical experiences and often states that to live fully one must accept the end.

In his bestselling book, *Love's Executioner,* which is comprised of synopses of 10 case studies, Yalom stated that he believes anxiety about dying is a cause of many people's grief. His other bestselling book, *When Nietzsche Wept* (1993), indicated that many patients present with neurotic symptoms from anxiety about dying. Often Yalom (1989) talks about his own anxieties relating to his own death:

> The primitive dread of death resides in the unconscious—a dread that is part of the fabric of being, that is formed early in life before the development of precise, conceptual formation, a dread that is chilling, uncanny, and inchoate, a dread that exists prior to and outside of language and image (p. 45).

He believes existential pain is the source of basic anxiety universal to all humans.

Yalom's latest book is *Staring at the Sun* (2009), in which he speaks of his own personal experience relating to the fear of death-related anxiety. The recognition frequently is precipitated by awakening experiences such as terminal illness, trauma, the death of a loved one, divorce, or aging. According to Yalom, once we confront our own mortality we are inspired to rearrange our priorities, communicate more deeply with those we love, appreciate the beauty of life, and increase our willingness to take the risks necessary for personal fulfillment. In *Staring at the Sun,* he stated, "death anxiety is the mother of all religions" (p. 5) and he quoted a poem from one of his patients: "Death pervades, its presence plagues me, grips me; drives me. I cry out in anguish. I carry on" (p. 14).

Yalom (2009) states, "learning to live well is learning to die well" (p. 33), and he often quotes the sayings of stoic philosophers such as Zeno, Cicero (44 BCE) and Marcus Aurelius. Anothor of Yalom's books, *The Schopenhauer Cure* (2005), is a novel that

relates to suffering, cancer illness, and death anxiety. The main character, Julius, is a physician facing death while simultaneously helping others who are having issues with anxiety over dying.

Yalom (2000) wrote another interesting series of clinical stories in *Momma and the Meaning of Life: Tales of Psychotherapy.* This book is a sequel to *Love's Executioner* (1989) and contains six long narratives relating encounters with a loved one's death and one's own mortality. In one story, the main character is an uneducated mother who devoted her life to the care of others. She demanded attention and loyalty on her own terms. Her son struggles to deal with her death, but 10 years after her death he is still trying to fulfill her desires. The other five narratives involve discussions relating to group support in a wide range of cancer care. According to Yalom, compassionate connection, combined with the wisdom of great thinkers who have wrestled with mortality, enables us to overcome the terror of death and lead happier, more meaningful lives. Although he claimed his views to be secular and rejected the supernatural, he favors the Buddhist aspect of philosophy which itself is rooted in spirituality.

Many other American existentialists also discussed themes of death and dying. Ernest Becker (1924–1974) wrote his classic *Denial of Death* (1973) while terminally ill, suffering from cancer. The theme of this book involves the fact that American culture denies death and has a problem accepting it:

> Obviously, all religions fall far short of their own ideals. What is the ideal for mental health, then? A lived, compelling illusion that does not lie about life, death and reality; one honest enough to follow its own commandments: I mean, not to kill, not to take the lives of others to justify itself (p. 204).

Kramer in his book *The sacred art of dying* (1988) states that "the fear of death must be present behind all our normal functioning for the organism to be armed toward

self-preservation. But the fear of death cannot be present constantly in one's mental functioning; else the organism could not function." (p. 15)

## Key Concepts of Existential Therapy

The guiding concepts of existential therapy include: (a) capacity for self-awareness; (b) freedom and responsibility; (c) creating one's identity and establishing a meaningful relationship with others; (d) searching for meaning, purpose, values and goals; and (e) accept anxiety as a condition of living; and (f) awareness and acceptance of death (Solomon & Higgins, 1996).

### *Self-awareness.*

Human beings are capable of self-awareness. The greater the awareness, the greater the possibility for freedom. So expanding our awareness will increase our capacity to live freely. We are finite and do not have unlimited time to do what we want to do in life (Corey, 2005). We have the potential to take action or not, to choose our actions, and create our own destiny. We are subject to anxiety, loneliness, meaninglessness, emptiness, guilt, isolation, and illness. We are alone, yet we have the opportunity to relate to other beings. As we increase our awareness of the choices available to us, we also increase a sense of responsibility for the consequence of these choices. Increasing self-awareness includes awareness of alternatives, motivations, and personal goals (Solomon & Higgins, 1996).

*Freedom and Responsibility*

We are free to choose but also must accept responsibility for our freedom. We are responsible for our lives, actions, and failures. Freedom and responsibility go hand in hand, but patients often tend to blame others (Solomon, 2005).

*Identity, Loneliness, Connectedness, and Relationship*

People believe in personal identity but also are interested in being connected to others. They need to be dependent on others and held by one another. Awareness of one's ultimate loneliness can be frightening and patients may attempt to avoid solitude and isolation. Physicians and nurses must help balance this loneliness by developing relationships with terminally ill patients (Solomon, 2005).

*Search for Meaning*

Existential therapy may provide a conceptual framework for helping patients find meaning in their lives. Meaninglessness creates an existential vacuum in patients described by Viktor Frankl as a major neurosis. Logotherapy is designed to help clients add meaning to life. Meaning allows human suffering to be transformed into achievement. Meaningfulness is helpful to confront pain, guilt, and despair. Spiritual care helps patients go from meaninglessness to meaningfulness, renews relationships, forgiveness, satisfaction, and contentment. Finding meaning in life is a byproduct of engagement (Frankl, 1959).

*Anxiety as a Condition of Living*

Anxiety arises from one's personal striving to survive and to maintain and assert one's being. Existential anxiety is conceptualized as an inevitable result of being confronted with the givens of existence, death, freedom, existential isolation, and meaninglessness (Corey, 2005). Existential anxiety should be distinguished from neurotic anxiety. One has to accept existential anxiety as an unavoidable part of normal living. Life cannot exist without anxiety (Corey, 2005). Existential anxiety can be considered a constructive form of emotion and can be a stimulus for growth and creativity. According to May (1994) freedom and anxiety are two sides of the same coin.

*Awareness of Death and Nonbeing*

Existentialists do not view death negatively. They believe that awareness of death as a basic human condition provides significance for living. It is necessary to think of death when thinking significantly about life. From Frankl's (1959) perspective, death should not be viewed as a threat. Rather, death provides motivation to take advantage of each opportunity to do something meaningful. If we guard ourselves against the reality of eventual death, life becomes insipid and meaningless. Those who fear death also fear life. If we affirm life and live in the present as fully as possible we will not be obsessed with fear of the end of life. Yalom (2005) recommended that the therapist must talk directly about the reality of death with clients at the appropriate time.

In summary, the existential view of human nature is that human existence is never fixed once and for all; instead, we continually recreate ourselves through our projects. Human beings are in a constant state of transition, emerging, evolving, and becoming.

Being a person implies that we are discovering and making sense of our existence (Corey, 2005). We continually ask questions of others, the world, and ourselves, such as: "Who am I? What can I know? What am I to do? What can I hope for? Where am I going?"

Existential psychology effectively is integrated with other schools of psychology (e.g., humanistic, psychodynamic, transpersonal, psychosynthesis, imaginal, feminist, eastern, and cognitive behavioral).

## Humanistic Existential Psychology

The humanistic existentialist school of psychology came into existence in the 1950s and 1960s. Abraham Maslow (1908–1970) was a pioneer of existential humanistic psychology and was a professor at Brandeis University. He is well known for his theory of the hierarchy of needs and self-actualization (Daniels, 2001). He postulated that human beings have a strong desire to realize their full potential—to reach a level of self-actualization. The hierarchy of needs is depicted as a pyramid consisting of five levels. The first four levels are associated with physiological needs, safety, love, belonging, and esteem.

The fifth, and last, level of self-actualization and transcendence includes morality, creativity, spontaneity, problem solving, lack of prejudice, and acceptance of facts (Maslow, 2007). According to Maslow, the tendencies for self-actualizing people are awareness, honesty, freedom, and trust. Self-actualizing people have come to a high level of maturation and self-fulfillment and have a clear perception of reality, acceptance of self, others, and nature, are spontaneous, have a problem-solving orientation toward life, are unselfish, and enjoy solitude and privacy (Wilson, 1972; Maslow, 1954). They

have a mystic sense about themselves and the environment; they identify the feelings of others, sympathize, and are compassionate. They have deep interpersonal relationships, are capable of close love, are humble, highly ethical, philosophical, imaginative, and creative (Maslow and Lowery, 1998).

Toward the end of his life, Maslow postulated that transpersonal psychology is the fourth and final force. Psychodynamics constituted the first force, behaviorism the second force, and existentialism and humanism comprised the third force (Goble, 2007). The later part of his life he was influenced by eastern philosophical and spiritual concepts.

Ken Wilber is a modern transpersonal psychologist and author of *The Atman Project*. This project represents an important step in the history of transpersonal psychology. It is a synthesis of major schools of western psychology and religious traditions. Wilber wrote about various levels of evolution of consciousness. His view was probably influenced by Maslow and other eastern spiritualists/existentialists including Aurobindo (1872–1950).

Carl Rogers (1902–1987) was a prominent psychologist known for his research in areas of humanistic psychology, which was based on relationships with patients. He emphasized understanding individual experience and the importance of personal freedom of choice. He was known chiefly for his book, *Client-Centered Therapy* (1965). This is based on the active and voluntary participation of the patient, without any notion of surrendering his own responsibilities for the situation. A nondirected therapy fosters growth, health, and adjustment. In addition, it places greater emphasis on the emotional aspects of the situation than on intellectual aspects. There is more emphasis placed on

the immediate situation than on the individual's past. It promotes a therapeutic relationship itself as a growth experience in which the patient understands himself or herself to make independent and significant choices. Attainment of insight is one of the primary goals, and to achieve insight one must clarify one's feelings. An individual's subjective experience is the fundamental psychological reality (Rogers, 1961).

Rogers stated that every individual exists in a continually changing world of experience in which that individual is the center (Monte & Sollod, 2003, p. 475). It is, therefore, important to have an empathetic understanding of the experiential world of the client and to communicate this understanding to the patient. There are three important aspects of Rogerian therapy: self-congruence, where both client and therapist minimize the discrepancy that exists between them; unconditional positive regard for the client in a nonjudgmental way; and having an empathic understanding of the client and communicating this to the client (Rogers & Stevens, 1967).

Rogers defined a fully functioning person as one who is fully open to experience and unafraid of his or her own feelings (Rogers, 1980). The fully functional person has the ability to experience life in an existential fashion. Fully functioning people have an increased trust in their own abilities; they are more creative and more competent to meet any challenge. Rogerian therapy may well be the best therapy for the dying or terminally ill patient (Rogers, 1965).

James Bugental (1915–2008) was one of the leading existential humanist therapists and was influenced heavily by Rollo May and Viktor Frankl. He was known for his books, *Search for Authenticity* (1965) and *Psychotherapy Isn't What You Think* (1999). Bugental postulated five important existential concepts: (a) human beings cannot

be reduced to components; (b) human beings have in them a uniquely human context; (c) human consciousness includes an awareness of oneself in the context of other people; (d) human beings have choices and responsibilities; and (e) human beings are intentionally seeking meaning, value, and creativity. He was the first recipient of APA's division of psychology's Rollo May humanistic award.

## Eastern Spiritual Existentialism

In the eastern traditions the term *existentialism* is not used often but existential themes are expressed vividly in Hindu scriptures called the Upanishads, Vedas, and Puranas (Radhakrishnan, 1957; Radhakrishnan, 1994; Muller, 1962). Buddhism, Jainism, and Taoism also embrace many spiritual existential themes. Many existential principles are adopted symbolically in daily routines and in eastern rituals, art, music, poetry, and philosophy. In the southern states of India, the Shiva worshippers, called Saivites, routinely apply holy ash on the forehead in the morning and evening after prayers. This practice reminds them to be authentic and honest; it also reminds them of the transient nature of human life. The holy ash ritual originates from the mythology of lord Shiva who is known for his dance of creation (Lasya) and destruction (Tandava) (Nallaswami Pillai, 1910, Coomaraswamy, 2006). These two existential natures of Shiva are symbolized in the same cosmic dance as a symbol of creation and destruction. He symbolically holds fire in one hand, which is representative of destruction; in the other hand he carries a drum, which represents the rhythm of life. He is surrounded by a blazing fire and stars. His body is smeared with ash. He also carries a garland of skulls around his neck. All of these symbols remind the devotees of the transient nature of life and the inevitability of death. The popular epics such as *Mahabaratham*, *Ramayanam*,

and *Baghavad Gita* explore existential issues such as death, the meaning of life, the nature of life, the relationship with human nature, God or sacred, and duties.

In the Indian epic *The Mahabharata*, Yudhishtara talks about human denial of death: "Of all the world's wonders, which is the most wonderful? That no man, though he sees others dying all around him, believes that he himself will die" (Yalom, 2009, p. 99).

Buddhism and Taosim emphasize many aspects of existentialism, including renouncement, living in the present moment, detachment from material things, control of desires, and being compassionate. Jainism also has many existential themes similar to Buddhism. Many existential philosophers and saints lived in India, China, and the Far East. The 20th-century Indian philosopher Aurobindo has influenced many western existentialists, including Ken Wilber, Eliade, and Abraham Maslow. According to Aurobindo Divine, Brahman manifests as empirical reality through Lila or divine play. Life itself is divine. He was the founder of integral yoga methods (McDermott & Aurobindo, 2001).

## Contribution of Psychodynamic Disciplines

Carl Jung's psychological ideas included metaphysics and spirituality (Jung, 1976). Jung was the first to coin the term *transpersonal psychology*, which relates to the study of humanity's highest potential, recognition, understanding, and realization of spiritual and transcendent states of consciousness. Transpersonal psychology also includes spiritual peak experiences, mystical experiences, systemic trance, and other occult experiences. It was influenced by earlier schools of psychology including humanistic psychology and psychoanalysis. Transpersonal psychology attempts to

integrate philosophy and meaning and the experience of mysticism into modern psychology. Historically, western psychology had ignored the spiritual dimensions of the human psyche, and Jung was the one credited with reintroducing it (Jung, 1976).

Jung is known for his concepts of archetypes, the collective consciousness, the individuation process, images, symbols, and synchrony, among others. His views are compatible with both eastern and western traditions and resonate well with the mystical-spiritual concepts of Kabala and Sufism (Armstrong, 1994). Jung's ideas also are compatible with the spiritual views of many religious traditions such as Christianity, Buddhism, Islam, Judaism, and Hinduism (Jung, 1968). His concepts reflect the spiritual components of older traditions such as the Celtic, Greek, Nordic, Gnostic, Persian, Aboriginal, African, American Indian, and shaman practices, as well as new age faiths. All of his concepts have a universal spiritual appeal (Jung & Segal, 1992).

Jungian psychology includes the collective unconscious, the personal unconscious, ego, shadow, persona, introversion and extroversion, and archetypes (Jung, 1981). The human personality is influenced by both conscious and unconscious factors. The conscious is oriented toward the external world and is governed by the ego; it represents the individual's thoughts, ideas, feelings, sensory perceptions, and memories. The unconscious is made up of both the personal and the collective unconscious. The personal unconscious contains experiences that were once conscious but are now repressed or forgotten or were perceived unconsciously. The collective unconscious is the repository of latent memory that can be passed on for generations like genes. Included in the collective unconscious are archetypes, which are primordial images that cause people to sense, experience, and understand certain phenomena (Jung, 2006).

Archetypes particularly are important to personality development and transformation. The self represents a striving for unity of different parts of personality: the persona, the shadow, the anima, and animus. Jung described personality as consisting of two attitudes, extraversion and introversion, and four basic psychological functions: thinking, feeling, sensing, and intuition. Although all four functions operate in the unconscious of all people, one of the functions ordinarily predominates in consciousness. Feeling, sensing, and intuition are considered major spiritual components of care for the terminally ill (Jung, 1981).

Jung's ideas of archetypes, shadows, and images have great significance to many religions whether polytheistic, monotheistic, or nature worship. The religious concepts of gods, angels, devils, and ancestral spirits may relate to various archetypes. Jung focused on the concept of synchronicity and dreams, which is prevalent in the writings of all religious and spiritual traditions. Jung also wrote about numinous experiences, which may have powerful spiritual transformative effects on the psyche (Jung, 1989).

Jung pointed out that most societies prepare individuals for the second half of life and aging and end-of-life issues. The second half of human life relates to the individuation process and psychological maturity. The psychological path of individuation is a process of maturation and spiritual growth (Jung, 1989). During this time one becomes conscious of the shadow, which is the "dark side" containing repressed experience. The shadow may manifest to us in dreams as images of archetypal figures.

Another stage of individuation is becoming conscious of the archetypal spirit. This archetype often is depicted in fairytales and myths as a wise old man, a motherly figure, or other forms. The individuated self often is symbolized by a circle or mandala,

which represents completeness. Individuation is an ongoing, endless process and one needs to be careful of the risk of inflating the ego. Jung's individuation is similar to, but not identical with, the self-actualization of Maslow (Monte & Sollod, 2003). Personal archetypes are called daemon (guardian angels), which are helpful for the transformation process.

Jung is known for his classics, *Modern Man in Search of a Soul* (1933) and *Memories, Dreams, Reflections* (1989), which serve as important guides for many spiritual psychologists. He wrote about various religions including Gnosticism and Daoism. He concluded that religion is a journey to find the self and the search for the divine. Spiritual experience is essential for one's being and for sanity. He compared psychotherapists and priests. Priests may not know much about scientific concepts but they do know about values, which are necessary for the soul. He believed many people become psychologically disturbed in their middle age because they lose their spiritual outlook. Science and logic may not be the path to achieve balance and harmony. One often returns to spirituality when facing life's challenges and problems. Jung compares the modern man with the archaic man. Modern man relies on science and logic and ignores the unconscious, instinct, and spirituality. He talked about the simplicity of the archaic man's lifestyle and belief system, which helped him to live a peaceful, spiritual existence. Jung stated:

> Through dreams and symbols, through mysticism and myths, we can trace the unconscious need for meaning and purpose in man's life. Religion is a journey of self transformation, in which we discover ourselves. Deep spiritual experiences can lead us to develop and grow. Modern man has gained much, but he has also lost contact with his instincts and unconscious. As a result he often suffers from spiritual unease, and the modern mindset prevents him sometimes from seeking religious remedies for this. Science and logic teach us a great deal but sometimes

> they are not enough. Instead we need to return to the simpler values of faith, love, and trust in our unconscious (Russell, 2009, p. 191).

The Italian Assagioli (1888–1974) was a physician and psychologist, who strongly believed religion and spirituality should be incorporated with psychology. He developed the concept of psychosynthesis, which has made a significant contribution in the field of transpersonal psychology (Assagioli, 2008). He offered a broader view of consciousness and offered a map of the human psyche.

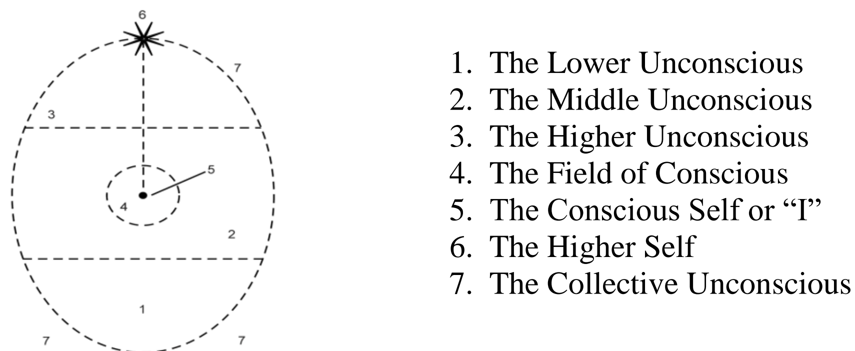
Assagioli is known for his egg or oval diagram, which reflects a view of the human psyche and its multiple dimensions. He divided the unconscious into three different levels. The "lower unconscious" contains the repressed and traumatic memories, fundamental drives and impulses, and elementary psychological functions. The repressed feelings are buried in the lower unconscious. The mental pathologies have their roots in the lower unconscious, where neuroses and psychoses arise into the conscious. The "middle unconscious" is the part of the unconscious to which we have access during our waking state. Our thoughts and feelings can arise from here; it is an intermediate state between waking and sleeping (Assagioli, 2000). The "higher unconscious" has the elements of transpersonal experiences that connect to universe, human beings, and to the world of spirits. All higher thoughts and feelings enter the "higher conscious" and include intuition, inspiration, ethical feelings, altruistic love, and self-sacrifice. It is also a place where the higher qualities and abilities originate as well as higher spiritual states, ecstasy, and enlightenment.

The "collective unconscious" carries archetypal experiences; the communal knowledge that one shares with other humans throughout the world and through the ages. The "field of conscious" applies to our waking state, where sensations, images, thoughts,

feelings, desires, and impulses exist so that we can analyze and judge the conscious self or ego.  It is similar to the ego described by Freud and is the center that regulates and observes all contents of our consciousness.  It is analogous to a charioteer controlling everything.

Assagioli discriminated between different levels of self.  The living conscious human entity in the center of the diagram is called the conscious self, or “I.”  This self indicates our will, thoughts, emotions, sensations, etc.  The “higher self” is located at the top of the egg diagram, a source of wisdom, inspiration, meaning, and unconditional love. The integration, synthesis, or unification of the personality happens around this higher self (Assagioli, 1999).

Figure 1.  Egg Diagram of Psyche by Assagioli




As mentioned previously, Assagioli is the founder of the theory of psychosynthesis, which refers to achievement of a higher level of consciousness by integrating various components of the psyche or subpersonalities.  He divided psychosynthesis into three stages: spiritual, interindividual, and cosmic.

In spiritual psychosynthesis there is integration of the superconscious into the conscious personality of the individual.  This could also be achieved through music, which activates spiritual synthesis through highly religious emotions (Assagioli, 2000).

Music can elevate our conscious to higher realms where love, joy, and light reign. Some music, including music composed by Beethoven, Gregorian chants, and eastern mythical music are acknowledged to induce spiritual psychosynthesis.

Interindividual psychosynthesis is a stage that promotes a collective synthesis between humans. Music in this category includes national anthems and other group-oriented compositions. Cosmic psychosynthesis includes Pythagoras' concept of an ordered universe built according to harmonious and musical laws. It also involves the effect of music in evoking universal symbols of archetypes. Assagioli envisioned a future for psychosynthesis that includes evolutionary force in psychology or energy psychology known as psychoenergetic (Assagioli, 2000).

Erik Erikson (1902–1994) was a developmental psychologist who was well known for his theory on social development, also known as ego psychology. He theorized that there are eight stages of development in one's life (Weiner, 1979). Each stage of psychosocial development is marked by a conflict for which successful resolution will result in a favorable outcome. These favorable outcomes are known as virtues. For example, for the conflict of trust versus mistrust, when trust prevails the virtue that emerges is hope. The virtues of other stages are: courage, purpose, competence, fidelity, love, care, productivity, and wisdom. The last two stages, seven and eight, emphasize the aging process, and are described as generativity versus stagnation, and ego-integrity versus despair (Erikson, 2001). Favorable outcome of the eighth stage is wisdom. After Erikson's death, his wife Joan took into consideration the increase in life expectancy and described a ninth stage called gero-transcendence

(Tornstam, 2005). This stage deals with love, care, hope, trust, courage, wisdom, transcendence, spirituality, and acceptance of death.

## Archetypal Psychology—Soul Psychology (Depth Psychology Perspectives)

Archetypal psychology was proposed by James Hillman, who was influenced by Jung. He is one of the leading experts in death psychology who has incorporated classical Greek, Renaissance, and Romantic ideas. He is well known for many books including *Re-visioning Psychology* (1977). For many years he held a position as the head of the Jungian Institute in Zurich. Currently he lectures at Pacifica Graduate Institute and is the leading depth psychologist in the United States. His concepts reflect the works of poets and philosophers including Keats, Fitzgerald, Gandhi, and Lord Byron. He emphasizes the soul-making process as a key aspect of psychology and therapy (Hillman, 1997).

Archetypal psychology involves images derived from past cultural experiences. It goes beyond other concepts of psychology, medicine, and similar disciplines (Hillman, 1977). Archetypal psychology is rooted in the imagination. It also differentiates between the concept of soul and spirit. The soul relates to this world, whereas the spirit relates to other forms of human existence beyond this world. The soul recognizes suffering, depression, pain, and other unpleasant states of human existence. According to archetypal psychology, the world has universal soul called *animae mundi*. There is a soul in both animate and inanimate forms (Hillman, 1997).

According to Hillman, the psyche expresses itself through dreams, images, myths, and fantasies. Dreams are important in the soul-making process and must be interpreted in phenomenological rather than analytical terms. Images in dreams are helpful to

provide a broader perspective and insight. An active imagination also is helpful in the soul-making process; it is the way to welcome the images that have a healing effect. Dream tending is one of the therapeutic methods employed by depth psychologists (Hillman, 2000).

The imaginal spiritual realm was described by Henry Corbin (1903–1978), the French philosopher, theologian, and professor of Islamic studies at the Sorbonne University in France. He referred to the imaginal world as "Mundis Imaginalis," which serves as a space for spiritual development (Cheetham, 2003; Corbin, 1989). He was influenced by the Islamic Sufi philosophers Suhrawardi and Mulla Sadra. They founded the illuminist school of philosophy, which later became known as the imaginal school of psychology. The imaginal world is neither an abstract world of intelligence nor one of pure sensation, but is a world in-between these two. According to Romanyshyn, the head of imaginal psychology at Pacifica Graduate Institute, the imaginal world is an intersection of the sensory and intellectual world (Romanyshyn, 2007). Hillman proposed that the psyche's function is to produce images. These images manifest as dreams, fantasies, and various experiences (Corbin, 1989).

American philosopher Edward Casey, currently the president of the American Philosophers Association, stressed that imagination and memory go together; without imagination, memory cannot exist (Casey, 1991). Carl Jung wrote in his books of dreams and fantasies about archetypal images of the collective unconscious.

Imagination is important for spiritual practices. During worship or prayer one imagines sacred images, sacred locations, sacred times, rituals, and experiences. In many traditions one may invite images of sages, ancestors, and saints to guide and inspire the

spirit. Music, art, drama, poetry, and sculpture all originate from the imaginal realm of the human psyche.

Famous Italian artists such as Da Vinci, Michelangelo, and Picasso were able to express the imaginal figures of spiritual significance in the world of art. Romantic poets including Samuel Beckett, Wordsworth, Coleridge, and Keats used their imaginations in their poetic works. Imagination precedes the creation of poetry, artwork, and rituals. Religious rituals induce a myriad of images in the human psyche. William Blake, a famous poet, believed that imagination is not only a state but is the human existence itself. Einstein stated that imagination is more important than knowledge or intelligence (Wordsworth & Wordsworth, 2006; Auden & Pearson, 1977).

The imaginal realm has its root in mystical traditions of various religions and cultures. Many Sufi spiritual practices involved the imaginal. The imaginal realm deals with the soul, compassion, love, connection, and empathy. Prayers, meditation, and rituals as well as active imagination, dreams, and intuition are closely linked to this imaginal realm.

## Liberation Psychology

Liberation psychology, rooted in spiritual ideas, is a new field that looks into various community issues and contemporary social problems that have been neglected by mainstream psychology and social sciences. It focuses on psyche, culture, nature, and spiritual equality. It encourages art, imagery, poetry, dreams, and symbols in addition to language as an expression of psyche. It seeks to repair the fragmentation in relationships, value experiences, and create an environment to encourage dialogue, creative thinking, and utopian imagination. Liberation psychology values inspirations and energies, which

evolve from spiritual, religious, and artistic practices. It also values mythology and helps to create a new mythology that serves as a reservoir of symbols. It nurtures peace, harmony, and healing among the diverse members of the community. Liberation psychology recognizes the importance of giving priority to issues that are marginalized in both psyche and society. It stresses the importance of listening to and acknowledging voices that have been silenced both in individual and community work. Other areas include economic justice, hunger and poverty, repression, oppression, and violence. Liberation psychology empowers and encourages members of the community to participate in diminishing disparities in the world and in the psyche. It promotes the creation of intrapsychic spaces where dialogues of diverse points of view can take place. Women and minorities were suppressed and discriminated throughout the world for many centuries. Many liberation psychologists are creating new ways to bring equality including in the area of spiritual practices.

Martin-Baro (1942–1989) was a Spanish-born Jesuit priest and liberation psychologist who worked tirelessly against poverty and oppression in South America (Martin-Baro, 1996). He wrote several books in the area of liberation psychology. He was executed in 1989 by the Salvadorian death squad for his liberation ideas and human rights activities. Mary Watkins is a phenomenologist known for her intensive work on liberation psychology (Watkins & Shulman, 2010). She also incorporates many spiritual themes in her teachings and writings. She is a senior professor at Pacifica Graduate Institute, which is well known for depth psychology.

## Spirituality and Feminine Principles

Many leading female psychologists claim that spirituality is related to nurturing and is closer to the feminine principles (Auset, 2009; Monaghan, 1999). In eastern cultures feminine principles are described as *yin* rather than the masculine or *yang* principles. Thousands of years ago the worship of goddesses was prevalent in every culture, and the female life-giving principle was considered divine. Even now, goddess worship is prevalent in many parts of the world. Mother symbolizes feminine power, fertility, and nurturing. In the past, Ishtar in Mesopotamia, Athena, Artemis, and Aphrodite in Greece, Isis in Egypt, Magna Mater in pre-Christian Rome, and Quan Yin in China were worshipped prominently (Monaghan, 1999). Anthropologists recovered artifacts of the goddess Venus of Willendorf, whose worship is estimated to have been common approximately 20 thousand years ago, evidence that feminine worship has existed for many thousands of years. Early European culture was dominated by the worship of female divine principles prior to the appearance of Christianity. This practice also was present in the East, with the goddesses Durga, Kali, Saraswathi, and Luxmi (Amazzone, 2010; Kinsley, 1988). Many eastern traditions balanced both male and female principles. Lord Shiva is balanced by Parvathi, Vishnu is balanced by Luxmi, Bramma is balanced by Sarasvathy. Earth itself is considered a feminine principle, referred to as Gaia, the feminine earth.

Recently there has been a renewed interest in spirituality and feminine principles. Many feminine spiritualists claim that our present world is not in harmony and that this imbalance has resulted from suppression of feminine energy. As a result, many female spiritualists would like to restore feminine spirituality. Currently, in the East the worship

of Guan Yin (the female Buddha) is again prevalent. In other eastern areas, Durga worship is being incorporated into spiritual practices. In South America and the United States there is also a new trend of incorporating feminine worship, and there are rituals to invoke the feminine energy in prayers. It can be seen that the worship of Guadalupe empowers women.

## Interspirituality—Integration of Diverse Spiritual Traditions

Many spiritual leaders are courageous enough to cross the borders of religious distinction to find a commonality in the core ideas of diverse religious and spiritual traditions. Many established peace by bringing various sects who had opposing views together in harmony. The American mythologist and philosopher Joseph Campbell (1904–1987) stated:

> We have not even to risk the journey alone, for the heroes of all times have gone before us. The labyrinth is thoroughly known. We have only to follow the thread of the hero path, and where we had thought to find an abomination, we shall find a god. And where we sought to slay another, we shall slay ourselves. Where we had thought to travel outward, we will have come to the center of our existence. And where we had thought to be alone, we will be with all the world (Santorelli, 2000, p. 85).

Wayne Teasdale, a Catholic priest, in his book *The Mystic Heart* (1999) wrote about those leaders who brought peace and harmony together by integrating core traditional values. He explained the power of universal spirituality and summarized it into eight practical elements: solidarity with all life; moral capacity; nonviolence; self-knowledge; selfless service; simplicity of lifestyle; daily practice; and serving as a prophetic witness in causes of justice, peace, and protecting creation. He wrote about history in a multifaith context and included the spiritual traditions of Buddhism,

Hinduism, Sufism, Judaism, Christianity, Islam, and indigenous people, as well as ecologists and their mystical sense of the world as divine manifestation.

The spiritualists of the East who embraced and respected other religious and spiritual beliefs include Al-Kabir (1440–1580), Ramakrishna (1836–1886), Shiridi Sai Baba (birth unknown–1918), Vivekananda (1863–1902), Paramahansa Yogananda (1893–1952), and Meher Baba (1894–1969). Al-Kabir was a 15th century Muslim saint who integrated Sufi, Hindu, and Zoroastrian philosophy. He was the first Islamic spiritual leader who attempted to mend the violent split between Hinduism and Islam by preaching a common path. In addition to Islamic ideas, he also incorporated the Hindu ideas of reincarnation and karma. He described life as the interplay of two spiritual principles: the personal soul, *Jivatma*, and God, *Paramatma*. Bringing these two together was essential to the process of salvation (Dass, 1991).

Baha'u'llah (1817–1892) was a Persian prophet who believed all religions originate from the same source, one God, and are in essence successive chapters of one spiritual philosophy. His message is one of unity as the oneness of God, the oneness of the human family, and the oneness of religion. The Baha'i religion is a rapidly growing religion with a major proportion of the group having migrated to India, and western countries (Esslemont, 2006).

Ramakrishna (1836–1886) was a saint and considered by many Hindus to be an avatar. The Vedanta Society, otherwise known as the Ramakrishna mission, is based on his teaching. His philosophy incorporated the spiritual ideas of Buddhism, Islam, Sufism, and Christianity. Westerners who were influenced by his teachings include Max Müller, Aldous Huxley, and Henry Zimmer. Ramakrishna's ideas essentially originate from

Vedanta philosophy and include the idea that God can be realized through all paths and that all religions are true. One should not think that his or her religion exclusively is the correct path and that other religions are false. There are infinite paths and opinions, truth is one and is only called by different names. Lovers of God are not restricted to any caste, creed, or sect (Nikhilananda, 2000).

Shiridi Sai Baba was a Muslim Sufi saint whose parentage and birth details are obscure. Though he lived in Northern India during a time of conflict and violence between Hindus and Muslims, he incorporated both Hindu and Muslim spiritual philosophy and reconciled the differences. His core philosophy included love, forgiveness, charity, selfless service, attainment of inner peace, and devotion to God. To this day, he is admired and worshiped by many Indians of various religious groups (Williams, 2004).

Swami Vivekananda was a disciple of Ramakrishna. He was instrumental in introducing Vedanta teaching to the West, and was considered the spiritual ambassador from the East to America and the western world (Ghosh, 2003). He integrated the religious ideas of the East and the West into one harmonious spiritual philosophy. He inspired many westerners including William James, Max Müller, and Paul Deussen.

Paramahansa Yogananda is a spiritual figure well known in the western world for his book *Autobiography of a Yogi* (2000). He spent much of his life in the United States and established the Self-Realization Fellowship, or SRF. During his lifetime, he emphasized, “The true basis of religion is not belief, but intuitive experience. Intuition is the soul’s power of knowing God” (Yogananda, 2000, p. 31). He also stated:

> Self-realization is the knowing in all parts of body, mind and soul that you are now in possession of the kingdom of God; that you do not have to pray that it

> come to you; that God's omnipresence is your omnipresence; and that all that you need to do is improve your knowing (Yogananda, 2000, p. 197).

SRF members belong to different religious and cultural traditions. This organization is active in southern California.

Other pioneers who crossed the inter-religious and intercultural boundaries into interspirituality are Bede Griffiths, Thomas Merton, Alan Watts, and Rodger Kamenetz. Essential themes of interspirituality must include solidarity with all living beings, nonviolence, simplicity of life, selfless service, and compassionate action. Alan Wilson Watts was a British Episcopalian priest known as an interpreter of eastern philosophies for a western audience. As a priest early in his career, Watts attempted to work out a blend of contemporary Christian worship, mystical Christianity, and Asian philosophy. Later on in his career, Watts presented more of a universal worldview, drawing on Hinduism, Chinese philosophy, pantheism, and modern science (Watts, 1994).

Bede Griffiths (1906–1993), another pioneer of interspirituality, was an English Benedictine monk. Also known as swami Dayananda, he became a yogi embracing an integrated spiritual philosophy of Christianity and Hinduism. He incorporated science into the equation of interspirituality. He made Tamil Nadu his home and lived in the ashram known as Shanthivanam, a place of peace, as he continued to teach his integrated spiritual ideas (Teasdale, 2003).

Thomas Merton (1915–1968) was a Trappist monk well known for his interspiritual philosophy. He opened the door to enable Christians to explore the teachings of Hinduism and Buddhism. He wrote many books including *Zen and the Birds of Appetite* (1968) and *The Seven Story Mountain* (1998). He studied eastern religions, including Buddhism, Taoism, Hinduism, Jainism, and Sufism, extensively and

traveled to many eastern countries. He had spiritual dialogues with several spiritual leaders including the Dalai Lama, Suzuki, and Thich Nhat Hanh.

The Italian Jesuit missionary Roberto De Nobili (1577–1656) was the first pioneer of interspirituality (Cronin, 1959). He traveled to India, learned Sanskrit and Tamil, and studied the Vedas, Upanishads, and Bhagavad Gita. His life became a dialogue between two traditions, Hinduism and Christianity (Cronin, 1959). Constanzo Beschi (1680–1747), another Italian Jesuit priest who was a missionary in India, studied the south Indian languages and became a scholar in Tamil language and southern Indian wisdom literature. He also was known under the Tamil name of Viramamunivar (Brave Saint). He was considered a saint by the Indian Hindus and Christians. He was known as Sanyasi, which means Indian ascetic, and adopted their saffron-colored robes. His contribution to the south Indian languages was substantial and he earned the title of Father of Tamil Prose (Guldner, 1907).

Another famous figure is Thomas Keating, a Trappist monk. He integrated the spiritual ideas of Christianity, Hinduism, Buddhism, and Jainism. Many Jewish scholars also were involved in learning Buddhism and Hinduism, which gave rise to the fascinating phenomenon of Jewish Buddhists who refer to themselves as BuJus or JuBus. Rodger Kamenetz, a professor of English and Religious Studies at Louisiana State University, wrote the book *The Jew in the Lotus* (Kamenetz, 1994). Though he explored Buddhism as a Jew, he did not leave his faith behind. Thich Nhat Hanh, a Vietnamese Buddhist monk, has become a leading proponent of the interspiritual approach. Many Indian sages and saints of modern times, including Sathya Sai Baba, are proponents of incorporating the essence all religious traditions.

Teasdale (1999) also predicted the coming of the Interspiritual Age. According to him, humankind is at the dawn of a new consciousness with a new approach to life. There is an emergence of ecological awareness of the natural, organic world along with an acknowledgement of concerns about the fragility of this earth. There is also a new awareness of the rights of other species and other sentient beings. The recognition of the interdependence of all the realms of life and reality is coming to the forefront. There is a universal consensus against nationalism and a move into an area of interdependence among nations.

Teasdale (1999) further contended that there is increased recognition of and respect for other religious groups and their members. Human beings are beginning to understand the relationship among the cosmos, humans, and the earth, one that is larger than previously realized. For Teasdale, this relationship defines a new period in history, the Ecological age. There is new awareness of our interconnectedness to ecological, moral, aesthetic, political, cultural, and social activity. We need to find a balance between the individual and society and appreciate that interdependence is necessary for our world. Incorporation of the spiritual philosophies of the East and West will complete our spiritual beliefs (Tarnas, 2007).

Teasdale (1999) further stated that spirituality is a holistic understanding of contemplative experience with all kinds of experiences, methods of prayer, and transformation. He studied eastern traditions extensively and wrote about consciousness as the root of identity. He quoted from the Upanishads that Brahman is consciousness. Brahman also is higher intelligence and is the absolute. The inner awareness of oneself is referred to as *atman*. The Upanishad emphasizes that atman is Brahman and Brahman is

atman. According to Teasdale, divine consciousness is the totality within which all things abide. It is through our individual consciousness that we touch the divine consciousness in the mystical experience. We can reach this authentic spiritual state through practices. There are as many forms of spiritual practices, but they all have the same goals, which is the individual's transformation and integration with the cosmos (Teasdale, 1999).

Teasdale (1999) further stated that the spiritual journey integrates the inner and outer life, bringing together both contemplation and action. The process of engagement takes form in selfless service and compassionate action, including the responsibility to speak out against the abuse of the earth, all its inhabitants, and human rights.

## Spiritual Figures of 20th Century

This portion of the review relates to the modern spiritual thinkers of the 20th century who have contributed in the area of spiritual care by considering the social and scientific aspects of spirituality. I will summarize recent qualitative and empirical research work done by social scientists, physicians, psychologists, and other healthcare professionals. Many spiritual leaders from different societies, cultures, and backgrounds have contributed to the spiritual growth of human beings. They approached spirituality from multiple perspectives that was helpful to fulfill the human spiritual needs of the 20th century.

Gandhi (1869–1948) was an innovative, novel, ground-breaking spiritual thinker and political leader who emphasized spirituality and nonviolence (*Ahimsa*). (Attenborough, 2001; Clement, 1996). Throughout his life he observed self-control, moral discipline, honesty, altruistic behavior, and compassion. He also followed a strict

physical and dietary regimen, which included daily exercise and a healthy vegetarian diet. After his early studies in India, he continued his legal education in Cambridge and became a barrister. He practiced labor law and human rights law in South Africa before returning to India.

Gandhi kept his mind active by immersing himself in the works of the Bible, the *Bhagavad Gita*, and Jain literature of *Ahimsa*. He also studied western writings including those of Henry David Thoreau and Tolstoy. Gandhi was inspired by his study of the New Testament, particularly where Jesus urged his followers not to fight back but rather to "turn the other cheek." He studied the teachings of spiritualists including Patanjali, Vivekananda, and Ramakrishna. He studied *Bhagavad Gita* extensively, describing it as a dictionary of moral conduct that guided him throughout his life. He also read the Koranic, Buddhist, and Jain philosophical teachings. He was influenced by the teachings of Jain spiritual leader and philosopher Shrimad Raj Chandra, Leo Tolstoy, and John Ruskin. He liked the spiritual classics of Leo Tolstoy including *Confession* (2005), *The Kingdom of God is Within You* (1984), and *Resurrection* (2004). He also liked John Ruskin's *Unto This Last* (1986), and inspired by Ruskin, Gandhi formed a movement he called Sarvodhaya, which gives equal value and respect to everyone's labor.

Gandhi's spirituality was of the self-made variety, with each idea and faith balanced by his search for the truth. These ideas are written clearly in his book *Experiments with Truth* (2008). He tried to unify Muslims and Hindus using his religious theme that all religious traditions were expressions of the one God. In the following excerpt, Gandhi described that truth is of the utmost importance in one's life:

> All that appears and happens about and around us is uncertain, transient. But there is a Supreme Being hidden therein as a Certainty, and one would be blessed

> if one could catch a glimpse of that Certainty and hitch one's wagon to it. The quest for the Truth is the summum bonum of life (Butler-Bowdon, 2007, p. 88).

Gandhi was instrumental in achieving independence for India by using spiritual and nonviolent means.

Ananda Kentish Coomaraswamy (1877–1947) was a British citizen with a mixed parentage; his mother was English and his father was British Ceylonese and came from an affluent background. His initial training was in geology, in which he obtained a doctorate degree. His interests later extended to include spirituality, symbolism, and art relating to Hinduism and Buddhism. He was interested in philosophy and Perennialism, which refers to the universal concept that each ancient religious tradition shares a common universal truth as a basic foundation. This universal truth is rediscovered in each epoch by prophets, saints, sages, yogis, and other spiritual figures. He was the first to introduce the eastern concepts of symbolism to the western world.

Coomaraswamy served as a curator in the Museum of Fine Arts in Boston and was instrumental in bringing a massive collection of eastern artwork and artifacts to the United States. Furthermore, his concurrent interest in Greek philosophy allowed him to draw parallels between the Vedanta and Platonism (Coomaraswamy, 1988). With Rene Guenon and Frithjof Schuon, he founded the school of Perennialism, also referred to as the Traditional school. The Perennial school of thought refers to a recurring philosophical insight that is independent of time, culture, and religion, including universal truths about one's own consciousness, the nature of humanity, and reality. He visited many countries in the world and moved in circles of well-known poets, writers, philosophers, and spiritual leaders, including Tagore, Campbell, Eliade, Zimmer, and many others. He was attracted to ancient spiritual philosophy of India.

Coomaraswamy wrote many books, including *Dance of Siva* that has been quoted by many western authors. Fritjof Capra is an ardent supporter of Coomaraswamy's writings, which are reflected in his writings:

> How supremely great in power and grace this dancing image must appear to all those who have striven in plastic forms to give expression to their intuition of Life! No artist of today, however great, could more exactly or more wisely create an image of that Energy which science must postulate behind all phenomena . . . . Nature is inert, and cannot dance until Siva wills it. He rises from his rapture, and dancing sends through inert matter pulsing waves of awakening sound, and lo! Matter also dances appearing as a glory round about Him. Dancing, He sustains its manifold phenomena. In the fullness of time, still dancing, he destroys all forms and names by fire and gives new rest. This is poetry; but none the less, science (Smith, 1998, p. 2).

As a product of both eastern and western cultures, Coomaraswamy claimed he often thought in both Hindu and Christian terms. He clarified the western misconception of eastern symbolism and myths by educating the West on Indian art and symbolism. Heinrich Zimmer, a German philosopher and historian, described Coomaraswamy as "that noble scholar upon whose shoulders we are still standing" (Zimmer, 1972).

Hermann Hesse (1877–1962) was a German spiritual writer and novelist who was the son of a Lutheran pastor. He moved away from the traditional dogmatic views of religion to develop a broad and universal concept of spirituality. He studied both eastern and western traditions and formulated his own concept of spiritual philosophy. He was a Nobel Prize winner, known well for his literary contributions. His book, *Siddhartha* (2008), is based on his own spiritual journey and illustrates the journey from boyhood to manhood and his struggles to realize the truths of life. The character Siddhartha is the hero in the book who, with his friend Govinda, searches for spiritual enlightenment. The friends decided they should each find enlightenment on their own path. Siddhartha decided to go back into the material world to experience it. In his journey he encounters

Kamala, a beautiful courtesan who allows him to appreciate and experience worldly pleasures; though his relationship with her is ephemeral, he soon realizes he has become an ordinary man. Years into their relationship, he becomes restless and eventually leaves Kamala and his son to pursue his spiritual search. At last he meets an old ferryman who spends time in observing the river. This man's simple life and philosophy attract Siddhartha, and he joins him as a ferryman. He finds himself in rhythm with the flowing river and nature and finds true spiritual wisdom. Overall, this book is a synthesis of Buddhist, Hindu, Taoist, and Christian concepts. This story reflects Hesse's spiritual journey, which emphasizes the importance of practical wisdom rather than acquiring extensive knowledge. His existential philosophy is best summarized in his work "All Deaths" (*Alle Tode*) in *Poems* (2008), translated by James Wright:

> I have already died all deaths,
> And I am going to die all deaths again,
> Die the death of the wood in the tree,
> Die the stone death in the mountain,
> Earth death in the sand,
> Leaf death in the crackling summer grass
> And the poor bloody human death.
>
> I will be born again, flowers,
> Tree and grass, I will be born again,
> Fish and deer, bird and butterfly.
> And out of every form,
> Longing will drag me up the stairways
> To the last suffering,
> Up to the suffering of men.
> (Hesse, 1877)

Kahlil Gibran (1883–1931) was a spiritualist, mystic, and poet of Lebanese American origin. He is the third bestselling poet of all time. He adopted a broader view of life beyond that of traditional Abrahamic faith. Gibran's spiritual views are expressed in his book *The Prophet*, a book of prose poetry (Gibran, 2001). *The Prophet* provides

timeless spiritual wisdom on a range of subjects including charity, friendship, beauty, religion, death, punishment, and learning. His work gained popularity in the western world during the 1960s and was translated into more than 40 languages. Admired by many, he was respected by both the Christian and Islamic communities. Many of his views are thought to resemble those of the Sufi philosophers:

> You are not enclosed within your bodies, nor confined to houses or fields. That which is you dwells above the mountain and roves with the wind. It is not a thing that crawls into the sun for warmth or digs holes into darkness for safety. But a thing free, a spirit that envelops the earth and moves in the ether? (Butler-Bowdon, 2007, p. 96)
>
> When love beckons to you, follow him. Though his ways are hard and steep. (Butler-Bowdon, 2007, p. 87)

Aldous Huxley (1894–1963) was an English author and humanist who was educated at Eton College and Oxford University. Best known for his novel *Brave New World* (Huxley, 2006) that describes a dystopian vision of society in which technology has outstripped morality. Huxley tried to illustrate the concept that totalitarian governance over an individual's consciousness may result in a loss of the human spirit. One way to avoid this conformity, Huxley stated, was through achieving a mystical or religious state of mind. His book *The Perennial Philosophy* (2009) identified a number of common threads in the world's religions, quoting at length from various saints and mystics who had achieved a higher level of human consciousness.

Ramana Maharishi (1879–1950) was an Indian sage who was known for his purist teaching and silent meditation. He influenced many western spiritual figures, including Somerset Maugham, David Godman, Richard Hittleman, and Eckhart Tolle. His teachings were of the Advaitic School of Hinduism pioneered by Sri Sankaracharya. His teachings were based on love, self-inquiry, happiness, and detachment. Leading a very

simple life, he refused to accept charity from anyone. Diagnosed with cancer, Maharishi continued to help others, with little concern for his own pain until the day of his death. He often is referenced and quoted by modern spiritual writers, including Eckhart Tolle and Wayne Dwyer.

Jiddu Krishnamurti (1895–1986), a renowned writer and philosopher, was born to a Brahmi family in Colonial India. As a young boy, he was introduced to theosophical traditions by Annie Besant. These leaders had hoped for him to work as a vehicle for the Theosophist Society and to serve as a world teacher (Krishnamurti, 1995). Unfortunately, he disavowed these ideas and went on to develop his own ideas and philosophy. He went beyond the restrictions of any religious tradition and formed his own existential philosophy based on love, beauty, happiness, and truth:

> Most of us live as mere technicians . . . . We study mechanically and pass exams, get jobs; we learn the techniques to succeed in this society. But if we don't pay attention to things like beauty, love, and peace, then we will live in what seems like a hard, fragmented world. So we have the choice of being either a technician or a creator; to be less or more human . . . . You can be creative only when there is abandonment—which means, really, when there is no sense of compulsion, no fear of not being, of not gaining, of not arriving. (Butler-Bowdon, 2007, p. 151)

He stated that love is the most practical thing in the world. Krishnamurti renounced any allegiance to a particular nationality, race, religion, culture, or philosophy. He believed in complete psychological freedom and wrote a number of books that reflect this spiritual philosophy, including *The First and the Last Freedom* (1975). He stated that we seek power outside and are unaware that the greatest power is within us. Great love is great intelligence because it recognizes that ultimately love is the only thing that matters (Krishnamurti, 1999).

The book *Ending of Time* (1985), co-authored by the physicist David Bohm refers to the wrong turn human beings have taken in engaging in ego-centered activities. They can change fundamentally if they cleanse their mind and follow the path of compassion and love, which goes beyond thought, time, and emptiness (Krishnamurti & Bohm, 1985).

Joseph Campbell (1904–1987) was well known for his work in comparative religions, philosophy, and mythology. Campbell was well versed in eastern and western mythology, and religions. He had several discussions with many spiritual figures, namely Krishnamurti, Coomaraswamy, Zimmer, Eliade and other spiritualists of that time (Case, 1994).

Campbell was a supporter of the Jungian philosophy but did not accept it in its entirety. He was well known for his interviews with Bill Moyers and for his books, especially *The Power of Myth* (Campbell, 1991). According to Campbell, in all spirituality there is search for a basic, unknown force from which everything originated. Though this basic driving force cannot be expressed in words, it can be referred to in stories through metaphors. Campbell wrote that all religions may bring one to an elevated sense of awareness, above and beyond a dualistic concept of reality. His book, *Hero with a Thousand Faces,* addressed important myths from around the world that survived for thousands of years and all share the same foundation, which Campbell called the monomyth, in which a hero ventures from the world into the supernatural. During this journey he encounters many adverse forces, which he defeats, and returns as a hero to the community (Campbell, 2008). Examples of the monomyth include the stories of Osiris, Prometheus, the Buddha, Moses, and Christ.

He wrote about the evolution of mythology in relation to spirituality over the time of human existence. The myths evolve through four stages: (a) the Paleolithic hunter-gatherers focused on shamanism and animal totems and were influenced by the power of animals; (b) the Neolithic culture was agrarian and, therefore, the myths related to mother goddess and fertility; (c) the Bronze Age, in which the myths related to the pantheon of Gods ruling from the heavens, and led on earth by a masculine god-king; and (d) the Axial Age, where the myths relate to philosophy and religion and the myths of the early eras are integrated and reinterpreted in psycho-spiritual context. Mythological stories illustrate sacrifice, bliss, love, harmony, lifecycle, initiation rituals, and healing. Mythological facts are embedded as stories in every religious and spiritual tradition. These myths enable the individual and society to accept and tolerate the final end, death and suffering, as a part of their journey.

Elisabeth Kubler-Ross (1926–2004) was a Swiss psychiatrist and thanatologist. Known well for her work in end-of-life care, she proposed the five stages of grief for those who are either facing tragedy or their own impending death. These stages are denial, anger, bargaining, depression, and acceptance. These stages can be applied to the survivors as well as to those who are faced with serious and terminal illnesses. Kubler-Ross applied these five stages to any major loss, such as loss of a job or one's house, the death of a spouse, or infertility (Kubler-Ross, 1969). Well published in this field, she is also known for her books *Death: The Final Stage of Growth* and *On Death and Dying.*

According to Kubler-Ross, the ultimate lesson we have to learn is unconditional love for others and ourselves. Everyone is responsible for one's choices and has to accept the consequences of every deed, word, and thought throughout one's lifetime

(Kubler-Ross, Berry & Heidrich, 2000). She stated that death can be a creative force for those who understand it, and the highest spiritual values can originate from thinking and studying death. She was very spiritual, and every chapter in her book begins with quotations from Tagore, the spiritual philosopher and poet. In her book, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families,* she gave many examples of terminally ill patients, sample interviews, and conversations that give the reader a better understanding of the stages of the dying process (Kubler-Ross, 1997).

According to Kubler-Ross, "The more we are making advancements in science, the more we seem to fear and deny the reality of death" (Kubler-Ross, 1969, p. 21), and also:

> We would think that our great emancipation, our knowledge of science and of man, has given us better ways and means to prepare ourselves and our families for this inevitable happening. Instead the days are gone when a man was allowed to die in peace and dignity in his own home (Kubler-Ross, 1969, p. 21).
> One of the most important facts is that dying nowadays is more gruesome in many ways, namely, more lonely, mechanical, and dehumanized; at times it is even difficult to determine technically when the time of death has occurred (Kubler-Ross, 1969, p. 21).

One of her unexpected discoveries regarding the dying was that physicians were more reluctant to participate than were their patients, who often felt relief and gratitude at the opportunity to be heard.

Cicely Saunders (1918–2005) is responsible for the hospice movement and built the first hospice in the UK, the St. Christopher's Hospice. She was trained as a nurse at Nightingale Training School in London's St. Thomas' Hospital (Saunders, 1986). She was very spiritual and her famous quote is from Psalms 37, "Commit thy way unto the Lord; trust also in him; and he shall bring it to pass." She focused on holistic care to

meet the physical, social, psychological, and spiritual needs of patients as well as their family and friends (Saunders, 2004). Her hospice is a place where patients can garden, write, and talk. She was promoted to knighthood and became Dame Cicely Saunders.

Mother Teresa (1910–1997) was involved actively in the care of the elderly, sick, and dying patients. She was a Roman Catholic nun who witnessed many human tragedies in her early life. Her focus went beyond Christian religious beliefs. Most of her patients were destitute, non-Christians:

> Whether one is a Hindu or a Muslim or a Christian, how you live your life is proof that you are or not fully His. We cannot condemn or judge or pass words that hurt people. We don't know in what way God is appearing to that soul and what God is drawing the soul to; therefore, who are we to condemn anybody? (Chalika & Le Joly, 1996, p. 391)

She also believed loneliness was a major cause of suffering in the elderly and sick (Mother Teresa & Gonzalez-Balado, 1997).

Mother Teresa claimed her goal was to care for the hungry, the naked, the homeless, the crippled, the blind, and the lepers. She extended her care to those who felt unwanted, unloved, and uncared for—people who have become a burden to the society and are shunned by everyone (Mother Teresa, 2000). According to Mother Teresa the poverty in the western countries is a different kind of poverty, it is not only poverty of loneliness but also of spirituality.

To the doctors she stated:

> Have you experienced the joy of loving? You can do that as doctors. You have a beautiful opportunity when the sick come to you with great trust and confidence not only to receive a few tablets from you but to receive your tender love and care and especially when you have to make a sacrifice to look after the poor. Jesus said: 'Whatever you do to the least of my brethren, you do it to me." (Chalika & Le Joly, 1996, p. 54)

When she received the Nobel Prize for her compassionate care of the sick, poor and dying she expressed:

> The reason I was given the Nobel Prize was because of the poor. However, the prize went beyond appearances. In fact, it awakened consciences in favor of the poor all over the world. It became a sort of reminder that the poor are our brothers and sisters and that we have the duty to treat them with love. (Mother Teresa & Gonzalez-Balado, 1997, p. 107)

Sai Baba (1926–) is a spiritual figure living in India who teaches a philosophy that has universal appeal. He emphasizes selfless service, love, duty, happiness, and faith. His followers come from many parts of the world. He has built schools, hospitals, and facilities to supply drinking water to regions where it is scarce. He has worked at the personal as well as community level. He is internationally well known and respected by many spiritual thinkers. Many American and European authors have written books about him. One of these books was written by the well-known psychiatrist Sandweiss and entitled, *Sai Baba the Holy Man and the Psychiatrist* (Sandweiss, 1975). Other scientists have written books about him including physicists, biologists, and many physicians. The first book named *Sai Baba Man of Miracles* was written by an Australian journalist named Howard Murphet (1975). He emphasized love, peace, truth, and righteousness. For children he emphasized the value of education and character.

Sai Baba also places great importance on health and has built many hospitals where very high standards are maintained and services are free for all. Many physicians from various parts of the world spend their time there providing free medical service. Spiritual care is incorporated with medical care. Sai Baba's organization organizes medical conferences and health clinics in India as well as other countries, including Russia, Africa, and Asian countries. Sai Baba's organizations provide hospice and

palliative care for the terminally ill. His medical work includes public health and preventative measures, surgical care, and nutritional support. The following is an example of his teachings:

> Man today is a victim of worry. Lack of contentment is the cause of worry. The rich man is not contented in spite of the accumulation of wealth. Worry causes hurry and both together bring about ill-health. (Baba, *Sathya Sai Speaks*, 2000, Vol. XXVII, pp. 25-28)

He speaks about spirituality and science:

> Spirituality and Science represent the two dimensions of the human being—the rational mind and the spiritual. These two dimensions cannot be divorced from each other. They must be coordinated, correlated, and integrated, if man is to become a true human being. Even Science does not say that the intangible is nonexistent. The ultimate principles, which are intangible, are essential for the understanding of the Universe (Murphet, 1975, p. 174).

Sai Baba emphasizes the unity of all religions:

> The truth proclaimed by all religions is one and the same. All religions have a common ultimate goal. All religions aim at promoting righteous conduct by transforming the mental attitude of man, thereby bringing about harmony of body, mind, and intellect. The foundation of all religions is morality. Morality is equated with selfless love. Religions were thus instituted to foster the well-being of society through the promotion of love for all beings (from a conference, Sai Youth of the World, 1999).

At this conference Sai Baba recognized the spiritual values of all the religions.

The Dalai Lama (1935–) is a Buddhist monk who appeals to various religious and spiritual groups. His spiritual themes involve compassion, nonviolence, tolerance, empathy, and love. Many westerners are inspired by him and involved in providing spiritual care to the sick, elderly, and the dying. He teaches that whether one believes in a religion or not, and whether one believes in rebirth or not, there is no one who does not appreciate kindness and compassion. Human beings by nature want happiness and do not want suffering.

According to the Dalai Lama, happiness can be achieved through the systematic training of our hearts and minds, through reshaping our attitudes and outlook; happiness is in our hands. Love and kindness are the very basis of society. If we lose these feelings, society will face tremendous difficulties; the survival of humanity will be endangered (Lama & Cutler, 1998). The foundation of universal ethics is based on achieving happiness and relates to finding contentment, appeasement of suffering, and forging meaningful relationships (Dalai Lama, 2001).

His book *Open Heart* is a synopsis of some of his popular lectures and an introduction to specific spiritual practices. Spiritual practice involves awareness and taming of unwanted emotions through meditation. He claims one can cultivate a helpful state of mind and eliminate harmful states thereby developing compassion and happiness for self and others (Dalai Lama, 2001).

Albert Schweitzer (1875–1965), philosopher, theologian, and missionary doctor, strongly believed in the concept of reverence for life that he considered a moral issue. He emphasized the values of service and compassion. He worked as a missionary in Africa servicing the poor and sick (Brabazon, 2000) for which he received the Nobel Prize. His personal philosophy, which he considered his greatest contribution to humankind, was the idea of reverence for life. He thought western civilization was decaying because it had abandoned affirmation and respect for life as its ethical foundation. He also believed humankind must choose to create the moral structures of civilization. The worldview must derive from the life-view and, because the world is an expression of will-to-life, respect for life has to become the highest principle (Schweitzer, 1987).

Ram Dass (1931–) integrated eastern and western religious philosophy. Born Richard Alpert and raised in a Jewish-American family, he became a psychology professor at Harvard University. During the 1960s he held appointments across four departments at Harvard and had research contracts at Stanford and Yale. With the status and money that came with these positions he apparently had a good life (Dass, 2005). Alpert's life began to change dramatically when he met Timothy Leary, who at the time also was a psychology professor at Harvard and became a leader in the 1960s counterculture. Leary and Alpert experimented with psilocybin, a form of hallucinogen obtained from mushrooms. Alpert continued to seek psychedelic experience and eventually lost his job at Harvard. After this experience, he became disillusioned with the academic world and traveled around the world searching for some meaning in life. Ultimately, he ended up in India and studied under a guru, Hari Dass Baba, learning about East Indian philosophies, both Hinduism and Buddhism.

He subsequently returned to the United States with a different philosophy of life and took the spiritual name Ram Dass, or servant of God. His philosophy incorporates the core philosophy of all the major religions. He continues to teach spiritual philosophy at many institutions throughout the world. He says:

> Compassion is the basis of all truthful relationship; it means being present with love—for ourselves and for all life, including animals, fish, birds and trees. Compassion is bringing our deepest truth into our actions, no matter how much the world seems to resist, because that is ultimately what we have to give this world and one another (Dass & Bush, 1992, p. 5).

Thich Nhat Hanh (1926–) is a Buddhist monk known in the West for his spiritual teachings. He is an active participant in peace movements and promotes nonviolent solutions to conflict. His teachings involve mindful meditation and appeals to various

religious groups. Both he and Martin Luther King, Jr. opposed the Vietnam War based on their spiritual beliefs regarding compassion and love. According to him, mindful meditation has strong healing powers (Hanh, 1975).

According to Hanh, extraordinary things happen when we are fully present with others and at peace with ourselves, both of which require openness and deep searching within ourselves. One can dispel grief and fear, transforming them into happiness and insightful living. Death does not have to be a roadblock (Hanh, 2003).

He wrote that people are reluctant to let go of their suffering. Out of a fear of the unknown, they prefer suffering that is familiar. He stated, "Life is filled with suffering, but it is also filled with many wonders, like the blue sky, the sunshine, the eyes of a baby" (Hanh, 1996).

Eckhart Tolle (1948–) is a spiritual teacher who claimed he was enlightened through relinquishing his ego and identity to self. Tolle stated that he suffered from acute, suicidal depression, followed by a numinous, spiritual experience (Tolle, 2005). Immediately He felt that no fear existed, he remained in a state of uninterrupted deep peace and bliss.

Tolle pointed out that emotional pain is an intrinsic part of the egoistic mind and manifests itself as a deep-seated sense of lack or incompleteness. People often will enter into a compulsive pursuit of ego-gratification and try to find things to identify with to fill a void they feel within. Once a person finds out that the ego's needs are endless, they may become depressed and feel hopeless (Tolle, 1999).

Tolle's wisdom has been shared by many spiritual teachers and mental health professionals. Understanding how the ego can run one's life is the first step toward

gaining deeper insight into the true nature of the psyche. Tolle's main message is to be free from attachment to the egoistic mind and be in the present moment.

Eric Cassell is a well-known practicing US physician and writer. His expertise revolves around end-of-life care, and he has written a number of articles and books in the area of death, suffering, and dying. These books include *Nature of Suffering, Healer's Art, The Place of Humanities in Medicine,* and *Changing Values in Medicine*. He defined suffering as a state of severe distress associated with events that threaten the intactness of personhood. He emphasized spiritual, psychological, and social distress as causes of suffering (Cassell, 1982; Cassell, 1991). Spirituality is one of the components of personhood. Spirituality addresses a meaning of life, which is a larger concept than family attachments and career development; it relates to one's purpose, value, and self-worth (Baumeister, 1991; Bakan, 1971).

The above spiritual writers and leaders continue to have a positive effect on millions of people around the world. In essence, they emphasize love, compassion, empathy, service, forgiveness, relationships, presence, and charity as necessary components in the care of the sick.

## Can Science Complement Spirituality?

From the 14th through the16th century there were radical and rapid changes in the western world marked by rationalism, scientific advances, societal organization, and advancements in medicine. Clergymen no longer held the role of physician because the separation between science and religion had become increasingly apparent. This split intensified in the 16th to the 17th century with the works of Descartes. Many scientists

were caught in the controversy at that time, including Galileo, Newton, Descartes, and Pascal.

From the Newtonian era onward, there was a conflict as to whether the soul existed. Descartes proposed that the mind and body are two separate entities. This separation continued over the last 300 years and the division between the church and medical community intensified. Galileo's scientific concept of heliocentrism was disputed by the Catholic Church, resulting in an ongoing separation between the scientific and the religious community (Finocchiaro, 2008). Medicine in the western world continued to evolve as pure science with technological advances. The concepts of spirituality, soul, and God were left to the Church, as religious notions were now considered nonscientific. Spirituality was ignored by physicians and other medical professionals (Solomon & Higgins, 1996).

The new generations of philosophers also were skeptical of the importance of spirituality and religion. The British philosophers, including Bentham, Mills, and Locke, were influenced by Stoic philosophy and put forth Utilitarian ideas (Magee, 2001). David Hume and other British philosophers supported empirical views about the world and were skeptical about religious concepts. Darwinian concepts opposed many religious and spiritual philosophies. German philosophers, including Hegel, Nietzsche, Heidegger, Spinoza, and Schopenhauer, proposed existential and phenomenological ideas that starkly contrasted with previously accepted Judeo-Christian dogmas.

Several scientists who made great contributions to science still held true to their spiritual and religious views, namely Paracelsus, Blaise Pascal, and Isaac Newton. Paracelsus (1493–1541) was an Austrian physician and scientist. He practiced both

western and holistic types of medicine, incorporating herbs and minerals (Webster, 2008). He was spiritual and believed in gods, devils, angels, and spiritual beings, which he proclaimed had an effect on health and healing. He claimed nature and the cosmos have a healing effect. He also believed astrology affects our health. He traveled extensively to the Middle East and other countries and learned about forms of medical treatment. Paracelsus viewed the universe as one coherent organism pervaded by a uniting life-giving spirit and this, in its entirety and including man, as God.

Blaise Pascal (1623–1662) was a brilliant scientist who at the age of 31 underwent a profound religious experience. He rejected any form of philosophical rationalism that opposed Christian concepts. He believed faith alone was not enough and salvation requires both faith and charity. His theological ideas can be traced to Neoplatonism and the philosopher Plotinus (Miel, 1969). He is known for his quotation, “The heart has its reasons, of which reason does not know” (Solomon, 2002, p. 58).

Isaac Newton (1643–1727) was well known for his immense contribution to science in the West. He also remained committed to religion and spiritual work (Westfall, 1994). During his time, the scientific worldview stood head-to-head against his established religious ideas. At times, the conflict was unbearable for other scientists, but Newton’s faith remained unshakable. In the latter part of his life, he wrote more on religion than on natural sciences (Brettell, 2000). Newton and Pascal, although men of science, maintained a separation between their religiosity and their scientific work (Brettell, 2000). Their scientific theories were based upon objective investigations whereas their religious views were highly subjective and personal.

Alfred Wallace (1823–1913), a British naturalist who proposed independently a theory of evolution similar to that of Darwin, also believed in spirituality. He was known as the "father of biogeography," extensively working with the geographical distribution of species. Wallace believed in the spiritual nature of the higher mental faculties of humans. This caused a strain in his relationship with the scientific establishment, especially with other early proponents of evolution (Smith, 2009).

Gregor Mendel (1822–1884) was an Augustinian friar and scientist, known as the "father of genetics." While practicing in the monastery he came out with the theory of genetics, described in his paper "Experiments on Plant Hybridization."

Another famous Protestant priest and scientist was Joseph Priestley (1733–1804). He is credited with the discovery of oxygen and other gases. He tried to unite scientific ideas with philosophy and organized and supported the movement of Unitarianism. He influenced many other famous English philosophers, including Jeremy Bentham and Stuart Mills. He is known for his writings, including "Institutes of Natural and Revealed Religion," "History of Electricity," "Experiments and Observations on Different Kinds of Air," and "Theological Repository."

Albert Einstein was respected for his concepts on quantum physics and the theory of relativity. However, he, too, was interested in spirituality and was influenced by the pantheistic views of Spinoza. Einstein was attempting to integrate his scientific views, especially quantum physics, with spirituality (Calaprice, 2000, p. 60):

> To one bent on age, death will come as a release. I feel this quite strongly now that I have grown old myself and have come to regard death like an old debt, at long last to be discharged. Still, instinctively one does everything possible to postpone the final settlement. Such is the game that Nature plays with us (Calaprice, 2000, p. 63).

Einstein's views supported a universal view of spirituality, and renounced the dogmas dictated by organized religions:

> Einstein's religion, as he often explained it, was an attitude of cosmic awe and wonder and a devout humility before the harmony of nature, rather than a belief in a personal God who is able to control the lives of individuals. He referred to this belief as cosmic religion. It is incompatible with the doctrines of all theistic religions in its denial of a personal God who punishes the wicked and rewards the righteous (Calaprice, 2000, p. 201).

Einstein summarized the relationship between religion and science: "Science without religion is lame, religion without science is blind" (Calaprice, 2000, p. 213).

Einstein stated that a human being was a part of a whole, limited in time and space. Everything experienced as separate from the rest is a kind of optical illusion of the mind. This delusion is like a prison that restricts us to personal desires and to affection for a few persons nearest to us. Einstein's writings also reflect mystical concepts. His view of mysticism is reflected as a cross between Spinoza and Pythagoras. There is a central order to the cosmos, an order that can be directly apprehended by the soul in mystical union. He devoutly believed that although science, religion, art, and ethics are necessarily distinct endeavors, it is wonderment in the face of the mystery of the sublime that properly motives them all (Wilber, 1984, p. 101).

Many theoretical physicists have contributed to the field of quantum physics. Ken Wilber, a modern thinker who is interested in quantum physics, explored their lives, research work, and their personal beliefs. His book *Quantum Questions* (Wilber, 1984) examined the mystical and spiritual beliefs of these famous physicists' lives and their writings. Wilber explained that the essence of mysticism is the deepest part of our own being, the very center of our own pure awareness. It is fundamentally one with spirit, one with God, one with all, in a timeless and eternal unchanging fashion. To support this, he

relied upon the mystical writings of some of the world's great physicists, including Heisenberg, Schrodinger, Einstein, de Broglie, Jeans, Planck, Pauli, and Eddington. Each of these men produced great contributions to the areas of quantum mechanics, the theory of relativity, particle physics, and astrophysics. While the world has perceived them as pure and rational scientists, in actuality, mystical beliefs played an integral role in the evolution that occurred in these men's lives. They were not particularly religious, but they believed in another level of existence or consciousness, which was rooted in mysticism and spirituality. They embraced the transcendent worldview that embodies the world as spiritual rather than as merely a material phenomenon. Many of them stated that mystical thinking was the very essence of their reality (Hiley & Peat, 1991).

According to these men, one should go beyond the limited self to transcend and discover a higher power, an identity with the All, infinite, and all-pervading, eternal and unchanging. Many mystics have described the unique experience of their lives in words that can be condensed in the phrase *Deus factus sum*, or I have become God. Similar experiences were seen with Sufi saints.

De Broglie argued that all genuine science is motivated by spiritual ideas. Sir James Jeans, in the book *Mysterious Universe*, concluded that since we understand the physical world through mathematics we may conclude that God is a mathematician, and the universe begins to look more like a great thought than a great machine (Brown, 1931). Wolfgang Pauli received the Nobel Prize for the prediction of the existence of the neutrino two decades before it was discovered. Pauli believed there should be a synthesis between the rational understanding and mystical experience (Wilber, 1984).

Sir Arthur Eddington spoke of the relationship of a human soul to a divine spirit. He offered the first proof for Einstein's relativity theory. In his book *The Nature of the Physical World* he defended mysticism and mystical ideas. The Nobel-prize-winning scientist Schrodinger (1887–1961) stated:

> It is not possible that this unity of knowledge, feeling, and choice that you call your own should have sprung into being from nothingness at a given moment not so long ago; rather, this knowledge, feeling and choice are essentially eternal and unchangeable and numerically one in all men, nay, in all sensitive beings. Inconceivable as it seems to ordinary reason, you—and all other conscious beings as such—are all in all. Hence this life of yours which you are living is not merely a piece of the entire existence, but is, in a certain sense, the whole . . . . This is that sacred, mystic formula which is so simple and so clear: "I am in the east and in the west, I am above and below, I am this whole world." (Wilber, 1984, p. 98)

These quantum physicists gave equal weight to mysticism, spirituality, and science. They were humble and admitted that scientific knowledge is limited, even while they were contributing tremendously to science. Other physicists such as Stephen Hawking (1942–) and Oppenheimer share the same beliefs (Hijiya, 2000). Oppenheimer was familiar with and admired the mystical and spiritual aspects of Indian philosophy and was familiar with the *Bhagavad Gita*, often quoting lines from this book.

Deepak Chopra, a physician specializing in endocrinology and an author, writes about the concept of quantum healing and other ancient methods of healing, namely *ayurveda*. In addition to lecturing extensively on the topic of Ayurvedic medicine, Chopra integrates the principles of holistic medicine in his practice. According to Chopra, quantum healing takes place at a higher level of consciousness, which in turn promotes the healing of body and mind. Quantum-healing methods prevent the aging process and many other degenerating illnesses (Chopra, 1990). He states that at a higher

level of consciousness, energy permeates every cell in the human body and facilitates the healing process (Chopra, 1990).

Professor Amit Goswami is a scientist and professor who specialized in quantum physics at the University of Oregon. He worked on a quantum physics model for many years to understand the human soul and consciousness. He also explored the areas of soul energy in relation to reincarnation, immortality, the process of dying, and afterlife. In the area of reincarnation, he claimed the human soul is quantum energy that survives after physical death. He quoted from the Upanishads, which talk about immortality of the soul. According to him there are many famous figures from the western traditions who believed in reincarnation including Emerson, Thoreau, and Goethe.

Goswami wrote about perennial philosophy, which originates from Vedanta traditions. Everything in the world is a manifestation of higher consciousness. He sums up the quantum concept in two parts: nonlocality and the observer effect (Goswami, 2001). Nonlocality is the direct influence of one object on another distant object, without being connected beyond both time and space. For example, an electron in one location can communicate with an electron on another planet without having any connection. This can only be explained through the concept of "quantum consciousness," which is spaceless and timeless. He tried to explain angels and bodhisattvas in terms of nonlocality. He discussed how we can communicate with people in distant places based on the principle of nonlocality and be connected with everything in the universe. The observer effect is the notion that there is no phenomenon until it is observed. The behavior of the particle is different when it is being observed. This concept eliminates any difference between objectivity and subjectivity.

Goswami compliments the book *The Atman Project* written by Ken Wilber (1980), which also explains the levels of consciousness and energy. According to Goswami, one can explain afterlife experiences and stories according to quantum memory. In addition to being a scientist, Goswami examined the work and lives of many famous sages and saints, such as Aurobindo, the Buddha, and the Dalai Lama. He concluded that consciousness operates at different levels, from the physical body to the state of bliss or nirvana.

Goswami concluded that he believes in a monistic idealism, the philosophy that defines consciousness as the primary reality. Materials originate from consciousness. In his book *The Self-Aware Universe: How Consciousness Creates the Material World*, Goswami concluded that consciousness is the basis of everything (Goswami, 1995).

Goswami draws a parallel between the development of our universal consciousness and the evolutionary development of the human brain. In doing so, he describes how the brain evolved over millions of years through various stages, from the reptile stage (fight or flight brain), to the emotional brain (limbic system), and finally the development of the neocortex (rational brain). The evolving process of the human brain will continue until it becomes a superbrain, which may connect to a higher level of consciousness. A parallel development may occur in our physical body, in consciousness, in nature, and in the cosmos. Some of Goswami's concepts of quantum physics were depicted in the movie and book *What The "Bleep" Do We Know?* (2004).

Fritjof Capra (1939–) is a theoretical physicist interested in the mystical aspects of humans. He compared quantum physics with eastern mystical traditions and found there is a deep connection between physics and mysticism (Capra, 1999). He believed physics

and spirituality are two sides of the same coin. According to Capra, in quantum physics the creation or destruction of particles often happens for no apparent reason (Capra, 1999). There is a field out of which these particles arise and into which they return, but they seem to act as if they are beyond cause and effect. There is nothingness that is not emptiness, and this void is referred to as *Brahman*, a field of potentiality from which all things emerge. The mythical story of the Dance of Shiva depicts the endless process of creation and destruction of matter (Chakravarti, 1994). In the Bhagavad Gita, the dance of Krishna and Radha in the garden of Brindavan is referred to as the "divine leela," which has no cause and reflects the progression of life. In Buddhism, the *Sunyata* is a living void that gives birth to everything physical. Taoism's central feature is the *Tao*, the empty, formless nature of the universe, which is the basis of creation.

Capra stated:

> We shall see how the two foundations of twentieth-century physics—quantum theory and relativity theory—both force us to see the world very much in the way a Hindu, Buddhist or Taoist sees it, and how the similarity strengthens when we look at the recent attempts to combine these two theories to describe the phenomena of the submicroscopic world . . . . Here the parallels between modern physics and Eastern mysticism are most striking, and we shall often encounter statements where it is almost impossible to say whether they have been made by physicists or by Eastern mystics (Butler-Bowdon, 2007, p. 42).

Spirituality and genuine science can coexist and can be integrated to achieve maximal benefit to the patient and the caretaker (Krishnamurti & Bohm, 1985; Schwartz & Begley, 2004). Recent scientific studies in neuroscience, astrophysics, particle physics, and gene studies revalue the importance of spirituality to humanity (Goleman, 2003). The Dalai Lama is an ardent supporter of scientific studies on spirituality and its relationship to brain development, neuroplasticity, positive psychology, compassion, and meditation (Goleman, 2006; Begley, 2007). He invites neuroscientists,

neuropsychologists, and neuroimaging experts from the West to study the brains of his monks (Hiley & Peat, 1991).

## Spirituality of Skeptics, Agnostics, and Atheists

Many scientists are skeptics, atheists, or agnostics and oppose organized religions for their dogmatic views. A common misconception among many is that those who lack religious beliefs also lack spirituality. On the contrary, history has shown that many people have rejected organized religion but not spirituality. Many philosophers, rationalists, and scientists who did not believe in organized religions and dogmas of their time still maintained the spiritual practice of caring for others (Solomon, 2006).

In his book, *Spirituality for Skeptics* (2002), the modern day philosopher Solomon, who has a scientific background, referred to spirituality as a thoughtful love of life. He stated that spirituality is not limited to religion and it transcends organized dogma. He further postulated that spirituality is the byproduct of learning and reflection and therefore cannot be dictated to one by another. Solomon believes spirituality is unique to each person and is the sum of one's life experiences.

Schopenhauer was an atheist who experienced spirituality in nature, art, and music. Likewise, Thoreau found spirituality in nature as he described it in *Walden* (2006). Hegel, Spinoza, and Nietzsche rejected the limited concept of God and the supernatural. Buddha found spirituality in tranquility and peace of mind, while Spinoza experienced spirituality in nature (Solomon, 2006).

According to the Greek philosopher Aristophanes, love is important for our pursuit of wholeness and to be complete. This love is subjective and cannot be dictated to us by religion. Eastern or tantric philosophies relate love to a sexual experience,

focusing on transcendental spirituality through union of the flesh and mind. Bentham and other Utilitarian philosophers of England found spirituality in pleasurable activities just as the Epicureans did.

Hegelian spirituality refers to our understanding of self as part of a cosmic whole and rejects the concept of God as a separate entity. Spinoza supported a view in which man is an integral part of nature who experiences spirituality through the natural world (Solomon, 2002).

Kathy Higgins, a modern philosopher and a Nietzsche scholar, is a practicing Catholic. Nevertheless, she defends Nietzsche's statement in *The Gay Science* that God is dead. Nietzsche's belief relates spirituality to the realization of higher goals and ideals independent of a dictated morality. To Schopenhauer, music was the direct manifestation of spirituality, not merely an expression of it (Solomon & Higgins, 1996).

Solomon reconciled the earlier philosophies of Pythagoras, Plato, Aristotle, Socrates, and Kant, affirming that spirituality must be both rational and reflective. Pythagoras was the first to recognize music and mathematics as a necessary component of spirituality. For Socrates, spirituality refers to the statement "know thyself," meaning that attaining an understanding of one's life—self-knowledge—makes a life worth living. Aristotle said man is a rational animal; his spirituality was linked with virtue. Emmanuel Kant's spirituality is based on knowledge and moral duty, which he referred to as the "categorical imperative" (Solomon, 2002).

According to Viktor Frankl, one finds meaning in *logos*, which implies finding meaning in life. According to Jean Paul Sartre, an atheist, spirituality is a good faith freedom in which one may deny the existence of God. For Camus, the meaning of life

referred to facing the absurd, and spirituality is a form of rebellion against reason. Camus's themes are reflected in his books, *The Stranger* and *The Myth of Sisyphus* (Solomon, 2006). Belief in fate is a form of spiritualism that can be unrelated to religion. Fatalism is exemplified in Melville's (2003) novel, *Moby Dick*.

According to recent neurological research done by Ramachandran, the neuronal system is responsible for our spiritual beliefs whether it relates to God, the sacred, nature, music, or art. From his observation, one can infer that spirituality is based on an individual's nature and may be polytheistic, monotheistic, atheistic, agnostic, nature, or relationship-oriented (Ramachandran & Blakeslee, 1998).

## Spirituality, Aging Process, and Wisdom

Aging commonly is associated with mental and physical deterioration, and often results in disability, suffering, anguish, and pain. Historically, spirituality has played a positive role in the aging process (Sapp, 1987). It allows one to navigate through these difficult times from the later years to death. Sacred places such as temples, churches, synagogues, and other houses of worship have provided social, physical, and emotional support to the elderly during this aging process. This is strikingly true, as even today the majority of the church population is represented by the elderly. Recently, medical personnel have focused increasingly on achieving a higher quality of life in the elderly population, referred to as successful aging.

Successful aging is defined broadly as multidimensional, encompassing the avoidance of disease and disability, the maintenance of high physical and cognitive function, and sustained engagement in social and productive activities (Ardelt, 1998). Many social scientists believe the maintenance of optimal health, achievement of

wisdom, and the nurturing of personal relationships in the latter half of one's life are key factors for successful aging (Rowe & Kahn, 1998). In the US during the last two decades many gerontology schools have been actively involved in many studies. Researchers from Davis school of gerontology are the pioneers and leaders in the field of gerontology.

The current areas of research focus on subjective well-being, life satisfaction, longevity, cognitive and intellectual functioning, creativity, optimism, and social-cultural interaction. These areas embrace spirituality as the core principle.

Many gerontology researchers believe that early stages of spiritual development may play a significant role in aging successfully in the latter half of life. Both nature and nurture continue to influence the developmental process. The work of Costa and McCrae showed that successful aging depends on measures of personality characters, including openness to experience, dependability, and agreeableness (McCrae & Costa, 1996). These dimensions are stable across years and into the early part of old age.

In 2005, Tornstam, a Swedish social scientist, postulated a theoretical concept termed *gerotranscendence*, which relates to the aging process in the elderly. He exposed several myths on aging, advocating a phenomenological approach and minimizing the stereotypical negative image of aging. He stressed the importance of individuation and transcendence as ongoing processes throughout life (Tornstam, 2005).

He postulated eight dimensions relating to the theory of gerotranscendence: a view of time and space, view of life and death, self-understanding, decrease in self-centeredness, transcendent wisdom, meaning and importance of relationships, the mystery dimension of life, and attitude toward material assets. An individual typically

experiences a reduction of self and relationship with others as well as a new understanding of fundamental existential questions (Tornstam, 2005).

The theory of gerotranscendence is similar to certain contemplative traditions such as Zen Buddhism (Austin, 2006). This does not assume that gerotranscendence necessarily is connected with religion; in fact, it is a shift in metaperspective from a materialistic view of the world to a cosmic and transcendent one (Tornstam, 2005).

## Wisdom Aging and Spirituality

We acquire wisdom as we age through life experiences and knowledge. Wisdom is helpful in dealing with end-of-life care issues. Many believe wisdom is related to the knowledge that comes from studying the teachings of historical figures relating to philosophy, literature, and mythology. It also comes from studying the lives and preaching of spiritual leaders of the past, such as Buddha, Christ, Augustine, Gandhi, and Martin Luther King, Jr. Martin Luther King, Jr. preached and followed a spiritual path in every aspect including human rights politics (King, King, & King, 1998).

Baltes emphasized that wisdom involves expertise in the fundamental pragmatics of life. It includes emotion, motivation, and virtue. It is multifaceted and multidimensional, and incorporates principles of culture and history. The criterion of wisdom is not only theoretical knowledge about life, it is also procedural knowledge about life, contextualism, values in life priorities, and recognition and management of uncertainties (Baltes, Smith, & Staudinger, 1992; Baltes, Baltes, Freund & Lang, 1999). This kind of wisdom comprises the essential component of successful aging.

Monika Ardelt is a sociologist and a leading wisdom theorist and researcher with a particular emphasis on the relationship among wisdom, spirituality, aging well, and

dying well. She stated that wisdom is inherently realized by a person. It is a combination of personality qualities that cannot exist independent of the individual. She proposed a model of wisdom as a three-dimensional personality characteristic. The three dimensions are cognitive, reflective, and affective. The cognitive dimension includes an understanding of life and a desire to know the truth, to comprehend the significance and deeper meaning of phenomena and events, particularly with regard to interpersonal matters. It includes knowledge and acceptance of the positive and negative aspects of human nature, of the inherent limits of knowledge, and of life's unpredictability and uncertainties (Ardelt, 1998). The reflective dimension relates to the perception of phenomena and events from multiple perspectives. It requires self-examination, self-awareness, and self-insight. The affective dimension is composed of sympathetic and compassionate love for others. This model emphasizes and recognizes the importance of learning spiritual philosophy and wisdom of the spiritual figures.

## Positive Psychology

Positive psychology has increasingly become a popular area of healing studies, which has significant link with spirituality. Positive psychology focuses on promoting a happy and fulfilling life, and is applicable in both normal and diseased states of mind. It focuses on three areas: the study of emotion, the study of positive traits, and the study of positive institutions. The study of emotions emphasizes the positive emotions of confidence, hope, and trust that help one build virtues such as integrity, loyalty, and honesty. The study of positive traits refers to strengths, virtues, intelligence, happiness, and other human abilities. The study of positive institutions includes strong families and other institutions that support freedom, virtues, and values.

Positive psychology promotes wellness and happiness while many other branches of psychology, psychiatry, and current medical care focus on disease states. Positive psychology focuses on experiences in which there is contentment, satisfaction, and well-being (Keyes & Haidt, 2003). It focuses on happiness, ecstasy, optimism, and hope. Positive psychology does not dwell on the negativities of the past, nor does it foster grandiosity. Positive psychology creates a healthy state of mind even when facing adverse situations (Ikeda, 1983).

There are several research studies supporting the importance of positive psychology in healing. Martin Seligman (1942–), psychologist, clinical researcher, and former president of the American Psychological Association is well known for his research work, in which he referred to learned optimism and learned helplessness. Learned optimism is the habit of attributing one's failures to causes that are external not personal, variable not permanent, and specifically limited to a specific situation. This is associated with better performance, work productivity, greater satisfaction in interpersonal relationships, better coping, less vulnerability to depression, and better physical health.

Seligman's work on learned helplessness involved animal models. He applied the findings of the study on human beings and postulated that learned helplessness can become a behavior and have adverse effects. Other studies also support the fact that dispositional optimism has several positive effects on aging, including better health, higher achievement, lower incidence of depression, higher sense of subjective well-being, higher self-esteem, and more positive perceptions of financial status. Optimism helps people reinterpret negative events, adding hope and courage. It enhances interpersonal

skills, perseverance, and honesty, gives capacity for insightfulness, and builds strength to counter depression (Seligman, 1998).

Many humanistic psychologists such as Maslow, Rogers, and Erich Fromm advocate practices involving human happiness. They consider human nature as positive and believe it will flourish given positive environments and positive interactions (Maslow, 1964). The development of character, strength, and virtues has been important for the development of positive psychology. According to Peterson, six important virtues contribute to the positive state of mind: wisdom, knowledge, courage, humanity, justice, temperance, and transcendence (Peterson & Seligman, 2004).

Vital engagement is another concept often used in positive psychology. It refers to an absorbing and meaningful relationship between self and the world, and can be found in any sphere of life. It relates to experiences from the interaction with and activities involving the environment, music, art, nature, religion, and other passionate activities. The effects of these experiences leave a strong impression on the individual for a lifetime (Otto, 1958).

Positivity enhances family and social relationships and creates harmony, trust, commitment, and intimacy. Russian philosopher Tolstoy stated, “Happy families are all alike. All unhappy families are unhappy in their own way” (Tolstoy, 2001, p. 3). The Indian saint Sai Baba often said, “Start the day with love, fill the day with love, and end the day with love and that’s the way to happiness” (Sandweiss, 1975). He further reminded us that God is one and he is the manifestation of love, which may be called by many names.

Forgiveness is an important aspect of positive psychology. Mother Teresa in India promoted positive states of mind among people of different races and cultures based on the principles of forgiveness, love, and help. She stressed that forgiveness is strength, not a weakness (Mother Teresa & Gonzales-Balado, 1997). Forgiveness is a common theme often emphasized in many religions and spiritual traditions.

## Mind and Body Medicine

There is renewed interest in the area of mind and body medicine among neuroscientists and psychologists. Since the Cartesian split the body and mind have been considered separate entities by many medical practitioners. In recent years the interaction between the body and the mind has been studied extensively to understand the nature and origin of the disease process.

Historically, in every culture and tradition, the heart was considered the seat of the soul, spirit, love, compassion, and kindness. Modern medicine considered the heart as the organ that circulates blood in the body while the brain was the organ for emotions and feelings. As mind and body medicine expands, many researchers are focusing on other functions of the heart that may influence the mind.

Mimi Guarneri, a reputed cardiologist who practices integrated medicine in San Diego, wrote *The Heart Speaks*, in which she explored the role of the heart in human emotions (Guarneri, 2006). She argued that the heart is more than just a muscular pump; it is the seat of the human soul and spirituality. While there have been many advances made in cardiology over the last 25 years, there are still more than 65 thousand heart attacks annually in the United States, and more than 50% of total deaths are from heart attacks in spite of all the modern advances in medicine.

Guarneri stated that the heart is more than just a pumping structure, it processes intelligence and memory, has decision-making capabilities independent of the brain, and its healing is influenced by the soul, mind, and spirit (Guarneri, 2006). According to her, the heart has multiple layers not accessible even to modern technology and other currently available tests. These multiple layers of the heart may be responsible for a variety of functions. The mental heart is affected by depression, hostility, and anger while the emotional heart is affected by sadness and loss. The heart is an independent organ with its own intelligence and nervous system. It coordinates with other vital organs, not just by pumping blood, but also through chemical mediators. Each heart cell has its own intelligence and works in harmony with other heart cells. If the cells function independently, in an uncoordinated way, the result is an abnormal rhythm called ventricular fibrillation, which is fatal.

Guarneri also discussed the effect of grief on the heart. Many studies confirm that the incidence of heart attacks is increased significantly in those who suffer from complicated grief processes and depression. She also claimed that forgiveness, prayer, meditation, and other spiritual activities have a strong beneficial effects on the heart, while anger, isolation, and hostility have negative effects.

Guarneri also explored the beneficial effects of mind and body medicine in greater depth. The cellular structures of the organs of the body have tremendous healing abilities and help maintain balance. She also wrote about the interesting experiences of heart transplant patients, and reported that many patients who have had a heart transplant experience the same emotions and perceptions as the donor, such as smell, feelings, and temperament. Contrary to the scientific belief that the brain is the only organ of

sensations and emotions, there is now evidence that the heart may also influence feelings, sensations, and emotions.

## Brain Chemistry, Neurobiology (Neuroscience), and Spirituality

Is our brain hardwired to produce God, or is our brain hardwired to perceive God? This is a question posed by modern neuropsychologists and neuroscientists. Andrew and Alexander Fingelkurts, brothers and collaborating neuroscientists, questioned the essential nature of spiritual experience. They concluded that one should focus more on the description of the experiences than on the explanation (Fingelkurts & Fingelkurts, 2009).

Empathy and compassion are primary components of spirituality of most world religions and spiritual schools of thought. Jesus, Gandhi, Buddha, Tolstoy, and other spiritual figures preached love, compassion, and empathy as essential components of spirituality.

Neurophysiologist Giacomo Rizzolatti and his colleagues from University of Parma, Italy, were the first to identify a special neuronal system called mirror neurons in Macaque monkeys. These special neurons are found in the inferior regions of the frontal and parietal lobes and in the anterior cingulate gyrus and are responsible for immediate imitative behavior. This observation is supported by Professor V. Ramachandran from San Diego, who also believes that mirror neurons are involved in social interaction, empathy, and learning (Ramachandran & Blakeslee, 1998). Mirror neurons enable an individual who merely observes another individual's actions to understand both the intent of the action and the condition that prompted it. These neurons are believed to contribute to spiritual and selfless activity. A relative lack of mirror neuron activity has been

observed in conditions such as autism, which is characterized by an inability to relate to others. Conversely, caretakers who are able to respond to and empathize with their patients may have a highly developed mirror neuron system.

The reward center of the brain includes the frontal portion of the brain and the nucleus accumbens in the striatum. This area is associated with increased activity of dopamine and with highly pleasurable feelings and experiences. This system is associated with spiritual experiences that can come from rituals, meditation practices, and pilgrimage to holy places. The prefrontal cortex and cingulate gyrus are associated with spiritual discipline, which includes self-control and willpower. Many spiritual figures are known for their willpower, moral behavior, control of desires, and fasting disciplines.

New technologies, which include dynamic brain imaging (i.e. flow MRI and the PET scan), have allowed scientists to investigate the structural and functional activity of the brain during self-reported spiritual experiences (e.g., prayer and meditation) (Austin, 1999). A study by Richard Davidson, a professor of psychiatry and psychology at the University of Wisconsin, investigated the functional brain changes of Tibetan Monks during meditation (Davidson et al., 2003). Davidson observed an increase in neuronal activity in the frontal and parietal regions, which were also implicated in mirror neuron activity. Furthermore, these same areas are known to have higher serotonin, dopamine, and norepinephrine activity during feelings of contentment and happiness (Davidson & Harrington, 2001).

Is God a true, external entity that we have evolved to recognize, or did we create God as part of our own evolution? The aspect of human experience we call “the spiritual” may be merely an adaptive reaction to our higher level of intelligence, a simple

coping mechanism to live long enough for the sole purpose of species reproduction. Scientific studies still are inadequate to clarify many aspects of spirituality and related experiences (Fingelkurts & Fingelkurts, 2009). Spiritual practices and rituals may have positive effects on brain development and behavior as shown by the recent epigenetics research studies (Rushton, 2004).

## Current Studies of Terminally Ill Patients by Healthcare Professionals

In the last 20 years, over 500 research articles focused on spiritual care and addressed the following areas: a general discussion of spirituality and religions, definitions of spirituality, the spiritual needs of patients, the effects of religion and spirituality in palliative care, and the spirituality of palliative care professionals (Daaleman & VandeCreek, 2000). These also covered the nature of hope and therapies in relation to spirituality. Unfortunately, only a few papers relate to the spirituality of the caretakers. The literature review will focus on spiritual practices related to the dying patient and the role of caregivers including the physician.

Researchers claim that there are difficulties in defining spirituality adequately for research purposes. Emblem (1992) reviewed nursing literature published between 1963 and 1989 for definitions to distinguish between the concepts of religion and spirituality. The most frequent key concepts that occurred with respect to religion were *system*, *beliefs*, *organized*, *person*, *worship*, and *practices*. The concepts closely aligned with spirituality were *personal, life, principle, animator, being, God, quality, relationship*, and *transcendence*. The only word to appear in both definitions was *person*(*al*). Emblem suggested that if these concepts are not defined clearly there is potential for confusion

while caring out spiritual care research. She claimed that religion is only one of the many forms of spiritual expression.

The survey of Chiu and Emblem explored how health research has reported the spiritual concepts in the past decade to develop a theoretical understanding of spirituality (Chiu, Emblem, Van Hofwegen, Sawatzky & Meyerhoff, 2004). Their examination was based on quantitative and qualitative review approaches. The sample included 73 spirituality research articles, which were published between January 1990 and September 2000. They concluded that earlier literature on spirituality had a more religious focus, but it is being replaced by a more human-values system approach. This approach emphasizes connectedness with self and others, nature, a higher being, and natural force/power.

Zinnbauer's paper, "Religion and Spirituality: Unfuzzying the Fuzzy," presents a study of how individuals define the terms *religiousness* and *spirituality* and examines whether these definitions are associated with different demographic, religious/spiritual, and psychosocial variables (Zinnbauer et al., 1997). The complete sample of 346 individuals was composed of 11 groups of participants drawn from a wide range of religious backgrounds. Analyses were conducted to compare participants' self-rated religiousness and spirituality, to distinguish between participants who described themselves as spiritual and religious from those who identified themselves as spiritual but not religious. The results suggest several points of convergence and several points of divergence between the constructs of religiousness and spirituality.

Davidson addressed the practice of mindfulness meditation with respect to alterations in brain and immune function (Davidson et al., 2003). A randomized,

controlled study was performed on the effects of mindfulness meditation on immune function. The study was carried out on healthy employees. The findings indicated that mindfulness meditation produces beneficial effects.

Harris (1999) studied the effects of prayer in two groups of cardiac patients. The study involved 990 patients; one group received 4 weeks of daily prayer and spiritual counseling, and the other group received none. He claimed that the group receiving prayers had statistically significant improvement (Winslow & Winslow, 2003).

Koenig is a leading researcher and psychiatrist in the field of spirituality and palliative care. He is the director and founder of the Center for Spirituality, Theology, and Health at Duke University Medical Center and has published over 250 scientific articles. In one of his studies, 838 patients over 50 years old admitted to general medical services were given a cross sectional survey (Koenig, George, & Titus, 2004). The research found that presence of religiousness and spirituality consistently predicted better cognitive function, greater cooperativeness, greater social support, and fewer depressive symptoms in patients in comparison with those who did not describe a spiritual or religious component in their lives.

In another study, Koenig and his colleagues examined the relationship between religious attendance and prolonged survival in older adults (Koenig et al., 2000). A probability sample of 3,968 community-dwelling adults (aged 64–101 years) residing in North Carolina were surveyed in 1986 as part of the Established Populations for the Epidemiologic Studies of the Elderly (EPESE) program by the National Institute of Health. Attendance at religious services and a wide variety of sociodemographic and health variables were assessed at baseline. Their study concluded that older adults,

particularly women, who attended religious services at least once per week, appeared to have a survival advantage over those who attended services less frequently.

In a prospective study, Walsh illustrated the link between spirituality and bereavement (Walsh, King, Jones, Tookman, & Blizard, 2002). Walsh studied 135 relatives and close friends of patients with terminal illness admitted to the Marie Curie Center for palliative care. He followed them over a 14-month period following the death of their loved ones. Participants with strong spiritual beliefs resolved their grief over a shorter period whereas those without a spiritual belief did not resolve their grief at 14 months.

Fry conducted a study showing that social resources, income, and negative life events play a significant role on well-being later in life, along with the presence of existential/spiritual factors (Fry, 2000). She claimed that existential factors such as personal meaning, involvement in formal religion, participation in spiritual practices, degree of comfort derived from religion, sense of inner peace with self, and accessibility to religious resources were significant predictors of well-being.

Fisch studied the link between quality of life and spiritual well-being in a study that attempted to evaluate the association between quality of life (QoL) impairment as reported by patients and as judged by nurses or physicians with and without the consideration of spiritual well-being (Fisch et al., 2003). A total of 163 patients with advanced cancer were enrolled in a therapeutic trial and data were derived from clinical and demographic questionnaires obtained at baseline, including assessment of patient quality of life and spiritual well-being. He concluded that there is a strong relationship between spiritual well-being and quality of life ($P<.0001$).

In the 1999 Lancet article, "Religion, Spirituality, and Medicine," by Sloan et al., the authors stated that even in the best studies, the evidence of an association between religion, spirituality, and health is weak and inconsistent. Furthermore, the group urged that it is premature to promote faith and religion as adjunctive medical treatments. They contended that the central weakness is the failure to provide control for confounding variables, such as socioeconomic status, behavioral differences, age, physical mobility, and social support (Sloan, Bagiella, & Powell, 1999). Freedman analyzed all 329 peer-reviewed research studies cited by Larson and discovered that the studies largely reflected the experiences of Caucasian (85%), American (73%), Christian (95%) subjects and, therefore, concluded that these studies cannot be generalized (Freedman, Orenstein, Boston, Amour, & Mount, 2002).

Numerous physicians address suffering relatied to terminal illnesses. According to Ventafridda, many patients suffer terribly as they die from advanced cancer and other terminal diseases (Ventafridda, Ripamonti, Tamburini, Cassileth, & DeConna, 1990). When the patient's distress is examined closely, the extent of suffering appears to be enormous (Cleeland et al., 1994). Distress and suffering can affect the patient's final days of life deeply, and the memory of it can haunt the care providers and family for many years (Storey, 1998). Even an experienced physician may experience problems in dealing with these situations (Breitbart & Passik, 1993). Unless a physician or caretaker truly understands the spiritual pain that frequently accompanies dying and the multifaceted nature of loss and suffering, interventions may not only fail to relieve suffering, but may also become sources of additional suffering (Cassell, 1982; Groves & Klauser, 2005).

The importance of addressing the spiritual needs of family members was addressed by Cherlin et al. (2004). The study "Family Perceptions of Clinicians' Outstanding Practices in End-of-Life Care" discussed the practice of nonabandonment, respect, and care for the family in the time of illness. They insisted that timing of the communication between physicians and family members was an important factor. In a similar study by the same group, titled "Communication between Physicians and Family Caregivers about Care at the End-of-life: When Do Discussions Occur and What Is Said?" Cherlin found that ineffective communication about end-of-life issues likely results from physicians not discussing the topic appropriately or the family members having difficulty in hearing and processing the news.

Astrow, Puchalski, and Sulmasy have written extensively in the field of spirituality and healthcare. Collectively, they found that a majority of patients in the hospital setting desire that their spiritual needs be addressed by their physicians or other healthcare workers (Astrow, Puchalski, & Sulmasy, 2001). They observed that the practice of spiritual care differs greatly from one medical discipline to another. Ross (1997) and Prochnau et al. (2003) noted that medical disciplines addressed spiritual care in different ways. Some disciplines involve theoretical discourses (Turbott, 2004; Simmonds, 2004) while others focus on the practical aspects of spiritual care.

On many occasions, the use of different language and terminology creates problems when it comes to the practical application of spirituality. Ross (1997), in the paper titled "The Nurse's Role in Assessing and Responding to Patients' Spiritual Needs," provided a literature review that examines the spiritual dimension and need. Ross claimed that spiritual needs during terminal illness are broader than religious ones

and include the need for meaning, purpose, fulfillment, hope/will to live, and belief and faith in self, others, and God.

Terminology regarding spirituality varies from nursing literature to medical literature. Nursing literature predominantly mentions the concepts of spiritual dimension and spiritual needs (Ross, 1997), whereas medical journals often use the terms *quality of life* and *spiritual well-being* (Bryson, 2004). Walter (1996) discussed three approaches to spiritual care: religious, ecclesiastical, and search for meaning. A number of the recent palliative care articles discussed spiritual needs such as hope, overcoming fears, the meaning of life, spiritual resources, and finding peace. The majority of palliative care literature focused on the spiritual needs of palliative care patients (Kearney & Mount, 2000; Speck, 1998).

Most literature on spirituality and end-of-life care reflects three main themes: the historical background, the necessity of spiritual care, and a discussion on definitions and distinctions between religions and spirituality.

Zimmerman wrote on the denial of death (2004), stating that western society is in denial of terminal illness, which has implications for palliative care delivery. This may be one of the reasons so few patients are treated in hospice settings. She argued that the emphasis of palliative care may be focused less on the denial of death than on the relief of suffering.

In the book *What Dying People Want: Practical Wisdom for the End-of-Life*, well-known spirituality expert Kuhl (2002) focused on the spiritual needs of love, meaning, purpose, and transcendence in the dying process. He discussed the presence of anxiety, pain, and wisdom during the dying process. Kuhl advised caregivers and family

members not to dwell too much on the prospect of death, but to live and relate to people in the best way possible, finding new life in the process of dying, understanding the inner reality of living with a terminal illness.

Moadel (1999) studied terminally ill cancer patients. In 248 patients he observed the following needs: overcoming fears (51%); hope (42%); meaning in life (40%); finding spiritual resources (39%); seeking someone to talk to about and finding peace of mind (43%); meaning of life (28%), death and dying (25%). Patients reporting five or more spiritual/existential needs were more likely to be Hispanic (61%) or African-American (41%), more recently diagnosed and unmarried. Treatment status, cancer site, education, gender, age, and religion did not influence the needs.

Steinhauser (2000) talked about a number of factors considered important at the end-of-life by patients, their families, physicians, and other care providers. His study included 340 seriously ill patients, 332 recently bereaved family members, 361 physicians, and 429 other healthcare providers (e.g., nurses, social workers, chaplains, hospice volunteers). Twenty-six items were rated as being important across all four groups, including pain and symptom management, preparation for death, achieving a sense of completion, decisions about treatment preferences, and being treated as a whole person. He observed that eight items received strong importance ratings from patients but less from physicians, including being mentally aware, having funeral arrangements planned, not being a burden, helping others, and coming to peace with God. Ten items had broad variation among the four groups, including decisions about life-sustaining treatments, dying at home, and talking about the meaning of death. Participants ranked freedom from pain most important and dying at home least important among nine major

attributes. He observed that the majority of the four groups admitted that pain/symptom management, communication with one's physician, and preparation for death were among the most important factors.

Many authors wrote extensively in the areas of control and dignity in terminally ill patients. Kenneth Bryson (2004) said that end-of-life care provided an opportunity to help a patient find meaning in the experience of dying. Bryson claimed this is a challenge because the experience of dying can deprive a patient of meaning in life. He said the first step is to view death as being a progression of life rather than an event.

Chochinov (2002), in his paper "Dignity in the Terminally Ill," described a Dignity Model focused on three areas: illness-related concerns, dignity-conserving repertoire, and social dignity inventory. Illness-related concerns deal with the level of independence and symptom distress. In the dignity-conserving repertoire section, he described dignity-conserving perspectives and practices. In the social dignity inventory category, Chochinov described the principles of privacy boundaries, care tenor, burden to others, social support, and aftermath concerns.

Speck (1998) wrote in his article, "Spiritual Issues in Palliative Care," that in exploring spiritual identity death allows one to confront one's past, present, and future life. In reviewingone's life, one must acknowledge the challenges one has faced as well as one's subsequent achievements. Personal beliefs must be challenged and re-examined, but it is also important to realize that this evaluation of one's self may create feelings of guilt, remorse, and regret that may need to be addressed.

Michael McCabe (1997) emphasized the necessity of exploring the effects of spiritual concerns on the presence of pathologic symptoms in patients with a progressive

medical illness. He emphasized that by giving minimal importance to the spiritual concerns of a given patient, we are limiting our medical ability to be an effective caregiver. McCabe advocated evaluation and understanding of one's spirituality as an absolute prerequisite in the holistic treatment of a patient with a medical illness.

Maria Suarez-Almazor (2002) conducted a survey of 100 cancer patients to determine the relationship between the desire for euthanasia and the degree of one's symptoms. She observed that the association between euthanasia and symptoms was weak. Instead, she found a stronger correlation between the desire for euthanasia and male sex, lack of religious beliefs, and beliefs about suffering. She also found that suicidal ideation was associated with poor well-being, depression, anxiety, and shortness of breath, but not with other somatic symptoms such as pain, nausea, and loss of appetite. She concluded that severity of symptoms had less influence on the attitude toward euthanasia when compared to psychosocial beliefs.

In the 1960s, Howard Clinebell, author of *Basic Types of Pastoral Care and Counseling: Resources of Healing and Growth,* sought to develop a new, innovative method of relationship counseling. Unhappy with the inadequacy of the popular psychoanalytic approach for pastoral counseling, Clinebell developed a model based on family/group therapy, transactional analysis, crisis intervention, reality therapy, existential psychotherapy, and ego psychology. He described this model as not insight-oriented but, instead, a relational, supportive, ego-adaptive, reality-oriented approach to therapy. His interviews shifted toward a less formal, encouraging, and inspiring environment where one could experience love in a dependable relationship. By integrating both psychological and theological elements, Clinebell believed pastoral care

and counseling could be holistic in their approach (Clinebell, 1984). Clinebell regarded self-realization as the ultimate goal of counseling.

Kearney and Mount (2000) described spiritual pain as alienation from the depth of one's being. Dame Cicely Saunders, founder of the modern hospice movement, coined the phrase *total pain* to describe the physical, spiritual, and emotional suffering experienced by persons with life-limiting illness. Spiritual pain and suffering may often be exacerbated by physical pain and other symptoms such as loss of personhood, despair, and feelings of abandonment by God.

Albaugh (2003) used a phenomenological approach to spirituality of patients with a life-threatening illness, and found that spirituality greatly affected patients' sense of meaning. Another study of 160 terminally ill patients identified spiritual well-being as the greatest factor in protecting against end-of-life despair (McClain, Rosenfeld & Breitman, 2003). Chochinov's (1999) study showed that in palliative care patients' depression, anxiety, and shortness of breath were the main negative predictors of the will to live, while a sense of well-being was the main positive predictor.

Another phenomenological study by Wright (2002) showed that the spiritual essence of palliative care is based on the fact that all people are spiritual beings. His theory suggests that spiritual care seeks to affirm the value of each person based on nonjudgmental love.

Hope is an important aspect of spirituality often addressed by patients, physicians, and families. Rosenfield and his colleagues (2004) studied the construct of hopelessness in the context of a life-threatening or terminal illness. Using the Beck Hopelessness

Scale they observed that the factors that correlated with hopelessness were lack of motivation, pessimism, suicidal ideation, and lack of spirituality.

Buckley and Hearth (2004) conducted a study to identify strategies terminally ill patients use to maintain and foster hope in the final stage of life. The study objective was to track changes in hope using the Hearth Hope Index (HHI) and semi-structured interviews. The HHI is a 12-item interviewer-administered scale designed to gather data concerning hopefulness from patients. The HHI is composed of three dimensions: temporality and future, positive readiness and expectancy, and interconnectedness. Buckley and Hearth's results showed that hope, regardless of proximity to death, remained present.

Judith Miller (1989), in her paper entitled, "Hope-Inspiring Strategies of the Critically Ill," said the importance of hope is universally accepted but, despite its wide acceptance, how patients can maintain hope while confronting adversity is not well known. In her study, 60 critically ill people were examined to determine what mechanisms they used to maintain or increase their hope while they confronted life threatening events. The responses of the 60 study participants were used to categorize nine hope-inspiring themes. These findings were then pooled to develop strategies to inspire hope in the critically ill.

Centers (2001) wrote of hope in the context of amyotrophic lateral sclerosis (ALS), focusing on her personal experience as both an occupational therapist working with ALS patients and as the daughter of an ALS patient. For hope to occur, she noted that one often goes through a process of hopelessness and denial. In doing so, ALS patients arrive at a far deeper understanding of hope, "This is not hope for survival, but

for something richer and more meaningful—a peaceful acceptance of life, and its inexplicable beginnings and endings" (Centers, 2001). Brant (1998) noted, "Spirituality instills hope that extends beyond the grave" (pp. 995-1004).

Schwartz (2003) studied 596 cohorts to measure the concept of a good death. The term good death has been used in palliative care for decades. Schwartz measured three distinct domains, reflecting the psychosocial/spiritual, physical, and clinical aspects of a good death. Walters (2004) noted that the idea of a good death finds support in individualistic societies, a commonality that is shared with the concept of euthanasia.

Chochinov (2002) provided a list of interventions aimed at the maintenance of dignity:

> Dignity-conserving care comprises not only what one does to patients, but how one sees patients . . . . When dying patients are seen, and know that they are seen, as being worthy of honor and esteem by those who care for them, dignity is more likely to be maintained (pp. 2026-2141).

Breitbart (2002) discussed the need for spirituality and incorporated the concepts of Frankl on spirituality in relation to meaning. Kissane (2001) proposed the term *demoralization syndrome* and defined it as "a psychiatric state in which hopelessness, helplessness, meaninglessness, and existential distress are the core phenomena" (Kissane, Clarke, & Street, 2001, pp. 12-21).

Several articles discuss the effects of religion on the perception of death. Alvarado (1995) found that strong religious conviction and belief in an afterlife were associated with less anxiety, depression, and distress. Cartwright (1991) described the reflections of relatives whose loved ones recently died. These reflections showed that strong religious convictions had a positive effect in terminally ill patients, although belief in an afterlife did not.

There are many tools and instruments to evaluate spiritual care and therapies used in terminally ill patients. One popular tool is the System Belief Inventory (SBI) validated by Holland et al. (1998). This instrument is designed to measure religious and spiritual beliefs, as well as the social support derived from a community sharing those beliefs. Ten items addressed religious ritual and practice. Five items focused on support from one's religious or spiritual community. This inventory is designed to measure the extent to which self-reports maintain their validity when administered in a different country with its own distinct language, culture, and religion. Another instrument is the Duke Religious Index by Sherman et al. (2000). This index is best used to measure religious involvement of a patient. Brady et al. (1999) developed the Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being (FACIT-Sp) to measure faith (the traditional religious factor) and the meaning of peace (the spiritual factor) in a patient. The Fetzer Multidimensional Scale by Fetzer Institute (1999) uses multiple subscales to assess religion and spirituality. Finally, Pargament et al. (1998) developed the brief R–COPE instrument to measure positive and negative religious coping. Negative coping is defined as conflict in an individual and anger at God.

## Spirituality of Caregivers

A limited number of articles concentrate on the spirituality of caregivers, demonstrating the need for further research. O'Connor and Kaplan (1988) explored the spirituality of hospice workers in a small study. The workers became more spiritual while caring for terminally ill patients.

Millison and Dudley (1990) conducted a small study of physicians, nurses, social workers, and clergy working with the terminally ill. All participants reflected a stronger

spiritual connection, which had a positive effect on patient interaction. A second study by Millison et al. (1990) correlated job satisfaction and spirituality in hospice directors. The authors found that 91% of the participants felt spirituality was important to the hospice team in their program. They claimed that the findings seemed to indicate that healthcare professionals choose hospice work to answer a spiritual calling (Hillman, 1996). Since the sample population consisted of hospice directors, the results may not be generalizable to all caregivers.

White (2000) explored the concept of spirituality with nine multidisciplinary professionals working at two cancer centers. He found that their spirituality was expressed through a search for meaning, purpose, or sense of connection. Earlier studies have shown the positive spiritual effects of working in palliative care. One study involving hospice nurses showed a stronger belief in the afterlife and a stronger sense of satisfaction in life and work than in nonhospice nurses (Vincent & Garrison-Peace, 1985). Another study showed spirituality became more meaningful among occupational therapists because of working in palliative care (Prochnau, Liu, & Boman, 2003). Sinclair (2006) showed that interdisciplinary palliative care teams believed spirituality was a central experience in palliative care work.

Terminally ill patients have expressed that they expect the qualities of compassion, empathy, respect, self-awareness, nonabandonment, and “being present” are essential attributes of caretakers that contribute to spiritual well-being (Kearney & Mount, 2000; Kuhl, 2002; Wright, 2002). A study by Wasner et al. (2005) showed significant improvements in compassion toward the dying and oneself, attitude toward

family and colleagues, satisfaction with work, and reduction in work-related stress after spiritual care training for palliative care professionals.

Maddix stressed the importance of reflection by palliative care workers to assess the impact at personal and collective levels (Maddix & Pereira, 2001). Palliative care expert Souter (2003) emphasized the importance of using structured reflection on furthering palliative care nursing. She found it was helpful in exploring the role of intuitive knowledge and spiritual care. Speck (1998), in his article addressing spiritual care, also stressed the importance of narrative therapy.

Drobin (1999) proposed an integrated model with traditional as well as new and esoteric spiritual ideas to transcend all limitations. This supports the view of integration from eastern, western, and New Age philosophies.

## Evaluation of Research Literature

The current literature focuses on the patient's or family's perspectives based on their spiritual needs. Most of the studies concluded that spiritual care has positive effects on patients and on their families. A limited number of studies examined the spirituality of physicians and other caregivers. Caretakers providing spiritual care are supported by literature. Historically, the spirituality of physicians and other caretakers leads to a better understanding of patient issues. Spirituality helps the physicians understand and accommodate a patient's beliefs when they are different from their own. Many people who are religious but not spiritual may not tolerate another's beliefs. The spirituality of a caregiver is important even if the patient is a skeptic or nonbeliever. Spiritual care relates primarily to compassion, empathy, listening, presence, and concern for the patient.

The literature is not clear about how to provide spiritual care. Can this care be provided by a physician who is not trained in or interested in spirituality? Can physicians be trained or educated in dealing with issues related to spirituality? There are a limited number of empirical studies relating to the spirituality of the physician or caretaker.

## Chapter Summary

This chapter begins with a focus on reviewing literature about the historical development of spiritual care relating to the sick and the role of spirituality of the caregivers. It examines the contribution of spiritual thinkers to the universal basic foundation of spirituality. It includes leading figures of major religions including Christianity, Judaism, Buddhism, Islam, and Hinduism. Tremendous contributions were made by many Christian spiritual thinkers including St. Paul, St. Augustine, St. Francis, Meister Eckhart, Swedenborg, William James, and Mother Teresa. Eastern spiritual figures include Buddha, Tao, Nagarjuna, Confucius, Patanjali, Rama Krishna, Suzuki, the Dalai Lama, and Thich Nhat Hahn among others. Other religious traditions that contributed to the spiritual development including Sufism, Taoism, Confucianism, Zoroastrian, Kabbalah, and Baha'i traditions were examined. These traditions and thinkers continue to have a very strong spiritual influence and inspire many through their teachings.

Hinduism is an ancient religion in the Indian subcontinent from which other traditions originated, including Jainism, Buddhism, Sikhism, and other Hindu sects such as Shiva, Vishnu, and Shakti (goddess worship). Dying patients and caregivers connect to these traditions through service and prayers to find peace, solace, and strength (Nallaswami Pillai, 1910).

In the field of spiritual care the work of philosophers, poets, and psychologists were considered. Jung and Erikson's contributions were examined. Jung's contribution in spirituality was significant as was that of his contemporary, psychologist Assagioli. Recently theories relating to the medicine of body and mind along with quantum physics have been used to explain spiritual healing. Quantum theories support beliefs based on human subjectivity as one of the important factors for healing. Intelligence is not confined to the mind but extends to other organs and cells as shown by the researcher Candice Pert. The body and mind connection may explain the beneficial effects of various forms practice and medicine, including Tai Chi, yoga, and other holistic practices.

Perspectives and views of scientists and psychologists who integrated spirituality with science were examined. Such figures include Paracelsus, Pascal, Newton, Einstein, Pauli, and Planck. In addition, the work of existential philosophers and writers like Kierkegaard, Tolstoy, Nietzsche, Heidegger, Schopenhauer, Yalom, and Becker were reviewed. Some were atheists and skeptics, while others believed in a higher spiritual power and humanistic values. Views of spiritualists who integrated nature and the cosmos as a spiritual source were also studied. American transcendentalists, including Thoreau and Emerson, also were inspired by nature and their writings were reviewed. Perspectives of 20th century spiritual thinkers were explored to show the beneficial effect of spirituality on the healing process.

The aging process and the issues associated with the elderly were reexamined in relation to spirituality in modern context. Social scientists such as Baltes saw wisdom as knowledge whereas Ardelt looked at wisdom as a personal attribute. Carstensen (1995)

focused on the latter half of life as a time for spiritual development whereas others considered it a process that happens throughout life.

In the field of spiritual care, major research papers were examined regarding the work done by physicians and other caretakers such as nurses and psychologists. Most of the research papers indicated that spirituality was important, although only a limited number addressed the spirituality of the physician. Sulmasy, who scrutinized the role of Christian physicians, concluded that doctors who were spiritual were able to provide better care than those who were not spiritual.

The connection between ethics and spirituality of caretakers was studied. Historically, ethics have been heavily influenced by religious and spiritual traditions. The Hippocratic Oath played a key role in western medical ethics. Virtue ethics and care ethics as they relate to spiritual issues are becoming important in the care of the terminally ill. My literature review is an attempt to view end-of-life care through the lens of psychology, philosophy, science, and art.

# CHAPTER 3

# RESEARCH DESIGN AND METHOD

## Chapter Overview

This chapter describes the methods used in the investigation of spirituality of caretakers, including physicians and nurses. It begins with a restatement of the problem followed by a specific presentation of the objectives for these studies and the rationale for each objective. There is then a brief overview of the research plan.

## Problem Statement

Does the spirituality of caretakers, the physicians and nurses, improve the quality of care in the terminally ill?

## Objectives and Their Rationale

The objectives of this study were to:

1. Evaluate the spirituality of the caretaker.
2. Evaluate how spiritual care is implemented by the caretakers.
3. Ascertain if spiritual care benefits or improves the quality of care of the terminally ill patients.
4. Evaluate the beneficial effect of spirituality on the caretaker and on the patient's family and how this enhances the ability to continue to provide care.

Many patients want to discuss issues related to spirituality and the end of life when they are given a diagnosis of terminal, incurable illness. Research shows that dying patients often want to discuss ultimate issues with their physicians, for example, the meaning of life, death with dignity, fear of death, and fear of suffering (Breitbart, Gibson, Poppito, & Berg, 2004). Physicians without spiritual inclination are, however, both reluctant and unprepared to answer their dying patients' questions related to spirituality. In addition, patients often ask their physicians about life expectancy and want to know how much time they have left to "make things right" and to make up for lost opportunities.

Physicians with a spiritual inclination are more comfortable dealing with these spiritual issues brought up by terminal patients and, as a result, may be able to continue care without suppressing or denying the patient's issues. A trained spiritual physician may be able to better cope with the stress of a dying patient and continue to provide more effective care than a nonspiritual physician.

## Research Design

This study involves descriptive clinical data regarding the experiences of doctors, nurses, and, in some cases, the patients themselves with respect to spirituality as it relates to care given to terminally ill patients. It is a three-part study that involved interviews, case reports, and a questionnaire.

Retrospective reviews and discussions were carried out relating to terminally ill patients managed at the cancer hospital with caretakers, namely the physicians and nurses, of the interdisciplinary team. From this review, common themes emerged that included existential issues such as spiritual pain, anxiety related to death, fear of illness

and disability, meaning of life, and fear of death. Additional spiritual themes related to the quality of care delivered by the caretaker's conduct were reflected in multiple ways. These themes included communication, presence, listening, relationship, rapport, providing hope, dignity, and connection with patients.

In the first part of the study, semi-structured interviews were conducted with physicians who had many years of experience and were considered experts in their fields of medicine. The second part of the study included a review of case studies that explored the above-mentioned spiritual and existential themes in clinical situations. The third part of the study was composed of a detailed questionnaire given to caretakers with questions relating to their spirituality and spiritual care.

Prior to this investigation there were no questionnaires available to measure the spirituality of the caretakers. Therefore, a questionnaire was designed based on the feedback and advice of experts such as physicians, psychologists, nurses, priests, and spiritualists. This questionnaire was used to measure the perspectives of physicians and nurses who dealt with end of life care issues of terminally ill patients.

## Preliminary Pilot Studies

Preliminary pilot studies were performed at the Kenneth Norris Cancer Center intensive care unit (ICU). In the first study, we distributed a questionnaire to caretakers working in the ICU with terminally ill patients. The questionnaire was designed to assess the importance and the extent of spiritual care provided to dying patients by their caregivers. Preliminary results demonstrated a positive, direct relationship between the spirituality of the caregiver and optimal care given to the dying patients.

The second pilot study tested the interview protocol planned for the assessment of the quality of spiritual care given to terminally ill patients. Ten caregivers were individually interviewed. Preliminary results indicated that spirituality is an important aspect of care for the terminally ill patient and that religiosity or spirituality helps the caregiver cope with the dying patients' issues and helps them to address the patients' individual problems and concerns.

## Research Study

### Participants

This study focused on the spiritual care provided by the caretakers at the University of Southern California Medical Center, Norris Cancer Hospital. These include medical oncologists, intensive care specialists (also referred to as critical care specialists), surgeons, ICU nurses, and resident physicians.

### Procedures

Semi-structured interviews were carried out with caregivers, each lasting approximately one hour. Semi-structured interviews were used because they permit exploration of a framework of ideas while also allowing flexibility for asking new questions based on the interviewees' answers. The themes for the framework included the beliefs of the caregivers and their importance and how these beliefs affected the care of terminally ill patients. Additional questions explored the components of spiritual care, the influence of spirituality on the quality of care, how spirituality helps the patient, caregiver, and family cope with terminal illness, and how caregivers can continue to

effectively provide optimal care. Personal life experiences of the caregivers were also explored in relation to the patient care.

The interviews were summarized with written notations. These interviews addressed individual caregiver spirituality and quality of care, their views on spirituality, and how they implement their spiritual practice. The interviews comprehensively examined the benefits to the patient and the patient's family, to the caregiver, and to the quality of care provided.

Case studies of terminally ill patients were selected from over the past 20 years and were examined to explore the benefit of spiritual care given to terminally ill patients. These cases were selected because spiritual issues were most significant in this subset of patients.

The questionnaires on spirituality were administered to experienced caregivers responsible for the care of terminally ill patients. The participants had a minimum of 5 years experience in dealing with dying patients and included nurses and physicians.

## Instrumentation: Spirituality Survey

The spirituality questionnaire was helpful to address those issues not completely addressed during the interviews. Prior to this study no standard instrument had been formulated to measure spirituality relating to the caregivers involved in the care of terminally ill patients. There are, however, nationally-used instruments that have been developed and tested to examine spirituality relating to patients. The questions in the study questionnaire were derived from these instruments, whose level of psychometric development, validity, and internal consistency (Cronbach's alpha and factor analysis) have been well documented.

A Likert scale questionnaire was administered to the caregivers. The basic ideas for the formulation of the questions were derived from existing instruments including the Fetzer Multidimensional Scale by Fetzer (Plante & Sherman, 2001), the Brief R-Cope by Pargament et al. (1997), and the Systems of Belief Inventory by Holland et al. (1998). The Fetzer Scale has multiple subscales, the Brief R-Cope deals with coping and distress, and the Systems of Belief Inventory deals with beliefs/experience and religious social support. The questionnaires were further modified by input received from physicians, psychologists, hospital chaplains, nurses, and other caregivers.

Items on the scale corresponded to a 1 to 5 grading system, with a response of "1" signifying that the respondent strongly agreed with the statement, and a response of "5" signifying that the respondent strongly disagreed. Respondents were given a brief definition of spirituality with regard to end-of-life care to minimize confusion with religiosity and moral issues. The questionnaire was then pilot tested to determine its applicability to the selected issues.

The questionnaire was divided into six discrete categories. The categories included the importance of spirituality, the importance of the spirituality of the caretakers, family expectations, qualities of the spiritual caretaker, the current financial constraints in spiritual healthcare, and the benefits of spirituality to the caretakers and the patient's family members.

The questionnaire was evaluated for content validation through the examination of the literature in this area, and these questions were drawn from previously validated questionnaires. Physicians who are known to have expertise in spiritual issues also validated the questionnaire, as did nurses experienced with spiritual issues specific to the

ICU setting. The questionnaire also underwent predictive validation. Physicians who filled out the questionnaire were deemed to be spiritual or not based on their responses. Nurses who worked with these same physicians were then separately asked their opinion as to the spirituality of the physicians. The results of these two responses were compared and a high correlation was found.

Semi-structured interviews were used. The ideas for these interviews were derived from two existing instruments and further input obtained from existing literature in the field, physicians, psychologists, hospital chaplains, nurses, and other caregivers. The instruments included the Modified FICA Questionnaire and the HOPE scale.

FICA was developed and refined by Christina Puchalski, MD (2000) to obtain a brief spiritual history. It has four components, which correspond to letters in the FICA acronym:

- F (Faith and belief): Do you consider yourself spiritual or religious?
- I (Importance): What is the importance of your faith or belief in your life?
- C (spiritual or religious Community): Is this of support to you and how?
- A (Address in care): If you were the patient, how would you like your physician to address spiritual issues in your healthcare?

The HOPE instrument by Anandarajah (2001) was also helpful for physician interviews in evaluating spirituality. The HOPE instrument measures

- H: hope, strength, comfort, and connection;
- O: organized religion;
- P: personal spirituality and practices; and
- E: effects on medical care and end-of-life decisions.

## Data Processing

### *Interviews*

Interviews were transcribed and analyzed for common themes. All interviewees had previously completed the questionnaire. The interviews were conducted in two phases. Each included a preliminary interview followed by a more detailed, extensive interview. Prior to each interview, the definition of spirituality was discussed with the interviewee to clarify the concept. Group interviews with two or three participants were conducted when individual interviews were not feasible.

### *Questionnaire*

Means and standard deviations were calculated on each of the scales of the instruments so that there were two sets of tables produced, one for the former and one for the latter. These results are shown in Chapter 4.

## Assumptions and Limitations

Caregivers at the University of Southern California are representative of caregivers throughout the United States. They have undergone similar, standardized training, have satisfied the national testing and training requirements, and have successfully passed all relevant licensing examinations. They also have satisfied recertification requirements and continuing education requirements.

Terminally ill patients at the Norris Cancer Hospital of the University of Southern California with a cancer diagnosis are representative of all terminally ill patients. Epidemiological studies have demonstrated that most cancers throughout the United

States have a similar prevalence rate throughout the country, with the exception of skin cancer. This study is limited by the relatively small number of caregivers directly involved in caring for terminally ill patients at Norris Cancer Hospital of the University of Southern California.

The cultural diversity of the site may not be representative of the rest of the country because Los Angeles has a multicultural composition. As a private university hospital, the patient population tends to be more affluent, compared to facilities like the Los Angeles County facility at the University of Southern California. Caregivers with minimal involvement in the care of terminal patients were excluded from the study.

## Ethical Assurances

Written informed consent was obtained from each of the participants. Each participant was given a handout defining spirituality in terms of spiritual care and the operational definition of the various constructs. Ethical assurance was given to ensure the privacy of participants. The questionnaires were anonymous. All interviews were confidential. Prior to commencement, the study was approved by the Institutional Review Board at the University of Southern California.

## Chapter Summary

This chapter described the research plan used in the investigation on the impact of caregiver's spirituality on the quality of care provided to terminally ill patients. It began with a restatement of the problem followed by a statement of the hypothesis, rationale supporting the hypothesis, a description of the research design, methods, instruments,

participants, ethical assurances, and statements of assumptions and limitations. Also included were descriptions of previous pilot studies and research instruments.

# CHAPTER 4

# FINDINGS AND EVALUATION

## Chapter Overview

This chapter presents data, results, and findings of interviews, clinical case reports, and surveys. A summary of the interviews of caregivers is presented followed by discussion of the findings. Each case report is described followed by a discussion of the care with a focus on its spiritual components. The survey responses of the physicians and nurses are then discussed. The responses are tabulated in Tables 1 and 2 (Appendix B) and a comparison of the means of the responses are shown in Table 3 (Appendix B). Pseudonym initials are used to identify interviewees to preserve confidentiality.

## Physicians' Interview Report—Findings

The attending physicians interviewed were specialists who had academic appointments as assistant, associate, or full professors and who were actively practicing medicine in their areas of specialty. For participation, physicians needed to have at least 5 to 10 years of clinical experience and have an in-depth familiarity with end-of-life care issues.

Most of the participating physicians made major contributions to clinical research and teaching in addition to leading clinical care of patients. The interviews were conducted over two to three occasions, with the total interview time varying from an hour

to an hour and a half. Interviews were semi-structured with open-ended questions and followed by a subset of questions depending on the responses. These questions were related to the caretaker's perspectives about spirituality and the effect of the caretaker's spirituality on care given to the patient. The questions focused on how each interviewee defined spirituality and spiritual care. Other questions were related to the benefits of spiritual care and its effect on the physician, community, and the health care system.

*Interview 1*

RM is a 49-year-old African-American male physician with 16 years of experience in his field. He is specialized in ICU care, peri-operative care, with special interests in nutrition, spiritual care, trauma, and blood transfusion medicine. He is actively involved in community and religious work with marginalized populations. He is married with two children, and is a Seventh Day Adventist with a strong faith. He claims that over time he has become more spiritual with an increased tolerance and respect for other religious traditions. He has witnessed and experienced end-of-life issues in his personal life involving friends and relatives, and was recently a caregiver to a close friend during his final days.

He feels very strongly that the spirituality of the physician is important in patient care, and uses a mnemonic—FORT (Family, Occupation, Religion, and Testimony)—in his own practice. He affirms that he has a faith-based duty to his patients. He values listening to patients, visiting them, phoning them, praying for them, and spending time with them. He believes these activities have therapeutic and healing effects. He believes in a multidisciplinary, team approach to end-of-life care.

RM does not use alternative therapies but would allow his patients to do so if they wished. He tries to help patients by giving them some form of hope. He feels death is not the end and, regardless of outcome, promotes positive feelings including humor. He states that caring for these patients brings him closer to God, and dealing with end-of-life care issues provides meaning to his life. He will pray with patients if they request him to do so and feels prayers help him to establish rapport with patients and family members. He supports the views of Dr. Larry Dossey's research and writing that prayers and distance prayers have healing effects.

He claims spirituality helps him to be honest and truthful. He has a spiritual network of friends and colleagues that allows him to discuss issues without disclosing identities and while maintaining confidentiality. He feels that there is enough scientific evidence to support the fact that spirituality improves quality of life. He also feels that medical science and spirituality can complement each other. He reads biblical literature relating to the Seventh Day Adventist faith. He is inspired by the writings, research work, seminars, and lectures of the palliative care and end-of-life care expert Dr. Koenig, a proponent of spiritualty.

*Interview 2*

MM is a 41-year-old Caucasian female physician, assistant professor of anesthesiology and addiction medicine. She has over 12 years of experience specialized in intensive care, intraoperative care, high risk and cardiac anesthesia, addiction medicine, and holistic medicine, with interests in pain and palliative care. She has expertise in family psychology and received a Master's degree in psychology at a Christian university. She has many scientific publications to her credit that include

palliative care, pain relief, comfort care, and treatment of suffering and demoralization. She states that faith and spirituality are very important to her and to her practice. She prays daily and attends church regularly.

She claims that spirituality is extremely important for physicians and nurses relating to end-of-life care. She claims that because she is spiritual, she is able to understand and respect the spiritual needs of her patients regardless of their culture, race, faith, or beliefs. Still, she finds that death and dying are very stressful and painful aspects of human life, and she relies on a network of friends and church members from her parish to alleviate some distress and anxiety. She prays for her patients and their families and asks God for wisdom, strength, and understanding when caring for terminally ill patients. She tries her best to provide compassionate care to patients at end-of-life situations. She feels her strong Christian faith sustains her when caring for these patients.

She has observed that there are many obstacles to effective spiritual care. According to her, monetary interests are the driving force in modern medical culture, often rising above the best interest of patients. She claims that standard of care is deteriorating as medical training becomes focused on technology and super-specialization among doctors and nurses. The current medical culture does not incorporate total care, which would include the psychological, social, emotional, and spiritual needs of each patient. For this reason, she believes medical costs are rising, especially compared to other countries.

She feels that every patient should be treated as a special case since the issues are different, even if they are of the same faith. She opposes any form of euthanasia protocols or laws promoting euthanasia. She is also happy to pray with patients and their

family members if they belong to the same faith, and if they request it. She claims that she does not know much about other religions or cultures, but she affirms that her quality of care is the same and that she is tolerant of other's beliefs.

She claims that the Christian faith helps her cope tremendously with the stresses of working in an ICU, including death and dying. For her, religiosity based on the Protestant evangelical Christian faith is not different from her spirituality. She has personal experience of tragedies, end-of-life issues relating her father and her grandmother, within the last 5 years and she now has a better understanding of what her patients undergo. She now understands how personal experience is important in learning about spiritual care, and that it has had a transformative experience in her life. According to her, the meaning of life stems from the Christian faith and she is a wounded healer because of her experiences.

*Interview 3*

PR is a 43-year-old Caucasian male. He is an associate professor of anesthesiology with multiple publications and 16 years of experience. He has a special interest in critical care, pain, and palliative care. He looks after high-risk cardiac, thoracic, and cancer patients. He believes his profession is not only an occupation but also a calling. He is married without children. His faith is Greek Orthodox; he was religious as a child, less so as a teenager, but currently feels strongly about his faith. He does not attend church on a regular basis. He became spiritual during his college years and since then has tried to live his life with compassion, empathy, and care for others. He is tolerant and respectful of other religions, and many of those close to him are of faiths other than Christian. Spirituality enables him to see a picture of the reality from the

perspective of the physician as well as that of the patient. He has not yet experienced end-of-life care issues in his personal life or family life although both of his parents are elderly. He believes that spirituality is important when dealing with all patients and that it has a special importance when dealing with end-of-life care.

It is his opinion that at his institution the patients are not often well prepared for in regards to spiritual issues upon admission to the ICU. He feels that his spirituality influences his way of practicing medicine. For him, listening to patients and their families and being present is very important and has therapeutic effects for all involved. He believes that spirituality eases the patients' psychological suffering, gives them hope, and minimizes depression. He feels connected to all his patients regardless of their race, culture, or beliefs. He believes in a multidisciplinary approach and will involve religious figures at the family's request. He feels equipped to deal with most of the patient's spiritual issues but at times feels inadequate.

During critical moments, he will quietly pray for patients and for guidance in their care and will pray with the family if they ask. He believes that the soul continues after death, and when a patient dies he will say a silent prayer for them and for their family to ease suffering. He stated that spirituality helps him deal with the death of patients. He is respectful of the family's wishes with regard to rituals and has allowed these to occur as long as they do not interfere with care. He believes that science and spirituality can coexist and that God gave us the ability to make and understand advances in science. He also feels that each patient encounter enriches his spiritual experience. He reads spiritual classics. As an associate director of critical care and associate director of the anesthesiology residency program, he is trying to introduce palliative care and ethics

curriculum to residents, nurses, and medical students. He believes that physicians must focus on practical experiences by being by the side of the patient rather than spending time on computers and distancing themselves.

*Interview 4*

JB is 63-year-old Caucasian Jewish physician specialized in pain management and end-of-life care. He was also involved in hospice and palliative care in the past, currently focusing on regional pain medicine and research. He has written several books and published many articles.

He considers himself more spiritual than religious, and states his spirituality influences his care. While he incorporates spirituality and faith in his treatment, he has difficulty incorporating religion because his knowledge of religions is limited. He claims that he does not believe in any organized religions or cults. Often he is a skeptic or atheist or agnostic. He claims he is strongly spiritual because he cares for human beings and finds happiness in helping and healing them. He had seen many people who claim to be strongly religious and are self-righteous but don't help or care about the suffering of others. He keeps an open mind and will refer his patients to pastors, chaplains, and other religious/spiritual experts if it is beneficial.

He feels fully competent to deal with spiritual issues at end of life, but admits his clinical limitations to his patients. He feels that spirituality helps him establish a strong relationship with the patient and family. He is very frank with them about patient prognosis and encourages them very early on to take care of any necessary arrangements and unfinished business, including forgiveness, relationships, and other issues. He will spend significant time with these patients and their family, no matter how difficult it may

be, because he feels obliged to be honest. Though skeptical about religion, he feels spirituality helps a great deal with suffering and believes in listening, being present, expressing empathy, and caring. He tries to create an environment that will meet the patient's needs.

He feels his spirituality helps him deal with death, and will go to the synagogue to meet with his friends and acquaintances. Although he does not practice rituals, he feels they can be helpful to those who do. He believes in a higher power and interconnectedness to others, nature, and the cosmos. He feels that the soul exists after death and is connected to others. He believes in forces such as angels, and said his dying patients often see their deceased relatives. These are not hallucinations in his opinion, as they have a recurring pattern. He feels death can be a source of strength to the family, and states that the mystical experiences patients go through can only be explained in spiritual terms. He stated, "Healthy people fear dying, but the dying fear the process, not the death." According to his belief, he reassures patients not to fear death, as "when one door closes, another one opens." He claims that he is a proponent of passive euthanasia.

Philosophically and culturally he admires the teaching of Judaism. His father and mother experienced the death of many during the Holocaust and told many stories about their experiences at Auschwitz. In his father's opinion, the survivors of the Holocaust developed a special strength and knowledge about meaning in life, similar to what Viktor Frankl wrote about. His father still speaks at the Museum of Tolerance in Los Angeles, and he admires and respects his parents very much. In this discussion, it was apparent that he supports euthanasia in end-of-life situations. He has administered terminal sedation in cases in which the family requested it, and he has withdrawn life support in

hospice and palliative care situations. He feels one must help the patient find meaning. He claims that spirituality has adaptive function and is rooted in human nature. He admires many great physicians, namely Viktor Frankl, Moses of Maimonides, and Freud.

*Interview 5*

RG is a 42-year-old Indian physician who graduated from medical school 15 years ago, initially practicing in the field of surgery and now practicing as a specialist in pain medicine. He is married and has two children, comes from a family of professors and teachers, and has experience working in different areas of the United States. He believes in rituals, karma, reincarnation, and continuation of life after death.

He has experienced miraculous events in his own personal life, and he feels that God's grace helps him in his personal practice to be a better physician. He considers himself both religious and spiritual, although when caring for patients he is guided his spiritual beliefs. He accepts and admires all other religions and spiritual views. He feels fully equipped to deal with spiritual issues, although he will not begin this type of discussion unless the patient opens the subject or gives him cues. He admits his limitations to his patients. He advocates holistic care in his practice and believes in a multidisciplinary approach, and he will refer his patients to spiritual groups, chaplains, and so on according to their wishes.

He feels connected to his patients regardless of their race, religion, or social status. It is important, in his view, to listen, be present, and express sympathy. He states that spiritual care helps the patient accept death and can even bring optimism and improve relationships. He will not abandon the patient, and the intensity of his care remains the same regardless of prognosis.

He feels a moral duty to the patient until the end. He feels spiritual care provides positive meaning in life and that caring for dying patients promotes an inner growth of spirituality. His spiritual beliefs allow him to accept the patient's death and, thus, that death does not stir up any unpleasant memories. He will, however, discuss issues with other spiritual people for support. He feels that one needs to be spiritual, but not necessarily religious, to give good spiritual care. He feels that people who are not spiritual cannot provide good spiritual care because they will not be as committed as those who are. He also feels that physicians should receive training in spirituality. His final goal in caring for a dying patient is to give them peace and a peaceful state of being. He reads Bhagwad Geeta as spiritual guide. He stated that many medical students, residents, and nurses are not interested in spirituality because they are not trained about spirituality and spiritual care.

*Interview 6*

TD is a 73-year-old Caucasian male thoracic surgeon who has practiced for over 35 years. He is a pioneer in his specialty area of esophageal surgery. He is a Calvinist. He is currently physically and emotionally involved in three end-of-life care situations that involve his mother, his mother-in-law, and his father-in-law. He also recently had open heart surgery.

He considers himself both spiritual and religious and stated that his beliefs strongly influence his patient care. He will not open the topic of spirituality unless cued to do so by the patient, and feels uncomfortable discussing religions outside of his own due to a lack of familiarity with them. He does respect other religions and feels he is sensitive to the patient's needs in this area. He will invite a chaplain to speak with the

patient if that is the patient's wish. He feels connected to the patient, and stated that he believes this connection is the very reason patients choose him to care for them.

He will admit his limitations and is open to alternative forms of therapy. He strongly believes in a higher power, caring, having empathy, listening, and in being supportive and present. He feels that spirituality influences the quality of care, reduces patient suffering, gives hope, helps to develop relationships, decreases depression, and gives meaning to the patient's life. He will contact others to decrease his stress.

He does not pray with patients but will be present for the prayer if asked to be. He does, however, pray for his patients and for guidance before, during, and after surgery and feels God guides him through surgery. This has led to spiritual experiences, including one occasion when he operated on a patient with a transected aorta. He was unable to control the bleeding and, while compressing the aorta, silently prayed. When he released his pressure from the aorta, a clot had formed that allowed him to gain control of the situation and save the patient's life. He felt this was a miracle. If, however, a patient dies, he does not view this as a failure and accepts it; it does not evoke unpleasant memories in him. He believes that science and spirituality can coexist because science is a gift given by God. He is currently going through some external stressful issues with the hospital administration and his spirituality gives him hope. He stated that he felt his profession to be a calling. He goes to church every Sunday. He loves to read Christian scriptures and books, especially C. S. Lewis's writings relating to spirituality and a favorite book is *Chronicles of Narnia*. He admires famous Christian spiritual figures including Martin Luther and Dietrich Bonhoeffer.

*Interview 7*

JC is a 64-year-old psychiatrist in practice for 37 years. He is a strong Catholic and considers himself religious but not spiritual. Spirituality to him is the equivalent of a "new age movement." He does feel his beliefs influence his patient care, but he does not regularly discuss them with the patient unless they open the topic. Though not familiar with other religions, he does respect other faiths. He feels that religion helps him in caring for the patient, and likes to refer the patient to a chaplain or pastor if they wish at end of life.

He also feels spirituality is important in psychiatry and that the field is becoming more accepting of it, something he welcomes. He stated that spiritual practice should involve listening to the patient and family, expressing empathy, and being supportive. He believes spirituality helps patients overcome their suffering, cope, and find meaning. He feels connected to his patients and believes man was created in God's own image.

He spends much time listening to patients and supporting them. He is honest from the start with his patients and admits his limitations. Because he believes a soul does exist, death is not final to him. He discusses issues with his colleagues and also prays on his own; he will not pray with the family unless asked to. He believes in miracles and stated that there is a divine hand in the process of healing. He has experienced personal tragedies including losing his eldest daughter when she was a few months old, as well as losing his parents. He feels death is inevitable and, therefore, the death of a patient does not shake him; he is more worried about the living. He indicated that the Prayer of Saint Francis restores his spiritual strength all the time, personally as well as taking care of patients and family members.

*Interview 8*

MR is a 43-year-old female peri-operative specialist who is a strong Christian and considers herself spiritual. She stated that her beliefs influence her relationship with patients and she considers her work an important part of her mission in life. She feels it is not always possible to discuss the topic of religion with all her patients, but will tell them, if the topic arises, that she feels the healing power lies in God's hands. She feels blessed to be an instrument through which God's hands work. She feels that death is a sad event, and that the spirit separates from the body at death. She notes that currently, with advanced life support, life can be maintained in the physical form while the spirit may have already departed.

The death of the body is not as worrisome to her as death of the spirit, which if connected to God will not perish. She does, however, believe that, if one's soul is not connected with the Eternal, and the physical body dies, the soul dies an eternal death as well. She believes that salvation does not require any qualifications and that it is given as a free gift from God. Thus, a dying patient can be granted eternal life even in the last moments of life just by asking God.

She finds it comforting that one does not need religious rituals to get into a relationship with God and find eternal rest. She is reminded of the story of the thief hanging on the cross next to Jesus and how he was granted eternal salvation at that very moment. Even though she has very strong religious beliefs, she respects others for their character and values. She also treats patients of different spiritual backgrounds equally. She does pray for her patients to have good outcome and is comforted that, if they accept the eternal God, their salvation is at hand. She is very generous.

*Interview 9*

JP is a 42-year-old Indian physician who has practiced for 20 years and has worked with a cardiac team for open heart surgeries. He has specialized training in echocardiography and is board certified. Due to the high-risk nature of these cases he has seen many deaths. He considers himself both religious and spiritual, stating that he has become more spiritual over time. In the past he engaged in religious practices and went to the Hindu temple though he currently he does not feel it is necessary to go to temple to maintain his spirituality. Now that he is more spiritual, he performs fewer rituals but is more involved in listening to spiritual philosophies, and he is tolerant of other religions and spiritual beliefs.

His spiritual beliefs play an important role in his care of his patients, but he does not discuss the topic with patients unless they begin the discussion. If they do, he is comfortable doing so because he feels equipped to deal with spiritual issues. He believes in incorporating other forms of therapy and does not feel that western medicine is the only appropriate method of care. He believes that alternative medicine has its place, as long as it does not interfere with the primary treatment.

He has no difficulty accepting death, but dying patients evoke unpleasant memories for him, and he is upset for a few days after they die. He does come to terms with this and does not consider it a failure on his part. He does not discuss this issue with anyone, and comes to a state of acceptance on his own. He does believe in God, karma, reincarnation, interconnectedness with others, and the existence of a soul.

He feels it is important to listen to the patient, to be with them, and to care for them, and that one must try to create a spiritual environment. To him, spirituality helps

tremendously with suffering and building strong relationships, gives hope, prepares the patient for death, and gives meaning to life. He admits that, outside of cardiac cases, he has limited experience with terminally ill patients and does not recall any miraculous interventions during his patients' care. He does feel that he has advanced to a higher level of spiritual thinking due to his spiritual experience. He believes that one needs to continue to develop spiritually, which would make one a better person and a better physician.

*Interview 10*

MD is a surgeon who specializes in urology and state-of-the-art robotic surgery of kidney, bladder, and prostate cancer with over 14 years of experience. He uses the most modern technology possible, and is always involved in new technology design. He also has published extensively in the area of modern technological advances in surgery. He considers himself both religious and spiritual, and believes that his care is influenced by his religious and spiritual values. He believes in God and the interconnectedness of man with nature and the cosmos, and performs his own rituals such as prayers and chanting. He also believes in karma and life after death. He wholly respects other persons and their views and does not normally open discourse about spirituality unless his patients broach the subject first. If the topic does arise and he comes to understand the patient's faith and spirituality he integrates that into his care plan. He does refer his patients to other spiritual figures, such as chaplains and pastors, but only at the patient's request. He also incorporates other forms of complementary therapy as long as it does not interfere with the main course of treatment.

After establishing a solid physician-patient relationship, he spends a great deal of time with the patient and the family to adequately discuss all the medical issues. He feels spirituality has helped him listen to and care for the patient, as well as develop empathy and truthfulness. He assists with other caretakers to provide the patient and family hope. According to him, spirituality helps the patients deal with death, gives them hope after death, helps them to find closure and deal with unfinished business, and minimizes suffering and depression.

More than anything, he believes that spirituality gives them peace. As a physician, it helps him to cope with stress and to be positive. He has a spiritual mentor who is not a religious person but rather a spiritual philosopher. Spirituality helps him deal with the suffering of patients and with the mysteries of human life. He cannot recall any incidents in which miracles have happened in his professional life. He believes that God is always helping him, that God's grace is there to guide him, and that miraculous events have happened in his family and personal life. He feels the most important aspect of care when dealing with end-of-life patients is to support them and the family and give them peace. He believes that science, technology and spirituality can coexist and be complementary.

*Interview 11*

PR is a specialist who has expertise in trauma and cancer along with expertise in pain management. She also works closely with her husband who is a pain medicine specialist. She has been practicing for over 20 years after graduating from medical school, is in her late 40s, is from a Muslim background, and declares herself to be both spiritual and religious. She has worked in multiple states, including California where she

is currently practicing. Furthermore, she has personal experience in caring for her dying father who was afflicted with a terminal illness.

She strongly believes in spiritual care for terminally ill patients, and also believes that physician spirituality is important in providing optimal care for the terminally ill patient. She feels that spiritual care is not adequately provided by the majority of physicians in the United States, and is many times ignored all together. She feels that this is due in part to ignorance of physicians along with lack of training in this area during medical school.

She also feels that there is apathy and lack of consideration for those who are perceived to be different than those within the Judeo-Christian faith. She says she feels that, with Islamic patients, for example, physicians never discuss spiritual issues, nor do they make arrangements to provide these services. She thinks it is highly important to have an understanding of other cultures and religions to care for people from those various traditions. It is necessary to have knowledge, patience, and understanding for this transformation to occur.

She also believes that Christianity, Judaism, and Islam share a common belief in monotheism based on Abrahamic traditions. Still, she feels that Muslims are considered to be part of a violent religious faith and are, therefore, not considered equal to other faiths. She believes in miracles, based in part from personal experiences, although unfortunately she was reluctant to disclose these experiences during the interview. Furthermore, she believes that spirituality is seen to provide hope with the transformation to a state of realization greater than one's self. In addition, it helps the physician to cope with the grieving and loss of a deceased patient. She believes that the physician who is

involved in the care of terminally ill patients should be culturally sensitive and well informed about the patient's religious background, spirituality, and beliefs; these individuals can then formulate a common, practical approach directed to optimizing the patient's care in the final stages of life.

She feels that one should refrain from making judgment based on one's own personal beliefs, and should be willing to accommodate a wide variety of patient preferences. Essentially, care should be patient-centered and not physician-centered. She emphasized the importance of being nonjudgmental, flexible, and accommodating with patient spiritual and religious beliefs.

## Content Analysis

Several common themes emerged during the interview process. The main themes include the ability of spirituality to enable the caretaker to find meaning in life, coping, belief in a higher power and in the existence of a soul or form of afterlife, forming a connection with the patient, and minimizing depression and anxiety in the patient. The idea of helping the patient find a meaning in life was a prevalent theme among the majority of physicians. RM, the spiritual religious physician who was a Seventh Day Adventist, claimed that his faith helps him find meaning in life, whereas JB felt that there was no intrinsic meaning to life and that meaning needs to be sought in one's own way. He felt one must help the patient find meaning. Everyone interviewed believed that there is an afterlife and a higher power or energy that exists. Physicians from the western traditions strongly emphasized the faith component, while those from eastern traditions emphasized the concepts of karma and rebirth. TD, an experienced thoracic surgeon, emphasized faith, while JP, the Indian physician, placed his emphasis on karma as a duty.

All also felt that they were connected to their patients. TD felt that this connection is predetermined and that that is the reason a patient comes to be treated by him in the first place.

They unanimously agreed that spirituality helps the patient accept death and minimizes suffering, anxiety, and depression. It helps create a positive attitude and improves the relationships with and connection to the family and caretakers, including physicians. All the physicians interviewed agreed with this idea. Most were in agreement that their own spirituality helps them cope with stress-related issues and to accept the death of a patient, their limitations, and the mysteries of human existence.

Those from a Christian background relied more on prayers and support from pastors and friends, whereas those from eastern traditions relied on personal rituals much more than support from spiritual mentors or leaders. JP chants specific mantras routinely, which he believes to have helped him tremendously. They all felt that physicians who gained experience, both professional and personal, are better equipped to deal with spiritual issues and that wisdom comes with this experience. Younger physicians may have minimal life experience and professional experience and may not be adequately equipped to deal with spiritual issues without the guidance of more senior physicians, who should act as role models.

Although those interviewed stated that spirituality guides them in their daily work, most felt that they have had more spiritual experiences in their personal life with regard to life and death situations than at work. Western spiritualists consider it a calling, whereas those from eastern philosophies considered it part of their duty. The Catholic psychiatrist, JC, felt it was a calling, as did TD. Additionally, most senior physicians

stated that, even though they are spiritual, they may not be able to maximize their spiritual care since the environment is not always conducive to this in the current healthcare setting; there is a lack of a support system and often time limitations. One physician, a Coptic, felt that if the physician is not spiritual he might not be able to understand anything about the spiritual issues of the patient. All of the physicians were in agreement that nonreligious people can still provide spiritual care, irrespective of their views and opinions.

## Interview with the Nurses

The interview with the nurses was conducted in a group setting. The questions asked were:

- Is spiritual care important?
- How should it be provided?
- Does it help the patient and the family?
- Does it help the caretakers cope and be effective healers or therapists?

Based on their answers, individual participants were asked further exploratory questions.

The nurses focused on the alleviation of pain and suffering, communication, availability, or being present, and emotional support. Nurses supported the view of a soul or another form of existence but did not feel very strongly about the meaning in life, their focus being mainly on the more practical aspects of care. They felt that spiritual care should come from the physicians, especially the primary physician or leader of the multidisciplinary team. Most nurses felt that spiritual care should be incorporated into the total care of terminally ill patients. Part of this spiritual care involves preparing the

patient and family early in the process and on finding out information regarding their spiritual support system, beliefs, and preferences on end-of-life care.

The nurses felt that spiritual care is neglected in most hospitals except those with religious affiliations such as Catholic hospitals. They felt that in their own institution spiritual care was not provided by the primary oncology (cancer) team but, rather, by the ICU team. They felt this was due to a lack of spirituality, awareness, and training in the oncology program. They all agreed that spiritual care should involve a holistic approach in which the oncology (primary care) team coordinates the care, is present at bedside, listens, communicates, and is truthful with the patient and family members.

Their current perception was that spiritual care was not given adequately in their institution and that this is also true for most other hospitals in the United States. They believed that the reason for this is a lack of awareness and inadequate theoretical and practical training of physicians in the area of spirituality. The nurses also felt that there was limited discussion with the primary physicians on these topics. The nurses' opinion was that spiritual care should be given by those who are present with the patient and family members. The nurses' coping skills primarily come from their own family members, spiritual practices, discussions with other colleagues, and the ICU physicians. The nurses did not feel that it was important for physicians to pray with the patients. Only a few of the nurses were aware of the spiritual literature that is available from nursing literature (Narayanasamy, 1991).

## Clinical Case Reports

Eight cases of end-of-life care situations are presented here; in these cases the author was involved mainly as a physician, but the extent of involvement varied from full

responsibility to consultant-level care. These case reports relate to the theme of spirituality and how it was translated into patient-centered care, acceptance of death by both the physician and the patient, being present and listening, and coping. The residents who provided the support were rotating through the residency as a requirement for their specialty training. Some of these case reports have been published in various journals, though not in relation to spiritual care, but because they presented interesting examples of medical challenges. These cases have also been used as examples to teach residents about spiritual care. Patient names have been changed to maintain confidentiality.

*Case 1*

A 75-year-old movie star with a prolific career was diagnosed with bladder cancer. He also had one completely blocked carotid artery, which meant he was high risk for surgery and anesthesia. He was provided with maximal monitoring and care in the operating room and intensive care unit (ICU), and he was surgically cured of cancer. Initially he did well and was even able to go to the Oscars. Two years later, however, he again developed symptoms of cancer, and this time was found to have cancer of the rectum, which was extensive. He was readmitted to our institution for further treatment, but every attempt to cure him, including chemotherapy, failed. Nonetheless, palliative measures were undertaken, chemotherapy was continued, and a colostomy was performed to relieve some of his symptoms. His pain and discomfort were controlled with medications and supportive therapy. His positive attitude and that of his family were helpful in the successful provision of this comfort care.

The relationship between the ICU physicians, the family, and the patient grew stronger throughout the process, and the physicians were able to find out the family's

spiritual views. They were very spiritual, but not religious. Some of his movies also gave a clue to his views about life and death. His family had many existential questions that were spiritual in nature, including why this had to happen to him "of all people," and what was the meaning of his illness and suffering? The caretakers were unable to provide all of the answers. The family did not actually expect concrete answers but wanted to explore these questions. The intensive care team members were present most of the time, provided compassionate care, and allowed constant access to the family. The team and family jointly explored the spiritual issues. Interestingly, he never complained and was always cheerful, something very unusual for someone who had gone through so much.

His disease progressed to a point where it was obvious he was going to die. Aggressive medical management was continued and emotional and psychological support provided. Two days before his death, his wife told the caretakers how much he loved and missed his dog. ICU policy prohibits pets but this was overruled, and the dog was brought in after visiting hours. Seeing his dog was his happiest moment; there was clearly a very strong connection between the two. He died the following day in peace. My team provided comfort care until he died. Two weeks later, the family requested that the intensive care team be present at the memorial service and were happy to see them there.

The spiritual care provided helped the primary intensive care team to connect with the patient and his family. The spiritual themes demonstrated here include constantly being present and listening, developing a strong caretaker-family relationship, jointly exploring the existential problems relating to dying, trying to provide hope, and having a

positive attitude. Hope in this case was not to promise immortality but to assure the patient and family that the caretaker would be there until the end.

*Case 2*

A 30-year-old man who was a senior officer in NATO came to the United States for treatment of testicular cancer. His government supported his expenses because at one time he had been a national hero who had led the Air Force to defend against the enemy troops. He and many expert physicians and surgeons had done extensive research into this type of cancer and felt he needed to come for treatment at a hospital known for treating this disease where the surgeons had more experience and knowledge of this type of case than anyone else in the world. It was a very difficult cancer to remove, but, because of his youth, the surgical team agreed to perform the 10-hour surgery. The surgical incision was from the abdomen to the neck and all the possible tumors were removed; he was then given chemotherapy.

Five years later he had an extensive recurrence involving the lungs. He contacted the professor-surgeon again, but everyone who went through his reports felt that he was beyond any form of surgical or medical intervention. With great reluctance, the surgeon explained to him that nothing could be done. Within a week, the patient was at his doorstep begging the surgeon to do something. The chances of any cure were less than 1%, but the surgeon agreed. The surgery took 14 hours and involved major blood replacement and removal of major portions of both lungs, which were significantly affected both by the disease and by the previous treatment. For the 2 months following surgery the patient needed to be supported by a respirator. During this time his tumor increased, but he remained completely alert and understood what was happening.

The team had many discussions about what to do, and it was felt that any attempt of treatment would be futile. Some experts even suggested that he be placed on terminal sedation, a form of passive euthanasia. The patient was intelligent and knew he was going to die, but he still wanted to live and felt that life on a respirator was better than simply dying. Several meetings were held that emphasized comfort care, pain relief, and symptom management. The ICU staff developed a close connection with him, and that made him happier.

His condition continued to deteriorate, and he realized that he would not last even a few more weeks. He had only one friend in the United States, and indicated that he wanted to go home to Greece to see his friends and family before dying. The ICU team was agreeable to that idea, even though it involved many hurdles, including the nature of his illness, transportation difficulties, the number of personnel involved, and the reluctance of the airlines to transport such a sick patient. Finances were not a problem because the Greek embassy was willing to support the cost, and eventually Pan Am agreed. They were willing to give the patient the space but would not make any special accommodations for the respirator or monitors. The team consisted of a senior ICU physician, an experienced ICU nurse, and a senior respiratory therapist.

During the morning of our transport, his condition deteriorated. Two of the team members began praying because they wanted to fulfill his wishes. He was bleeding from his lungs. No one believed he would even survive the trip to the airport. There were many setbacks along the way. During the transfer from Pan Am to Olympia Airlines in New York the ambulance ran out of oxygen, and medication had to be administered to sedate him; the airline would not allow the use of more than two liters of oxygen; he had

suffered cardiac rhythm irregularities during the flight. The plane landed in his capital city after an 18-hour journey, and his government transported him to one of best hospitals nearby. The sedation was stopped and, when he woke up, he was told he was in his homeland. All of his friends and relatives, including his parents, were there. The trip was both a success and a disappointment because he had been flown back to his homeland to die. The team said goodbye to him, they cried, and in a few days he died. Two months later the Prime Minister's wife, an active member of the government, visited the hospital in the United States to thank the members of the team and the institution.

This case illustrates another component of spiritual care. Part of spiritual care is to listen to the patient's wishes. This man accepted the finality and inevitability of death, but it was very important for him to be in his own country. Caretakers should listen and, as much as possible, try to grant patients' last wishes because this fulfills the spiritual needs of the patient, friends, and family members.

*Case 3*

An 86-year-old African American female was admitted to the ICU suffering from sepsis. She had a history of extensive cancer and had undergone multiple rounds of chemotherapy over the previous five years. She was well educated, had many friends, and had been one of the pioneers in the Civil Rights movement, working along with Martin Luther King, Jr. and Rosa Parks. Her daughter, who was a television reporter, wished for everything to be done to keep her mother alive.

Many oncologists involved in the case felt that the patient's disease was so far advanced that the daughter should think of withdrawing treatment. However, these providers failed to understand the spiritual aspects of the patient and her family. Over the

previous decades, the family had adopted Buddhist beliefs but remained connected to other religious groups, including Christians and Jews.

Even though the patient appeared old, her family members felt that she was still leading a very productive life and was able to help people in spite of the fact that she was dying. A strong conflict developed between the primary doctor, who advised withdrawal of care, and the family, who wanted everything possible done. The role of the intensivists was to relieve pain, provide breathing support, and treat the infection. The team felt that the family was not prepared for the patient's death, that they were emotionally vulnerable, and they needed a few days to process what was happening. Thus, the intensivists felt it was best to continue to provide care in all ways possible until the family reached an understanding and resolution.

The patient was in the ICU for more than a month, during which time the conflict between the family and primary team became worse. However, the family developed a strong and trusting relationship with the intensive care team. Eventually, the ICU team was able to connect with the family to such an extent that they were able to explain the situation and pacify the anger the family felt toward other physicians. In a way, they became the primary physicians. One month later she died a peaceful death. The family was relieved and happy to know that their loved one had received the best treatment, which included spiritual care. Two weeks later the intensive care team was invited to the memorial service where they were introduced to many well-known Civil Rights activists. Her daughter spoke about the compassion, love, and spiritual issues that were part of her mother's care while she struggled with cancer.

In this situation, religion was not discussed. The spiritual care consisted of simply being present, understanding the family's expectations, and becoming connected to them. Initially the family felt that the primary doctors did not listen to their requests and wishes and did not integrate their beliefs in the total care of the patient. In many ways the intensive care team was able to pacify them and take away some of the anger they had for other physicians. The ICU team became the mediators and helped the family forgive the other doctors.

*Case 4*

An 80-year-old Egyptian male urologist trained in the United Kingdom who had practiced in Egypt and was now retired and living with his son and daughter in California was diagnosed with kidney cancer. As a surgeon, he had been an expert in the same type of cancer and ironically had performed many similar surgeries for this disease. After significant research, he felt that the surgeon at my institution was the ideal person to perform his surgery.

He had other coexisting conditions including emphysema, diabetes, high blood pressure, macular degeneration leading to blindness, and untreated depression. Further testing revealed that the tumor was very large and was invading other tissues and vessels. This information as well as his poor general health caused him to change his mind and he opted not to have surgery. His wife and children pressured him to come to Norris Cancer Hospital, however, and have the tumor removed. The intensive care team was skeptical about the success of the surgery because he was at a great risk for complications, but the family made the decision to operate. The patient himself had a very negative attitude prior to surgery.

The ICU team took care of him diligently while in the operating room and in the intensive care unit. After surgery he needed to be on a respirator, and his other kidney failed. Eventually he was weaned off the respirator, and at that time he stated that he no longer wanted to live because of the poor quality of his life. He felt he should be left to die. Still, his family asked that everything possible be done to keep him alive. At this time, they stated that he had lost most of his vision for the last few years and had become very withdrawn because of his inability to work as a surgeon.

During the period he was in the ICU, many calamities happened involving his close family members. His grandson became sick with a major illness and his daughter's father-in-law died of a heart attack, and she and her husband had to go back to Egypt. His wife had unrealistic expectations that he would recover and go back to work. These incidents affected the family greatly. There were also some language barriers even though they spoke English fairly well. The intensive care team worked hard with the family in trying to understand their problems.

The patient's respiratory status deteriorated and he was placed back on a respirator at the family's insistence. He was kept comfortable, but 3 weeks later x-rays of the chest showed his lungs to be full of cancer. It was felt that the cancer had likely also spread to his brain. The fact that it had spread so rapidly was a surprise because this is normally a slow-growing cancer. His poor prognosis was explained to the family, and after much struggle and turmoil they eventually accepted it. He was given comfort care and passed away peacefully. The intensive care team continued to support the family through the grieving process and even attended the funeral. After a few weeks the family seemed to have accepted his death.

This case illustrates many issues. First, the patient himself knew from his own professional experience and his inner feelings that his cancer was not curable. Everything was done against his wishes and without his support. Second, it was an emotional rollercoaster for him as well as the caretakers due to the unreasonable demands of his family, which may have been in part the result of cultural differences. Third, the family was only concerned with science and the rational aspects of his care. Until it became futile due to the recurrence and spread of his cancer, his family refused to accept that he was going to die and were in denial. Though the family was in denial, the ICU team was present all the time. Eventually the family became convinced that the team was fully involved with the care and was trying to act in the best interest of this man.

*Case 5*

A 68-year-old male from Italy was diagnosed with bladder cancer. He was a wealthy businessman who was referred by physicians in Rome to my hospital. He was to be operated on by the chief surgeon of urology who had the reputation of being the best in his field. Unfortunately, during the surgery the patient suffered a heart attack. He was admitted to the ICU and suffered numerous setbacks, including shock, heart failure, and cardiac arrhythmias. His wife and two sons had all come from Italy on their first visit to Los Angeles and were always present at his bedside. The ICU team understood the problems the family was facing not only from a medical perspective but also in light of the fact that they were far away from home and in an unknown environment. Only one son was fluent in English, and, because of communication difficulties, the team had to rely on nonverbal communication, gestures, and facial expressions to make the family

comfortable. Even without the benefit of spoken language the ICU team became very close to the patient and his family.

There was a decision to be made regarding whether his heart condition needed to be fixed in Los Angeles or whether he could go back to Italy and see his own doctors. At that time in Italy only a few physicians were able to perform the cardiac surgery he needed, and Americans were far advanced in this field. Everyone agreed that this operation should be performed here even though it was a high risk procedure. The patient was therefore referred to another highly reputed institution in the area and he was transferred there. An ICU physician accompanied him during transport to make him more comfortable on his arrival to a strange hospital. Unfortunately, the next day the team learned from the other institution that during surgery his heart could not be restarted and he had died. The ICU team members joined the family to provide moral support and help with the grieving process, because the patient did not have any relatives here, though they had a few friends.

The family was very grateful for the ICU team and the effort they had made in taking care of the patient. The ICU physicians decided not to charge for their services because the family had traveled all the way from Italy and, due to their lack of insurance, would have had to pay them cash on top of the large amounts they had already paid the hospitals and other physicians.

This case report emphasizes empathy, compassion, support of the family through the grieving process, and the altruistic act of providing free service even though the hospital and other physicians did not waive their fees. True spiritual care promotes

altruistic behavior. Many physicians are indifferent and oblivious to the financial struggle of the patients and family.

*Case 6*

A 21-year-old patient was admitted to the ICU for difficulty in breathing. Initially this was attributed to pneumonia, but within the course of a few days the patient's symptoms deteriorated, and further examination showed his symptoms were due to cancer that had spread to his lungs after initially being confined to the abdomen. For 6 months his cancer was treated aggressively with chemotherapy, but it had not responded well. His parents were completely shattered. In the meantime, the ICU team was able to optimize his breathing status and wean him off the ventilator.

The patient and his family were then informed that he had less than a month to live. He was depressed and continued to have breathing difficulties due to his disease. Even though he was on high-dose morphine, his distress and suffering continued. Many other forms of supportive therapy were tried without any success, and other specialists were consulted for advice, but nothing seemed to work.

Eventually the ICU team tried ketamine, a drug not usually used in the treatment of depression but that had been recently reported to have some success. This drug worked extremely well for him and allowed other antidepressants such as desipramine, which had not been very effective previously, to have a much more therapeutic effect.

The patient's mood noticeably improved, and he began to interact more with his family, his girlfriend, and the ICU staff. Despite his continued difficulty with breathing, he remained cheerful and without complaints until the day he died.

A spiritual physician should strive to achieve maximum competence by learning, applying, asking for help and second opinions, and being up-to-date with the latest literature. In this case, competent physicians tried to find the latest advances in the area of total care. Science and spirituality need to exist together and care cannot simply be left to only one of the two aspects. (The above is modified from a paper presented at the American Society of Critical Care Anesthesiologists)

*Case 7*

A gentleman in his mid-60s, who was the CEO of a reputable and prominent company in the US, was diagnosed with recurrent, inoperable prostate cancer. He was initially operated on in at a hospital on the East Coast, but the cancer recurred several years later and spread to his lower pelvis. Many surgeons felt that his cancer was inoperable. He also contacted a surgeon in California who was an international expert in this type of surgery and inquired about the possibility of another operation. Since the disease was extensive and terminal, the surgeon was hesitant even though the patient was willing to take the risk of reoperation. The risks were high due to the patient's debilitated state and the extent of the disease. The surgery was extensive and lasted over 10 hours, requiring many pints of blood. His immediate post-operative course was satisfactory, and he was cared for in the ICU.

While the surgeon felt that he had removed the entire tumor, the patient required more than the usual dose of pain-relieving drugs because he was experiencing intense pain. The ICU physicians felt that the pain was real and was possibly due to residual tumor that could not be removed during surgery. The ICU team was therefore aggressive in the patient's pain management, whereas the surgeon and the patient's young wife were

in denial that the pain was real and felt that the aggressive type of pain management might cause addiction. The nurses agreed with the ICU physician that his pain was genuine.

The patient's surgeon and wife transferred him to another unit where another pain physician was willing to stop the pain medication. For 2 weeks he suffered from continuous pain as the conflicts continued. After 2 weeks, the pain became so excruciating that he needed another surgery. When they attempted to operate, they found that the cancer had spread and covered the entire abdominal cavity, and a few hours later he died.

This risk to this patient was extremely high but the surgeon proceeded due to his high-profile status. Furthermore, his family and the main surgeon were in denial about the true nature and extent of the disease. Because of the patient's status, the surgeon tried a heroic surgery, which only prolonged his suffering. He should never have been subjected to such a complicated surgery that then left him in excruciating pain for 2 weeks. The main surgical team did not listen to the ICU team about the possibility of the genuine nature of his pain and the recurrence of cancer. This is an example of doctors trying to play the role of God. Death many times is not preventable, especially in the case of widespread cancer. Life and death are full of mystery, and physicians cannot always provide the answers. (Puchalski, 2002)

## Summary of Case Reports

The case reports describe and highlight the nature of spiritual care rendered by the caretakers. They also reveal the characteristics and conduct of the caretakers in these emotional and end-of-life situations. They emphasize the importance of relationships,

understanding, listening, and being present with patients. The reports also address the importance of empathy, competence, altruistic behavior, respect of others, and human dignity. Spirituality also helps the caretaker cope with anxiety, depression, acceptance of failure and death, and in many cases is a positive, transformative, and valuable experience. Each patient must be valued on his or her own merits; one must not be judgmental, or prejudiced relating to religion, culture, age, or race. Care must be individualized and should not be solely driven by protocols because this leads to ambiguous, demoralizing, and dehumanizing care. While physicians and other caretakers must use their judgment when it comes to medical decision-making, they must not be judgmental when it comes to the spiritual care of a patient.

## Survey Findings

### *Physicians' Responses*

The survey showed that the physicians strongly agreed that spirituality is important in treating the terminally ill patient and that there is a connection between spirituality and end-of-life care. They felt that spiritual care instills hope, minimizes suffering, and creates optimism in patients. They strongly felt that it is an important part of holistic care and an essential component in hospice care, and that spiritual care should be started early in the disease process. They also felt that physicians should continue to communicate with the family during the grieving period and have a healthy attitude and tolerance regarding diverse cultures and beliefs. Also, it is important to note that most physicians felt that prayer and special rituals should be allowed to occur in the hospital, but felt that most physicians are not currently well trained in the area of spirituality.

They believed that spirituality helps to develop positive qualities in the physician, such as putting the interest of the patients first, being humble and authentic, admitting their limitations, and maintaining a positive attitude. They also felt that spirituality helps in coping with failures, disappointment, and death and in respecting other caretakers. (See Table 1 and Table 3 in Appendix B)

*Nurses' Responses.*

The results of the nurses' survey revealed that they supported the attending physicians' viewpoints. (See Table 2 and Table 4 in Appendix B)

*Summary of Survey Results.*

Overall, it was apparent from the survey that both groups had very similar views. There was no significant difference of opinions on any of the questions answered. The perspectives of the nurses were in agreement with the physicians on most issues, as seen in Table 5.

Physicians were in agreement that they are not adequately trained to deal with spiritual issues, whereas nurses felt less strongly that this was the case. In response to the question, "should physicians consider spiritual care to be an important part of integrated or holistic care?" physicians were strongly affirmative, whereas the nurses were affirmative but not as strongly. Physicians more than nurses also felt it was very important to continue communication with the family after a patient's death, as seen in Question 19. Both groups strongly agreed that spiritual care is important with terminally ill patients, and also strongly agreed that physicians should continue to communicate with the family during the dying and grieving periods. Both groups strongly disagreed with

the statement that spirituality and care of the terminally ill are not connected to one another. They strongly agreed that spiritual care instills hope in terminally ill patients, spiritual care minimizes the suffering of terminally ill patients, spiritual care gives rise to optimism in patients, spiritual care helps to deal with caretaker burnout and exhaustion, and spiritual care should be an essential component of hospice care. The groups were neutral in the areas of family expectations such as expecting the physician to be spiritual or expecting the physician to pray with the family and patient (Oldnall, 1996). On the question addressing whether only certain physicians could provide quality care to these patients, both groups were neutral.

## Chapter Summary

In this study, the perspective of the physicians and nurses is that the spirituality of the caretakers helps in providing spiritual care. They agreed that there is a correlation between the spiritual care given and the quality of life. Spirituality also helps the caretakers to cope with the stresses, anxieties, and disappointments related to caring for a dying patient. Many felt that spirituality makes them more creative and helps them experience growth and maturation.

The perception of the physicians was compared to the responses of the nurses. Their results correlated with those of the physicians, although the strength of the responses was slightly less on certain questions. Nurses are more focused on the relational aspects of care.

# CHAPTER 5

# SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

## Summary

Awareness of the importance of spirituality in medical care has increased recently among both the medical community and patients (Roof, 1993). Many people use the term spirituality, but only few know the actual meaning of it relating to the care of terminally ill patients (Rose, 2001). Regarding care of the terminally ill, the body of literature that deals with spirituality in medicine has been increasing. Current studies strongly support the need for spiritual care, especially at the end of life. Spirituality has been shown to help patients by giving them a sense of hope, direction, and meaning, inspiring compassion and empathy, and allowing acceptance of their terminal condition and death with dignity (McGrath, 2002; Rumbold, 2002).

Many terminally ill patients have a protracted course of dying, which may result in a significant degree of suffering. Physicians and nurses may have issues when treating these patients regarding their own competence and the possibility of failure because of an inability to cure the patient. Currently, most physicians and nurses are not trained to deal with ultimate questions and existential issues of the final days of life. Many caretakers are skeptical about the therapeutic benefits of spirituality and religion, and they may minimize their involvement in any type of spiritual care. Other caretakers are reluctant to get involved in spiritual care because they believe they are going beyond their scope of

duty, and they would rather adhere to symptomatology protocols. Cicely Saunders emphasized the spiritual needs of patients and felt these needs were often not addressed adequately by physicians and nurses (Saunders, 1988).

It is important to examine physicians' and other caretakers' perspectives regarding the therapeutic effects of spirituality and determine if spirituality improves the quality of care of the terminally ill. Spirituality makes the physician more accepting of the existential issues of the patient, more open to others' opinions and input, less egotistical and narcissistic, and more competent in providing care (Kramer, 1988). If the caretakers are not spiritual they may have difficulty understanding the spiritual issues of the patient.

Before the 20th century there was a strong component of spiritual care incorporated into medicine. Historically, in many cultures spiritual leaders joined as healers in the care of the terminally ill (Sulmasy, 1997). The caregivers of the past focused their attention on total patient care: the physical, psychological, spiritual, and social aspects of care. They also incorporated the community in the care of the patient. This relationship between medicine and spirituality became strained over the last hundred years, partly due to the split between science and religion. In the last two decades, caregivers have realized that, in spite of the significant progress made medical science, patient emotional and spiritual suffering have not been reduced. Most patients and families wanted spiritual issues to be addressed, and this made caretakers realize the importance of spirituality as a part of the total care of the patients (Marler & Hadaway, 2002).

When defining spirituality, a broad definition is preferable to include and address the needs of a diverse group of patients. It may or may not be inclusive of religiosity, God, sacred symbols, or a higher power, but must include the relational aspect of care that involves humanity. Some people find spirituality in nature, cosmos, ecology, art, music, and other areas of life that give them fulfillment (Hill et al., 2000). Most caretakers prefer a definition that includes holism, authenticity, the meaning of life, existentialism, nature, and community.

Spiritual practices can be traced to prehistoric times relating to the rituals of the Neanderthal and Cro-Magnon (Armstrong, 2006). Spiritual transformation became more pronounced during the Axial Age, the period from 800 BCE–250 CE. In Israel, spiritual figures such as Jeremiah, Isaiah, and Elijah contributed to spiritual transformation. Later, Christianity played a major role, and St. Paul was instrumental in universalizing the spiritual themes of love and faith. St. Francis and St. Augustine were other influential spiritual figures of early Christianity. In India, Hinduism, Buddhism, and Jainism changed traditional practice, while Confucius and Lao-Tzu did the same in China (Armstrong, 2006). From the 10th to 14th century in the Middle East, Sufi philosophers developed spiritual ideas that differed from the traditional dogmatic Islamic views.

During the Middle Ages in the western world, Eckhart, Steiner, Emmanuel Kant, and Swedenborg incorporated many spiritual ideas in their philosophies and practices. Other philosophers such as Hegel, Spinoza, and Kant moved away from the dogmatic and empirical ideas of Hume and formulated broader, universal spiritual concepts. Existentialist philosophers and phenomenologists, especially Marcel, Jasper, Heidegger, Nietzsche, Schopenhauer, Kierkegaard, and Tillich contributed to this spiritual

development with many appropriate ideas relating to life and death. Their essential themes were freedom, choices, and acceptance of death. American transcendentalists such as Thoreau explored the relationship between nature and spirituality.

Pioneering psychologists including Freud, Jung, Erikson, and Assagioli examined the issues related to the latter part of human life, emphasizing the areas of development, death, and the transformation process. Erikson focused on the final stage of life, while Jung focused on the individuation process and transformation. Many Jungian psychologists, such as Hillman, further explored this line of analysis and postulated concepts on the acceptance of end-of-life issues. Assagioli, a contemporary of Jung and Freud, focused on psychosynthesis, which involves the synthesis of various aspects of one's personalities (Assagioli, 2000). Existential humanist psychologists Maslow, Rogers, Binswanger, Boss, Frankl, and Bugental focused on practical spiritual issues that include authentic relationships, compassion, responsibility, listening, understanding, sense of harmony, and transformation (Maslow, 1971).

Research relating to body-mind medicine and quantum mechanics have become popular study areas of late. Quantum physics theories support human subjectivity and the concept of universal consciousness. Body-mind medicine emphasizes the strong connection and interrelationship between the two and supports the concept of mindfulness (Pert, 1999). Body-mind medicine incorporates many forms of eastern medicinal practices including Tai Chi, Chi Gong, yoga, and meditation.

Many scientists and physicians have attempted to incorporate spirituality into science, including Paracelsus, Pascal, Newton, Einstein, Pauli, and Planck (Wilber, 1984). There is now a growing acceptance by scientists that science and religion can co-

exist and are complementary to each other (Larson, 1993). Many scientists believe spiritual practices increase the release of natural healing hormones and neurotransmitters in the body, induce neuroplasticity, which controls behavior, influence one's state of mind, and promote self-healing (Larson, Sawyers, & McCullough, 1997).

Recently, many social scientists and gerontologists, such as Baltes (from the Planck Institute), Carstensen, and Tornstam, are focusing on successful aging concepts and emphasize spirituality in their models. Baltes also focused on lifespan development and the final days of one's life. According to him, human beings develop through successive experiences of gains and losses with more gains in the earlier stages of life and more losses as one ages. The compensation process as one gets older includes incorporation of belief systems, especially religious and spiritual beliefs. This compensation takes place in the form of self-transcendence, which supports the ability to accept loss. Self-transcendence involves the ability to live fully in the moment without regret for the past. It also focuses on the meaning and purpose of one's existence.

Tornstam introduced the concept of gerotranscendence, which is a desire to be one with the universe and accept the mysteries of life as one ages. Gerotranscendence encompasses the development of increased awareness, resilience, and the capacity to accept the uncertainties and vicissitudes of life (Tornstam, 2005). He also focused on self-understanding, meaning, and the importance of relationships. Kubler-Ross emphasized that death was the final stage of growth and used this concept in the development of hospice care.

Martin Seligman, an expert on positive psychology, performed his studies on animal models (Peterson & Seligman, 2004). Positive psychology gives one a feeling of

optimism and helps to reinterpret negative events, thereby adding hope and courage. It also enhances interpersonal skills and perseverance, gives capacity for insightfulness, and builds strength to buffer against depression.

Guarneri, the well-known cardiologist from Southern California, discussed body and mind medicine and advocates the development of habits, which minimize stress. Many current studies confirm the fact that patients suffer in the final days of their lives (Ventafridda, Ripamonti, Tamburini, Cassileth, & DeConna, 1990). These studies also validate the beneficial effect of spirituality on the immune system, which minimizes infection, a very common cause of death in the elderly. Kuhl (2002) discussed the spiritual needs for love, meaning, purpose, and transcendence, as confirmed by Moadel's (1999) study. Kearney (2000) and others addressed the importance of maintaining control and dignity while suffering in the final days.

Brandt emphasized the importance of maintaining hope and stated that spirituality instills hope that goes beyond the grave (Brant, 1998). Kissane (2001) developed the concept of the demoralization syndrome, which is prevalent in terminal patients and includes hopelessness, helplessness, meaninglessness, and existential distress.

Major empirical research papers were analyzed regarding the benefits of spiritual care and the relationship between spirituality and the work of medical personnel such as physicians, nurses, and psychologists. While most of these papers concluded that spirituality was important, very few studied the importance of the spirituality of the physician. Sulmasy's (1997) research revealed that spiritual doctors provided better care compared to those who were not spiritual. Most of the issues that dying patients confront are spiritual in nature. The question is whether the spirituality of the physician correlates

to the quality of care they provide, especially when dealing with terminal patients. (Markam, 2000; Lynn, 2000)

Both theoretical and empirical studies have addressed the issue of spirituality. Throughout these studies, recognition was given to the need for a multifaceted and multidisciplinary approach. The question of how the practice of spirituality relates to each objective was the focus throughout this dissertation. The following is a restatement of the objectives.

The objectives of this review and the study were to:

1. evaluate the spirituality of the caretaker;
2. evaluate how spiritual care is provided practically by the caretakers;
3. ascertain if spiritual care is of benefit or improves the quality of care of the terminally ill patient; and
4. evaluate the beneficial effect of spirituality on the caretaker, patient's family, and the community.

## Conclusions

All the physicians interviewed and surveyed agreed that spiritual care should be provided to terminal patients. Some believed it was more comfortable for them to discuss spirituality with the patient if the discussion involved their own religion or a religion with which they were familiar. Rather than discussing spirituality directly, most physicians focused on the practical aspects of spiritual care, such as listening, having compassion, being present, not abandoning the patient, being truthful, accepting limitations, and providing integrated care. Physicians had difficulty accepting the loss of patients. Less than half of them agreed that their own spiritual beliefs allowed them to

accept the dying process without any major emotional impact. Others mentioned that they had to pray and speak to mentors or seek spiritual support to deal with the death of their patient.

Physicians agreed that each patient provides a transformative experience enabling them to gain knowledge and wisdom. Most also agreed that there is some life force after death and felt that they were connected to their patients. Some felt this connection is predetermined and is the reason a patient comes to be treated by them in the first place. They all agreed that spirituality gives patients a better quality of life, provides hope, enables them to accept death, and minimizes depression, anxiety, and suffering. Additionally, all believed that spiritual care alone is insufficient and must be incorporated with competent and scientific medical care. Finally, a few said that they have had spiritual experiences, and half of the caretakers had experienced miracles in their own lives, separate from their patients.

*Analysis of Case Studies*

The case studies illustrate that each individual is unique and emphasize the importance of the patient-doctor relationship. Spirituality strengthens this relationship and provides mutual respect to the physicians, patients, families, and other caretakers. If the leading caretaker is spiritual, this attitude has a positive effect and guides and facilitates the interaction with other caretakers. The presence of the primary physician encourages others to pay more attention to the patient's needs. A recent study of teaching techniques showed that most medical residents agreed that they learned more from informal discussions and bedside contact than from formal lectures. This illustrates the importance of the spiritual behavior of the physician/teacher.

Each dying patient has his own journey and the physician, nurses, and other caretakers become a part of this journey. These case studies also show that it is important for physicians to be sensitive to cultural and religious differences. The physician's own life experience helps him or her to understand what others are experiencing, including the patient, family, and others who are involved in and affected by the care provided. Depending on the needs of the family, the physician may need to continue the relationship with the family through the grieving period, while maintaining appropriate boundaries. From these case studies, it is clear that the spirituality of the physician plays a crucial role in the care of the patient and brings increased awareness of the importance of spirituality to the caretakers.

*Research Objectives*

Research Objective #1 was to evaluate the spirituality of the caretaker and determine what the term spirituality means to the caretaker. The most frequent response given was that spirituality goes beyond religion and is much broader, but is still inclusive of some aspects of the respondents' religious views and philosophy. Spirituality, however, goes beyond religion to include a one's understanding of one's place in the world, the meaning of one's life, and one's ultimate destination after death. Spirituality also involves love and respect for other human beings, which should be translated into action rather than remaining an abstract concept. With regard to the physician, it implies a mutual respect for others' religious or spiritual beliefs and tolerance of differences. It also involves humility and accepting one's own limitations in the setting of dealing with the mysteries of life. As a physician, the relationship with the patient is a sacred one.

Objective #2 was to evaluate how spiritual care is provided practically by the caretaker. Spirituality includes various forms of practical care that can address the physical, emotional, and psychological well-being of the patient. These aspects are respect, being physically present, listening, and understanding what the patient is going through (empathy), trying to be competent and truthful, and asking for help in areas in which one does not have expertise (coordinating care). Spirituality helps when attempting to give hope even beyond one's death and in not abandoning the patient. It allows one to open one's mind to alternative therapies such as music or nature therapy, and spiritual practices such as prayers, chanting, and other rituals that do not interfere with patient care. It helps the physician support the patient's family and other caretakers and to prevent burnout. It allows for forgiveness; patients and families can at times be emotional and distressed resulting in illogical behavior that one must be able to forgive.

Research Objective #3 was to determine if spiritual care is of benefit or improves the quality of care of the terminally ill patient. All respondents answered "yes" to this question. According to them, spiritual care instills hope, minimizes suffering, and gives a sense of optimism and positivity. Families often become exhausted emotionally, physically, and economically when they have a terminally ill loved one. Respondents stated that, in their practical experience, families are more at ease when they sense that spiritual care is being provided. Even if the family is not religious, they appreciate spiritual care as a better quality of care that also improves the doctor-patient relationship. Those that are deeply spiritual and religious are not in favor of euthanasia but are supportive of the idea that a patient's life should not be continued by extraordinary means indefinitely, especially when adding to the patient's suffering.

Objective #4 was to evaluate the beneficial effect of spirituality on the caretaker, the patient's family, and the community. Again, all agreed that their own spirituality and their own personal practices help them cope with issues related to dying. They either pray, meditate, chant, or call a spiritual mentor, pastor, chaplain, or close friend. Spirituality helps them to accept the finality of the patient; they thus do not have to feel that they have failed. It helps them accept this loss. Most interviewed believe that there is some kind of afterlife and felt a connectedness to another life. More than half said they are not afraid of death, because they feel death is a continuation of life. Despite not being religious, one participant felt himself to be connected to the patients, and in some way connected to the life force.

Many also felt that spirituality helps them stay with their patients rather than abandon them. It is not uncommon for physicians to abandon a terminal patient without realizing it because it is difficult to see the patient suffering, and this creates a sense of personal failure on the part of the physician (Byock, 1994).

Spirituality also allows physicians to accept their limitations and deal with the mysteries of life. It helps them to understand their own life and future. Some of those interviewed felt there is no inherent meaning in life and, therefore, one has to create meaning, which indirectly relates to Joseph Campbell's famous saying, "Follow your bliss." Some interviewed stated that their faith had become stronger through these caring experiences. If they have provided their best spiritual care they are free of guilt, and the experience transforms them to a higher level, reflecting that spirituality absorbs all of the anxieties and insecurities related to caring for the terminally ill.

Physicians not involved with providing spiritual care may experience guilt, and it may affect their own physical and mental health. Many stated that they have observed younger, inexperienced physicians not trained in the area of spirituality experience difficulties in coping and suffering from stress-related symptoms. Physicians exposed to the provision of spiritual care, however, become more competent and develop higher emotional intelligence.

When spiritual care is provided appropriately by the physician, family members verbalize greater satisfaction and contentment with the holistic nature of this care. The family, close friends, and relatives appreciate the care provided, and this has a positive effect on the community. Nurses, other personnel, other caretakers such as social workers, and others working closely with the patient also feel satisfaction knowing that they have provided total care to the terminal patient.

## Recommendations

Since this study was conducted at one location and involved a small number of subjects, in the future a multicenter study should be performed. Future studies should also involve a more diverse group of patients because, in this study, the focus was primarily on cancer patients. This study was conducted at a university setting; many patients, however, are cared for at community hospitals and clinics and, therefore, studies should also be performed at these locations as well. It is also important to receive input from family members and other caretakers involved with these patients on a regular basis, such as nurses, social workers, physical therapists, and respiratory therapists.

Many Christian hospitals, including Adventist hospitals, have a more organized system designed to incorporate spirituality in end-of-life care as compared to other

hospitals, and some universities currently have a curriculum for spirituality. There is still no requirement, however, to provide spiritual care to patients. Based on this study, it is important to increase awareness of spiritual issues, initiating a curriculum for all medical students, residents, and nurses. The success of these programs would then need to be evaluated. Currently, there exists no mechanism to monitor the quality of spiritual care provided, and the formulation of such a mechanism is vital to ensure that optimal encompassing care is rendered to end-of-life patients.

Physicians who are not experts in spiritual care should encourage or delegate spiritual communication to other members of the interdisciplinary team when they interact significantly with terminally ill patients. For example, many oncologists are more interested in laboratory research relating to molecular biology and the pathophysiology of diseases than in hands-on care. While these issues are important, physicians more capable and willing to provide the spiritual care necessary for patients with terminal illness should be the ones with direct patient involvement. Currently spiritual care is not taught at many medical schools, nursing schools, or residency programs. There is no requirement to have even a curriculum. Many teachers are reluctant to teach spiritual care, believing it should be left to clergy or priests, and a few consider it as unscientific even to consider. This type of attitude is an impediment to the total care of our patients. As caretakers we must be aware of the importance of spiritual care and must have the courage to teach, train, and guide for the benefit of patients (Palmer, 2007).

There are several other issues that need to be addressed. First, even if one is spiritual, it is important to have some understanding of the cultural and religious

backgrounds of patients and their families and to develop healthy attitudes, awareness, and tolerance for these patients' preferences. The amount of time a physician has available to spend with a patient is another issue. Presently, due to the stresses in the current healthcare system, physicians often do not have time to deliver certain aspects of spiritual care that may be more time consuming. In addition, palliative care personnel usually are not involved in patient care until the final stages of the disease; it is important for them to become involved earlier in patient care and to be trained in spiritual issues. Patients and family members should be encouraged to give feedback on their caretakers and the nature of the spiritual care provided by them. The interdisciplinary team should include members that represent the community, including priests, spiritualists, theologians, or spiritual psychologists who have expertise in these areas to elicit feedback from them.

Physicians and other healthcare providers must have a broader view of spirituality. Spirituality should go beyond religiosity and involve authentic relationships with focus directed at the more practical aspects of care. There may be ethical problems related to how much a physician can be involved with spiritual issues. Physicians must provide spiritual care but not assume the role of a pastor or priest. If patients wish to communicate with a priest, pastor, or chaplain, this could be arranged through the institution, and this individual would be included as a member of the interdisciplinary team. The caretaker team focus should be on helping the patient, with the family, navigate the final days of life.

Fear not. What is not real never was and never will be.
What is real always was and can never be destroyed.
- Bhadgavad Gita

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# APPENDIX A

# INFORMED CONSENT AND QUESTIONNAIRE

## INFORMED CONSENT

**TITLE: END OF LIFE CARE AND SPIRITUALITY**

**PRINCIPAL INVESTIGATOR: DURAIYAH THANGATHURAI, MD, JD, M PSYCH**

**DEPARTMENT: ANESTHESIOLOGY**

**24-HOUR TELEPHONE NUMBER: 323 865 3441**

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**WHY IS THIS STUDY BEING DONE?**

We invite you to take part in a research study. This study is about the relationship of spirituality of health care providers on end of life care of terminal patients. We hope to learn the role that spirituality of providers plays, if any, on the quality of care given to terminal patients. You are invited as a possible participant because of your experience in dealing with the needs of terminally ill patients.

**WHAT IS INVOLVED IN THE STUDY?**

If you are interested to discuss your questionnaire responses and participate in a follow-up interview session, this is what will happen:

1. You will be asked to contact the Principal Investigator to schedule an interview. During the interview session, you will be asked a few more specific questions pertaining to spirituality and end of life care.
2. Duration of interview session is expected to be approximately one hour.
3. Interview sessions will take place at the Kenneth Norris Cancer Center consultation rooms.

**WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

Possible risks and discomforts you could experience during this study include volunteering approximately one hour of your personal time for the interview with you. Some of the questions may make you feel uneasy or embarrassed. You can choose to skip or stop answering any questions that make you uncomfortable.

11/5/07

**WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART IN THIS STUDY?**

You may not receive any benefit from taking part in this study. However, your participation in this study may help us learn the role and impact of spirituality on the quality of care provided to the terminally ill and dying patients facing end of life issues.

**WHAT OTHER OPTIONS ARE THERE?**

You may choose not to participate in this study.

**WILL YOUR INFORMATION BE KEPT PRIVATE?**

The investigator and the Institutional Review Board (IRB) will keep your records for this study private as far as the law allows. We may publish the information from this study in journals or present it at meetings. If we do, we will not use your name.

**WHAT ARE THE COSTS?**

There is no direct cost to participate in this study. However, the study will require you to volunteer one hour of your free time to complete an interview session with the investigator.

**ARE THERE ANY PAYMENTS TO YOU FOR TAKING PART IN THE STUDY?**

You will not be paid for your participation in this study.

**WHAT HAPPENS IF YOU GET INJURED OR NEED EMERGENCY CARE?**

If you get hurt, sick or emotionally upset from taking part in the study, we will give you the medical care you need. You must pay for the care. Normally, you will not receive any compensation for being hurt or sick.

**WILL YOU RECEIVE NEW INFORMATION ABOUT THIS STUDY?**

During the study, we may learn new things about the risks or benefits of being in the study. If we do, we will share this information with you. You might change your mind about being in the study based on this information. If new information is provided to you, we will ask for your agreement to continue taking part in this study.

11/5/07

## UNDER WHAT CIRCUMSTANCES CAN YOUR PARTICIPATION BE TERMINATED?

If you do not follow the investigator's instructions you may be removed from the study.

## WHAT ARE YOUR RIGHTS AS A PARTICIPANT, AND WHAT WILL HAPPEN IF YOU DECIDE NOT TO PARTICIPATE?

Your participation in this study is voluntary. Your decision whether or not to take part will not affect your current or future care at this institution. You are not waiving any legal claims or rights. If you do decide to take part in this study, you are free to change your mind and stop being in the study at any time.

## WHOM DO YOU CALL IF YOU HAVE QUESTIONS OR CONCERNS?

You may contact Duraiyah Thangathurai, MD at 323 865-3441 with any questions or concerns about your participation in this study.

If you feel you have been hurt by taking part in this study, please contact Duraiyah Thangathurai, MD at 323 865-3441.

If you have any questions about your rights as a study subject, please contact the Institutional Review Board Office at LAC+USC Medical Center, IRD Building, 2020 Zonal Avenue, Suite 425, Los Angeles, CA 90033. (Telephone number: 323-223-2340). You will get a copy of this consent form.

## AGREEMENT:

I have read (or someone has read to me) the information provided above. I have been given a chance to ask questions. All my questions were answered. I have decided to sign this form in order to take part in this study.

| | | 11/17/2007 |
|---|---|---|
| Name of Subject | Signature | Date Signed |
| | | 11/17/2007 |
| Name of Witness | Signature | Date Signed |

11/5/07

I have personally explained the research to the subject and answered all questions. I believe that he/she understands the information described in this informed consent and freely consents to participate.

Durriyah Thanasittharm [handwritten] | [signature] | 1/17/2007 [handwritten]

Name of Investigator/Person Obtaining Informed Consent | Signature | Date Signed

Form Valid For Enrollment From
11/5/2007 To 11/4/2008
Institutional Review Board
HS-07-00475

Questionnaire for Physicians

1 = strongly agree, 2 = agree, 3 = neutral, 4 = disagree, 5 = strongly disagree

Importance of Spirituality

1. In the terminally ill patient, spiritual care is important.

   1 2 3 4 5

2. Spirituality and the care of the terminally ill are not connected to each other.

   1 2 3 4 5

3. Spiritual care (as defined) instills hope in terminally ill patients.

   1 2 3 4 5

4. Spiritual care minimizes the suffering of terminally ill patients.

   1 2 3 4 5

5. Spiritual care gives rise to optimism in patients.

   1 2 3 4 5

6. Spiritual care helps to deal with caretaker burnout and exhaustion.

   1 2 3 4 5

7. Spiritual care should be an essential component in hospice care.

   1 2 3 4 5

Importance of Spirituality of the Caretakers

8. Spirituality of practitioners is important in the final quality of care.

1 2 3 4 5

9. Physicians should consider spiritual care to be an important part of integrated or holistic care.

1 2 3 4 5

10. Physicians should consider spiritual care early after the diagnosis/prognosis of a terminal illness.

1 2 3 4 5

Family's Expectations

11. Patients and families expect the physician to be spiritual.

1 2 3 4 5

12. A physician should pray with the family and the patient.

1 2 3 4 5

13. Physicians should continue to communicate closely with family members during dying and grieving periods.

1 2 3 4 5

Qualities of the Spiritual Caretaker

14. Only certain physicians can provide quality care to these patients.

1 2 3 4 5

15. It is easier to work with physicians who are spiritual.

1 2 3 4 5

16. Spiritual physicians are available all the time.

1 2 3 4 5

17. Physicians should discuss spiritual issues with the nurse.

1 2 3 4 5

18. Physicians should have a healthy and tolerant attitude towards diverse cultures and religious beliefs.

1 2 3 4 5

19. Physicians should continue to communicate with the family after the death of the patient, especially during the grieving period.

1 2 3 4 5

20. Physicians should allow flexible arrangements for dying patients to have contact with Nature, such as allowing visiting pets or flowers and plants in patient rooms.

1 2 3 4 5

21. Physicians with life experience can offer more spiritual guidance.

1 2 3 4 5

22. Religion of the physician helps them to deal with spiritual issues.

1 2 3 4 5

23. Physicians should allow prayers in end of life care settings in the hospital.

1 2 3 4 5

24. Physicians should allow special rituals as long as they do not interfere with medical care or the routine functioning of the intensive care unit.

1 2 3 4 5

25. Spiritual physicians are equipped to understand and deal with the struggles that dying patients go through during the end of life stage.

1 2 3 4 5

26. Spiritual physician will encourage other religious leaders to be involved in the patient's care.

1 2 3 4 5

27. Spiritual physicians will respect other caretakers, including nurses and residents.

1 2 3 4 5

28. The spiritual physicians relates to and understands the problems of the family.

1 2 3 4 5

29. Spiritual physicians have a positive attitude toward life and put the family at ease.

1 2 3 4 5

Current Situation

30. Currently physicians are not adequately trained in spiritual issues.

1 2 3 4 5

31. In your opinion, dying patients in the United States do not get adequate spiritual care from physicians.

1 2 3 4 5

32. Physicians are reluctant to discuss spiritual issues with patients and their families because of fear of repercussions.

1 2 3 4 5

33. Currently physicians are able to provide all spiritual aspects needed for end of life patient care.

1 2 3 4 5

Benefits of Spirituality to Caretakers

34. Spiritual care helps the physician/caretaker to cope with failures, disappointment, and the death of patients.

1 2 3 4 5

35. Physicians become more spiritual when they deal with the spiritual issues of terminally ill patients and their families.

1 2 3 4 5

36. Spirituality helps physicians physically and mentally.

1 2 3 4 5

37. Spirituality helps the physician to provide total care involving various forms of treatment, rather than simply relieving physical signs and symptoms.

1 2 3 4 5

38. Spirituality helps not to put financial interests ahead of patient care.

1 2 3 4 5

39. Spiritual physicians are willing to accept their limitations.

1 2 3 4 5

40. Spirituality makes physicians humble and more authentic.

1 2 3 4 5

41. Spirituality allows the physician to put the patient first.

1 2 3 4 5

42. Spiritual physicians feel that they are connected to each other.

1 2 3 4 5

Questionnaire for Nurses

1 = strongly agree, 3 = neutral, 5 = strongly disagree

1. In the terminally ill patient, spiritual care is important

   1 2 3 4 5

2. Patients should be made comfortable

   1 2 3 4 5

3. Spirituality of the practitioners is important in the final quality of care

   1 2 3 4 5

4. Only certain physicians can provide quality care to these patients

   1 2 3 4 5

5. Age and experience of the patient relates to spirituality

   1 2 3 4 5

6. Patients and families expect the physician to be spiritual

   1 2 3 4 5

7. It is easier to work with physicians who are spiritual

   1 2 3 4 5

8. Spiritual physicians are available all the time

   1 2 3 4 5

9. Spiritual physicians favor euthanasia

1 2 3 4 5

10. A physician should pray with the family and the patient

1 2 3 4 5

11. Spirituality and the care of the terminally ill are not connected to each other

1 2 3 4 5

12. Religious institutions provide better care than secular institutions

1 2 3 4 5

13 Physicians should discuss spiritual issues with the nurse

1 2 3 4 5

14. Age of nurse, experience, number of terminally ill patients managed are important

1 2 3 4 5

15. Nurses and physicians should have a healthy and tolerant attitude towards diverse cultures and religious beliefs

1 2 3 4 5

16. Nurses and physicians should continue to communicate with the family after the death of the patient, especially during the grieving period

1 2 3 4 5

17. Physicians should allow flexible arrangements for dying patients to have contact with Nature, such as allowing visiting pets or flowers and plants in patient rooms

1 2 3 4 5

18. Residents and junior doctors are not adequately trained in spiritual issues

1 2 3 4 5

19. At present, nurses either do not have expertise or the time to address spiritual issues with patients.

    1 2 3 4 5

20. Physicians with life experience can offer more spiritual guidance.

    1 2 3 4 5

21. Religion of the patients helps them to deal with spiritual issues.

    1 2 3 4 5

22. Education level of the patient is helpful when dealing with spiritual issues.

    1 2 3 4 5

23. The last days of a patient's life may not be the most appropriate time to address spiritual issues, unless requested by the patient or family.

    1 2 3 4 5

24. Prayers should be allowed in hospitals.

    1 2 3 4 5

25. Special rituals should be allowed as long as they do not interfere with medical care or the routine functioning of the intensive care unit.

    1 2 3 4 5

26. It would be favorable to create a natural and comfortable environment for dying patients, for example, a good view of nature, flowers, artwork, music, etc.

    1 2 3 4 5

27. In your opinion, dying patients in the United States do not get adequate spiritual care.

    1 2 3 4 5

28. Spiritual care is considered to be an important part of integrated or holistic care.

1 2 3 4 5

29. Spiritual care should be considered early after the diagnosis of a terminal illness.

1 2 3 4 5

30. Physicians should continue to communicate closely with family members during dying and grieving periods.

1 2 3 4 5

31. Physicians are equipped to understand and deal with the struggles that dying patients go through during the end of life stage.

1 2 3 4 5

32. Physicians are reluctant to discuss spiritual issues with patients and their families because of fear of repercussions.

1 2 3 4 5

33. Science and the scientific community are able to provide all aspects needed for end of life patient care.

1 2 3 4 5

34. Many physician specialists keep a distance from the nurses, communicate less with nurses, and often do not ask for their opinion or feelings.

1 2 3 4 5

# APPENDIX B

# TABLES

Table 1. Responses of Physicians to Questionnaire

| | Physician | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Question** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** |
| q1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 2 |
| q2 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 4 | 5 | 4 | 4 | 5 | 4 | 5 | 4 |
| q3 | 3 | 3 | 2 | 1 | 1 | 1 | 3 | 1 | 2 | 1 | 2 | 1 | 2 | 2 | 3 |
| q4 | 1 | 2 | 1 | 1 | 2 | 1 | 3 | 2 | 1 | 2 | 2 | 2 | 3 | 1 | 3 |
| q5 | 1 | 2 | 1 | 1 | 1 | 1 | 3 | 2 | 1 | 1 | 3 | 1 | 2 | 1 | 3 |
| q6 | 3 | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 1 | 2 | 1 | 2 | 4 |
| q7 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 |
| q8 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 3 | 1 | 4 |
| q9 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 2 |
| q10 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 2 |
| q11 | 3 | 3 | 3 | 3 | 2 | 1 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 4 |
| q12 | 3 | 5 | 3 | 3 | 2 | 3 | 3 | 4 | 3 | 4 | 2 | 2 | 5 | 3 | 4 |
| q13 | 2 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 1 |
| q14 | 2 | 4 | 3 | 2 | 2 | 5 | 2 | 3 | 3 | 2 | 3 | 3 | 4 | 2 | 2 |
| q15 | 2 | 3 | 3 | 2 | 1 | 1 | 2 | 2 | 2 | 3 | 2 | 3 | 2 | 3 | 5 |
| q16 | 5 | 2 | 4 | 1 | 4 | 1 | 3 | 4 | 3 | 3 | 4 | 4 | 3 | 4 | 5 |
| q17 | 3 | 2 | 3 | 1 | 2 | 1 | 3 | 4 | 2 | 3 | 3 | 2 | 2 | 3 | 5 |
| q18 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 |
| q19 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 3 |
| q20 | 3 | 1 | 3 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| q21 | 3 | 2 | 3 | 3 | 2 | 1 | 3 | 3 | 3 | 2 | 1 | 2 | 2 | 1 | 5 |
| q22 | 1 | 3 | 3 | 2 | 1 | 3 | 3 | 2 | 2 | 3 | 1 | 1 | 3 | 2 | 5 |
| q23 | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 |
| q24 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| q25 | 3 | 3 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 4 | 2 | 2 | 1 | 4 |
| q26 | 3 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 3 | 1 | 2 | 3 | 2 |
| q27 | 1 | 1 | 2 | 1 | 1 | 1 | 3 | 3 | 1 | 3 | 2 | 1 | 3 | 1 | 4 |
| q28 | 2 | 3 | 3 | 2 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 4 |
| q29 | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 1 | 1 | 1 | 2 | 2 | 2 | 5 | 2 |
| q30 | 1 | 2 | 2 | 2 | 2 | 1 | 3 | 1 | 1 | 2 | 2 | 2 | 2 | 4 | 3 |
| q31 | 1 | 2 | 2 | 4 | 2 | 1 | 4 | 1 | 3 | 1 | 2 | 3 | 3 | 3 | 4 |
| q32 | 5 | 5 | 4 | 3 | 4 | 5 | 3 | 5 | 3 | 4 | 2 | 4 | 4 | 4 | 4 |
| q33 | 2 | 1 | 2 | 1 | 2 | 1 | 1 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 3 |
| q34 | 1 | 4 | 3 | 3 | 2 | 1 | 2 | 3 | 3 | 2 | 4 | 2 | 2 | 1 | 3 |
| q35 | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 3 |
| q36 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 3 |
| q37 | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 2 | 2 | 1 | 2 | 2 | 4 | 1 | 5 |
| q38 | 3 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 3 | 4 |
| q39 | 3 | 1 | 3 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 3 | 3 |
| q40 | 2 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 2 | 3 | 3 | 4 |
| q41 | 2 | 3 | 3 | 2 | 1 | 1 | 2 | 3 | 2 | 2 | 1 | 2 | 4 | 3 | 4 |
| q42 | 2 | 1 | 2 | 1 | 2 | 1 | 3 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 4 |

Table 2. Responses of the Nurses to Questionnaire

| Question | Nurses | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| q1 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 |
| q2 | 4 | 3 | 3 | 5 | 3 | 3 | 4 | 5 | 5 | 5 | 5 | 5 | 2 | 5 | 3 |
| q3 | 2 | 2 | 3 | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 1 | 1 | 4 | 2 | 4 |
| q4 | 2 | 2 | 3 | 3 | 3 | 3 | 1 | 1 | 1 | 1 | 2 | 2 | 3 | 2 | 4 |
| q5 | 2 | 2 | 3 | 1 | 3 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 3 | 2 | 2 |
| q6 | 2 | 2 | 4 | 4 | 2 | 3 | 1 | 1 | 1 | 1 | 3 | 3 | 4 | 3 | 3 |
| q7 | 1 | 1 | 3 | 2 | 2 | 3 | 1 | 1 | 1 | 1 | 1 | 2 | 3 | 1 | 2 |
| q8 | 1 | 2 | 4 | 2 | 2 | 3 | 2 | 1 | 2 | 1 | 2 | 5 | 4 | 4 | 4 |
| q9 | 2 | 2 | 4 | 2 | 4 | 3 | 2 | 1 | 1 | 1 | 1 | 2 | 3 | 2 | 2 |
| q10 | 2 | 2 | 5 | 2 | 2 | 4 | 1 | 1 | 1 | 1 | 1 | 3 | 2 | 2 | 2 |
| q11 | 2 | 3 | 5 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 1 | 3 | 4 |
| q12 | 3 | 3 | 5 | 3 | 4 | 3 | 3 | 3 | 3 | 1 | 4 | 4 | 3 | 4 | 3 |
| q13 | 2 | 2 | 3 | 1 | 3 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 |
| q14 | 2 | 4 | 5 | 4 | 2 | 3 | 2 | 4 | 3 | 5 | 4 | 4 | 4 | 4 | 4 |
| q15 | 2 | 3 | 5 | 4 | 4 | 2 | 1 | 2 | 2 | 1 | 3 | 5 | 4 | 4 | 3 |
| q16 | 3 | 3 | 5 | 4 | 4 | 4 | 5 | 4 | 4 | 1 | 5 | 4 | 4 | 4 | 3 |
| q17 | 2 | 3 | 4 | 3 | 4 | 3 | 2 | 2 | 1 | 1 | 2 | 4 | 4 | 4 | 4 |
| q18 | 2 | 2 | 3 | 1 | 3 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 |
| q19 | 3 | 2 | 4 | 4 | 3 | 3 | 1 | 1 | 2 | 1 | 4 | 3 | 1 | 3 | 3 |
| q20 | 2 | 2 | 4 | 2 | 2 | 2 | 1 | 1 | 3 | 1 | 1 | 2 | 2 | 1 | 2 |
| q21 | 2 | 2 | 4 | 3 | 3 | 3 | 1 | 3 | 2 | 1 | 3 | 3 | 1 | 2 | 2 |
| q22 | 2 | 2 | 3 | 3 | 2 | 2 | 2 | 2 | 3 | 1 | 3 | 3 | 2 | 3 | 3 |
| q23 | 2 | 2 | 3 | 3 | 3 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 2 | 1 |
| q24 | 2 | 2 | 1 | 2 | 3 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 |
| q25 | 2 | 2 | 2 | 3 | 3 | 3 | 1 | 2 | 3 | 1 | 1 | 4 | 3 | 2 | 3 |
| q26 | 2 | 2 | 4 | 3 | 3 | 3 | 1 | 2 | 3 | 1 | 2 | 4 | 3 | 2 | 3 |
| q27 | 2 | 2 | 2 | 2 | 3 | 2 | 1 | 2 | 3 | 1 | 3 | 3 | 3 | 1 | 3 |
| q28 | 2 | 2 | 2 | 2 | 3 | 3 | 1 | 2 | 3 | 1 | 1 | 3 | 2 | 2 | 3 |
| q29 | 2 | 2 | 2 | 3 | 2 | 5 | 2 | 3 | 1 | 5 | 3 | 3 | 3 | 2 | 3 |
| q30 | 2 | 4 | 3 | 2 | 2 | 1 | 1 | 2 | 1 | 5 | 3 | 4 | 3 | 1 | 2 |
| q31 | 3 | 3 | 2 | 3 | 3 | 2 | 1 | 2 | 2 | 5 | 2 | 4 | 3 | 1 | 4 |
| q32 | 4 | 2 | 4 | 3 | 3 | 4 | 5 | 4 | 5 | 4 | 2 | 2 | 3 | 1 | 4 |
| q33 | 2 | 2 | 3 | 2 | 2 | 3 | 1 | 1 | 2 | 1 | 1 | 4 | 2 | 1 | 4 |
| q34 | 2 | 2 | 4 | 3 | 3 | 2 | 2 | 1 | 2 | 1 | 4 | 3 | 3 | 1 | 2 |
| q35 | 2 | 2 | 3 | 3 | 3 | 2 | 1 | 1 | 2 | 1 | 2 | 4 | 3 | 2 | 3 |
| q36 | 2 | 2 | 3 | 3 | 3 | 3 | 2 | 2 | 1 | 1 | 3 | 2 | 3 | 2 | 2 |
| q37 | 2 | 2 | 4 | 3 | 4 | 3 | 2 | 1 | 1 | 1 | 3 | 3 | 2 | 2 | 3 |
| q38 | 2 | 3 | 4 | 3 | 4 | 3 | 1 | 2 | 1 | 1 | 2 | 3 | 1 | 2 | 2 |
| q39 | 2 | 3 | 4 | 3 | 3 | 2 | 1 | 2 | 1 | 1 | 4 | 3 | 3 | 2 | 2 |
| q40 | 2 | 2 | 3 | 3 | 4 | 2 | 1 | 1 | 1 | 1 | 4 | 3 | 3 | 2 | 3 |
| q41 | 2 | 3 | 3 | 3 | 4 | 3 | 1 | 2 | 3 | 1 | 4 | 3 | 3 | 2 | 3 |
| q42 | 2 | 2 | 2 | 3 | 3 | 2 | 1 | 1 | 1 | 1 | 2 | 3 | 2 | 2 | 3 |

Table 3, Means, Standard Deviations, and Range of Physicians' Responses to Questionnaire

| | MEAN | SD | RANGE |
|---|---|---|---|
| q1 | 1.10 | 0.35 | 1 - 2 |
| q2 | 4.75 | 0.49 | 4 - 5 |
| q3 | 1.65 | 0.83 | 1 - 3 |
| q4 | 1.80 | 0.77 | 1 - 3 |
| q5 | 1.50 | 0.83 | 1 - 3 |
| q6 | 1.55 | 0.88 | 1 - 3 |
| q7 | 1.05 | 0.26 | 1 - 2 |
| q8 | 1.80 | 0.91 | 1 - 3 |
| q9 | 1.30 | 0.51 | 1 - 2 |
| q10 | 1.45 | 0.49 | 1 - 2 |
| q11 | 2.73 | 0.64 | 1 - 4 |
| q12 | 3.15 | 0.96 | 2 - 5 |
| q13 | 1.20 | 0.46 | 1 - 2 |
| q14 | 3.15 | 0.94 | 2 - 5 |
| q15 | 2.60 | 0.99 | 1 - 5 |
| q16 | 3.40 | 1.23 | 1 - 5 |
| q17 | 2.90 | 1.06 | 1 - 5 |
| q18 | 1.15 | 0.41 | 1 - 2 |
| q19 | 1.35 | 0.59 | 1 - 3 |
| q20 | 1.50 | 0.74 | 1 - 3 |
| q21 | 2.25 | 1.06 | 1 - 5 |
| q22 | 2.40 | 1.11 | 1 - 5 |
| q23 | 1.35 | 0.46 | 1 - 2 |
| q24 | 1.25 | 0.35 | 1 - 2 |
| q25 | 2.10 | 0.94 | 1 - 4 |
| q26 | 1.85 | 0.74 | 1 - 3 |
| q27 | 1.85 | 1.06 | 1 - 4 |
| q28 | 1.95 | 0.85 | 1 - 4 |
| q29 | 1.65 | 1.11 | 1 - 5 |
| q30 | 1.95 | 0.85 | 1 - 4 |
| q31 | 2.30 | 1.12 | 1 - 4 |
| q32 | 3.60 | 0.88 | 2 - 5 |
| q33 | 1.90 | 0.62 | 1 - 3 |
| q34 | 2.25 | 0.99 | 1 - 4 |
| q35 | 1.80 | 0.56 | 1 - 3 |
| q36 | 1.80 | 0.62 | 1 - 3 |
| q37 | 2.25 | 1.16 | 1 - 5 |
| q38 | 1.95 | 0.96 | 1 - 4 |
| q39 | 1.85 | 0.83 | 1 - 3 |
| q40 | 2.05 | 0.88 | 1 - 4 |
| q41 | 2.20 | 0.98 | 1 - 4 |
| q42 | 1.80 | 0.86 | 1 - 4 |

Table 4. Means, Standard Deviations, and Range of Nurses' Responses to Questionnaire

| | MEAN | SD | RANGE |
|---|---|---|---|
| q1 | 1.20 | 0.41 | 1 - 2 |
| q2 | 4.00 | 1.07 | 2 - 5 |
| q3 | 1.93 | 1.03 | 1 - 4 |
| q4 | 2.20 | 0.94 | 1 - 4 |
| q5 | 1.86 | 0.74 | 1 - 3 |
| q6 | 2.46 | 1.12 | 1 - 4 |
| q7 | 1.66 | 0.82 | 1 - 3 |
| q8 | 2.60 | 1.30 | 1 - 5 |
| q9 | 2.13 | 0.99 | 1 - 4 |
| q10 | 2.06 | 1.16 | 1 - 4 |
| q11 | 3.13 | 0.92 | 1 - 5 |
| q12 | 3.26 | 0.88 | 1 - 4 |
| q13 | 1.60 | 0.74 | 1 - 3 |
| q14 | 3.60 | 0.99 | 2 – 5 |
| q15 | 3.00 | 1.31 | 1 - 5 |
| q16 | 3.80 | 1.01 | 1 - 5 |
| q17 | 2.86 | 1.13 | 1 - 4 |
| q18 | 1.53 | 0.74 | 1 - 3 |
| q19 | 2.53 | 1.12 | 1 - 4 |
| q20 | 1.86 | 0.83 | 1 - 4 |
| q21 | 2.33 | 0.90 | 1 - 4 |
| q22 | 2.40 | 0.63 | 1 - 3 |
| q23 | 1.73 | 0.88 | 1 - 3 |
| q24 | 1.53 | 0.64 | 1 - 3 |
| q25 | 2.33 | 0.90 | 1 - 4 |
| q26 | 2.53 | 0.92 | 1 - 4 |
| q27 | 2.20 | 0.77 | 1 - 3 |
| q28 | 2.13 | 0.74 | 1 - 3 |
| q29 | 2.73 | 1.10 | 1 - 5 |
| q30 | 2.40 | 1.24 | 1 - 5 |
| q31 | 2.66 | 1.11 | 1 - 5 |
| q32 | 3.33 | 1.17 | 1 - 4 |
| q33 | 2.06 | 1.03 | 1 - 4 |
| q34 | 2.33 | 0.97 | 1 - 4 |
| q35 | 2.26 | 0.88 | 1 - 4 |
| q36 | 2.26 | 0.70 | 1 - 3 |
| q37 | 2.40 | 0.98 | 1 - 4 |
| q38 | 2.26 | 1.03 | 1 - 4 |
| q39 | 2.40 | 0.98 | 1 - 4 |
| q40 | 2.33 | 1.04 | 1 - 4 |
| q41 | 2.66 | 0.90 | 1 - 4 |
| q42 | 2.00 | 0.75 | 1 - 3 |

Table 5. Comparison of Average Responses of Physicians and Nurses to Questionnaire

| | Physicians | Nurses |
|---|---|---|
| q1 | 1.10 | 1.20 |
| q2 | 4.75 | 4.00 |
| q3 | 1.65 | 1.93 |
| q4 | 1.80 | 2.20 |
| q5 | 1.50 | 1.86 |
| q6 | 1.55 | 2.46 |
| q7 | 1.05 | 1.66 |
| q8 | 1.80 | 2.60 |
| q9 | 1.30 | 2.13 |
| q10 | 1.45 | 2.06 |
| q11 | 2.73 | 3.13 |
| q12 | 3.15 | 3.26 |
| q13 | 1.20 | 1.60 |
| q14 | 3.15 | 3.60 |
| q15 | 2.60 | 3.00 |
| q16 | 3.40 | 3.80 |
| q17 | 2.90 | 2.86 |
| q18 | 1.15 | 1.53 |
| q19 | 1.35 | 2.53 |
| q20 | 1.50 | 1.86 |
| q21 | 2.25 | 2.33 |
| q22 | 2.40 | 2.40 |
| q23 | 1.35 | 1.73 |
| q24 | 1.25 | 1.53 |
| q25 | 2.10 | 2.33 |
| q26 | 1.85 | 2.53 |
| q27 | 1.85 | 2.20 |
| q28 | 1.95 | 2.13 |
| q29 | 1.65 | 2.73 |
| q30 | 1.95 | 2.40 |
| q31 | 2.30 | 2.66 |
| q32 | 3.60 | 3.33 |
| q33 | 1.90 | 2.06 |
| q34 | 2.25 | 2.33 |
| q35 | 1.80 | 2.26 |
| q36 | 1.80 | 2.26 |
| q37 | 2.25 | 2.40 |
| q38 | 1.95 | 2.26 |
| q39 | 1.85 | 2.40 |
| q40 | 2.05 | 2.33 |
| q41 | 2.20 | 2.66 |
| q42 | 1.80 | 2.00 |

# APPENDIX C

## DIAGRAM

Areas of Literature Search on Spiritual Development and Healthcare