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EXAMINING THE INTERSECTIONALITY OF RELIGIOUS FAITH, SPIRITUALITY,
AND HEALTHCARE COMMUNICATION

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements
for the degree of Doctor of Philosophy

By

Felix Onyebuchi Okeke

December 2020

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2020

EXAMINING THE INTERSECTIONALITY OF RELIGIOUS FAITH, SPIRITUALITY,
AND HEALTHCARE COMMUNICATION

By

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ABSTRACT

EXAMINING THE INTERSECTIONALITY OF RELIGIOUS FAITH, SPIRITUALITY, AND HEALTHCARE COMMUNICATION

By

Felix Onyebuchi Okeke

December 2020

Dissertation supervised by Janie Harden Fritz, Ph.D

This dissertation is my own contribution in responding to the concern raised by certain communication scholars. Their concern was that little research and few publications have been done in the communication field by communication scholars that trace the relationship among religious faith, spirituality, and healthcare communication. While Parrott (2004) describes this apparent neglect as “collective amnesia,” others label it “religion blindness.” Thus, in trying to trace this relationship, this project uses Christian, biblical, and bioethics backgrounds to establish the value, sacredness, and dignity of human life, since these concepts make healthcare and healthcare communication necessary in the first place. These Christian, biblical, and bioethics backgrounds reveal an intricate connection among religion, medicine, healthcare, and healthcare communication. God communicated to humans through divine revelation (telepathy) and sometimes through human mediation, informing them of what they need to do in order to be well

and remain in good standing with Him. On his part, Christ greatly promoted dialogic communication in his dealings with the people, especially the sick and the needy. Additionally, each historical period—ancient, medieval, Renaissance, and modern—also shows the deep ties that religion has to medicine and healthcare. The views that developed in each of these periods show a progressive outlook and connection to healthcare communication. The ancient period shows that the priest doubled as both the spiritual leader and the physical healer. The Renaissance marks the development of discourse in favor of reason and the verifiability principle as roadmaps that guide decisions about health and questioning of the church’s authority. The modern period introduced the Protestant Reformation and a mix of the church’s authority and science in decision making about health concerns.

This research has further shown that the call by those communication scholars has received enormous attention, since scholars from diverse fields of study have risen up to the challenge, producing many articles that touch on different aspects of the relationship among religion, medicine, healthcare, and healthcare communication. Other scholars carried this effort further by discussing different forms of religious coping with illness. Their efforts were a necessary antithesis to efforts to discredit the religious role in coping with illness.

DEDICATION

I dedicate this work to my late dad, Mr. Semion Ikwele Okeke (Mbakogu), a man with an uncommon knack for peaceableness and simplicity of life—sometimes choosing peace to his own detriment. You desired to see me become a priest but left us before the dream could be realized. Dad! May you continue to rest in peace. Amen. I also dedicate this to my mom: an extremely resilient woman, a woman who knows the pains of raising eight kids. A woman who doesn't look back when it comes to saying as it is, not minding whose horse is gored. A woman who is always sought after by her kinsfolk when it comes to saying the truth. She would always look you in the face, and tell you, "You are wrong. Stop your bad behavior, or else . . ." None of us can easily forget that trenchant and unassuming side of you. That part of strong character has impacted some of us. You once taught me a big lesson in not giving up in the face of difficulties in life. When I was sent to the Chad Republic as the first missionary from my diocese, I grew cold feet, having learned of the nonstop war in that country. When I told you, you asked me, "But that country you are talking about, are there still living human beings there?" To which I replied, "I guess so, that's why I'm being sent there." Immediately you responded, "If there are still human beings there, and they are not all dead, then go there. Nothing will happen to you. I will always pray for you." That response alone gave me goose pimples and sealed my resolve with iron-cast confidence. It has equally prodded me on in life in the face of difficulties. Thank you, Mom! More so, I dedicate this work to my late maternal grandma, Nwuloko, who partly raised me. I lived with you for two years and learned the importance of hard work. It was two years of constant teaching and learning. With you, there were no dull moments, and with you, it

was either you work hard or perish. Now, to stay dormant a whole day without working makes me feel lifeless, and out of this world.

I also dedicate this to my uncle, Nze Obiwubelu 1 of Agulu, who has partly contributed to my education. Your natural wisdom is unequaled, and you don't believe in giving fish to anybody, but instead in teaching them how to fish. Rest in peace. Finally, I dedicate this work to my wonderful uncle: Mr. Romanus Ibebilo Okeke Oraeki. As I write this, you are lying in the morgue waiting to be interred during this extraordinary time of coronavirus pandemic. You were an educationist all through your life and retired as a director of schools. You chose decency as a mantle of your life and shunned corruption. Helping others is your second nature: You saw many through schools (including some of my siblings) and helped others secure employments. To put it simply, you believed in practical and unpretentious Christianity. You have made your mark in this world. May the good Lord grant you peace and the serenity you deserve. Rest in peace, BIG UNCLE.

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makes the star shine. I have always known your disdain for “stark illiteracy.” You continuously inquired about the progress I was making, and kept asking when this would be over. Well, I’m happy to inform you it’s finally over. Thanks for your encouragements. I thank my friends, Dr. Philip Taraska of the U.S military; the Fontana family, Don, Erin, and the kids; Frs. Charles Obinwa, Cajetan Anyanwu, Segun Odeyemi, Emma Osuigwe, Evaristus Obi, Peter Osuji, Uche Onu, Charles Ugwu, and Cyprain Duru. Finally, I thank my mom for being such a rock in my life. I also want to thank Ms. Rita McCaffrey and all the members of the staff that work behind the scenes, but without whom nothing moves. I as well thank the entire Gumberg Library staff for making my work far easier, providing me resources with a lot of smiles, even if I come 10 times a day. You gave me all the help I needed. You guys rock. May God bless all of you with His abundant favors. I remain grateful. I also thank Ms. Emmalee Torisk, who painstakingly gave this work a thorough editing. With your work, I feel as if I am taking a course in how to write in APA style. Thank you, Emmalee.

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Introduction

My interest in choosing to examine the intersectionality of religious faith, spirituality, and healthcare communication as my dissertation topic was piqued while doing a general reading of the article “A Content Analysis of Research on Religion and Spirituality in General Communication and Health Communication Journals.” In this article, authors Miller and Teel (2011) express their concern that little research has been conducted in the area of the intersection of religious faith and health communication. Moreover, Miller maintains that during the second half of the 20th century, scholarly concern regarding “the relationship between spirituality and health was relegated to the margins of the academic endeavor in medical and health-related fields” (as quoted in Thompson, 2014, p. 1162). Miller further notes that content analysis of medical journals of the 1990s has revealed that “little attention to the topic, and the dearth of attention to religion in the field of public health was so glaring it raised accusations in some quarters of ‘religion blindness’” (as quoted in Thompson, 2014, p. 1162). Although Miller and Teel (2011) acknowledge that interest in this area has grown over time among communication scholars within a space of two decades, they argue that it has been explored less than any other field in communication.

Another article, ‘Collective Amnesia’: The Absence of Religious Faith and Spirituality in Health Communication Research and Practice” by Parrott (2004), further buttresses this concern. Parrott decries the paucity of publications in the area of health communication, religion, and spirituality, and concludes that “it does not yet appear that we as a discipline have made much progress toward overcoming our collective amnesia” (as quoted in Miller and Teel, 2011, p. 11). Moreover, as Egbert, Mickley, and Coeling (2004) note, “as religion and spirituality continue to be central to at least half of the population of North America, social scientists and

communication scholars cannot afford to continue our dormant state with regard to its influence on health communication and health outcomes” (as quoted in Parrott, 2004, p. 22). As a result, Miller, Parrot, and their colleagues urge communication scholars to launch into this field.

This project is a response to this call, that is, to trace that intersectionality among religious faith, spirituality, and healthcare communication. I will do this by primarily examining the work of communication scholars in this field. Accordingly, Chapter 1 will look into the value, sacredness, and dignity of human life from the Christian perspective. It will do this by examining biblical, Catholic, scholarly, and bioethics (abortion and euthanasia) perspectives on human life, as well as connections of these entities to healthcare communication. Chapter 2 will deliberate on the brief history of the relationship of religion and medicine to healthcare. This includes the interactions among religion, medicine, and healthcare as seen across diverse historical periods: ancient, medieval, Renaissance, and modern. Each of these historical periods shows important developments that link religion and medicine to healthcare communication.

Chapter 3 will aim to show the intersection of religious faith, spirituality, and healthcare communication from communication scholars’ perspectives. It will begin with the definitions of some important concepts—religiousness, spirituality, and health communication—before assessing the multidimensional nature of the study of healthcare. Numerous important concepts to be examined in relation to healthcare include spiritual well-being, religious satisfaction, better adjustment, mental health, behavior change, and healthier lifestyle; all will be considered in relation to healthcare communication. Finally, Chapter 4 will examine the arguments of some scholars against the role of religion and spirituality in healthcare. This will be followed by discussions of different forms of religious and spiritual coping, such as positive and negative types of coping.

Chapter 1:

Assessing the Value and Dignity of Human Life from the Christian and Bioethics

Perspectives: Its Relevance for Health Communication

“Human life is a gift and a responsibility—a gift, because man could never create himself; a responsibility because man must use this gift properly. God, Life itself, is a source of all other life and to Him alone, therefore, belongs every power over it” (Cronin, 1958, p. 2). In line with this declaration, St. Paul states, “None of us lives to himself, and none of us dies to himself. If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or whether we die, we are the Lord’s” (Romans 14:7–8, *Revised Standard Version*). Among the natural gifts that God has given to mankind, none exceeds life, since it is life that is the basis for all that man has or can hope to attain. The declaration above encapsulates the essence, dignity, and value of human life from a Christian perspective.

The discourse on the value and dignity of human life, as seen from a Christian perspective, is relevant to healthcare communication. Stout (2006) notes that religion has always had a lot to do with communication. What would the religions of the world be without voice, the word, the text and all their associated arts? Religious practice and thought have always employed a great variety of communication practices.” (p. 83)

To illustrate this point further, Zulick (2009) observes that Christian rhetoric relies on divine revelation and interpretation of signs (as in the Augustinian theory of signs) rather than on invention for the discovery of argument (p. 128). Thus, God’s communication with humans in the ancient biblical tradition was generally based on divine revelation. Additionally, even in our present day, Christianity teaches that God communicates to humans through the scriptures.

The scriptures have ample examples of these types of interactions, where God reveals His feelings about human life to people through telepathy and sometimes through dialogic communication, made in the context of interpersonal relationships. Such examples abound in situations where God seems to interact one-on-one with humans, through the mediation of the prophets. Telepathy as a model of communication is described as “the transference of thoughts from one person to another without any visible connection” (Stout, 2006, p. 83). This is typically the type of communication that happens between God and man, as the former makes His intentions about pretty much everything (including life) known to the latter. Furthermore, in most cases, it is believed that God’s intentions transcend the dynamics of language, body, space, and time. In telepathy, as a model of divine communication, God is not portrayed as consensually sharing ideas with humans, but rather simply informing them of His intentions. This process of communication is linear in nature, since often no feedback is expected. There is simply a divine revelation of information. We shall see abundant examples of this type of communication in a later section that discusses the biblical foundation of and Christian perspectives on the value and dignity of human life.

Additionally, discussions on the value, dignity, and sacredness of human life have relevance for health communication. For instance, human life fundamentally gives meaning to healthcare communication. Similarly, for many people, religious faith and spirituality are essential components of healthcare giving. This chapter lays a foundation upon which discourse on the intersection of religious faith, spirituality, and healthcare communication could effectively be carried out. Therefore, to deny or overlook these important aspects in any healthcare discussion is unrealistic. Religious faith and spirituality are part and parcel of healthcare giving and, subsequently, healthcare communication.

Christians fundamentally believe that life is sacred and invaluable. To acknowledge this, therefore, is to admit that human life ought to be protected, respected, and treated with utmost care. This is why healthcare is given a pride of place among the whole of human enterprises and why, in the past few decades, religious healthcare communication has also become a new area of interest for communication scholars. According to Dicks (1963), “we are made for health, not sickness” (p. 57). Therefore, to trivialize human life and, subsequently, human health is to make light of the essence of our humanity. In this regard, McCartney (1999) states that reverence for human life in all its dimensions, be they

biological, psychosocial, ethical and spiritual[,] is one of the hallmarks of Christian life and practice, and the dignity and sanctity of human life, especially the lives of the poor, marginalized, disabled, or oppressed, is one of the constant holdings of Christian ethics (p. 71).

Citing *The Gospel of Life: Evangelium Vitae* by Pope John Paul II (1995), McCartney (1999) notes that Pope John Paul II emphasizes that the Gospel (or “good news”) of life is at the heart of Jesus’s message. Therefore, if this is true, we should be able to maintain reverence for life as manifested by the followers of Jesus in this contemporary world, since the church considers itself as the sacramental instrument of Jesus’s saving activity extended through space and time.

In essence, religious spirituality and practices are of fundamental importance to healthcare ethics communication. Hence, being conscious of the indispensability of these entities in caregiving, most hospitals, caregiving facilities, and healthcare managers make sure to include these aspects of caregiving in their overall healthcare plan. Parrott, Silk, Krieger, Harris, and Condit (2004) contend that, when faced with the seemingly inexplicable, some people tend to rely on religious faith as a guide to their knowledge and outcome expectancies. For these

authors, religious faith refers to the predisposition to feel, think, or act based on one's belief in the spiritual power that is greater than humans to affect the course of nature and the role of humans regarding healthcare. Thus, there exists a substantial amount of evidence that alludes to the role of religious faith as a social and personal resource for health.

We cannot underestimate the fact that religious spirituality is a very important aspect of most people's lives, both in good health and in sickness. In this vein, pastors of churches and chaplains of hospitals share with God the crises in the lives of people. Both of them provide spiritual counseling in their different capacities when needed. Religious counseling, according to Vaughan (1969), is a "special type of communication between two people, one of whom seeks to improve the spiritual welfare of the other" (p. 19). Vaughan (1969) maintains that religious counseling helps the individual deal with problems of life that involve, either directly or indirectly, his commitment as a Christian. This type of counseling focuses on the religious dimension that exists in every problem and is done through interpersonal communication, specifically dialogue.

There is a plethora of biblical references on divine communication about illness, including texts that contain guidance on the best healthcare for the sick, the poor, and the elderly, as well as on faith-based healing. Stemming from ancient times, religious faith has never been successfully separated from the process of healthcare. In fact, it has always been considered integral to the process of healthcare and healing, because human life is held in the highest esteem in religious circles. Gushee (2013), for instance, asserts that "the belief that each and every human life is sacred is a grand moral conviction of ancient origin" (p. 1). One of the fundamental sources for his conviction is the Christian faith, where sacredness of human life is portrayed as one of the fundamental core beliefs, especially as it is evident in its condemnation of abortion

and euthanasia. Christian moral teachings on these two issues abundantly portray the high esteem that Christianity places on human life. These teachings are, indeed, part of the greatest moral contribution of the Christian tradition to the world's civilization.

Gushee (2013) laments the obscurity of the provenance of this moral conviction, at least in American culture. Especially during election years in the United States, this issue surfaces and intensifies as a political slogan among conservative political candidates during political debates, particularly in their opposition to abortion law. In such events, discourse on such a sensitive topic becomes a matter of political expediency and convenience, to the utter relegation of its more in-depth and moral implications. Christian discourses on these concepts correct this wrong impression. (I will discuss this in more detail in the section concerning bioethics on euthanasia and abortion.)

Why is Human Life Considered Sacred, Invaluable, and Dignified in Christianity?

In discussing the sacredness of human life, Cardinal Joseph Bernardin, as quoted by Gushee (2013), observes the following:

The person is the clearest reflection of the presence of God among us. To lay violent hands on the person is to come as close as we can to laying violent hands on God. To diminish the human person is to come as close as we can to diminishing God. . . . From our recognition of the worth of all people under God flow the responsibilities of a "social" morality. (p. 16)

In addition to the cardinal's declaration, Gushee (2013) describes sacredness as reflecting an ascribed status, referring to something or someone having received a special status through consecration by another, while dignity means "worthiness, elevation, nobility, honor and distinction" (p. 19). Gushee (2013) maintains that Christians often use "human dignity" as a term

equivalent to sacredness of life (p. 19). As such, sacredness and dignity are sometimes used interchangeably.

Following in the footsteps of Gushee (2013), Bayertz (1996) corroborates the Cardinal's assertion. He observes that every human being is in agreement that human life and human dignity are inviolable. There is no doubt that human life is worthy of protection, and human dignity worthy of respect (Bayertz, 1996, p. xi). This human dignity, Bayertz (1996) believes, gets its bearing in the Christian idea of *imago Dei*, or image of God, meaning that the human person is created in the image of God. Therefore, as "part of the human species, which has an extraordinary position within creation, each human being is attributed with an inherent dignity which—like its immortal soul—should ultimately be exempt from human interference" (Bayertz, 1996, p. xiv). Medical science recognizes the extraordinary respect that is accorded human life. Thus, as early as the Middle Ages, physicians have avowed to uphold respect for human life; this is expressed in the Hippocratic Oath, which, as McCormick and Connors (2002) state, focuses on doctors' duties to their patients (p. 283). McCormick and Connors (2002) maintain that at the heart of this professional ethics is

a vision of the virtuous physician, a competent, conscientious and compassionate professional committed to the good of the patient and the skillful practice of the medical arts. Doctors are to be objective and unselfish, to conduct themselves with integrity, grace and decorum, to respect patient confidentiality and to avoid sexual impropriety. They are to refrain from overcharging or harassing the sick about their fees and from offering useless remedies, encouraging false hopes or needlessly prolonging the suffering or death of their patients. And they are to maintain their own health and weight as proof that they have the skills and virtues needed to help or heal others. (p. 284)

This quote demonstrates not only extraordinary recognition of the fact that human life is worthy of respect, but also supports the view that the human person is created in the image of God and that his life has an immeasurable value and dignity, resembling the same values from the Bible. In fact, there is an abundance of biblical evidence in this regard. Moreover, books and articles written about this often have the Bible as the source for their claims. The following section provides such biblical evidence.

Biblical Foundation of the Dignity and Sacredness of Human Life

With respect to the biblical foundation of the dignity and sacredness of human life, Gushee's (2013) observation is once again crucial. He affirms that in every genre of Scripture, the belief that human life is sacred receives its firmest grounding in the Bible's revelation of the character, activity, and decision of God, which lies at the root of all its proclamation related to how human beings should be perceived and treated." (Gushee, 2013, p. 38)

Kilner, Cameron, and Schiedermayer's (1995) perspective is in sync with Gushee's (2013), as they uphold that the Bible is the basis for thoughts about the sacredness of life. In the words of Kilner et al. (1995), when

rightly interpreted, the Bible alone provides a reason to treat human beings with genuine dignity and provides a rationale for the sanctity of human life. Every human life—unborn, born, disabled, healthy, unhealthy, or aged—possesses derivative value because it is (or they are) made by God in his image. (p. 126)

In essence, life remains sacred no matter the health condition of a person.

Kilner et al. (1995) further state that the value of human life is not calculated by virtue of its functionality, as if humanness is merely the possession of faculties such as reason, volition,

and awareness. Moreover, the value of human life is not determined by social worth or utilitarian criteria, as if it were valuable only because other humans value it. Instead, “the value of human life is measured ontologically (i.e., by the kind of being we are). Human life possesses sacred value by virtue of what it is, or, more appropriately, who humans are and whose they are” (Kilner et al., 1995, p. 126). Thus, the church, in her prophetic role, declares that every human being owes his or her existence and unique value to the God who has created him or her. This idea is reflected by Cronin: “To God then, belongs the power of life, and man must never fancy that he may determine the hour of death—Thou shalt not kill. By this fifth injunction of the Decalogue, God forbids not only homicide but also suicide” (as quoted in Smith, 1989, p. 5).

Gushee (2013) sums up the value, sacredness, and dignity accorded to human life in the following elements: (a) creation theology—that is, the concept of God as Creator, and humans as made in the image of God; (b) portrayal of God’s compassionate care for humanity, particularly the poor and the suffering; and (c) the covenantal materials, precisely the protections offered to human life in the law codes of the people of Israel.

Going back to the creation theology, in the Catholic Study Bible, we read, “Then God said: Let us make man in our image, after our likeness. . . . God created man in his image: in the divine image he created him; male and female he created them” (Genesis 1:26–1:27). Here, God’s revelation of his intention tends to follow dialogic communication style, implying a collaborative relationship with God, the Son, and God, the Holy Spirit (according to Catholic teaching). By the virtue of this divine elevation of the human person, his or her life is thus deemed sacred. As we learn from Kilner et al. (1995), being created in the image of God means then that

humans have some attribute (or attributes) which sets them apart from all other

created beings. Irenaeus saw these attributes as human rationality and freedom, Augustine as capacity for self-knowledge, self-memory and self-love, and Aquinas as intelligence. All these views see the attributes that make up image of God as those capacities which allow humans to know and love God: their spirituality, rationality and morality. (p. 200)

Essentially, the views of Kilner et al. (1995) align with those of Pope Francis (2015).

Pope Francis (2015) upholds “the immense dignity of each person, ‘who is not just something, but someone. He is capable of self-knowledge, of self-possession and of freely giving himself and entering into communion with other persons” (para. 65). Pope Francis (2015) further maintains that

the special love of the Creator for each human being “confers upon him or her an infinite dignity.” Those who are committed to defending human dignity can find in the Christian faith the deepest reasons for commitment. How wonderful is the certainty that each human life is not adrift in the midst of hopeless chaos, in the world ruled by pure chance or endlessly recurring cycles. (para. 65)

God has not only elevated the human person to a special position by catering for him, but He (God) has also expressed this burning desire to preserve the precious gift of life.

Hence, He demonstrates his special love of the human person by giving the rest of the creatures as food and as a means of sustenance to him or her. In the following God–human person exchange, God once more reveals His intention by engaging in interpersonal exchange: disseminating information, much more than engaging in dialogic model of communication with humans. In most biblical passages, disseminating information, more than engaging in dialogue,

seems to be the preferred model of communication, which is typical of the top–bottom, master–servant model of communication.

God said: See, I give you every seed-bearing plant all over the earth and every tree that has seed-bearing fruit on it to be your food: and to all the animals of the land, all the birds of the air, and all the living creatures that crawl on the ground, I give all the green plants for food. (Genesis 1:29–1:30)

The uniqueness and the primacy that God places on the human person and, subsequently, on his life, over and above all other creatures, is sealed in this divine mandate: “Fill the earth and subdue it; have dominion over all creatures of the sea and air, and all the living things that move on the earth” (Exodus 1:28).

The creation theology is one of the unique ways God manifests the significance he places on human life. Kelly’s (2004) views on creation theology and the primacy of human life seem so much in sync with the views expressed by Gushee (2013) and Pope John Paul II (1995), as we already saw. He upholds the Christian (and, by extension, Jewish) understanding of the human person, viewing men and women as “the pinnacle of God’s creation” (Kelly, 2004, p. 12). While deliberating on the creation of the human person in the image and likeness of God, Kelly (2004), however, points out that this likeness of the human person to God is not physical but spiritual, for God is a spiritual being. It is our soul that is created in the image of God. He argues that although men and women receive the same blessing as the other animals to go forth and multiply, he gives the former “dominion or authority over the rest of creation” (Kelly, 2004, p. 13). This special privilege singles out the human person, from the rest of creation, as a special creature endowed with special dignity.

In exploring the theological basis of this dignity, Kelly (2004) states that “the human person is of special worth, and the Christian understanding of the human person supports this concept of human dignity” (p. 11). Kelly (2004) refers to this dignity as “alien dignity,” meaning that

human worth is not found in any mere usefulness granted us by other women and men.

We are of worth. That worth is from God, not from the individual or social agreement of other humans. We are more than utilitarian value. Our worth remains even when sin filled persons or sin-filled structures ignore it. (p. 12)

Kelly (2004) maintains that this Christian view of the dignity of human life transcends us and the possibilities of us rejecting it. Hence, this provides the foundation for healthcare and healthcare ethics. Caring for our lives is not something we may freely rebuff. Therefore, this Christian perspective makes it clear that humans are intrinsically worthy and that “God has said yes to human life” (Kelly, 2004, p. 12). In essence, God’s “yes” to human life precludes any claim humans may make on it.

On the other hand, Kelly’s (2004) explanation portrays God–human interactions as linear, or a one-way communication process. This implies the outright dissemination of information from God to humans that is, once again, without much possibility for feedback and personal input from humans. Humans simply have to accept the gift of life and must endeavor to preserve it. This, of course, explains why active suicide is never accepted in Christianity, no matter what shape or form. Biblically, God–human communication, in most cases, shows evidence of paternalistic and authoritative tendencies, following the top-to-bottom communication process or a supervisor–subordinate style. However, it must be noted that we arrive at this type of analysis from the use of human language in descriptions of the God–human relationship; this does not, in

any way, take away from the value that God places on human life. This primacy of the human person over all of God's creation is further exemplified in the recognition of his or her fundamental goodness: "God saw that it was good" (Genesis 1:1–25).

Kelly (2004) further discusses divine election in his attempt to demonstrate the dignity and sacredness of human life. He affirms that

God created the human person with a destiny to be chosen. The human person is special, according to Christian theology, because we are created at the start with a graced destiny of self-transcendence. . . . Human dignity arises in large measure from the fact that God has created us with this predestiny to transcend ourselves, to move beyond our own horizons and that of our surroundings to share God's life. (pp. 15–16)

This type of predestination is differentiated from the second but wrongful understanding of predestination. This wrongful understanding describes predestination as "an arbitrary divine decision, whereby only some are given the real possibility of salvation, while others, comprising most of humankind, are left inevitably without God's power and life, condemned to endless death" (Kelly, 2004, p. 16). However, this second and wrongful conception of predestination is not my central concern in this discourse. Rather, I intend to demonstrate here the high esteem to which God holds human life, according to its great value, dignity, and sacredness. This is evident in the theory of divine election of the human person.

This theory (divine election) is another important way through which God reveals his infinite regard for the human person and human life. The Book of Genesis 12:1–20 recounts the call of Abram, who was later renamed Abraham by virtue of his call. God asks him to leave his country and kindred and go to a new place that he would show him. Abraham's call was marked by his unwavering obedience to God, as well as his eagerness and readiness to do God's bidding.

This obedience is seemingly rewarded by an outpouring of divine blessings comprising the multiplication of his descendants and the bequeathing to him of the land of Canaan. Following God's promise to Abraham and, subsequently, his obedience to God, Abraham's descendants, the Israelites, became God's specially chosen people. However, Pannenberg (1977) states that God's election of humankind was not reserved simply for Abraham and his posterity as objects of God's love: "God's goal transcends Abraham and his posterity, since the promise of God's blessing is extended through Abraham to 'all the families of the earth'" (p. 48). In the God–Abraham interaction, we once more witness the typical linear (one-way) process of paternalistic communication. Abraham receives a message from God and carries out His demands accordingly, without objection or his own personal input. The divine choice that God made of humans started with Abraham (Genesis 17) and continued through Moses (Exodus 24:1–8). God explicitly declares, "I will take you as my people, and I will be your God. You shall know that I am the Lord your God, who has freed you from the burdens of the Egyptians" (Exodus 6:7). Following this covenant, God commits himself to the people who, in turn, pledge allegiance to him. Pannenberg (1977) maintains that Abraham's vocation introduces a universalistic tendency into the notion of election, whereby every human person and, subsequently, his or her life is valuable to God.

The concept of divine election is evident in the Book of Deuteronomy, with its explicit declaration of the sacredness of the human person. It states the following:

For you are a people sacred to the Lord, your God; he has chosen you from all the nations on the face of the earth to be a people peculiarly his own. It was not because you are the largest of all nations that the Lord set his heart on you and chose you, for you are really the smallest of all nations. It was because the Lord loved you and because of his fidelity

to the oath he had sworn to your fathers, that he brought you out with his strong hands from a place of slavery and ransomed you from the hand of Pharaoh, the King of Egypt (Deut. 7.6–8).

Pannenberg (1977) observes that the rescue of the Israelites from slavery in Egypt is viewed as an expression of God’s love for Israel. He describes election as a selection of one out of many. The goal of such selection is that the beloved one is to belong to God and to share community with him (Pannenberg, 1977, p. 48). Belonging to God in this sense comprises the life of the beloved, which God has taken the responsibility to protect and to nourish. Only God himself has the exclusive right to remove this.

God’s adoption of the people of Israel is very much evident throughout their history, as we witness in His tendency to fight their wars for them; His liberation of them from slavery in Egypt through Moses (Exodus 3); His fighting for the Israelites against the Amalekites (Exodus 17:8–15); His defeat of the Canaanites (Numbers 21:1–3), the Amorites (Numbers 21:21–35), and the Midianites (Numbers 31:1–8); the siege of Jericho (Joshua 6); and the resettling of the Israelites in the land of Canaan (Joshua 1–24). Even after settling them in the promised land, God continues to take care of them. Thus, by virtue of the value and dignity that God places on human life, the fifth commandment enjoins us “not to kill” (Exodus 20) and instead to heal (Jeremiah 30:17). Moreover, as Nguyen (2010) argues, “Since God is always on the side of the oppressed and weak and furthermore promotes justice and righteousness, protection of widows—who are usually poor and vulnerable—is heavily emphasized throughout the Bible” (p. 8). To this effect, the Book of Exodus admonishes,

You shall not afflict any widow or orphan. If you do afflict them, and they cry out to me, I will surely hear their cry; and my wrath will burn, and I will kill you with the sword, and your wives shall become widows and your children fatherless. (22:22–24)

It further urges us not to deny justice to the poor (Exodus 23:6; Proverbs 14:31) and not to ignore the suffering (Job 2:11–13).

God's steadfastness to his covenant with humankind is then made more manifest in the New Testament, as exemplified in the incarnation of his son Jesus Christ, who was sent to die in order to liberate human beings from eternal damnation. In his dealings with his disciples and the people, Christ engages in interpersonal interactions—more specifically, empathic, relational, and dialogic communication. He engages with them one-on-one. We have an abundance of biblical passages in this regard, which I am going to address shortly. Raja (2008) describes Jesus as

a role model in dialogic communication. He established contact, relationships, and understanding with others, including those who were identified as sinners by the community (Luke 15). Jesus engaged in discussion with his contemporaries, including Pharisees and Sadducees, who were often opposed to some of Jesus' radical views (Matthew 19). (p. 569)

Jesus was known to hold dialogue with God, whom he refers to as his Father (John 17), and with the devil (Matthew 4). Jesus's dialogic and relational model of communication was typical of the Aristotelian peripatetic system. Aristotle was known to be a peripatetic teacher, as he moves around from place to place teaching. Christ also never stayed at a place. He was an itinerant teacher, moving around with his disciples, giving them instructions, preaching, and curing the sick.

Christ's dedication to caring for the sick, the suffering, and society's downtrodden has ample biblical references. His acts of fidelity to his promise—to be the God of the Jews—run the whole length and breadth of the New Testament, evidenced in the selfless life of Jesus Christ: a life entirely devoted to saving humankind and setting them on the path of friendship with God. For instance, John's gospel states, "For God so loved the world that he gave his only son, so that everyone who believes in him might not perish but might have eternal life" (3:16). Here, belief in Jesus is made a *conditio sine qua non* (an indispensable condition) for eternal life in God.

Additionally, Matthew stresses that the value placed on human life far surpasses that of other creatures: "Look at the birds in the sky; they do not sow or reap, they gather nothing into barns, yet your heavenly Father feeds them. Are you not more important than they?" (Matthew 6:26). Similarly, Christ assures his election as a selection of one out of many. The goal of such selection is that the beloved one is to belong to God and to share community with him followers continuous care and protection because their lives are worth more than *many sparrows*:

Are not five sparrows sold for two small coins? Yet none of them has escaped the notice of God. Even the hairs of your head have all been counted. Do not be afraid. You are worth more than many sparrows (Luke 12:6–7).

In the same vein, St. Paul refers to human beings as "God's temple" and warns against the destruction of this temple: "Do you not know that you are the temple of God, and that the Spirit of God dwells in you. If anyone destroys God's temple, God will destroy that person" (1Corinthians 3:16). This passage portrays the high esteem to which God holds the life of every human being: a view that aligns with Nguyen (2010). He states that "it is the responsibility of the Christian community to care and protect the rights of the weak" (p. 9). "If any believing woman has relatives who are really widows, let her assist them; let the church not be burdened, so that it

can assist those who are real widows” (1 Tim. 5:16). Therefore, any act of violence or disrespect of human life brings about some grievous consequences. Not only did any act of violence against the human person and, subsequently, his life receive harsh condemnation from Christ, he also took this condemnation to a more critical level by including anger against a fellow human being as abhorrible; the perpetrator is liable to judgment. Christ declares, “You have heard that it was said to your ancestors, ‘You shall not kill; whoever kills will be liable to judgment.’ But I say to you, whoever is angry with his brother will be liable to judgment” (Matthew 5:21–22).

Moreover, Christ devoted his entire short life to curing the sick, as well as taking care of the poor and the marginalized of society. In his discourse regarding the prerequisites for entering the kingdom of God, Christ made it clear that caring for the poor and the sick is indispensable: “For I was hungry and you gave me food, I was thirsty and you gave me drink, a stranger and you welcomed me, naked and you clothed me, ill and you cared for me, in prison and you visited me” (Matthew 25:35–36). In the same vein, Christ made healing the sick the central focus of his ministry: “When it was evening, they brought him many who were possessed by demons, and he drove out the spirits by a word and cured all the sick” (Matthew 8:16). Similarly, in chapter 14:14, Matthew states, “When He went ashore, He saw a large crowd, and felt compassion for them and healed their sick.” Matthew further acknowledges Christ’s focus on healing the suffering and the sick: “Great crowds came to him, having with them, the lame, the blind, the deformed, and many others. They placed them at his feet, and he cured them” (Matthew 15:30). Similarly, in Luke 4:40, we read, “At sunset, all who had people sick with various diseases brought them to him. He laid his hands on each of them and cured them.” Christ’s devotion to healing is noticeably holistic, as he focuses not only on bodily cure but also on spiritual healing of the whole person.

Jesus entrusts his apostles with this healing power, allowing them to heal and care for the sick. This is evident in Matthew 10:1 and 10:7–8, Mark 6:13, and Luke 9:1–6 and 10:1–12. The apostles took up this ministry after the Easter events. As such, Peter healed a crippled beggar (Acts 3:1–10), a paralyzed man named Aenas (Acts 9:32–35). Nguyen (2010) notes that

inspired by the examples of Jesus and the apostles, caring for the sick has become the hallmark of the church's corporal works of mercy. . . . For Christians, when we care for the aged and the sick, we are treating that person as one created in the image of God. (p. 9)

This Christ-like model of care has, in fact, influenced many Catholic religious orders with vocations centered around care of the poor and the needy, prompting some of them to establish hospitals and health centers all over the world.

There are a lot of biblical passages on healthcare in the New Testament that urge us to take care of the sick (James 5:13–15); the elderly, the orphans, and the needy (1 John 3:17); the widows (1 Timothy 5:3–16); and, in fact, all the world's downtrodden (Matthew 25:34–40). All these injunctions attest to the value, sacredness, and dignity that God places on human life, which makes healthcare an absolute necessity. Moreover, human life has also been described as sanctified.

Kennan (1996) defines sanctity as “a quality that is revered as somehow touched by divinity, and therefore untouchable for humans; sanctity is that which divinity protects from violability” (p. 3). When used in relation to life, sanctity portrays the sacredness and inviolability of life. Going further, Kennan (1996) maintains that because human life is sacred, its sanctity prohibits us from committing murder or suicide. Thus, the sacredness of life establishes a line we cannot by our own authority cross, even with our own lives. God (the author of life) has absolute

dominion over human lives—be it our life or the lives of others (Kennan, 1996, p. 3). Kennan (1996) quotes from an article from the Congregation for the Doctrine of the Faith (the *Declaration on Euthanasia* from 1980) regarding the sanctity of life:

Most people regard life as something sacred and hold that no one may dispose of it at will. Intentionally causing one's own death or suicide is therefore equally as wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. (p. 4)

This means then that life is to be treated with utmost respect and care, particularly in sickness and in the care of the sick. Simmons (2008) acknowledges this, arguing that healthcare is an arena where the interests of religion, science, and politics meet. Most religions highly value human health and associate their understanding of God with the social and moral obligations to provide care for the young and old (Simmons, 2008, p. 67). Since Simmons (2008) aligns with the biblical injunctions regarding the care of the sick, he equally includes care of the poor, the powerless, and the stranger in a foreign land. He maintains that the reasons adduced for protecting the poor and those without land were not abstract and philosophical but historical and personal (Simmons, 2008, p. 85). In this vein, the Bible declares:

When an alien resides with you in your land, do not molest him. You shall treat the alien who resides with you no differently than the native born among you. Have the same love for him as for yourself; for you were once aliens in the land of Egypt. (Leviticus 19:33–34).

Expatriating further on this law of care and hospitality to strangers who sojourn in the Jewish land, Simmons (2008) observes that the stranger has to be treated with dignity and respect, and

not humiliated and injured by harmful and despicable acts (p. 85). For Simmons (2008), the poor and the vulnerable of society were considered to be special objects of God's love and protection.

From this discussion so far, it is evident, therefore, that Christianity and, indeed, most religions view the value, sacredness, and dignity of human life as something that cannot be overestimated. Consequently, "healthcare and healthcare ethics presuppose at their very core that the human person is of a special worth, and the Christian understanding of the human person supports this concept of human dignity" (Kelly, 2004, p. 11). As a result, Kelly views religion as concerned with the meaning of human life in its ultimate dimension. . . . Thus, religion, faith, and theology are all centrally interested in the meaning of human life. Why do we exist? When and how do we live at our human best? What kind of respect do we owe our human lives and those of others? (p. 4)

Accordingly, this way of looking at religion vis-à-vis healthcare explains the importance of the former to the latter. It further buttresses Kelly's (2004) observation that human health and healthcare are of central importance to much of Christian theology and Christian practice, especially in the pastoral care of the sick.

Pastoral care of the sick is a very important aspect of care in most United States hospitals. It has been an integral part of the church's task, as it represents the believer's concern for the recurring needs of a person's fellow man (Dicks, 1963, p. 70). Dicks (1963) carries Kelly's (2004) idea further, noting that the church embraces diversified activities, such as care of the dying and support of world missions. Hence, some pastoral care programs, such as care of the sick, are carried on in every church, whether large or small, or city, suburban, or rural. Pastoral care here also includes religious counseling. As an important aspect of health communication, religious counseling is usually done by a pastor in a parish or a chaplain (Vaughan, 1969, p. 19).

In fact, any type of communication involving a clergyman as a counselor is also included here (Vaughan, 1969, p. 20). To this effect, from the early ecclesial historical periods, religious men and women, clergy and laity alike, have dedicated their lives to the pastoral care of the sick, the healing of human body and spirit, while theologians and healthcare professionals have collaborated in developing theologies and anthropologies of healthcare and of healthcare ethics.

Furthermore, Simmons (2008) rightly points out that Jesus's miraculous healings equally provide support for a Christian approach to healthcare. According to Simmons (2008), Jesus did not diminish the body in preference for a transcendent spirituality. He carried out concrete cures in the name of God's love:

He healed people who were blind, epileptic, hemorrhaging, paralyzed, or comatose.

Lazarus was resuscitated (John 11:43), an action that now takes place almost routinely in hospitals and elsewhere. Jesus healed people to enable them to glorify God in a body that was whole and with a mind that could will to serve God. (John 9:4). Paul spoke of the person as a psychosomapneumatic (mind, body, spirit) whole (1 Thessalonians 5:23) who is the object of God's concern. (Simmons, 2008, p. 86)

In other words, God is not the one who inflicts punishment, pain, and suffering on the human person, as people are wont to believe; instead, he is the comforter who attempts to bring healing or provides wisdom, strength, and courage to those ostracized by debilitating illnesses, especially the poor—in fact, all the most vulnerable. In such people, he clearly manifested that the human person and his or her life is priceless. As Simmons (2008) puts it, instead of turning people away from him, “Jesus reached out and touched them, bringing both healing and acceptance into community. . . . Stories involving Jesus' crossing the invisible lines of ethnicity that created barriers to community also inform the Christian attitude toward justice in healthcare”

(p. 87). It does not matter whether it was a Gentile centurion or a woman with hemorrhage—Jesus still “reached out to people ostracized by prejudice and superstition” (Simmons, 2008, p. 87), welcoming them into a community of love and acceptance. In his attempt to demonstrate the value and dignity he places on human life, Christ counters the effect of the social and religious stigmatization that humans have placed on certain diseases and disabilities, to which, consciously or unconsciously, they manifest a combination of abhorrence and sympathy.

In line with this Christian attitude to the sick, Simmons (2008) admonishes that “the people of God have the mission of encouraging compassion; they are to reach out and accept those rejected by bigotry, fear, or ignorance” (p. 87). Sympathy for the suffering has to be intensified, while revulsion has to be challenged for what it is: lack of love and acceptance of persons: “Fear of the diseased is a sign of superstition and anxiety that prevents a moral response to those in need of health and care” (Simmons, 2008, p. 87). This is, no doubt, a negation of Christian teaching.

As being against fear and revulsion of the sick, the Letter of James enjoins fraternal love in the care of the sick. James emphasizes communal care of the sick, thereby insinuating that the care of the sick is a collective responsibility. He asks,

Is any among you sick? Let him call for the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord, and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven. (James 5:14–16)

Albl (2002) observes that this passage from the Letter of James gives readers a glimpse into the understanding of illness and healing among the early Jewish community. It is a community-oriented care of the sick, in which sick people are counseled to employ the services of

community elders to pray for and anoint them. Such prayers and anointing have the efficacy of healing and ensuring forgiveness of sins (Albl, 2002, p. 123). In other words, Albl (2002) is pointing out that, from a biblical perspective, prayer and anointing are indispensable for the healing of the sick.

St. James's and Albl's (2002) perspectives on community-oriented care of the sick also encourage communal dialogue and listening as important aspects of the care of the sick. As we have already seen, dialogue is a very critical aspect of health communication, especially among family members taking care of their loved one; the same applies to listening. This is typical of Christ's model. Raja (2008) asserts that Christ sets out to

establish contact and to create dialogue, relationship, and understanding with all the people with whom he interacted. This is the greatest model for us as we engage in dialogue with others. . . . Through dialogue he continued to interact with people of every type in society, regardless of their refusal to accept him and his teachings. (p. 570)

In addition, Raja (2008) observes that "by listening, Jesus communicated, and for communicating, Jesus listened" (p. 570). In other words, communication and listening are two intricately woven entities that cannot operate independently.

Christian perspectives on the value, sacredness, and dignity of human life are also very intimately connected to the bioethics view, with many ramifications. This is obvious in the discourse on abortion, suicide, euthanasia, and physician-assisted suicide. This will be the concern of the following section.

Bioethics on the Sacredness and Dignity of the Human Life Vis-à-Vis Abortion, Suicide, Euthanasia, and Physician-Assisted Suicide

Most of the bioethics perspectives on the value, dignity, and sacredness of human life as it relates to abortion, suicide, euthanasia, and physician-assisted suicide are anchored on the Christian and biblical perspectives, especially for Christian bioethicists. The implication of this for health communication is that bioethicists' discourse is embedded in the Bible and follows the biblical and religious rhetoric format. It is also worthwhile to note that, in this present era, there are increasing calls from some political quarters for the legalization of abortion, euthanasia, and even physician-assisted suicide.

In regard to abortion, Christianity, particularly the Catholic Church, has always been at the forefront of the fight against abortion; it is a similar situation for euthanasia (suicide) and physician-assisted suicide. There have been arguments for and against these ethical issues. According to Sulmasy and Mueller (2017), calls for the legalization of euthanasia or physician-assisted suicide are related to people's concerns regarding how they are going to die. Informed by the ethical principle of autonomy, some have advocated that "physician-assisted suicide should be a legal option at the end of life" (Sulmasy & Mueller, 2017, p. 576). This raises some serious health communication implications between those who advocate for its legalization and those who are against it.

The argument raised by those advocating for this legalization is based on an underlying fear: the conviction that medicine's and society's emphasis on intervention and cure has sometimes come at the expense of good end-of-life care (Sulmasy & Mueller, 2017, p. 576). According to Sulmasy and Mueller (2017), "How we die, live, and are cared for at the end of life is important, with implications for individuals, their families, and society" (p. 576). Those who

make this argument believe that inappropriate treatment that is harmful and physically, emotionally, and financially draining for patients and their families is usually given at the end of life. Therefore, while some patients receive unwanted care at the end of life, others do not receive needed care.

The American College of Physicians, a proponent of patient-centered care, is against such legalization. Although the American College of Physicians admits that the arguments of those who seek legalization are quite compelling, they contend that such a move is problematic, given the nature of the patient–physician relationship. As far as health communication is concerned, such legalization would affect trust in the relationship and in the caregiving profession, as well as fundamentally alter the medical professional’s role in society. Legalization would put the caregiver in an uncomfortable situation of being viewed with suspicion by either by patients or their family members. Moreover, legalization would affect the physician’s duties to provide care based on clinical judgment, evidence, and ethics. These physicians believe that society’s focus at the end of life should be directed toward efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care. They conclude that the American College of Physicians remains committed to improving care for patients throughout and at the end of life. These ethical issues continue to raise serious concerns in bioethics in general, and in healthcare communication in particular. To gain a better understanding of this subject, I will now define each of these ethical issues.

Abortion is defined by Reiman (1999) as “the intentional termination of pregnancy either by killing the fetus directly or by removing the fetus from the womb with the result that it dies” (p. 8). Similarly, Ashley and O’Rourke (1997) state that abortion is “the termination of pregnancy with resulting death of the human fetus” (p. 253). They declare that abortion may

occur spontaneously, in which it is called miscarriage (and is, therefore, not intentional), or it may be intentionally caused, in which it is called induced or procured abortion. According to Ashley and O'Rourke (1997), Catholic theologians distinguish between direct and indirect procured abortions:

A direct abortion is one in which the direct, immediate purpose of the procedure is to terminate pregnancy by destroying the human fetus at any stage after conception or to expel it when it is not viable. Most procured abortions are direct in nature. An indirect abortion is one in which the direct, immediate purpose of the procedure is to treat the mother for some threatening pathology, but in which the death of the fetus is an inevitable result that would have been avoided had it been possible. (p. 253)

Suicide is described by Ashley and O'Rourke (1997) as "the choice to destroy one's own life" (p. 411), while assisted suicide is "formal cooperation with the suicide of another" (p. 411). In the same vein, a physician-assisted suicide is described by Brock as "a patient's ending his or her life with a lethal dose of a medication requested of and provided by a physician for that purpose" (as quoted in Bauchamp & Walters, 2003, p. 216). In other words, it is the patient who kills himself or herself through the help of the doctor, meaning that both the patient and the doctor cooperated in killing the patient.

In euthanasia, the physician kills the patient; in this case, according to Brock, "the physician acts last by performing the physical equivalent of pushing the button" (as quoted in Bauchamp & Walters, 2003, p. 216). Brock concludes that in both cases (physician-assisted suicide and euthanasia), the choice rests fully with the patient: "In both, the patient acts last in the sense of retaining the right to change his or her mind until the point at which the lethal

process becomes irreversible” (as quoted in Bauchamp & Walters, 2003, p. 216). Therefore, the choice to terminate one’s life in this situation absolutely resides with the patient.

Abortion, suicide, euthanasia, and physician-assisted suicide have long been considered controversial issues, particularly within the church. For instance, medieval and British common law considered abortion to be a serious crime, while the United States’ first statute law on abortion in 1803 (before abortion’s legalization in 1973) declared abortion to be “a crime punishable by death if the child had ‘quickened, and by lesser but serious penalties if the child had not’” (Ashley & O’Rourke, 1997, p. 265). England and the United States passed very strict laws against abortion throughout the 19th century, with the exception of therapeutic abortions carried out with the aim of saving the mother’s life. However, with the passage of time, many arguments and fights in defense of abortion have been made. One such argument, which is considered to be one of the strongest, was championed by prominent moral philosopher Judith Jarvis Thomson; it is what I will concentrate on. Thomson based her argument on the belief that it is the right of a woman to control her own body and to make her own choice.

Thomson maintains that a woman’s right to control her body gives her “not so much a right to abort the fetus as a right to evict it as property owner may evict an intruder or an uninvited guest” (as quoted in Reiman, 1999, p. 55). Assuming that a fetus is a person with the right to life, Thomson tries to prove that a woman has a right to abort the fetus. She upholds that a famous violinist involved in a fatal accident does not have the right to be plugged into your circulatory system (at the behest of the Society of Music Lovers) in order to use your kidney to extract poisons from his blood, as well as from your own blood without your consent, even though permitting that to happen may result in saving the violinist’s life. Although unplugging from the violinist would inadvertently kill him, and although he has a right to life, you are not

obligated to remain plugged into him. A person's right to life does not place a moral bar on your disconnecting him from your body, although doing this will bring about the death of the fetus. This argument tends to be made in opposition to laws against abortion, on the grounds that the choice to abort or not to abort belongs to the mother alone, while the right of the fetus is completely ignored.

A lot of antiabortion arguments have also materialized, especially among bioethics scholars. Most of these arguments attack the claim regarding a woman's right to control her body, since most proabortion arguments are in alignment with this view. Reiman (1999) considers the argument defending a woman's right to control her body a mistake, since, for him, the "right to control one's body does not entitle one to harm another person's body" (p. 52). The common phrase is, "My right to swing my fist ends where your nose begins," meaning that my moral right to control my body ends where your right to have your body not interfered with begins. As a result, if the fetus is a formal person, as antiabortionists uphold, then "a woman's right to control her body will end where it is about to invade the fetus's—another person's—body (Reiman, 1999, p. 52). Most pro- or antiabortion arguments are based on discussions concerning whether or not a fetus is the sort of being whose life it is seriously wrong to end. These arguments further hinge on another argument: whether the fetus is a human person or not. Opponents of abortion argue that the fetus is a human person from the moment of conception. Therefore, to abort the fetus is tantamount to killing a human person and infringing on his or her right to life. Antiabortion scholars contend that

it is at the least highly probable—and therefore in moral decisions practically certain—that from conception (syngamy) the human organism is a human person endowed with a spiritual soul and therefore endowed with the same human rights as any adult person. Its

rights cannot be placed in competition with those of the mother, because both have the same basis and are equally to be respected. (Ashley & O'Rourke, 1997, p. 252)

Reiman (1999) advances an argument that attempts to puncture a hole in Thomson's proabortion argument. Although Reiman (1999) admits that pregnancy due to rape would be the most obvious instance in which the pregnant woman has the right to expel the fetus, he introduces the aspects of voluntary and intentional cooperation in the act that results in pregnancy. Going back to the violinist argument, Reiman (1999) contends that if a woman had voluntarily and intentionally invited the violinist to use her body, it would probably be wrong to disconnect him: "Thus, the legitimacy of disconnecting a fetus will vary with the degree to which the pregnancy was intentional, that is, the degree to which the woman can be thought to have invited the fetus in" (p. 256). Reiman (1999) argues further that Thomson's argument does not follow if we have a special obligation to protect the lives of fetuses that go beyond what we owe the violinist. Reiman (1999) uses John Arthur's question to buttress his antiabortion argument. According to Arthur, as quoted in Reiman (1999),

Suppose you arrive at your remote mountain cabin for a winter of solitary writing, only to find an infant on the front porch. If we assume it's too late in the season to get the baby to town, can you then leave her outside to die, claiming that it is your cabin, and you didn't invite the baby to stay? That most people don't find it easy to say "Yes" suggests that adults may have duties to provide more positive assistance to uninvited (even unknown) infants than is required by the standard right to life. (p. 56)

Arthur contends that this might apply to fetuses as well. While the standard, negative right to life may govern our relations with normal adults who can fend for themselves, vulnerable and defenseless beings, like infants and fetuses, may have a right to our protection.

At the forefront of the antiabortion movement is the Christian Church, especially the Catholic Church, whose argument is based on scripture. As Ashley and O'Rourke (1997) state, For the Jews, all human life has its author the One God whose creative power produces the child in the mother's womb and brings it step-by-step to full life. The parents play only an instrumental role in this creative process, so that from the beginning, a direct, personal I-Thou relation exists between the Creator and the human being whom he is creating, just as truly as he created Adam and Eve. (p. 254)

Several of the Jewish prophets express deep conviction of human life as an act of divine creation and formation in the woman's womb. Some biblical passages attest to this. For instance, Samson's conception and birth are portrayed as an act of divine ordinance: "For behold, you shall conceive and bear a son. No razor shall come upon his head, for the boy shall be a Nazirite to God from birth (Judges 13:5). In the same vein, the Book of Psalms is very explicit about the divine formation of life in the womb, which deprives human beings of any right to tamper with life. In *The Gospel of Life: Evangelium Vitae*, Pope John Paul II (1995) states that "more than anything else, at work here is the certainty that the life which parents transmit has its origin from God" (p. 73). Psalm 139:13 declares, "For you formed my inward parts, you knitted me together in my mother's womb." Similarly, Prophet Isaiah declares, "Listen to me O islands, and pay attention, you peoples from afar. The lord called me from the womb, from the body of my mother he named my name" (Isaiah 49:1). Isaiah's call is also similar to that of Jeremiah, as evidenced in the following declaration: "Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet to the nations" (Jer. 1:5).

In the Book of Job, Job questions, “Did not he who made me in the womb make him? And did not one fashion us in the womb?” (Job 31:15). Therefore, as Ashley and O’Rourke (1997) point out, the Old Testament belief that

God is the creator of human life from the moment it begins, so that the human person is defined fundamentally by this unique ‘I–Thou’ relation to its Creator rather than by the legal provisions of the Exodus, has always guided Christian thinking about the unborn child. (p. 256)

As we have seen, numerous biblical passages constitute the basis for the defense of human life in the Judeo–Christian tradition. In fact, they are fundamental to Judeo–Christian antiabortion arguments, arguments that enjoin respect for the unborn. Ashley and O’Rourke (1997) contend that

Judaism has resolutely opposed any form of infanticide and has required Jews even to accept martyrdom rather than to kill innocent persons. But the rabbis also held that in conflict situations where the life of the mother is endangered, the child can be considered an “unjust aggressor” or “pursuer” against whom the woman can defend herself. In such cases, therefore, for Jews induced abortion is permitted. (p. 255)

In this respect, in Judaism, in the case of danger to the life of the mother, the mother’s life is considered paramount vis-à-vis that of the unborn child. As such, a child is not viewed as possessing a full right to life until birth, or when the head emerges. The Catholic Church, differing from this Judaic line of thinking, fully advocates for the right of the unborn. Like most Christian stances, the Catholic Church advocates for the utmost respect and value for human life. Walter and Shannon (2005) note that the Christian tradition’s approach to abortion is based on great respect for human life, where every life is valued on account of its relation to God’s

creative act and divine vocation. Jesus already called from his mother's womb (Luke 1: 31) stresses God's care for every human being irrespective of their sinfulness, ignorance, or ritual uncleanness. He preached the good news of God's love for the little ones (the most vulnerable), the outcasts of the society, including "powerless little children, whom he declared should be given special respect as privileged members in his Father's Kingdom" (Walter & Shannon, 2005, p. 255).

Following the biblical perspective, we have the early Christian church fathers, whose view on abortion vis-à-vis health communication was absolutely based on messages that promoted radical morality and was guided by them. Some of these moral high ground messages also guided the early church in its approach to abortion and healthcare communication. Among the early church fathers were Tertullian, Jerome, and Augustine, who absolutely condemned abortion. As Walter and Shannon (2005) observe, this was in their bid to "distance the Christian community from the pagan practices of abortion and infanticide, and to call members of this community to imitate the love that God has for all human life, especially for innocent human life" (p. 149). As such, the Catholic tradition (which is not overly concerned with philosophical questions, like when the human soul is infused and when the fetus becomes a person as such) views all unborn life as "innocent." Thus, the Catholic Church maintains that from the moment of conception, the life that is present at all stages of development must be treated as a person, i.e., all human life from the moment of conception must be treated and respected as the moral equivalent of a person. Therefore, no matter what the stage is of development, the unborn life is granted an identical ethical value, and it must be respected in an absolute way. To this effect, all unborn life makes a moral claim on us to respect its fundamental right to life. In line with this, the church has consistently and vehemently condemned abortion from the time of conception as

a grave sin, although the penalties for aborting an animated fetus were greater than the ones for aborting an unanimated one. In the same vein, some popes have rejected abortion under any circumstance. For example, Pope Pius XII excluded all direct abortions, considering them all to be morally wrong, i.e., “every act tending directly to destroy human life in the womb ‘whether such destruction is intended as an end or only as a means to an end’” (2013, #62). Pope John XXIII reaffirmed that human life is sacred because “from its very beginning it directly involves God’s creative activity” (as quoted in Pope John Paul II, 1995, p. 101).

Notwithstanding the moral high grounds of zero tolerance proposed by these popes, with the passage of time, Catholic ethical and religious directives began to soften on their stance regarding indirect abortion. As a result, the Church began to give consent to indirect abortion, as long as the following conditions were met: The procedure is carried out for the purpose of treating the pregnant woman, and she and the physician do not have any sinister circumstantial intention of killing the fetus (that is, they would want to save the life of the child if they could); the death of the child is not the means by which the mother is treated but only happens as a result of treatment; and there is a proportionate reason if the treatment is necessary to save the life of the pregnant woman particularly because the child would never have made it anyway. Besides these circumstances, the church condemns procured abortion in very strong terms.

Therefore, the basic principles of agreement among Jews and Christian churches are as follows: Abortion goes contrary to the will of God, who is the creator of the human person, and if abortion is ever to be allowed in the most conflicting situation, it must be justified only by the most serious reasons. To this effect, *Vatican Council II* raises the dignity of life to the highest echelon, upholding that the God of life has entrusted to men the mission of safeguarding life and that humanity must carry it out in a manner worthy of themselves. Thus, “life must be protected

with the utmost care from the moment of conception: abortion and infanticide are abominable crimes” (*Gaudium et Spes*, #51). Pope John Paul II (1995) further strongly condemns abortion:

Therefore, by the authority which Christ conferred upon Peter and his successors, in communion with the bishops—who on various occasions have condemned abortion and who in the aforementioned consultation, albeit dispersed throughout the world, have shown unanimous agreement concerning this doctrine declare that direct abortion, that is, abortion willed as an end or as a means, always constitutes a grave moral disorder, since it is the deliberate killing of an innocent human being. This doctrine is based upon the natural law and upon the written word of God, is transmitted by the Church’s Tradition and taught by the ordinary and universal Magisterium. (p. 102)

This unambiguous papal declaration establishes the church’s teaching and perspective in regard to abortion. While discouraging abortion, the church vehemently urges and promotes preservation of life. The same tough stance with which the church regards abortion is also applicable to physician-assisted killing and active euthanasia.

Euthanasia and Physician-Assisted Suicide

The value and sacredness attributed to human life, as evidenced from the Christian perspective, hinges on the Catholic Church’s tradition and its stance on euthanasia and physician-assisted suicide. In physician-assisted suicide, it is the patient who acts last in administering the lethal dosage provided by the physician to himself or herself. In euthanasia, the physician acts as the agent who administers the terminal dose, but the choice rests fully with the patient. In both cases, the patient still retains the right to change his or her mind until the point has been reached in which the lethal process has become impossible to reverse.

Discussions on what is referred to as palliative sedation and terminal sedation are equally important. Terminal sedation is closely related to euthanasia. Although palliative sedation refers to the caregiver's intent to relieve refractory pain, terminal sedation refers to the intent to end the patient's life as a result of the perceived suffering the patient is going through (Walter & Shannon, 2005, p. 225). This brings up questions including the following: How does the Catholic tradition view suffering or pain in relation to the care provider and patient interaction? Do caregivers have a duty to alleviate pain and suffering? The immediate answer is "yes." This has implications for healthcare communication. In the interaction between the patient and the care provider, paramount consideration has been given to patient satisfaction outcomes. In essence, when physical suffering emanates from pain, it should be relieved, if possible: "When patients seek relief, physicians have a duty to offer painkillers to alleviate pain. This is not just an option; it is a duty for the physician within the Roman Catholic community" (Walter & Shannon, 2005, p. 226). Therefore, human and Christian prudence would suggest the use of medicines that are capable of alleviating or suppressing pain for the majority of patients, even though doing so may result in a secondary effect of "semi consciousness and reduced lucidity" (Walter & Shannon, p. 226). This, in effect, introduces what is considered to be the "principle of double effect" (PDE) in medical ethics.

The PDE tries to respond to this moral question: "Is it right to perform an action from which two or more effects result, some of which are good and may rightly be intended and some of which are bad and may not rightly be intended?" (Kelly, 2004, p. 108). Kelly (2004) argues that this question falls within the realm of normative ethics, which discusses actions where there is some controversy or disagreement—those actions that do some good as well as some evil (acts with both good and bad effects). Euthanasia falls within this category, since it carries with it the

PDE. It is perceived as doing both good and bad; although it stops pain, saves money, and ends the dying process, it kills, hurts doctor–patient interpersonal communication, and threatens the poor and the disabled.

The PDE proposes that an action with both good and bad effects is right or permissible if, and only if, the following four conditions are met: (a) The act in itself must not be morally wrong; (b) the bad effect must not cause the good effect; (c) the agent must not intend the bad effect (as an end to be sought); and (d) the bad effect must not outweigh the good effect. Active euthanasia falls short of meeting the requirements of these conditions and, therefore, is forbidden by the PDE. This means that any act that brings about or hastens the death of a dying person is forbidden. However, any drugs that help to lessen pain can be administered, provided that these drugs do not directly hasten death.

Although ordinary means of preserving life are mandated in the Catholic tradition, extraordinary means are not required. Ordinary means of preserving life, according to Walter and Shannon (2005), are “all of those potential treatments, surgeries, medications, and anything else that could offer the patient a reasonable hope of benefit and that can be offered without excessive expense, pain or inconvenience” (p. 228). Conversely, extraordinary means of prolonging life are all those potential treatments, surgeries, medications, and anything else that could not offer a reasonable hope of benefit or could not be obtained without excessive pain, expense, or other inconveniences. Thus, negative euthanasia is allowed. It occurs when extraordinary means of treatment is refused or withdrawn; meaning that extraordinary means are not required to preserve or prolong life. This is always a patient or family determination after calculating benefit or burden. (Walter & Shannon, 2005, p. 228)

In a case where treatment, nutrition, or hydration is disallowed, death of the patient would eventually occur. This is what Kelly (2004) refers to as allowing patients to die of their underlying condition. The argument in this regard might be that delivering nutrition and hydration could be considered extraordinary for a patient, in that doing so would not offer any reasonable hope of benefit, or that it would simply be burdensome for that patient to accept treatment, given their condition of unrelieved neurophysiological pain (Walter & Shannon, 2005, p. 228). With all the aforementioned factors taken into consideration, extraordinary means of prolonging life could still be stopped once begun, depending on the patient's desires.

The church teaches that any direct killing or direct hastening of death must be avoided; the same also applies to direct suicide. Suicide is considered illicit and evil. Hence, preservation of life is both a human responsibility and a duty. Cronin (1958) maintains that explaining that suicide is evil is as well, a virtual demonstration of an equally true proposition: self-conservation is a duty. Cronin (1958) believes that deeply entrenched in the human fiber is a strong drive that urges man to strive for self-preservation; this is coupled with a very definite duty to conserve one's life.

On the contrary, indirect suicide (allowing oneself to die either by refusal or withdrawal of extraordinary means of preserving life) is permitted. The general idea, according to Kelly (2004), is that "while it is often right to withhold or withdraw medical treatment that would prolong the lives of dying persons, it is not right to kill them or to help them kill themselves" (p. 196). Kelly (2002) echoes the stance of the church with regard to euthanasia and assisted suicide, saying that "the direct killing of an innocent person is never morally right, but allowing to die is sometimes morally right" (p. 8). In essence, although passive euthanasia is allowed by the Catholic Church, active euthanasia is not.

St. Augustine states that it is not without significance that there can be found nowhere in the passages of the holy canonical books any divine precept or permission to take away our own life, be it for the sake of entering the enjoyment of immortality or of shunning or ridding ourselves of anything whatsoever. As Cronin observes, rightly interpreted, the law even prohibits suicide where it says, “Thou shalt not kill.” The commandment is, “Thou shalt not kill man,’ so, neither neighbor nor yourself, for he who kills himself has killed nothing else but a human being (as quoted in Smith, 1989, p. 5).

Lactantius (an early Christian author and one-time counselor to the first Christian Roman emperor, Constantine I) declares that if the one guilty of homicide is considered to be wicked, as the result of taking the life of another, the same is to be attributed to the one who kills himself, because he has also killed a man. For Lactantius, suicide could even be considered greater, and its revenge lies with God alone. According to Cronin, we did not come into this life of our own free will; in the same vein, we also must leave this domicile of the body, given to us to watch over, by the command of the person who placed us in this body to inhabit it until such a time he orders us to depart from it.

In the 6th century, the church remained constant in her teachings against suicide, especially in the Council of Orleans. During this council, it was decided that no one should accept the offerings of any man who died by his own hands. The Catechism of the Council of Trent proclaims, “No man possesses such power over his life as to be at liberty to put himself to death, hence, the divine commandment does not say, Thou shall not kill another, but simply, ‘Thou shalt not kill’” (Cronin, as cited in Smith, 1989, p. 7). Accordingly, Catholic theologians basing their arguments on the scriptures, the writings of the fathers and doctors of the church, have always been mindful of the problem of suicide and, as a result, have condemned it as

despicable in their writings. St. Thomas Aquinas presented a three-fold argument on the malice of suicide: (a) Suicide is against natural inclination and charity with which everyone should love himself; (b) since everyone is part of the community, and so belongs to the community, he does injury to the community when he destroys himself; and (c) according to the scripture, since God alone is the author of life, he alone should decide the time of death of each person; therefore, whoever deprives himself of life by suicide is actually usurping the judgment of a matter over which God actually never gave him jurisdiction.

Summary

This chapter has set out to show that human life has a great value, dignity, and sacredness because it is a gift from God and because human beings are God's special creatures. The abundance of biblical and Christian tradition in this regard provides reasonable grounds to prove that Christianity has always taken great interest in human life and in healthcare. This further explains the reason why, in this present day, religious faith and spirituality continue to play a pivotal role in healthcare communication. In essence, although healthcare is a relatively new area in the field of communication, the church's stance on matters of healthcare has great significance and implications for healthcare communication. This is because, over the years, Christianity has had constant interaction with healthcare communication. This is evident from the Bible, where communication between God and humans was most of the time accomplished through divine revelation—specifically through telepathy, using a linear communication style, which does not permit much feedback from the receiver of the message, that is, humankind. Other times, God-human communication was shown to be dialogic and relational. Here, God communicates his intentions and performs actions geared toward preservation of human life. Christ exhibited great

interpersonal skills in his dealings with his disciples and with the people, especially the sick. With him, communication with people becomes more personal, relational, and empathic.

The Catholic Church and the church fathers following in the footsteps of Christ place a great value on human life, taking time to encourage and promote its preservation. This explains their hard stance on certain ethical issues that pertain to life: abortion, suicide, euthanasia, and physician-assisted suicide. They adopted a message of radical morality with regard to these issues in terms of the doctor–patient–family relationship. Although calls have been made for the legalization of these issues, they have implications for healthcare communication: lack of trust in doctor–patient interactions, alteration of the role of the medical profession in society, duties of medical practitioners based on the use of clinical judgment for the good of the patient, and so forth.

Finally, this chapter is a justification of sorts for what I will be dealing with in the remaining chapters. For instance, in Chapter 2, I will be examining a brief history of the relationship of religion, medicine, and healthcare across different time periods. In Chapter 3, I will look into the intersection of religious faith and spirituality, according to healthcare communication scholars. Chapter 4 will explore different religious coping strategies against the backdrop of scholars who deny the role of religious faith and spirituality in healthcare.

Chapter 2:

A Brief History of the Interaction of Religion, Medicine, and Healthcare:

Implication for Health Communication

Many people in the Western world today consider belief in religious faith and spirituality as indispensable panacea in the healing process of the sick, as anachronistic, archaic, and myths that should not have any place in modern times. For such people, religion and healing are incompatible given the giant strides that medical science has made in relation to medical technology and scientific innovations. In addition, for these people, most of whom are well educated, it is absurd to even imagine religious faith and spirituality as playing any vital roles in the process of caregiving and healing. For them, therefore, scientific medicine and technology are the beginning and end of any discourse on human health. The “transcendental ‘why’ questions are not seen as belonging under the province of physicians but are typically delegated to the members of the clergy” (Thompson, 2014, p. 1162). This modern attitude, according to Ferngren (2014), is consistent with the naturalistic values that are in vogue among the intellectual and scientific circles today. The reason for this line of thinking is as Ferngren (2014) expresses here:

We are conditioned to see medicine as purely biological or physical phenomenon. Those who pray instead of consulting their local physician we deem foolish and irresponsible. In some cases, they are taken to court and sentenced to prison for their irresponsibility in not seeking medical care for their children. (p. 1)

Ferngren (2014) contends that more religiously minded people might offer a prayer, seeking the intervention and help of the divine healer, while driving to the hospital. Ultimately, it is the doctor to whom we first take our medical problem and in whom we generally place our trust.

This notwithstanding, Ferngren (2014) is of the opinion that most societies all throughout history have espoused a religious view of the world, and many still do so today. In Ferngren's (2014) words, religion for these people "encompasses the totality of life and is connected with every facet of existence, including healing" (p. 1). For such people, religion is life, and life is religion.

Accordingly, this chapter explores the interactions among religion, medicine, and healthcare across different historical periods, namely the ancient, medieval, Renaissance, and modern periods. Moreover, it attempts to show their relevance to healthcare communication. This historical documentation as we shall come to see, is further proof of the existing, long-standing interaction among religious faith, spirituality, medicine, and healthcare.

To this effect, in their research regarding the interactions of religion, medicine, and healthcare, Koenig, King, and Carson (2012) state that throughout most of recorded history, religion, medicine, and healthcare have been linked. It is only recently that they have been separated.

Additionally, Koenig (2000) maintains that "religion and medicine have a long, intertwined, tumultuous history, going back thousands of years. Only within the past 200–300 years (less than 5 percent of recorded history) have these twin healing traditions been clearly separate" (p. 385).

Ferngren (2014) agrees with this claim, declaring that "medicine and religion have had a close association throughout history, one that can be traced back to the earliest human attempts to heal the human body and to understand the meaning of illness" (p. 1). The following section looks at this association of religion, medicine, and healthcare across different historical periods, and its relevance to health communication.

Religion, Medicine, and Healthcare During the Ancient Period: Implications for Healthcare Communication

My investigation has revealed that although there was a confluence of religion, medicine, and healthcare in the ancient period, there is a total dearth of literature relating these entities to communication, much less healthcare communication. Thompson (2014) captures this view in the following words:

Academic research on religion and spirituality in the broader field of communication is a relatively recent phenomenon, with the Religious Speech Communication Association (now the Religious Communication Association) formed in the 1973, and the Spiritual Communication Division within the National Communication Association instituted in the mid-1990s. (p. 1162)

Additionally, Kreps (2014) observes that “health communication is a young . . . interdisciplinary area of study” (p. 567). Although it traces its roots to early Greece and to the medical philosopher Hippocrates, health communication “started to formalize in the early 1970s” (Kreps, 2014, p. 567). Hippocrates established the Hippocratic Oath regarding the ethics of medical practice, whereas healthcare communication sets out to examine the many ways that communication influences healthcare delivery and health promotion. There were no explicit discourses on the relationship among religion, medicine, illness, healthcare, and healthcare communication during the ancient period. Given these enormous challenges, in addition to the dearth of literature that explicitly explored this relationship, it becomes a daunting task to relate religion, medicine, illness, and healthcare to healthcare communication during this period. Therefore, most of the inferences I will be making on this section could best be described as

adaptions. With this in mind, I will now venture into a discussion of possible traces of the relationship among these entities and their relevance to health communication.

Koenig (2000) is a prominent scholar who has deeply explored this field of study. In his attempt to trace the relationship among religion, medicine, and healthcare, he maintains that “religion and medicine are no strangers” (Kreps, 2000, p. 386). This is evident right from the ancient period. For instance, in the prehistoric times,

priests are those who practice healing. The first medicine men care not only for the physical needs but also the religious and magical needs of the tribe. This priest-physician is believed to possess supernatural powers and to be able to reverse the effects of an evil spirit or punishment by the gods, which is thought to be the cause of sickness. As part of the healing process, the medicine man says prayers and repeats magic formulas [incantations]; he dances around the patient to the beat of a drum and touches him with various sacred objects. (Koenig et al., 2012, p. 15)

In regard to health communication, the priest becomes the principal communicative agent about disease, the decision-maker on health issues, and the healer. The priest/physician–patient relationship could best be described as paternalistic communication, in which the priest/physician wielded enormous power and authority in health decision-making, without much opportunity for input from the patient himself. The priest/physician’s words were held as sacrosanct in matters of illness and healing. Furthermore, Koenig et al. (2012) note that artifacts from the predynastic period in Egypt, between 6,000 and 5,000 BC, show that mental illness and physical illness were not distinguished from each other, and both were understood in religious terms: evil spirits, demonic possession. All sicknesses were viewed as mental.

In line with Koenig et al. (2012), Zilboorg and Henry (1941) also attempted to trace the relationship among religion, medicine, and healthcare. These scholars Zilboorg and Henry (1941) claim that the primitive man was a very frightened human being who viewed the world as populated with spirits, which were, of course, images of his own anxiety. His psychological energies were mainly devoted to getting rid of the uncertainty and fear brought about by the illness than to the more realistic efforts of getting rid of the illness itself (Zilboorg & Henry, 1941, p. 28).

Moreover, during the pharaonic period in the history of Egyptian civilization (5000–1500 BC), there was little distinction between religion and magic (heka); both were regarded as controlling factors in daily life. According to Prioreshi, “Egyptian medicine continues to urge a supernatural paradigm of medicine, but combines the naturalistic approach of the physician, the nonscientific healing of the priest, and the magic of the sorcerer” (as quoted in Koenig, 2012, p. 17). While the ancient healing art of laying on of hands was portrayed in the hieroglyphics, pictographs, and cuneiform writings of Egyptian, Assyrian, and Persian civilizations, the shamans of primitive tribes in northern Asia used hypnotism to influence the sick (Koenig, 2012). Zilboorg and Henry (1941) state, “Priests indulged in a form of hypnotic treatment, using an assistant as a medium” (p. 28).

Among the ancient Mesopotamians, medicine between 3200 and 1025 BC involved a mixture of supernaturalistic and naturalistic paradigms, in which treatments were sometimes administered through spiritual practices, and through natural methods, such as plant leaves, roots, and mixtures of animal parts, at other times. During this period, diseases were believed to have been caused by unappeased ghosts who attacked or possessed humans, leaving marks of illness upon them (Koenig et al., 2012). Healing was administered through natural methods, as well as

through what Du Pre (2005) calls medical spiritualism. According to these methods, medical discourse between the sick and the priest was guided by “the belief that illness is governed by supernatural forces, such as gods, spirits and ghosts” (Du Pre, 2005, p. 28). Thus, with regard to health communication, the priest once more becomes the mediator between the gods and the patient, intervening on behalf of the sick to bring healing to him. This suggests that there was no direct communication between the gods and the patient. Instead, health communication requires a three-way process: god–priest–patient.

This was similar to what was believed in the Middle Kingdom of ancient Egypt (2000–1800 BC). The priest exorcised evil spirits by using the name of the central god, Horus; invocation of deities, which involved asking for their help, was done as a first resort when a medical condition was being treated. Priests directly addressed incantations to disease-demons, ordering them to leave the body (Koenig et al., 2012, p. 16). This act was viewed as a favorable act by the exorcist and considered as a way of appeasing the gods in the eyes of the central government. Remedies for trauma among the ancient Egyptians rarely contained incantations, unlike the treatment used for medical conditions.

Although the Western world historically traces medicine to ancient Greece and considers Hippocrates as the first physician, Du Pre (2005) claims that the first doctor recorded in history was Imhotep, an ancient Egyptian who lived about 2,000 years before the birth of Hippocrates. Zilboorg and Henry (1941) observe that Imhotep was considered to be the father of Egyptian medicine, while Hippocrates was seen as the father of Greek medicine. Imhotep, as the first known physician, formed part of the ancient medical community that is still admired for its vast knowledge. As Du Pre (2005) puts it, Imhotep was not only a healer but also a priest, sculptor, and architect. Centuries after his death, he attained godlike status. Some legends view him as the

son of Ptah, the Egyptian god of architecture. Others revered him as a medicine god and evoked his name in healing ceremonies. It must be remembered, however, that in those remote days, medicine dealt with physical pains only, while psychological problems were often not suspected of being diseases and were hardly considered to be the special concern of the physician. We can experience vestiges of this thinking in our current era.

There is the belief that Imhotep was the basis for the Greek god Aesculapius whose name is mentioned in the famous Hippocratic Oath. Aesculapius is traditionally considered the god of medicine. Many people during the time of Hippocrates believed that disease was God's punishment, and so it was regarded as a thing of shame. Hippocrates, however, helped to dispel this notion, so that instead of spiritual explanations for illness, there was a rational or empirical model of medicine. He contends that, based on a rational or empirical approach, disease is best understood through careful observation and logical analysis. This notion later reemerged and developed further during the Renaissance period.

On the whole, "the ancient Egyptians took a religio-empirical approach to medicine, combining spiritualism and physical study. Healers were holy men such as Imhotep, but the ancients also recognized a physical component of illness" (Du Pre, 2005, p. 26). Thus, these ancients developed an impressive variety of instruments, including surgical appliances, sutures, drugs, and immobilizing casts.

In the Homeric tradition, man was considered mentally sick because the gods had taken his mind away. Koenig (2012) explains that "mental illness is thought to originate from influences by the gods of mythology" (p. 17). Koenig et al. (2012) reveal that there is a separation between priests and physicians according to the work they do, as seen in the biblical texts. The physician had clear-cut duties that he performed, and he had no responsibility in

dealing with mental illnesses. For example, demonic powers were believed to be responsible for any condition where organic factors could not be identified in a patient; such cases were handled by priests. In healthcare communication, the priest plays a leading role as a mediator or intercessor between the patient and the gods, sometimes combining both physiological and spiritual aspects of healing in his communication with patients. This practice was prevalent in ancient times across most cultures.

In regard to ancient Greece (500–300 BC), Pollak (1963) claims that gods and evil spirits explained all sicknesses until the seventh century. Pioreschi (2001) explains that during the classical times (490–323 BC), a new medical paradigm emerged that viewed disease as resulting from natural causes, whereas healing resulted from the inherent virtues of medicinal drugs. Between 300 and 0, physical and mental illnesses were considered to have natural causes in the Western world, although they were affected by divine forces. As a result of great influences exerted by the Greek Aesculapian cult, treatment was administered primarily through astrology, magic and herbs.

During the pre-Hippocratic days, medical centers were the Aesculapian temples. The Aesculapiadae (the priestly inheritors of the secrets of healing) would start the treatment with imposing religious ceremonies:

The powers of the god of healing were recounted. The patient would sleep near the temple and dream of the god appearing and producing miracles of cure; depending upon the nature of these dreams, various fomentations with decoctions of odiferous herbs were used. Even a little over a century before Hippocrates the Aesculapian temples were still the centers of medicine and the oracles were still the source of great deal of medical, and especially medico-psychological advice. (Zilboorg & Henry, 1941, pp. 37–38)

Mentally ill people were usually taken to the temple to be healed or even to do the healing, while others were forbidden entrance into the temple. When people become mentally ill, the explanation was usually attributed to an offense against an oracle (Zilboorg & Henry, 1941 p. 38).

In regard to ancient China, Koenig (2000) claims that early Chinese society (2000–500 BC) believed that life was under the control of spirits and demons. As such, this society believed that the ancestral spiritual world needs a kind of pacification so that diseases and chaos could be avoided. Koenig (2000) points out the following:

Whereas Hippocratic medicine practiced in early Greece was more concerned with achieving a balance of bodily fluids or humors, Platonic medicine mixed science with mystical elements and Asclepian medicine treated illness by means of astrology, magic, and herbs. Private physicians attended the wealthy, while most of the common people sought cures through miraculous healing, relied on folk remedies, or after 400 AD, sought help from clergy with medical skills. (p. 387)

The ancient Chinese people did not engage in the practice of dissecting the body because they considered this to be a violation of the precept of ancestor worship. They believed that body parts are part of one's parents; hence, disease is treated with medication, not mutilation. In ancient Chinese culture, physicians were identified with sorcerers, while illness was associated with demonic influence.

For Ferngren (2014), in the ancient world, a period when little was known about theoretical medicine or the structure of the body, those considered to be healers often treated the symptoms of common illnesses, while the causes remained mysterious, ascribed to vague and malignant spirits or to demons or divine beings, such as Apollo. (Apollo was known to shoot

disease-bearing arrows at Greek armies.) These so-called healers were known to treat many health conditions for which there were no known cures. In the ancient world, people often turned to supernatural forces for help: “Those who practiced the healing arts understood that in cases where they could do little, the best—and in some cases the only—hope of physical restoration came from the gods” (Ferngren, 2014, p. 2). The gods, more than anything else, held the final answer in health matters. The period from 2000 to 1900 BC changed the narrative, as it introduced the Judaic tradition, where religious belief almost solely guided understanding of disease, sickness, and healing.

With the call of Abraham emerges the monotheistic religion, with its deep connection to the belief in divine infliction and divine cure of sickness. Because I have already explored this in depth in Chapter 1, particularly in the section that dealt with biblical and Christian perspectives on healthcare, I am going to only briefly reexamine this.

In the Old Testament periods, sick people were examined and kept under careful observation by the priest (Koenig, 2012, p. 17). Pioreschi, as quoted by Koenig (2012), states, “Biblical medicine is exclusively super naturalistic; no other naturalistic medicine paradigm developed as seen in other ancient cultures. Moreover, this supernatural paradigm is entirely religious, separated from incantations and exorcism” (p. 17).

As already mentioned in Chapter 1, it is evident in the Old Testament that in the early Hebraic times, people viewed sickness as an act of divine affliction. God afflicts people with madness, blindness, and confusion of mind because of their sins: “And you shall grope at noonday, as the blind grope in darkness, and you shall not prosper in your ways; and you shall be only oppressed and robbed continually, and there shall be no one to help you” (Deut. 28:28–30). The same book further declares, “See now that I, even I, am he, and there is no god beside me; I

kill and I make alive; I wound and I heal; and there is none that can deliver out of my hand” (Deut. 32:39). The Book of Exodus warns,

If you listen carefully to the Lord your God and do what is right in his eyes, if you pay attention to his commands and keep all his decrees, I will not put on you any of the diseases I brought on the Egyptians, for I am the Lord who heals you. (15:26)

Viewed in this manner, cause of sickness has no biomedical basis since everything revolves around God.

As I have already explained in Chapter 1, in this type of encounter, the God–human relationship was portrayed as a master–servant, or top–bottom, model of communication. As such, health communication was purely linear (a one-way process), where God dictates to humans his intentions, without much chance for feedback or input from them.

Because of the tendency to view all ailments as divine affliction, as caused by sin or as caused by disobedience to divine commands, cure was also viewed as emanating from divine volition, often resulting from one atoning for his or her sins. There were no hospitals to take care of the sick among the general population before the Christian epoch.

Nevertheless, Koenig (2012) notes that from AD 0 to 500, as evident in the New Testament,

Jesus focuses on the meaning of suffering and the healing of the whole person; little distinction is made between healing of the body, mind, or spirit. Emphasis is placed on the power of the *thought life* to affect health (Matthew 15:17–20). Early Christians believe that sickness, whether caused by sin or not, can be healed through prayer (James 5:14). (p. 19)

However, when the ancient world eventually fell to pieces, the church continued to be the only bulwark in which science and culture still found refuge. Thus, “the Christian priests, as the

representatives of civilization and culture, also became physicians, and so, they remained for five hundred years” (Koenig, 2012, p. 19). Koenig (2012) points out, though, that during early Christianity, Christians were remarkably hostile to physicians, especially as a result of miraculous healings performed by Jesus and his apostles by laying on of hands or through anointing with oil, not medicine.

As Pollak (1963) explains, there was a noticeable drop in support of physicians by Judaism before the Christian era as a result of religious distrust and other bitter experiences. This resulted in the lack of development of an independent Jewish medicine. There is also no medical manuscript that describes the Jewish healing art in antiquity, except for what is written in the Bible on the subject. While medicine of the Jewish era was largely based on social hygiene (which is traceable to the Egyptian tradition), the Levites (priestly class) had the responsibility of enforcing social hygiene laws. As such, Jewish laws required that these Levites did not treat or mingle with the sick. Instead, treatment of the sick was reserved for the physicians called *rophe*, or healers. These practicing doctors were supplementary to specialists, like internists, surgeons, oculists, and gynecologists. These physicians were not well respected because their healing tactic was based only on magic.

There were special temple-physicians appointed for priests, who suffered from abdominal conditions from bathing in the cold, wearing light clothes, and going barefoot on cold stones. The following section looks at medicine and religion in the era of Christianity and the period’s contributions to medicine and healthcare.

Christian Religion, Medicine, and Healthcare During the Medieval Period

The Middle Ages was indeed the era of Christianity. It was when Christianity dominated, as well as gave meaning to most human endeavors. As such, healthcare communications about

illness, medicine, and healthcare had very deep Christian undertones. Koenig (2012) contends that medicine was practiced as a private trade in the ancient world. It was not available to the general public, who were cared for by the members of their families. Nevertheless, with the emergence of the reign of Emperor Constantine (a Christian emperor who ended the persecution of Christians in AD 313), things took a different turn. Constantine made Christianity the legal state religion of the Roman empire. Charity was then considered as the supreme religious virtue. Therefore, for love's sake and with the conviction that every human soul needs to be saved, Christians were urged to "care for those in need: the destitute, the handicapped, the poor, the hungry, those without shelter, and perhaps, above all, the sick" (Porter, 1993, p. 1452). With this new development, care of the sick and salvation of souls became important aspects of Christian practice.

Case (1929) corroborates Koenig's (2012) view, declaring that it was generally assumed that Christianity was a religion of salvation and healing, or of the medicine of the soul and body. The veracity of this statement is made even clearer by Sigerist (1945), who notes that "in a world in which the church played an overpowering role and in which religion permeated all aspects of life, religious medicine was close to the people and bound to be very much in the foreground" (pp. 140–141). As such, the function of religion was believed to be to heal diseases. There is no denying the fact that this perception has gained the status of an orthodoxy in Christianity. This view was captured by Nutton (1984), who described Christianity as a "healing religion par excellence" (p. 5). Sigerist, as cited by Ferngren (1992), also aligns with this standpoint, stating that Christianity came into the public scene as the religion of healing, promising a restoration both spiritual and physical. This view notwithstanding, Ferngren (1992) argues that there is no

evidence that, for the first three centuries of Christianity, conventional Christianity guaranteed physical healing, as did the pagan healing of the day:

Nor should one speak of the cure of the sick as a special healing ministry of the early church. It was an important part, but only a part, of the general philanthropic outreach of the church, which included caring for the widows and orphans, aiding the poor, visiting those in prison, and extending hospitality to traveler. (Ferngren, 1992, p. 14)

Caring for, rather than curing, the sick was the principal ministry of the early Christian community. Primacy was given to caring for the sick, especially when it was later institutionalized by the creation of the hospital. The principal concern of Christianity in the first three centuries, therefore, was not healing. This was contrary to the major concerns of the great healing religions of the classical world, such as the cults of Asclepius, Isis, and Serapis.

However, it is worth noting that it was only from the fourth or fifth century AD that physical healing became a leading and prevalent Christian practice. In the words of Du Pre (2005), Christianity dominated the course of Western medicine for hundreds of years during the Middle Ages or medieval periods (AD 500–1450). As Porterfield (2005) states, “In an age replete with violence, bloodshed, blindness, crippled limbs, and festering sores, Christianity advanced in Europe during the Middle Ages as a popular aid to human recovery, strength, and vitality (p. 69). During the medieval period, according to Sigerist, Christianity introduced the most revolutionary and decisive change in the attitude of society toward the sick. . . . The social position of the sick man thus became fundamentally different from what it had been before. He assumed a preferential position which has been his ever since. (as quoted in Ferngren, 1992, p. 13)

Ferngren (1992) declares that, indeed, “this was Christianity’s novel contribution to healthcare. The pagans had no care of the sick organized on communitywide basis” (p. 13). However, Christianity was not shown to create boundaries when it comes to taking care of the sick.

Whereas there is no evidence indicating that the Jewish community extended care across its own people, evidence abounds that the Christian church went above and beyond, offering its philanthropy not only to Christians but also to others. It was a community form of care, which is consistent with what Dutta (2014) referred to as “participatory communication” (p. 234). Members of Christian communities were actively engaged in caring for one another, and especially for the sick, as expressed in Acts 2:42–47. The believers shared whatever they had in common and prayed together, and a lot of people were converted to the faith.

Equally, in the wake of the Middle Ages, “medical spiritualism which never fully died under Hippocrates’ influence, was renewed with vigor” (Du Pre, 2005, p. 28). As already explained, “medical spiritualism is the belief that illness is governed by supernatural forces such as gods, spirits, or ghosts” (Du Pre, 2005, p. 28). The belief that Jesus performed healing miracles gives credence to medical spiritualism. Thus, healing was closely tied to Christianity, and monks were the principal physicians during the medieval period (Du Pre, 2005, p. 28). Therefore, monks and a limited number of secular practitioners were the providers of healthcare. However, monastic medicine varied from the scholarly to the superstitious; it was sometimes praised and sometimes condemned. The clergy studied medical theories in cathedral schools, such as Salerno in southern Italy, and these schools eventually became the models that European medical schools followed. According to Koenig (2012), St. Benedict of Nursia wrote *The Rule of St. Benedict* for the monks of the monastery of Monte Cassino; it later became the central

monastic rule in the West in the eighth century. In this rule, St. Benedict directs, “The care of the sick is to be placed above and before every other duty, as if indeed Christ were being directly served by waiting on them” (as quoted in Koenig, 2012, p. 21). In this regard, monasteries came to serve as primary centers of medical care until AD 1300.

It is worth noting that also during the Middle Ages was the practice of Christian magic, with its bizarre ceremonies and exorcisms condoned by the church. In an attempt to disgust the evil spirits enough to leave the patient’s body, the patient might be told to eat toad or livers, or to drink rats’ blood. Additionally, the church also became involved in selling fetishes and hosting miracles. These fetishes were holy relics that were understood to protect those who purchased them from calamities, such as shipwreck, fire, lightning, and difficulty in childbirth. Those who could afford to buy fetishes or who could visit holy sites made lavish offerings to the church in exchange for divine intervention.

Additionally, since the Catholic Church was the only recognized religion in medieval Europe, it was involved in enacting laws, allocating land and resources, and caring for the sick and the homeless. To this effect, the church had enormous influence over all facets of people’s lives, including their well-being and healthcare. Du Pre (2005) opines that “the church’s ideology affected the nature of health communication. From a spiritualist perspective, disease was treated through prayer and faith, and sometimes, through application of natural (God-given) substances such as plants” (p. 29). For Nutton (1984), medieval Christian healing

was not that of the doctors. It succeeded where they had failed, often over many years and at a great expense; it was accessible to all; it was simple. It was medicine of prayer and fasting, or of anointing and laying on of hands. (p. 2)

Healing was outrightly carried out through religious practice.

Sickness manifests differently in each person; as a result, a patient's thoughts and feelings, faith and behaviors, were considered to be directly relevant to the subject of healing. At some point during the Middle Ages,

the church banned the practice of secular medicine, particularly surgery. Surgeons were often regarded as sorcerers, butchers and atheists. Because the soul was believed to inhabit a person's entire body, to cut into the body (before or after death) was to interfere with God's work. (Du Pre, 2005, p. 29)

To this effect, it was easy to view the church as being antiprogressive for her discouragement of secular medicine. However, viewed more critically, the church's stance on surgery then could be understandable, given how dreadful surgery seemed at that time. Duffy (1979) explains that surgery was "a grim and bloody business" that required the "surgeon to be strong, fast, forceful operator, ruthlessly immune to the screams and struggles of the patient" (p. 130). With the passage of time, barbers started providing some surgical procedures in addition to hairstyling, because they owned sharp instruments and the necessary public facilities. In this regard, they were invited to perform simple surgeries, such as bloodletting and tooth extractions.

However, through a gradual process, early Christianity began to overcome its mistrust of ancient philosophy, natural history, and scientific medicine, which seemed intricately bound up with paganism. As Pollak (1963) puts it, "at first, all 'profane' physicians were rejected by the church, and in addition to the nursing of the sick only 'sacred' methods of healing, such as prayer, exorcism and laying on of hands were permitted" (p. 73). Pollak (1963) points out that the biblical passages from Matthew 25:36 and 25:40 were foundational to practical charity and assisted the active practice of medicine to a point where breakthrough occurred. Matthew 25:36–37 insinuates that any good act performed with the intention of helping someone in need is a

good act performed for Christ: “For I was hungry, and you gave me food, I was thirsty, and you gave me drink, I was a stranger and you welcomed me. I was naked, and you clothed me, I was sick, and you visited me.” Matthew, 25:39–40 says, ““And when did we see you sick or in prison and visit you?”” “And the King will answer them, ‘Truly I say to you, as you did it to one of the least of these my brethren, you did it to me.’” These words from Christ are, therefore, basic to the church’s commitment to the care of the sick, as well as charity to the poor, the disabled, and, indeed, all the downtrodden.

In essence, “the ethical obligation to help the poor and the sick included in itself the duty of promoting further medical research” (Pollak, 1963, p. 73). Pursuant to this ecclesiastical commitment, which is in line with the biblical injunction to take care of the sick, Pollak (1963) states that the first great hospital (*noscomia*) established in Western civilization was in Asia Minor, through the prompting and recommendation of St. Basil, Bishop of Caesarea. This hospital was built in his hometown around AD 370–372 to take care of the sick in the general population. These hospital buildings included hostels for strangers, poorhouses, homes for the aged, buildings for infectious diseases, and a particular section of the hospital for lepers. Thereafter, hospitals were built all over the Orient with state assistance (Pollak, 1963, p. 74). Koenig (2000) synchronizes with Pollak’s view, stating that during the Greek and Roman times, patients who were unable to afford a private physician or treatment in an Asclepian temple were either cared for by their families or abandoned to die unattended.

With regard to psychiatry, medical historians Alexander and Selesnick (1966) observe that in the Middle Ages, “faith and ethics are related to psychology; saving souls is closely related to curing troubled minds” (p. 79). They further explain that the psychiatry of the Middle Ages can scarcely be differentiated from prescientific demonology, while mental treatment was

synonymous with exorcism. In the same vein, Christian scholastics and Arabian physicians made significant contributions to humanitarian psychiatric care, as “the Christian spirit of charity was responsible for offering comfort and support to the mentally ill” (Alexander & Selesnick, 1966, p. 79). Nevertheless, as these authors maintain, when these early Christian ideals became degraded, and although reliance upon authority and supernatural explanation for disease has become characteristic of monastic medicine, psychiatric care deteriorated to the point where it became indistinguishable from demonological exorcism. Alexander and Selesnick (1966) believe that “originally exorcism was not punishment. The exorcistic rites were directed against the devil who had taken possession of a man’s body and soul, not against the man himself” (p. 79). However, whether insanity was considered as arising from emotional upset or diabolic possession during the medieval period, Alexander and Selesnick (1966) point out that “proper care of the ill individual was a matter of community responsibility” (p. 80). During this time, patients received a lot of attention and sympathy from the community and were treated with much concern. In the thirteenth century in Gheel, Belgium, an institution was founded to take care of retarded and psychotic children. These children, as Alexander and Selesnick (1966) explain, “were often boarded out to and adopted by sympathetic families in the neighborhood” (p. 80). These families were entrusted with the responsibility of providing care for these children.

In this respect, healthcare communication, therefore, was guided by Christian admonition on practical charity and empathic relationships, both of which were demanded of all Christians, for one another and for all human beings. Similar communicative practice, later continued in the church, has been the driving force behind the church’s corporal works of mercy, as we know them today. Once again, all the Christian communities were guided by a semblance of participatory communication, according to Dutta (2014), or team communication, characteristic

of the deeds of the disciples of Christ after the death of their master. According to the Acts of the Apostles: “And all who believed were together and had all things in common; and they sold their possessions and goods and distributed them to all, as any had need” (Acts 2:43–45). As Dutta (2014) explains, in participatory communication, rural communities engage in brainstorming solutions and initiatives that address the problems experienced by local communities. The designing of a solution was “founded on the principles of community participation” (Dutta, 2014, p. 234), where local Christian community members were actively involved in caring for one another, especially the sick and the poor.

The humanitarian aspect of medieval medicine was a contribution of the Judeo-Christian spirit. Alexander and Selesnick (1966) aver that “it was not until the fourteenth century that the mentally ill were considered witches and became the victims of persecution” (p. 80). The first hospital for the mentally ill was established in Jerusalem in AD 490, while the first medical hospital in China was established in AD 491 by Hsiao Tzu-Liang, a Buddhist prince.

Porterfield (2005) argues that Christian healing grew in Africa, Asia, and Europe through devotion to the miraculous powers of the saints and their relics. For Amundsen, taking recourse in the bones of saints and their relics had become the very core and practice of Christianity for converts to Christianity during the Middle Ages; this took “the place of theological subtleties that they could not hope to understand” (as quoted in Porterfield, 2005, p. 69). Sigerist (1945) corroborates this view, declaring that “when a man was sick, he made offerings and prayed for healing, addressing himself, not to God directly, but to Virgin Mary and to the saints, asking them for their intercession” (p. 141). Among the cult of saints, an interesting specialization developed with time. The saints all notably performed miracles. They all had the power to pray and intercede for a sick man with God. Gradually, the saints became specialists whose help was

invoked during prayer for a case of definite disease. For instance, beginning in the seventh century, St. Sebastian became the patron saint who protected people from plague. Similarly, St. Lazarus became the patron saint of lepers, while St. Vitus became the patron saint of those suffering from epilepsy and other spastic diseases. St. Anthony cured those suffering from ergotism, and St. Blaise was responsible for those having throat diseases. There were many other saints to whom cure of specific diseases was attributed.

There was reverence for the relics of these saints. For instance, Porterfield (2005) maintains that many Christians revered the bones and even the dust of saints because of the perceived healing miracles attributed to them. Porterfield (2005) refers to the writings of Bede (an eighth-century chronicler of English history), in which postmodern healings performed by Oswald, a very Christian king, are described. Oswald fell while gallantly fighting another tribe and their pagan king (circa AD 642). Henceforth,

hopeful Christians sought cures by traveling to the spot where Oswald was slain and by ingesting dirt brought home from there. Many people took away the very dust from the place where his body fell, and put it in water, from which sick folks who drank it received great benefits. (Porterfield, 2005, p. 69)

During this era, the cult of saints was much in vogue.

It became a common practice for the detritus of saints' remains to be used to make tonics. Christians sometimes had to move relics of saints from one site to another, often with great fanfare and detailed accounts of the saint's life and miracles. Sometimes, medals of such saints were worn as amulets or as signs of their veneration by their admirers. Porterfield (2005) claims that medieval Christians venerated the saints for diverse reasons, which included victory in battle, revenge, repentance, happiness, goodness and purity, fear of hell, and desire for eternal

life. However, “by far the most common reason was hope of a cure” (Porterfield, 2005, p. 70). Sigerist (1945) states that “when patients had been cured by their intercession, votive offerings representing the organ from which they had been suffering were often given to the church, just as had been done in pagan antiquity” (p. 42). In fact, belief in the healing miracles of the saints coexisted with and contributed to other aspects of medieval life. With time, shrines that were dedicated to the bones of saints became centers of community life, and local religious authorities built, rebuilt, or redesigned churches and alters to house them.

Both during the ancient period and the Middle Ages, and even long after the Middle Ages, people were wont to ascribing epidemics and sicknesses to the wrath of God, and so they tried to placate Him. Mentally ill patients were believed to be possessed of the devil in some folk traditions, and so were exorcised. Some sicknesses were attributed to astrological and humoral causes, while others were attributed to overwork or sexual indulgence, according to the medical literature. Ferngren (2014) explains that monks who were familiar with the medical literature sometimes differentiated between natural causes of mental illness and demonically induced ones. Nevertheless, educated persons of the Middle Ages (almost all of them were members of the clergy) believed in the existence and activity of demons, and attributed the causes of some diseases to them.

Health communication became redefined once more, by “medical spiritualism,” guided by the “transactional communication” process, according to Du Pre (2005). In this transactional communication process, healing is possible only through prayer, exorcism, and placation, in return for granting a normal condition to the patient. In essence, one has to appease the demonic spirit that inhabited the body of the patient in exchange for a return to health for the patient.

Generally, monasteries maintained medical facilities for the sick in the Middle Ages, while “Benedict’s Rule admonished monks to care for sick children, guests, and the poor within the confines of the monastery” (Ferngren, 2014, p. 98). Cassiodorus (AD 487–583), a Roman senator and the founder of a monastery, urged his monks with medical experience to care for the sick. In his admonition to his monks, he states the following:

Learn, therefore, the properties of herbs and perform the compounding of drugs punctiliously; but do not place your hope in herbs and do not trust health to human counsels. For although the art of medicine is found to be established by the Lord, he who without doubt grants life to men makes them sound. (Ferngren, 2014, p. 99)

Because schools for medical training did not yet exist in the West, learned medicine, based on knowledge of medical theory, was restricted to monasteries, while philanthropic medicine, offered by infirmaries in the Latin West, was provided and administered by monks. According to records, most hospitals began as an outgrowth of monastic medical care. Thus, monasteries became the refuge for the sick and the poor. Ferngren (2014) claims that Bishop Masona of Merida (Spain) founded a hospital (*xenodochium*) in the sixth century, staffed it with physicians, and then sent his clergy to go find patients. In dispensing treatments to patients, they did not demarcate between Christian and Jew, slave and free. The medical literature that has survived from classical antiquity was hand-copied by monks and preserved in monastic libraries. Such literature is diverse, ranging from general surveys of medical knowledge to treatises dealing with specific areas of medicine. One manuscript that dates back to the eighth century enjoins physicians to take care of not only the rich but also the poor, as well as to look for eternal rather than material reward. Similarly, another ninth century manuscript urges physicians to “take care of rich and poor, slave and free equally, or among all such people as medicines are

needed” (as quoted in Ferngren, 2014, p. 99). Both of these manuscripts enunciate the ideals of Christian medical philanthropy and reflect the compassionate ideal of Christian medicine.

Zilboorg and Henry (1941) discuss depression among the Greeks and the Romans. They assert that for the depressed man,

every little evil is magnified by the scaring scepters of his anxiety. He looks on himself as a man whom the gods hate and pursue with their anger. A far worse lot is before him; he dares not employ any means of averting or of remedying the evil, lest he be found fighting against the gods. (Zilboorg & Henry, 1941, p. 67)

The physician, who ought to be the consoling friend, is driven away: “‘Leave me,’ says the wretched man, ‘me the impious, the accursed, hated of the gods, to suffer my punishment’” (Zilboorg & Henry, 1941, p. 67). Sometimes, this depressed man sits outside the doors, wrapped in sackcloth or in filthy rags confessing about this and that sin. He believes that he has eaten or drank something wrong, or he has gone some way or other which the Divine Being did not approve of. The festivals in honor of the gods give him no pleasure, but, instead, fill him with fear.

Ferngren (2014) informs us that in the Middle Ages, some Christian missionaries to western Europe tried to eradicate folk pagan medical approaches to illness, introduced by the Germanic people during the Greco-Roman era. Examples of such practices include placing a child on a roof or in an oven to cure fever, and a wife’s tasting of her husband’s blood to cure sickness. Others included mingling pharmacology, herbal lore, folk medicine, and spells to help individuals treat their own illnesses. In contrast, church leaders tried to oppose this magico-medical approach that often combined spells and incantations with the occult properties of germs and herbs. Unfortunately, the efforts by Christian leaders to prohibit pagan healing practices and

other customs proved impossible; these practices remained widespread throughout the Middle Ages as an aspect of folk culture. People continued to resort to folk remedies for healing, although monasteries became the sole sources of books and learning during the Middle Ages.

As far back as late antiquity, the philanthropic medicine offered by hospitals was, in fact, usually administered by monks, although most of them were not physicians. As monasteries grew exponentially in number during the Middle Ages, medicine became an important factor in monastic life. In fact, the first period of medieval medicine was designated as monastic, or “monastery,” medicine (AD 500–1200). As Koenig (2012) puts it, “it is practiced and taught under the direction of the church. In the Council of 742 AD, the church established that all monks and nuns must organize their monasteries according to the Rule of St. Benedict” (p. 22). Therefore, in medieval Europe, hospitals were usually associated with a church or monastery, within religion defining life within them (Koenig, 2012, p. 23). Ferngren (2014) claims that, during this time, “each monastery had an infirmary and an herb garden and collected medical recipes. Many monks began to acquire medical skills informally through apprenticeship or practice. Physicians still provided few truly therapeutic services to the sick” (p. 96). Additionally, these physicians continued to offer prognosis and diagnosis, while stressing the importance of prevention over therapy.

Two kinds of physicians existed then: secular practitioners and clerical physicians. Thus, during the medieval era, almost everyone who was educated received their education from the monasteries and ended up becoming members of the clergy. They continued to read classical medical literature, since medicine had by then become a part of the curriculum of the monastic schools. According to Ferngren (2014), one such monastic scholar was Gregory of Tours (AD 540–594), who frequently referred to the sick people whose physicians failed to heal them but

who later found healing at the shrine of St. Martin. Gregory was, however, not opposed to the use of medicine, for it was known that he frequently consulted medical and pharmacological handbooks derived from Greek texts. As Porterfield (2005) maintains, Gregory considered Christianity as having “superior efficacy over ordinary medicine. Gregory of Tours gloried in examples of how the power of the saints triumphed after the efforts of the doctors had failed” (p. 71).

Gregory, according to Porterfield (2005), cites example of patients who, after witnessing God-sent miracles, still sought recourse to earthly remedies and their attendant consequences (p. 71). One example is the case of Leunast, the archdeacon of Bourges, who was afflicted with cataracts in the sixth century. The archdeacon unsuccessfully sought help from a number of doctors, then traveled to the shrine of St. Martin, where he prayed and fasted for weeks until the saint’s feast day when he eventually regained his sight. Not feeling satisfied with this miracle, however, Leunast sought remedy from a Jew, “who bled his shoulder with cupping-glasses, the effect of which was supposed to be that his sight would improve” (Porterfield, 2005, p. 71). At the moment the blood was removed, full blindness came back. Porterfield (2005) states, “Hoping for forgiveness and relief, the archdeacon repaired to St. Martin’s for another long stay, but his prayers were spurned; he dared to seek improvement on a miracle from the ‘earthly remedies’ of a Jew” (p. 71). In other words, seeking healing from means other than the accepted ones subjects an individual to divine retribution.

Gregory of Tours’s argument is in agreement with that of Pope Gregory I (AD 604), who actively championed the course of healing miracles of the saints, but also retained the services of a physician from Alexandria, making him part of his household. In this sense, medieval

historians often portrayed Christ and his saints as superior physicians, while considering medical procedures to be useful models for describing how Christian miracles worked.

It was touted that an angel successfully treated St. Martin's wounds, while St. Simon of Montfort recommended surgery to a monk in a dream and then went even further, picking the monk's foot, curing him, and leaving noxious fluid on his bed. Gregory incorporated into his thought the idea of traditional medicine and miraculous healing, as well as natural and demonic causes of illness. Evidently, he had the understanding that medicine and religious healing coexisted without obvious tensions between the two; it seemed apparent from many people's experiences that God healed sometimes by natural means and sometimes by religious means.

As far as health communication is concerned, this combined natural and spiritual approach to healing continues to show a persistent interrelationship between the two. It is difficult for both approaches to remain completely apart from each other. Du Pre (2005) observes that "the presence of spiritualism has endured to some extent, even in the context of high-tech biomedical care" (p. 30). There has always been a persistent tendency for these two approaches to find a balance between them.

Some early Christian physicians were St. Cosmas and St. Damian, who were Arabian twins. They were widely known for their philanthropic miracle healings. Pollak (1963) maintains that their cures were done out of piety and not for gain. Patients spent one or more nights in the church to receive a saintly vision while sleeping at night, advice from the saints in the morning, or a miraculous cure on the spot. The healing specialty of these brothers concerns sicknesses of the glands, ulcers, and infectious diseases (Pollak, 1963). In 1572, the Brotherhood of Cosmas and Damian was founded in Solothurn; it is regarded as the first medical professional society.

One important medical achievement of the medieval era was, as Pollak (1963) points out, “improvement of military hygiene and an increase in the number of hospitals in the Roman Empire of the East” (p. 74). At the same time, there were closures of pagan schools of learning in Alexandria and Athens. These schools, known to attract the best of students, were replaced partly by religious, and partly by private institutions: “The monastery schools took over the heritage. And so, Byzantine medicine developed a monastic character” (Pollak, 1963, p. 74). Around AD 1135, with the encouragement of Emperor John Comnenus, there was annexation of hospitals and schools for physicians to the monasteries of the Pantocrator. The Hippocratic Oath was then retained in Christian form, where God and Christ appeared in the place of pagan gods. The sacrifices to Asclepius (god of medicine) were replaced with church festivals and individual saints, while the place of Asclepius was taken by saint-physicians who treated patients without charge. At the head of these saint-physicians were St. Cosmas and St. Damian.

According to Pioreschi (2001), the Byzantine monasteries also provided important social services, such as administration of orphanages and hospitals. They formed funeral associations, providing burial places both for emperors’ and unclaimed paupers’ corpses. Furthermore, they offered refuge for the political or prominent persona non grata and for the fugitive criminal, including Ecclesiastics caught in inappropriate business, such as bishops or monks caught gambling or going to theatrical shows; adulteresses; fugitive monks; deposed emperors; and unpopular queen mothers. Persons of such ilk could be found in monasteries, as well as “emperors approaching death, who preferred to meet their maker in the plain habit of a monk than the imperial purple” (Pioreschi, 2001, p. 25). Besides the sick, these were the categories of people who were harbored and taken care of in the monasteries.

Additionally, an important development in the history of the intersection of medicine, religious faith, and healthcare in the late Roman period of the Middle Ages, according to Pollak (1963), was the firm establishment of religious and liturgical healing. This was comprised of the anointing of the sick with oil, baptism, the use of the sign of the cross, and liturgical exorcism. Such practices were evident in penitentials, which were the handbooks for the clergy who heard confessions. Exorcism, however, was considered a common feature among all these. Even though church leaders admitted that medicine had a place in Christian life, they took a harder stance against any practices that seemed to undercut Christian doctrine and authority.

Eligius, a seventh-century bishop of Noyon, according to Porterfield (2005), cautioned that “no pretext, no illness, nothing whatsoever can permit of the presumption of your approaching or questioning lot casters or seers or soothsayers or enchanterers. Such wickedness will instantly deprive you of baptismal grace” (p. 72). He further advised against the common practice of setting devilish charms at springs, trees, or crossroads, which was then in vogue, insisting that people should trust in God’s mercy alone and receive the sacrament of the body and blood of Christ in faith and reverence. He counseled that a sick Christian might ask for some holy oil of his church and have his body be anointed in Christ’s name. However, he should never turn to material elements, incantations, or wonderworkers not authorized by the church. Eligius warned of dire consequences for Christians who became involved in activities that undermined Christian authority. He likened crossroad charms to the holy oil, while considering the former as a forbidden form of spiritual intervention.

Another development of medieval Christianity was the rise of reverence of icons. In this regard, icons as representations of the divinity were considered to be more efficacious than even prayers. Icons were understood to have the power of influencing the course of events. They were

used to solve private problems of citizens, as well as used during critical moments of the Byzantine period, such as to win a battle or to save a city from conquest. In the words of Pioreschi (2001), “miraculous interventions of this kind were considered something normal and common. It was perhaps the extreme to which the Byzantine belief in the power of icons was carried that generated a reaction” (p. 21). Belief in the efficacy of icons was taken to an epic level.

The use of icons in the healing process of sickness during the Byzantine era actually took root from the cult of relic of saints. In this way, believers could express their need to be closer to certain saints, as to Christ and the Virgin Mary. This desire was achieved through the use of solid objects. Icons had the same purpose; they represented saints, and believers attributed miraculous powers to them. During the eighth century, the Iconoclasts (those who championed the movement in the Byzantine church, from the eighth to the ninth century, to abolish the veneration of icons and other religious images) declared that the worship of icons was tantamount to idolatry, and so proposed that icons were to be banned. Iconoclasm finally came to an end when Michael III (Byzantine emperor from AD 842–867) came to power. The “monastic medicine” period also came to an end around the thirteenth century, while “the influence of the church on medicine continues. The monastery is replaced by the university, and the monk by the cleric, beginning the period called ‘scholastic medicine’” (Koenig, 2012, p. 24). In some ways that are similar to Christianity, Islam, Buddhism, and Hinduism have been shown to have a lot to do with medicine and healthcare.

Islamic, Buddhist, and Hindu Approach to Illness, Medicine, and Healthcare

Similar to Christianity, the Islamic, Buddhist, and Hindu approaches to medicine, as well as healthcare, have special significance. Moreover, their approaches have some relevance to health communication as well.

Islamic approach to illness, medicine, and healthcare, and implications for healthcare communication.

As far as the Islamic worldview is concerned, the human being is considered as God's representative or God's vicegerent. Human beings are created by God in the best possible form, for the purpose of knowing and worshipping God, and eventually returning to him. Therefore, "only healthy humans can fulfill their religious obligations fully and accomplish the purpose of their creation, although those who are sick also have religious and ethical obligations" (Ferngren, 2014, p. 121). This perspective guides Islamic thought about medicine, sickness, and healthcare. While Muhammad's messages on health are based on divine revelation (just like the Judeo-Christian tradition), the Qur'an is the major recorded source of communication of these messages. In terms of health communication, he was the mediator between God and human beings. As such, most of his health messages and explanations were purely spiritual. Islamic leaders also have the Hadith (reports of the words and deeds of Muhammad), from which they draw information and health messages.

According to Islamic health communication, a Muslim is under an obligation to care for his or her body as a religious duty. A Muslim is expected to be careful with his or her health, since the body is not considered to be a private human possession, but rather a gift entrusted to one by God. Ferngren (2014) explains further, saying that the belief that a human being is not the real owner of his or her body, but that he or she owns it only in this life, imposes an obligation

on Muslims to treat it appropriately. To this effect, Islam views health as God's hidden blessing to his people, a blessing whose value is more deeply appreciated and sensed when it is absent. Thus, Muslims are advised to appreciate this blessing through careful preservation of health and by showing thankfulness to God, who has bestowed it. Part of normal, common prayers among Muslims (whether they are in good or ill health) are petitions for health.

Illness (*marad*) is used in the Qur'an in both a literal and a metaphorical sense, according to Ferngren (2014). In the literal sense, illness includes any bodily or physical disorder or malfunction associated with physical pain and suffering. In the metaphorical sense, illness refers to diseases of the soul and the spirit, such as disbelief, hypocrisy, jealousy, lack of piety, and doubt about the existence of God. In its metaphorical sense, illness is linked to divine admonition and damnation, whereas physical illness is connected to God's mercy and comfort. This compassionate attitude toward the sick is exemplified in some verses of the Qur'an where the sick are exempt from various religious obligations, such as fasting, pilgrimage, ritual washings, and some social obligations. Thus, "the sick do not need to feel inferior to others or guilty toward God if they cannot fulfill their religious or social duties" (Ferngren, 2014, p. 121). This special exemption shows compassion for suffering members of the community.

The explanation given among Muslims regarding disease and illness is that illness is a gift of grace, as well as an opportunity to be purified and have one's sins forgiven by God. Another teaching in the Qur'an is that illness is a divine test. Illness is considered as a test not only for the sick, but also for their relatives and friends in dealing with the sick and caring for them. The Qur'an claims that God created the world with all its beauties and wonders, pains and sufferings, and he puts his people to the test: "Any joy and sorrow in this world, including illness and suffering, can be a test of faith, patience, and trust in God" (Ferngren, 2014, p. 122). For

example, it is the understanding in Islam that illness of parents is considered a divine trial for their children, who are advised to care for these parents and treat them with the utmost care, respect, and compassion. Sickness is not something to be despised or hated. Instead, it is a test of faith and trust in God, and it can be chastening, expiatory, and meritorious. This illustrates a sharp difference between Islam and Christianity; the view that illness and, ultimately, death are divine punishment for sin is less emphasized in Islam than it is in Christianity.

The term “health” in Islamic sources does not only comprise physical wellness, but also refers to a holistic concept that embraces physical, mental, and spiritual well-being. When we think of the Islamic understanding of health, we think of Islamic medicine as well. So, what actually is “Islamic medicine”? Prioreshi (2001) describes the term “Islamic medicine” as “medicine that developed within the Islamic civilization after the Arab conquests of the seventh and eighth centuries” (p. 203). The term “Islamic medicine” is most of the time used interchangeably with the term “Arabic medicine” since it refers to the medicine of the Arab world that has its texts written in the Arabic language. Rahman, alluding to Ibn Khaldun (a celebrated pioneer of cultural history), observes that

the medicine attributed to the prophet is actually the old Arab medicine, which is based on experience but not on scientific experimentation and hence is not founded on scientific principles. He admits, nevertheless, that such treatments can prove useful, particularly if their user “has strong faith.” (as quoted in Sullivan, 1989, p. 154)

Even though the term “Islamic medicine” or “Arabic medicine” is used, it is worth noting that during the Prophet Muhammad’s time, most physicians in Arabia were Jewish or Christian, while Muhammad himself was believed to have been treated by a non-Muslim physician. As a

result, Muhammad did not require his followers to be treated by Muslim physicians (Koenig, 2012, p. 21). Maimonides, a great Jewish physician, served the Sultan of Saladin in Cairo.

Rahman contends that Islam as a religion has played a very crucial role in creating a culture that has nurtured the cultivation and development of medicine. He explains further that the Hadith powerfully emphasizes mercy toward all creatures, especially humans. Additionally, it enjoins Muslims to actively exercise good will. According to Rahman, “These potent moral-spiritual factors prepared the ground for the wide-spread reception and astonishing evolution of medicine in Islam” (quoted in Sullivan, 1989, p. 149). He claims further that before the manifestation of Islam at the hands of the Prophet Muhammad in the first part of the seventh century, the Arabs had a tradition of medicine that, on one hand, consisted of magical rituals and amulets; on the other hand, it consisted of a more scientifically rooted medicine involving the use of seeds, herbs, and surgical practices like cupping and cauterization.

It is argued that the Prophet Muhammad had initially forbidden amulets and other magical practices. However, at the request of his followers, who insisted that they had been using amulets with some health benefits, the prophet reluctantly permitted the practice, on the condition that writings on the amulets would consist only of verses from the Qur’an. One of the contemporaries of the Prophet Muhammad was al-Harith ibn Kalada, one of the Islamic medical men. It was reported that he learned medicine at the medical school of Gundai Shapur, which offered medical knowledge and resources to the Arab Muslims in Baghdad.

As Rahman reports, the Qur’an, which is the Islamic scripture, accepts the miracle performed by earlier prophets or wrought by God through the prophets, but maintains that miracles ceased with the coming of the Prophet Muhammad (quoted in Sullivan, 1989).

Moreover, *zakat* (tax) levied on the well-to-do members of society, to be used on the poor and

the needy, was mandated in the Qur'an. Helping people, especially Muslims who are in distress of any kind, is seriously emphasized in the Qur'an. As Rahman (1989) observes, the Qur'an does not explicitly speak of medical treatment; however, it places a high value on health and its restoration. It is important to note that a body of medical knowledge has been universally attributed to the Prophet Muhammad himself. Thus, Rahman (1989) states that, beginning in the tenth century, a series of works were written including *Prophetic Medicine* and *The Prophet's Medicine*. These writings were attributed to orthodox scholars and pious men who had learned about ancient Arabian medicine, as well as the Greek tradition of scientific medicine. Moreover, the Shi'a also wrote a similar work titled *The Imans' Medicine*. Although these men did not actually practice medicine, their motivations, according to Rahman, were

to provide the public with an easy guide to health and to confer a high religious value on the art of healing. In fact, several writers of both so-called Prophetic and scientific medical works state that after the performance of basic religious duties, there is no greater service to God than to heal the people. (as quoted in Sullivan, 1989, p. 155)

According to Rahman, the Hadith contains Prophet Muhammad's injunction: "Get yourself treated when you are sick, for every disease God has sent a remedy as well" (as quoted in Sullivan, 1989, p. 155). To this effect, Muhammad advised a sick companion to consult al-Harith ibn Kalada, who had studied medicine at Gundai Shapur, according to Muslim historians of medicine. According to Rahman, it is also said that when asked about the advisability of medical treatment, the prophet affirmatively asserted, "Medications are part of God's pre-written decree" (as cited in Sullivan, 1989, p. 155).

The implication for health communication in the Islamic understanding of medicine and healing, therefore, is that sickness has both natural and divine causes. However, it has a divine

healing performed through the intervention of humans, specifically Islamic religious leaders, who took health decisions and carried out healings without much input from the patient.

Prioreschi (2001) observes that Islamic medicine relates to medicine of the Greco-Roman period. However, it is called Islamic medicine because it refers to the development of this medicine at the same time the West was trying to recuperate from the catastrophic collapse of the classical world. Prioreschi (2001) has observed that Islamic medicine greatly influenced Western medicine and has played a very significant role in the growth and development of modern scientific medicine. The first known Arabian physician was the Persian Rhazes (AD 850–923). Others were to follow in his footsteps as they made their own contributions to the medical field in the areas of medical chemistry, pharmacy, and the growth of hospitals into medical schools.

By the tenth century, Muslim physicians such as Muhammad ibn Zakariya al-Razi were classically trained and were sophisticated. According to records, al-Razi endeavored to differentiate smallpox from measles. According to Pollak, “Arab medicine eventually finds its way to the West in the eleventh century, coming to the great medical school in Salerno, Italy (as quoted in Koenig, 2012, p. 22).

Prioreschi (2001) further makes us understand that documents concerning medicine in pre-Islamic Arabia are scarce. However, he asserts that evidence abounds showing that “folk-medicine, a mixture of magical formulas and crude remedies . . . was commonly practiced” (Prioreschi, 2001, p. 205). Women often performed therapeutic incantations. Prioreschi (2001) observes that from the pre-Islamic period up until the early Islamic period, there were no significant changes in the practice of medicine: “The Koran did not mention medicine and early Islamic medical practices are described in Hadith, ‘tradition.’ Later canonical collections of Hadith . . . all have their own chapter on medical teaching and recommendations” (Prioreschi,

2001, p. 205). For instance, the Hadith mentions the use of camel urine, milk, various vegetable products (e.g., henna, olive oil), and other animal products (e.g., sheep, fat, honey) as effective remedies for diseases. In fact, camel urine was viewed as the most common remedy for cure, while human urine was used to treat camels. However, according to the Hadith, wine was forbidden even for medicinal use.

Cauterization (burning the skin or flesh of a wound with a heated instrument or caustic substance) and cupping were the most commonly used surgical procedures, although the latter was used more than the former. Pioreschi (2001) maintains that supernatural and magic explanations of diseases were still mentioned. For example,

epilepsy was considered the result of demons entering the body, and the plague, the result of the sting of a jinni (a spirit, often malevolent). Magic spells as remedies were usually prohibited except in special cases (e.g., snake or scorpion sting). (Pioreschi, 2001, p. 206)

Nevertheless, the remnants of the supernaturalistic medical model were destined to fade—but not disappear completely—as Islamic culture eventually came into contact with other medical systems. With time, however, those practices were once more resuscitated under the label of “prophetic medicine.”

Pioreschi (2001) indicates that although the Qur’an does not explicitly mention medicine, it contains many hygienic precepts, such as rules regarding which meat is suitable for consumption. Furthermore, the Qur’an enacts rules that promote healthy behavior, as well as rules regulating sexual activity, sexual hygiene, and sexual continence. It condemns homosexuality. The Qur’an is actually the principal communicative source in matters of sickness and health, while the Islamic leaders were the principal communicative agents after Muhammad.

Prioreschi (2001) claims that three physicians lived in the early Islamic period: Tiyadhuq, said to be a physician to the governor Hajjaj ibn Yufuf; Masarjawayh, who was understood to have been of Persian–Jewish descent; and Israil, who was said to have been a physician of Caliph Sulayman ibn Abdal-Malik. These three physicians to prominent men did not practice folk medicine; instead, they practiced a type of Hellenistic medicine.

Although the Qur’an is often mentioned as a source of healing for spiritual illnesses, Islam advises its adherents to treat their illnesses and to treat themselves by using medications. In addition, although particular medications are not advocated in the Qur’an, there are some mentions of cures for human diseases (e.g., honey). In all these, however, God is seen as the first cause of healing; he bestows curative powers on medical substances.

Buddhist approach to illness, medicine, and healthcare, and implications for healthcare communication.

According to Kitagawa (1989), Buddhism was founded in the sixth century BCE, between 600 and 500 BC, in northeastern India by Sakyamuni or Guatama Buddha. In this area, the indigenous culture and the Indo–Aryan, Brahmanic tradition converged. Early Buddhism endorses religious beliefs, religious ritual (otherwise known as *Pirit*, a religious ritual that was used to cure of the sick), and medicine as valid tools for healing. It was Buddha who usually gave the authorization for a *Pirit*. Salguero (2015) notes that knowledge concerning physical health and disease has been given a pride of place within Buddhist thought, while healing has remained a persistent part of Buddhist practice since the earliest periods. For him, Buddhists’ views on health, disease, healers, patients, and therapies are characteristically spoken of by East Asian scholars and devotees as “Buddhist medicine.”

Kitagawa (1989) claims that Buddhist teaching is traced to the Buddha. Buddha was believed to be the principal communicative agent in matters of sickness and healthcare. He was believed to be a supreme physician. As far as healthcare communication is concerned, his message regarding the spiritual healthcare of humankind gives a pride of place to morality. The rest of the message can be summarized under the four headings, or the Four Noble Truths: (a) suffering as the basic feature of existence; (b) the cause of suffering; (c) the cessation of the cause; and (d) the eight-fold path that leads to cessation, namely right understanding, right thought, right speech, right action, right livelihood, right effort, rightmindedness, and right concentration. Chueng et al. (2017) insinuate that that these, in addition to the practice of compassion, are the recommended ethical behaviors in counseling that can bring about healing.

Kitagawa (1989) claims that according to the canonical tradition, the Buddha took a special interest in medicine. Salguero (2015) trims down the Buddhist approach to disease, healing, and well-being of the body to the following points:

- Illness is considered an unavoidable aspect of human existence, although there is the possibility of escaping it through Buddhist practices and insights. At the very least, one who detaches himself or herself from his or her body or realizes its empty nature is not troubled by its discomforts. There is as well the common teaching of the fourfold afflictions—birth, old age, sickness, and death—which are believed to be eradicated through Buddhist liberation.
- A corollary position is that the component parts that make up the body are inherently repulsive and equally antagonistic. For these reasons, discomfort, unease, and instability are the natural states of the human body, at least for

uneducated persons who have not yet achieved mastery over the material world or cultivated superhuman bodies through ritual, visualization, or practice of yoga.

- Although a number of factors are indicated as being the proximal causes of sickness, it is nonliberation from karma that is the deeper reason for one's bodily discomforts from birth until death. This too is the deeper determinant of one's lifespan.
- The whole collection of Buddhist ritual practices, such as making offerings, reciting scripture, prayers, chanting, *dhārani*, talismans, image-making, exorcisms, and esoteric rituals, can be employed or modified precisely for the purpose of curing disease, maintaining health, or extending the lifespan.
- Caring for the sick is considered one of the principal ways through which one can improve his or her own karmic standing. This, of course, is considered a moral obligation for members of the monastic community. Moreover, which categories of sick people should be cared for differs in various Buddhist traditions; Pali texts appear to suggest that caring for the laity is a violation of monastic discipline. Nevertheless, many Mahāyāna texts advocate for caring for the sick of all types. In some esoteric or Vajrayāna traditions, it is viewed as an imperative to heal the entire cosmos.
- Deities, informed individuals, and skilled members of the saṅgha can control disease, health, and longevity, both of their own bodies and of the bodies of others. These prominent figures can be invoked or sought by the devout in need of healing. Objects that have come in contact with or are otherwise associated with such beings can be empowered with their blessings and are healed as well.

- Moral restraint and moderation are good for one's health. This characteristically includes avoiding drastic changes and extremities in behavior, as well as maintaining proper ethical discipline. This includes upholding vegetarianism among many groups of Buddhists. Moreover, he counsels about the necessity of regulating one's diet and regimen in accord with the seasons to maintain optimal health. Negative mental or emotional states, such as hatred and delusion, also should be controlled, because they are among the key factors leading to illnesses of the body. Meditation or contemplation is an important method for conquering these, and it helps in maintaining mental and physical health. Excessive or improper meditation can itself lead to mental and physical illness.
- The Buddha has been referred to as the "Great Physician," and the Dharma has been called the "Great Medicine"; these are routine ways of speaking. Metaphors such as these, in addition to an entire range of medical similes, analogies, and parables, are frequently used for illustrating points of Buddhist doctrine.

While all of these precepts can be said to represent medical thought about illness and healthcare in the Buddhist tradition, Salguero (2015) rightly provides this warning:

There is no checklist that could adequately represent all of the health-related knowledge presented in all Buddhist texts across Asia; nor should we try to erect rigid boundaries to separate Buddhist versus non-Buddhist perspectives. Nor are all of the above points unique to Buddhist medical discourses (Āyurvedic texts also talk about karma, for example, and Chinese medicine stresses the ill effects of emotions). Nevertheless, it can generally be said that the above doctrinal perspectives tend to predominate in Buddhist texts to a greater degree than in other traditions. They are often the very features that have

struck recipient cultures as being novel about Buddhist teachings on illness and health, and they have remained durable parts of Asian Buddhist traditions up to the present. (p. 39)

The article “Buddhism, Medicine & Health” from the Dhamma Nikethanaya Buddhist Academy (2011) looks at the Buddhist perspective on medicine and healthcare from a different dimension. According to this article, Buddha believed that just as one could suffer from a physical illness, one could also suffer from an unhealthy mindset. While Buddha sought to cure both physical and mental illness, greater emphasis was placed on the mind. He employed the knowledge of the Dharma in order to heal the illness that emanates from three poisons: greed, anger, and ignorance. Buddha’s medicine treats disease starting from the patient’s mind, curing him or her of these three poisons. According to Buddhist belief, the pure and the amazing Dharma is the perfect medication for an ailing mind and the sick body. Therefore, keeping both the mind and the body healthy is important, for the body is the vehicle in which we can practice the Dharma. The mind and the body are believed to be interdependent; the health of the mind influences the health of the body, and vice versa. Having a healthy body as a tool can help us cultivate a compassionate heart and a clear mind. Equipped with a cultivated mind, we are able to examine ourselves and clearly see the nature of our problems, then work to resolve them. In doing this, we will then be approaching the path to true health.

Hindu approach to illness, medicine, and healthcare, and implications for healthcare communication.

Just like other religions, Hinduism also has a lot to do with medicine and healthcare, and their relationship to healthcare communication is equally relevant. Koenig (2001) reveals that Hinduism emerged out of the Indus Valley civilization, the Indo–Aryan Vedic civilization, and

the hunting, nomadic, agricultural folk tradition of India (2300–1700 BC). To help us understand more about the Hindu approach to medicine and healthcare, it is expedient to highlight the basic concepts of Hinduism. Sukumaran (1999) underscores the most important of these concepts as they pertain to health issues, declaring that Hinduism is a very complex belief system and that it is more than a religion. It is a way of life.

For the Hindus in India, the general belief is that meditation leads to true knowledge, which, in turn, leads to freedom from the cycle of death or disease and rebirth, and facilitates the reunion with Brahman, which is the absolute existence. Koenig (2012) opines that in the Avestan period (the old Persia, circa 600–300 BC), there were three healers: “the physician, the surgeon, and the incantation priest. The naturalistic and supernatural medicine are practiced side by side (p. 18). In regard to healthcare communication, there is constant interaction between naturalistic and supernaturalistic medicine. The priest and the physician/surgeon are the communicative agents regarding sickness and healthcare. The onus of communicating health messages and health decisions, as well as providing treatment to the sick, belongs to them; the physician/surgeon employs the natural method, whereas the priest performs healing using the supernatural method. The priest performs the ritual of dancing, recites incantations, and uses amulets in his attempt to cure patients of different forms of ailments. Disease demons were believed to be transferable from a patient to his enemy as part of Vedic healing in India. The patient has to trust the health decisions of the physician and the priest, carrying out their demands without question, input, or the possibility of feedback; therefore, health communication, once again, could best be described as a linear, or a one-way, process.

Another general belief about healthcare, according to Sukumaran (1999), is that vegetarianism is taught in Hinduism as part of respecting the sacredness of life, although many who live near the sea eat fish, considering it a “flower of the sea.”

Sukumaran (1999) notes a few basic concepts of Hinduism, as well as their relevance to medicine. According to Sukumaran (1999), ahimsa (non-violence) is a concept that advises Hindus to cause no harm to other living beings through their actions, words, or thoughts. This explains why Hindus are vegetarians, because by eating meat, a person is taking the life of another living creature. They argue that all creatures contain the life of God, the divine. Therefore, by harming another creature, a person causes harm to God’s soul. Because all living creatures are part of God, by harming another person, one is ultimately harming himself or herself.

According to Sukumaran (1999), karma is a kind of universal law that teaches that what you put out into the world, be it good or bad, will eventually come back to you. It is a way of describing the experiences that one has had that help to balance the person’s soul. For instance, if a man loses a leg in an accident, this could mean, according to Hindu understanding, that the person must have caused someone else to lose a leg in the last life, or it could mean that he needs to learn compassion for handicapped people to further the development of his soul. However, the Hindus believe that religious services, prayer, and acts of devotion can help to soften karma.

Medicine and medical treatment in the Hindu perspective.

Zilboorg and Henry (1941) claim that “Hindu medicine was an original system which developed independently of the Greek” (p. 30). As Zimmer (1948) reveals, “The earliest documents of Indian medicine are found in the metrical parts of the ancient tradition of the Vedas, mostly in Atharva-Veda” (p. 1). In his discourse on religion and medicine, Tucker (2003)

states that the practice of Vedic medicine in India began in the latter part of the second millennium BCE. “Veda, ‘the knowledge,’ came from the Sanskrit liturgical literature of the hereditary priests, which primarily involved a magical and religious approach to illness and its treatment” (Tucker, 2003, p. 375). Zimmer (1948) agrees with this view, asserting that the Vedic records of early medicine are laid out in terms of imprecations or curses against demons, sorcerers, and enemies. They carry out their healing action by using charms for expelling diseases caused by demons or sent by the gods as a punishment for man’s sins; they are used as incantations intended to bestow health, longevity, success, and victory.

Vedic medicine did not distinguish between diseases and demons. Internal diseases were thought to have magical and demonic causes, while traumatic injuries, such as broken bones, were assumed to be due to external causes. The distinction would later be developed during the growth of classical medicine, which attempted to “treat many maladies strictly along the lines of humoral therapy or through surgery” (Zimmer, 1948, p. 2). In the later periods, although the demarcation between diseases and demonic powers remains undefined, only those diseases that, to some extent, defied rational treatment were treated by propitiation and magic. According to the Veda, diseases were viewed as possession by demonic personalities or as visitations by the gods. Dropsy, or edema, was believed to be sent by Varuna, the god that resides in the all-knowing, all-encompassing primal waters of the universe.

Nevertheless, the Ayurvedic medicine that came later has been a significant part of Indian civilization for more than 2,000 years. As Tucker (2003) explains, according to this Ayurvedic view, the world consists of five elements—earth, water, fire, air, and space—which, in turn, make up the three humors that the body consists of: wind, bile, and phlegm. The central focus of the Ayurvedic physician was maintaining or restoring the equilibrium of these three humors.

This is achieved through practical measures, such as the use of herbal medicines or procedures that include interventions such as enemas and ointments. Furthermore, there is the understanding that many childhood diseases represented attacks by demons. Nevertheless, for the most part, emphasis has been placed on the naturalistic view of health and sickness. While Ayurvedic medicine emphasizes the natural world, it does not disregard the religious one. In essence, respect for the spiritual and the religious was inherent from the start in Ayurvedic traditions.

In regard to psychiatry, Zilboorg and Henry (1941) opine that “in the Hindu system, mental disorders remained largely within the domain of priestly metaphysics” (p. 31). Thus, Hinduism holds the traditional belief in demoniacal possessions. As already pointed out, health communication here is done by the priest and is strictly guided by the belief in supernatural revelation. Zilboorg and Henry (1941) argue that the main trend of Hindu medical psychology parallels that of the Greek, upholding the belief that the soul inhabits the cavity of the heart. Mental disease for Hindus remained a mystery and continued to be viewed as reprehensible and not belonging to the domain of medicine.

The discussion so far shows that, over the centuries, different religions—Judeo-Christian, Islam, Buddhism, and Hinduism—have always exerted tremendous influence in matters of illness, medicine, and healthcare across these religious cultures. Among all of them, Christianity has always played a leading role in healthcare, especially during the Middle Ages, with monks taking the lead in performing major tasks. Therefore, for almost 1,000 years, the church was engaged in founding and operating hospitals, as well as granting licenses to physicians to practice medicine until after AD 1400. In fact, the church is given credit for being the founder of the first hospitals. It staffed these hospitals with its own learned practitioners (Du Pre, 2005, p. 29).

Ironically, though, as medicine advanced, the work of the monks practicing it started to become increasingly secular. According to Du Pre (2005),
the very technology and pharmacology they developed were at odds with the church's position on healing by faith and were diverting the monks from other spiritual pursuits. . . . In 1311 the church forbade monks to practice medicine any longer. (p. 30)

Therefore, with the beginning of the Renaissance period, certification of doctors became a responsibility of the state, heralding a growing separation between medicine and religion.

Religion, Medicine, and Healthcare in the Renaissance and Modern Periods: Relevance to Health Communication

The Renaissance. From the medieval period, we come to the Renaissance, a period that is marked by movement from one extreme to another. In the medieval period, the Catholic Church set the tone of most discourses, of which illness, medicine, and healthcare were not exempt. According to Du Pre (2005), the Renaissance began in the 1300s and continued into the 1600s. This was a period that Zilboorg and Henry (1941) describe as the period of the revival of intellectual curiosity. It was a time when science and critical thinking took center stage, questioning truth and knowledge by revelation, as well as the church's teaching authority. It remained a difficult task for health communication to find its relevance to religion, medicine, and healthcare, given that health communication had not yet emerged as a discipline of study. The field was simply a recent development in comparison to most disciplines of study.

The starting point in the development of health communication, according to Kreps (2014), "was rooted in the communication discipline's adoption of theories and methods from other social sciences, such as psychology and sociology, which were actively studying the healthcare system" (p. 2). Scholars in these social science fields began to examine

communication variables in health, which then encouraged communication scholars to follow suit. Keeping this in mind, my research reveals that the term “healthcare communication” was also not used verbatim during the Renaissance, just like in previous historical periods. Instead, discourses that related to, but were not explicitly referred to as, healthcare communication were held about religion, illness, medicine, and healthcare by philosophers and scholars of diverse orientations.

As already mentioned, the Renaissance was a period marked by intellectual curiosity. It involved a move from the church as the sole authority in matters of knowledge to science, mathematics, and verifiability principles. Scientific studies of nature increasingly became popular, and there was continuous dissociation from religious faith as universities developed apart from ecclesiastical institutions. In the face of these developments, mathematical and scientific precision became conventional. Hence, when confronted with the age-old question of “What is real?” the “artists and philosophers of the Renaissance looked to mathematics and matter for answers, instead of the church and the supernatural. Their theories changed the Western worldview, including the nature of medicine” (Du Pre, 2005, p. 31). It was also the period that monastic medicine ended (the thirteenth century). The monastery was replaced by the university, and the monk was replaced by the cleric, ushering in the period referred to as “scholastic medicine,” which was characterized by a remarkable shift in the relationship between religion and science (Koenig, 2012, p. 24). It was also the period in which the church and science began to butt heads, following the remarkable scientific discoveries of the eighteenth century; this marked the beginning of the separation of religion and scientific medicine. Despite this effort to separate medicine from religion, the church was still actively engaged in the care of the

sick and the mentally challenged, while facilities for the treatment of the mentally challenged were opened by the clergy in Spain during the early 1400s.

Nevertheless, humanism and intellectual skepticism continued to flourish, bringing with them the rediscovery of ancient philosophers' methods of thinking. With humanism emerged the belief in man's ability to know and think rationally, rather than placing emphasis on the divine. The main significance of humanism does not necessarily lie in the content of its ideas, rather in "its spirit, the discovery of the full concrete complexity of human existence, and above all, a new reliance of man on his own convictions and feelings" (Alexander & Selesnick, 1966, p. 78). The humanists, according to Alexander and Selesnick (1966), "substituted the authority of the ancients for that of the church" (pp. 102–103). This became a step toward emancipation; the ancients disagreed with one another, and individual judgment was required to decide which of them to follow.

In the wake of these new developments, particularly in relation to healthcare communication, religion ceased to be the sole determining authority in giving meaning to illness, medicine, and healing messages. Alexander and Selesnick (1966) provide this example:

The Renaissance painters and anatomists discovered the human body in its full concreteness. Authority and tradition had yielded so completely to the inquiring mind that even the most sacred medieval institutions and concepts were being questioned. Reformers like Calvin, Knox, Wycliffe, Zwingli, and Luther challenged the authority of the Catholic Church, astronomers attacked the celestial concepts of the ancients, and the anatomists attacked the anatomy of Galen. Rabelais and Montaigne, in the sixteenth century, challenged the decadent practices of clergymen and city officials. (p. 103)

All of this came about as a reaction to the dominance of religion in the Middle Ages. Renaissance thinkers began to be skeptical about anything they could not prove scientifically, including matters of illness, medicine, and healthcare messages. Thus, “as man began to trust his own senses and his own experiences without relying on the written word of authority, science could enter the Renaissance” (Alexander & Selesnick, 1966, p. 104). Scientific proof and the verifiability principle became guards for human claims to knowledge about anything, including health.

An influential thinker and mathematician of the Renaissance period was Rene Descartes, who introduced the method of systematic doubt wherein he doubted everything, including his own existence, until he could verify it: “I think, therefore I am.” For Descartes, to doubt means to exist: He must exist in order for him to doubt or to think. Running parallel to Cartesian methodic doubt is the principle of verification: Do not believe it if you cannot prove it. This affected the nature of healthcare communication, for people were no longer considered ill based on their feelings but on the condition of verifiability. In addition, no longer was the church the sole determinant in communicating directives in matters of illness, medicine, and healthcare. Thus, “physicians and others began to look for verifiable signs of illness (a perspective consistent with today’s biomedical approach” (Du Pre, 2005, p. 31). What this means is that as long as any claim to illness is verifiable, people become convinced that they are sick, even though they may not be feeling any sickness. Alternatively, although one may feel sick, he or she is considered to be OK because tests have verified that nothing is wrong with him or her. In this regard, the Renaissance puts observable signs of illness over and above “invisible influences such as spiritual, social, and psychological factors” (Du Pre, 2005, p. 33). Thus, any claims that cannot be verified scientifically are subjected to doubt or outrightly dismissed.

Additionally, Descartes introduced what is known today as Cartesian dualism, which also has some implications for health communication. According to Cartesian dualism, people have both souls and bodies, and the two are not the same. It was Descartes's opinion that the soul dwells only temporarily inside the human body. This belief was based on the conviction that the soul lives on even after the body has died. The medical implication of Cartesian dualism is the separation of medicine into two branches: one for the mind and the other for the body (mental and physical). Therefore, while medical doctors (internists, cardiologists, neurologists) consider treating physical ailment to be their primary function, the patient's mental health condition is considered to belong to the domain of psychiatrists, psychologists, social workers, and so forth. Cartesian dualism has also created significant boundaries for healthcare communication. For example, the "Western physicians' traditional reluctance to discuss matters of emotion or faith is rooted in the dualism model" (Du Pre, 2005, p. 33). These physicians consider physical ailment and treatment to be their fundamental area of interest, whereas discussions on matters of emotion or faith (spirituality) are considered to be the exclusive preserve of psychiatrists.

The principle of verifiability and the reliance on observation rather than on theory was taken up by the greatest anatomist of all time, Andreas Vesalius (1514–1564), to whom modern medicine owes its foundations. Thanks to his work *De Humani Corporis Fabrica* (a famous primal book in human anatomy, published in 1543), by the sixteenth century, physicians began to look at their patients more closely and to record what they saw (Alexander & Selesnick, 1966, p. 106). Anatomy then became the central point of early modern medicine, following the rediscovery of medical texts attributed to Galen, the Greek physician. This rediscovery enkindled interest in dissection and anatomy at medical universities in Renaissance Italy (Porterfield, 2005, p. 104).

Nevertheless, in the face of all of these apparent changes in thinking and worldview, Alexander and Selesnick (1966) aver that the supernatural world still existed in man's mind but had lost its vitality. Ortega y Gasset speaks of the man of the fifteenth century as living in two worlds, as 'being torn away from one system of convictions and not yet installed in another. . . . He still believes in the medieval world, that is to say, in the supernatural other world of God, but he believes it without a living faith. His faith has already become a matter of habit . . . although this does not mean that it is insincere. (pp. 109–110)

A common denominator among the great intellectual movements of this period is a new sense of confidence that man has developed concerning his capacity to learn about nature and discover truth through his own personal, observational, and reasoning faculties, as opposed to through belief in divine revelation. Thus, the use of reason and observation in discovering truth became a complete departure from "the medieval practice of schoolmen who used deductive reasoning in order to prove revealed truth" (Alexander & Selesnick, 1966, p. 110). Thus, the implication for healthcare communication is the understanding that "the healing art could only be perfected by the way of thoughtful observation. An advance was only possible if, as in antiquity, free investigation triumphed over prejudice and belief in authority" (Pollak, 1963, p. 103). Effectively, this apparent shift toward modern, secular ideas about nature and material reality in regard to ways and methods of investigating truth had a profound impact on sickness and healthcare.

The modern period. The Renaissance continues into the early modern era without a clear-cut demarcation of its beginning. Of great importance during this era was the Protestant Reformation of the early modern period. The Protestant Reformation impacted all facets of life,

bringing on changes in religion, worldviews, ways of thinking, and, most importantly, ideas about sickness and healing. Modern thinkers continued to butt heads with the church's teaching about revealed truth; such thinkers held steadfastly to their convictions about truth that are based on science, observation, and the principle of verifiability. The church continued to wield its influence, although this influence came under constant attack. For instance, among the Protestant reformers, there was a tendency to reject miraculous healing practices. Ferngren (2014) puts it clearly:

The Reformers believed that miracles had ceased at the end of the age of the apostles. . . . Catholics, on the other hand, taught that God had given to the church the continuing gift of miracles, one of which is transubstantiation, the doctrine that in the mass the bread and wine of the Eucharist are miraculously transformed into the body and blood of Christ. (p. 138)

However, Martin Luther underplayed the role of miracles, even in the New Testament, emphasizing instead the preaching of the word, conversion, and transformation of lives; these were viewed as more impressive than spectacular miracles. He maintained that “while the apostles had healed the sick by anointing them with oil, as in Mark 6:12–13, God no longer healed by oil and that the injunction in James 5:14–15 to heal by oil no longer applied to the church” (Ferngren, 2014, p. 138). John Calvin supports Luther's view, describing miracles as having “fulfilled their purpose in accrediting the ministry of the apostles and had therefore ceased” (Ferngren, 2014, p. 138). This view was in tandem with that of the Renaissance humanists. It became the common position of Protestantism that was widely held in Protestant circles.

The Catholic belief in the healing roles of saints also was attacked under Protestantism, while shrines and pilgrimage centers fell into disrepute in the Protestant regions of Europe. In the wake of all of this was the move by Henry VIII to confiscate the church's properties, including some hospitals and many pilgrimage shrines, in a bid to sever England's ties to Rome (Porterfield, 2005, p. 110). In the same vein, some Protestants tended to view contemporary accounts of Catholic miracles as superstitious. Despite this, Ferngren (2014) observes that some later Protestants still claimed to witness instances of supernatural healing in times of stress and persecution. Catholics persevered in their religious commitment to public healthcare: Religious orders continued their long-standing tradition of supporting hospitals in many regions of Europe. In the same vein, pious laypeople, particularly women, continued to render their services to hospitals as a means of enacting devotion to Christ: "Catholics inherited a historic commitment to care for the poor and sick that stretched back through medieval reform movements, through monastic investment in medicine and poor relief" (Porterfield, 2005, p. 110). Catholics have always had strong historical ties not only to the institutions established and managed by the church to provide relief to the poor and care to the sick, but also to a spiritual tradition marked by public devotion to human suffering. Conversely, Protestants backed away from religious commitment to healthcare; instead, they focused their attention on the home as a center of worship, Christian education, and social welfare.

It is worth noting, however, that the reformers (including Luther and Calvin) respected both medicine and the scientific revolution of the sixteenth and seventeenth centuries, seeing it as a "beneficial gift of God for the healing of disease and an expression of God's common grace to all humankind. 'God created medicine and provided us with intelligence to guard and take care of the body so that we can live in good health,' wrote Luther" (Ferngren, 2014, p. 139).

Going contrary to Calvin's and Luther's tendency to associate medicine and science with a divine gift is English philosopher John Locke (1632–1704). As the father of British empiricism, Locke claims that all knowledge comes from experience that results from investigation of things by the bodily senses.

In relation to health communication, what we can witness in the wake of all of these developments is a recurring practice of combining the natural (science, observation, experience) and the supernatural in the cure of illness. Health communication was guided by scientific facts because health information emanates from these sources. People still counted on divine healing but also availed themselves of the services of a physician—that is, natural or scientific remedies. Nevertheless, the scientific revolution continued to gather momentum. This marked the Age of Enlightenment that began in France.

The Age of Enlightenment, again and again, calls into question traditional religious beliefs and values. It equally carried on the church's gradual loss of control over the medical profession. Reason was held in high esteem and was essentially viewed as the essence of human nature, while science was considered as a way to completely explain the universe. Loss of reason came to be equated with loss of humanity. As such, “madmen were seen as little better than animals” (Gamwell & Tomes, 1995, p. 19). As a result, the first hospitals were founded “to protect citizens from the threat to social order posed by violent lunatics” (Gamwell & Tomes, 1995, p. 19). With the elevation of science, there is no further need for God: “The rise of science in the eighteenth century slowly eroded the foundations of religion and ultimately led to the secular science of the modern world” (Gamwell & Tomes, 1995, p. 19). In essence, the implication for healthcare communication is that science holds the answers to all of the questions about sickness, medicine, and healthcare. The general assumption of the Enlightenment was that

the “human mind is capable of comprehending the inner workings of the world, which can be communicated through rational methods” (Gamwell & Tomes, 1995, p. 19) Despite this gradual but apparent shift from religion to science, many physicians of the Enlightenment, like Rush, strove to keep science in line with Christianity by claiming that the

Newtonian universe was designed by God. Old beliefs that God or Satan intervened directly in human affairs were replaced by a conception of disease as a violation of natural law. God created humans with a certain physical and mental makeup; as long as they followed the principles of right living, they would stay healthy. But if individuals violated these laws, by either physical or ethical indiscretions, disease would inevitably follow. (Gamwell & Tomes, 1995, p. 20)

The implication of this quotation for healthcare communication is the tendency to explain the mental health of individuals within the purview of individual freedom. We have the freedom to live rightly in order to stay healthy, or to live wrongly and run the risk of being infected with diseases. As a result, mental sickness was at this time seen as “less a random form of supernatural punishment and more the product of individual action” (Gamwell & Tomes, 1995, p. 20). To this effect, we are totally responsible for whichever path we choose to toe in questions regarding our health.

Subsequent to the Enlightenment’s faith in institutions to cure society’s ills, in North America, the establishment of mental hospitals followed the British and European trends. During this period, families were the bedrock in providing care to the sick and the disabled at their homes, with women playing the most important role in such situations. Town officials expected—and, if need be, compelled—relatives to provide care for their mentally ill relatives. Only in cases of extreme poverty did the community step in and assume the responsibility of

these mad persons. As of this time, schools of nursing had not yet been established (Du Pre, 2005, p. 34; Gamwell & Tomes, 1995, p. 20).

In the United States, the first medical school was established in 1765 at the College of Philadelphia; it later merged with the medical school of the University of Philadelphia. Later, King's College in New York followed, becoming the second institution in the American colonies to confer a Doctor of Medicine degree. King's College later became the College of Physicians and Surgeons at Columbia University. As of the early 1800s, there were only three medical hospitals in the United States: the New York Hospital, the Pennsylvania Hospital, and the Massachusetts Hospital (Koenig et al., 2012, p. 28).

Treatment of mentally challenged people at this time was often harsh. There was mass confinement of the mentally ill, who were gathered together into insane asylums mainly to protect others from them (Koenig et al., 2012, p. 28). In the late seventeenth century, according to Koenig (2000), "the Daughters of Charity of St. Vincent de Paul organized Catholic nuns to serve both religious and secular hospitals (the first nurses). By 1789 there were 426 hospitals run by the Daughters of Charity in France alone" (p. 387). In 1803, the first official nursing school opened in the United States; it was opened in Emmitsburg by the Catholic Sisters of Charity. These religious Sisters performed home nursing as well as institutional care. In 1817, the Quakers opened one of the first mental hospitals in the United States, in Philadelphia, applying moral treatment with resounding success. In 1836, a Lutheran pastor, Theodore Fliedner, opened a nursing school in Kaiserwerth, Germany, known as the Deaconess Institute, that was founded to train women to serve the sick. In 1840, Elizabeth Fry founded the Institute of Nursing in London. It was originally named the Protestant Sisters of Charity, but later changed to nursing sisters.

Despite the continuous interactions of religion and medicine, efforts continued to be made toward achieving complete separation of the two. These efforts remained active for the next 200 years until recent decades. Nevertheless, “today, nearly 70 of 126 U.S. medical schools have either required or elective courses on religion, spirituality, and medicine” (Koenig, 2000, p. 388). This tends to further thwart efforts to separate religion and medicine.

The apparent change in attitude regarding the significance of religion to medicine in general, and to healthcare in particular, could be traced to the rediscovery of the role that the former plays on the latter, as well as the tight hold that religion has in the delivery of medical services and in general healthcare. Hence, continued efforts to separate religion from medicine and healthcare have always remained a mirage, for the uniting force between these entities seems to remain unbreakable. Research by communication scholars and others have provided us with abundant information in this regard, as we are going to see in the next chapter.

Summary

In this chapter, my research has shown that despite modern-day continuous resistance among scientific and academic circles in acknowledging the relevance of religion, medicine, and illness to healthcare, history has shown the existence of a consistent and irresistible magnet that tends to pull these entities together. Moreover, this research has further revealed the relevance of these entities to healthcare communication across different historical periods, despite the recency of the emergence of healthcare communication as a field of study. For instance, during the ancient period, priests doubled as spiritual caregivers and healers. In this vein, they also served as principal communicative agents between the gods and the patient in health matters, while their communication process could best be described as paternalistic and linear. This was because there was no possibility of input or feedback from the patient.

The tendency to portray priests as healers and mediators between the gods and the patient in matters of healthcare runs through many ancient European, Middle Eastern, and Far Eastern cultures: Greek, Roman, Jewish, Egyptian, Assyrian, Chinese, Indian, Mesopotamian. In all of these cultures, sickness was seen as a punishment that was caused by unappeased gods, malignant spirits, or disease demons. Accordingly, sickness demands the intervention of priests, some of whom combined both naturalistic and supernaturalistic methods of healing. The Jewish tradition, as recorded in the Old Testament of the Bible, portrays illness as an act of divine affliction that is caused by human disobedience to the divine ordinance, while cure depends entirely on God. Health communication was totally dependent on divine revelation, with the priest or the prophets serving as the intermediary between God and the sick. With Jesus in the New Testament, health communication became more relational, guided by empathy and compassion.

In the Middle Ages, Christianity dominated all aspects of human life, including medicine, illness, and healthcare. As such, diseases were treated with Christian magic, exorcism, prayer, faith, miracles, and, sometimes, natural means. Moreover, the Bible and the church's tradition were the principal sources of information in matters of medicine, illness, and healthcare; the church authorities became the principal communicative agents in the same regard. In addition to health being carried out as a charitable act, as is evident in monastic healthcare, Christianity encouraged participatory communication in the care of the sick and among the whole Christian community.

Just like Christianity, Islam also has its convictions about medicine, illness, and healthcare. Although the Qur'an (and, subsequently, the Hadith) is the major source of information and messages about medicine, illness, and healthcare, the Prophet Muhammad was

the chief communicative agent, whose health messages were based on divine revelation, just like in the Judeo-Christian tradition. Succinctly put, he stated that only healthy humans could fulfill their religious and ethical obligations. Thus, a Muslim is obligated to care for his or her body as a religious duty. While the body is a gift from God, illness is a test of faith for the sick, and health is a blessing to people.

Health in Buddhism can be traced to its founder: Buddha. While endorsing religious beliefs, religious rituals, and medicine as valid tools in healing, Buddha gives priority to morality, compassion, and the right way of living. He prescribes moral restraint and moderation as being necessary for good health. On the contrary, disease and bodily discomfort are linked to nonliberation from karma.

Just like the other religions, Hinduism also has a lot to do with medicine, illness, and healthcare and has relevance to healthcare communication. The Hindu's strong belief that meditation leads to true knowledge—which, in turn, liberates one from the cycle of death and disease and facilitates reunion with Brahm—drives its perspectives on medicine, illness, and healthcare. While Hinduism leaves the onus of communicating health messages to priests and physicians, it also shows its acceptance of the combination of naturalistic and supernaturalistic approaches to medicine and healing.

With the emergence of the Renaissance, attention shifted from the church (together with its revealed truth) as the principal authority and the chief communicative agent about medicine, illness, and healthcare, to mathematics and science, with the verifiability principle and observation. There then emerged the promotion of humanism, reason, and human beings' ability to discover truth by themselves. All of these realities brought about enormous challenges to the church's authority. Thus, in regard to healthcare communication, proof of illness was subjected

to scientific testing and verifiability. In essence, health messages became dependent on what science said they were, and healing or treatment was based on scientific recommendations.

The modern period involved the Protestant Reformation, further challenges to and questioning of previously held beliefs within church circles, and science taking deeper root in public discourse. Prominent reformers, such as Luther and Calvin, however, viewed medicine and the scientific revolution as beneficial gifts from God in the healing of illness. These developments show evidence of the resurgence of the practice of combining natural and supernatural remedies in the curing of sickness. Thus, despite challenges to the church, she continued to play a vital role in medicine, illness and healthcare, as seen in the exponential establishment of hospitals, the promotion of family-based care, and participatory and team communication, since families became more and more involved in the care of their loved ones.

Despite apparent efforts made to keep religion apart from healthcare and illness, their union continued to grow ever stronger, gaining more ground and recognition, even in different areas of human endeavor, including the communication field. Many communication scholars have made efforts to trace the relationship among religion, medicine, and illness in healthcare communication. Chapter 3 is devoted to looking into the works of these scholars.

Chapter 3:

The Intersection of Religious Faith, Spirituality, and Healthcare Communication: A

Review of Scholarly Literature

Chapters 1 and 2 have shown that there is a deep connection among religion, medicine, and healthcare, despite attempts to separate them. As such, through the review of some works by different scholars, this chapter attempts to further trace this connection and show its relevance to healthcare communication. Accordingly, history consistently lends credence to the intricate connection among these three areas. While some scholars have advanced arguments in favor of separation, most scholars, such as Thoresen and Harris (2002), have attempted to trace this intersection of religion, medicine, and healthcare. Thoresen and Harris (2002) observe that “cultures throughout history have viewed health and disease as directly related to a variety of religious beliefs and practices, as evidenced by specific religious prescriptions concerning diet, physical activities, and quiet reflection and prayer” (p. 3). Thus, the Christian, Islamic, Buddhist, and Hindu religions have indicated, all through their history, that priests, physicians, and other traditional healthcare practitioners “have combined sacred and physical aspects of healing in their communication with patients across centuries and cultures” (Miller, as quoted in Thompson, 2014, p. 1162). This integrative tendency across different religious traditions appears to be based on the philosophical belief that human beings are a composite of body and spirit. Hence, one cannot successfully focus on one and neglect the other.

Similar to Thoresen and Harris (2002), Roberts (1995) affirms that “throughout history, healing and religion have been inseparable. Only in the past 400 years, especially in the West, have the two disjoined” (para. 1). Referring to Dossey’s book *Healing Words: The Power of Prayer and the Practice of Medicine*, Roberts (1995) insists that it is one of a growing number of

works written by doctors who are returning to religion (or spirituality) as part of the healing process. In this book, Dossey, according to Roberts (1995), argues that “prayer . . . should be integral to healing and to the practice of medicine” (para. 2). Before seeing patients each day, Dossey takes time in his office to pray or meditate, since he believes the two are the same” (Roberts, 1995, para. 2). Dossey declares, “Never once did I pray for specific outcomes—for cancers to go away, for heart attacks to be healed, for diabetes to vanish. ‘May the best possible outcome prevail was the strategy I preferred” (as quoted in Roberts, 1995, para. 3). Roberts (1995) concludes that Dossey invokes both the Western and Eastern religions in his survey of prayer’s role in healing. He insists that hope heals, while prayer and meditation remind us that disease and death, however unpleasant, are part of our destiny. Finally, Dossey, according to Roberts (1995), upholds the idea that prayer and religion are never far from medicine.

This popular belief notwithstanding, Miller (2014) notes, “[The] Western biomedical model has generally insisted that physicians are better advised to focus only on physiological issues” (p. 1162). Some scholars share this view, insisting on the necessity of separating religion from medicine and healthcare. For them, transcendental questions should be an exclusive preserve of the priests and should not belong to the domain of the physicians. One scholar who shares this frame of thought is Lawrence (2002). He advances what could be viewed as a constructive argument, considering the joining of spirituality and medicine to be facile and ill defined. Lawrence (2002) views the notion that physicians have the time or training to make assessments and recommendations about spirituality as misguided. He contends that whenever a physician shows personal caring for a patient, the healing process is likely enhanced. By so doing, physicians often promote the spirituality of the patient.

In the same vein, proposals to extend the physician's task to assessing religion and guiding the patient toward approved forms of spirituality are inappropriate to Lawrence (2002). He maintains that the languages of religion and science are radically different. The cultural body-mind split will not be solved by simplistic solutions, such as having physicians endorse spirituality. To do so will only result in the denigration of both medicine and religion. Lawrence (2002) notes that physicians are instead urged to rely on clinically trained ministers for assistance in understanding the patient's state of mind or spirit, as well as its possible effects on the course of illness and health.

On the other hand, Schnorr (1999) directs her own criticisms to the nursing practice vis-à-vis spiritual care. She points out that nurses usually claim to be concerned about the whole person, even though their emphasis often lies on the physical dimensions of care. According to Schnorr (1999), many nurses hesitate to include spiritual care as a part of caregiving for the simple fact that they don't want to "push, manipulate or force religion onto their patients. Patients will "choke if nurses try to 'cram religion down their throats.' Nurses need to be natural and live their beliefs, not preach them" (p. 49). Instead, they consider religion to be the job of the minister or believe that religion is too personal. In essence, whereas some nurses identify the psychological, social, and spiritual dimensions as they pertain to humankind, some are uncomfortable discussing religion. Some believe that they have considered the spiritual needs of their patients simply by inquiring about their religious preferences upon admission. In short, Schnorr's (1999) work advocates spiritual caregiving as a key component of parish nursing, contrary to the tendency of nurses to focus solely on physical care, to the utter neglect of spiritual care.

Schnorr (1999) maintains that parish nurses, by their very nature, may be more accustomed to the religious needs of their patients. Unlike other nurses, parish nurses should not only provide spiritual care but also be spiritual caregivers. Schnorr (1999) insists that nurses can encourage devotional activities, like reading, attending worship services, and listening to inspirational music. Some patients find private devotions meaningful, while others prefer to participate in group devotions:

Nurses can encourage the person to participate in personal or group devotions; nurses can also offer to share a devotion with the individual (patient, family member, etc.). Nurses should know the religious belief of their patients and the rites and sacraments practiced by that religion. (Schnorr, 1999, p. 48)

Moreover, nurses should pay attention to the dietary regulations and significant artifacts (e.g., medals, beads) of their patients' faith. The same goes for other religious practices that may be meaningful to their patients. Schnorr (1999) states, "When the caregiver and the recipient of care do not share the same religious beliefs, the nurse must address the religious needs of the recipient of care and not those of the caregiver" (p. 48). She argues that the onus is on nurses to minister to the needs of the whole person. In short, Schnorr (1999) highly encourages parish nurses to pay attention not only to the physical needs of their patients but also to their spiritual needs. She believes, though, that exercising caution is necessary in carrying out this duty, because the right to accept spiritual care resides with the patient. He or she should not be forced to participate in spiritual and/or religious care.

With regard to healthcare communication, Schnorr (1999) urges that "[r]eligious conversations can be quite informal and nonthreatening" (p. 48). Having simple conversations with patients can be meaningful approaches to allowing the individual to sort out spiritual

concerns. Schnorr (1999) indicates that listening skills are indispensable in the patient–parish nurse relationship. Listening in this respect includes

(a) making an effort to hear what the person feels and (b) encouraging the person to express feelings. Listening is the most important skill the nurse can use. Listening includes more than hearing the words that are spoken. Listening includes catching feelings expressed and understanding the meaning these feelings have for the individual. Listening involves getting to know people, their interests, their supports, and their aspirations. (1999, p. 49)

Essentially, this means that in the art of listening, the parish nurse must be fully invested in his or her encounter with the patient. His or her attention must be undivided and full.

Schnorr’s (1999) insights regarding the significance of religion and spirituality to healthcare (in relation to parish nurse caregiving), coupled with the increased demand for holistic attention to patients’ needs, constitute part of the argument in favor of further research into the spiritual aspects of the patient–provider relationship. Moreover, surveys also indicate that many American physicians are guided by their faith beliefs in their practice of medicine, while some believe that incorporating religious matters into medical interviews can be a welcome component of such enterprises. This point is made very clear in Miller’s (2014) observation: “Religion, spirituality, and participation in faith-defined communities are central to the human condition. For many people, religion and spirituality are powerful tools for understanding their well-being and health” (p. 1162). As Miller (2004) further indicates, although surveys reveal varied opinions among the U.S. population in regard to this perspective, a large proportion of American patients “would appreciate their physicians mentioning spiritual issues to them during the course of a clinical encounter, but others would not” (p. 1163). Additionally, while some patients advocate

religious discussions during their regular medical visits, there are others who believe such discussions should be reserved for serious, life-threatening situations. The bottom line in this, however, is that discussions concerning combining the physical and spiritual aspects of the provision of healthcare remain critical in healthcare communication. Hence, interest in this area continues to grow in different fields of study, including medicine, psychology, biomedical ethics, healthcare, and communication, eliciting different responses by means of individual articles, reports, journals, and books.

In this respect, Miller and Thoresen (2003) rightly acknowledge that the study of spirituality and health is a true frontier for psychology, and one with high public interest. Thus, their research explored the persistent predictive relationship between religious variables and health, and its implications for future research and practice. Miller and Thoresen (2003) further review the epidemiological evidence connecting religiousness to morbidity and mortality, as well as possible biological pathways that link spirituality or religiousness to health.

More researchers have followed suit in an effort to find associations of religion to medicine and healthcare, with a certain implicit connection to health communication. Some of these works serve as nascent literature in this domain, prompting more scholars to launch into further research. Two such scholars are Miller and Rubin (2011). While admitting that there is a growing body of literature addressing the intersection of health and religious spirituality, Miller and Rubin (2011) claim that their book *Health Communication and Faith Communities* is the first book-length treatment that addresses health messaging in, by, and through religiously identified groups. The book offers a broad outlook on the entire domain of health communication and faith-based contexts and organizations. It draws from a wide range of knowledge from researchers and practitioners in various fields of study: public health, pastoral care, medicine,

religion, culture, and health communication. Miller and Rubin's (2011) research reveals the emergence of cases from a variety of religious traditions, ethnicities, and nationalities. The chapters focus on three major topic areas of praxis and theory: (a) health communication through communities of faith—that is, cases in which public health entities use religiously affiliated channels of communication to convey their messages; (b) health communication by communities of faith—that is, interpersonal or public interactions in which religiously identified message sources articulate their stances on health protection and disease treatment; and (c) health communication in faith communities or in religiously identified patient–provider communication. Collectively, this volume reveals myriad opportunities for enhancing connections between health communication practice and faith communities.

Similarly, in the book *Communicating Spirituality in Health Care*, also described as the first of its kind in the health communication field, Wills (2009) presents a multifaceted analysis of the role of spiritual communication in health and healing. Each of the fourteen chapters of this book was written by either a contributing communication scholar or health professional, and addresses specific issues pertaining to religious and spiritual communication practices and the effects on individual health. There are also a variety of health communication contexts noted, with analyses that examine spiritual communication and its role in health behavior or health outcomes in traditional contexts. Examples of such health and spiritual communication include that which exists in the church (pastor/health minister and parishioner) and in the hospital (nurse and patient), as well as in alternative contexts, such as holistic healing communities.

Progressively, the medical and scientific communities are now beginning to recognize the potential significance of spirituality in health behavior and outcomes. Thus, an examination of spiritual communication and healing can help healthcare practitioners in widening their

perspectives on viable paths to wellness. It can equally help individuals, informing and empowering them as they seek to recover, sustain, and better their health. This research then suggests that in the face of an ongoing crisis, as well as the increasing diversity of the United States, broadening people's conception of well-being to include a spiritual component appears essential.

Bull's (2017) work looks into how to evaluate, as well as communicate, the needs of a child in the hospital if we happen to have a conflicting understanding of the spiritual. Bull (2017) further proposes the use of a language of connectedness, which can fully express a child's feelings and his or her understanding of the hospital experience, instead of relying only on religious or medical language. The work of Bull (2017) further explains the concept of connectedness and provides details of a practical assessment tool that employs play and storytelling to connect with the child, as well as collect information about the child's hospital experience, relationship with others in the hospital setting, feelings about the current state, and needs. Finally, Bull (2017) discusses elements that help to enhance communication among medical practitioners, chaplains, and other support groups, enabling them to provide the best support for children in their care.

Similarly, Mill (2002) has looked into the significance of religiousness and spirituality to health. He argues that interest in religiousness and spirituality with regard to healthcare has grown over the years in medical and graduate school curricula, owing to the fact that medical science, which previously separated the mind from the body in its inquiry, now finds it compelling to reexamine the relationship among spirit, mind, and body. While maintaining that "spirituality and religion have been relative constants of cultures," Mill (2002) believes that the reason for this growth could be traced to a "growing field of complementary and alternative

medicine, as well” (p. 1). Further impetus for this renewed interest came from patients themselves, who are interested in the move toward bringing acknowledgment of the whole person back into medicine.

Some of the themes reflected in different research, according to Mill (2002), were “devoted to the determination of whether spirituality or religious behavior actually has significant effects on health (positive or negative)” (p. 2). Additionally, the contributors to the research examined some clinically oriented questions, including whether physicians should take a spiritual history (i.e., whether they should inquire about a patient’s faith or religious commitment) and whether physicians should prescribe religious activities as adjunctive medical treatment. Other scholars, such as Levin (2009), are equally concerned about the question of which area of religion and health is to be researched.

More articles that prompted this incursion into finding the relationship among religion, medicine, and healthcare include “‘And Let Us Make Us a Name:’ Reflections on the Future of the Religion and Health Field.” In this article, Levin (2009) acknowledges that after years of marginality, research on religion and health is entering the academic mainstream, insisting that scholarship on this topic has evolved into a large, productive field. As such, there are varied opinions regarding what should be researched. While words such as “prayer,” “religion,” “spirituality,” “health,” “healing,” “medicine,” and “healthcare” may mean different things to different people, the study of their interconnections can also take different forms. Levin (2009) argues for a welcoming approach that is open to the widest range of research subjects.

This interest in tracing the connection among religion, spirituality, and medicine has been demonstrated by Sloan, Bagiela, and Powell (1999), who have published several articles on the subject. For instance, in a survey they carried out, Sloan et al. (1999) opine that religion and

science share a complex history as well as a complex presence. They maintain that at various times in the history of the world, medical care and spiritual care were dispensed by the same person. Sometimes, passionate (even violent) conflicts were characteristic of the association between religion and science. Sloan et al. (1999) observe that, following the growth of interest in alternative and complementary care, the notion of linking religious and medical interventions has become widely popular, particularly in the United States. Thus, for many people, when faced with illness, religious and spiritual activities provide comfort. Seventy-nine percent of those polled in the survey believe that spiritual faith can help people recover from disease, and 63% believe that physicians should talk to patients about spiritual faith. This development has motivated U.S. medical schools to increasingly offer courses in religion and spirituality. Moreover, as reports continue to indicate interest in this subject, among both doctors and the general public, it becomes necessary to examine how, if at all, medicine should address these issues—that is, spirituality vis-à-vis healthcare.

To review, as noted in Chapter 1, the following is quite evident: There have long been arguments for and against combining religion and spirituality with medicine and healthcare. Evidence of this abounds throughout history. However, as much as scholars continue to search for reasons to actualize this separation, more scholars have come up with arguments in defense of a deep, impenetrable connection between these entities. This claim is evident in some emerging themes of their research. Some studies have proposed that caregivers incorporate spirituality into caregiving, as the article “Spiritual Caregiving: A Key Component of Parish Nursing” advocates.

Overtime, more articles have emerged, including “‘And Let Us Make Us a Name:’ Reflections on the Future of the Religion and Health Field” by Levin (2009) and “Religion,

Spirituality and Medicine” by Sloan et al. (1999). While the former article notes that after years of marginality, research on religion and health has entered the academic mainstream, the latter admits that religion and science share a complex history as well as a complex presence.

The development of interest in exploring religious and spiritual aspects in providing healthcare has also extended to communication study. Thus, many communication scholars, in an effort to break the impasse created by long-time negligence of this area of study, have, over time, engaged in research in this nascent field of study. In addition, scholars from other fields have also carried out inquiries in the same area, producing outstanding works that made important revelations. To this effect, the next section will look into work by communication scholars, as well as others, that manifests the relevance of religious faith and healthcare to health communication. The section will start with definitions of some important concepts, since examining them is crucial for understanding the intersection of religion, spirituality, and healthcare communication. This is essential, because it is now evident that religious beliefs, faith, and spirituality constitute an integral component of health communication and practice. Additionally, as this research reveals, it is expedient to point out that a lot of these scholars did not make an explicit connection between religious faith and spirituality and healthcare communication. For most of them, the connection is rather implicit at best.

Defining Religiousness, Spirituality, and Health Communication

Some communication scholars have provided helpful definitions of the following concepts: religiousness, health, and communication. For instance, Egbert et al. view religiousness as “society-based beliefs and practices relating to God or a higher power commonly associated with a church or organized group” (as quoted in Parrott, 2004, p. 8). In the same vein, Egbert et al. also define spirituality as “individual experiences relating to God or a

higher power, as well as existential aspirations of finding meaning and purpose in life” (as quoted in Parrott, 2004, p. 8). Similarly, Harris, Thoresen, McCullough, and Larson (1999) define spirituality as “a person’s orientation toward or experiences with the transcendent or existential features of life (e.g. meaning, direction, purpose, connectedness), sometimes referred to as the search for the sacred in life” (p. 413). As these authors explain, that which is sacred is, of course, something beyond oneself, such as a divine being, ultimate power, communal spirit, or nature.

Miller defines religion as “a set of beliefs and practices about a transcendent reality that are shared by a community” (as quoted in Thompson, 2014, p. 1162). Again, Harris et al. (1999) describe it as “the external manifestations of spiritual experience, although people can engage in religious activities independent of having private and affective spiritual experiences” (p. 414). Essentially, religious faith usually draws from religious beliefs and individual experiences, and it is deeply rooted in them, so much so that, most of the time, they become the bedrock upon which important health decisions are made. In this respect, it becomes a serious oversight for physicians and healthcare workers to ignore the importance of religious faith and spirituality in dealing with health concerns, and for communication scholars to do the same in their health communication research.

With regard to health, the World Health Organization (WHO), while acknowledging the complexity involved in the definition of health, defines it as “a state of complete physical, mental and social well-being” (as quoted in Wright, Sparks, and O’Hair, 2008, p. 5). The definition given by WHO further acknowledges that health goes beyond physical health and includes aspects like as a person’s quality of life. Moreover, complete physical well-being may not conveniently exclude spiritual well-being if a person is to achieve holistic well-being.

Northouse and Northouse (1985) discuss health communication from the perspective of the sharing of meaning, as well as the exchange of information between the caregiver and the patient. They argue that in the healthcare setting, “an example of the source and a receiver sharing meaning is illustrated by the ongoing exchange of information between a social worker and a nurse” (Northouse & Northouse, 1985, p. 2). These two partners in the health communication process (social worker and nurse) collaborate to work out rehabilitation plans that will ultimately promote quality of life of a patient with a spinal cord injury. In a health communication process such as this, Northouse and Northouse (1985) maintain that it is necessary that the meaning of the concept of quality of life be shared among the social worker, the nurse, and the patient, if the communication process is to be successful. The individuals involved here need to express their points of view in the bid to agree on treatment plans intended to advance the patient’s quality of life. This view aligns with the idea expressed by Northouse and Northouse (1985), who described health communication as a “subset of human communication that is concerned with how individuals in a society seek to maintain health and deal with health-related issues” (p. 4). They maintain that in health communication, attention is directed to specific health-related transactions, together with factors that influence these transactions. The transactions in question are the ones that happen between health professionals themselves, and the ones that occur between professionals and clients. These transactions could be verbal or nonverbal, oral or written, personal or impersonal, issue- or relationship-oriented. These elements hold particular interest in health communication.

Also including the element of information sharing is Du Pre (2014), who defines health communication as involving the process of sharing, seeking, and making sense of health-related information. For Du Pre,

People are involved in health communication when they seek and provide medical attention, but also when they talk to neighbors and loved ones about health and when they encounter (or distribute) health-related messages via internet, television, movies, magazines, and other venues. (as quoted in Thompson, 2014, p. 205)

In essence, any interactions that are geared toward health concerns, treatment, and health improvement can qualify as health communication.

Admittedly, it has been acknowledged that there is complexity inherent in the definition of health communication, just like other aspects of communication. This complexity is made more manifest due to the fact that a definition of health communication could be of a multidimensional nature. In other words, health communication includes many other aspects of communication, according to how it is dealt with by different communication researchers.

Multidimensional Nature of the Study of Healthcare Communication

As Kreps (2015) has pointed out, healthcare communication is multidimensional in nature. Its scope and focus range from individual concerns, in that it identifies serious communication issues that threaten the quality of healthcare and health promotion, to organizational issues. For instance, Kreps (2015) maintains that some health communication scholars and practitioners choose to focus their attention on health communication from the organizational standpoint. Researchers who belong to this camp tend to explore features of health organizations, including information flow in organizations, how people communicate as they negotiate the healthcare system, crisis management, marketing and public relationships, and employee–management relationships. The scholars who pursue group health communication inquiry examine health communication as it pertains to small-group settings. Such small groups include families, healthcare teams, and support groups, with a particular emphasis on identifying

effective and ineffective communication among group members and the factors affecting that communication.

Those who focus on intercultural health communication direct their attention to the unique role that culture plays on how people from diverse cultural backgrounds understand health and illness, as well as how intercultural differences affect healthcare relationships. To this effect, while some cultures regard health in largely physical, biomedical terms, other cultures conceive of health as “a harmonious balance between physical and spiritual factors,” according to Du Pre (as quoted in Thompson, 2014, p. 207). In this respect, the provision of healthcare has to take into account the biomedical, as well as the spiritual, aspects of caregiving. Even in certain situations, caregiving is solely spiritual, especially if the cause of the sickness is perceived to be of spiritual origin. As Thompson (2014) observes, the cultural differences between biomedical and spiritual dimensions in healthcare giving pose a big challenge to individuals, inviting them to be knowledgeable and respectful about a wide range of cultural beliefs. According to Du Pre, “Cultural competence is an important aspect of health communication” (as quoted in Thompson, 2014, p. 207). This is considered an absolute necessity; otherwise, caregivers may find themselves falling prey to avoidable mistakes in providing healthcare to diverse populations.

A typical example of how culture can affect health communication can be seen by considering the nonfiction narrative in the book *The Spirit Catches You and You Fall Down* by Fadiman (1997). In this book, Fadiman (1997) narrates the true story of a Hmong refugee family, the Lee family, who is from Laos in Southeast Asia but currently resides in Merced, California. The major protagonists in the story are Lia Lee (an epileptic Hmong child), Nao Kao and Foua Lee, (Lia Lee’s parents), and the American doctors, nurses, and administrative workers at Merced Medical Center. Lia, who started suffering from severe epilepsy when she was barely

three years of age, eventually became brain-dead after having been in a vegetative condition for a while. Lia's fate was blamed on miscommunication and ignorance on the part of both her parents and the American doctors. Each of these groups adamantly stuck to the belief in the superiority of their medical knowledge: the American doctors with their Western biomedical knowledge, and Lia's parents with their Hmong medico-cultural and traditional knowledge. None were willing to compromise, leading the two parties to a very intricately woven impasse.

The apparent gridlock between these two groups led to the maladministration of Lia's treatment. The miscommunication was, in turn, able to be blamed on Lia's parents' unimaginable stubbornness, their ignorance of the English language and American medical culture, and their distrust of the American doctors. It was also able to be blamed on cultural disparities in regard to illness and treatment between the Hmong and American cultures, as well as the American doctors' refusal to concede to the fact that cultural diversity plays a huge role in caregiving. Resulting from the whole caregiving encounter was overwhelming stress, frustration, and tension between the doctors and this Hmong family; the end result was the death of Lia. This caregiving saga demonstrates the negative role that intercultural medical miscommunication can play in caregiving.

Apart from communication scholars who focus on health vis-à-vis intercultural communication, there are also others who focus on health communication and social influence. Such people channel their efforts into understanding how health messages and campaigns can be enhanced to achieve health behavior changes for a larger group of people. On the other hand, some health communication scholars are more interested in the role of the mass media in helping to tailor our understanding of specific health-related issues and our more general conceptions of health and illness.

Researchers who study health communication from an intrapersonal point of view tend to direct their attention to people's attitudes, beliefs, values, and feelings regarding health-related concepts and messages. On the other hand, communication scholars who conduct research from an interpersonal perspective tend to be concerned more with communication pertaining to relationships, such as those between providers and patients, or engage in the study of how everyday relationships, such as those with family members, coworkers, and friends, impact our health. According to Du Pre,

Research shows that the quality and structure of talk between patients and health professionals affects how openly they express themselves, the quality of their decisions and the likelihood that people will follow through with healthy behaviors and seek care in the future. (as quoted in Thompson, 2014, p. 207)

Therefore, when patients are disposed to engage in high-quality communication with their caregivers, they tend to be more open, make better health decisions, and endeavor to adhere to healthy behaviors.

A growing number of healthcare communication scholars are interested in discovering the role that technologies play in disseminating health information, promoting relationships among people who have similar health conditions, and advancing communication between providers and patients and within health organizations. This is done in the context of interpersonal communication, where the paramount interest is the welfare of the patient.

Whereas the aspects of health communication previously discussed are all bona fide health communication research areas, intrapersonal and interpersonal perspectives more closely relate to the purpose of this project, since they focus on how healthcare providers and patients relate to each other. Within this field, we can also read about how these individuals use religious

beliefs and spirituality in healthcare in the context of interpersonal communication. Some healthcare communication scholars, as well as others, have carried out empirical studies that examine relations between religious spirituality and health communication, and their findings are quite revealing. Their works tend to answer the question raised in the following article: “Religion and Medicine: How Are They Related?” by Vanderpool and Levin (1990). These authors affirm that “religion and medicine are more deeply interconnected than is commonly assumed. How are they related, and what are the implications of their relationship for the practice of medicine?” (Vanderpool & Levin, 1990, p. 9). In this article, the authors supply a comprehensive and dynamic profile of religion–medicine interrelationships. Different authors have looked into this interrelationship from diverse perspectives, as we shall see in the following section.

Review of the Works of Communication Scholars and Others: Their Different Perspectives on the Relationship Among Religion, Spirituality, and Healthcare Communication

Some communication scholars have accused the communication field of neglecting to explore the relationship between religious spirituality and healthcare communication in their research. The significance of this section is to show a seeming rise to the occasion by some communication scholars, as well as other scholars. Thus, this section is devoted to additional review of the works of these scholars on the relationship between religious spirituality and medicine, as well as their implications for health communication. Their works are equally relevant as they reveal more interest among these scholars in the health communication field. They aim to deal with this seeming amnesia in the communication field in tracing the relationship among religion, medicine, and healthcare.

To this effect, Egbert et al. (2004) offer a cohesive fusion of the ways and means through which religious faith and spirituality have been evaluated. Through their review, they show the

development of research, which is designed to make religious faith and spirituality more practical and show how and where health communication might be placed in regard to this topic. Egbert et al. are of the opinion that scholars have come to realize “the multifarious and extensive influence that religion and spirituality can have on individuals’ health beliefs and practices” (as quoted in Parrott, 2004, p. 8). This belief is buttressed by the fact of everyday experience, where religious faith continues to be an issue in healthcare giving.

Moreover, this conviction becomes all the more expedient at the time when some communication scholars, such as Larimore, Parker and Crowther (2002) raise the following questions in the title of their article: “Should Clinicians Incorporate Positive Spirituality Into Their Practices? What Does the Evidence Say?” These questions seem to be answered by yet another communication scholar, Miller (2014). Miller has written about religion and spirituality in relation to patient–provider communication. She notes that a substantial number of American physicians say that “they believe that explicitly discussing religious issues can sometimes be an acceptable component of the medical interview” (Miller, 2014, pp. 1162–1163). Larimore et al. (2002) toe a similar line of thinking as Miller. They declare that most of the rhetoric decrying the incorporation of basic and positive spiritual care into clinical practice is not based on reliable evidence. Their research led them to make the following conclusions: (a) there is frequently a positive association of positive spirituality, mental, and physical health and well-being; (b) most patients really desire to be provided with basic spiritual care by their clinicians; (c) most patients censure our professions for ignoring their spiritual needs; (d) most clinicians believe that spiritual interventions would help their patients but have little training in providing basic spiritual assessment or care; (e) professional associations and educational institutions are beginning to provide learners and clinicians with information on how to incorporate spirituality

and practice; and (f) anecdotal evidence indicates that clinicians who have received such training find it immediately helpful and do apply it to their practice.

On the other hand, referring to the negligent attitude adopted by some healthcare providers in regard to the spiritual aspect of care, despite the fact that patients have demonstrated their need of it, Hefti and Bussing (2018) note the following:

Patient care frequently focuses on physical aspects of disease management, with variable attention given to spiritual needs. And yet, patients indicate that spiritual suffering adds to distress associated with illness. Spirituality, broadly defined as that which gives meaning and purpose to a person's life and connectedness to the significant or sacred, often becomes a central issue for patients. Growing evidence demonstrates that spirituality is important in patient care. Yet healthcare professionals (HCPs) do not always feel prepared to engage with patients about spiritual issues. (p. 3)

This notwithstanding, the importance of religious faith or spirituality to healthcare cannot be overemphasized. Although some patients' interest in religious spirituality in relation to healthcare may be based on what religion can offer them, rather than on an internal commitment to religion, these patients continue to manifest enormous avidity for spiritual needs as a means of coping, especially during an encounter with serious illness.

In this respect, Allport and Ross (1967) differentiate between what they refer to as extrinsically and intrinsically motivated individuals with regard to how they use religion to their advantage. While the extrinsically motivated individual uses his religion via instrumental and utilitarian tendencies, the intrinsically motivated individual lives his religion. In regard to health communication behaviors, the former (extrinsic orientation) finds his religion useful in terms of the purposes it serves him—security, solace, sociability, self-justification—while the latter

(intrinsic orientation) “find their master motive in religion. Other needs, strong as they may be, are regarded as of less ultimate significance, and they are, so far as possible, brought into harmony with religious beliefs and prescriptions” (Allport & Ross, 1967, p. 434). Because of the creed they have embraced, such individuals try as much as possible to internalize and live it to its full extent. Other authors have also examined different facets of religion, spirituality, and medicine in relation to healthcare.

This section has examined the tendency by different communication scholars and others to rise up to the challenge, posed by neglect by the communication field, to look into the intersection of religious faith and spirituality. Their efforts have resulted in the production of different articles. Some of these works include “A Review and Application of Social Scientific Measures of Religiosity and Spirituality: Assessing a Missing Component in Health Communication Research” by Egbert et al. (as quoted in Parrott, 2004); *Conference Proceedings Integrating Religion and Spirituality into Clinical Practice* by Hefti and Bussing (2018); and “Should Clinicians Incorporate Positive Spirituality Into Their Practices? What Does the Evidence Say?” by Larimore et al. (2002). The work of Larimore et al. (2002) eventually led to the conclusion that, indeed, most patients really desire to be provided with at least basic spiritual care by their clinicians. However, although most clinicians believe that spiritual interventions would help their patients, Larimore et al. (2002) found that these clinicians have little training in providing such care. Nevertheless, the recognition of this need has led professional organizations and educational institutions to begin to provide learners and clinicians with information on how to incorporate spirituality into their caregiving practice.

Larimore et al. (2002) have additionally revealed, through their findings, that interest in religious spirituality in relation to healthcare by some patients may be based solely on what

religion can offer them, rather than on their commitment to religion. They referred to extrinsically motivated individuals and intrinsically motivated individuals; the latter convincingly live their religion, regardless of whether they perceive immediate gain or not.

It is worth noting that none of these scholars have explicitly related these findings to healthcare communication. Thus, such a relationship is mostly implied, since expressions of the religious/spiritual needs of patients in a caregiving situation usually take place in the context of the patient–provider interaction. I believe future research would fill this void, but this is a move in the right direction for now. Meanwhile, further studies have been carried out by scholars in other areas that show the relevance of religious spirituality to healthcare. I will now discuss these scholars according to the different but related dimensions through which they approach their work.

Scholars on Spiritual Well-Being, Religious Satisfaction, Coping, and Better Psychological Adjustment, in Relation to Healthcare Interaction

Some scholars have carried out research on how religious faith affects spiritual satisfaction and spiritual well-being in relation to the health encounter; others have focused on religious faith as it pertains to coping with illness; still others have dealt with religion and spirituality in regard to better psychological adjustment regarding the healthcare encounter. One such scholar is Ellison (1983), who discusses a spiritual well-being scale that measures both religious and existential well-being. He further attempts to fill the void created by communication scholars who have ignored discussions about the quality-of-life movement that relates to religious and spiritual satisfaction, aspects of human welfare, and the role that such beliefs and practices play in well-being. A scholar who has ignored this aspect of spiritual well-being is psychologist Campbell. While completely neglecting the religious and spiritual

dimensions of human well-being, despite finding out that religious spirituality is very important for the well-being of many Americans, Campbell (1981) suggests that human well-being depends on the satisfaction of three basic kinds of needs: “The need of having, the need for relating and the need for being” (as quoted in Ellison, 1983, p. 330). These three basic needs leave out spiritual well-being altogether.

Contrary to Campbell (1981), Ellison’s (1983) research reveals that “all of the great religions of the world recognize and call human beings to transcendence as the path to the highest levels of well-being” (p. 330). His research further declares that the Gallup Poll shows that “86% of Americans regard their religious beliefs as fairly or very important” (Ellison, 1983, p. 330). To this effect, the significance of Ellison’s (1983) findings cannot be overemphasized. The use of religious spirituality variables goes hand in hand with physical well-being. Both are very important to healthcare communication. Miller (2014) points out that “with the growing emphasis on holistic attention to patient needs in patient-centered communication, the door has opened to a reconsideration of spiritual aspects of the patient-provider relationship” (as quoted in Thompson, 2014, p. 1162). As I have previously stated, many patients are not averse to their caregivers discussing religious and spiritual matters as they relate to their healthcare.

In line with Ellison’s (1983) discourse on spiritual well-being, Peterman, Fitchett, Peterman, Brady, and Hernandez (2002) explore spiritual well-being in regard to chronic illness therapy. Their findings align with Ellison’s (1983) view. Their research was carried out among a variety of healthy and patient populations, and it reveals a significant relationship between religion and better health. Peterman et al. (2002) observe that in the past several years, there had been a focus on the role of spirituality in health promotion and coping with illness. The article further discusses the development and testing of a measure of spiritual well-being, the Functional

Assessment of Chronic Illness Therapy, within two samples of cancer patients. The tool uses two subscales: one measuring a sense of meaning and peace, the other assessing the role of faith in illness. A total score for spiritual well-being is also produced. The study showed a significant relationship of religious faith with better quality of life.

Similarly, Carson, Soeken, Shanty, and Terry (1990) explore spiritual well-being in relation to healthcare. They examine the impact of AIDS on the emotional and spiritual health of its victims, and they summarize current research findings on spiritual well-being in the ill. It is obvious that “without a cure yet on the horizon, there is a need to identify ways to sustain hope and spiritual well-being in patients with AIDS” (Carson et al., 1990, p. 28). Persons with AIDS are always confronted with certain existential and spiritual issues, such as a search for meaning, the purpose of the illness, and where they stand with regard to their spiritual well-being. Accordingly, a lot of chronically ill patients tend to cling to their religious and spiritual beliefs for hope in the face of their unfortunate condition. The authors discover that “spirituality contributes to psychological and physical well-being and, as such, is a worthwhile research pursuit” (Carson et al., 1990, p. 28). Therefore, in addition to psychological and physical well-being, religious faith and spirituality also give them hope, because, as Raleigh (1980) observes, the individual who has lost hope is in critical condition; hope is an absolutely necessary condition for the sustenance of life.

Parallel to Carson et al.'s (1990) study, Mickley, Soeken, and Belcher (1992) also carry out a study on spiritual well-being, religiousness, and hope. In their research, they attempt to clarify spiritual health by examining the role of spiritual well-being, religiousness, and hope in spiritual health. Through the use of questionnaires, patients classified as intrinsically religious were found to have significantly higher scores on spiritual well-being than those classified as

extrinsically religious. Existential well-being, which is a component of spiritual well-being, was observed to be the primary contributor to hope. Since hope and spiritual well-being are positively related, spiritual well-being is found to be important to coping responses. In both Carson et al.'s (1990) and Mickley et al.'s (1992) studies, the central message is that is the message of hope comes through the medium of religious community. This message is, most of the time, communicated through spiritual counseling, preaching, and religious community support. It involves imparting in the patient the necessity to have psychological confidence in the better future outcome of a situation.

Kaczorowski (1989), just like Mickley et al. (1992), undertook a related study, examining the claim that anxiety is lower in highly spiritual persons confronting life-threatening illness. The study was conducted among 114 adults diagnosed with cancer. The relationship between spiritual well-being and state-trait anxiety was measured using the spiritual well-being scale, with the outcome supporting the theory that persons with higher levels of spiritual well-being have lower levels of anxiety.

On the other hand, Daaleman and Dobbs's (2010) work evaluates the association of religiosity and spirituality in regard to fear of death and death acceptance attitudes in chronically ill older adults. Based on in-home interviews conducted with 257 community-dwelling elders with chronic illnesses, it was discovered that self-efficacy beliefs, anxiety, and physical functioning were significantly associated with fear of death attitudes. In contrast, self-reported religiosity, closeness to God, and age, were significantly associated with acceptance of death attitudes. In this respect, by counting on their religious faith and beliefs, these patients were able to cope with vicissitudes associated with their different ailments.

Holland et al. (1999) also carried out a study regarding chronic and life-threatening disease. Their work examines the role of spiritual and religious beliefs in ambulatory patients coping with malignant melanoma. In their study, 117 patients suffering from melanoma being seen in an outpatient clinic completed a battery of measurements, including the newly validated Systems of Belief Inventory (SBI-54). Through this research, Holland et al. (1999) discovered that there was a correlation between greater reliance on spiritual and religious beliefs and use of an active–cognitive coping style. Data indicate that the use of religious and spiritual beliefs is associated with an active rather than a passive form of coping. Thus, the authors suggest that such beliefs offer a useful active–cognitive framework for many individuals by which they can face the existential crises of life-threatening illness.

This observation seems to echo the view of Egbert et al. in relation to coping and health communication. They contend that “there is much to be learned about how communication within a religious group affects one’s self-concept regarding health” (as quoted in Parrott, 2004, p. 19). Egbert et al.’s (2004) claim is observable in all of the findings of the health communication scholars previously discussed. As far as their findings go, in health communication, there is the tendency to associate chronically ill patients’ feelings of well-being, as well as their better management of anxiety, fear, and acceptance of death attitudes in life-threatening situations, to religious spirituality and religious convictions. This is evident in the way that these patients describe their attitudes toward sickness, anxiety, fear, and death vis-à-vis their religious convictions. It is apparent that these religious convictions are, in turn, based on religious messages and teachings, and shared among the respective faith communities, which double as religious and social support groups.

Monod et al. (2011), through their research, inform us that for more than the past 15 years, many studies have been published on the relationship between spirituality and health in different fields of research, such as medicine, nursing, sociology, psychology, and theology. Initially, most of the researchers investigated the association between religiousness or religion and health. Monod et al. (2011) reveal that clinical research on the relationship between spirituality and health finds that spirituality is a very important resource for many patients in coping with illness. It is also a critical component of quality of life, especially for those suffering from chronic or terminal diseases. This spiritual need is often provided by the faith community, the pastoral caregiver, or the chaplain in the context of interpersonal interaction. This interaction can be seen in pastoral visitation of the sick, spiritual counseling, nonverbal communication behavior demonstrated through empathy, and performance of religious ritual. Monod et al. (2011) also find that some aspects of spirituality have been negatively associated with health outcomes. For instance, low spiritual well-being and religious struggle have been linked to higher mortality rates, hopelessness, more severe depression, and desire for hastened death. Owing to these observations, clinicians have come to agree about the importance of assessing and addressing spiritual issues in healthcare settings.

Kass, Friedman, Leserman, Zuttermeister, and Benson (1991) discuss clinical observations, indicating a relationship among spiritual experiences, life purpose, and satisfaction. Their evaluation reveals that improvements in physical health have resulted in the development of an index of core spiritual experiences (inspirit). Multiple regression analysis showed the inspirit to be associated with increased life purpose and satisfaction, a health-promoting attitude, and decreased frequency of medical symptoms.

Other communication scholars who have assessed religion as one of the strategies in coping with illness are Pargament et al. (1992). They explain that religion is an often-ignored system of caregiving and healing. In their article, Pargament et al. (1992) examine the role of religion in the coping process. They also evaluate the relationship between intrinsic, extrinsic, and quasi-religious orientations to religious and nonreligious coping in relation to a significant negative life event in a sample of 538 mainstream Christian church members. Each orientation was associated with a different coping strategy for specific life problems. Pargament et al. (2002) declare that empirical studies have shown religious practices to be commonly involved in the coping process, even though exploring the importance of this healing process has received only limited attention. In my own practical experience, as far as healthcare communication is concerned, this aspect of care sometimes starts within the context of the physician–patient interaction or interview. Some physicians refer patients to the hospital chaplain, who, by means of spiritual counseling and religious rituals, provides this aspect of care. Sometimes, too, the faith community of the patient in question plays an important role.

The need for this important aspect of caregiving cannot easily be ignored, in spite of the tendency to overlook it by some health caregivers. This explains why more and more scholars in the communication field have opted to engage in research on these issues. For example, Paloutzian and Kirkpatrick (1995), through their research, assert that religious belief and behavior have far-reaching influences on personal and social life, in both beneficial and deleterious ways. They examine these religious influences on a variety of aspects of well-being, including both personal and societal levels of analysis. Paloutzian and Kirkpatrick (1995) look into these relationships across a diverse sampling of conceptualizations of well-being, including coping, mental health, physical health, and substance abuse and recovery. They further examine

social issues and problems, such as religion-related and ritualistic child abuse, prejudice, and right-wing authoritarianism, among special populations (adolescents and the elderly).

In a related study, Carson (1992) examines the relationship between spiritual well-being and hardiness in a group of 100 subjects who either tested positive for HIV or who have been diagnosed with AIDS. Following the completion of the spiritual well-being scale, the personal views survey (used to measure hardiness), and a demographic data survey, results showed a significant relationship between spiritual-well-being and hardiness.

Puchalski's (2001) study examines elements of compassionate care. Puchalski (2001) reviews research focusing on the role of spirituality in healthcare, with an emphasis on the advantages of understanding patients' spirituality in healthcare. Also described are means to practice spiritual care, and certain national efforts to incorporate spirituality into medicine are summarized. In doing this, Puchalski (2001) recognizes that advances made in medical technology, which have changed the focus of medicine from a caring, service-oriented model to a technological, cure-oriented model, have led to neglect of the spiritual aspect of healthcare. However, in the past few decades, there has been a move by physicians to rediscover and balance their care by reclaiming medicine's more spiritual roots, recognizing that until the modern period, spirituality was often linked with healthcare. Puchalski (2001) believes that spiritual or compassionate care involves serving the whole person, which includes the physical, emotional, social, and spiritual.

The implication for healthcare communication, as far as the physician-patient relationship is concerned, is that there should be a combination of physical care (provided by the doctor) and spiritual care (where the chaplain or priest, through a one-on-one interview that involves talking and listening to the patient in an interpersonal setting, interacts with the patient).

By so doing, the chaplain or priest can administer pastoral and spiritual counseling to the patient. According to Puchalski (2001), during such an encounter, the chaplain or pastoral counselors utilize prayer, scripture study, and participation in the congregation or community as resources to help guide people on their journey toward transcendence, transformation, and greater connection to others.

Blaine, Trivedi, and Eshleman's (1998) work examines religious beliefs, self-concept, and psychological adjustment. They explore the relationship between religious beliefs and spirituality to psychological adjustment, upholding that measures of religious commitment, devotion, or belief strength are associated with a variety of positive mental health parameters, such as decreased anxiety, depression, increased self-esteem, tolerance, and self-control. Additionally, Blaine et al. (1998) maintain that, in accordance with this approach, religious institutions provide the individual with a range of resources for preventing the psychological impact of negative or uncontrollable life events, thereby contributing to mental health. Religion, in their view, is a prominent and robust sociocultural influence on the self-concept that shapes the way people think about and describe themselves. They further point out that religious belief strength is associated with more positive and certain self-conceptions, while the influence of religiousness on self-concept is evident in multiple self-knowledge domains.

Levin's (1994) work is a review that shows evidence for a relationship between religion and health. He reveals that hundreds of epidemiologic studies have turned up statistically significant, salutary effects of religious indicators on morbidity and mortality. While this does not necessarily mean that religion influences health, it does show that religion has a lot of positive salutary effects to offer in health matters. In a related study, Levin and Vanderpool (2008) affirm that there is a long tradition of interconnections of religion and physical health.

They claim that the existence of such religion–health connections is a nearly universal feature within the cosmologies of religious traditions. Empirical evidence from various scientific traditions lends credence to this claim. They further survey religious factors in physical health, discussing why religious indicators should be significantly related to health status.

In a similar review article, Levin and Schiller (1987) look into epidemiologic studies that consider religious factors as an independent construct in relation to health. The study finds that most social scientists, such as sociologists and psychologists, have found some relevance of health to religion and spirituality, yet most epidemiologists have a very limited appreciation of religion in relation to health. This view is based on the argument that God intervenes in the affairs of men; therefore, the effects of God’s healing grace should be demonstrable, even if many disbelieving scientists might debate the source. On the other hand, several scholars have argued from the perspective of “holistic health” that religiosity is promotive of health and “wellness.”

Additional communication scholars whose work attempts to trace the intersection of religious faith to healthcare and healthcare communication are Robinson and Nussbaum (2004), who review the relationship between social support and elder health. Their article focuses on how religion, particularly church attendance, emerges as a topic of discussion in visits when older adult patients see internal medicine physicians with the aim of dealing with a chronic routine problem. Their work begins by reviewing the social support dimensions of religion as a means of coping and then further discusses the relation between church attendance and elder health. They examine the place of religion in the biopsychosocial model of medicine, as well as medical education’s position on physician–patient communication about religion. Furthermore, they look into the emergence of the topic of religion in actual visits. Their efforts reveal that in

nine of the visits, religion was raised as a topic by the patient, the most frequent topic being church attendance.

Also, Keeley (2004) explores religion as a coping mechanism for the survivors of a terminally ill patient. Her article is a report from a project that explored final conversations—that is, the final communicative encounter with the terminally ill from the often-overlooked survivor's perspective. The main focus for Keeley (2004) is the major theme discovered in final conversations interviews: Messages were shared pertaining to religious faith or spirituality, showing that communication at the end of life is also important for the surviving family members seeking opportunities for final communication with their dying loved ones. They express concerns similar to those expressed by the dying person. What is found to be of paramount importance in this encounter, whether for the dying person or the family members, is the search for meaning, the examination of the religious belief system, and an exploration of spirituality:

Religious or spiritual beliefs often offer family members a consoling explanation for events that cannot be explained by reference to science and logic alone. . . . People that have religious or spiritual beliefs are likely to be less anxious about death. (Keeley, 2004, p. 88)

The final conversations interview reveals three rules of conduct: (a) how to cope with life's challenges after a loved one is gone, (b) how to be involved in the death and dying process, and (c) how to enact or live your religion or spirituality.

Anderson (2004) examines the role of faith-based organizations in the delivery of healthcare. Her study gives special consideration to parish nurse programs, as well as to the unique relationship between parish nurses and faith members. These nurses attend not only to the

physical needs of the faith members, but also to the needs associated with emotional and spiritual wellness. Nurses responded to questions about health ministries in faith-based organizations, their role as nurses, and the benefits of partnering with these organizations to promote healthcare. They further described the delivery of care through the educational clinic and viewed themselves as promoters of health.

Rafferty, Billing, and Mosack (2014) assess religious involvement and spirituality as coping mechanisms for patients living with chronic illnesses. They note that spirituality and religion have been linked to positive outcomes, including lower anxiety and depression and emotional states of happiness, optimism, hope, gratitude, and forgiveness.

Many religious practices are interactive and involve communication (e.g., community spoken prayer, participation in religious services with a group of individuals who share similar beliefs, conversations with a spiritual mentor). These social and communicative components to religious spirituality may be one reason why religious spirituality leads to emotional improvement (Rafferty et al., 2014, p. 1871).

Indeed, Rafferty et al. (2014) advocate for a better understanding of the communicative features within religious spirituality conversations. They believe that this understanding may help to illuminate how different messages are associated with social support and psychological states, such as emotional improvement. For Rafferty et al. (2014), conversations offer a “medium in which a distressed person can express, elaborate, and clarify relevant thoughts and feelings’ in order to develop positive reappraisals about a stressor” (p. 1872). Thus, comforting is considered to be an interactive process during which the messages from the supporter assist the distressed person.

Long (2004) focuses his research on examining the role played by Christian faith on health and wholeness. He declares that “to be whole persons, we realize that health integrates our spiritual, physical, intellectual, emotional, and social lives. Therefore, health can be experienced in relationships with God and others: Health involves a willingness to change and health is a choice” (as quoted in Parrott, 2004, p. 129). As far as health communication in relation to religion and spirituality is concerned, healthcare is relational, carried out in an environment of community participation, whereby “local congregations can become centers for healing, caring and teaching. Through regular healing services, prayers offered for those in hospitals, and various grief and support groups, people experience the church as a place of healing” (as quoted in Parrott, 2004, p. 129). In some churches, there exists what is called a “Stephen Minister.” This church organization provides caring ministry by walking with a person during difficult and painful moments of his or her life. Other faith communities have care groups that check on each other for caring assistance as and when needed. Others possess teaching ministries where matters concerning health and wholeness are taught. Long (2004) points out that many doctors and nurses believe in the power of prayers, even as there have been efforts to separate church and state issues. He states that some medical schools include classes on how to talk with patients about their faith (as quoted in Parrott, 2004, p. 130).

Another communication scholar who looks into measures of spiritual well-being is Moberg (1984). In his work, Moberg (1984) states that “a central concern of the Christian faith, if not also of Islam, Judaism, Hinduism, and Buddhism, is to enhance the spiritual well-being of people” (p. 351). This concern is located at the very core of many religious goals. Moberg (1984) describes the components of spiritual well-being in terms of the human need to deal with sociocultural deprivations, fears and anxieties, death and dying, self-image, personality

integration, social alienation, personal dignity, and philosophy of life. Analysis of data shows that the rating of the importance of faith happens to be one of the strongest predictors of the feeling that life is worthwhile, with religious activities also playing an important role.

Plante and Sherman (2001) present an overview of theory and research showing a link between religious faith and physical and mental health. Some of the contributors to this work opine that the relationship between faith and health is likely to be complex, reciprocal, and wide-ranging. They state that faith is a complex, multifaceted construct, with other aspects that are likely to have different associations with health. Plante and Sherman (2001) note that “McCullough reviews a number of studies, reporting that the more religiously observant people are, the longer they are likely to live” (p. 144). While some contributors to the book portray religion and spirituality as major promoters of forgiveness in our society, others review studies reporting modest associations among religious involvement, adjustment to illness, and outcomes. Additionally, McCullough’s reviews, according to Plante and Sherman (2001), highlight the need to seek a wide-ranging understanding of wholeness, well-being, and illness in both research and clinical work. It equally emphasizes the need to address an individual's particular faith context.

Smith, according to Plante and Sherman (2001), looks into the status of research on faith and health as it concerns health psychology. He examines the representation of religion and spiritual issues specifically in regard to three topics: (a) health behavior and prevention, (b) stress and disease, and (c) psychological aspects of medical illness and care. He then declares that matters of religion and spirituality are relevant to each of the foci of health psychology.

Zorn and Johnson (1997) affirm that spirituality is acknowledged as an important component of healthcare practice with elderly people. Nevertheless, there have been minimal

discussions regarding the role it plays for elderly women on a day-to-day basis. Furthermore, their article sets out to describe the level of religious well-being and selected characteristics of religiosity in a sample of 114 noninstitutionalized, mainly rural elderly women. Moreover, it tries to identify the level of religious well-being. The findings show a high level of religious well-being among the participants, as well as a significant correlation between religious well-being and variables of social support and hope. Hope is viewed as the single most significant predictor of religious well-being. Most of the respondents reported regularly participating in religious activities.

Kraus's and Van Trans (1989) work involves a study conducted in a nationwide sample of Black Americans, with an aim of establishing whether involvement in religion helps to reduce the negative impact of stressful life events. The major outcome measures were self-esteem and feelings of personal control. Empirical evaluation of three models of the stress process—the suppressor, moderator, and distress-deterrent models—were conducted. Findings from this model demonstrate that even though life stress has the tendency to erode feelings of self-worth and mastery, these negative effects were offset or counterbalanced by increased religious involvement.

Sloan and Bagiella (2002) argue that religion, spirituality, and health have recently made frequent appearances in both the popular media and professional journals. They opine that many studies have examined the relation between religious involvement and health outcomes. Most of these studies have revealed that “religious people are healthier” (Sloan & Bagiella, 2002, p. 14). These studies have demonstrated the beneficial impact of religious practices on the adherents of those religions. In this respect, there is a corresponding rise in calls to incorporate religious and spiritual activities into clinical practice.

Sloan and Bagiella (2002) further found out, though, that 17% of the work they examined regarding health, wellness, and religion affirms the claim that health benefits are associated with religious involvement. In December 2000, the Harvard Medical School Department of Continuing Education offered a program on spirituality and healing titled *Mainstreaming Spirituality*. Many of the articles written about the topic, however, did not really dwell on the association of religious involvement and health outcomes. Sloan and Bagiella (2002) conclude that few of the articles could truly be described as demonstrating beneficial effects of religious involvement.

Similarly, Simpson and King (1999) explore health-related and organizational religious activities in an Appalachian community. The authors discover some cultural issues in the development of religion–health partnerships. They affirm that partnerships between religious groups and health caregivers are a channel for health promotion efforts among vulnerable populations; as such, they have to be approached from the culture of the community. Furthermore, an ethnographic, exploratory study of health-related and organizational activities among non-mainline religious groups produced the use of prayer requests, anointing, testimonial, and denominational links as potential health resources. Decisions made in the organization were guided by congregational consensus and theological interpretation. The communal place of worship, which serves as an informal resource to a community of believers, especially the vulnerable, was a practical model for religion–health partnerships in central Appalachia. Implications for nursing practice, education, and research also were addressed.

Curlin and Hall (2005) acknowledge that debate about whether and how religious concerns emerge have started from inadequate terms. Discussed is a model of dialogue: religion as a form of therapeutic technique, whereby one stranger, the physician, engages another

stranger, the patient. Curlin and Hall (2005) believe that dialogue regarding religion could be better approached as a form of philosophical discourse about ultimate human concerns. They insist that such moral discourse is frequently essential to the patient–physician relationship. Instead of shying away from such discourse, physicians should be encouraged to engage patients about their religious concerns under the guidance of ethic of moral friendship, which seeks the patient’s good through wisdom, candor, and respect.

Gijsberts, Liefbroer, Otten, and Olsman (2019) focus on spiritual care in palliative care in Europe. These authors note that spiritual care is viewed as attention to spirituality, presence, empowerment, and bringing peace. Their research shows that several studies have reported positive effects of spiritual care, such as easing of discomfort. There is growing evidence that spiritual care at the end of life is of great importance to patients, as well as that patients want their health professionals to provide this type of care. Spiritual care is seen to be an intrinsic and essential component of palliative care. It has been recognized and included in the WHO definition of palliative care for almost fifteen years. Contrary to this positive effect and the positive view of spiritual care in palliative care in Europe, Gijsberts et al. (2019) aver that evidence for spiritual care is still low. What is required for implementation of spiritual care in palliative care is development of spiritual competency that includes self-reflection and visibility of spirituality and spiritual care, all of which are required from spiritual counselors who participate in existing organizational structures.

In her research, Kline (2011) demonstrates that scholars have directed their focus to the interrelationship of religion, spirituality, and health. Her findings show the effects of prayer and religious involvement on well-being. Moreover, she notes that communication researchers have also begun to study these relationships. She analyzes religious health testimonies and how

testifiers use religion to maintain their health. Testimonies from two periodicals across two years (2008–2009) were analyzed (N = 225), and six themes were uncovered: practitioners' provision of relief, love, and reassurance; affirming a conception of God and spiritual law; affirming one's spiritual identity; delegitimizing disease and injury; attaining a spiritually based understanding about health; and expressing love and gratitude. Comparative research on religious testimonies may help to explicate how communication facilitates the spirituality–health connection.

Warner, Carmen, and Christiana (1989) examine the role of spirituality in patient care for persons with AIDS. These scholars assert that it is not uncommon for persons with AIDS to be drawn closer to their spiritual beliefs. According to them, this claim is evident from a survey carried out among 24 AIDS patients, in which these patients expressed their beliefs in a caring, higher power; the value of life; the importance of support from religious laypersons and close friends; and living an ethical life. More so, they expressed the importance of facing death and the presence of inner peace in identifying meaning in their lives.

Some of the important themes in the findings made by scholars ranged from how religious faith affects spiritual satisfaction and well-being in the course of health interaction, to how patients use religion and spirituality to achieve better psychological adjustment. Ellison's (1983) article, "Spiritual Well-Being: Conceptualization and Measurement," clearly captures this. His study further negates attempts to vitiate the importance of religion to healthcare.

More themes emerged in other studies, such as that by Carson et al. (1990). These authors explore the dimension of spiritual well-being as it pertains to better coping among patients coping with chronic diseases, such as AIDS. They reveal the tendency for patients with HIV to cling to their religious faith as a way to sustain hope and cope with this terminal illness. They aver that hope is communicated through spiritual counseling, preaching, and community support.

Included in this venture is Carson (1992), who looks at the relationship between spiritual well-being and hardiness among HIV-positive patients in a way similar to Warner et al. (1989) in their focus on HIV patients vis-à-vis religion and spirituality.

Also, among those who have looked into the role of religion and spirituality in coping with chronic illness are Holland et al. (1999). They conclude that as far as health communication goes, there is a tendency of chronically ill patients to associate feelings of well-being, as well as better management of anxiety, fear, and acceptance of death attitudes in life-threatening situations, to their religious spirituality and religious convictions. On the other hand, Puchalski's (2001) article, "The Role of Spirituality in Health Care," besides examining the role of spirituality in healthcare, also looks at how medicine has turned from being a caring, service-oriented model to a technological, cure-oriented model. He views this tendency as the reason for neglect of the spiritual aspect of healthcare.

Scholars such as Blaine et al. (1998) examine other themes, such as the relationship among religious beliefs, self-concept, and psychological adjustment. On their part, Robinson and Nussbaum (2004) review the social support dimensions of religion as a means of coping and the relation between church attendance and elder health. Scholars like Keeley (2004) took this investigation to a different dimension. Keeley (2004) was concerned about showing that end-of-life communication is important to surviving family members who seek the opportunity to have a final conversation with a dying loved one, just as it is also for the dying person. Some scholars examine the role of faith-based organization in the delivery of healthcare. Kraus (1989) focuses his study on African Americans, while Gijsberts et al. (2019) focus their research on spiritual care in palliative care in Europe. Kraus (1989) examines whether involvement in religion helps to reduce the negative impact of stressful life events among Black Americans. In addition to the

scholars discussed previously, some communication scholars have written articles that focus more on examining religious spirituality and its relevance to behavior change, healthier lifestyle, and mental health, while showing their pertinence to healthcare communication. The next section is a review of their works.

Religious Spirituality Vis-à-Vis Mental Health, Behavior Change, and Healthier Lifestyle in Relation to Healthcare Communication

As indicated earlier, Koenig (2012) is one of the major communication scholars that have produced works attempting to trace the congruence among medicine, health, illness, and religion. Koenig (2012) he starts by offering a brief historical background on religion/spirituality, showing its relevance to or influence on mental and physical health. His review research focuses more on religion/spirituality and health behaviors, such as physical activity, cigarette smoking, diet, and sexual practices. He maintains that religious spirituality helps people to cope with a wide range of illnesses or in a variety of stressful situations. These include people dealing with general mental illness, chronic pain, kidney disease, diabetes, and pulmonary disease.

Koenig (2012) believes that religious spirituality can provide an indirect sense of control over stressful situations. People are able to do this by believing that God is in control and that prayers can change situations, which accords the person a greater sense of internal control, instead of the person depending on external agents of control, such as powerful people. Finally, Koenig (2012) assesses the relationship between both positive and negative outcomes of religious spirituality on health. Positive outcomes include well-being, happiness, hope, optimism and gratefulness, and negative outcomes include depression, suicide, anxiety, and substance abuse.

As it concerns healthcare communication, Koenig (2012) maintains that religious doctrines influence health decisions and health behaviors: “In the Judeo-Christian scriptures, for example, there is an emphasis on caring for the physical body as a ‘Temple of the Holy Spirit’” (1 Corinthians 6:19–20) (Koenig, 2012, p. 1). There is also emphasis from other religious traditions on a person’s responsibility to care for and nourish his or her physical body: “Behaviors that have the potential to harm the body are usually discouraged. This is reflected in teachings from the pulpit and influences what is considered appropriate within religious social groups” (Koenig, 2012, p. 8). Most major world religions communicate morals of behavior that can, in fact, influence change in behavior, while positively impacting health outcomes.

In another work, Koenig (2007) discusses the doctor’s role in dealing with the spiritual needs of disaster survivors. While admitting that physicians are not clergy or spiritual care experts, he maintains there are at least six reasons why physicians should communicate with patients regarding spiritual issues. The first major reason, according to Koenig (2007), is that many patients are religious and, therefore, want their physicians to be aware of their religious or spiritual backgrounds. Second, many religious patients use these beliefs to cope with stressful events. Third, patients may be at least temporarily isolated from their religious communities in healthcare settings, and alternative means of addressing spiritual needs should be provided. Fourth, religious beliefs can influence medical decisions and conflict with medical care, which could affect compliance. Fifth, religious involvement may impact mental and physical health outcomes. Sixth, religion may affect the support and care that patients receive in the community. Koenig (2007) then declares that each of these factors can directly influence the healthcare and health outcomes of disaster survivors. Additionally, there are usually not enough chaplains to deal with these issues in the event of a catastrophe or even in a non-disaster setting.

Ellison and Levin (1998) admit that “interest in the religion-health connection has grown markedly in recent years, by virtually any indicator” (p. 700). Thus, they examine the medical and epidemiologic research on religious factors, physical health, and mental health. They also attempt to identify the most promising explanatory mechanisms for religious effects on health, while investigating more deeply the relationships between religious factors and the central constructs of the life stress paradigm. They find that high levels of religious involvement are moderately associated with better health status among those of different racial and ethnic backgrounds, and among a wide range of religious groups. Succinctly put, “it appears that religion, in a broad sense, represents a protective factor that offers a small but significant primary-preventive effect against morbidity in populations” (Ellison & Levin, 1998, p. 701). As the findings relate to health communication, they reveal that social relationships or participation in religious communities, religious attendance, and religious guidance reduced depression in a prospective study of Mexican Americans, while African Americans who attend religious services more than once a week and who report receiving a great deal of guidance from religion in their daily lives enjoy reduced psychological distress, as well as reduced risk of major depressive disorders. All of these are possible through messages that discourage certain health risk behaviors and encourage positive ones.

In related research, Ellison and George (1994) affirm that according to evidence, various dimensions of religious involvement could improve subjective states of well-being and longevity, lower levels of depression and psychological distress, and reduce the risk of certain types of serious chronic illnesses. In addition, religious practices and belief systems may offer a sense of meaning, coherence, and self-esteem. The health message is shown here to be possible through social, relational, and participatory communication among religious communities. This

type of message is geared toward fostering positive health behaviors, as well as reducing the risk of other stressful events and conditions. People who belong to religious groups develop more friendship networks and enjoy more frequent interactions with network members more than “the unchurched counterparts” (Ellison & George, 1994, p. 47). In essence, this type of interaction ensures more positive health outcomes among the members of this religious group than for those who do not belong to the group.

As for Soweid, Khawaja, and Salem (2004), their research looks at the association between religious identity and the smoking behavior of adolescent university students in Beirut, Lebanon. According to these authors, the overall findings suggest that functional religiosity in late adolescence may assist in promoting health and decreasing morbidity of both men and women. The implications for future research in this area were also discussed.

Cole-Turner’s (1999) work discusses the importance of providers of genetic services being broadly aware of the role that religious beliefs can play in public knowledge and understanding of genetic information and of the choices that are posed. In this regard, Cole-Turner (1999) identifies three religious themes that usually arise when people who are religious, particularly Christians, are involved in genetic testing and presymptomatic diagnosis. The first theme, according to him, is fate and freedom, which leads to the prediction that religious people will be less likely than others to assign fatalistic or deterministic powers to genes but will want to maintain room for human and divine freedom; perhaps they will err too much in this direction.

The second theme that concerns the religious community indicates that religious people will experience a tension between the need for genetic privacy and the desire to share personal concerns with their faith community. The third theme is that the religious regard the unborn with respect, even if not all regard the fetus as a person. Those who accept abortion for genetic

reasons are likely to grieve the loss and look for rituals to mark the value of the life that was not continued.

Parrott et al. (2004) investigate the role of religious faith on behavioral outcomes associated with information about genes and health. Once more, their investigation reveals the use of extrinsic and intrinsic religiosity in dealing with the role of genes in health. Extrinsic religiosity functions as a social resource that provides information or assistance through direct communication:

Extrinsic religiosity may impact individual beliefs about the role of genes in health based on exposure to the opinions and experiences of faith-based leaders and community members. Intrinsic religiosity functions as a personal resource associated with cognitive and emotional functioning. (Parrott et al., 2004, p. 30)

This may provide a coping mechanism in association with information about genes and health.

Hamilton and Rubin's (1992) research examines how religiosity affects attitudes and behavior, as well as influences television use. By looking into the social-psychological communication perspective, which seeks to explain media behavior choices and consequences (it is an approach that is consistent with uses and gratification theory), they try to explain the nature and consequences of religion in people's lives, finding that religiosity "helps to structure cognitions by which people approach communication and construct their realities. It reflects religious beliefs and practices, such as theological outlook and devotion" (Hamilton & Rubin, 1992, p. 667). Religious beliefs affect individual attitudes and behavior. For example, religious conservatives and nonconservatives differ in their television viewing motives, their choice of programs to watch (e.g., programs that contain sex and violence), and general TV attitudes. Hamilton and Rubin's (1992) analysis demonstrates that religious conservatives, when compared

with nonconservatives, were less motivated to watch television as a result of the sexual appeal characters. In this respect, they watched fewer programs with sexual content and felt that television was less important in their lives. In other words, their religious belief determines the choices they make regarding what they feed their minds with. This attitude is presumably good for a healthier lifestyle, including spiritual, mental, and psychological health.

Weaver, Flannelly, Flannelly, Koenig, and Larson (1998) review quantitative research studies, carried out between 1991 and 1995, in three major mental health journals. They reveal that approximately 10% of these studies comprised a measure of religion or spirituality. The results of these findings further suggest that “mental health nursing research is more sensitive to the role of religious-spiritual factors on mental health than research in related disciplines” (Weaver et al., 1998, p. 264). This indicates that religion and spirituality are significant factors in the lives of most Americans, as they provide meaning, support, and affiliation. A considerable number of professional nurse personnel have called for more clinical attention to and consideration of spirituality and religion within their specialties. Part of the responsibility for this interest in religion and spiritual practices in the nursing literature may be attributed to recognition by the nursing profession that, in the context of patient–caregiver interpersonal communication, large numbers of individuals to whom nurses provide care show a tendency to take recourse in their faith as a means of coping with their physical and mental health problems.

On the other hand, Miller and Ngula (2013) observe that church doctrine regarding sexual behavior has long been assumed to have an impact on some aspects of the sub-Saharan AIDS epidemic, while Pentecostal churches have a stronger influence on the sexual behavior of their adherents. Nevertheless, few studies have focused on investigating the denominational differences in sexual attitudes and behaviors of youth. It was discovered that Pentecostal and

Evangelical churches offer more teaching about sex to their youth and appear to provide a more intense experience of community than the mainline churches. The implication for health communication of this research is that religious and spiritual messaging that encourages a moral approach to sexual behavior has been found to exert a positive influence on sexual behavior among the youth in Nairobi, Kenya.

As I come to the end of this section, a quick review of some of the prominent themes that have emerged from the writings of some eminent scholars is once more pertinent. For instance, Koenig (2012) and Soweid et al. (2004) tried to trace the pertinence of medicine, illness, and health to religion by looking into health-relevant behaviors. Such behaviors include activities like cigarette smoking, sexual practices, and diet. These scholars also examined how religious doctrines and teachings help in health decision-making, which, ultimately, influences one to adopt a healthier lifestyle and behavior change. Most world religions, of course, teach moral behaviors, which lead followers to healthier choices.

Ellison and Levin (1998) direct their own research to religious factors, and the relationship of these factors to physical and mental health. They lay out their ideas in the article “The Religion-Health Connection: Evidence, Theory, and Future Direction. Health Education and Behavior.” It is their belief that high levels of religious involvement are moderately associated with better health status among different racial backgrounds. Similarly, Ellison and George (1994) found that religious involvement helps to improve states of well-being and longevity and may offer a sense of meaning. Another important theme could be traced to Cole-Turner (1999) and Parrott et al. (2004). They focused on examining the role that religious beliefs can play on public knowledge and understanding of genetic information. On the other hand,

Hamilton and Rubin (1992) directed their own research to explore how religiosity affects attitudes and behavior, especially with regard to television viewing.

Given the diverse articles and books, as well as the numerous approaches taken by different scholars in discussing the intersection of religious spirituality/faith in relation to medicine, healthcare, and health communication, that have been reviewed in this chapter, one cannot deny the fact that the field of communication has woken up to the reality of this need. It has become a bona fide area of study among communication scholars. It is my belief that further incursions will be made as new issues continue to emerge in the area of medicine, healthcare, and religion.

Summary

We learned from Chapter 1 and Chapter 2 of this project that despite numerous efforts by the Western biomedical model to separate religion and spiritual care from medicine and healthcare, these entities have persistently stuck together. Evidence of this abounds throughout human history. As such, there is no denying the fact that all major religions—Christianity, Islam, Buddhism, and Hinduism—view religion and spiritual care as very vital components of holistic healthcare. In essence, religion should also constitute an integral part of health communication discourse. Moreover, it has been noted that all great religions of the world call human beings to transcendence as the path to the highest level of well-being. Additionally, this clamor for spiritual care as an integral part of caregiving is made all the more compelling by patients themselves, who demand holistic care. Moreover, some healthcare providers have equally demonstrated the importance of their faith as a guide in carrying out their mission of providing care.

Putting the above arguments into perspective, therefore, the exigency of combining physical and spiritual care in providing healthcare, as seen throughout history, has put into the limelight the failure of this field of study to gain decisive entrance into the academic mainstream. In other words, this failure has called into question the apparent negligence by scholars, but especially by communication scholars, to carry out research and discourse on the intersection of religious faith, spirituality, medicine, and healthcare. Accordingly, interest in this area has recently developed and started to gain traction among scholars of different walks of life, especially communication scholars. This has resulted in the production of many articles and some books dealing with different aspects of this intersection. The focus of this research has been multifaceted, tracing the intersection of religion, medicine, and health to different dimensions of healthcare communication. This chapter has, therefore, attempted to focus on some of the works of these scholars. To facilitate understanding, it started by clarifying some important terms that were prominently featured therein: religiousness, spirituality, health, and healthcare communication.

Some eminent scholars, such as Koenig et al. (2012), have written articles focusing on the history of the congruence of religion, medicine, and healthcare. Miller (2011) has also been versatile in her research, dealing with health communication in faith-based contexts and organizations, tracing the role of spiritual communication in health and healing. However, others have examined this intersection from the dimension of the role played by culture in healthcare communication and how people from different cultural backgrounds understand health and illness. For others, it was religious satisfaction and spiritual well-being as very important means of coping with chronic and debilitating illnesses, be it physical, mental, or psychological adjustment. Some scholars wrote articles reflecting the influence of religious spirituality in

relation to a healthier lifestyle and behavioral change, including how religious spirituality exerts influence on media content consumption. For some, their research was directed at examining how faith-based communities serve as platforms for social support and advancement of better health. As a result, health communication is carried out through religious involvement, as well as through relational encounters of members who use prayers, counseling, and teaching ministries to support one another. In this respect, communicating religious doctrines to members influences their health decisions and health behaviors and, in the long run, leads to more positive health outcomes. With this in mind, the next and final chapter of this project will then examine different religious coping strategies.

Chapter 4:

Questioning Religious Practices in Healthcare Versus Forms of Religious/Spiritual Coping:

Relationship to Healthcare Communication

Chapter 3 examined the works of different scholars that highlight the intersection of religious faith, spirituality, medicine, and healthcare, and their relevance to healthcare communication. This examination revealed that in spite of the belief by some scholars that biomedical science and technology hold the answers to all of our human medical conditions (given the enormous biomedical scientific breakthroughs), the role of religion in medicine, health, and caregiving cannot be undermined. The iron-clad conviction of some scholars and medical professionals in the unilateral sufficiency of biomedical science and technology in restoring holistic health to humans serves as a motivational factor for them to undermine, or even outrightly deny, the role of religion in coping with illness. Perhaps this absolute neglect of the religious or spiritual role in the coping process of illness is also responsible for why scholars have neglected research in this area, until recently. However, Pargament (1997) underscores the inherent irony in this situation, because practical evidence abounds of the significant relationships between spiritual or religious coping during illness and its positive health outcomes.

Larson and Mathews argue in favor of the importance of spiritual and religious interventions in medical practice. They hope that, with time, there will be a tearing down of the wall that separates medicine and religion. Additionally, they affirm that the “medicine of the future is going to be prayer and Prozac” and recommend that clinicians ask, “‘What can I do to support your faith or religious commitment?’ to patients who respond favorably to questions about whether religion or faith are helpful in handling your illness” (as quoted in Sloan et al.,

1999, p. 664). To overlook this need in caregiving is to overlook a very important aspect of a patient's overall wellness process.

The views expressed by Mathews and Larson (see Sloan et al., 1999) corroborate Parrott's (2004) idea. For Parrott "individual predisposition to think, feel, or act based on belief in a spiritual power greater than humans affecting the course of nature, and the role of humans within that realm has far-reaching health effects" (p. 1). Parrott (2004) has, of course, shown deep interest in tracing the intersection of religious faith and spirituality as related to healthcare communication. She reveals that "literally hundreds of published empirical studies have explored relations between religion and physical health. One review in the early 1990s found more than 300 studies in a range of fields that included epidemiology, gerontology, and the behavioral sciences" (Parrott, 2004, p. 1). Parrott (2004) further demonstrates a firm belief that "religious faith and spirituality often direct thoughts, feelings, and actions of many of us, giving life and—as Keeley affirms—death meaning" (p. 3). In this vein, religious faith cannot be ignored as an important aspect of the coping process.

Some scholars have also joined Parrott (2004) in discussing religious coping in relation to health communication. Egbert et al. (2004) for instance, have observed that "coping is already a topic of interest for communication researchers, for example, those who study breast cancer survivors . . . or bad news delivery" (as quoted in Parrott, 2004, p. 16). They believe that communication research on coping would be remiss if all possible avenues used by individuals in their healthcare encounters were not considered when dealing with health-related events.

What, then, is coping? Coping has been defined by Lazarus and Lazarus (1994) as "what we do and think in an effort to manage stress and the emotions associated with it" (p. 152). As with religiosity, coping is further conceptualized as an intrapersonal process, an effect, or an

outcome of a particular emotion. Additionally, these authors refer to coping as “the self-management of emotion” (Lazarus & Lazarus, 1994, p. 152). On his part, Pargament (1997) has defined coping as efforts to understand and deal with life stressors in ways related to the sacred. The term “sacred” here refers not just to the traditional notions of God, divinity, or higher powers, but also to other aspects of life that are associated with the divine.

For Lazarus and Lazarus (1994), during times of stress, some people tend to cope individually. However, many individuals turn to members of their social networks for help when confronting stressful circumstances like chronic illness (Burleson & Goldsmith, 1998; Goldsmith, 2004; Peterson, 2011). In instances when individuals tend to seek help from others, coping becomes an interpersonal process that focuses on the communication between individuals, rather than individual psychological behaviors (Goldsmith, 2004). Such an interpersonal communication process can take place among faith-based groups. In addition to serving religious and spiritual needs geared toward holistic healing, these faith-based groups also serve as a social network, where members can take recourse in each other’s social and moral support.

However, not all scholars believe in the efficacy of religion as a contributor in achieving holistic caregiving and healing. Thus, in this chapter, I will first briefly examine the arguments of those who deny this role of religious faith in coping with illness. Then, I will examine different strategies of religious or spiritual coping while showing their relationship to healthcare communication.

Arguments Questioning the Efficacy of Religious Practices in Coping with Illness and the Healing Process

While some scholars question the efficacy or role of religious practices and rituals in coping with illness, others outrightly deny or undermine their effectiveness or usefulness. One such scholar was Sigmund Freud. Freud (1961-a) was notably hostile to religions, especially Christianity, in his practice of psychotherapy. As an atheist, he considered God to be an illusion. The idea of God, for him, is based on man's infantile need for a powerful father figure: "Everything was the son-father relationship. God was the exalted father, and the longing for the father was the root for the need of religion" (Freud, 1961-a, p. 28). Freud expatiates on this further:

As we already know, the terrifying impression of helplessness in childhood aroused the need for protection—for protection through love—which was provided by the father; and the recognition that this helplessness lasts throughout life made it necessary to cling to the existence of a father, but this time a more powerful one. (as quoted in Weissner, 1984, p. 85)

Freud also believed that religious doctrines are illusions, delusions, and unsusceptible of proof, necessary only to help restrain us from violent impulses earlier in the development of civilization. In Freud's words, "Religious ideas, therefore, are in essence illusions. They are enunciated as dogmatic teachings rather than as the product of experience or of argument and proof" (as quoted in Meissner, 1984, p. 85). For Freud, therefore, religion can be set aside in favor of reason and science. As Weissner points out, "Freud contends that the teachings of religion violate the principles of reason and thereby forego any claim to acceptance" (Weissner, 1984, p. 91). Freud affirms that dogmatic religious training is a contributor to weakness of

intellect, because it forecloses inquiry. As far as Freud was concerned “nothing can withstand reason and experience, and the contradiction which religion offers to both is all too palpable” (as quoted in Weissner, 1984, p. 54). Freud compared prayer and religious ritual to obsessive acts of the neurotic, considering religion’s role in the process of healing as sickness itself. So, despite his obvious misgivings about religion, he continued to demonstrate a compulsive fixation on religion, even though it was from a negative perspective.

Freud (1959) states,

I am certainly not the first person to have been struck by the resemblance between what are called obsessive actions in sufferers from nervous affections and the observances by means of which believers give expression to their piety. The term ‘ceremonial,’ which has been applied to some of these obsessive actions, is evidence of this.” (as quoted in Strachey et al., 1959, p. 117)

He maintains that people who perform obsessive actions or ceremonials belong to the same class as those who labor under obsessive thinking, ideas, impulses, and the like: “Taken together, these form a particular clinical entity, to which the name of ‘obsessional neurosis’ . . . is customarily applied” (quoted in Strachey et al., 1959, p. 117). The patient carries out these obsessive actions in a methodical way. Although they may appear meaningless to us, they are not meaningless to the patient, who seems incapable of giving them up, “for any deviation from the ceremonial is visited by intolerable anxiety, which obliges him to make his omission good” (as quoted in Strachey et al., 1959, p. 118). This means, in essence, a kind of making up for his deviation.

According to Strachey et al. (1959), Freud believes that seeing where these resemblances lie (that is, resemblances between neurotic ceremonials and the sacred acts of religious ritual) is easy. They are evident in the qualms of conscience exhibited by the practitioners of these rituals.

In other words, these practitioners exhibit qualms when they neglect the practice of these ceremonials and exhibit conscientiousness in every detail of the performance when they perform them. Moreover, this is also evident in the sense of guilt they feel as a result of continual temptation and the expectant anxiety in the form of fear of divine punishment. Therefore, Freud, according to Strachey et al. (1959) equates obsessive neurosis to religious practice, arguing that in religion, there is also a displacement of psychical values, where petty ceremonials of religious practice gradually become an essential thing, to the detriment of the underlying thoughts that are pushed aside. Hence, he calls for a religious reform that will work retroactively and is directed at a reestablishment of the original balance of values.

As far as communication is concerned, the implication for Freud's theory is that thoughts and discourses about God, as well as religion and its practices, are not motivated by rationality and logic; instead, they are driven by emotion. They are dogmatic teachings that are not the product of experience, rational argument, or proof. These human thinking and communicative behavior processes with regard to God and religion shut off the intellectual capacity and foreclose scientific inquiry and experience. Viewed in line with this Freudian approach, one can confidently infer that further inquiry into the role of communication concerning religion in coping will be highly compromised and discouraging. Anyone claiming to engage in it may as well be engaging in a fruitless venture. This is because religious thoughts and practices (according to Freudian description) are neurotic engagement.

Freud is not alone in his cynical outlook concerning the employment of religious/spiritual practices as a coping strategy during illness. Ellis (1980) equally propagates a negative view. While his thoughts seem to synchronize with those of Freud, he tends to take his convictions to yet another level with what he calls "clinical humanistic-atheistic values" (Ellis, 1980, pp. 635–

639). Ellis (1980) purports that clinical humanistic-atheist values are ideologies that are widely held by most modern psychotherapists. Ellis (1980), who describes himself as a probabilistic atheist, outlines probabilistic atheistic hypotheses on psychotherapy and religion. He believes that devout, orthodox, or dogmatic religion (otherwise called religiosity) correlates with emotional disturbance in a significant way. Ellis (1980) is convinced that most people who believe in religion believe in such health-sabotaging absolutes, while emotionally healthy individuals are flexible, open, tolerant, and changing. This is not the case with the devoutly religious. In addition, to Ellis (1980), what is often regarded as religion, theism, or ultimate concern may be compatible with mental and emotional health. Also, the elegant therapeutic solution to emotional problems should have no relationship with religion, and although most religions embrace moral rules of conduct, there is no intrinsic correlation between religion and morality, for one can be a highly moral atheist or a distinct immoral religionist. His views, therefore, reject the efficacy of religious practices in positive health outcomes.

Watters (1992) is another scholar whose negative views regarding the efficacy of religious or spiritual practices in healing cannot be overlooked. Watters (1992) did not only deny the efficacy of religious and spiritual practices in the healing or coping process, but also goes as far as to associate Christianity with sickness, examining links between Christian doctrine and human suffering:

In all human cultures, in all ages, the state of “being ill” has been associated with fear and superstition, each culture developing its own causal explanations for the various illness states as well as its own treatments and “cure.” Such explanations were always reflections of that culture’s religious beliefs, ecological concerns, and its stage of economic and scientific development. (p. 13)

Moreover, he believes that “the connection between faith and healing has never been documented in any scientific study; indeed, faith healing has been roundly discredited by the famed debunker of the paranormal, James Randi” (Watters, 1992, p. 15). He argues that Christianity’s influence actually militates against human development in such vital areas as self-esteem, social interactions, and sexuality. The end result of this Christian conditioning is often anti-social behavior, sexual dysfunction, anxiety, poor psychological development, and some major psychiatric illnesses.

Watters (1992) invites us to take a fresh look at some of the roots of many human ills: “We contend that they may in fact lie in the deeply indoctrinated notions of the Christian church acting on men and women, generation after generation” (p. 16). He attempts to relate Christianity to sickness by establishing a connection between Christian attitudes about anger and peptic ulcer. According to Watters (1992), research into the causes of peptic ulcer has conclusively revealed that an inability to express anger in a healthy, adaptive manner directly contributes to the development of ulcers. In his words,

for centuries, Christianity has taught that anger is one of the seven deadly sins, an attitude that has been driven deeply into Western child-rearing practices, thus making it difficult for a child to learn healthy approaches to this normal human emotion.” (Watters, 1992, p. 16)

He proposes an individual’s innate humanism (innate human power or ability in contradistinction to divine powers) as an antidote to what he regards as toxicity from religious indoctrination. The humanism that he proposes includes the ability to remain skeptical in the face of all supernatural phenomena, while, on the contrary, encouraging promotion of the human person in all its ramifications. Watters’s (1992) view explains the reason why some health professionals believe

that “religious involvement lies at the root of emotional disturbance, low self-esteem, depression, and possibly even schizophrenia” (Koenig, 2000, pp. 388–389). Watters’s (1992) view totally negates reality that lies beyond human knowledge, as he bases all forms of truth on human experience.

Koenig (2000) argues that there are many reasons, though, why mental health professionals associate religion with mental illness. One reason is that mental disorders, such as schizophrenia, acute mania, or psychotic depression, often present with abnormal religious beliefs. For instance, the person with acute mania acting under delusion believes that he or she is God or some other divine being with unusual powers. On the other end of the spectrum, we have the schizophrenic who “hears voices from divine or demonic sources telling him or her to perform tasks or behave in a certain manner” (Koenig, 2000, p. 389). On his part, the psychotic depressive, saddled with religious guilt, is convinced that he or she has committed the unpardonable sin and, therefore, is forever doomed. In addition, the obsessive compulsive repeatedly performs detailed and time-consuming religious rituals to obtain absolution from real or imagined transgressions.

Further explanation, according to Koenig (2000), reveals that “even the textbook of psychiatric nomenclature and categorization—the *Diagnostic and Statistical Manual of Mental Disorders* used religious examples for years, to illustrate cases of serious mental illness” (p. 389). This tendency to compare religion to mental illness has, in fact, fractured the relationship between some health professionals and certain religious groups, so much so that some religious groups have distanced themselves from psychology and psychiatry. Some see religious belief and activity as necessary and possibly sufficient for mental healing. Some even go as far as to advocate for complete avoidance of contact with the mental health profession. Koenig (2000)

claims that the Church of Scientology, which has a Citizen's Commission on Human Rights "dedicated to exposing and eradicating criminal acts and human rights abuses by psychiatry," is perhaps best known for their aggressive stance toward psychiatry (p. 389). Additionally, Koenig (2000) observes that Christian writers, such as Martin and Diedre Bobgan and Jay Adams, advocate for the avoidance of all forms of secular psychotherapy—of course, this is an extreme position— although they are less opposed to the use of psychotropic medication for severe mental disorders.

In relation to health communication, scholars such as Freud, Ellis, Watters, and others of their ilk have tended to view religion in a negative light. It would, therefore, be apt to surmise, given the trend of their arguments, that health communication must be amply and unilaterally biomedical, in the sense that it should discourage religious communication in the patient–caregiver relationship; they negate the religious aspect of healing. For instance, they tend to completely reject the role played by spiritual counseling in the healing process. By so doing, they often also ignore the relational support network that members of a religious group bring to each other. Propst (1988) stresses that the *imago Dei* (image of God)

is reflected in our relationship to each other. Humanity is beings in covenant with each other. As we relate in wholeness to each other, and allow ourselves to be known as we know, we reflect the image of God that was manifested in Jesus. . . . If these encounters are whole, we will be whole. If these encounters are fractured, ineffective, or artificial, the image of God within ourselves becomes marred. (p. 176)

In essence, Propst (1988) views human encounters as necessary for the attainment of wholeness (good health), while its fracture brings about the opposing result.

In this section of the chapter, we saw scholars such as Freud, Ellis, and Watters who tried to deny the role of religion in medicine and healthcare. Freud saw the idea of God as an illusion, while religious practices in regard to healthcare, in his view, are obsessive actions of the neurotic. Religious principles for him stifle reason and intellect and must be debunked. Whereas Ellis believes that dogmatic religion correlates with emotional disturbance, Watters associates Christianity with sickness. In the face of these negative views, the implication is that religious or spiritual communication as contributory to wellness does not stand a chance. However, these opposing views of the role of religion or spirituality in regard to healthcare have been countered by scholars who have explored diverse religious coping methods. Their suggested coping methods have enormous positive and negative outcomes. I will examine these in the next section.

Forms of Religious or Spiritual Coping During Illness

Contrary to the negative positions questioning the positive roles played by religion in the healthcare of the sick, there is a growing tendency to view religious coping during illness as vital element in the provision of healthcare. Works of certain authors, such as Sloan et al. (1999), offer information that attests to this growing trend. Sloan et al. (1999) observe as follows: “As interest in alternative and complementary medicine has grown, the notion of linking religious and medical interventions has become widely popular, especially in the USA” (p. 664). Pargament, Koenig, and Perez (2000) point out that “a number of researchers and practitioners have called for greater sensitivity to, and integration of religion and spirituality into assessment and counseling” (p. 520). In the same vein, research focusing on religious and spiritual coping has captured the interest of communication scholars. For many people, “religious and spiritual activities provide comfort in the face of illness” (Sloan et al., 1999, p. 664). To buttress their point, Sloan et al. (1999) point out that in a poll of 1,000 U.S. adults, about 79% of participants

believed that spiritual faith could help people recover from disease, while 63% believed that physicians should talk to patients about their spiritual faith. They maintain that there have been some articles in U.S. newspapers (e.g., *Atlanta Constitution*, *Washington Post*, *Chicago Tribune*) stating that religion can be good for your health.

Referring to the functional use of spiritual and religious practice such as prayer, Sloan et al. (1999) allege that religion serves a variety of purposes in day-to-day living and in crisis. They argue further that there are other publications that have reported the use of prayer as medical therapy; a good number of inpatients wanted their doctors to pray with them. In the same vein, nearly 30 U.S. schools of medicine include in their curricula courses on religion, spirituality, and health. Thus, “out of 296 physicians surveyed during the October 1996 meeting of the American Academy of Family Physicians, 99% were convinced that religious beliefs can heal, and 75% believed that prayers of others can promote a patient’s recovery” (Sloan et al., 1999, p. 664). In relation to healthcare communication, this occurs in the form of community prayers said on behalf of the patient, seeking divine intervention in the healing process. This form of spiritual practice and counseling not only spiritually and morally uplifts the patient but also offers psychological relief from pain, giving the suffering patient hope.

Furthermore, Pargament et al. (2000) state that when people were asked about how they cope, many mentioned religion as a means of coping with stressful situations. Similarly, Pargament, Smith, Koenig, and Perez (1998) insist that “empirical studies indicate that religious coping is commonly used by many groups in times of stress, particularly the most disenfranchised in society” (p. 710). Some groups, especially the elderly, minorities, and individuals facing life-threatening crises, cite religion more than any other source as a means of coping.

Pargament et al. (1998) note that religious coping is multidimensional. According to them, the types of coping in question are designed to assist people in the search for a variety of significant ends in stressful times. They help to attain a sense of meaning and purpose, emotional comfort, personal control, intimacy with others, physical health, and spirituality. Hence, different religions of the world provide their adherents with a variety of mechanisms for coping in times of stress. A number of religious coping methods have been identified. These approaches have proven to be helpful in understanding the roles played by religion in the coping process.

In this section of the chapter, I examined scholars who have demonstrated the significance of religious or spiritual coping. Sloan et al. (1999) showed that contrary to negative views about religion in relation to healthcare, religion and spiritual activities offer comfort during illness and recovery. This is evident especially among the elderly, minorities, and individuals facing life-threatening situations. Pargament et al. (1998) investigated the multidimensional nature of religious coping. Their findings revealed that major religions of the world provide their adherents with a variety of mechanisms to help them cope with stressful times. In the long run, these scholars have made a successful attempt to retrace the tie that religion has as a coping mechanism in healthcare communication. The next section will help us understand the role of religion in the coping process. I am going to do this by first assessing the important functions of religion in the coping process.

Functions and Methods of Religious and Spiritual Practices in the Coping Process

Sloan et al. (1999) insist that religion serves a variety of purposes or functions in the day-to-day lives of people, especially during critical times. Pargament (1997) tends to agree with this view, insisting that religious coping serves multiple functions, including the search for meaning, intimacy with others, identity, control, anxiety reduction, and transformation. In line with these

views, Egbert et al. (2004) point out that “many researchers now favor a functionalist approach to the study of religious/spiritual and health-related variables—relating more than just if an individual engages in religious practices, but how religion helps an individual cope with life stress” (as quoted in Parrott, 2004, p. 15). Taheri-Kharamah, Zamanian, Montazeri, Asgarian, and Esbiri (2016) argue that not all religious coping strategies are useful in achieving desired health outcomes. In essence, there are two patterns of religious coping: positive and negative. Whereas positive religious coping is thought to be associated with benefits in psychosocial adjustment, negative religious coping leads to poorer outcomes. To this effect, it is considered maladaptive. Positive religious coping has been associated with lowered depression, improved physical and mental health, and reduced mortality (Taheri-Kharamah et al., 2016, p. 15). On the other hand, some coping strategies are also considered to have mixed results (producing both positive and negative results).

Positive religious coping strategies are designed to assist people in the search for a variety of significant ends in stressful times. Positive religious coping can be summed up as what can be described as benevolent religious reappraisals. These include actions and behaviors such as believing that there is meaning to be found in life, as well as finding spiritual connection (seeking a sense of connectedness with transcendent forces) and a sense of spiritual connectedness to others. Other positive religious strategies are religious forgiving (looking to religion for help in letting go of anger, hurt, and fear associated with an offense committed by others against us), religious purification (searching for spiritual cleansing through religious actions), and engagement in religious activities to relieve stress. Additionally, we have the search for spiritual support (seeking comfort and reassurance through God’s love and care, and through

the love and care of congregation members and clergy) and collaborative religious coping (seeking control through a partnership with God in problem-solving).

On the contrary, negative coping methods are expressions of a less secure relationship with God. This pattern is defined by a very different group of religious coping methods. They can be summed up in attitudes such as punitive religious reappraisals and demonic religious reappraisals (one demonstrates a tendency to view an illness as emanating from demonic forces or, worse still, believes an illness to be a punishment from God on account of an individual's sins). Other negative religious coping methods could be in the form of reappraisal of God's powers (redefining God's powers to influence the stressful situation, or waiting for God to control the situation), spiritual discontent (expressions of confusion and dissatisfaction with God), self-directing religious coping, and interpersonal religious discontent.

Whereas positive religious coping strategies are considered to provide better adjustments for patients (closeness with God, relationships with family and friends), negative ones are related to poorer adjustments. Each function is a form of a religious or spiritual coping method, and individuals may employ both of these coping strategies in their quest to find meaning in their lives. However, it is worth noting that individuals do not employ some of these coping methods independently but in combination with others. I am going to explain some of these coping methods more in detail below.

Positive Religious Coping Methods

Positive religious coping, which is characterized by benevolent religious appraisals, reflects a secure relationship with God and is associated with improved quality of life in persons suffering from serious illness or other crises in life. Besides helping one find meaning in life, some other examples of positive religious coping methods are benevolent reappraisal,

congregational network method, relationship with others, spiritual support, and collaborative religious coping. Others are religious forgiveness and purification. These are examined more in detail below. all in relation to healthcare communication. For instance, congregational network method, spiritual support, forgiveness, and even purification all take place in the context of interpersonal relationship. In this type of interpersonal encounter, congregation members meet, engage in spiritual activities, relate, and communicate with one another.

Finding meaning in life. Bearon and Koenig (1990) are of the view that “religion is commonly thought to help people understand the meaning of events, especially those which are painful, troubling, or unexpected” (p. 249). In other words, their faith beliefs form a bedrock upon which they make sense of their difficult life situations as they try to deal with them. This view has already been expressed by Geertz (1966) as Banton (1966) pointed out. According to him, Geertz argues that religion plays an important role in the search for meaning. Faced with suffering and difficult life experiences, religion provides frameworks for understanding and interpretation. Geertz (1966), according to Banton (1966) explains that meaning in stressful situations can be sought in several religious ways, such as redefining the stressor as an opportunity for spiritual growth. Pargament (1997) expatiates on this further by claiming that when faced with stressful life events or some kind of stressful condition, individuals try to find meaning in their situation by translating their general religious beliefs and practices into specific forms of coping. In other words, they try to attribute more positive meaning to their situation.

These specific coping methods seem to have the most direct implications for the person’s health in stressful times. In this respect, Bearon and Koenig (1990) advise that “knowledge of the religious scripts people draw on to make sense of their symptoms may help healthcare providers understand why clients make certain self-diagnoses and decisions about seeking medical care or

complying with treatment regimens” (p. 249). Knowledge such as this helps the caregiver readjust to the patient’s religious needs and can bring about more effective patient–caregiver communication. As a care provider, when communicating with your patients, it is important to think of their religious interests. This is one of the ways of establishing a relationship with them. According to Propst (1988), Christian theologians have discussed “health that is inherent in our relationship with others. . . . Our true humanness is best exemplified by Jesus. He placed himself in solidarity with others. He joined his emotions and feelings to the pain and emotions of others” (p. 31). Therefore, Jesus did not just help and uplift people from their suffering from a distance; he put himself in their place as well. This type of religious identification is one of the ways of pursuing the communicative task of assisted coping.

Being there for the patient is a tactic that has been in use even in counseling. In the patient–caregiver relationship, for instance, Propst (1988) insists that the whole counseling process is a process of mutual speech and hearing. The first task of any counselor is listening. . . . Everyone should be quick to listen, slow to speak, and slow to become angry. Healing in any relationship depends upon each person being heard by the other. The patient must feel that he has been heard and understood; so, the good healer must develop observational skills. (p. 33)

Furthermore, Propst (1988) notes that counseling students are usually surprised to learn that they can obtain much information and understanding just by hearing and watching. True healing only comes when the patient has also been able to hear and understand the healer.

Benevolent reappraisal as a positive coping method. Propst (1988) claims that emotional healing is something craved by every person, because life’s experiences often leave us bruised and fractured. As such, we feel the accumulated stresses ravage our egos and emotions.

In such a situation, life takes its toll on us. Pargament (1997) suggests that such negative events, as well as illness, death, and other losses, are easier to bear when understood within the ambience of a benevolent religious framework. In such a situation, one may engage in what is described as benevolent religious reappraisal, whereby the person in question redefines his or her stressor through religion as benevolent and, therefore, potentially beneficial. This means that one tries to find a lesson from God in a negative situation. In this type of situation, people also draw strength from their belief in God's might and control. For example, when it comes to religious coping for people dealing with chronic sickness, Jenkins and Pargament (1988) claim that when patients suffering from different kinds of cancer were asked about how much they felt God was in control of their illnesses, they ascribed greater control over their illnesses to God. They also reported higher self-esteem and better adjustment, according to the ratings of their nurses. Healthcare communication in this regard is overtly based on religious perspective (a typical example of benevolent religious reappraisal). In this respect, patients are wont to give credit to divine healing, and a less positive outcome is attributed to biomedical effort.

Congregational network as a coping method. In positive religious coping, people are far more likely to see God and the members of their congregation as sources of love and support than as a source of pain and punishment. This entails searching for comfort and reassurance through the love and care of congregation members and clergy. Propst (1988) maintains that we can seek reprieve or healing by finding relationships with others as sources of healing. She insists that when confronted with such a situation,

some of us mentally go through our address book ostensibly looking for someone to spend an afternoon with, play tennis with, or eat dinner with. What we really want is a

healer, a relationship where we can feel acceptance, a relationship where we can get rid of the residues. (Propst, 1988, p. 28)

As a matter of fact, congregational support serves this need as a form of religious coping.

Congregational support network equally involves religious helping, such as asking for prayers from members, attempting to provide spiritual support and comfort to others, and attempting to draw spiritual strength from others. Goldsmith (2004) affirms that “when stresses and hassles challenge our abilities to cope, we frequently turn to family, friends, and partners for help” (p. i). For Propst (1988), “in everyday life this means the relationship between the individual and his friends, spouse, or family” (p. 29). Durkheim (1915) also notes that intimacy with others is often encouraged through spiritual methods, such as offers of spiritual help to others and spiritual support from clergy or congregation members. Religion facilitates social cohesion and offers a mechanism of fostering social solidarity and social identity. The implications for healthcare communication here are (a) that great credit is given to the spiritual relationship as a vital element in positive health outcomes (this type of spiritual support is done in the context of interpersonal communication, such as through prayer, spiritual counseling, and help by the clergy and the congregation members) and (b) that social support, through interaction with family members, friends, and partners, fosters solidarity and promotes healing.

Views similar to Durkheim’s (1915) have also been expressed by some scholars, who maintain that significant numbers of people look to their church or synagogue for support in times of crisis, much more so than to any other professional (Chalfant et al., 1990; Pargament, 1997). This is contrary to the belief that dependence on the clergy for counseling in stressful or difficult times is on the decline. According to this view, secularization and accompanying professionalization are widely perceived to be contributing factors in the declining prestige and

scope of the clergy role in counseling. Additionally, this view holds that historical functions performed by the clergy have been absorbed by other professionals. An example of this loss of function, according to Mills (1985), is the alleged divestiture of counseling from the clergyperson's role. As Mills (1985) puts it, "professionalization in the mental health field has presented a special problem for the clergy as counselor" (p. 305). However, evidence shows that this view cannot be held as a given, because other contradictory views have emerged.

The contrary perspective affirms that a viable and psychologically oriented pastoral counseling movement has been active for more than 50 years. According to VanWagner (1983) and Strunk (1984), "since 1963 a highly professionalized organization, the American Association of Pastoral Counselors has provided pastoral counseling training based on theology and psychology/psychotherapy" (as quoted in Chalfant et al., 1990, p. 306). Indeed, the clergy unarguably play very important roles in helping members of their congregation deal with stressful conditions. Therefore, although there are some disagreements about the amount and type of training needed, it is widely acknowledged that counseling is a vital part of the parish minister's role among the members of his congregation. Chalfant et al. (1990) maintains that research carried out over a period of more than twenty years indicates that

the clergyperson is the most frequently sought source of help for problems of psychological distress. In general, these studies show that about 40 percent of those seeking help for psychological distress prefer going to a member of the clergy over other possible sources of care (p. 306)

These members of the clergy not only provide spiritual care but psychological counseling as well.

Chalfant et al.'s (1990) view is further supported by other scholars. While members of a congregation take solace in each other, the clergy have always played a vital role among congregation members. For example, the spiritual dimension of healthcare is an integral part of the total well-being of both the patient and the caregiver, and spiritual support is a valuable resource for families facing the stressful situation of caregiving for a dependent relative. Members of the clergy or pastoral counselors can fulfill this need. For instance, they can provide emotional and spiritual support for families facing critical decisions related to caregiving for a loved one, such as the decision to institutionalize a spouse, parent, or other relative.

Pargament (1997) claims that some congregations are viewed as second families to those who no longer have kin or friends that are available to care for them. Steinitz (1981) recounts an incident in which one recent widow described how her church became her mainstay:

That very day my husband died, one of the members sent over a huge pot-roast and practically a whole dinner. For two weeks, practically everyday somebody would call up and say, "Expect your dinner at such-and-such a time." . . . When I returned to Laketown (from a visit) a couple from the church picked me up, and the minister called me up regularly to see how I was doing. (as quoted in Pargament, 1997, p. 289).

This type of support falls into the domain of what Goldsmith (2004) calls "enacted social support," which she describes as "the things people say and do for one another" as a way of providing social support (p. 3). Frequent empathetic and emotional communication among members and leadership of a congregation provides a supportive climate for a person going through some crisis or health condition. Much of the social support such individuals receive comes from close relational partners, such as their congregation. The more the person in question shares his or her feelings and thoughts with the members of the congregation, the more he or she

will be able to manage his or her emotions and the stronger the relationship will be that develops among the members. Goldsmith (2004) maintains that “talking about problems with family and friends is important to individual and relational well-being” (p. 1). Equally, the pastor or minister supports members of his or her congregation who are undergoing crisis through prayer, visitation, and encouragement. In this regard, his support is, at the same time, relational, spiritual, and practical. Such a congregational relationship is enacted through interpersonal communication, for, as Propst (1988) notes, healing happens in the context of relationships. The relational dimension includes the pastor or the pastoral team, who assume the role of friend and listener, providing encouragement and support. By doing this, they serve as an outlet with whom to talk and to get emotional and spiritual support. This goes beyond offering the rituals of prayer. It combines prayer with the very practical human dimension of care in the context of an interpersonal relationship.

In discussing the significance of social support in a personal relationship, Gottlieb (1985) notes that “in the coping process, it is the behavioral manifestations of support expressed by my close associates—its materialization in interpersonal transactions that has greatest significance for the course and outcomes of my ordeal” (p. 361). The social transactions through which support is expressed are important building blocks of relationships and of support interventions. In view of these arguments, the efficacy of social support, especially with respect to congregational membership, cannot be overestimated. In this regard, social support has been “heralded as an inoculant by community psychologists who originally viewed it as an environmental commodity that afforded protection when coping demands overtaxed personal resources” (Gottlieb, 1985, p. 352). According to Gottlieb (1985), social support was originally defined as “social integration,” signifying contact with people, either individually or in groups;

“social attachment,” signifying meaningful alliance with at least one close associate; and “prosocial resources,” signifying the several forms of aid that could be rendered by primary group members.

Additionally, empirical studies have looked into the help offered by clergy, leaders, and members of the church during an illness or a stressful time. These studies reveal that support from the congregation is beneficial to its members. In a general sense, the support that members receive from their congregation appears to work in tandem with the spiritual support they get from their faith, both contributing to positive outcomes in stressful times. As Wright, Pratt, and Schmall (1985) put it, “Religion ennobles when it helps one who is himself suffering (as all do) to acknowledge his own humanity and hurt, and in doing so to acknowledge and care for the humanity and hurt of others” (p. 37). In other words, the importance of spiritual support cannot be overestimated with respect to caregiving, because it gives hope, spiritual upliftment, and emotional relief to the suffering patient.

Relationship with others as a form of positive coping strategy. Closely aligned to congregational support network is relationship with other people in general. This form of religious coping strategy encompasses people in general, not just the congregation members. In her analysis of psychotherapy and spirituality in the emotional healing process, Propst (1988) observes that “psychotherapists, regardless of their orientation, consider healthy human relationships to be indispensable for wholeness” (p. 31). In other words, good health has a close relationship with our human connections. Effectively, the importance of our relationships with others for our own self-identities cannot be overemphasized. Propst (1988) describes the counseling process as listening and hearing the other out. Healing occurs in such a relationship, where each person feels heard by the other. This is also applicable in the patient–counselor

relationship, where mutual listening and hearing are absolutely necessary. Acknowledging that our understanding of each other is incomplete should be a motivator for us to engage in dialogue in order to gain greater understanding.

More so, in her work, Propst (1988) refers to Barth (1960) as saying that true humanity consists of gladly rendering mutual assistance to each other, which means that we must place ourselves at the service of the other, as exemplified by Jesus Christ. In the counselor–patient relationship, the counselor must exhibit the desire to render help and must truly care for the patient, while the patient must also freely cooperate with the help that is extended to him or her. Mutual therapeutic healing emanates from mutual assistance. Therefore, a healthy relationship with one another is embedded in mutual and positive interaction, guided by mutual respect.

Spiritual support and collaborative religious coping. Spiritual support and collaborative coping are other forms of positive religious coping. As such, belief in God’s guidance and support during critical times is considered beneficial for coping in times of crisis. According to Pargament (1997), those who have noted a greater sense of spiritual support have been shown to experience more positive outcomes. A study by Wright et al. (1985) offers a good example of how spiritual support helps caregivers of patients with Alzheimer disease wade through their trying times of caregiving. They argue that caregivers need encouragement and support in order to identify and effectively use sources of support.

Wright et al. (1985) argue that a family’s coping resources are acutely tested when a family member is diagnosed with dementia, including Alzheimer disease. As the patient with Alzheimer disease progressively loses his or her memory, he or she becomes totally dependent on the caregiver for his or her basic needs. According to the findings from these authors, caregiving is extremely stressful; the care provider no longer has a life of his or her own, and he

or she has no more identity of his or her own. In their words, “insofar as our self-hood is defined by what we do, the care provider has no opportunity to be anything but a care provider” (Wright et al., 1985, p. 31). This is because as this disease progresses, the patient becomes increasingly dependent on family and natural support systems to provide care. In such a situation, “caregivers are often faced with the prospect of social isolation; lack of time for self, family, and friends; career disruptions; financial drain; and the unresolved heavy physical labor in caregiving” (Wright et al., 1985, p. 33). To this effect, unless family caregiving efforts are augmented and solidified, emotional and physical problems may be perpetuated down through the generations, eventually affecting all members of the family while increasing the social and economic costs to the community. Therefore, it is also important to state that families, friends, and other support networks, such as the pastoral community, need education in order to recognize and respond to the needs of the caregiver and of the patient with Alzheimer disease.

Therefore, by means of questionnaires distributed to 240 caregivers, Wright et al. (1985) intended to investigate caregiver burden and coping strategies, including the extent to which caregivers made use of spiritual support. Of all the strategies examined in this study, results revealed that spiritual support most strongly relates to lower burden scores. This closely ties into healthcare communication, where coping advice and messages are freely exchanged among family members, congregation, and clergy. Advice has been identified as a “helpful form of social support, especially when it was given by those with expertise or similar experience” (Goldsmith, 2004, p. 53). Similarly, Wright et al. (1985) point out that “families who use spiritual support as a coping strategy seek advice from clergy, attend church services, participate in church activities, and express faith in God” (p. 34). Propst (1988) captures this by affirming that “necessary living skills not only involve caring for our own bodies but communicating with

others” (p. 176). She believes that an effective wholeness entails having good communication skills. However, she regrets that many individuals who suffer from loneliness feel helpless in seeking relief from loneliness by forming relationships with others. Thus, Propst’s (1988) counseling is directed toward giving individuals assignments that encourage them to cultivate relationships with others. She sees this as an important part of treatment.

Spiritual support has also been shown to be correlated with reframing, which is an internal coping strategy. Reframing itself is described as the caregiver’s ability to redefine a demanding situation in a way that is more acceptable, so that the situation can be more manageable. On the other hand, spiritual support may allow meaning to be found in the tremendous losses that accompany Alzheimer disease. Wright et al. (1985) cite some of the comments made by family members of a patient with Alzheimer disease, including the following: “Support from others is the most important element for me as a caregiver and faith in God. It is the most rewarding and devastating experience of my life (Daughter, aged 45)” (p. 34). In the same vein, another patient’s wife says, “I have never felt resentful of the time in caring for my husband—only extremely tired at times. Our love is strong. Our faith is in the Lord” (Wright et al., 1985, p. 34). There is no doubt that spiritual support is of vital importance as a coping strategy. Thus, in an almost a hopeless situation, a lot of patients or family members have their faith to hang on to. Indeed, seeking spiritual support entails searching for comfort and reassurance through God’s love and care.

Studies have indicated that among the different coping methods carried out, religious coping behaviors were most popular. Koenig, George, and Siegler (1988) note that trust and faith in God, prayer, and help and strength from God were the most frequently mentioned of these activities. Among the various kinds of prayer distinguished by Clark (1958) were prayers of

petition, confession, communion, intercession, and thanksgiving. He suggests that different kinds of prayers serve different functions for the individual. Other components of spiritual support can be subsumed in the following: emotional reassurance (trusting that God will never permit any bad to happen to me), a close spiritual relationship (seeking God's love and care), and guidance in problem-solving (conviction that God showed me how to deal with the situation). Pargament (1997) affirms that "people who reported more spiritually-based coping also reported better adjustment to life crises. In fact, of all methods of religious coping, spiritually based coping emerged as the strongest predictor of outcomes" (p. 289).

Pargament (1997) observes that another form of coping, collaborative religious coping, is very closely related to spiritual support. In this type of coping, the individual and the divine work together to solve problems. The individual seeks control by partnering with God in order to solve the problem. According to this style, control is understood as derived through a relationship with God (collaborative). Hence, the responsibility of coping resides neither with God nor with the individual alone; instead, it is shared between both. However, since God is a spiritual being, the communication between Him and the patient who is engaging in collaborative coping is divine or spiritual. This type of communication is done through prayer on the part of the patient. On the patient's part, prayer can be carried out through verbal or nonverbal means. Verbal means involve a patient using words to communicate his or her feelings and desires to God, whereas nonverbal means involve reading God's words and discerning God's intention for him or her in a situation. In both means, prayer involves a collaborative relationship—a relationship "created and sustained by some type of spiritual communication" (Baesler, 1999, p. 41).

Just as I have previously reflected, Heiler affirms that prayer "has several characteristics including a living relation, mutual intercourse, conversation, fellowship and communication.

These descriptive words and phrases underscore the essential quality of prayer” (as quoted in Baesler, 1999, p. 40). In essence, prayer is a form of interactive or conversational communication, because it entails speaking and listening to God speak. Besides spiritual and collaborative coping strategies, we also have forgiveness and purification. Both of these are two other dimensions of spiritual coping.

Forgiveness as a form of coping. Waldron and Kelley (2008) claim that “research on forgiveness has been accumulating for more than a decade, but communication scholars, practitioners, and students have yet to fully reap its benefits or shape its direction” (p. vii). Thus, *Communicating Forgiveness* (described as the first book to take a truly communicative look at the process of forgiveness) is an attempt to rise up to this challenge by these two scholars. In this work, Waldron and Kelley (2008) describe forgiveness as “a negotiation enacted through the communication processes of transgression presentation/detection, emotion management, sense-making, forgiveness-seeking, forgiveness-granting, and relationship negotiation” (p. 82). In other words, forgiveness is depicted as a “transgression-driven, relational and morally negotiated process” (Waldron & Kelley, 2008, pp. vii–viii). Forgiveness is generally enacted in the context of interpersonal communication.

Freedman and Enright (1996) have defined interpersonal forgiveness as “an unjustly hurt person’s act of deliberately giving up resentment toward an offender while fostering the undeserved qualities of beneficence and compassion toward that offender” (p. 983). Nevertheless, for Pargament (1997), “forgiving has been described as one of the hardest things in the world to do and one of the greatest of human achievements” (p. 261). Our everyday experiences pretty much attest to this claim, because the hurt that one suffers in the hand of another person is viewed as an act of injustice the victim experiences in the hands of an offender.

By inflicting hurt on a person, the offender creates friction in the preexisting relationship between him and the offended person. Hence, for Freedman and Enright (1996), forgiveness is discussed in the context of deep injustice, in contrast to everyday annoyances. Because forgiveness is essentially a restorative process, an attempt to repair a breach in the relationship between two parties, “the forgiver gives up the resentment, to which he or she has a right, and gives the gift of compassion, to which the offender has no right” (Freedman & Enright, 1996, p. 983). He or she equally gives up the right of retribution, for the sake of closing the moral gap created by the offense. This involves a willingness to see the offender as if that person were not guilty. Corroborating this view, Newman (1987) acknowledges that

the attempts to seek and to grant forgiveness arise from a desire to restore this relationship to its original footing, by transcending or moving beyond the act that caused offense. It follows that the process of forgiveness entails, at very least, a change of attitude, a relinquishing of resentment, and, in some cases, no doubt, additional positive steps toward repairing what has been damaged. (p. 157)

Forgiveness has variously been criticized on account of these perspectives by some scholars, who argue that it can never be a moral imperative, especially when the offender has made no effort to redress the wrongdoing. Otherwise, “granting forgiveness could be tantamount to an outright condoning of the offense, which could lead the offender to repeat such actions in the future” (Newman, 1987, p.158). Viewed in this respect, forgiveness, according to Freedman and Enright (1996), could be considered by some as “morally unwarranted and psychologically unhealthy” (p. 983). Thus, some have described forgiveness as denial, whereby the offended tend to overlook an offense or pretend as if it never happened. People who belong to this group have described forgiveness as condonation, which is a form of excuse or pardon for misdeeds. Such

people would rather argue that it is precisely one's duty not to forgive in order to avoid reinforcing the offender's objectionable behavior. Forgiveness has also been misconstrued as pardon, for when we pardon, we let the perpetrator off the hook to do more damage. Additionally, it has been described as self-serving or a way to "get even by asserting one's moral superiority over a perpetrator" (Pargament, 1997, p. 261). These criticisms are some of the reasons why some people view forgiveness in a negative light.

Given all these opposing views of forgiveness, Freedman and Enright (1996) explain that "in forgiving, the offended realizes that an offender has committed a serious wrong. The offer of lowered resentment and increased compassion are given, nonetheless" (p. 983). Among theologians, philosophers, and a growing number of psychologists, forgiveness is viewed in a more positive light. According to Pingleton (1989), in forgiving, the individual is essentially "giving up the right to hurt back" (p. 27). In the context of coping, "forgiving represents an act of re-creation" (Pargament, 1997, p. 261). Forgiving follows an expression of anger, fear, and resentment after one has been intentionally and unfairly hurt, physically, emotionally, or psychologically. Research has revealed that these negative feelings are tied to heightened risks for grave medical illness, especially coronary heart diseases.

As a way of coping with anger and fantasies of revenge, one develops energy and power. These help to "counteract the feelings of paralysis and loss of control, so often a consequence of personal assault" (Pargament, 1997, p. 261). In relation to hurt is the belief that one is a decent person who deserves better treatment: "The expression of these feelings communicates the person's plight to others and gives them a chance to respond" (Pargament, 1997, p. 261). Actually, forgiveness is designed to effect a radical change that results from a life centered around pain and injustice.

In forgiveness, the offended person pursues the dream of a newly found peace, in both his or her personal life and social life. It offers him or her the possibility of peace of mind, giving him or her the hope that painful memories can be healed; the individual in question will no longer be emotionally held hostage by the bad acts of the past. Forgiveness offers the possibility of making peace with others. As one endeavors to deal or come to terms with the hurt and injury inflicted by another person, this move opens the door to a future of a better and more fulfilling relationship. As one seeks to acquire inner peace of mind, it becomes absolutely necessary to chart a new path through which this newly found peace can thrive. As Pargament (1997) puts it, in forgiveness “grudges and grievances can no longer be nursed and nourished” (p. 262). Effectively, past enmities are expunged and supplanted by the much sought-after peace.

Forgiveness is closely tied to religion, as implied in the popular maxim, “To err is human, to forgive is divine.” That is why every religion incorporates teaching about mercy and compassion, as well as the dangers of vengeance and hatred. Christianity and Judaism, for instance, view forgiveness as one of the most central of virtues. They consider it so central that the New Testament links man’s very salvation to his ability to forgive (Gartner, 1988, p. 313). Gartner (1988) believes that the capacity for genuine forgiveness is not only central to spiritual development but also to psychological development. He admits, though, that mature forgiveness does not eliminate negative feelings toward others or oneself, but that it involves the integration of negative and positive self-object representations and their connected effect. Therefore, anger at the offending persons must then be tempered by appreciating their concomitant good qualities and motivations. This leads to a more realistic and more balanced view of others and oneself. It also leads to a more genuine relationship, as well as a greater ability to respond constructively to frustrating persons and situations.

Christianity and Judaism have many biblical instances that are relative to forgiveness and the appeal for mercy. In both of these religious traditions, we find exemplary figures that teach us the significance of returning an act of hatred with one of love. Both of these traditions encourage their adherents to follow these models and to practice forgiveness in their lives. Biblical injunction mandates love, not only for every individual but even for the enemy: “But love your enemies, and do good, and lend, expecting nothing in return; and your reward will be great. . . . Be merciful, even as your Father is merciful” (Luke 6:35–36). Pargament (1997) cites Maimonides as saying that “the failure to forgive someone who sincerely requests it is great an offense as the initial wrongful act” (p. 155). Newman (1987) reflects this perspective:

It is shown that traditional rabbinic authorities regarded the duty of one individual to forgive another as conditional upon the repentance of the offender, who has a prior duty to seek forgiveness from the person harmed. These same authorities appear to have extended the duty to forgive, in theory at least, to all offenses regardless of their severity. (p. 155)

This Judeo-Christian idea about forgiveness attests to the fact that religious beliefs can determine ethical responsibilities as well as generate moral duty for both traditions. In essence, religion, according to Pargament (1997), can contribute to forgiveness in two ways: by lending significance to the act of forgiving and by providing a set of models and methods to facilitate this process. In relation to the spiritual significance of forgiving, human relationships are, in regard to many religious views, “working models of an ideal, namely, the relationship between the individual and the divine” (Pargament, 1997, p. 264). From this point of view, therefore, a breach in the relationship between two people that is not fixed can, ultimately, involve more than the two parties and can even extend to the larger community. It can equally become an offense

against the sacred. In the same vein, “forgiveness takes on a larger significance in the religious context. It offers the possibilities not only of peace with oneself and with others, but also of peace with God” (Pargament, 1997, p. 265). In other words, forgiveness has both psychological and divine dimensions.

In the context of interpersonal communication, it has been stressed that the image of God (*imago Dei*) is reflected in the relationships we have with each other (Propst, 1988, p. 176). This image of God subsists in the atmosphere of mutual friendship with others, not in enmity. To create such an atmosphere necessitates forgiveness of wrongdoing. Lasting relationships endure in such an environment. Propst (1988) argues that “we are a product of the accumulations of our relationships and exchanges with others” (p. 176). She insists that “true spirituality is a healthy spirituality that allows for free and open communication between individuals” (Propst, 1988, pp. 176–177). In such open communication, “partners discover transgressions, express and manage their emotional reactions, make sense of the situation they find themselves in, seek and grant forgiveness when appropriate, and (re)negotiate their relationship as they look to the future” (Waldron & Kelley, 2008, p. 47). This attitude makes forgiveness of an offense possible.

By forgiving others, the individual can seek his or her own forgiveness from God. Again, by forgiving, the individual has the opportunity to live a religiously based life and can seek out greater intimacy with other people and the divine. This is because as the individual forgives, he or she strives to attain a sense of spiritual fellowship—“a sense that as children of God we will all require forgiveness and we all need to be forgiving, of ourselves, of each other, and of God” (Pargament, 1997, p. 265). This enables the creation of a more peaceful, loving community that is filled with spiritual presence. This is essentially healing in and of itself.

The Bible is replete with stories of acts of forgiveness that, ultimately, led to spiritual healings, such as the story of Joseph and his brother (Genesis 50:15–21). In this story, Joseph forgives his brothers, who, out of jealousy and hatred, sold him into slavery. This act of forgiveness led to reconciliation and a peaceful reunification between Joseph and his brothers. Similarly, God asks Hosea to forgive his wife, Gomer, and to take her back despite her adulterous life, just as He (God) forgave the Israelites for abandoning him and worshipping other gods (Hosea 3:1–5). There are, of course, many New Testament verses on forgiveness. However, I will discuss just a few of them.

In Matthew 6:14–15, Christ admonishes, “For, if you forgive men their trespasses, your heavenly Father also will forgive you, but if you do not forgive men their trespasses, neither will your Father forgive your trespasses.” Similarly, in Luke 17:3, Christ states, “Take heed to yourselves; if your brother sins, rebuke him, and if he repents, forgive him; and if he sins against you seven times in the day, and turns to you seven times, and says, ‘I repent,’ you must forgive him.” Equally, in Ephesians 4:31–32, Paul advises, “Let all bitterness and wrath and anger and clamor and slander be put away from you, with all malice, and be kind to one another, tenderhearted, forgiving one another, as God in Christ forgave you.”

One can follow in the footsteps of Christ, who forgave his offenders “in the most extreme of moments” (Pargament, 1997, p. 264). Pargament (1997) insists that religion can assist in the expression of anger as well as pain to the offender. It can also assist in the decision to forgive, wherein “letting go of negativity can be framed as a ‘leap of faith’” (Pargament, 1997, p. 266). Religion can also facilitate the humanization of the offender, enabling him to attain a compassionate understanding of offensive acts. Forgiving is rooted in religious values, models, and methods, as is purification, which I will discuss next.

Purification as a form of religious coping. Purification is a form of religious or spiritual coping. It is a type of religious cleansing of spiritual infirmities after one has strayed away from his or her religious duties or paths, turning against the religious design. This can be described in religious circles as commission of sin. Sin can stain or bring about an outright breach in one's relationship with God or the sacred. In a situation where one's relationship with the divine is disrupted, such a person is considered to be spiritually unhealthy, while his or her restoration can be achieved through purification. Thus, different religions "provide coping mechanisms for reorientation, a return to the right way. Through rituals of purification, the sin, evil, or uncleanness associated with religious violations are removed, and the individual is reconciled to God" (Pargament, 1997, p. 218). In the art of purification, the sinner or offender is purged of his infirmities and, once more, restored to a pure state of life.

Every religion has its own method of carrying out the act of purification. In Christianity, for instance, purification can be done through sacrifice, exorcism, punishment, repentance, and so forth. In Catholicism, one can be purged of sin through confession, exorcism (for one considered to be spiritually possessed), and the baptismal act. For Muslims, purification can be performed through the act of ablution. Before handling the Qur'an, entering the mosque, or engaging in prayer, a devout Muslim is expected to get rid of the physical and spiritual pollutions that he or she encountered through physical contact with others. Jews are required to confess their sins to God once a year and to abstain from eating, drinking, washing, and engaging in sexual intercourse on Yom Kippur. According to Pargament (1997), "Sins committed knowingly or unknowingly, by the community as well as the individual, are all confessed in the liturgy of atonement" (p. 218). Although God is always receptive of repentance, Yom Kippur is considered

an important time of confession, for on that day one's fate is said to be sealed for the following year.

Religious rituals of purification appear to be designed to conserve both spiritual and psychological ends. One is encouraged to admit personal failures, so these rituals tend to increase the tension of the moment, in which case the stage is set for resolution. Ultimately, confessions of shortcomings are met with acceptance and forgiveness rather than condemnation. Relief and comfort ultimately follow. As Pargament (1997) puts it, "Confessions, it appears, increased tension and discomfort in the short-term, but enhanced physical health in the long run" (p. 220). The presence of a religious authority, such as the clergy who offers absolution to the individual, could add to the relief felt by the person who confesses his or her wrongdoing.

In the Catholic tradition, confession as an act of religious/spiritual purification takes place in the context of interpersonal communication between the priest and the penitent. In this type of interaction, communication is guided by strict, confidential canonical law. The confidentiality of such communication is treated with utmost seriousness, and it is considered a grave sin for the priest for him to attempt to divulge any part of the confession. Thus, the priest is bound (under penalty of excommunication) from divulging any information obtained therefrom to any third party. Confession offers both spiritual and psychological relief to the penitent, during an encounter where the priest acts as both a spiritual and professional counselor. Closely related to confession is conversion, which I am going to discuss next.

Religious conversion as a coping method. Some psychologists, theologians, social scientists, and mental health professionals have extolled the benefits of conversion. For instance, even though Jung (1963) belittled religions and saw Christianity as "collective mythologies," he believed that Christianity had a positive effect on the human personality. Jung (1963) noted that

religions are imaginary but good. He saw religions as being meaningful to many people and that they could be useful as myths. Jung contended that religions provide indispensable spiritual supports and said that psychoanalysis belonged in the sphere of religion. For Jung, conversion was a method of balancing personality.

Thus, the directive to seek cure through conversion is attributed to Jung. A story was narrated in relation to the effectiveness of cure through Christian conversion. The story was about a certain young and wealthy American banker who was on the brink of despair because of his inability to control his drinking habit. Having exhausted all avenues available to him for cure, he then traveled to Zurich to meet with Carl Gustav Jung, a renowned psychotherapist, and placed himself under the care of this famous physician. This patient in question (Rowland Hazard) worked closely with Jung for nearly a year, attained sobriety, and then left treatment with admiration for Jung. However, to his consternation, he once more relapsed to alcoholism and went back to Jung's psychiatric care. Upon his return, Jung frankly explained to Rowland his utter hopelessness as far as any further medical treatment or psychiatry was concerned.

Following Rowland's question regarding whether there was any other source of hope for him, Jung suggested "a spiritual or religious experience—in short, a genuine conversion" (Kurtz, 1991, p. 9). However, he noted a caveat to Rowland, cautioning him that "while such experiences had sometimes brought recovery to alcoholics, they were . . . comparatively rare" (Kurtz, 1991, p. 9). Acting on this advice, on returning home, Rowland joined the Oxford Group, an evangelical movement, then at the height of its success in Europe. This group laid emphasis upon the principles of self-survey, confession, restitution, and the giving of oneself in service to others. By so doing, Rowland found within the Oxford Group "the conversion experience that released him for the first time from his compulsion to drink" (Kurtz, 1991, p. 9). Although

catering to alcoholics was not the primary concern of the Oxford Group adherents in Europe and America, “Rowland chose to devote to such sufferers his efforts at living out and promising his own conversion experience” (Kurt, 1991, p. 9). His was a remarkable experience of the efficacy of conversion as a process of healing.

Rowland’s healing experience through conversion led to yet another healing through conversion of his friend, Ebby. Ebby admitted that his only hope lay in the conversion experience and that such was the function of religion. He admitted too that the Oxford Group was the most famed and respectable evangelical expression of religion in America at the time. So, he joined and found in it “friendship and fellowship of a kind he had never known” (Kurtz, 1991, pp. 9–10). It so continued that one who gets healed through the process of conversion seeks to help another friend in a similar situation.

An interaction of this nature relates once more to participatory communication, already discussed in some of the previous chapters of this project. Participatory communication involves teamwork, where thoughts, feelings, and experiences are shared among members for the purpose of providing healing to a member who needs it. This is done by sharing messages that aim at fostering positive health behaviors and reducing risky ones, which, in this case, was alcoholism. These exchanges of healing messages are expected to, ultimately, lead to conversion and healing.

Furthermore, conversion has been said to lead to a unification of character and an achievement of a new self—“a new birth by which a man ceases to be a mere psychological thing or a divided self, and becomes a unified being, with a definite direction under the guidance of a group of a consistent and harmonious purposes or ideals” (Pratt, 1946, p. 123). In essence, conversion leads to a radical transformation, which leads to an emergence of a new self.

Moreover, better psychological, social, and behavioral changes have been attributed to conversion. There is also increased self-esteem; a greater sense of joy; more sensitivity; fewer feelings of despair; more closeness to family and friends; a drop in the use of alcohol, drugs, and cigarettes; less emptiness and shame; less depression; less fear; an end to a life of promiscuity; and fewer fights and arguments. Studies show that more people experience psychological and behavioral relief after conversion.

On the contrary, it must be pointed out that in more recent years, religious conversion has also been perceived by some health professionals as a form of “brainwashing” or “thought reform” that is used by cults and new religious movements to coerce unsuspecting individuals into membership (Sargant, 1957). Additionally, religious conversion has been likened to “drug addiction, and schizophrenic decompensation” (Pargament, 1997, p. 295). Nevertheless, some clinicians have interpreted this view as oversimplistic and as a stereotypical understanding of the conversion process. Overall, it is clear that conversion has been shown to produce more positive than negative outcomes with respect to coping.

Negative Coping Strategy

Although religion has been shown to have a lot of positive outcomes with regard to coping, some methods have also been described as negative. Pargament (1997) labels such coping methods as “negative religious reframing.” There are different forms of negative coping, such as deserved divine punishment, and discontentment with God and the clergy or members of the congregation. The implication for this type of communication is that the content of the message lacks hope for the patient, as it portrays a dismal ambience. Hence, the patient blames him- or herself for the given condition. This, ultimately, leads to negative health outcomes.

Although we have several forms of negative religious coping methods, I will address only the most significant.

Deserved divine punishment as a form of negative coping. People have a tendency to see negative events that happen in their lives as God's punishment for their wrongdoing. God is, therefore, seen as a punishing God. In such a situation, people are usually wary of blaming God for their predicament. Instead, they tend to see themselves as responsible for what they are suffering from; they believe they brought it upon themselves. The fault for pain and suffering lies with oneself or others. Bearon and Koenig (1990) reference this type of negative religious coping in their research on health-relevant religious beliefs. According to these scholars, some respondents believed that God is a benevolent and loving God, who is a giver and protector of health. On the other hand, others believed that "God is responsible for sickness or bestows illness as a test of faith or as a punishment for disobedience. They explained illness as the result of sin, fate, stress, evil spirits, the devil, and negative mental attitude" (Bearon & Koenig, 1990, p. 249). Such punishment is considered by the individual to be just and deserved, rather than random. To the extent that the individual accepts this punishment, he or she feels reassured that God's grace can be regained by a change of heart or behavior.

A thinking process such as this is captured in this lamentation made by one woman to her friend suffering from cancer: "Surely, there is something in your life which is displeasing to God. . . . You must have stepped out of His will somewhere. These things don't just happen" (Pargament, 1997, p. 227). This type of blame tends to promote the belief in a just world. People who hold such belief are convinced that God would not cause pain unless it was in some way deserved by the person on whom it was inflicted. This type of coping offers a certain sense of security and control, because it is accompanied by the conviction that God punishes fairly.

Therefore, as long as wrongdoings can be avoided, retributions can equally be avoided. On the other hand, if the moral order is violated, the individual in question runs the risk of facing spiritual retribution as well. As such, those who operate within the ambience of this order do not have anything to fear, while those who go against it have a lot to worry about. This way of thinking no doubt fits in very well as a coping process. Besides punishment from God, there is also another form of negative religious coping: expression of displeasure with God and with the congregation.

Expression of discontentment toward God and members of the congregation. Ironic as it may sound, people's expression of discontentment toward God and the members of their congregation can be a form of negative religious coping, with harmful effects. Although it is not commonplace, anger toward religion could be a first reaction or initial stage in the coping process. When people turn a critical look on their religion, most of the time they direct their anger to the members of their congregation or clergy, who they feel have let them down. Also, when faced with traumatic situations, sometimes people express negative feelings toward God in their attempt to deal with such events. This outpouring of emotion by a hurting young person, cited by Kooistra (1990), is a good example of the expression of this negative feeling toward God:

I wonder if God really loves us like people say he does. Then why does he let people hurt so much, why are people homeless, why are people being murdered, and why is the world so screwed up? . . . The only time that I have felt that I have experienced God was when I was suicidal. How can a true God desert me through most of my life and only intervene when I want nothing more than to be side by side with him? I don't believe that this world is what God had in mind. Where did he go? (pp. 89–90)

Usually, a feeling such as this is an expression of abandonment and disappointment toward God. It is accompanied by other very strong feelings, such as despair, hopelessness, and resentment. Expressions of discontentment toward God and the congregation are often associated with negative outcomes. People who express greater dissatisfaction with clergy, congregation members, and God report poorer mental health outcomes, greater negative mood, and poorer resolution of negative life events.

Religious Coping Methods with Mixed Outcomes: Self-Directing and Deferring

Some religious coping methods easily fall into both the good and bad camps. Such methods are associated with mixed outcomes, meaning that some religious coping strategies can be associated with positive outcomes but associated with negative outcomes in other situations. Self-directing and deferring strategies can be categorized as belonging to this category. These methods can help adherents of a religion attain a sense of power and control in coping. In the case of self-directing, control can be centered in the self. This is borne out of the belief that God gives people the wherewithal to solve problems for themselves. The self-directing style of religious coping emphasizes the free will that God gives to the individual, which enables him or her to solve the problem. The self-directing religious coping strategy has been linked to higher levels of self-esteem, higher levels of competence, and belief in personal control. Higher levels of depression and lower levels of spiritual well-being have also been attributed to it (Philips, Pargament, Lynn, and Crossley, 2004, p. 409). In such situations, the individual tends to have little control, while the most appropriate thing to do may be to give up. For Philips et al. (2004), self-directing “was considered similar to Fromm’s humanistic religion, in which the power of the individual is high-lighted, and self-realization is the focus” (p. 410). This style of religious coping appears to say, “I act to solve my problems without God’s help,” (Pargament, 2011, p.

163). and it further suggests that power resides with the individual. The individual in question is active while God is inactive.

The deferring religious coping style directly opposes the self-directing style. In the deferring style, control is centered in God. The individual believes that the ultimate responsibility for one's life rests solely in the divine. The individual may passively defer to God in troubled times, relying heavily on God without taking any personal responsibility for the situation. As such, there is a delegation of responsibility for problem-solving to God. Whereas this deferring style has been associated with higher levels of depression and lower levels of competence, it has also been connected to higher levels of well-being. The individual does not surrender to hopelessness or to a foreign power but to a benign, omnipotent being. Therefore, when one considers the alternatives, when personal control is no longer possible, this may be one of the most empowering choices (Pargament, 1997, p. 294). Consistent findings reveal "mental health benefits of internal locus of control" (Pargament, 1997, p. 293) in the use of these two styles of coping, as well as their benefits in problem-solving. Pargament (1997) cautions against jumping to the conclusion that the self-directing style of religious coping is healthier than the deferring style. He suggests that the values of these styles might vary from situation to situation. In this section of the chapter, I have explored the contributions of scholars regarding different coping strategies. Prominent among these scholars was Pargament. However, others have also studied different coping strategies. These scholars maintain that there are two patterns of religious coping: positive and negative. All other coping strategies are subsumed into these two. Positive religious coping strategies were described by Pargament (1997) as benevolent religious reappraisal, producing more positive outcomes, whereas negative strategies were labeled as negative religious reframing, with the tendency to produce poorer health results. Some positive

coping strategies include congregational network, relationship with others, spiritual support, collaborative religious coping, forgiveness, and purification. On the other hand, deserved divine punishment and expression of dissatisfaction with God and members of the congregation are some negative coping strategies. Other strategies, such as self-directing and deferring, have been considered as having mixed outcomes: positive and negative. Nevertheless, it was Propst (1988), along with Gottlieb (1985) who showed a clear relationship of religious coping strategy to healthcare communication. The implication for healthcare communication is clear in Propst's (1988) argument. She insists that complete wholeness depends on the relationship we have with one another. Moreover, listening and hearing in the counselor–patient relationship are essential in counseling. Gottlieb (1985) directed his attention to social transactions to point out a way that support is expressed and through which relationships are built.

Summary

Belief in the efficacy of biomedical science and technology as unilaterally holding answers to the human medical condition and the outright denial of the role of religion in the same regard underscore the necessity of this entire project. Thus, this chapter examined the arguments of some scholars who, despite the overwhelming evidence that medicine, healthcare, and religion are closely tied together, outrightly deny the role of religion in the caregiving process. It then delves into discussions of the different types of religious coping and their relationships to healthcare communication.

Among those who deny the efficacy of religion in the provision of healthcare, Freud (1959) Ellis (1980), and Watters (1992) are notably outstanding. Freud's atheistic views of God and religion led to his consideration of religious practices as obsessive acts of the neurotic. As such, religious doctrines and practices are good, but only as tools that restrained humans from

violent impulses in the early period of the development of civilization. Closely synchronizing with this Freudian thinking are Ellis (1980) and Watters (1992). While Ellis (1980) considers psychotherapy and religious hypothesis as emotional disturbance, Watters (1992) associates Christianity with sickness itself, blaming Christianity for certain human ills, fear, and superstition. As seen in these perspectives, any thoughts and communications about God are, therefore, guided by irrationality that is devoid of logical reasoning.

Notwithstanding opposing views to the religious/spiritual role played in healthcare, different forms of religious coping have been shown to be prevalent in healthcare giving. Hence, different scholars have explored the functional use of religion in caregiving and healing. Although there are other scholars that have researched and produced works in this area, Pargament (1997) has proved to be particularly outstanding. His research has focused on multidimensional forms of religious/spiritual coping. He discusses at length the two patterns of religious coping: positive and negative. The positive religious coping method is multifaceted, as is the negative one. While positive religious coping can be described as benevolent religious reappraisals (religious coping methods that are beneficial to caregiving), negative coping methods are expressions of a less secure relationship with God. Positive religious coping is thought to be associated with potential benefits in psychosocial adjustment, whereas negative religious coping is maladaptive and leads to poorer outcomes or worse well-being in people going through crises. On the other hand, some coping methods are considered to produce mixed results (positive and negative). Healthcare givers, therefore, must be conscious of these nuances in their relationships and communication with their patients.

General Conclusion

This project has examined the intersection of religious faith, spirituality, and healthcare communication. In an attempt to do this, Chapter 1 explored the dignity, value, and sacredness of human life, starting from the biblical and Christian perspectives. Biblically, the divine mandate has the utmost respect for life—human life is considered to be sacred, and it is a divine gift and a responsibility. Human life has a dignity that by far surpasses the life of other creatures. This mandate makes the purpose of healthcare both expedient and necessary. Religion has been shown to have a lot to do with communication, according to Stout (2006) since religion must have a voice, the word, and the text. All these are communication devices and practices it employs in its operation.

Stout's (2006) claim is evident in how God reveals his feelings about life through the scriptures, where He sometimes employs a telepathic model of communication (transference of message without any visible connection) and sometimes through interpersonal mediation (whereby messages are conveyed through the prophets or church ministers). God's model of communication could sometimes also be linear (a one-way communication process), where a message is just given to humans, without any possibility of feedback from them. In some ways different from the Old Testament, in the New Testament, Jesus Christ has been shown to be a dialogic communicator and a listener par excellence. The value he places on human life is exemplified in his interpersonal relationship skills, which were more pronounced in his relentless care of the sick, the poor, and the needy.

The value that Christianity places on human life is not so different from the bioethics perspective, where most of the arguments against abortion and euthanasia are also mainly based on biblical teachings. Although there have been pro-abortion and pro-euthanasia arguments,

arguments against these ethical issues tend to drown them out. Therefore, as much as there is support for abortion or euthanasia in caregiving, there is always the problem of trust in the patient–caregiver relationship; it is a situation that may render the physician or health personnel a suspect. The major argument is that the fundamental function of medicine (and, by extension, the caregiver) is to preserve life and not take it.

Chapter 2 focused on tracing the history of religion, medicine, and healthcare from Egyptian civilization, to the ancient Greek and Chinese traditions, to the modern period. This examination revealed a long-time interaction between the three; hence, attempts at their separation have only been recent. For most of human history, as far as religion and healthcare are concerned, sickness was considered to be punishment afflicted on the patient by the gods because of his or her transgressions. The priest did spiritual work as well as work of the physician, combining both the supernaturalistic and the naturalistic paradigms in his attempt to provide cure to the sick. The priest was also the principal communicative agent in matters of decision-making during sickness and healing. Since mediated communication then seemed to be the preferred communication model, he was both the mediator and intercessor.

In the Middle Ages, Christianity dominated all aspects of life, including healthcare communication. As such, medicine, health, and healing had a lot of Christian undertones. Christianity gave voice and meaning to everything. The popes and bishops, in collaboration with the emperors, were the principal agents of communication, and their words were held with the highest reverence. Cure of sickness was generally done through supplication of the cult of saints for miracles. During the same period, the church encouraged caring for the sick, which was done mainly through empathic and participatory communication. Although Islam teaches that illness is a gift of grace and an opportunity to be purified, as well as a chance to have one’s sins forgiven

by God, it insists that every Muslim is under obligation to care for his or her body as a religious duty. However, similar to Christianity, Islam also propagates divine healing through the mediation of humans, usually the Islamic leaders. The Qur'an is the major source of information and messages about medicine, illness, and healthcare.

In the case of Buddhism, healing has been a part of Buddhist practice since its earliest foundation. The Buddha was believed to be the chief communicator in matters relating to sickness and health. He was believed to be the supreme physician, whose principal message on health promotes morality, compassion, and the right way of living. Just like Christianity, Hinduism also combines both naturalistic and supernaturalistic medicine, where the priest and the physician/surgeon are the principal healthcare communicators. They communicate health messages, make health decisions, and provide treatment to patients.

In the Renaissance, a period marked by the revival of intellectual curiosity, attention was diverted from the church as the chief custodian of knowledge in all facets of life, including health understanding, to science, mathematics, and reason. This was the beginning of the separation of religion from medicine and healthcare. During this time, science, reason, and experience were considered to hold answers to everything, through observation and proof. As such, health messages were considered valid if verifiable through scientific tests. It was also a period that involved gigantic breakthroughs in medicine and health technology. The combination of the naturalistic and supernaturalistic models of healing were also prevalent during the modern era, just as in the ancient and Renaissance periods. However, the modern period brought with it the Protestant Reformation and its continued attack on the church's teaching regarding revealed truth and miraculous healing. During this era, disease was seen as a violation of natural law instead of divine law.

The call for communication scholars to engage in study of the intersection of religious faith, spirituality, and healthcare communication, as well as findings noted in Chapters 1 and 2, made Chapter 3 a necessity. This is because communication scholars' negligence of this field of study had become glaring until recently. As a result, Chapter 3 focused on the rise to this challenge by scholars in various fields of study, but especially in the communication field. Their work led to many articles and some books. Hence, most of this chapter was a review of the works of health communication scholars and others, showing this connection among religion, medicine, and healthcare. The initial part of the chapter clarified some important concepts, such as religiousness, spirituality, health, and healthcare communication. Some other prominent themes examined by these scholars in their bid to trace the intersection of religion, medicine, and healthcare were the role of culture in healthcare communication, communication in faith-based contexts and organizations, religious satisfaction and spiritual well-being as means of coping with chronic illness, the influence of religious spirituality in relation to a healthier lifestyle and behavioral change, how religious spirituality exerts its influence on media content consumption, and how faith-based communities serve as platforms for social support and promotion of better health. In essence, health communication is carried out through religious involvement and relational encounters with members of the congregation through the use of prayers, teaching ministries, and counseling. All these are shown to yield better health decisions and more positive health outcomes.

The last chapter of this project dwelt on different forms of religious coping, starting with scholars who negate or outrightly deny the efficacy of religious practices in the healing process. Such scholars were Freud (1961), Ellis (1990), and Watters (1992). As their arguments insinuate,

thoughts and communications about God and religion could be viewed as guided by irrationality and devoid of logical reasoning.

However, other scholars emerged with counterarguments in favor of the functional use of religion in caregiving and healing. Among them, Pargament (1997) proved to be outstanding, focusing on two forms of religious coping strategies: positive and negative. Positive strategies were benevolent religious reappraisals, whereas negative strategies were expressions of a less secure relationship with God and maladaptive, leading to poorer health outcomes. On the other hand, some coping methods such as self-directing and deferring were considered as producing mixed results: positive and negative. Knowledge of these nuances is meant to pique the consciousness of healthcare givers to rise up to the occasion in their communication with patients.

As a little digression, I find to my surprise that the hospital chaplaincy program appears to be an important area that has also not received enough attention by communication scholars, despite its popularity in the American health system. The paucity of publications in this field tends to lend credence to this oversight. It is my hope that communication scholars would turn their attention to this field as well. I hope to engage in this enterprise in the future.

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