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Avery Glover April 10, 2017

Clarifying Spirituality in Hospice and Palliative Care: Existential Pain and Spiritual Care Approaches

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An abstract of
a thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Department of Religion

2017

Abstract

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By Avery Hennigan

Based on my discussions with patients and families and observing their interactions with hospice practitioners, especially medical practitioners, I find that there is a problem in the way that we talk about spirituality and death. Patients and families bring with them what I think are more traditional religious and cultural views on dying that entail an interactive relationship both before and after death. Yet these views clash with modern medicine that ties death to a final point in time. The mainstream medical notion of death poses dire existential challenges for patients and families and neglects a social dimension to dying. I believe that any spiritual approach should tackle this fundamental issue with dying in the modern era. In this opinion piece I hope to clarify what we mean by spirituality and what purpose it serves in hospice care. Over the past 6 months I've read the relevant literature from a diverse set of fields including pastoral care, sociology, psychology, and biomedicine. I have identified two major trends that I will call the postmodern and psychological approaches to spirituality. I will draw quotes from several representative sources in order to illustrate how they conceptualize spirituality and design their spiritual interventions. I divide this work into three chapters. In the first, I dive into the medical treatment of dying and illustrate the problems that arise in this setting. I draw on historical sources from the hospice movement to show that issues with dying that existed in the mid to late 20th century are still prevalent today. I then turn to the postmodern and psychological approaches in chapters two and three, respectively. After clarifying hospice notions of spirituality and its interventional methods, I then ask whether these spiritual care approaches address the existential problems posed by medical treatment.

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Acknowledgements

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Chapter I: The Modern Existential Plight & the Call for Spiritual Care

Introduction

In 1968, Cecily Saunders founded the first hospice care facility at Saint Christopher's hospital in London, England. She intended to revolutionize the modern treatment of the dying within medical institutions, and her vision caught on quickly. Within ten years, the hospice movement spread to America. Elisabeth Kübler-Ross published her groundbreaking work *On Death and Dying* and the first hospice facility in America opened in Branford Connecticut. Needless to say, the Western world had awoken to the needs of the dying. Death crept out of the corners of hospital wards and demanded attention on an international scale. The world realized that modern medicine and its biomedical focus alone would not suffice for our care for the dying, and more needed to be done so that people could die with dignity and meaningful care.[25]

These architects of the hospice movement certainly brought immeasurable changes to dying in the modern era. Today, hospice care considers itself "the model for quality compassionate care for people facing a life-limiting illness. Hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes."[24] Taking a focus that emphasizes care over cure, the hospice movement draws death to the forefront and allows its patients to progress through the dying process on their own terms. It takes a holistic approach that attends to the entirety of physical, psychological, social, and spiritual needs.

Yet I believe that the hospice movement is not yet complete. That last aspect of care, the spiritual approach, remains problematic. Much of the literature on hospice and palliative care offer vague notions of spirituality that lack cohesive concepts and clear goals

in care. In this work, I intend to clarify the ways in which spirituality is addressed in hospice and palliative care literature. I unearth overlooked biases within the field and expose potential pitfalls in care. In this first chapter, I start by examining what exactly a spiritual approach to care seeks to mend. In short, I equate spiritual needs with unique forms of existential distress arising from the modern medical treatment of death. As death was pushed into the body and linked with disease, death entailed a moral defeat and an erasure of the self. These two points will become clearer as we observe the reworking of death alongside physically reductionist ideology and technological advancements. Of course, hospice and palliative care has made significant strides to correct the shortcomings of a medicalized death, but I question to what extent it has removed itself from medical ideology. I end the chapter with a discussion on the practice of palliative sedation and show that hospice care is still rooted within a larger biomedical discipline. This will prepare us for subsequent chapters that explore contemporary approaches to spiritual care.

Redefining Death as a Physically Reductionist Event

By the mid-20th century, modern medicine firmly wrestled death and dying from religious spheres. Western society came to view medicine and physicians as society's lead healers and believed in their abilities to ward off death. This shift from the religious to the medical sphere brought about a wave of change in the conceptualization of death and dying. Allan Kellehear provides some initial context to this development:

> *Aries documented the shift in personal power from dying person to doctor as the understanding about the 'facts' of death made their transformation from religiously inspired social imagery to the mere physical and cellular. As the power of religious social imagery concerning death bled away and as the asocial scientific imagery*

> *regarding death strengthened, the political authorities of one (medicine) correspondingly strengthened against the other (religion).*[16]

There is much at stake here. Institutions play a significant role in dictating how society interacts with and relates to death, the dying, and the dying process. Amid this shift from the religious to the medical, we can see that medical ideology worked its way into the social concept of death. Modern medicine placed these experiences under the physician's gaze. Reduced to the physical processes of the body, death is treated as an objective and singularly experienced event. There is one way of going about death, and patients undergoing treatment must succumb to mainstream medicine's ideologies and rituals on death and dying.

Medicine shrunk the spaces not only where death occurs – from homes and communities to institutions – but also where death is experienced. In its previous religious form, Judeo-Christian notions of death emphasized the soteriological aspects of dying. It was a phenomenon experienced by the individual as he or she progressed into the next community. According to the teachings of many Judeo-Christian denominations, death entailed a transfer from this world to the afterlife. Medical views of death, however, lacked these communal and soteriological features. In a rather physically reductionist point of view, death was reduced down to the body:

> *Disease and death once signified human finitude and pointed toward the hope of healing and resurrection. But in the new space of death – a space in which time is frozen – death can only be self-referential, being defined completely within the realm of the efficient causes that link disease and death. Death, in being fixed in the body, is*

> *well on its way to circumscription in the immanent structures of medical knowledge and practice.*[3]

Death was understood in terms of the pathological processes that led to it. Following the objective study of science, there can only be one cause that determines the outcome of death. The body contained all knowledge of this causative thread from normal functioning to disease state to death. It encapsulated the physical space in which the patient experienced death and from which the medical practitioner interpreted it. The shift from religious to medical reduced the dying experience into an objective study. It could only be understood according to the body.

However, death was not brought into a neutral medium. The body was conceptualized as a fine-tuned machine designed to maintain life. Its *raison d'être* was to maintain a homeostatic state amidst the chaos of disease. Health and disease swung back and forth in a constant struggle within the bodily arena. For medical practitioners, they were tasked with treating the body in order to resist the effects of disease.[39] And this idea exists even today. Our blood pressure must not stray too far from 120/80 or we must take steps to ensure that it falls within a normal range. Blood glucose levels can't fall too low or too high. People who experience a stroke must undergo therapy to restore normal brain functioning. Death pushes the body into chaos and opposes the objectives of modern medicine. In short, death is the enemy of health and medicine.

This physically reductionist view of the body implicates modern interpretations of the self. Taken from a biomedical perspective, the complete picture of the experiential self is lost as the body is separated into its organ systems and their functional components. This viewpoint runs deep in the medical community. Even in introductory biology courses,

initial lectures often begin with a breakdown of anatomical tiers. The body is separated into organ systems, organ systems into organs, organs into tissues, all the way down to the cellular level. Within hospitals, one can find a similar breakdown of the body sketched out on a building directory. Take your heart up to the second floor to see the cardiologist, send your brain over to the neurologist on floor five – the body is stretched out across the spaces of medical centers. Biomedicine knows no bounds in its pursuits to unearth minute details of the human body and its organized functions. The body is compartmentalized and separated out into an anatomical diagram, with dire consequences on the medical experience of death.[39]

Losing the Medical Battle: Death as a Moral Defeat

Within this setting, the dying individual is not a *person* receiving care but a *patient* undergoing treatment. Death is a battle against the workings of disease and the dying exist only within that fight. Under modern medical care, the primary sense of identity is tied to death, disease, and the physical aspects of their being. Personhood is reduced to "patienthood." Patients exist within the medical structure and abide by its ethics on dying. Once a terminal prognosis is made, patients face a dreaded decision:

> *Saying no to continued treatment, removing life support, regardless of its efficacy, can feel to family like deciding to end their loved one's life, like a betrayal. For patients, it can be understood as giving up, as being uncooperative or depressed, even suicidal.*[23]

Patients and their families are taxed with the stigma of "giving up," which in part stems from the biomedical stance on dying. Patients were unable to overcome the workings of disease. Their bodies failed them in the morally driven arena of life and death. Physicians,

families, not even their own resolve could save them from the fate that awaits them. Death as such signals a defeat, a failure to continue fighting.

The modern medical physician-patient relationship of the mid-20th century drove this moral perception of death Many healthcare programs require their graduates to recite the Hippocratic Oath, which is often summarized in medical literature as "do no harm."[36] This axiom of medical practice originated in pre-modern medicine (some state as early as ancient Greece and others in the 19th century), but its interpretation took a radical turn in the mid-20th century. In their exhaustive historical analysis of the phrase, Virginia Sharpe and Alan Faden demonstrate that during the 1960's "do no harm" came to be associated with iatrogenic complications, or unintended harm as a result of medical care. American culture grew more aware of potential risks resulting from physician errors, and a slew of statements were published in the 1970's to establish patients' rights of autonomy. Notably, the Joint Commission on Accreditation of Hospitals (JCAH) issued a statement in *A Patient's Bill of Rights* that sought to replace the ethics of paternalistic care with patients' rights to knowledge of their diagnosis, treatment, and prognosis.[35]

Yet this development that prodded medical practice towards patient autonomy was couched in an ethic of beneficence. In terms of terminal conditions, while a patient could choose to receive knowledge of their condition, physicians were bound by a code to promote life. Sharpe and Faden demonstrate this point Citing a 1976 New Jersey Supreme Court case in which parents wished to remove their comatose daughter from a respirator in order to die a natural death:

> *They argued that 'removal of the respirator was not supported by accepted medical practice' and that 'no court…should require a physician to act in derogation of [the]*

> *sacred and time-honored [Hippocratic] oath.' The judges in the Superior Court substantively agreed, the said, by noting that 'our society has chosen to entrust to the medical profession the responsibility for determining when death occurs and what treatment shall be administered to the living.*[35]

This statement portrays death as the enemy of the medical trade, and physicians are entrusted to restore their patients to normal, healthy lives. In this sense, they are society's lead healers. The medical community created an expectation that life can, and *should*, be extended for as long as possible. The decision to undergo medical intervention rather than accept death involves a social duty for the patient, family, and physician.

Of course the cultural perception of patient and the role of medical professionals at the time of death has changed since the 20th century. Physician-assisted suicide is now legal in six states along with Washington D.C.,[30] which reflects a larger cultural change in attitude towards the role of physicians at the time of death. Death has been more readily accepted as a dignified event. Nonetheless, the focus to preserve life at all costs still works its way into contemporary dying discourse. Consider the following from geriatric medical specialist Michael Gordon:

> *One often hears family members describing the last period of life noting in great detail all the things that were done, at their behest, to 'save' their loved one…This becomes part of the ritual narrative of dying, and by allowing it to happen the family can be comfortable that they fulfilled their filial duty by doing what in the contemporary world is expected and available as part of the process of dying.*[13]

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[35] Sharpe, Virginia and Alan Faden. 1998. *Medical Harm: Historical, Conceptual, and Ethical Dimensions of Iatrogenic Illness*. Cambridge: Cambridge University Press. 66-72

Gordon states that this situation is common in the absence of advanced planning, but it is important to note the moral duty to preserve life is still prevalent in Western culture today.

At this point, I do not want to insinuate that religious notions of death no longer hold sway. The medical doctor has not completely usurped religion in all matters of healing, nor have we reached an era marked by total secularism. Many hospitals are affiliated with religious traditions. Chaplains are frequently employed in hospitals and offer their services to patients. Those undergoing medical treatment line their hospital rooms with religious objects and continue to pray and worship within these spaces. The spaces of modern medicine are not devoid of the spiritual. In fact, it is quite often a key component to death within the medical sphere. My point, however, is that death is no longer a predominantly religious event taken within the Judeo-Christian framework. As much as religion has faded from the dying process, the medical ideology of death has taken its place. It must be understood that this is no small matter, and medical practices geared towards death heavily implicate patient experiences. Death and disease were tied at the hip through an objective study of causation. Disease could either lead back to health, restored by the power of the medical physician, or progressively worsen until it reached its functional conclusion. Therefore, death is but one biological event within the body, but one loaded with ethical and moral implications.

Death's Final Moments: Loss of the Self

Progressing further into the 20th century, technological advancements redefined the modern notion of death. For most of life, death exists as an indefinite and far-way event. To some extent, modern medicine gained mastery over its timing. It is able to ward off death and push those final moments farther and farther off in time. For instance,

cardiopulmonary resuscitation (CPR) has permitted the reversal of dying processes. Even though the biological system has shut down – neither heartbeat nor breathing persisting [*]– CPR can restart life from where it left off. It was as though the body was paused in time and medical intervention merely presses the play button. It is able to control the timing of death just as we may continue along with a movie. Modern medical treatment has ushered in an era in which death can be avoided.[3, 23]

And these advancements that delayed death also changed what is considered final death. Defibrillators and respirators extended the functions of the heart and lungs beyond death, but the brain was left behind. No longer did death entail a simultaneous cessation of all three vital components.[23] Unlike the stoppage of the heartbeat or breathing, brain death requires technological measurement to determine final death. Consider the implications that this holds:

> *The electro-encephalogram is an instrument capable of probing the space of the brain even more deeply, extending the gaze of the physician. A flat line on the EEG has thus become the absolutely thin line separating life from death – time is spatialized on the graph of the paper…Time is fixed in the space of the brain, represented by a graph; the moment of death can be determined with extreme precision: death has occurred when there is no longer any space left under the curve of the flatlined EEG. Time is spatialized; fixed in space, death can be known and thus mastered.*[3]

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[*]The 1981 Uniform Determination of Death Act defined death as the "irreversible cessation of circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain. Later in 1995 the American Academy of Neurology attempted to standardize clinical definitions of brain death. Despite these efforts, there still exists significant variation amongst different states and individual hospitals regarding the policies of determining official brain death. See Bartscher, James and Panaylotis Varelas. 2010. "Determining Brain Death–No Room for Error." *AMA Journal of Ethics* 12 (11): 879-884.

[3] Bishop, Jeffrey, Philipp Rosemann, and Frederick Schmidt. n.d. "FIDES ANCILLA MEDICINAE: ON THE ERSATZ LITURGY OF DEATH IN BIOPSYCHOSOCIOSPIRITUAL MEDICINE." *The Heythrop Journal* 49 (1): 30.

When disease has finally run its course and the patient's fate is sealed, death becomes a finite event. The temporal dimension of death is transformed into spatial measurement. These technological advancements drew attention away from the social and religious notions of dying, and death takes a singular dimension. It became an either/or event without any transition phase. Either the patient is biologically functioning or gives no measurable signal.

In previous Judeo-Christian treatments of dying, death signified a point along an eternal stretch in time. It marked the transition from one community to the next. Existence within this world continued on in some form. Yet the placement of death within biomedical contexts shatters this doorway into subsequent existence. Death became a final point in time in which the patient faces a dire existential dilemma. Death for the dying patient is a signifier for the end of the road. The clock strikes zero and their role within the medical system ceases to have any functional capacity. After the time of death has been officially stated and recorded, the doctor no longer has a patient to cure. Heart rate monitors stop their steady beeping and drown into an incessant pitch. IV fluid wastefully drains into stagnant blood vessels. The dead patient has no place within medical facilities and his or her role is completely wiped away. As their personhood is reduced into patienthood, they lose all ground for their social identity and means of existing in the world. Death marks a final point in time in which patients possess a tie to the world.[3]

I want to emphasize the loaded psychological implications that follow. Once again, a vital component to existential being is narrowly reduced into a physical state. The brain as

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[3] Ibid., 29-31. This is in contrast to what I consider more traditional death practices that involve a gradual transition based on dynamic social roles. I first noticed this point in my volunteer work that's reasonable according to ritual studies in social transformation found in Bell, Catherine. "Ritual." In *The Blackwell Companion to the Study of Religion*, edited by Robert A. Segal, 403-406. Blackwell Publishing, 2006.

the site of personality, the container of the mind and self, is understood in terms of the neural networks that compose it. While medicine may artificially sustain life through resuscitators and respirators, the brain experiences lasting damage mere seconds after losing oxygen. Once that trauma occurs, then mind and body disintegrate into the flatline signaling that life has ended. The existential self is no longer contained in time. It is either physically present or ceases to exist in the world. Death now entails an existential crisis, what Paul Tillich gets at when he refers to "the natural anxiety of man as man…It is the anxiety of nonbeing, the awareness of one's finitude as finitude."[40]

This last point must be taken with a certain caveat. It cannot be stated that patients cease to exist for their families. They maintain memorable roles within religious, social, cultural, networks. Individuals are rooted into the world in a variety of ways that should not be overlooked. However, if we accept that the modern experience of death is drawn from medical views on the body and disease, then we must acknowledge that these biomedical views widen the void left behind. They complicate the struggle for both patients and families to grasp their loss.[31] And I use loss not on an emotional level or even in the sense that social relationships have been severed. Dying under the biomedical gaze reduces personhood and dying experiences into the physical nature of disease pathology. A patient's demise as functioning, biological systems resists further existential ties in this medicalized world. Their being as patients is completely annihilated at the time of death.

[31] I am making an assumption that as social, cultural, and religious notions of a transitional death are hampered by technological advancements, then transformative grief rituals are similarly affected. See Romanoff, Bronna. 1998. "Rituals and the Grieving Process." *Death Studies* 22 (8): 697-711.

The Call for a Spiritual Approach to Care

This takes us to the final section of the chapter in which I question whether hospice and palliative care addresses these existential concerns. While significant strides were made to resist a purely medical approach to death, I hold that hospice and palliative care has struggled to shed itself from medical ideology of dying and personhood. Hospice care should not be taken as an alternative form of treatment, but as a specialty within the larger medical field. To argue this point, I consider the claims made by Allan Kellehear who argues that contemporary dying practices are principally social events.[16] While this holds true to some degree, we should not overlook the biomedical influences that persist today, which are highlighted by the practice of palliative sedation.

Kellehear argues against a physically reduced notion of death in favor of its contemporary return to the social sphere. He points to the numerous rituals that exist across cultures in which communities commemorate and interact with the dead. Relics such as home videos and commemorative wreaths serve as reminders of the presence of the deceased. Even in popular media, the deaths of cultural icons such as Princess Diana are reworked and introduced to successive generations. The dying persist after death as they are creatively integrated into new social roles. In light of this, he argues death as a medical-existential phenomenon is pushed primarily within academic circles:

> *Irrespective of one's own academic explanations for such behaviour and experiences, the overwhelming majority of those inside these experiences view them as actual interpersonal experiences in their own right. In these ways too, then, the 'dead' are not 'nothing'. The dead are not 'dead'.*[16]

In this way, Kellehear seeks to debunk the narrow view that death is solely a medical phenomenon. He shows the richness of death and dying in the social dimension. The presence of the dead remains fluid within changing dynamics of social communities.

I agree that death and dying hold significant social implications in the contemporary era. Rituals centered on social transition and integration during the dying process have worked their way into the medical sphere. In some instances, death is understood as a liminal state in which the dying progress from one societal role into a new one as the "living" dead.[13, 17] But we still cannot disregard the impact of medical ideology within hospice and palliative care. It still influences a physically reduced concept of personhood which can implicate these rituals of social transformation. Whether social communities can overcome the absence of death is not the question I wish to ask. Instead, I want to examine how does the medical ideology of death still exist within hospice and palliative care? I hold that we must answer this question in order to properly assess the role of spirituality in hospice and palliative care.

The practice of palliative sedation involves a hot bed of ethical concerns. On the one hand, pain management drugs can reduce the physical aspects of suffering leading up to death. But on the other hand, pain management drugs are known to significantly reduce consciousness and may possibly detract from patient interaction with family and loved ones. Hospice and palliative care has taken a middle road in which the severity of physical symptoms is taken into consideration so as to minimize the effects of drugs on consciousness. Yet while psychological and physical concerns shape ethical discussions, existential and spiritual concerns lag behind. Consider the following statement produced by the American Academy of Hospice and Palliative Medicine on palliative sedation:

> *Although the Academy recognizes that existential distress may cause patients to experience suffering of significant magnitude, there is no consensus around the ability to define, assess, and gauge existential suffering, to measure the efficacy of treatments for existential distress, and whether it is in the realm of medicine to palliate such suffering when it occurs absent of physical symptoms. Patients with existential suffering should be thoroughly assessed and treated through vigorous multidisciplinary efforts which may include involving professionals who are not usual members of the palliative care team (e.g., experts in psychological, family therapy, or specific spiritual services).*[38]

There are two points to be made here that illustrate the biomedical dominance within the field of hospice and palliative care. First, the field does not possess a clear enough understanding on the relationship of existential distress to other forms of suffering . While the physical and psychological are understood to influence each other, existential concerns are set aside for other non-palliative specialists. While this stance is not a purely physically reductionist, it still assumes that physical intervention may only impact the forms of care that are rooted in the body. That is, palliative sedation only applies to the brain and nervous system, or the physical and mental. Existential concerns do not fit into this equation. While certainly acknowledged by the AAHPM, existential treatment lags far behind physical and psychological interventions. And this is probably owing to the direction that research takes. There has lacked a substantial amount of investigative efforts to empirically conceptualize existential and spiritual concerns. Therefore, spirituality is not legitimized for total integration into biomedical discourse.[20]

Second, hospice and palliative care espouses an interdisciplinary approach in which these four pillars of care – physical, psychological, social, and spiritual – are all interwoven and managed through compassionate and dignified care. Yet perhaps these different approaches to care are not as intertwined as the field would have it. This statement does not consider the embodied nature of existential suffering. The ways in which we talk about the body, touch the body, administer medication to the body – these physical forms of care that heavily implicate patient existential distress.[18]

Therefore it is important to note the role that the medical treatment of dying holds in hospice care. Even in hospice and palliative care, the timing and progression of death is understood in terms of medical symptoms. Hospice practitioners consistently monitor physical and cognitive symptoms as a means to measure their progression towards death. In a sense, this provides a temporal framework on which the dying process is framed. Death is still understood to be the final culmination, the end point, for symptomology. During 11th hour care, the last 24-48 hours of life in which patients deteriorate rapidly, practitioners attempt to normalize death through medical explanations. No matter the disease that led to this point, all individuals experience death within a given set of symptoms. Breathing patterns change, responsiveness declines, skin pales – the list continues. Ultimately, death is structured and practiced as a medical event.

This leads us to consider how the current spiritual approaches to care tend to the existential distress of patients. I hold that while not as obvious as in the mid-20th century, patients are still plagued with similar concerns. In the next two chapters, I will examine two approaches to spirituality that are prominent in the literature. After providing clarity

as to how they conceptualize spirituality and implement it into care, I will then reflect upon how these two approaches relate to the existential pain we have just discussed.

Chapter II: The Postmodern Approach to Spirituality

Introduction

In this chapter and the next, I hope to bring a sense of clarity to the use of spirituality in hospice and palliative care literature. I will identify two approaches to spirituality in hospice care that I call the postmodern and the psychological approaches. These are my own terms that I attach to two prevailing models within the literature. While many authors do not self-identify within this schema or neatly fit within one of two camps, my main objective is to point out subtle themes and developments within both approaches that I believe go unnoticed. I hope to raise questions about our current understandings of spirituality and reconsider the ways in which we apply our definitions into hospice and palliative care. This effort leads to a critique on considerations of spiritual wellbeing and the implications they hold for the patient. As described in chapter one, hospice and palliative care patients possess unique existential spiritual needs. It becomes our task to draw out the underlying tendencies in our spiritual care approaches in order to properly address these needs.

The present chapter focuses on the postmodern approach to spirituality. I will start by placing our discussion within the contexts of theological development in postmodern thought. I show that hospice and palliative care follows along this thread and takes on a distinctively theological voice. It adapted its practices and care roles to fit within a multicultural society in order to respect the wide demographic of patient viewpoints. Patients are encouraged to develop their own sets of religious and cultural beliefs. Nonetheless, I show that the postmodern approach does so while holding onto an implicit

view of spirituality. It legitimates diverse worldviews with a notion of spirituality posited as a universal need for transcendent meaning making.

Spirituality thus understood is placed within patient subjective worldviews, and practitioners are positioned as spiritual outsiders. A substantial gap exists between patients and HPC practitioners. I show that practitioners rely on this implicit and universal definition of spirituality in order to bridge that gap. The postmodern approach walks a tightrope between respecting individual worldviews while adopting a common language between the two parties. Yet as we will see, it relies on spiritual terminology so broad that the field is left without substantial meaning. Terms such as transcendence, meaning, and connection allude to individual spiritual matters, but ultimately lack any direction without a theological basis. This has direct consequences on spiritual diagnoses and spiritual interventions within applied hospice and palliative care settings.

I find this approach lacking, pointing to the way that this notion of spirituality is implemented in patient care. The postmodern model makes an assumption that all patients will eventually resolve their existential crisis by reflecting on their subjective value systems. While this may be beneficial in its own right, it does not directly follow that individual worldviews are structured in a way that provides an existential basis to life. I hold that the postmodern approach dodges the immediate ideological problem at hand and constructs its treatment around false assumptions. This leads me to reconsider the possibilities that medical practice holds as a more direct approach to spiritual care in hospice and palliative care settings. I believe that by rethinking our reliance on structuring the dying process around physical symptoms, we may potentially come upon a more suitable model of spiritual care.

In the current chapter, I hope to contribute to our understandings of spirituality, and I want to encourage reflection on what we consider efficacious within the contexts of hospice and palliative care.

Theological Influences in the Postmodern Approach

This section will take us through theological development within postmodern thought and examine the perceived role of chaplains in hospice and palliative care. In doing so, I show that a theologically derived notion of spirituality emerges from hospice and palliative care and the field's attempts to remain non-denominational in its spiritual approach to care.

Postmodernism is not a singular term. It can take many shapes and forms depending on the contexts in which it is applied. For the purposes considered, I'm focusing on certain features identified by Mark Wallace, who I recognize as a key figure in the postmodern discussion. Wallace, along with many other postmodern writers, reexamines Christian doctrine in light of modern critiques in order to develop a new, constructive view of theology. He takes a theological stance that I find highly relevant to our understanding of the postmodern approach to spirituality in hospice and palliative care. There exists a pervading theological voice in the field that, while stripped of its explicit Christian elements, mirrors the aims and progressions of this fairly new form of theology. I rely on Wallace's work in order to illustrate a similar directive under the postmodern approach to spirituality in hospice and palliative care.

As the postmodern era developed in the 20th century, Christianity received negative connotations as an exclusive and domineering tradition. Many postmodern writers assert that traditional Christianity pushes a totalizing historical timeline that propounds a narrow

value system. Not all cultural and spiritual identities find reconciliation through the death and resurrection of Jesus, nor do they accept the future prospects of a life after death marked by notions of heaven and hell. Many postmodern writers make epistemological claims that reject all rights to a single objective truth. Knowledge is necessarily filtered by the cultural lens from which it is viewed, therefore patient perspectives must be valued rather than impressed upon. God cannot be the only source of higher truth from which all people develop a sense of connection, identity, or ultimate purpose. Lastly, many postmodern writers reject theodicy in the face of suffering. It is not enough to simply endure hardship hoping that God will later enact divine judgment or explain away the seemingly senseless distribution of suffering with an unknowable master plan. Taken together, these elements of Christian doctrine are no longer accepted as obvious and dominant in a multicultural society that holds each worldview with equal weight.[41]

Therefore postmodern theology underwent significant changes in its course of study. That is, postmodern theologians sought to understand the *ways* in which people interpret doctrine. This allowed the field to detach itself from a strictly Christian belief system and include a variety of cultural and religious perspectives. In doing so, postmodern theology carved out a new role for itself:

> *…theology is no longer (nor was it ever) the supreme guarantor of sure access to this Other. A variety of discourses are potentially able to produce transformative life maps for the spiritually itinerant. It is the theologian's task to track these potentially transformative pathways, evaluate their origins, contours, and destinies, and help the traveler to decide whether any of these courses should be adopted as productive routes toward growth and understanding.*[41]

Postmodern theology wrestled a firm grip on the hermeneutical skills needed to interpret valid spiritual experiences. It declared the authority to dictate which paths are valid along the transformative processes understood to be at the heart of spirituality. Christian doctrine was not considered to be the only form of higher truth present in the world, but the Christian tradition was believed to display a prototypical method for other religious traditions to follow as they search for their higher order meaning. It was up to the theologian to analyze individual approaches and guide people along a suitable spiritual trajectory.

Bear in mind that my discussion of postmodern theology encompasses a narrow scope of what is considered contemporary theology, both in the 20th century and today. Nonetheless, I intended to highlight key features that will guide us along a discussion of the postmodern approach in hospice and palliative care. I now aim to show that the postmodern approach followed a similar development that lends itself a distinctively theological voice. It progressed from what Wilfred McSherry and Keith Cash, both researchers in nursing care, call the "old traditional form" to the "new postmodern form:"

> *[The first type of spirituality exists as] the historical or 'old' traditional form which is based on religious and theocentric descriptors. This form of spirituality is tangible and in a sense justifiable because such indicators as belief in a God or attendance at formal religious activity can provide a constant explanation…The second type of spirituality emerging has been classified as the new 'post modern form'…This form of spirituality contains an infinite number of descriptors that may be phenomenological and existentially determined such as meaning and purpose in life, creativity, and relationships. They may also reflect the different values, beliefs and attitudes that*

> *guide and shape individuals from different world faiths that are not recognized in Judeo-Christian approaches.*[21]

The delineation between the old and new forms of spirituality points to a significant shift in spiritual discourse. The field of nursing progressed from Christian-specific terminology into broader language suited to the vast ways in which people interpret spirituality within their religio-cultural worldviews. This progression illustrates need to broaden spiritual discussions to fit contemporary contexts. I want to dive into this point a bit deeper, noting where my take on the postmodern approach differs from what McSherry and Cash call the postmodern form. It's not that the primacy of Christian discourse fell to the wayside in hospice and palliative care; rather, it was reconfigured in the same vein as postmodern theology. The postmodern approach no longer espouses blatant expressions of Christian doctrine. Instead, it presumes an all-encompassing stance to spirituality that includes the wide range of patient worldviews while gripped by an underlying postmodern theological agenda.

Let's now turn to the role of hospice and palliative care chaplains, which can be best understood when compared to postmodern theologians. Chaplains are tasked with the lead position in the spiritual model of care. The content of their knowledge is not emphasized as much as their capacity to guide patients into a proper spiritual direction. I turn to the work of Marjory Byrne in order to illustrate the perceived role of the hospice chaplain as opposed to other practitioners. Although she served as a care nurse at the time of publication, I find that her portrayal of chaplains resonates throughout the postmodern approach to spirituality:

> *It could be suggested that the real training for spiritual care is not primarily intellectual, and asks for a hard and often painful process of self-emptying to make space for others. There is also a sense in which we cannot accompany another on a journey through territories that we have not to some extent explored ourselves. The qualification for being there is our own personal commitment to our own spiritual journey and crossing thresholds in our own experiences.*[5]

Hospice chaplains are understood to possess the requisite experience to know how to guide others within their individualized notions of spirituality. Again, it is not their knowledge of Christian doctrine that is as important; rather, the literature implies that chaplains have undergone an exemplary process of spiritual development themselves. They have personally cultivated the capacity to cross spiritual boundaries. Hospice chaplains can anticipate what challenges patients will face as they embark on their own spiritual journeys. Although chaplains have not experienced death per say, they contribute a novel spiritual perspective on the dying process that sets them apart from other hospice and palliative care practitioners.

Additionally, hospice and palliative care chaplains are distinguished in the literature by their unique repertoire of interpersonal skills. They are able to discern what is important in patients' spiritual lives and foster further reflection as patients continue along the dying process. In a personal reflection piece, Reverend William Purdy portrayed pastoral chaplains as:

> *counselors who take time to listen, discern the significance of the words they hear, and intuit the importance of what is unspoken. Lacunose conversations do not unnerve them: in the awkward spaces that others would fill with polite chat, chaplains affirm*

> *the peace that comes in shared silence…The spiritual work is to help identify the presence of God, for those who seek him, especially in the midst of suffering. Without the spiritual dynamic, patient care is less than complete.*[29]

Unlike other hospice practitioners, the literature portrays chaplains with a sense of comfort and familiarity with conversational aspects of spiritual development. They are able to pinpoint the correct timing and place in conversation to affirm spiritual development. What's more, their interpersonal skills extend into a spiritual language unfamiliar to other hospice and palliative care practitioners, allowing them to relate to patients in a more subtle, yet impactful way. They speak a language that supersedes explicit thought, a language contained in the spaces of exchanged meaning. No matter the religious and cultural differences that patients present, chaplains are able to read between the lines and appeal to a universally shared spirituality.

I want to point out that what Reverend Purdy is really getting at here reflects a 20th century re-working of theological ambitions. His depiction of hospice and palliative care chaplaincy rings of cosmopolitanism, pushing a desire to build a unified spiritual community. No matter the variations contained across religious traditions, or individual worldviews, they are all one in the same when boiled down to their spiritual essence. Reverend Purdy is alluding to a deeper meaning that is shared across spiritual borders. Patients are understood to undergo similar processes of spiritual transformation.

Yet this portrayal of hospice chaplaincy contradicts the multicultural values that the postmodern approach allegedly adheres to. It glosses over the rituals, practices, and individualized beliefs of patient worldviews. This point draws out the complexity of the situation at hand. It must be stated that, in part, this notion of spirituality is necessary to

the work of hospice chaplains. Regardless of whether they are relating to patient spirituality through a theological lens, the chaplain approach was cultivated with a purpose in mind. Religious-specific institutions like private Catholic hospitals receive patients across the cultural and spiritual spectrum, not just Catholics alone. Hospice chaplains must be able to take a step back and talk about spirituality in universal terms. Now, whether or not these terms have substantial meaning outside of the theological context must be questioned and will be returned to later. For now it must suffice to say that hospice chaplains rely on this implicit notion of spirituality with good of the patient in mind.

Therefore, allow me to touch on whether I believe that this implicit notion of spirituality places chaplains in a proselytizing role. While it is safe to say that the typical hospice chaplain is not condemning patients to hell or brazenly bringing up Christian doctrine in inadmissible situations, one might say that they are covertly pushing Christian thought onto their patients, whether conscious of it or not. I want to address this concern by pointing to the training that chaplains must undergo in order to practice in hospice and palliative care. These are not men and women who simply decide to jump into these settings and do good in the world. They must undergo board certification and meet criteria set out by the National Consensus Conference that convened in order to improve the quality of spiritual care as a dimension of palliative care.[28] The training program entails interfaith education and brings together theological students and spiritual specialists across traditions, encouraging cross-denominational dialogue in training. They are expected to understand the boundaries that exist between healthcare professionals and patients.[27] Therefore hospice and palliative care chaplains are typically mindful of patient

boundaries and willing to incorporate their traditional religious training only if the patient requests it.

Admittedly, this is a simplified version of what spirituality in hospice and palliative care spiritual care looks like, and I would like to add a few reservations to this discussion. First, it's easy to fall into the trappings of homogenizing communities and their practices. Hospice and palliative care is no exception to this point, as the functional role of hospice chaplains does not always involve meticulous spiritual engagement with the patient. They may be called upon solely to act solely as a listening presence in situations of life review and storytelling. In this capacity they still play some role in the spiritual needs of the patient, but do so in a more passive role that does not require any notion of spirituality on their part. Second, patients may request other forms of spiritual intervention that extend outside the responsibilities of the hospice chaplain. Under these circumstances medical practitioners typically diagnose spiritual concerns and recommend therapeutic interventions such as massage, yoga, exercise, art therapy, and so on. These forms of spiritual therapies tend to be associated with either non-Christian religious practices or secular forms of healing.[28]

Nonetheless, it is important to note that a seemingly nondenominational approach to spirituality arose out of a long line of theological development in postmodern thought. This system seeks to validate diverse cultural views, and does so with a universal notion of spirituality that underpins the entire enterprise. This is not a problem in itself – I do not hope to push a whole-hearted attack on theology. Rather, it must be understood this postmodern and theological notion of spirituality poses issues within the medical contexts of hospice and palliative care. Medical practitioners and chaplains alike must verbally

diagnose spiritual distress in order to refer proper treatment. This requires that they put spirituality into explicit words. It is not enough to rely on interpersonal skills or prior experience to guide patients along spiritual development. As a result, the literature on hospice and palliative care struggles to agree on a precise guide to spiritual care. Spiritual intervention is hesitant to impose on individual cultural and religious values, but must somehow formulate a bridge into patient worldviews. I find that the literature has not fully tackled this challenge. It covertly relies on postmodern theological notions of spirituality that leave discussions and interventions lacking in substantial existential care.

Implicit Spirituality as Transcendent Meaning Making

I now show how theological developments within postmodern thought have come to influence the care roles of non-chaplain practitioners and structured hospice care practices. We see that an implicit notion of spirituality lies beneath a desire to respect individual religious and cultural belief. I demonstrate that the postmodern approach pushes spirituality as an inherent need for transcendent meaning making through vague terminology. While I do not wish to dive into the validity of this definition, I end this section by questioning whether it properly counteracts physically reductionist views on dying.

While hospice chaplains are assumed to take a more theologically oriented role, other hospice caregivers including medical staff, social workers, and volunteers are grouped together into a different pool of spiritual practitioners. It's almost a given in the literature that these traditionally secular roles are not required to possess the same level of spiritual expertise as chaplains do:

> *The chaplain is a healthcare professional who has been trained to offer spiritual care to all people of any or no religious tradition and whose primary focus is the spiritual*

> *needs of patients, families, and staff…As counselors, they take time to listen, discern the significance of the words spoken, intuit what is the importance of what is unspoken, and affirm the value of shared silence…"Health professionals can also provide support by silent witnessing, and presencing, as well as serving as a liaison with other health professionals in addressing physical, emotional, and spiritual needs.*[19]

The interpersonal and qualitative skills of the hospice chaplain that we have previously described are set apart from the less active roles of other healthcare providers. It's understood that non-chaplain practitioners are not as capable in navigating spiritual interactions. Yet hospice and palliative care structures its over-arching care model around four central tenets of patient care – physical, social, psychological, and spiritual wellbeing. It's held that no one part completes the entirety of patient care, that a fault in one aspect deserves equal attention amongst the rest. So how much attention do the more secular positions of hospice and palliative care lend to spiritual concerns, and in what capacity can they effectively identify and treat these concerns? A more nuanced discussion is to be had. Let us turn to the processes of spiritual diagnosis and spiritual intervention. We will come to see that the same implicit and universal notion of spirituality works its way into the roles of non-chaplain practitioners. It structures the way in which they discuss spiritual concerns and relate to patient worldviews. While a substantial effort is made to respect patient outward expressions of spirituality, it is still assumed that spirituality lies at the core of the human condition as an inherent characteristic.

Hospice and palliative care performs an initial spiritual screening upon entry into care, and follows with additional assessments along the length of patient care. These are typically geared towards identifying religious and cultural factors that are important to

patient worldviews. They serve as the starting point on which further spiritual conversation and future spiritual interventions are based upon. Numerous mnemonics (FICA, SPIRIT, etc.) have been developed to guide team members along these assessments. Although each possesses additional discussion points, every mnemonic guide hits on three key themes – personal and organized beliefs, importance of these beliefs, and the role of HPC in these beliefs.[12] It becomes apparent that spiritual assessments are structured so that hospice practitioners may inquire into patient spiritual identities without impressing upon them. Consider the following excerpt from a publication geared towards spiritually competent social work:

> *Conducting a spiritual assessment provides essential information for spiritually competent hospice work. This information facilitates a multifaceted understanding of the patient's religious and/or spiritual beliefs, provides an opportunity to communicate respect for the patient's spiritual worldview, and clarifies potential religious and/or spiritual resources that may be used throughout the intervention process.*[7]

I want to draw attention to the closing words *that may be used throughout the intervention process.* Spiritual assessments identify key features within the patient worldview that provide hospice practitioners with something substantive to work with. It's not so much that they are simply acknowledging and referencing these spiritual elements; rather, there is an underlying assumption that they can be relied upon in some fashion for directed spiritual care.[7]

Consider other sources of literature, such as some nursing manuals,[12, 19] that follow this trend to leave spirituality on a superficial level. These outward religious and cultural

factors are assumed to point inward and influence a patient's subjective notion of spirituality. Value systems are described in detail for African American, Chinese, Indian, Native American, and Hispanic and Latino populations. Contributing factors range from views on society, cosmology, symbolism, ritual, and attitudes regarding end of life care. One can find specifics related to specific doctrine that may arise such as karma or the Four Noble Truths, as well as objects relevant to cultural customs that may need to be referenced. Therefore hospice practitioners, whether chaplains or otherwise, are instructed to maintain a general awareness of systems of beliefs and practices in order to respect individualized expressions of spirituality.[12]

It becomes a daunting task, however, to include a working knowledge of the vast symbols that span across cultural and religious systems. What's more, spirituality is assumed to be a latent concept, relying on indicators that do not directly refer to the topic itself.[2] Patients frequently relate spiritual distress through physical or psychological terminology, a trend that reflects the dominant psychosomatic duality present in the English language.[26] As a result, a challenge arises on how to engage with patients in a manner that respects their individual viewpoints while maintaining a clear conceptual basis. I found that the postmodern approach draws upon a distinct repertoire of spiritual terminology to engage with patients and formulate spiritual interventions. The literature is replete with spiritual buzzwords like transcendence, meaning, connection, or purpose. While lacking substantial meaning on their own, these terms benefit hospice and palliative care practitioners because they can be morphed into the patient's subjective worldview. This leads to near endless possibilities in meaning depending on how patients interpret these words.[21]

Academic scholars, certainly those within the field of religion, will point to the loaded historical contexts surrounding these terms. We cannot, and should not, assume that meaning, transcendence, purpose, and so on underwent the same developmental trajectory. I do not intend to say that these spiritual buzzwords are one and the same, essentially acting as synonyms for one another. They each require nuanced attention and scrutiny to fully grasp their importance within the literature on hospice care. This task is beyond the scope of this paper. Instead, I hope to emphasize that their nuanced meanings are not delineated in the literature.

Allow me to touch upon the spiritual terminology that's found in empirically driven studies. I do so in order to illustrate why these terms are so prominently situated within qualitative studies as well as spiritual interventions. Briefly, as we have come to learn, hospice and palliative care followed in the postmodern trend away from Christianity to phenomenological and existential descriptions of spirituality. The aforementioned "old traditional form" of spirituality relied on Christian oriented descriptors of meaning. Hospice practitioners could easily locate and discuss these tradition-specific matters because they are identified under established frames of reference.[21] Such a take on spirituality could also be quantified utilizing Allport and Ross's Religious Orientation Scale. This survey relied on crude measurements of religion that focused on references to God and the afterlife, church attendance, or prayer frequency.[1, 2]

I think in general public health officials have difficulty talking about religion because empirical research doesn't go into what religion is really about. It doesn't take into account the social influences that shape the usual division between belief and practice. There's a strong tendency within the social sciences to separate spirituality as an alternative to the

institutionalized practices of religion. Researchers construct their studies around clearly "religious" activities or beliefs on the one hand, while turning to private and personalized spirituality on the other. In many cases, however, spirituality is closely tied to institutionalized practice, as a way to inject a sense of importance to traditional practices. In this way, spirituality has been proposed as a form of internal Christian discourse that critiques rather than rejects institutional practice.[34] I believe that the inclusion of certain spiritual terminology rides this trend to dig into the essence of religious practice underneath its outward coating of religious and cultural elements.

Therefore when we consider these spiritual buzzwords, it's important to understand that they are called upon to bring a sense of life to the study of spirituality in hospice and palliative care. They represent contemporary research attempts in the field to explain why people suffer and heal beyond a purely biological or psychological account. Yet when we examine these terms more closely, we see that there are significant similarities to our previous discussion on the progression of spirituality within postmodern theology. Within the postmodern approach, both theology and the social sciences, chaplains and non-chaplain practitioners, spiritual terminology relates to the same underlying notion of spirituality that humans at their core possess a need for transcendent meaning making. What's more, while the social sciences typically attempt to remain non-religious, this need for meaning beyond this world parallels postmodern development that shifted the focus point from God to other states of being contained in these spiritual buzzwords of purpose, connection, and so on.

A telling example can be found in Ann Callahan's treatment of spirituality as she provides guidance for spiritually-sensitive work in generalist practice. She draws from

what Martin Buber's "I-thou" relationship and bases her discussion on a theme of connection. That is, patients are not merely finding a sense of profundity in their relationships, but engaging with a timeless form of being with another through that connection:

> *The realm between refers to the transient psychic (or spiritual) space that is shared by those who closely identify with each other during an 'I-thou' encounter, based on the assumption that one can encounter the divine in others."*[6]

This example attaches a clearly theological reference to its claimed spiritual space of connection. It takes on an overt focus on meaning in spiritual practice. The function of spiritual care directs patients towards a transcendent plane of meaning through which they are understood to find a stable sense of being in their turbulent state of dying.

I bring this lone example to the table because I believe it represents the use of other spiritual buzzwords within the literature. Often these terms are lumped together within a single list or discussion that tends to blur their distinctions:

> *In relation to transcendence, researchers believed that spirituality transcends the context of reality and exists through and beyond time and place. Liberation from suffering and opening to life and death were considered an aspect of transcendence. In the theme relating to connectedness, the authors conceptualized spirituality as relationships with Self, Others, Nature, and Higher Being. Love, harmony and wholeness are important elements of these relationships. In relation to the theme of power/force/energy, concepts that emerged revealed that researchers defined spirituality as including creative energy, motivation, guidance, and striving for inspiration.*[5]

This sort of description leaves us with nothing more than a list of spiritual terminology explained by terms that require further explanation. I find this to be a problematic tendency that works its way into spiritual care practices within applied hospice and palliative care settings. Again, as we chip away at the individual ways in which spirituality is described in the literature, we find that it ultimately reverts back to a theologically derived notion of spirituality.

Hospice and palliative care stripped itself of explicit Christian doctrine, but in doing so, spiritual discussions and interventions have become too broad and utterly vague. There are few attempts in the literature to explain these terms in detail, instead relying on them to describe the more encompassing and undefined notion of spirituality. This leads to a gap in care as chaplains and other practitioners in hospice and palliative care are expected to lead patients towards these opaque goals. They assume that discussions on spirituality will somehow contribute to this effort, and they might actually do so, but I think there is an important problem with this stance. Without a theological basis, these terms do not always infer substantial meaning on the patient. They are left to their own faculties to interpret these words, which were directly derived and geared from a theological viewpoint.

Turning now to spiritual interventions under the postmodern approach, we now begin to see that an underlying notion of spirituality emerges as hospice practitioners engage with these perceived religious and cultural elements. Again, that is, the postmodern approach asserts spirituality as an inherent need for transcendent meaning making. It assumes that by interacting with expressed spiritual elements, the inner spiritual core can somehow be tapped. First and foremost, an emphasis is placed on listening to patients rather than instructing patients. Discussions are opened using nonreligious language and

rely on patient replies to frame further questions. For example, practitioners may ask "What gives you hope?" or "What sort of legacy will you leave behind?" Patients may respond with religious markers like God or faith or more nonreligious terms like connection or love. Practitioners further the conversation by parroting the patient responses. More creative expressions of spirituality are also encouraged through the use of spiritual life maps. Patients depict their spiritual timeline in the past, present, and/or future and include significant influences like relationships, events, or beliefs.[12] These discursive and creative methods of interaction frame the conversation within the patient worldview without inserting practitioner values. At times it's even acknowledged that discussions on spirituality do not require any responses at all; rather the mere act of listening and remaining present serve as a form of spiritual care.[28] It is as though this approach intends to spark a process of spiritual reflection that ultimately guides patients to a sense of spiritual wellbeing without a clear sense of how this procedure occurs.

Finally, this leads us to consider the nuances of spirituality under the postmodern approach. I want to highlight important aspects that I believe implicates patient care. I will rely on the National Consensus Project for Quality Palliative Care which convened in the attempt to establish a unified notion of spirituality. The contributing authors drafted the following definition of spirituality to serve as a starting point for relating to the wide range of spiritual viewpoints:

> *Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred.*[28]

Spirituality thus defined adopts a universal characteristic that pervades the various manifestations of cultural and religious beliefs. It's the ubiquitous drive to valorize one's own life. No matter the specific personal worldview that is constructed around it, all people possess an inner spiritual need to find meaning, purpose, and a sense of belonging in the world. Key to the contexts of patient care, this definition of spirituality simultaneously respects the many viewpoints that palliative care practitioners will encounter while leaving a common avenue through which they may relate and care for their patients.

Even for those who identify as non-religious, HPC literature points to an inner spiritual aspect that they cannot escape:

> *All people are spiritual because at some point in their life, all seek meaning and healing. Thus, spirituality, broadly defined, is inclusive of nonbelievers as well as the religious. Atheists, agnostics, spiritual but not religious, and religious patients all have an inner life that can be encompassed within the overall understanding of spirituality.*[28]

This universal definition of spirituality takes an implicit stance on human cognition. It posits that people make of sense the world around them – their environment, disease, relationships, self-image – in a way that either pulls them out of the dregs of the mundane or sends them crashing down into it.

In order to appreciate the ontological claims proposed through this universal definition of spirituality, I turn to the historian of religion Mircea Eliade and his notion of the *homo religious.* His famous dichotomy between the sacred and profane speaks of a system of values that overlays the ordinary world around us. It provides humans with a sense of purpose and comfort that reassures that life isn't a web of meaningless

relationships and pursuits. The *homo religious* derives a sense of his being in the world by modeling himself on a higher order system of the sacred. HPC similarly posits a state of transcendence beyond one's current states of physical and psychological suffering.[15] Individuals are able to conceive of their existence beyond their status as dying patients.

The postmodern approach models Eliade's perception of spirituality and the spiritual being. It takes a two-pronged stance that upholds multicultural and religious viewpoints while propounding a universal need for existential validation. We see parallels between the sacred and patient worldviews as systems of higher order meaning. Likewise, *homo religious* reflects the ontological premise that patients tap into this higher order meaning to transcend and find relief from their current state of suffering.[10]

I agree with this stance on spirituality that patients possess an innate need for higher order meaning in times of extreme suffering. I diverge from the postmodern approach, however, on whether to leave spiritual healing within the framework of patient worldviews. Under the current framework of patient treatment, this combined multicultural and universal approach relies on blind expectations. Spiritual wellbeing – " the ability of a person to find solace, comfort, connection, meaning, and purpose in the midst of suffering, disarray, and pain"[28] – alludes to the debilitating anxiety of existential annihilation, but there lacks any substantial reference to the medical ideology that lies at the roots of spiritual distress. The postmodern approach makes an assumption that all patients will eventually resolve their existential crisis by reflecting on their subjective value systems. While this may be beneficial in its own right, it does not directly follow that individual worldviews are structured in a way that provides an existential basis to life. I

find that the postmodern approach dodges the immediate ideological problem at hand and constructs its treatment around false assumptions.

That is why an alternative leap must be implemented in order to properly address the existential crisis brought about by the medical treatment of death. I hold we should not view spirituality so far removed from medical practice, that this aspect of care heavily shapes the patient experience during the dying process. All patients within hospice and palliative care are subjected to physically-oriented medical care. Many of the routine services provided are centered on pain and symptom management, provision of medical equipment and drugs, and familial instruction on how to provide care. Other services are included such as bereavement, counseling, respite, and of clear importance to this paper, spiritual and psychosocial care.[24] My point being, however, that social views on dying are impeded by a dominating physically reductionist stance. Drawing from a guide to the dying process that I received during my training as a hospice volunteer, it's apparent that the patient and familial experience of the dying timeline is framed around changes in physical and psychological symptoms. Families are instructed to look for changes that may indicate that their loved one is progressing closer towards death. Notable symptoms include breathing patterns, coughing, grayish skin color, cool feeling skin, and incontinence. The patient may become restless, confused, hallucinatory, or withdrawn.[11] Likewise, prior work has shown that both physical and non-physical symbolism provides context to patient and family experiences of dying as well as expressions of grief.[32] These elements construct the dying timeline into an ordered sequence of events that guide patient, familial, and even practitioner into the final moment of death.

Concluding Remarks

Hospice and palliative care presents a unique healthcare setting in its explicit willingness to include spirituality into the commonly perceived secular practice of medical care. I have shown that the postmodern approach is distinguished by a theologically derived notion of spirituality as a transcendent need for meaning making. We see it influences the ways in which hospice chaplains and non-chaplain practitioners relate to and engage with patients, and it structures both spiritual diagnoses and spiritual interventions. The postmodern approach prioritizes individual worldviews, but also pushes an implicit notion of spirituality. As I have shown, it takes spirituality as a universal need for transcendent meaning making in order to bridge the experiential gap between patient and practitioner worldviews and bring a sense of what it really means to be religious into the sphere of spiritual care. Both chaplains and non-chaplain practitioners are understood to be able to work with and engage with patient spirituality through their own means.

Nonetheless, there are problems with this approach that I hoped to draw out. The literature relies on vague spiritual buzzwords that find its way into spiritual care practices in hospice and palliative care. Furthermore, the postmodern approach makes the assumption that patients will cultivate this perceived inner need for higher meaning within their respective spiritual worldviews. I believe that this point needs to be revisited, possibly by rethinking the intense focus on physical symptoms throughout the dying process. I hold that the medical ideology of dying pushes a physically reductionist stance on dying that is not properly mediated.

I think that it goes without saying that spirituality is highly abstract and eludes precise conceptual definitions. This poses problems within a field that must construct a working framework to gauge health outcomes across treatment options. Following the postmodern trend away from explicit Christian doctrine, authors across hospice and palliative care literature have come to rely on concepts that are based the aforementioned vague, existential values.[2] I hope that my discussion clarifies points of coherency that may provide guidance and practical benefit, and show that theology, the social sciences, and medical practice are more closely intertwined than we previously considered. These fields do not simply work side-by-side in the treatment of the dying; rather, they modulate each other by influencing how researchers, practitioners, and patients relate to the dying process. I believe that hospice and palliative care provides a clear window into culturally engrained views on dying and spirituality that can be further applied to general medical care and American society at large.

Chapter III: The Psychological Approach to Spirituality

Introduction

In this chapter, I will largely apply a similar method of analysis from the previous chapter in order to clarify what I call the psychological approach. I found that much of the literature on hospice and palliative care embraces a tendency to align spiritual care approaches with psychological methods on religion. In the space that follows, I hope to unearth the motivations for doing so, and delineate both the benefits and drawbacks of taking such an approach.

I will start with the work of William James and his appeal to the psychological arena of the religious. His methods introduced an avenue to empirically study and interpret religious experience without taking an overtly reductionist stance. The psychological approach relies on similar methods that take psychological expressions as indicators for patient spirituality. Then, I turn to the developments of spirituality in the late 20th century. During this time spirituality was pushed inwards and related to notions of the self. In essence it took over the realm of humanistic psychology, and influences spiritual interventions structured to preserve a lasting identity through memory and narrative. I end the chapter by reflecting on the implications the spiritual care approach holds for existential distress. I question whether a stagnant sense of self is beneficial to dying patients.

But before diving in, it will be helpful to take a glance back at the previous chapter on the postmodern approach. It's important to understand that the two approaches are not opposed to each other. These are groupings that I applied to the hospice and palliative care literature in order to highlight two prominent usages and conceptualizations of spirituality.

There are certainly cases in the literature in which the psychological approach displays values and practices that are key to the postmodern side. This is especially true in the attempts to uphold individualized spiritual worldviews. Spiritual interventions based on the psychological approach respect the experiential qualities of patients and uphold the cultural differences that may implicate spiritual responses to dying.

Nonetheless, I hold that the psychological approach is more willing to step into patient worldviews. Psychological descriptions of spirituality provide hospice practitioners with a culturally neutral medium to gather a sense of patient spirituality. By appealing to certain emotions and cognitive states, the psychological approach provides them with the means to tap into and work with patients on a spiritual level.

"A Sense of" – a Means of Empirical Measurement

Hospice and palliative care presents a unique situation in its inclusion of spirituality. To my knowledge, there is no other field of medicine that so enthusiastically incorporates spirituality as a dimension of health even to the point that it's considered vital to patient wellbeing. This requires a balancing act between seemingly opposite ends of the spectrum, between religion and secularism, and why I believe the psychological approach to spirituality has proven useful to hospice and palliative care. It's taken as a valid way to understand and talk about spirituality within the medical profession. Therefore, at the expense conceptualizing spirituality, I want to first emphasize the methods that William James brought to hospice and palliative care. I hold that this has been his lasting contribution to the field. James' methods have structured the methods of studying, measuring, and engaging with spirituality within the secular practice of modern medicine.

In *The Varieties of Religious Experience*, William James introduced a method of studying religion that has carried forward into the current literature on hospice and palliative care. The resulting discipline, coined the psychology of religion, focused on the mental states of religious adherents. It defined religious and spiritual experiences through emotional and cognitive descriptions. Consider an excerpt on what James considered vital to the religious experience:

> *If religion is to mean anything definite for us, it seems to me that we ought to take it as meaning this added dimension of emotion, this enthusiastic temper of espousal, in regions where morality strictly so called can at best but bow its head and acquiesce.*[14]

For James, a distinct emotional exuberance accompanies the religious life. This isn't just a feeling of joy or bliss; rather, the religious experience entails an intense and quite abnormal state of mind. The emotional quality of religion takes us out of the mundane workings of the world and makes us feel as though we are progressing towards what he called the "divine ideal." Religion, or spirituality for hospice and palliative care, leads us to believe that we are not merely agents acting out of necessity. Instead, our lives are filled with a sense of importance derived from these instances of unique cognitive states.

Of course it must be understood that James was wrapped in heated debates of his day. In the early 20th century, there was much discussion on whether a scientific study of religion would miss the mark entirely. By scrutinizing religion from afar, many scholars argued that the field would lose sight of important experiential qualities. A scientific approach would neglect why religion is important for its adherents and what it feels like to be religious. James sought to mediate this concern by conceptualizing religion on a transcendent plane on the one hand, while reducing its experiential qualities into

psychological descriptions on the other. This tactful move allowed James to appeal to the distinctive nature of religious experience while still analyzing it through methods suitable to a scientific approach. His methodology describes this otherly experience in cognitive terms. Although James couldn't fully get at what the religious experience truly entails (how could he if the religious experience supersedes this world), he allows us to peek into that experience through psychological references. His methods of study created a window for us to catch a glimpse of experiential religious qualities and created a means to refer to those experiences.[33]

And this is how I would like to characterize the psychological approach to spirituality in hospice and palliative care. Although we're concerned with medical contexts over a century later, we can draw parallels between their methods. William James brought a wave of attention to the psychological factors that play into religious experience. The feelings and descriptive experiences of religious adherents took precedence over the sources of those experiences. In other words, the psychological study of religion focused on the immediacy of the religious experience and its expression within the minds of religious adherents.[2] Similarly, the psychological approach refers to spirituality among a conglomeration of emotional qualities like sense of peace, sense of connection, or sense of resolution. It's this "sense of" that respects the experience of spirituality while permitting an outside analysis of that experience.

Harvey Chochinov and Beverley Cann highlight a key link between psychological expression and spiritual wellbeing. They reference the same spiritual buzzwords that we saw in the postmodern approach, terms like hope, connection, meaning, purpose, and so on, but they apply a psychological spin. They state:

> *If the essence of spirituality is connectedness to something that imbues life with a sense of purpose or meaning, a paucity of either would logically correlate with a disinvestment in life itself. It is therefore consistent that spiritual well-being may be a buffer against depression, hopelessness, and a desire for death in patients with advanced cancer."*[8]

The researchers apply these spiritual terms into a more psychiatric context, essentially posing spirituality as the driving force to live. It's understood to imbue one's world with motivating meaning and purpose. With that in mind, they then make an important proposition. If we assume that a lack of spirituality leads to psychological distress – "depression, hopelessness, and a desire for death" – then we can similarly assume that the reverse must be true. A state of spiritual wellbeing can be inferred by the presence of these expressed psychological markers. In this way, spiritual wellbeing and psychology are joined at the hip in patient discourse.

This point is crucial to the interventional methods of the psychological approach. Its interventions sidestep direct conceptualizations of spirituality and instead turn to its effects on the patient's psyche. Consider further the following statement that reworks an initial definition of spirituality as a concept into spirituality as a process or function:

> *Within the religious realm of this broad framework, spirituality aligns itself with a sense of connectedness to a personal God, whereas within the secular realm, it invokes a search for significance and meaning. Although the source or inspiration for such significance will vary from person to person, what they hold in common is their ability to imbue life with an overarching sense of purpose and meaning, including a sustained investment in life itself* [8]

Certain phrases within this quote deserve close attention. If we read into this seemingly definitive conceptualization of spirituality, we find that Chochinov and Cann are alluding to the unique methodological qualities of the psychological approach. Similar to the postmodern approach, spirituality is positioned as the human need for higher order meaning. But here we see that spirituality is not left within the patient's worldview. Instead, the psychological approach seeks to step into that worldview and understand how patients express their spirituality. Notice that there is an allowance for variance from person to person, but most importantly, spirituality leads to a sense *of* purpose, meaning, and investment in life. Spirituality arises from a universal cognitive framework. The brain is hardwired with some sort of process that leads to these cognitive mental states and expressed feelings. The psychological approach essentially leaves spirituality at face value, and instead tries to cultivate these derived psychological qualities. In doing so, it proceeds with the assumption that a patient's spiritual side will be fulfilled. Spirituality as a "search for" leading to "a sense of" is completed by psychological intervention. By attending to and attenuating the emotional distress that arises during the dying process, the psychological approach can reach a cognitive frame of mind that extends into what James identified as the "added dimension of emotion."[8]

Additionally, positioning spirituality as a "sense of" is practical for empirical studies. It allows researchers to quantify a patient's state of spiritual wellbeing by noting the frequency of certain emotional and psychological expressions. And perhaps, all things considered, this is the most practical means of spiritual measurement. The English language lacks ways in which people can fully articulate their spiritual experience. On the one hand, patients rely on terms like transcendence or connection that direct us towards

spiritual matters but don't necessarily say anything about the spiritual experience itself. On the other hand, they can couch their spiritual concerns in psychological symptoms, and in doing so describe spirituality with more relatability. I think that it can be agreed that Western culture is generally more familiar with the meanings of anxiety, fear, or regret. Therefore the psychological approach is understood to offer an accurate means to pinpoint and measure patient spirituality. It provides hospice and palliative practitioners with an avenue to discern and work with patients' spiritual needs.[22]

Spirituality as a Preservation of the Self

The psychological approach attends to a needed aspect of care. It helps patients develop a sense of emotional stability and psychological wellbeing as they proceed through the dying process. Patients and their families are able to create narratives that allow them to reach a cognitive state in which they feel connected to the life that was lived, and ultimately proceed into the final stage of death in a healthy frame of mind. I can't overstate how implicated the psychological approach is to holistic wellbeing.

But there is much more at stake under the psychological approach to spirituality. Its methods assume that spirituality is encapsulated through psychological interpretation without having to definitively define the concept. While it attends to a specific aspect of care and reaps immense benefits for patient wellbeing, it does not consider that other notions of spirituality may be at play within the hospice and palliative care settings. In many cases, spirituality comes to denote a core aspect of human being, the locus of individual identity. By attaching these concepts to patient emotions, it intertwines personhood with an embodied notion of the mind. As the patient cognitively and physically

declines, so too does their sense of identity. This leads me to consider the drawbacks to the psychological approach. Before that, allow me to provide some context to these claims.

Here I draw from the work of Lucy Bregman, who provides a much-needed analysis of spirituality in the latter half of the 21th century. She provides a historical note of clarity that I think will be useful to our current discussion of spirituality in hospice and palliative care. Her central question asks why spirituality has come to replace religion when one can seemingly interchange the two terms. We commonly think of spirituality as a synonym for religion, but historically speaking, spirituality picked up important connotations in relation to religion. The vagueness that surrounds the term is no accident. In fact, it's allowed the loaded term to insert itself into a wide range of contexts. For the purposes of hospice and palliative care, I want to emphasize two key developments that Bregman points out. First, spirituality was pushed into the private lives of individuals to the point that it was linked to conceptions of personal identity. And second, spirituality essentially replaced humanistic psychology as the companion to clinical psychiatry. I do not want to steer us too far into Bregman's historical analysis, but I will touch on it enough to consider its worth to hospice and palliative care.[4]

In the latter half of the 21st century, spirituality arose to prominence not only within academic circles but also among the American public. Spirituality transitioned from its roots in Christian asceticism to a term enshrouded by privatized and anti-institutional connotations. It followed a series of developments so that it came to convey one's personal philosophy of sorts. That is, it encapsulates the sets of rituals, values, ethics, and so on that define an individual outside of traditional belief systems. But the buck doesn't stop there.

Spirituality is not only an alternative to traditional religion, but also came to be understood as an essential quality of being. Bregman describes this as:

> *fulfilling our unique humanness, expressing our spiritual nature as we become who we know we can and ought to be. Religion, in this view, is a secondary category; it organizes and provides a cultural framing for this underlying core of "spirituality." Religion is not universal, nor is it necessary to our humanity; spirituality is both.*

In this way, spirituality could relate to any cultural, political, religious, or personal ideology. Swinging a golf club on a Sunday morning is just as relevant to our discussion of spirituality as receiving the host during a Catholic mass. Anything can be taken as a spiritual act. More importantly, the locus of spirituality was pushed further inwards away from institutionalized religion so that it came to be equated with the self. It's an inner sense of identity contained and expressed through the activities that we value most. Under this line of thought, just as the devout Catholic seeks communion in order to realize a moral self in line with Jesus Christ, so too does the pious golfer strive for the highest identity achieved in mastery of his craft.[4]

As spirituality situated itself into the interior lives of people, the move to replace humanistic psychology was made all the easier. Spirituality thus described denotes a process of self-transformation, a progression towards an ideal sense of self. And in the contexts of hospice and palliative care, this meshing of an inner spiritual with the cognitive language of psychology has blurred the distinction between the two fields. Bregman would go as far to say that the famed Elisabeth Kübler-Ross would align herself with spiritual work rather than contemporary notions of psychology:

> *At a meeting several years ago of a professional group dealing with death and dying, a participant stated that "If Kübler-Ross were working now, she'd be doing spirituality, not psychology." She would not have changed the content, the core ideas, or even the language she used; but "psychology" is no longer the best venue or domain in which to promote ideas such as "acceptance of death" or "death as the final stage of growth"…Kübler-Ross, who resisted "scientific thanatology," would surely prefer to dissociate from that kind of psychology, and ally her work with "spirituality."*

If this explanation holds true, then the link between humanistic psychology of Kübler-Ross and contemporary uses of spirituality is nothing more than a change in semantics. Spirituality took over the domain of self-actualization, and in the contexts of hospice and palliative care, inherited a cognitive language of self-growth. The dying process becomes a stage in life in which people must realize their true selves and finally solidify who they were meant to be.[4]

Thus the push to include spirituality into the contexts of hospice and palliative care was in part due to a need to resist a physically reductionist view on dying. But this has led to a convolution of theological and psychological interpretations on spirituality, a development that has not sat well on all fronts. Consider the work of Rachel Stanworth, a former researcher in hospice and palliative care, where we find a certain pushback against the final equation of humanistic psychology with contemporary spirituality:

> *Methods and standpoints may differ, but spiritual and psychological explorations are both concerned with the same creature. Theology can no more exclude from 'soul' what conventionally belongs to 'psyche' than psychology can exclude from 'psyche' what traditionally is ascribed to the 'soul'…A psychology founded exclusively on a*

> *scientific model, however, will always be frustrated by its inability to handle deeply personal questions regarding what we believe about the nature of human beings and our relationships.*[37]

Stanworth acknowledges that psychology and theology have taken on a similar subject matter in terms of personhood at the time of dying. Whether understood in terms of the soul or psyche, both refer to an immutable self that lies behind or even beyond the changes that occur during the dying process. They both point towards an inner essence that serves as a source of identity distinct from the physical body and the world.

What's more, Stanworth demonstrates a unique point of interaction between the postmodern and psychological approaches. While many researchers take on elements from both approaches, here lies a case in which one approach actively attempts to supersede the other:

> *Psychotherapy is about helping people to cope with daily life–such as earning a living or maintaining relationships, or at particularly times of stress, such as at divorce or bereavement. Spirituality may find expression in such moments but, for many, it is also concerned with our sense of connection to any 'cosmic design' or 'essential' that precedes our condition.*[37]

Stanworth follows what I label as the postmodern approach, that spirituality denotes an inner drive to find transcendent meaning in the world. But what exactly is she doing here, since she labels spirituality as "a sense of connection to any 'cosmic design,'" and before I stated that the psychological approach similarly aims for cognitive states indicated by a "sense of." Here, Stanworth reworks this phrase into a hierarchical paradigm. She takes what the psychological approach seeks to develop, in this case a broad sense of connection,

and places it within the boundaries of the immediate world. It is only concerned with cognitive and emotional states of mind. The efficacy of this approach lies in its ability to mediate psychological distress arising from particularly stressful situations. Conversely, she aligns the postmodern approach with a need for the sacred or transcendent. Its goals extend beyond this world into an area of experience that eludes the material or social. In this way, psychological treatment is understood to be a necessary, but lower form of treatment.

Stanworth takes on a political task within the field of dying that resists the psychological approach to spirituality. Her work represents theological efforts to neatly position the postmodern approach as a more suitable form of treatment. And most interestingly, he illustrates a subtle objective within hospice and palliative care literature to disentangle humanistic psychology from notions of the self. Stanworth acknowledges that psychological treatment provides some benefit to spiritual wellbeing, but its effects do not reach into the inner spiritual core of patient personhood. The psyche itself does not fully encapsulate the inner drive for meaning that she identifies as the essential quality of human being.

While I do not want to make a statement on how to properly understand patient personhood, this is an over-simplification of the psychological approach. It must be understood that psychological treatment of spirituality possesses more nuance than Stanworth would allow in its conception of personhood. As Bregman and Stanworth state, spirituality and humanistic psychology have become so intertwined the former now encompasses some contemporary notions of the self. Even prior conceptualizations of the Christian soul have been replaced by terminology geared towards the psyche. In this way,

psychological treatment in hospice and palliative care is not only directed towards certain cognitive states, but also towards the development of patient personhood. Many forms of spiritual treatment under the psychological approach work with memory and narrative in order to solidify a firm sense of self leading up to the final moment of death.

I now return to the work of Harvey Chochinov and draw upon his model of Dignity Therapy as an exemplary form of spiritual treatment under the psychological approach. This form of care is cited as one of twenty-three examples of spiritual health interventions according to the Consensus Conference on the Quality of Spiritual Care. While this might seemingly exclude a number of spiritual interventions, I found that Dignity Therapy encompasses many of the other twenty-three examples.

First allow me to explain the primary methods of Dignity Therapy, namely life review and life narrative. In the former, patients look back on key moments in their lives in order to identify points of conflict. It gives them a chance to reflect on these past experiences in order to develop a sense of resolution either on their own or with others involved. Patients often experience a moral drive to find a sense of closure before heading into their final moments. In a way, they are able to unhook themselves from issues in the past and turn their focus towards their immediate situation.[9, 15] Life narrative, on the other hand, aims to situate a patient's current experience of dying into their living timeline. Patients are led to create a new perspective on their experiences of dying and place them within the context of their life histories. In this way, the dying process is not merely a tragic end to it all but instead seen as a necessary finale. This way, patients view their physical and psychological needs as essential to this life event. They reconfigure the dying experience into one of self-worth and development.[9]

Dignity Therapy therefore relies on methods geared towards a lasting sense of self for both the patient and family. It takes a reverse-looking approach by working with memory and narrative. That is, Dignity Therapy focuses on past actions, events, and relationships in preparation for the upcoming moment of death:

> *The Dignity Therapy protocol poses questions that offer an opportunity for patients to address aspects of life that they feel most proud of or that were most meaningful; their personal history that they most want remembered; or things that need to be said…These sessions are tape recorded, transcribed and edited, and then returned to the patient. This creates a tangible product, a legacy, or generativity document, which in effect allows the patient to leave behind something that will transcend death.*[8]

The primary goal for this form of spiritual intervention is to capture the inner sense of self that the psychological approach equates to spirituality. Patients are able to draw up the most important aspects of their lives that are found in the things, relationships, and activities that ultimately define who they are. Just as Bregman points out, spirituality thus takes an inward turn as an alternative expression for the self and individualized identity.

It's no insignificant fact a tangible recording results from patient memories, narrative, and lasting instructions. In effect, patients create a succinct remnant of themselves that they may pass along to future generations. This is what Chochinov and other psychotherapists mean when they call upon the theory of generativity:

> *This "knowing," consisting of understanding one's place in and relationship to the family of origin may be gleaned through reading a generativity document. Such understanding may in turn inform and shape the experiences of future family members when faced with their own mortality. To the extent that such knowledge is*

> *fundamental to one's understanding of self and can help engender peace and a sense of meaning in the context of a life-threatening illness, the potential generational effects of the generativity document must not be underestimated.*[8]

This lasting recording serves to firmly root the patient's identity within the family network. This is immensely beneficial when patients lose the capacity to fulfill their normal familial and social roles, and grants them a sense that they are still relevant to the lives of those around them.

Yet this brings me to what I consider most problematic with the psychological approach. Dignity Therapy and other psychotherapeutic approaches create a stagnant sense of self. Unlike the normal happenings of everyday life in which our identity changes and grows depending on the contexts that we find ourselves in, this lasting documentation leaves only one version of the patient. It's making an implicit statement that the best we can do at the time of death is to hold on to certain memories and narratives. And this is a sentiment that I think we find in everyday culture, like the common expression "remember the good times." It's almost accepted that after death, the only thing that remains of the patient's existence is that which remains in our minds. The death of a loved one signals the end of their involvement in the world and leaves no room to develop any further relationship with that person.

Dignity Therapy furthers this stagnant impression of the self by situating the remnants of the dying in tangible forms. It takes a patient's identity out of the minds of family members and creates a form that is less likely to be reinterpreted. Once the dying has progressed into death, families are expected to fall back on the therapy recordings in order to remind themselves of what the patient used to be. This slows the process of

memory and narrative reconstruction that may actually create new roles for the patient after death. As loved ones continue on in their lives and find themselves in new contexts, they may view their relationships with the deceased in different ways. In this way, the dying still possess an active role in the lives of their loved ones.

Concluding Remarks

The move into the modern era relocated personhood from religious notions of the soul to the human psyche. Our emotions, thoughts, and personality quirks – all the elements that compose our minds – determine who we are and provide the basis for our existence. Treated as such, death necessarily implicates the final moment in which the psyche exists. Patients undergo significant cognitive decline as they undergo the dying process. Morphine dulls their awareness and ability to reciprocate in familial interaction. Especially in the final twenty-four to forty-eight hours in which patients are considered to be actively dying, patients seemingly have no cognitive capacity as they are totally unable to respond to stimuli. Hospice volunteers are instructed to tell loved ones that although patients do lose cognition, they retain a liminal degree of awareness up to the point of death, as though they would experience a premature death otherwise.[11]

This complete focus on the human psyche perpetuates the modern medical ideology of death as annihilation. Spiritual treatment coordinates a reverse looking perspective on the dying process. Death becomes the final moment of existence, as though there is no room for growth or changing relationships between the patient and family after that point in time. The best the family can do is remember the good times. They must try to proceed through their lives with a firm memory of the patient, lest they allow it to slip through their fingers.

This point leads me to consider the possibilities that a cross-cultural and cross-denominational study of spirituality at the time of death could hold for hospice and palliative care. I hold that the current psychological approach is stuck within patient cognitive states and completely misses existential qualities of dying. What could we learn from other treatments of dying and how they conceptualize spirituality? Is there even such a thing as spirituality in other contexts? While the psychological approach to care brings substantial and vital improvements to the current state of dying in American and Western culture, I still believe that there is more to be had. More efforts need to be made to delineate the use of spirituality within specific contexts rather than conceptualize it as a stagnant and universal phenomenon. Spirituality is wedged into a plethora of applications in order to fit a certain need.

In the case of hospice and palliative care, I hoped to show both the benefits and drawbacks of the psychological approach to patient care. While it appeals to certain cognitive states and develops a sense of wellbeing in memory and narrative, it does not address the existential breakdown of the body and mind throughout the dying process. There is a certain form of anguish that needs to be addressed within the hospice spiritual pillar of care.

Epilogue

A final question remains: what do I think hospice spiritual care should entail? At this point in my studies I am not prepared to provide a comprehensive answer, but I do have some thoughts based on my experiences as a hospice volunteer. In short, I think there exists an untapped way of discussing spirituality and death that emphasizes a social perspective. In many of my hospice encounters, I've found that patients and families often want to acknowledge a relationship after death. I will ask patients, "How do you think you'll continue to impact the world once you've moved on?" Or "In what ways will your loved one remain with as you continue in your life?" I try to emphasize that both sides with mature and grow through the experiences of death, and as a result their relationship will change as well. Death is not the end point in time for the patient. They will still continue to exist in the lives of their loved ones in an interactive manner and continue to be a lasting source of direction and inspiration.

Furthermore, although hospice care brought death back to the communal sphere, it returned in a medicalized form. High-barred medical beds, buzzing CPAP machines, and bottles of pain relievers are frequent sights in patient home settings. It's often stressful and exhausting for family members to tend to a patient's medical needs, and these experiences often define the dying process for patients and families. I think in some ways this struggle detracts from processes of spiritual development. This is why I think it's important to recognize that medical practitioners are in a unique position to facilitate spiritual growth. They can lead discussions on death away from a focus placed solely on pain relief and disease, and instead encourage reflection on other aspects of dying. For me, that includes

guidance of changing social relationships throughout the dying process and following death.

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