INTEGRATING SPIRITUALITY AND PSYCHOTHERAPY: EXPERIENCES OF A SAMPLE OF TERMINALLY ILL PATIENTS

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ABSTRACT

The general aim of this study was to determine the experiences of a sample of terminally ill patients in using spiritually focused psychotherapy. This was a qualitative study conducted to a sample of 2 terminally ill patients from hospice in Grahamstown, South Africa. The research was conducted in 3 phases: an initial in-depth interview conducted to determine the participants' level of spirituality as well as the extent to which their terminal illnesses had affected their functioning. This was followed by a minimum of 6 spiritually focused therapy (SFT) sessions as a second phase of the research. To determine the participants' experiences of SFT, 2-3 in-depth interviews were conducted during the 3rd phase of the research study. The research revealed that a belief in a higher power helps terminally ill patients cope better with their illness and that social disconnectedness is related to HIV/AIDS stigma. It also revealed that terminal illness is co-morbid with other psychiatric symptoms such as depression, evokes existential concerns, results in a change in the level of spirituality and affects the whole family. Participants blamed themselves for their illness, but found that engaging in the process of forgiveness of self and others brought about psychological healing for them. They experienced SFT as a coping resource that assisted them to deal with the fear of death as well as increased insight into the development of psychopathology and spiritual blockages. It is recommended that a comprehensive and holistic assessment during intake be undertaken so that where spiritual needs are available, therapy can be spiritually augmented to ensure that such needs/ struggles are addressed.

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DECLARATION

I declare that the work on "Integrating spirituality and psychotherapy: experiences of a sample of terminally ill patients" is my own work, both in conception and execution, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE
(BR CHEMANE)

7/11/2008
DATE

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CHAPTER ONE

INTRODUCTION

Introduction

This chapter presents a brief introduction to the statement of the problem, the area of investigation, South African research on spiritually-focused psychotherapy, rationale for integrating spirituality into psychotherapy, and the value of the study.

1.1 Statement of the problem

Spiritual concerns and needs of clients do not get adequate attention in psychotherapy (Hathaway, Scott, & Garver, 2004; W. R. Miller, 1999; Samuels, 1998). Viewed broadly, spirituality refers to one's relationship with a higher power or transcendent force by primarily engaging in transcendental consciousness (Cole, 2005; Kaye & Raghavan, 2002; Martin, 2003; W. R. Miller, 1999; West, 2000). The word psychotherapy is derived from two Greek words: *psych*e, meaning soul/breath of life and *therapei*a, meaning servant or attendant. The word psychotherapist therefore literally means attendant of the soul (Cloninger, 2006; Graham, 2001; West, 2000). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) has now included a codable category of disorders for use with individuals experiencing spiritual distresses (Sadock & Sadock, 2003). Although the inclusion of such a diagnostic code (i.e. the V-code) in the DSMIV-TR (American Psychological Association [APA], 2000) can be regarded as a positive step, it does not provide a guarantee that clinicians will necessarily assess for clients' spiritual needs and/ or struggles routinely (Hathaway et al., 2004). This V-code can be used in the event where the focus of clinical attention is a spiritual or religious problem (APA, 2000; Sadock & Sadock, 2003). This suggests a reactionary rather than a proactive approach to addressing spiritual problems, meaning that if the patient does not bring it up, the clinician won't ask about it during the in-take assessment session.

The problem of the neglect of clients' spiritual needs can be traced back to Freud, the father of psychoanalysis, who was well known for openly discrediting religion on account that it was unscientific and an illusion or expression of neurosis (G. Miller, 2003; West, 2000). Religion can be defined as an organised and institutionalised set of beliefs and practices involving a higher power (Cole, 2005; Martin, 2003; W. R. Miller, 1999). It provides us with a vision of what life is and ways to live it (Helminiak, 2001). Succumbing to the pressures of his time, where only positivist knowledge was seen as scientific, Freud adopted a mechanistic worldview of man which separated body, mind and spirit (Delaney, 2005). Freud's time is usually referred to as the period of modernism, which adopted an objective stance to human problems (Goldenberg & Goldenberg, 2004). This period was characterised by a quest for psychology to be a science (Goldenberg & Goldenberg, 2004). According to this view, the reality is out there, objective and knowable, and it exists as truth, eternal, and unchanging, and can therefore be strived for and understood by a detached observer (Bonadonna, 2003; Corey, 1996, 2005; Freedman & Combs, 1996; Goldenberg & Goldenberg, 2004; West, 2000). Anything that could not be measured objectively, such as spirituality, could therefore not be accepted as a credible entity. Viewed against this background, Freud's position to religion or spirituality can therefore be understandable.

Freud's school is one of the two major forces and intellectual currents in the field of psychology which is usually referred to as the first force (Maslow, 1964). The other major force known as the second force (Maslow, 1964), is behaviourist psychology. The fore-runners in these two major schools and their subscribers were well-known for dismissing, ignoring or even explicitly scorning the integration of spirituality into psychotherapy (Grof, 1985; W. R. Miller, 1999). This is unfortunate, considering the fact that research findings have consistently shown that the overwhelming majority of the population is religious (Hathaway et al., 2004). Research findings also rank spirituality as a high priority in helping patients in distress to cope during hospitalisation (Cole & Pargament, 1999; Delaney, 2005).

It was not until the advent of the "third force" in psychology that some of the theorists and clinical practitioners began to incorporate spirituality into their theorising of psychology (Maslow, 1964). The birth of the third force, which includes neo-Adlerians, neo-Freudians, post-Freudians, Existential psychology, Adlerians and Jungians, has seen many theorists openly supporting such integration. Notable amongst these theorists are Frankl (2006), well-known as the father of existential psychology, and Maslow (1964). The well known psychotherapy technique within the existential psychology framework, logotherapy, has been widely used to help address what Frankl (2006) terms existential vacuum for persons experiencing pain and suffering, such as terminally ill patients. According to Frankl, the existential vacuum refers to the loss of meaning in one's life. Hoy-Ellis and Fredriksen-Goldsen (2007, p. 836) define terminal as "An adjective used to describe that which is near, close to or in the final phase of reaching death." Based on this definition then, terminal illnesses are those illnesses that are in the final stages of death.

Transpersonal psychology, a sub-field of psychological inquiry that is usually referred to as a "fourth force" (Hoffman, 1988, p. 342), is another example that has seen many of its proponents incorporating spirituality in its practice. Transpersonal refers to that experience which goes beyond the personal. Knight (1997, p. x) defines transpersonal experiences as: "...experiences of nonordinary states of consciousness in which one's sense of identity or self extends beyond the individual or personal ego to encompass wider aspects of human experience, the psyche and the universe."

Martin (2003) posits that clinicians have a tendency to scorn or even minimise what is not valued by them. This may lead to spiritual neglect which, as Kaut (2002) argues, may in turn result in the exacerbation of cognitive, physical and emotional problems in terminally ill patients. Tart (1992) appears to agree with Kaut in his postulation that the spiritual aspect of man has been relatively ignored and regarded as pathological by mainstream, western psychology.

1.2 Palliative care for terminally ill people

According to Lawton (2000), before the twentieth century, death and dying used to be regarded as a normal, natural part of life and hence was not feared at all. During this era, people normally died in their homes where relatives and friends would visit the bereaved to view the corpse and say their good-byes. However, from the twentieth century, the number of people dying in hospitals, where nurses and doctors took responsibility for the dying, began to increase. Since this period, according to Lawton, home has become less and less appropriate as a place to die. There were complaints about this practice from the general public that the dying were not properly cared for and that the help given was insensitive to the needs of the dying and their families (Buckingham, 1983; Lawton, 2000). It became clear that hospitals were unhelpful to many of the dying and that homes had become inadequate due to many reasons, including, as Lawton (2000) maintains, social and occupational demands. Such dissatisfaction with the quality of care for the dying resulted in the advent of hospice facilities.

Hospice began as a conceptual drive in England in the late fifties and early sixties as Dr Cicely Saunders' 'brain child' (Hamilton & Reid, 1980), but has now grown and spread world wide (Doyle, 1994). Hospice can be defined as a place where people with terminal illnesses are cared for. These people have poor prognosis and know that their death is imminent as their diseases are irreversible (Hamilton & Reid, 1980). The National Health Organisation (cited in Buckingham, 1983, p. 3) defines hospice as follows:

> Hospice is a medically directed multidisciplinary program providing skilled care of an appropriate nature of terminally ill patients and their families to live as fully as possible until the time of death. Hospice helps relieve symptoms during the distress (physical, psychological, spiritual, social, and economic) that may occur during the course of the disease, dying and bereavement.

Although hospice is always thought of as an institution that cares for the dying, its proponents have always contended that it is not an institution but rather a philosophy (Buckingham, 1983; Corr & Corr, 1983).

1.3 The area of investigation and demarcation of the study

This study explores the interface between the emerging perspective of spiritually focused therapy (SFT) and the clinical area of health care for terminally ill patients. The emphasis is on the therapeutic impact of SFT, that is, its impact on the *existential* and *spiritual* struggles that people, nearing the end of life, experience.

1.4 Rationale for integrating spirituality into psychotherapy

Research studies have shown that meaning-based or spiritually focussed therapy techniques work as a valuable resource of dealing with stress and illness for terminally ill patients (Breitbart, Gibson, Poppito, & Berg, 2004; Cole, 2005; Cole & Pargament, 1999; Kaye & Raghavan, 2002). These authors further argue that finding a reason for being alive, identifying and coming to terms with one's unfinished business in their past, accepting their current condition as well as the uncertainty of the future becomes an existential resource for the terminally ill patient. Surrendering the uncontrollable to one's higher power can empower the otherwise powerless patient and give them hope for the future. Cole and Pargament (1999) argue that this may revive the patient's spiritual connection and relieve them of feelings of helplessness.

In support of the argument, Hathaway et al. (2004) propose that spiritual functioning should be regarded as an area of human functioning that is important in its own right. Spirituality, according to West (2000), does not only play an important part in many people's lives, it is also a large determinant of good health and psychological well-being. Terminal illness often evokes existential concerns in patients, which calls for spiritual solutions (Cole & Pargament, 1999; Farber, Egnew, Herman-Bertsch, Taylor, & Guldin, 2003; Kelly, McClement, & Chochinov, 2006). It follows from this argument therefore

that if spiritually focused therapy is important for clients seeking therapy, it is even more so for terminally ill patients. When a psychotherapist treats patients, he stresses the importance of mobilizing all of the patient's support resources. Such resources may include spirituality as important sources of strength and coping over and above social support (W. R. Miller, 1999). Studies have shown that meditation and prayer are important sources of strength and coping for terminally ill people (Kaye & Raghavan, 2002).

1.5 The value of the study

This study will add to the body of research studies which have already indicated that spiritually integrated medical and psychological intervention is linked to better health outcomes, coping skills, lower rates of depression, suicide and anxiety (Bussing, Ostermann, & Matthiessen, 2005; Cole, 2005; Cole & Pargament, 1999; Craig, Weinert, Walton, & Derwinski-robinson, 2006). It will also add another dimension into the clinical assessment of patients. Instead of only concentrating on the DSM – informed assessment, a new dimension, focusing on existential and spiritual issues, could be included. This is consistent with research findings, which have established that for terminally ill patients, issues of meaning and purpose are at the heart of the distress (Cole, 2005; Delpino, 2005).

It is further hoped that the findings of this study will provide practitioners with additional ideas about the nature of suffering facing people grappling with terminal illness as well as provide them with ways of incorporating spirituality into psychotherapy. This will hopefully help them to provide such patients with quality care. Furthermore, the study will enhance the growing interest in the topic of spiritually integrated approaches, which have indicated that, for terminal illnesses such as HIV/AIDS, cancer and motor neuron diseases, cure is out of the question while healing becomes the treatment of choice. Hermsen and ten Have (2004) state that hope and the ability to make meaning of their imminent death is a crucial component of terminally ill patients' psychological needs.

The holistic approach to assessment of distress, (i.e. involving mind, body, psychological and spiritual aspects of human functioning), advocated in this study may assist to understand whether a particular patient requires a multidisciplinary approach that includes, for example, spiritual leaders such as clergy or pastoral counselling. Cole (2005) concurs with this argument and further adds that spiritual patients may be more inclined to participate in programs that integrate spirituality and psychotherapy.

1.6 South African research on spiritually integrated psychotherapy

Although studies on integrating spirituality and psychotherapy have recently proliferated, very few have been specifically conducted on terminally ill patients. To the researcher's knowledge, there has been a dearth of studies attempting to provide spiritually integrated psychotherapy for patients suffering from terminal illness such as HIV/AIDS. Addressing psycho-spiritual issues has not been a primary focus of psychotherapeutic interventions in the South African context even though plenty of research has shown the primacy of spiritual needs for terminally ill patients addressing personal existential issues. There is abundance of literature on other HIV – related issues. Some of these issues are: stigma (Demmer, 2007a), the interaction of cultural practices and western treatments (Leach, Akhurst, & Basson, 2003; Ross, 2008), churches' responses to HIV/AIDS in South Africa (Krakauer & Newbery, 2007), political and professional challenges facing HIV counselling in South Africa (Leach et al., 2003), and responses to AIDS-related bereavement in the South African context (Demmer, 2007a, 2007b). The studies on HIV/AIDS have been primarily focused on medical and biological transmission and progression of this disease, resulting in a literary dearth in the lived spirituality or meaning-making of the affected individuals (Pretorius, Goldstein, & Stuart, 2005). Such one-sided focus can, arguably, be attributed to the dominant medical discourse based on the initial medical diagnosis of the disease (J. A. van den Berg, J. van den Berg, Nichol, & de Klerk, 2006). Unfortunately, this skewed focus serves to stifle the individuals' stories of their connectedness with their spirituality, spouses, families and the society at large. Psychotherapeutic interventions for people living with HIV/AIDS have concentrated on the traditional approaches, despite indications in the literature pointing to

increased levels of spirituality after the HIV/AIDS diagnosis in these people (Cotton et al., 2006; Ironson, Stuetzle, & Fletcher, 2006; Szaflarski et al., 2006; Vance, 2006). Similarly, the literature has indicated that there are cultural differences in the way other communities cope with HIV/AIDS (Edwards, 2003; Hodge, 2006; Leach et al., 2003; Mill, 2001; Ross, 2008). The majority of the South African Blacks believe in ancestral worship as a cultural method of spiritual coping (Chemane, 2004; Edwards, 2003), which makes a strong case for the incorporation of such a method into psychotherapy.

Only three studies on integrating spirituality and psychotherapy could be found in a South African context, of which none were focused on terminally ill patients. One study investigated the contribution of meditative experiences to personal growth (Knight, 1990), while the other two investigated the role of transpersonal phenomena in psychotherapy (Knight, 1997; Oberholzer, 1996). These studies demonstrated the value of allowing patients to tap into all their coping resources, including those that are spiritual, in order to facilitate growth and coping in psychotherapy. The main goal of transpersonal psychotherapy is to help the client transcend the ego in order to reach his true nature – the spiritual nature. For this reason Knight's (1997) and Oberholzer's (1996) studies are directly relevant here. During the practice of transpersonal psychotherapy, spiritual approaches such as meditation, guided imagery, holotropic breathwork and hypnosis are used. These studies will be unpacked in more details in chapter two.

Considering such dearth of research in the experiences of psycho-spiritual psychotherapy in a South African context, the purpose of the study will be to understand the spiritual values and experience of a sample of terminally ill participants with an aim of incorporating such values into their psychotherapy.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In the light of the previous chapter being an introductory chapter to spiritually focused treatment, this chapter presents contextual and theoretical foundations of spirituality. The chapter concludes by giving an account of the South African and international studies done on the integration of spirituality into psychotherapy.

2.1 Conceptualising spirituality and religiosity

Spirituality is an abstract construct that has been defined differently by various authors. Its definition has also stimulated a lot of debate and disagreement, with authors such as Heyse-Moore, McSherry and Draper and Martsolf and Mickley (as cited in Kellehear, 2000) proclaiming it as simply subjective and therefore indefinable. Despite this disagreement however, there seems to be a general agreement that it involves a belief in a transcendent force or higher power (Bartoli, 2007; Breitbart et al., 2004; Cole, 2005; Cole & Pargament, 1999; Corey, 1996, 2005; Cunningham, 2005; Delaney, 2005; Elkins, 1998; Frick, Riedner, Fegg, Hauf, & Borasio, 2006; Grof, 1998; Hodge, 2006; Kaut, 2002; Kaye & Rhaghavan, 2002; Meyerstein, 2004; G. Miller, 2003; W.R. Miller, 1999; Samuels, 1998; West, 2000; Woods & Ironson, 1999). While some of the authors argue that spirituality exists in a continuum and incorporates existential philosophy and practice (the search for meaning and purpose in life) as its important element (Delaney, 2005; Elkins, 1998; Frick et al., 2006; Kaut, 2002), others have simply defined it as one's search for meaning in life (Kaut, 2002; Martin, 2003; McClain, Rosenfeld, & Breitbart, 2003). What makes it even more difficult to define spirituality is its subjective, individualised nature (i.e. the guide is within oneself as it is personal and private) (Bartoli, 2007; Grof, 1998; Helminiak, 2001). Tart (1992, p. 4) defines spirituality as

"...that vast realm of human potential dealing with ultimate purposes, with higher entities, with God, with love, with compassion, with purpose."

Spirituality is therefore broad, complex and multidimensional and, because of this, some authors have tended to move away from simplistic, dictionary-like definitions that do not reflect such complexity. Kellehear (2000) for example, contends that people constantly strive to transcend their pain and struggles. Based on this line of reasoning he suggests a multidimensional view of spirituality, which posits that people have a tendency to seek an understanding and purpose of their current pain and struggles. This *making sense* transcendence may be in situations, moral or biographical contexts, and/or in religious beliefs (Kellehear, 2000). Quoting a number of authors to support his view, Kellehear (2000) argues that the idea of spirituality as an existential higher purpose is central to viewing spiritual values. In view of this, he has placed purpose as the first sub-dimension within the situational transcendence dimension. The other sub-dimensions under this dimension are: hope, meaning and affirmation, mutuality, connectedness and social presence. Under the moral and biographical transcendence, Kellehear includes the following sub-dimensions: peace and reconciliation, reunion with others, prayer, moral and social analysis, forgiveness and closure. Although this dimension appears similar to the religious needs category, Kellehear contends that it forms a separate category since, although these needs are philosophically related to religion, they do not necessarily require an intervention by theological or dogmatic means. Lastly, Kellehear discusses religious transcendence/needs, which he purports, subsumes the following sub-dimensions: religious reconciliation, Divine forgiveness, religious rites/sacraments, visits by clergy, religious literature and discussion about God, eternal life and hope. Although these dimensions are discussed separately, Kellehear warns against rigid view of them in a compartmental fashion. He indicates that there can be situations, especially near the end of life, where almost all the above needs will co-exist in one individual, in which case the individual may have to prioritise their realisation.

Kellehear (2000) is not the only author that has rejected the dictionary-like definition of spirituality in favour of a more comprehensive and dimensional view. Many other authors

have done the same (Cunningham, 2005; Elkins, 1998; Frick et al., 2006; Kaut, 2002; Kaye & Raghavan, 2002; West, 2000). Elkins's (1998) dimensional model of spirituality has been adopted by some of the other authors (West, 2000). His model has nine dimensions as follows:

Transcendent dimension, which can assume different forms for different people. For some the transcendent may be God, for others it may be a feeling of being in unity with the universe, while for some it may amount to transcending the realms of the conscious mind and delving the deeper (transpersonal) level of mind, which is also referred to as Greater Self (Elkins, 1998) or higher self/inner self or true self (Graham, 2001).
Meaning and purpose in life, a dimension of spirituality where people seek meaning and purpose of their existence.
Mission in life, a dimension that states that human beings are motivated by a belief that they are here to fulfil a specific purpose.
Sacredness of life, a belief that all of life is holy and should therefore be viewed with a sense of awe, wonder and reverence
Spiritual vs. material values, advancing the view that human beings know that spiritual needs in life can only be quenched by satisfying spiritual rather than material needs.
Altruism, a dimension that stresses the importance of connectedness, that people are interdependent and must extend a helping hand to one another.
Idealism, reminding us that human beings always strive for the betterment of the world, constantly working towards the highest ideals.
Awareness of the tragic, a dimension in which man is reminded that ultimately he is a mortal being. This knowledge, according to Elkins (1998), provides man with existential seriousness.
Fruits of spirituality, a dimension in which Elkin (1998) contends that spirituality bears fruit for an individual in that his relationships with self, others and the universe are bettered.

Another convincingly comprehensive view of spirituality has been advanced by Kaut (2002). He proposes a broad conceptualisation of spirituality, which embraces both the

reductionist (i.e. a scientific view, which argues that spirituality can be viewed purely from a biological perspective) and religious views. He contends that this is possible if spirituality is viewed as existing on a continuum that assumes the presence of a transcendent and relational notion of spirituality. For example, the belief that man is ultimately connected to a transcendent force (physical or natural), higher power (e.g. God) or people around him indicates the transcendent/relational duality of spirituality. The notion of spirituality as related to connectedness with others, environment and God has also been supported by Woods and Ironson (1999).

While spirituality can be rooted in formal religion (Samuels, 1998), it may also be regarded as a stand-alone, separate and subjective affair (Bartoli, 2007; Elkins, 1998; Grof, 1998; Helminiak, 2001; Hodge, 2006) as discussed above. Religion refers to prescribed and organised beliefs, practices, dogma/doctrines and rituals (Cunningham, 2005; Elkins, 1998; Hodge, 2006; Martin, 2003; W. R. Miller, 1999; Tart, 1992; Woods & Ironson, 1999), all of which involve relatedness to a higher power e.g. God. Religion can also be defined as a set of institutionalised spiritual values and beliefs (Frick et al., 2006; West, 2000). Elkins (1998) warns against those leaders in organised religion, who have a tendency of scorning and discounting the spirituality of those not affiliated with organised religion. He states that such behaviour has done indelible damage to the development of such people's spirituality. Elkins makes an interesting point that there are many people today who are highly spiritual yet not religious and as many who are religious without necessarily being spiritual. This suggestion clearly dispels the myth that being religious automatically makes one spiritual. Elkins further makes a call to everyone to respect genuine spirituality, regardless of whether it is found inside or outside of religious settings.

The distinction that Elkins makes is interesting if one considers Hodge's definition of religion. While Hodge (2006) agrees with those authors who define religion as an institutionalised set of rules, beliefs and practices, he further defines it as the expression of spirituality. This definition seems to be at variance with Elkin's (1998) argument that some religious people are not necessarily spiritual.

Religion is characterised by the shared understanding of transcendent reality among the members of the same religion (Hodge, 2006), whereas spirituality is subjective and private, meaning that two persons who describe themselves as spiritual do not necessarily experience the same spirituality. Other authors have argued that, because religions are a social phenomenon, they can provide a powerful social support to terminally ill patients (Frick et al., 2006).

Alternate definitions of religion and spirituality have tended to oversimplify these two constructs, perhaps in an attempt to make them fit neatly into simple categories. For example, Woods and Ironson (1999) quote a definition by Davidson, which views religion and spirituality as respectively related to vertical and horizontal belief systems. According to this view, vertical beliefs are deemed to be related to an individual's relationship to God, whereas horizontal beliefs are said to be related to an individual's social relationships. As can be seen, this view is too simplistic as it does not allow for the merging between the vertical and horizontal nature of spirituality and religiosity. In fact, as mentioned above, many definitions view spirituality in terms of connectedness with God or higher power, others in the community and the environment or universe at large.

The existing literature has revealed that different authors view the relationship between spirituality and religion differently. Some regard religion in a more traditional sense as a broad construct that encompasses spirituality, while others view it as a subset of spirituality (Hodge, 2006). In this research study, spirituality is regarded as a broad concept that encompasses religion. Therefore, spiritually augmented psychotherapeutic intervention, which is the subject of this research, encompasses both spiritual and religious dimensions.

2.2 Integrating spirituality and psychotherapy

A question can be asked as to why it is necessary to integrate spirituality and psychotherapy. As it will be apparent below, there are many ways this question can be answered. Helminiak (2001, p. 163) for example, answers it by stating that "Human

healing and wholesome growth are concerns in both spirituality and counselling". Helminiak's argument makes a strong case for such integration in view of the common goal between these two concepts. Advancing a similar argument, Corey (2005) states that both counselling and spirituality emphasise forgiveness of self and others, uncovering and dealing with unfinished business and resentments, and learning to challenge one's dysfunctional thinking, feeling and behavioural patterns. In view of this convergence between the two, Corey contends that the integration is possible. Other authors have supported such integration on the basis that many of the clients that seek professional help regard spiritual faith as something that plays a significant role in their lives (Abernethy, Houston, Mimms, & Boyd-Franklin, 2006; W. R. Miller, 1999; Wen-Shing, 2004).

Research studies have indicated that goals and foci of care for the terminally ill people change towards the end of life, from biomedical to improving quality of life (Breitbart et al., 2004; Cole, 2005; Kaye & Raghavan, 2002; Lin & Bauer-Wu, 2003). Lin and Bauer-Wu (2003) posit that quality of life has psycho-spiritual, physical and functional components to it. The authors further argue that, for the terminally ill, the former component is a subjective experience that includes having connectedness with others, a sense of empowerment and living with meaning and hope. Gaffney and Harvey (2002) support this argument by stating that, while hospice movements should be commended for providing the dying with physical and emotional care, the dying also need to discover personal meaning to life and death. These authors contend that it is only through spiritual knowledge that death can be faced and understood.

Criticism of psychotherapies that reduce humanity to dualism of mind and body abounds in social science literature (Cloninger, 2006). A number of authors are beginning to realise the importance of dealing with people and their psychological problems in a holistic way, recognising the role of spirituality as a third dimension to the human constitution over and above the body and the mind (Breitbart et al., 2004; Cloninger, 2006; Graham, 2001; Helminiak, 2001; W.R. Miller, 1999; West, 2000). Breitbart and his colleagues refer to a number of research studies that have demonstrated that spiritual

well-being is inversely correlated to the experience of existential vacuum and depression. Similarly, Helminiak (2001) contends that the spirit component of the human strives to achieve unity with all that is, while, together with the psyche, ensuring both personal growth and mental stability.

Research findings have associated spiritually augmented therapies with reduced relapses and improved feelings of hope and functional recovery (Cloninger, 2006; Townsend, Kladder, Ayele, & Mulligan, 2002). These findings in turn underscore the importance and urgency for the integration of spirituality into psychotherapy. W.R. Miller (1999) and West (2000) for example contend that spirituality should be incorporated into psychotherapy since it plays a substantial role in people's lives and their psychological well-being. Juxtaposed with these authors' argument is the fact that many people report being spiritual or religious (G. Miller, 2003; W.R. Miller, 1999; Tisdale, 2003). Hence, if the psychotherapist's duty is to honour the client's story as G. Miller (2003) contends, integrating spirituality with psychotherapy may be the appropriate mode of treatment. This means that psychotherapists should always assess the spiritual well-being and/ or spiritual needs of clients routinely before commencing with treatment, so that those clients who are spiritual and have spiritual struggles can have this attended to as part of treatment plan (Breitbart et al., 2004; Kelehear, 2000; G. Miller, 2003; West, 2000). It is important to emphasise that, not all clients seeking psychotherapy will benefit from or even be interested in a spiritually focused type of therapy. However, the psychotherapist may ascertain this if the in-take assessment includes asking about spiritual struggles.

Spiritually augmented therapy is not in itself a specific type or mode of therapy but it simply means incorporating the spiritual dimension into any form of therapy that lends itself to this integration. There have been arguments in the literature that all psychotherapists, regardless of theoretical orientation or training, can incorporate clients' spirituality successfully into psychotherapy (W.R. Miller, 1999; Watts, 2001). This argument will be viewed closely by examining different psychotherapy approaches in the sections that follow. As there are many psychotherapy orientations used by mental health professionals, only those that were used in the present research will be discussed here.

These were: cognitive-behavioural therapy (CBT), transpersonal psychotherapy, existential psychotherapy, gestalt therapy, transactional analysis, and integrative approach. Each one of these will be examined briefly to indicate how spirituality can be integrated into it.

2.2.1 Cognitive-Behavioural Therapy (CBT)

Behavioural therapy arose as an alternative to psychoanalytic therapy in the 1950's and early 1960's (Corey, 2005; West, 2000). Behavioural therapy looks at observable maladaptive behaviours and, through using a number of behavioural techniques such as journal keeping, thought watching, meditation or relaxation, it attempts to eliminate the unwanted or increase the desired behaviours (Corey, 2005; West, 2000). The classical behaviourists did not acknowledge that factors other than the observable can influence behaviour. Only later on did they begin to acknowledge the role played by social learning in observable behaviour. In the 1960's, Bandura (as cited in Corey, 2005) played a critical role in developing a social learning theory to illustrate this point. Developments continued in an attempt to improve behavioural therapy. The 1960's for example, saw a mushrooming of approaches that combined cognitive and behavioural therapies into a single approach (Corey, 2005). Behavioural therapists began to appreciate the role of mental processes mediating behaviour as well as the reciprocal interaction or mutual influence of cognitions, emotions and behaviour (Corey, 1996, 2005). One of the well-known pioneers in this field was Albert Ellis (Corey, 2005) who showed, with his ABC theory (i.e. activating event, belief and emotional and behavioural consequences), how emotional disturbance develops. Ellis then developed his well-known therapy technique known as rational emotive therapy (R.E.T), which later became known as rational emotive behavioural therapy (R.E.B.T) (Corey, 1996, 2005). Clients involved in cognitive-behavioural therapy are expected to assume an active role in identifying dysfunctional thinking, affective and behavioural patterns and in changing these. The approach is therefore action-oriented, requiring clients to complete homework exercises of various types (Corey, 1996, 2005) aimed at uncovering and challenging dysfunctional thinking patterns as well as disabling behaviours.

The classical behaviourists criticised spirituality (specifically religion) as non-scientific and as something that held psychology back (G. Miller, 2003; West, 2000). However, viewed against the above brief background, it is clear that the position of some behaviourists has changed and that spirituality can be easily incorporated into CBT.

Spiritual beliefs that enhance adaptive functioning and act as a source of strength and coping should be encouraged in therapy for those clients that are spiritual and willing to explore their spiritual struggles in therapy. This can be done by encouraging the individual to practice behavioural techniques inside as well as outside therapy (Cole, 2005; Cole & Pargament, 1999; G. Miller, 2003; W.R. Miller, 1999). In the same way, maladaptive spiritual beliefs, which, according to Corey (2005), are usually based on misinterpretation of spiritual and religious aspects, can be dealt with by means of cognitive restructuring techniques based on cognitive therapy principles (Corey, 2005; W.R. Miller, 1999). However, the cognitive part of CBT is not limited to cognitive restructuring of dysfunctional thinking patterns. There are a number of cognitive techniques aimed at enhancing the desired behaviour that can be used. The success of spiritually augmented therapies is well documented in literature (Cole, 2005; Cole & Pargament, 1999; Hodge, 2006; W.R. Miller, 1999; West, 2000). Guided imagery as a cognitive technique has been widely used in spiritually augmented psychotherapy (G. Miller, 2003; Scherwitz, McHenry, & Herrero, 2005).

W.R. Miller (1999) argues that the theory and methodology of cognitive science is well suited to the integration of spirituality. Unresolved spiritual struggles may be reframed using the usual cognitive strategies such as evaluation of one's thoughts and behaviours in relation to core beliefs (W.R. Miller, 1999). Clients can be taught the basic principles of cognitive-behavioural techniques, for example, where they are shown the link between one's beliefs and emotions. Kaye and Raghavan (2002) support this argument and add that, encouraging clients to seek purpose and meaning in their lives and their suffering can change their whole outlook into their situation. This way, clients can begin to see that, within the constructivist's view, people somehow create their realities because they can choose how to understand and respond to their reality (Corey, 2005; W.R. Miller,

1999; Zimberoff, 1997). Changing perception of one's condition by cognitively reframing the stressful events may result in the change of emotional experience.

Psycho-education is one of the techniques used in cognitive therapy approach. In his research study, Cunningham (2005) psycho-educated cancer patients about common patterns of thinking that block spiritual experience and healing. The program showed patients how to diminish these obstacles so as to strengthen their spiritual connection. Cunningham also used mental imagery and thought watching as the other cognitive therapy techniques that can be used in a spiritually augmented type of therapy.

2.2.2 Transpersonal psychotherapy

Transpersonal psychology is a field that came about around the late 1950's to early 1960's (Elkins, 1998; Grof, 1998; West, 2000) as an alternative to the three dominant forces in psychology. The word transpersonal is basically made up of two syllables: 'Trans', meaning beyond and 'personal' from the word 'persona', meaning "mask" (Cowley, 1993; Leight, 2001; Tart, 1993). The word literally means beyond the ego/ personal (Cowley, 1993; Graham, 2001; Grof, 1998; 2006; Leight, 2001; Lukoff, Lu, & Turner, 1998). Grof (2006, p. 92) defines transpersonal phenomena as:

> The experiences that originate on this level involve transcendence of the usual boundaries of the body/ego and of the limitations of three-dimensional space and linear time that restrict our perception of the world in the ordinary state of consciousness.

Walsh and Vaughan (1993, p. 3) define transpersonal experiences as "Experiences in which the sense of identity or self extends beyond (*trans*) the individual or personal to encompass wider aspects of humankind, life, *psyche,* and cosmos." This means that, while consciousness/awareness is important for ordinary talk and transpersonal therapies, the latter go beyond the dualistic (body-mind) limitations and delves into the spiritual realm. This does not mean that traditional talk therapies are viewed as valueless by

transpersonal therapists. These therapies are still incorporated as appropriate, in line with an individual client's needs (Knight, 1997; Smith, 2001; West, 2000).

Transpersonal psychotherapy places great emphasis on spiritual development and the transformation of consciousness as a goal of therapy (Cowley, 1993). Oberholzer's (1996, p. 1) definition of transpersonal psychology supports this claim "Transpersonal Psychology is an emerging paradigm that recognizes the transbiographical domain of consciousness and accepts spirituality as an intrinsic property of the deeper dynamics of the psyche". According to Maslow (as cited in West, 2000), transpersonal psychology concerns itself with transcendent values and experiences.

Transpersonal psychotherapy therefore distinguishes itself from other traditional psychotherapy approaches by not merely incorporating spirituality but making it the main goal of psychotherapy (Cowley, 1993; Knight, 1997; Lukoff et al., 1998; W.R. Miller, 1999; Tart, 1992). Transpersonal psychotherapy, according to Knight (1997), strives for holistic healing. By healing, Knight (1997, p. 44) contends, is meant "...remembering of our true nature (spiritual nature)". The conception of spirituality as the humans' true nature is also shared by West (2000). Transpersonal psychology views the human experience differently from the other approaches in that it "...recognises experiences which take place beyond consensual reality as being meaningful and a part of the full range of human functioning" (Knight, 1997, p. 1).

The point of departure in transpersonal therapy is that transpersonal experiences are not accessible through the use of traditional talk therapies (Knight, 1997). Hence, to access such experiences directly, the ordinary state of consciousness has to be bypassed by using altered states of consciousness (Grof, 1998, 2006; Knight, 1997; Tart, 1992). Grof (1998) argues that the word altered or nonordinary state of consciousness can be misleading as consciousness can also be altered by pathological processes. To differentiate these pathological forms from those used in a transpersonal sense, Grof (1998, p. 5) coined the term *holotropic states,* which literally means "moving in the direction of wholeness". Grof (1998, p. 50) describes holotropic states as follows:

> Holotropic states are characterized by a specific transformation of consciousness associated with perceptual changes in all sensory areas, intense and often unusual emotions, and profound alteration in the thought processes. They are also usually accompanied by a variety of intense psychosomatic manifestations and unconventional forms of behaviour. Consciousness is changed qualitatively in a very profound and fundamental way but, unlike in the delirant conditions, it is not grossly impaired.

The methods used to induce altered states of consciousness are many and varied. For clinical purposes, powerful forms of experiential psychotherapy, such as hypnosis and holotropic breathwork are among those that are used the most (Grof, 1998; Grof & Grof, 1989; Knight, 1997; Oberholzer, 1996). Transpersonal experience therefore involves transcendence of temporal, spatial and biographical boundaries (Grof, 2006; Oberholzer, 1996). A person can relive experiences that happened very early on in life. Things that happened prenatally, perinatally, in early childhood and even at conception when the sperm met the ovum, can be relived by using regression approaches in hypnosis (Grof, 2006). The transcendence of spatial limitations, according to Grof (2006), involves experiences of being in unity with the universe, e.g. plants and animals, as well as merging with other people in other parts of the world. David (1993) supports Grof's view of oneness of all in the universe and further contends that, if the world is made up of a lot of bits - animals, plants and humans - then the humans are spiritually connected with all in the universe as part of one whole. David argues that, once humans make sense of this fact and achieve a deeper meaning, they will move closer towards the question of spirituality.

Another category of transpersonal phenomena described by Grof (1998) is the one that is similar to Jung's concept of collective unconscious. According to this category, all humanity of different racial, historical, cultural and ancestral background is connected in some way. Grof (1998) further contends that, in holotropic states, the content of the collective unconscious becomes accessible to the ordinary states of consciousness.

Transpersonal psychotherapy therefore, focuses on doing therapy through strengthening the ties of spiritual connection. While the ego strength of a client is important to transpersonal psychotherapists, it is not the ultimate goal of therapy as in psychoanalytic approaches for example. The ultimate goal of therapy for transpersonal therapists is the transcendence of the ego to reach the spiritual nature (Knight, 1997).

2.2.3 Existential psychotherapy

Existential approaches are not based on a neatly defined set of therapy techniques. They are rather a philosophical than an independent school of therapy (Corey, 1996, 2005; Frankl, 1967; West, 2000). Existential psychotherapy is an approach that focuses on existential (life and death) issues (West, 2000). The existential approach to psychotherapy is based on the principles that are described below. Firstly, the existentialists argue that human beings are free and responsible for their choices. Hence, even inaction is a decision. Secondly, they contend that people can partially create their realities because they have power of choice. This has implications for the way existentialists view the development of psychopathology. In connection with the latter, existentialists argue that people suffer from existential despair (i.e. a feeling of meaninglessness) and a spiritual distress rather than an emotional disease or a mental illness. The goal of therapy is therefore to challenge clients to find meaning in their lives as well as to explore the meaning of spirituality or religion for them personally. Thirdly, human beings, according to this philosophy, are both alone and connected to others. They came alone into this world and will therefore leave alone. The knowledge of this basic principle may raise humans' awareness of death as a basic human condition, which may in turn give meaning to suffering and living. Lastly, existential philosophers contend that, although people may be unable to change certain events or conditions, they can choose how to respond to them. They further argue that people can still feel worthwhile despite their past limitations, for they need not be perfect to feel worthy (Breitbart et al., 2004; Corey, 2005; Frankl, 1967; West, 2000).

Although many existential philosophers are known for being the pioneers in the field of existentialism (Breitbart et al., 2004), Victor Frankl is arguably one of the most influential (Corey, 2005). Frankl developed logotherapy, heavily basing his concepts on his predecessors' ideas, such as Nietzsche's famous concepts of the will to power (Breitbart et al., 2004). Corey (2005, p. 135) summarises the central themes running through Frankl's works as follows: "...life has meaning, under all circumstances; the central motivation for living is the will to meaning; the freedom to find meaning in all that we think; and the integration of body, mind and spirit". Existential approaches are not as deterministic as psychoanalysis in their approach to therapy; hence they do not prescribe meaning for the client. The therapist's goal is rather to help clients find their own personal meaning in life (Corey, 2005; Frankl, 1967; West, 2000). Therefore, existential psychotherapy is very closely related to phenomenology (West, 2000), allowing the client to choose a spiritual path that is most meaningful to them.

The above discussion clearly shows that spirituality can be easily incorporated into existential approaches to psychotherapy. Other authors, as it was shown above, have chosen to assume an existential approach to the definition of spirituality, pronouncing existential therapy as a spiritual approach to psychotherapy. There has also been an argument that, since existential psychotherapy focuses on the same issues that also concern religions in the world, the integration is a necessity (W.R Miller, 1999).

2.2.4 Gestalt therapy

Gestalt therapy is an existential-phenomenological approach rooted on the belief that clients are capable human beings who can lead an independent life and make mature choices (Corey, 2005). It is rooted in the existential principles which emphasise holistic approach to psychotherapy (i.e. body, mind and spirit). Gestalt approach to therapy is experiential, promoting the immediate, here-and-now approach to dealing with one's problems (Corey, 2005; W.R. Miller, 1999). When clients complain of problems or figures in their past, which are affecting their functioning presently, the therapist

encourages them to bring them to the present, experiencing all the feelings fully, to resolve them (Corey, 2005).

The main aim of this approach is to bring clients to full contact with their environment or feelings. Instead of talking about their past experiences and analysing them, they relive a full range of feelings that went with these experiences with a view to process those feelings. Gestalt therapists talk about healing or completing unfinished business of the past (Corey, 2005) and, through a series of experiments or role plays, e.g. empty chair exercises or clearing processes, they get to re-experience these and in so doing giving themselves a chance to heal by processing the underlying emotions (Corey, 1996, 2005; W.R. Miller, 1999). These exercises, according to W.R. Miller (1999) can bring about insight, better social and healthy psychological functioning.

The Gestalt therapy approach also stresses the importance of reintegration of the split off parts that the individual may have disowned (Corey, 2005). An individual who grew up in a home environment for example, where expression of one's anger was unacceptable can disown these feelings. In therapy, this can be practiced where such an individual can be helped to express his repressed anger to his/her parent on an empty chair basis. This can help the person to realise that it is ok to have angry feelings and that they are part of his own self.

It is clear from the above overview that spirituality can be easily integrated into Gestalt therapy based on its view of man. Supporting this view, Lynn (2006) states that literature as well as her personal experience has shown that there is a connection between Gestalt therapy and spirituality. She further states that Gestalt therapy not only shares a close relationship with spirituality, but it is also closely related with transpersonal psychotherapy. This is a point shared by Freeman (2006) who further stresses that Gestalt therapy has been hard to separate from transpersonal psychotherapy and spirituality since its inception.

2.2.5 Transactional analysis approach

Transactional analysis, as the name states, involves the analysis of transactions, the smallest unit of human interaction (Burke, 1989; Clarkson, 1992). Eric Berne developed transactional analysis in 1950's and 1960's (Burke, 1989; Ivey & Simek – Downing, 1980; Kotler & Brown, 1992; Morse & Watson, 1977). As an offspring of psychoanalysis, transactional analysts still believe in intrapsychic dynamics as determinants of behaviour but add a focus on interpersonal forces as another determinant as well (Clarkson, 1992).

Although transactional analysis is an offspring of psychoanalysis, its practitioners practice integratively, drawing even from existential-humanistic psychology (Clarkson, 1992; Kotler & Brown, 1992). Its belief in human beings' capability in making their own decisions and correcting old maladaptive ones as well as its emphasis in freedom of choice makes it firmly embedded in humanistic-existential approaches (Clarkson, 1992; (Kotler & Brown, 1992). Transactional analysts believe, like psychoanalysts, that childhood problems can and do affect present behaviour (Kotler & Borown, 1992).

Berne (as cited in Burke, 1989; Clarkson, 1992; Ivey & Simek-Downing, 1980; Kotler & Brown, 1992) argues that, among other things, human behaviour is motivated by three ego states: parent, adult, and child. As we behave, our actions can be construed as existing in one of the main ego states. Ego states can be described simply as "the states of the mind and their related patterns of behaviour as they occur in nature" (Clarkson, 1992 p. 42). Clarkson (1992) contends that these ego states are an individual's internalised psychic representations of what took place in their earlier times. He argues that the ego states can be relived vividly or are so deeply entrenched that they are not accessible but they continue to influence the person's life. Behavioural problems can arise if a person fixates in one ego state (Ivey & Simek-Downing, 1980). Such a person, according to these authors, may be considered immobilised and lacking in intentionality. The authors further argue that, to be successful and comfortable, a human being requires parental

behaviour at times, adult behaviour at other times, and the free, creative expression of the child at still other times.

Transactional analysis is therefore humanistic in the sense that it values the subjectivity of human experience as it is existential in its emphasis of freedom and responsibility in making choices (Clarkson, 1992; Corey, 2005). This view of human nature makes it possible to incorporate spirituality into transactional approach. When using hypnotherapy for example, one can invite the client to ask their wise adult ego state (Clarkson, 1992) together with their spiritual connection to advise them to make wise, healthy choices. Some clients have weak, fragmented or no ego strengths. In such cases, a weak ego may be strengthened or, in a case of a fragile ego (e.g. patients with borderline personalities), implanted, to help a client to function better. In therapy, a pathological child ego state can be healed by, for example, using regression therapies (Grof, 2006; Janov, 1996; Pert, 1997; Rossi, 1986) or Gestalt therapies (Corey, 2005) to help a client connect with the exact developmental stage where they got stuck so they can process all the underlying emotions that were not dealt with at the time. Using regression or experiential therapies may help therapists to access and retrieve clients' wounded ego states and, in so doing, helping clients to re-experience, abreact and process underlying emotions (Gainer, 1993; Van der Kolk & Greenberg, 1987). This can be done by following emotional or somatic bridge (Gainer, 1993; Zimberoff, 1997) to get a client back to the source of their point of being stuck. Once clients connect with their wounded ego state, work can then be done using any combination of therapy methods.

2.2.6 Integrative approach

Theoretical integration, according to Corey (2005), involves drawing from a diverse theoretical repertoire without confining oneself to one school of therapy orientation. Corey warns against a haphazard picking of theories without being guided by the merit of the case at hand. Spiritually augmented and/ or transpersonal approaches usually use hypnotherapy as an approach to doing therapy (Grof, 1998; Knight, 1997; Oberholzer, 1996). As mentioned earlier, spiritually augmented psychotherapy is not a type of therapy

mode but merely an approach encompassing a whole range of therapies. It is therefore integrative in nature in that all the approaches mentioned above can be easily integrated in a single spiritually augmented therapy session.

An example of a hypothetical case of an adult woman who was sexually abused as a child can illustrate this point. Suppose that such a woman is struggling with intimacy with men but she can't figure out why. She fears intimacy and, if she finds a partner, she struggles with emotional responsiveness. She attends therapy with a hypnotherapist who then, under hypnosis, helps them connect with the event using regression approach (Grof, 1998; Knight, 1997). In therapy, she regresses to the child ego state (transactional analysis) (Clarkson, 1992) and, through the therapist's lead, she processes the feelings (gestalt way of dealing with unfinished business) (Corey, 2005). While in the child ego state, the therapist listens to what she believed at the time, to see whether there were any dysfunctional cognitions and, if any, do cognitive restructuring (cognitive therapy). Examples of dysfunctional cognitions could be "It was all my fault, because I trusted him too much". For this same client, the therapist can do wise adult strengthening or implantation (where there is none) (transactional analysis) just after hypnotherapy induction. A spiritual connection and safe place can also be strengthened as part of a heart-centred, spiritually focussed psychotherapy to help the client enlist these spiritual resources for strength and coping. The client's subjective, phenomenological experience is respected rather than doubted, hence following humanistic principles of therapy.

2.3 Therapeutic techniques

This section briefly discusses the techniques that therapists, practising spiritually integrated psychotherapy, may use. Most of these techniques are not necessarily exclusive to spiritually focused psychotherapy. Only those that were used in this research study will be discussed here. These were: meditation, hypnosis, instillation of hope, encouraging forgiveness, creating safe place, facilitating a spiritual connection, corrective visualisation, and contacting your inner teacher.

2.3.1 Meditation

Meditation is a technique that originated from the East (W.R. Miller, 1999). Despite its origin, this technique is widely used in the west for physical, psychological and spiritual health dimensions (G. Miller, 2003; W.R. Miller, 1999). Bonadonna (2003, p. 309) defines meditation as "the practice of becoming aware, of paying attention, or the act of inward contemplation". Contrasting meditation, as a transpersonal approach, with traditional psychotherapy, Diers (1999, p. 119) states "Meditation is the spiritual practice of losing the self construction, while psychotherapy aims to strengthen the self-construct and make its foundations more sturdy". Meditation facilitates spiritual, emotional, physical, mental and intellectual growth (G. Miller, 2003; Walsh, 1999). It also helps to calm the mind, thereby helping it to transcend negative experiences while focusing on more positive dimensions of experience such as compassion, acceptance, and forgiveness (W.R. Miller, 1999). Meditation, according to Graham (2001), heals by structuring mental contents as well as by promoting wholeness in an individual. He further states that, in the east, meditation is considered as medicine. Meditation practice has also been linked with reduced anxiety, stress, pain and depression and enhanced mood and self-esteem (Bonadonna, 2003).

While there are many methods of meditation, only two types will be discussed here: concentration, which involves focusing on something specific inside or outside of the person and mindfulness, in which a person observes thoughts without judgment (Cunningham, 2005; G. Miller, 2003; W.R. Miller, 1999; Walsh, 1999). Meditation has been used extensively in conjunction with psychotherapy to reduce stress and bringing about relaxation (Cunningham, 2005; Kaye & Raghavan, 2002; G. Miller, 2003). In support of this claim, W.R. Miller (1999) contends that mindfulness meditation is connected to such behavioural therapy techniques as self-monitoring as well as to cognitive techniques that emphasise challenging one's dysfunctional or distorted beliefs and thinking patterns. Guided imagery as a form of concentrated meditation can be used inside as well as outside therapy session (G. Miller, 2003).

2.3.2 Hypnosis

Hypnosis refers to an altered state of consciousness in which the conscious mind becomes less active while the subconscious takes over (Hewitt, 1997; West, 2000). West (2000) argues that hypnotic experiences are transpersonal and that they are healing. Hypnosis is induced by "boring your conscious mind so that it relaxes and stops thinking" (Hewitt, 1997, p. 2). Once the conscious mind has been bypassed by means of hypnotic induction, therapeutic suggestions are then given to the subconscious, which, according to Hewitt (1997), is very receptive of suggestions. Hypnosis has been linked to reduction of pain intensity and negative side effects of chemotherapy for cancer patients (Cole & Pargament, 1999). Since hypnosis brings about a deep relaxation of the conscious mind, there have been suggestions to train patients in self-hypnosis to help them reap the benefits of this technique on their own (Cole & Pargament, 1999; Hewitt, 1997). Studies have shown that relaxation and imagery can work well in reducing depressive symptoms and enhancing adjustment and coping (Hirai, Morita, & Kashiwagi, 2003; West, 2000).

2.3.3 Instillation of hope

Hope has been defined differently by various writers. Gum and Snyder (2002, p. 884) define hope as "a cognitive set that is based on a reciprocally derived sense of successful (a) agency (goal-directed determination) and (b) pathways (planning of ways to meet goals)". Research findings have shown that patients who have connectedness with others, their spirituality and health care professionals usually have a strong sense of meaning and hope in life (Lin & Bauer-Wu, 2003). Similarly, many authors and researchers have discussed different ways that can be used to instil hope in patients that are grappling with the effects of terminal illness (Gum & Snyder, 2002; Lin & Bauer-Wu, 2003; W.R. Miller, 1999). W.R. Miller (1999) conceptualises hope as something that comes from reliance on a transcendent force rather than on one's own control. One way of encouraging hope therefore, as Cole and Pargament (1999) have argued, is encouraging patients to surrender what is beyond their control to their higher power. W.R. Miller

(1999) discusses various ways in which hope can be instilled. One such way is to psycho-educate patients that, while one may not choose their situations, one can choose how to respond to one's situation. He further suggests that patients can be encouraged to join self-help groups to derive hope and a sense of support.

Gum and Snyder (2002) conducted a research on the role of hopeful thinking in coping with the distress of terminal illness. They suggested practical things that a therapist can do to revive or instil hope: help patients mourn loss of valued unattainable goals; find meaning or benefit in suffering; recognise one's worth despite goal losses; recall past goal achievements and important relationships; develop alternative goals; choose goals important to self; enlist others' help and describe goals clearly, so that progress can be measured. The authors discuss these techniques individually, explaining how a therapist can go about using them.

2.3.4 Encouraging forgiveness

The power of forgiveness to bring about psychological healing is largely underestimated by many secular psychotherapists (West, 2000). West speaks about three levels of forgiveness, namely: forgiving others, forgiving oneself and receiving forgiveness. With regard to self-forgiveness, the therapist can encourage life review with the client, not only to focus on positive achievements as windows to the soul, as Kaut (2002) suggests, but also so that the client can forgive himself for his shortcomings. This can be used to balance things up so that the client sees things realistically, instead of placing undue emphasis on his failings while discounting his achievements.

While forgiveness is important, some authors warn against premature forgiveness without proper processing of feelings that go with it (W.R. Miller, 1999; West, 2000). Miller, for example, argues that the client should not be forced to forgive if they are not ready to do it. According to him, clients should be psycho-educated on the pros and cons of forgiving as well as the adverse consequences of anger on their psychological and physical health.

He further states that, in cases where the client is not ready to forgive, letting go of anger can still be practised in keeping with the client's spiritual or religious values.

Sometimes it may not be possible for the offender to be present to receive forgiveness or the offended to receive the apology. In such cases, especially in the case of a dying patient, an empty chair technique can be used. Two chairs can be used; the client can sit on one, while the imaginary offender can be assumed to be sitting on the empty one. The client can then be instructed to express all their emotions to the imaginary person on the empty chair. The therapist helps the client to process all those feelings before letting go of the anger and express forgiveness. Wood and Fox (2005) contend that, in cases where there is no full cooperation from those with whom a client has had disagreement, the client should take responsibility for his own actions and reactions and set himself and the other parties free. W.R. Miller (1999) stresses the importance of telling the clients that forgiveness is a process that may not be achieved immediately. Hence the client may need to continuously do cognitive reframing on this process.

Closely related to the concept of forgiveness is what Matthew (1994) calls healing resentments. Matthew argues that helping clients to heal hatred, self-pity and bitterness is one of the most important goals of transpersonal and ordinary psychotherapies. Matthew argues that clinging to hatred can have negative psychological consequences to people. This process of forgiveness can therefore be facilitated in a therapy session so that clients may feel lighter thereafter.

2.3.5 Creating a safe place

A safe place is usually created with a person in hypnosis or deep relaxation. The human mind is a wonderful tool that can be used to create numerous healing visualisations (Walsh, 1999). The person or his subconscious is instructed to picture or visualise himself in a nature place of his choice or in his backyard, where ever is most suitable to him, where he feels most relaxed (see Appendix A (i): Deep relaxation/Hypnotherapy script). Suggestions to the effect that in such a place there are no worries and troubles are

then downloaded into his subconscious. G. Miller (2003) warns that therapists should guard against suggesting safe places that apply to them rather than to their clients. That is why it is important to let them choose *what is most suitable to them* so that they create a place in their minds that will be safe for them to seek refuge in times of difficult emotional experience. Safe places can be created with a person in an ordinary state of consciousness by asking leading questions which show the client and the therapist what spiritual places or experiences in the client's past have been regarded as safe by the client. Other authors use the word safe place and safe place of refuge interchangeably to mean the same thing. What is meant here though is what W.R. Miller (1999) refers to as inner Haven, a place that brings serenity and tranquillity, which an individual accesses through visualisation or guided imagery. Miller suggests that safe places can also be resourceful for clients to use as insulation for stress and flashbacks. This presupposes that the client has thoroughly mastered the technique and can easily visit his inner Haven at will in times of difficult emotions. Some clients, as W.R. Miller (1999) also confirms, prefer to listen to relaxing music as induction to their safe places.

2.3.6 Facilitating a spiritual connection

A spiritual connection can be facilitated by using positive mental imaging of a transcendent power during a therapy session (Kaye & Raghavan, 2002). This can be done with a client in deep relaxation or trance state, where the therapist may ask the client if he would like to invite his spiritual connection (e.g. God or ancestral spirit) into the session for guidance and healing. If the answer is affirmative, the therapist can then tell them to visualise and feel the presence of their higher power in the session and inside them. While in this trance state, the therapist can then suggest that they visualise surrendering their troubles and cares into the hands of their higher power and further visualise themselves being bathed in a white light (Cole & Pargament, 1999). Facilitating a spiritual connection in this way in a session can bring about a sense of identity and connectedness. According to Cole and Pargament (1999), such a feeling of connectedness is particularly helpful to cancer patients who are already experiencing feelings of loneliness and disconnectedness.

The knowledge that one's transcendent force is on one's side brings about that feeling of intimacy which terminally ill patients lose due to being bed-ridden and disconnected from their loved ones. Kokach (2000), speaking about the suffering of HIV patients, concurs with this argument. He further argues that the real suffering for terminally ill patients is not due to them being in physical pain, but due to being disconnected from the social network. Facilitating a spiritual connection in a psychotherapy session may therefore help patients realise that they can call upon their spirituality to provide a sense of support and coping in times of difficulties. Outside of therapy, patients can be encouraged to enlist their spirituality by visualising the presence of their higher power as said above or by saying prayers, reading scripture, engaging in rituals or seeking spiritual refuge (Kaut, 2002; Kaye & Raghavan, 2002; Meyerstein, 2004; G. Miller, 2003; West, 2000). To strengthen this sense of intimacy and connectedness with a transcendent force, Cole and Pargament (1999) constantly encouraged participants in their study to view their spirituality as a partner in their coping struggles. Cole and Pargament's study encouraged collaborative partnership, whereby participants were encouraged to imagine their spirituality working with them rather than passively deferring their problems to God. This firmly drove home matters of control, whereby participants were encouraged to separate their issues into two: those in their control and those in their transcendent's control.

2.3.7 Corrective visualisation

Corrective visualisation is another way of teaching oneself self-forgiveness (Walsh, 1999). Using an induction to deep relaxation (see Appendix A (ii): Corrective visualisation), the client can be guided to relive a time when they spoke or acted in a way they now regret (Walsh, 1999). Once the client slips into trance, Walsh suggests that he be guided to visualise the whole process unfold up to the end. In each step he is to relive the situation and the underlying feelings fully, while watching himself make the error and observe the outcome. Thereafter, he is instructed to restart the whole visualisation process, but this time exercising a wise choice to avoid commission of error, and observe the feelings that go with it. According to Walsh, such exercises can bring about a sense of healing.

2.3.8 Contacting your inner teacher

The process of activating wisdom within has been a subject of discussion since antiquity (Walsh, 1999). Walsh argues that each individual has this gift within them, which is accessible any time as long as they know how to use it. This concept of inner wisdom or inner teacher is similar to the concept of wise adult that transactional analysts talk about (Burke, 1989; Clarkson, 1992; Ivey & Simek-Downing, 1980; Kotler & Brown, 1992). After inducing a deep relaxation as in corrective visualisation above, a suggestion is made for the client to visualise a time in the past when someone they admired for their wisdom acted wisely on their behalf (see Appendix A (iii): Activating wisdom from within/Ego strengthening script). They are further instructed to relive the unfolding of the entire situation and the feelings that went with this experience. Walsh (1999) suggests instructing them to visualise the presence of a wise man/woman visiting them in their safe inner Haven (W.R. Miller, 1999). For example the person could be told "This man/woman is so charismatic that just the experience of being next to them evokes wonderful feelings inside you". Later on the therapist suggests a merge with this person so that the client himself becomes this person, with a further suggestion that, this sage is, after all, the creation of the client's mind. At the end of the exercise, when the client has opened their eyes, Walsh (1999) suggests that the therapist may tell the client to use this exercise when they need guidance with difficult choices or questions. Cunningham (2005) has reported success with this spiritual technique in the study that he conducted with cancer patients. Consulting "inner wisdom" through "the inner healer" was one of the techniques he used to facilitate spiritual connectedness in his study (Cunningham, 2005, p. 180).

2.4 HIV/AIDS as a terminal illness: International and South African literature

In view of the fact that both participants of this study have HIV/AIDS as a terminal illness, a separate section addressing issues relating to this disease is warranted. Since the discovery of HIV/AIDS in the early 1980's (Scragg, 1995), a number of difficulties that people living with this disease grapple with have been identified. There have also been

many observations, suggestions and developments made since then. In this section the following issues will be briefly discussed: stigma and cultural context; loneliness/social disconnectedness; western treatments vs. complementary alternative treatment methods; psychiatric symptoms and death anxiety; the chronic/ terminal dichotomy of HIV/AIDS; HIV/AIDS as affecting the whole family; spiritually focused psychotherapies and immunity; the diagnosis of HIV/AIDS as changing one's level of spirituality.

2.4.1 HIV/AIDS stigma and cultural context.

Since the identification of HIV/AIDS, the affected individuals have grappled with negative attitudes, hostility and stigmatisation (Nyawose, 2004). Stigmatisation can be attributed to a number of causes that can be differentiated in terms of universal, differential and unique cultural presentations. Nyawose (2004, p. 41) defines stigma as:

> ...a social process that allows for construction of exclusion, rejection, blame or devaluation of the identified group or individuals. It is associated with labelling, stereotyping, separation, loss of status and discrimination of those that are identified as being different.

The general public's tendency to view HIV/AIDS as a moral rather than a medical condition (Nyawose, 2004) is universal. However, there are cultural differences as well. Upon its discovery in the early 1980's, HIV/AIDS was associated with shame because it was thought to be spread by gay men, lesbians and intravenous drug users (Demmer, 2007a; Holt, Houg, & Romano, 1999; Nyawose, 2004; Sitkin & Roth, 1993). However, in Black African communities in South Africa (Demmer, 2007a) and Ghana (Mill, 2001), HIV/AIDS is associated with immoral, promiscuous behaviour. Hence the knowledge that someone has HIV/AIDS evokes feelings of disgust towards them from the public. Supporting this argument, Broun (1999) contends that stereotyped roles are culturally scripted for women with HIV/AIDS, resulting in them being shamed and discriminated against. She further states that such discrimination gives rise to feelings of guilt, fear of rejection and loneliness. There have been unique differential presentations where this

hatred has been taken to extremes, resulting in the killing of those who disclose their AIDS diagnosis. A well-known case happened in December 1998 in the KwaZulu-Natal province of South Africa, where a woman was killed violently for disclosing her HIV positive status (Nyawose, 2004). The cultural forms of stigma appear to be harshly levelled at women, blaming them of being promiscuous (Holt et al., 1999). Historically, South African Blacks regard a sex-related subject as a taboo (Demmer, 2007a). This leads to most women preferring to suffer in silence in fear of being judged by the society. Churches themselves have not been exempt from the blaming and estrangement of HIV/AIDS sufferers (Demmer, 2007b; Holt et al., 1999; Krakauer & Newbery, 2007).

Therefore, stigma results from numerous factors that can be classified as universal, cultural or unique and differential.

2.4.2 Loneliness/ Social disconnectedness.

Due to fear of being stigmatised, most people's social functioning becomes impaired as they begin to be socially withdrawn and confined in their homes (Martin, 1994). Some become ostracised by fellow workers and even by employers (Sitkin & Roth, 1993) and end up quitting employment. In some cases, people with HIV/AIDS disease are ostracised by their families of origin or extended families (Ironson, Solomon, Cruess, Barroso, & Stivers, 1995). Studies have associated an increase in HIV-related symptoms with poor or lack of social support, suggesting that good social support is a good predictor of positive health outcomes over time for HIV/AIDS sufferers (Ashton et al., 2005). As mentioned above, the isolation of people living with HIV/AIDS comes from members of the general public as well as churches. This leads to social and spiritual disconnectedness at the very time when the terminally ill person living with HIV/AIDS requires spiritual fulfilment. It is for this reason that integrating spirituality into psychotherapy and any other treatment becomes crucial for these people (Dalmida, 2006; Dane, 2000; Miller, Chibnall, Videen, & Duckro, 2005; Siegel & Schrimshaw, 2002; Tuck & Thinganjana, 2007).

2.4.3 Western treatments vs. complementary and alternative medicine (CAM).

Many authors have called for concerted efforts between traditional- and western-based healing/treatment methods in the fight against HIV/AIDS and other health conditions (Chemane, 2004; Edwards, 2004; Leach et al., 2003; Mill, 2001; Nyembe, 2002a; Okello & Ekblad, 2006; Romero-Daza, 2002; Ross, 2008). Literature indicates that historically, western psychotherapies and other treatment forms have stigmatised and opposed traditional forms of treatment and labelled them as pre-scientific (Nyembe, 2002a). This is unfortunate because, when viewed closely, traditional healing forms and western psychotherapies are not mutually exclusive (Chemane, 2004) and, as Romero-Daza (2002) argues, the fight against HIV/AIDS requires the utilisation of all sources of health care. Psychotherapists and other mental health professionals should endeavour to use existential-phenomenological approaches to understand their clients, refrain from being judgmental but, instead, strive to understand their interaction with the world (Nyembe, 2002a). Many Black South Africans are still suspicious of the western methods of treatment. Hence, incorporating local cultural practices into treatment can bring about acceptance, commitment and trust in psychotherapy (Hodge, 2006; Leach et al., 2003; Mill, 2001; Ross, 2008). Studies have shown that people who support the use of CAM, use different criteria to decide whether to use or not to use ARV treatment for AIDS (Bishop, Yardley, & Lewith, 2007; Kremer, Ironson, Schneiderman, & Hautzinger, 2006). Such incorporation may merely mean being more accepting and willing to learn from the client. A study conducted by Krakauer and Newbery (2007) indicates that practices that incorporate local culture appeal more to people compared to those which do not. Incorporating traditional healing practices into the treatment of HIV/AIDS makes sense if one considers the findings of the study conducted by Peltzer, Mngqundaniso and Petros (2006), which revealed that, in a year, 36% of South African Blacks with sexually transmitted infections consult traditional healers.

2.4.4 Psychiatric symptoms and death anxiety.

The literature has indicated that people living with HIV/AIDS have to contend with the co-existence of this terminal illness and psychiatric symptoms as well (Cooperman & Simoni, 2005; McDaniel & Blalock, 2000; Yi et al., 2006). Neurovegetative symptoms such as insomnia, poor appetite and fatigue can be observed as indications of depressive symptoms (McDaniel & Blalock, 2000). Depressive symptoms can result from worries about issues of life and death, unfinished business, the fact that one will die and leave loved ones behind, funeral costs putting financial burden to the family and the way HIV was contracted (Chibnall, Videen, Duckro, & Miller, 2002; Yi et al., 2006). In their study, Chibnall et al. (2002) found that spiritual well-being was negatively correlated to death anxiety. They operationalised spiritual well-being as a state of meaning in life, along both religious and existential dimensions. It is therefore possible that, the sense of meaninglessness or existential vacuum, leads the individual to a point where nothing matters anymore, pushing them to suicidality. It can be deduced from this study that, to counteract death anxiety and suicidal thoughts, the patient's spiritual connection should be strengthened (Cooperman & Simoni, 2005). Along similar vein, Yi et al. (2006) have argued that poor spiritual well-being can be associated with psychiatric symptoms such as depression. Living alone, emanating from poor social support due to fear of being stigmatised increases the risk of ruminating and can therefore contribute to depression.

2.4.5 The chronic/ terminal dichotomy of AIDS.

In this study, HIV/AIDS is classified as a terminal disease. However, the researcher is aware of the recent debate about whether it is still appropriate to classify this disease as a terminal illness in view of the new developments in terms of its treatment. There have been arguments that the recent discovery of new therapies such as antiretroviral therapy (ARV) has turned HIV/AIDS into a chronic disease like any other chronic diseases (Baer & Roberts, 2002; Holt et al., 1999; Hoy-Ellis & Fredriksen-Goldsen, 2007; Schneiderman, 1999). The term chronic in the medical fraternity "...is used to describe ailments or diseases that have as their hallmark, presence over a long period of time and

often, though not necessarily, of progressive severity" (Hoy-Ellis & Fredriksen-Goldsen, 2007, p. 836).

2.4.6 HIV/AIDS as affecting the whole family.

Interventions targeting the HIV/AIDS affected population have continued to be scarce despite indications in literature that HIV/AIDS affects the whole family rather than just the infected individual (Demmer, 2007a; Hedge & Sherr, 1995; Holt et al., 1999; Lindsey, Hirschfeld, Tlou, & Ncube, 2003; Williams & Stafford, 1991). Demmer (2007a) argues that the magnitude of the distress caused by HIV/AIDS-related death is so great that psychotherapy alone is not enough in South Africa given the shackles of poverty that people have to contend with. He suggests that the problem should be addressed from the socio-economic perspective as well. Apart from having to contend with the burden of caring for the sick, the caregivers of HIV/AIDS victims have to deal with the painful prospect of losing the loved one. In some cases as mentioned above, the family may be angry at the victim whom they see as bringing a shame and disgrace to the family. This may be the epitome of how HIV/AIDS is viewed by the whole society or a particular community.

2.4.7 Spiritually focused psychotherapies and immunity.

The psychiatric problems that people with a terminal disease grapple with may weaken their immune system, making them more susceptible to opportunistic diseases. In view of the fact that people with HIV/AIDS and other terminal illnesses grapple with spiritual struggles, Dane (2000) argues that spiritually augmented approaches to treatment may influence immune functioning. The literature on psychoneuroimmunology has also supported the link between the treatment of negative emotions and the improvement of the immune functioning (Cohen & Herbert, 1996; Tsigos & Chrousos, 2002). This is stressing the importance of integrating spirituality with treatment even further for those clients that are spiritual and can benefit from it.

2.4.8 The diagnosis of HIV/AIDS as changing one's level of spirituality.

Having a terminal illness such as HIV/AIDS evokes existential issues, which may lead to a serious revision of one's spiritual life. Literature has indicated that existential issues that the diagnosis of HIV/AIDS evokes may manifest as changes in one's level of spirituality (Cotton et al., 2006; Ironson, Stuetzle et al., 2006; Szaflarski et al., 2006; Vance, 2006). Studies have indicated that most people with HIV/AIDS report that the level of their spirituality has increased since they were given the diagnosis of HIV/AIDS (Ironson, Stuetzle et al., 2006; Szaflarski et al., 2006; Vance, 2006). Although this change is hard to explain, Szaflarski et al. (2006) have speculated that it could be due to viewing health problems as less threatening to one's core sense of self, hope and greater psychological adjustment. The authors further claim that their findings are similar to those of patients with cancer, where patients attributed greater levels of spirituality to hope and greater psychological adjustment.

2.5 Spiritually focused therapy (SFT) for terminally ill patients

The foregoing sections addressed a question as to why integrating spirituality into psychotherapy is important. The researcher of this study is advocating for openness, during the assessment stage, to multicultural issues, spirituality being one of them. In this section, however, the focus is specifically on spiritually focused psychotherapy. Once it is clear that the clinical focus is the patient's struggle with his/her spirituality, a spiritually focused psychotherapy may be used as a treatment of choice. This means that all or a better part of psychotherapy sessions are dedicated to helping the patient address these concerns. SFT is almost always a treatment of choice for terminally ill patients who are grappling with existential concerns. Different therapy techniques used are spiritually focused, being geared at helping the patient address their spiritual concerns as well as helping them come to terms with the reality of their illness and imminent death.

2.5.1 International studies on SFT

A plethora of studies conducted internationally have demonstrated the value in providing terminally ill patients with spiritual needs (Bussing et al., 2005; Craig et al., 2006; Frick et al., 2006; McClain et al., 2003; Scherwitz et al., 2005). These studies have established that terminally ill patients grapple with existential questions that require spiritual answers (Breitbart et al., 2004; Cole, 2005). The studies have also clearly emphasised the importance and need for the integration of spirituality and psychotherapy (Breitbart et al., 2004; Cloninger, 2006; Cole, 2005; Cole & Pargament, 1999; Cunningham, 2005; Hathaway et al., 2004; Hodge, 2006; Kellehear, 2000).

Although there have been many studies conducted on the integration of spirituality and psychotherapy to date, to the researcher's knowledge, there has been almost nothing specifically designed to determine patients' experiences of such interventions (Cunningham, 2005). Three studies will be discussed in detail here. These are Cole (2005), Cunningham (2005) and Scherwitz et al. (2005). These studies were chosen because of their similarity with the present research in terms of the nature of participants (terminally ill) and methodical design, which would make comparison with the results of the current study possible.

Cole's (2005) study specifically set out to investigate the outcome of integrating spirituality into psychotherapy for cancer patients. Her research study is an extension of a study she conducted jointly with Pargament in 1999 (Cole & Pargament, 1999). Cole conducted an intervention that centred around four existential themes, namely control, meaning, relationships, and identity. Existential concerns, which Watkins (1992) defines as one's deepest feelings about God (or one's higher power), life and its purpose, and existence, are arguably spiritual in nature. Cole's (2005) study had positive impact on two issues, namely pain severity and depression. Results showed that facilitating spiritual connection with the higher power may act as an insulator against pain experiences. Depression in the cancer patients also stabilised across the three periods, namely pre-treatment, post-treatment and at follow-up. Cole's framework included both the didactic

and the experiential components. The latter included a weekly meditation/guided imagery, which was intended to help participants with difficult spiritual struggles. They were encouraged to divide their issues into two: those in their control and those in the transcendent control and to seek answers or surrender the struggles that are out of their control to the higher power through meditation. The didactic component included activities that centred around a weekly theme such as reading narratives by people suffering with cancer and discussing participants' own experiences.

Cunningham's (2005) research study was designed to investigate the outcomes of integrating spirituality into a group psychological therapy program for cancer patients. This was a stepwise program conducted over 3 stages as follows: Level 1: Coping with cancer stress (4 group sessions comprising communicating feelings, two methods of deep relaxation, thought monitoring, mental imaging and goal setting); Level 2: Skills for healing (8 group sessions comprising self examination and journaling, consulting "inner wisdom" through the inner healer" technique, meditation, dropping resentments, setting goals); Level 3: Steps toward spiritual healing (8 sessions comprising connecting spiritually, doubts about the existence of the Divine, judging, forgiveness, guilt, self-criticism, self-acceptance, judging as a projection of our guilt and frustration, extending love, self-importance and self-will, living a more spiritual life and 5 techniques of meditation). Cunningham's (2005) study revealed that meditation left some of the participants with feelings of bliss, absolute peacefulness and happiness. One participant reported feeling at one with the universe, and the discomfort in her hip and neck disappeared. Cunningham also found that fear of death was diminished by the spiritual work for some of the patients, while most of the participants made good progress with guilt issues. Cunningham reported that his participants achieved new insights

In Scherwitz et al.'s (2005) study, the outcome of interactive guided imagery (IGI) therapy with a group of 323 medical patients was investigated. This group received 6 IGI sessions on a weekly basis over a 2-month period. The aim of the study, according to these researchers, was to assess whether IGI would be perceived as being helpful by patients, and to identify patient, situational, and treatment-related factors that would

predict treatment-related outcomes. There are four stages through which the participant goes. In the first stage, the patient is interviewed, fears identified and dealt with and the patient put at ease. In the second stage, deep relaxation is induced, a safe place is created and thereafter it is suggested that the patient invites an inner guide with qualities of wisdom and compassion. In the third stage, the patient is invited to let an image form, which represents their symptom or concern. He is then invited to explore this image further. The fourth (final) stage is reserved for feedback, where the patient returns to the room and shares his/her experiences.

Results of Scherwitz et al.'s (2005) study revealed that patients were able to relax, breathe deeply and to follow instructions; they also developed more insight into their problem/illness and became aware of some aspects of self (self-knowledge); about 50% of them reported reduced symptoms of anxiety, depression and increased wisdom (insight into the workings of their psyche); lastly, patients reported benefits that included: release of stress, self-insight, feeling supported, and gaining techniques to practice in the future.

2.5.2 South African studies on SFT

As it was mentioned in chapter 1, there is a dearth of studies conducted on spiritually integrated psychotherapy with HIV/AIDS patients in a South African context, even though a plethora of studies have indicated that spiritual concerns increase in this population of patients. The studies conducted in the South African context will now be unpacked. Knight (1990) conducted a study on the contribution of meditative experiences to personal growth. She defined personal growth from transpersonal and ego-psychology perspectives. Personal growth, seen from ego-psychology perspective, refers to "The movement towards self-knowledge and understanding" (Knight, 1990, p. 9). Transpersonal psychologists view personal growth as "The transformation of consciousness, from one that is identified purely with ego, to one identified with a wider level, one related to the cosmos and universe, one in which identity is based on *unity consciousness*" (Knight, p. 16). From this perspective then, as Knight argues, the movement towards the highest level of consciousness culminates in the achievement of a

transpersonal self. Knight's (1990) study was a case study investigating the level of growth achieved by engaging in meditation over a period of three months. Out of the four school adolescents engaged in this process, Knight focused and did a write up on a 17-year-old adolescent learner who engaged in this process every day for the entire 3-month period. Her findings indicate that the 17-year-old experienced personal growth primarily from the ego-psychology perspective and less so from the transpersonal psychology perspective. Knight put forth three hypotheses to explain the minimal growth from the latter perspective: length of the actual meditation period, length of daily meditation sessions and developmental readiness of the adolescent to reach a level of cognitive, emotional, social and spiritual maturity necessary to experience identification to the transpersonal self.

Knight's (1997) study was a phenomenological-hermeneutic case study of a middle-aged woman who spontaneously regressed to nine past-life experiences while in psychotherapy with her. Past-life can be briefly conceptualised as "...the ability to recover 'memories' from a previous lifetime" (Knight, 1997, p. 69). According to Oberholzer (1996, p. 25), a past-life regression can be described as follows:

> The past-life regression...has the essential characteristic that a subject experiences him/herself in a different form, at another place and time, and in a different context, but with a convinced sense of remembering something that happened to him/herself before.

Knight's (1997) study revealed that past-life stories and images, as transpersonal experiences, contribute to the process of inner healing and transformation, a process she terms spiritual emergence. She further concluded that, as healing stories of the unconscious, such stories are the expressions of an individual's internal unconscious conflicts.

A similar study to that of Knight's (1997) was conducted by Oberholzer (1996), who also investigated past-life experiences of an adult woman. Hers was a longitudinal study

extending over four years with an adult survivor of physical and sexual abuse. Over a four-year period of intensive psychotherapy, her participant experienced a wide variety of transpersonal phenomena, which included a total of 123 past-life regressions. During this therapy process, Oberholzer's participant gradually moved from dissociation of emotions to connecting with and processing of repressed emotions of rage, fear, grief and disgust. Oberholzer (1996) concluded from her study that, spirituality is an intrinsic property of the psyche and that the healing of psychological trauma is on a continuum with the process of spiritual purification and growth.

Viewed collectively then, the above three studies confirm the importance of incorporating spirituality into psychotherapy for clients that are open to spiritually augmented therapies. However, none of these studies was aimed at terminally ill patients. This appears to be a huge challenge for researchers in South Africa given that the existential issues troubling terminally ill people are universal. The work of addressing the spiritual concerns of terminally ill patients cannot be left to clergy alone because, as it was stated in chapter 1, not all spiritual people are religious. Even those that are religious may not want to go to clergy for fear of being judged as lacking in faith (W.R. Miller, 1999). This places the challenge squarely on the shoulders of psychologists and other medical professionals at hospices to work holistically by ensuring that they integrate body, mind and spirit in their assessment and treatment.

In view of the paucity of research on psycho-spiritual integration, the aim of the present study is to conduct a spiritually integrated psychotherapy with a sample of terminally ill patients. Thereafter, the participants' experiences will be evaluated by means of qualitative interviews.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter provides a description of the philosophical assumptions, aims, research design, methodological procedures of data collection and analysis.

3.1 Design of the study.

This is an exploratory study and the following broad research question was addressed: What are the terminally ill patients' experiences of spiritually focused psychotherapy?

A qualitative approach was chosen because of its ability to allow participants to provide a thick and rich account of how they make sense of their experiences, lives and condition or illness (Chemane, 1998; Creswell, 1998; Smith & Osborn, 2003). Qualitative research is descriptive and open-ended in nature. The open-ended questions asked during the data gathering elicit responses that frequently go beyond explanatory quantitative ideologies into the area of hidden motivations that underlie attitudes, interests, preferences and decisions (Chemane, 1998). Qualitative research is directly concerned with the interpretation of experience as it is lived, felt and constructed by the participants. The basic assumption is that nothing is trivial, that everything has the potential of being meaningful in order to unravel a complicated or complex phenomenon and promote understanding (Bogdan & Biklen, 1992). Sifunda (2001) argues that meaning is of great concern to the qualitative researchers. She further contends that qualitative researchers find it intriguing to ascertain how different people make sense of their lives. A qualitative approach is usually preferred when the aim is to convey the complexity of the situation in order to provide the readers with sufficient detail to judge for themselves whether the researcher's interpretation of the phenomenon is justifiable (Denscombe, 1998).

The underlying assumption of the qualitative approach, which is situated in the interpretative and social constructivist paradigms, is that reality is subjective and multiple, with the researcher interacting with participants (Chemane, 1998; Conroy, 2003; Creswell, 1998). The research is value-laden and the researcher acknowledges this openly to the readers of his findings (Creswell, 1998). The whole process of research is partially inductive in nature in that conclusions are not drawn directly from themes emerging from the data but the researcher adds his interpretation onto the emerging themes to reach a conclusion. This is consistent with a double hermeneutic ideology, which states that the researcher interprets the research participants' interpretations of reality (Smith & Osborn, 2003). Conroy (2003) critically reflects on this idea, and indicates that the process of interpretation and meaning-making does not even end with the researcher but it continues to spiral as the readers of the research findings add their own interpretations.

In light of the above description, this study adopted an interpretive phenomenological paradigm, where reality was viewed inter-subjectively by the researcher and the participants (Terre Blanche & Durrheim, 1999). When this epistemological stance is assumed in research, the researcher and the participants adopt a shared and constructed, rather than individualistic interpretation of the world (Conroy, 2003). In the final analysis the researcher brings his own assumptions, which join with the participant's, so that one can speak of the interpretation of the participants' interpretation of reality, which is consistent with Smith and Osborn's (2003) idea of the double hermeneutic. The process of interpretation continues this way so that even the readers and, in this case, the supervisor or promoter of a student's thesis includes his or her own interpretation of the reality. This results in a build up of interpretations of a group of people, leading to the so-called hermeneutic spiralling as advocated by Conroy (2003).

The interpretive phenomenological approach (IPA) as described above, is phenomenological in nature in that it views reality through the participants' understanding (Smith & Osborn, 2003). However, it goes beyond description, to interpretation, where the researcher is aware of and brings his own values and

interpretation openly into the research process (Conroy, 2003; Creswell, 1998). The researcher does not attempt to hide his axiological assumption but acknowledges it openly (Creswell, 1998). Not only is this acceptable in qualitative research, but it is encouraged, given that, as Conroy (2003) contends, human beings are social beings bound together by shared meanings and understandings of the world. Their values bring about *biases* which are necessary in the interpretation. Conroy (2003), however, states that the word *bias* is pejorative and should not be used in research design, particularly when using IPA. According to him, the word *prejudice* is better as it suggests that one comes with prejudgement, which is a necessary part of interpretation in the spirit of hermeneutic spiralling. However, the researcher does not agree with this word either, because it presupposes that the researcher passes judgment (prejudice) without due consideration of reality or facts. It suffices to say that IPA allows for the inclusion of the researcher's own subjectivity into the report writing as a crucial part of the interpretation process. That is where the process of self-examination or reflexivity (Terre Blanche & Durrheim, 1999) comes in, which means that the researcher should constantly reflect upon his own values and biases. To ensure that the final interpretation does not only include primarily the researcher's subjective values while losing the participants' interpretation completely, the researcher needs to verify conclusions with the participants. This in turn ensures participant validity. Terre Blanche and Durrheim (1999) capture this point well in their contention that the researcher should make his identification and dis-identification with the participants clear in his report writing. In other words, when using IPA, the researcher does not bracket his feelings as he would do in a quantitative approach, but he deliberately uses them as an essential ingredient in the final product of his research.

3.2 Participants and ethical issues

Two terminally ill patients were selected for this study. Initially, purposive sampling (Creswell, 2003) was chosen to provide rich and thick understanding of experiences, by selecting certain "rich" cases that could answer the research question. Terminally ill patients housed at hospice (in Grahamstown) were purposively selected to participate in

this study. The inclusion criterion was terminally ill patients who incorporate spiritual values in their lives and illness experiences. Furthermore, the patients needed to have physical ability and show commitment to participate in the study. A brief introduction of the participants is provided below.

The first participant, who will be named Caroline here, is a single mother of two in her mid thirties. Caroline had to leave her domestic work due to terminal illness. She was diagnosed with HIV/AIDS and cancer in January and April 2007 respectively. The second participant will be named Nomsa. Nomsa is also in her mid thirties, married with two children. She was unemployed at the start of this research, working together with her husband as traditional healers, to make a living. By contrast to Caroline who strongly condemned beliefs in traditional healing, Nomsa is a firm believer in ancestral spirituality. She and her husband worship ancestors and practice traditional healing, using the power of ancestral spirits for diagnosis and guidance in the actual treatment of their patients. Nomsa was also diagnosed with HIV/AIDS last year (2007). In both these participants, the terminal diseases were diagnosed very late. Nomsa's CD4 cell count was 22 when the diagnosis was made. Both participants were already under hospice's care at the time of the research. Caroline and Nomsa were chosen specifically because they fit the inclusion criteria as stated above.

A meeting was arranged with a director of hospice whereby the nature, intentions of the project and a request for permission to conduct the study were discussed. Issues relating to sampling, the researcher's responsibility to the participants, the fact that hospice would indirectly benefit because the participating patients would get a *minimum* of six psychotherapy sessions (free of charge for the duration of the project) and that disruption of hospice program would be avoided or kept minimal, was also discussed (Creswell, 2003).

A letter of confirmation followed the above-mentioned face-to-face meeting to emphasise and formalise what was discussed. Another meeting was arranged to inform participants of the intentions of the study in order to obtain informed consent (a sample of the form

has been attached at the back of the thesis as Appendix B: Consent Form). Ethical considerations were addressed as follows: information obtained from the participants was treated as confidential and anonymous; the transcribed material was shredded and audio-tape recorded tapes destroyed after the completion of the study; the ability to contain, deal with crises and address the needs of vulnerable population such as terminally ill people was a component of the ethical consideration of this study. Being an intern clinical psychologist at the time of the project as well as a qualified educational psychologist, the researcher was able to deal with difficult emotions that arose and provided psychotherapy as professionally required. The fact that the researcher is trained in heart-centred hypnotherapy that integrates spirituality into different psychotherapy modalities was also helpful.

In this section, sampling, locating site/participants and method of gaining access into the research site were discussed. Creswell (1998) describes these procedures as some of the stages of an important seven-stage data collection circle. According to him, data collecting procedures proceed according to interrelated seven-circular stages. The following six-circular stage diagram has been adapted from him to summarise these procedures:

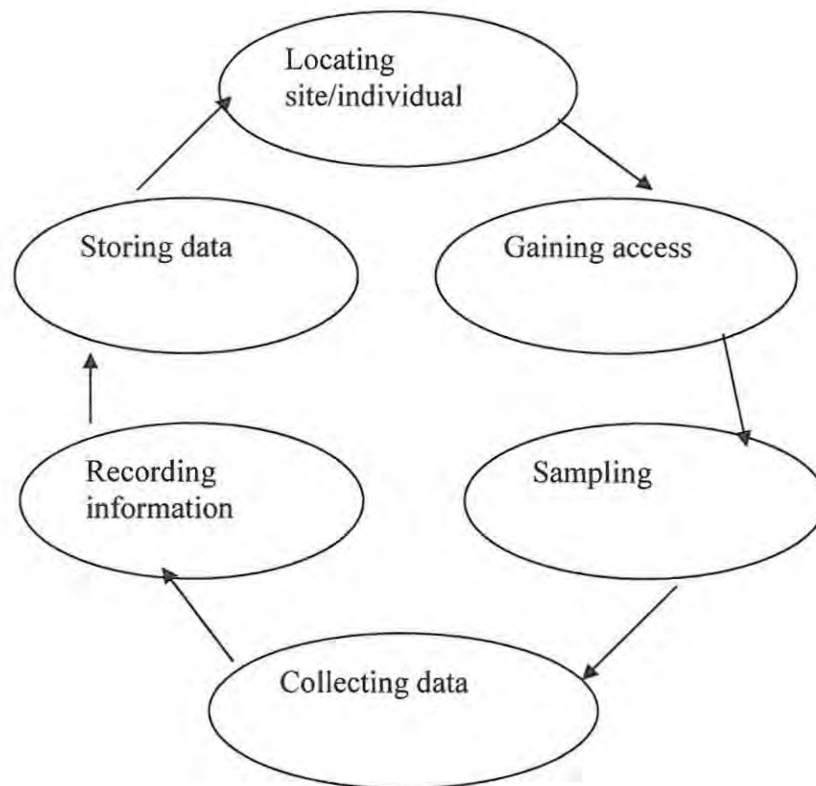

Figure 1: Six stages of data collection (Adapted from Creswell, 1998)

As the diagram indicates, the first stage involved locating the site with the information-rich case, which was hospice in this case. Thereafter the researcher gained access by meeting with the relevant authorities where the sampling procedures were discussed and agreed upon. The remaining three stages, namely data collection, recording and storage of information/data will be discussed in the sections that follow.

3.3 Data collection

The data was collected in three phases. The first phase, which included a single initial intake interview, assessed for spiritual beliefs and emotional issues to be addressed by means of spiritually focused intervention. The second phase (comprising a minimum of six psychotherapy sessions) involved implementing the spiritually focused therapy, while the third phase (comprising a minimum of one interview session), attempted to understand the participants' experiences of the intervention in the context of their terminal illness. A maximum of three in-depth semi-structured interviews were

conducted with Caroline and two with Nomsa. Two in-depth interviews were deemed sufficient to collect the data – one at the pre-treatment and another one at the post-treatment phase of the research. However, due to Caroline's health condition towards the end of the research period, the third phase had to be broken into two sessions. During the therapy sessions, short interviews were conducted, whereby participants were asked to share their experiences of deep relaxation exercises. Therefore, phases two and three were not completely independent of each other in practice.

Research interviews followed the guidelines of Smith and Osborn (2003). The first interview was followed by a minimum of six therapy sessions after which up to two research interviews were conducted in order to understand the participants' experiences of spiritually focused psychotherapy. The interviews and psychotherapy sessions were audio-tape recorded and reliability of data collection was addressed in this way. The psychotherapy sessions were spiritually focused. These sessions provided phenomenological experiences of spiritually integrated psychotherapy so that participants could comment on and evaluate such experiences in the research interviews.

The participants were asked open-ended questions that were based on broad themes guided by the general and specific aims of the study. Some of the themes were adapted from Martin (2003), Frick et al. (2006) and Hathaway et al. (2004). Examples of these are provided in Appendix C: Schedule of semi-structured questions.

3.4 Spiritually focused psychotherapy techniques

People with terminal illness experience the end of life as a reality that is gradually closing in on them. For that reason, existential concerns are pivotal (Cole, 2005; Cole & Pargament, 1999). To help them face such spiritual issues, the treatment techniques that were used focused on: encouraging life review to help them identify and explore guilt, remorse, forgiveness and reconciliation. Further emphasis was focused on facilitating spiritual expression and cognitive reframing of dysfunctional thinking patterns as well as on unhealthy spiritual expressions (Breitbart et al., 2004; Revheim & Greenberg, 2007).

Issues of control were also discussed where the participant was encouraged to differentiate between aspects that are in their control and those that are not. Therapy then focused on encouraging active behavioural efforts on matters they could change to help themselves feel better. These included: self hypnosis to reduce pain; relaxation; visualizing their safe/favourite, and most relaxing nature place to reduce physical or emotional pain; recruiting their spiritual connection or higher power to help them deal with matters beyond their control (i.e. surrendering difficult and unchangeable situations to their higher power/transcendent force). Formation of a social support system to ensure connectedness was also encouraged (Cole & Pargament, 1999; Revheim & Greenberg, 2007). Such emotion-focused coping has been found to be effective in dealing with situations that cannot be changed, such as those faced by terminally ill patients (Revheim and Greenberg, 2007).

Cognitive reframing was used in challenging undue judgment of self and others coupled with inappropriate guilt and unrealistic negative self-concept. Where guilt was appropriate, self forgiveness was explored. Most of the sessions ended with 10-15 minutes of visualisation/relaxation. Thereafter a time of up to 5 minutes was set aside for sharing of experiences of such an exercise. Participants were psycho-educated about the connection between thoughts, behaviour and emotion - the basic principles of CBT, and further educated about how they could visualise their spiritual connection growing inside of them so that they could face difficult situations. They were also taught that putting oneself in one's safe/nature place through visualisation while experiencing a difficult emotional experience reduces the emotional response and, in that way, helping one to gain control over one's emotional state. Loneliness and feelings of disconnectedness befall persons who are bedridden due to illness. This is particularly true for terminally ill people. Facilitating spiritual connection and encouraging participants to invite their transcendent force to help them heal and provide emotional support acted as a physical inoculation for physical pain (Cole, 2005).

Cognitive reframing/restructuring was done using guided imagery (Scherwitz et al., 2005), by inducing relaxation or by means of hypnotic deepening techniques (e.g. the

elevator or the staircase or the gently sloping hillside). The researcher would first induce deep relaxation by means of eye fixation followed by a deepening technique. As time went on, participants were able to put themselves into deep relaxation and just go into their safe place quickly without guided imagery or hypnotic induction. Minimization (looking at the bright side of things) and normalisation (telling participants that it is normal for terminally ill people to question their spiritual beliefs and to have existential concerns) were also used as psychotherapy techniques (Lukoff et al., 1998; Revheim & Greenberg, 2007). More details on these techniques will be provided in chapter four.

3.5 Data analysis

Data analysis is done to tease out and infer meanings that are hidden within data.
Sogoni (1997) sees data analysis as aimed at reducing data and synthesizing them into interpretable form so as to systematically search and discover what is significant and worth reporting. According to Valle (1998), analysis is the breaking down of phenomenon into its constituent parts.

The phenomenological approach demands that the researcher be true to the experiences of the participants and stay close to the phenomenon being researched (Diers, 1999). According to Diers, this necessitates 'bracketing' of the researcher's preconceived assumptions. In this research study, this phenomenological tenet was adhered to by transcribing the interviews verbatim and having such transcripts in writing so that the researcher could constantly refer to them. Moreover, participants' words were frequently quoted in the report writing as a way of ensuring such loyalty to phenomenological description. However, the researcher has to make sense or understand the participants' understanding of the phenomenon. By the time the researcher puts it in writing in his report it is already an interpreted version of the participants' experiences. This is where the hermeneutic (interpretative) element comes in. Smith and Osborn (2003) refer to it as double hermeneutic because the researcher is in essence interpreting the experiences that are themselves already the participants' interpretation. Diers (1999) posits that the interpretative process is based on theoretical knowledge as its guiding principle; hence it

can be regarded as a hermeneutic dialogue between the phenomenological description and the theoretical conceptualisation. The researcher's interpretation in this research was not only based on his epistemological stance gained from books but also from his cultural and personal or spiritual values. This means that the culminating description, as will be seen in this research project, is the articulation of the researcher's understanding of the participants' experiences and hence an interpretation in the Heideggerian sense (Valle, 1998). This is acceptable in qualitative research and it shows, as Valle (1998) argues, that the researcher is not a *tabula rasa* waiting to be filled with knowledge by the data; rather he brings with him some pre-knowledge of the phenomenon. In the final analysis then, the hermeneutic dialogue is not only between the theoretical basis and the phenomenological description but also between the researcher's knowledge systems and the participants' experiences (Bradfield, 2006). Valle (1998, p. 9) captures this argument very aptly: "...the observer as well as the actor are existentially and epistemologically implicated in the creation of meaning".

On the basis of the researcher's axiological stance then, which obviously influenced his understanding of the participants' experiences, the emerging themes and new meanings had to be verified with the participants. This was a way of ensuring that the researcher remained true to the phenomenological experiences for validity purposes. It must be mentioned here, however, that this verification was only possible with one of the two participants because one of them had passed on just at the end of the research process.

The researcher prepared a verbatim transcript of the tape recording as soon as possible after each interview. The same procedure was followed with the psychotherapy sessions. The researcher listened to the tape recording and, from these and the manually recorded notes, typed session summaries. In this way the researcher stayed connected to the flavour of the participants' words. The transcription process was time-consuming. However, the feeling that the research was gaining impetus, that valuable information was being safely stored and that the researcher was becoming aware of the growing body of research information tempered this. A thorough reading and re-reading of the transcripts for a sense of the whole was done. To support this, Dickson (cited in

Chemane, 1998, p. 108) talks about this "immersion" in facts as being fundamental to the imaginative leaps researchers make in developing their explanations. The re-reading of the transcripts helped reconstruct the interview scene in the researcher's mind and provided him with the context for the emergence of meanings and themes to use later on. The fact that the researcher did the transcriptions himself also helped to firmly instil the interview experience in his mind. This, in a way, became a pre-analysis phase for the researcher, making the actual analysis process go much quicker than it would, had someone else done the transcribing.

All interview transcripts and therapy session summaries were typed as hard copy protocols with wide margins on either side. The protocols were then read to get an overview of the phenomenological descriptions. Any words or phrases that stood up for the researcher were recorded on the left margins in a coloured pen. The whole transcript would be read to the end before returning to the beginning. Upon return to the beginning of each transcript, the right margin would be used to transform the initial notes into themes, which moved the participant's responses to a more abstract level. Some passages were much richer with themes than others. A list of themes was then made on a separate sheet of paper. The researcher then moved on to the next stage of looking for connections in the themes. This process resulted in the clustering of themes, with the clusters themselves given names. These were also listed on a separate sheet of paper. This exercise was itself time-consuming as it was done for both participants and for both the interview and therapy sessions.

The researcher, while using psychological concepts for super-ordinate and subordinate themes, had to be wary of losing the gist of what was actually said in the phenomenological description. This was itself a huge challenge as it meant writing and erasing until the researcher was satisfied that he had captured the gist without losing what was originally said. Another task that was as formidable was for the researcher to identify potential quotes that could be used as vignettes in the presentation.

The analysis was based on the body of research material that was both audio-taped and manually recorded. The manually recorded data comprised the researcher's session notes, which included the participants' mental status examination at the time of the interview or each psychotherapy session. This resulted in volumes of collected data. It was realised that not all the material could be used. At the time of data gathering, the researcher did not know what information would assume relevance and significance. The information gathered required some processing; it was not immediately available for interpretation and analysis. Field notes and interviews captured on tape needed to be transcribed edited and extended.

After the first step, which included reading and re-reading to gain a sense of the whole, the next step involved coding the meaningful units into themes, by constantly comparing the similarities and differences between meaningful segments. The initial themes were discussed with the one participant (the other participant passed on before this could be done) in order to ground the interpretive inquiry and enhance participant validity. Based on the principle of constant comparison (Charmaz, 2003), the third step involved clustering the themes into higher order (super-ordinate) themes. The construction of these higher order themes was also discussed with participant to further enhance participant validity.

The development of themes and higher order or super-ordinate themes is challenging and may easily result in the loss of participants' phenomenological descriptions. To prevent this from happening, the researcher worked closely with a colleague who served as an inter-rater to further enhance validity of coding. Together they closely examined the development of themes and higher order themes. This resulted in some of the themes being left out or renamed. The final sets of super-ordinate and subordinate themes that were constructed are illustrated in tables 1 and 2 below. Super-ordinate themes 2 and 4 (table 1) will be used as examples to illustrate how the process of theme development was done.

Table 1: Themes from the first interview (from both participants)

Super-ordinate Themes	Subordinate Themes
1. Belief in a higher power: A source of coping and support	- prayer - scripture reading - communication with ancestors - being a member of spiritual organisation
2. Social disconnectedness	- Fear of stigma or gossip - Poor family relationships - Lack of or inadequate social support
3. Terminal illness evokes existential concerns	- Children's fathers also have HIV - Anxiety about children's welfare after parents' death - Fear of death - Pleading with higher power to prolong life
4. Psychiatric symptoms co-morbid with terminal illness	- Living alone intensifies suicide thoughts - Abnormal neurovegetative features - Belief in higher power reduces suicidality
5. Spiritual struggles/dysfunctional spiritual beliefs	- Doubting the presence of higher power - Belief that she is being punished - Questioning authenticity of one's religion - Experiences of existential vacuum.
6. Unresolved relational problems	- Difficulty coming to terms with HIV status - Blaming ex-partner for illness - Interpersonal problems with in-laws - Marriage not culturally recognised
7. The whole family is feeling the stress of illness	- Lack of tolerance in the family - Poor academic performance - Loss of identity
8. Guilt or self blame	- Guilt for making bad relationship choices - Guilt for not listening to parents - Self blame for failing to finish school
9. Belief in the power of western medicine	- Ancestors requested to permit use of ARV's - Belief in western medicine only
10. Spirituality is subjective and private	- Spirituality differs from person to person
11. Dual spiritual beliefs	- Belief in God and ancestors

Initially, the researcher had included 'being an orphan' as the fourth subordinate theme under super-ordinate theme 2: Social disconnectedness. After the discussion with the inter-rater, however, this was dropped on account that it does not form an independent theme and it is subsumed in the last subordinate theme: lack of or inadequate social support. The next step was to ensure that, although only the super-ordinate themes are used as sub-headings in chapter four, all subordinate themes are discussed under the sub-heading, to illustrate that they are related to the super-ordinate themes. The following data segment will illustrate this point:

> I don't have support, except one friend to whom I tell my problems. My family is scattered and bad people. They are the kind of people who like to gossip and make my problems a laughing stock; so I can't tell my problems to them, you see.

These were Caroline's words, leading to the development of subordinate themes under super-ordinate theme 2: Social disconnectedness. Nomsa's words, adding to the development of the same subordinate themes were as follows:

> ...his mother is the main culprit who has stalled the whole procedure and she and my parents do not get along at all. Our parents have never formally met for the 17 years that we have been married. At one stage my parents were so angry with my husband that they would be constantly talking ill about him whenever I visited them.

The development of super-ordinate theme 4: Psychiatric symptoms co-morbid with terminal illness, was even more challenging. It resulted from collapsing two super-ordinate themes, namely 'Suicide thoughts' and 'Depressive symptoms co-morbid with terminal illness.' A closer look at them indicated that it would make more sense to collapse them into a single super-ordinate theme. It was further decided to code it 'psychiatric' as an umbrella term for disorders such as depression and anxiety for example. The development of subordinate themes under this super-ordinate theme was also as challenging. It appeared that living alone was a major contributor to the

development of Caroline's suicide thoughts "When I am alone I sometimes think of hanging myself. But then I think about who will take care of my two children." Caroline's belief in the higher power appeared to be one other thing, besides her children, that stops her from committing suicide "...I also think that I shouldn't kill myself because, while God gives me an opportunity to look after my children I must. May be by God's grace I will be ok again." It was also important to include neurovegetative symptoms of depression as an independent subordinate theme to further illustrate the super-ordinate theme. The same procedure was followed in the development of all the other themes.

Table 2 (below) provides a summary of super-ordinate and subordinate themes based on the participants' experiences of the spiritually focused therapy (SFT).

Table2: Participants' experiences of SFT (Clustered themes from both participants)

Super-ordinate themes	Subordinate Themes
1. The power of guided imagery in deep relaxation	- Insight into the workings of the psyche - Self transcendence –accessing unconscious - Mental creativity increases
2. Forgiveness brings relief	- Forgiving makes you feel lighter
3. Transpersonal exploration through dream imagery	- New insight into dream imagery
4. Social closeness leads to psychological wellbeing	- Strengthening friendship/ communication
5. Deep relaxation works as pain inoculation	- Pain disappears during deep relaxation - Experiences of peace and relaxation
6. SFT: A sacred space for participants to deal with emotions and heal	- Existential issues of control - Dealing with negative emotions - Feeling of relief after SFT sessions
7. Fear of death disappears	- Being open with the subject of death made it lighter
8. Improved insight into the development of psychopathology	- Basic CBT principles - Mind-body connection
9. Spiritual disconnection due to existential anxiety psychopathology	- Failure to meditate and pray weakens spiritual connection

The development of all the themes in table 2 was done, following the same procedure, as explained for themes in table 1 above. Based on the principle of sensitivity to context (Smith, 2003), vignettes, with accompanying research interpretations of the interviews in participants' words, were then provided to enhance the credibility of the findings. To enhance the principle of transparency that addresses the validity of the study, the researcher provided a clear account of data collection and analysis process (Smith, 2003).

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The previous chapter dealt with methodological procedures. This chapter presents the discussion and interpretation of results, in relation to the literature, to the reader. It is divided into 2 sections, namely SECTION A: participants' context, discussion and interpretation of results based on the first phase of this research. SECTION B: discussion and interpretation of results based on the second and third phases of this research study.

SECTION A

4.1 Participants context

In this section the context of the two participants, as introduced in chapter 3, is presented. The participants' names were altered for ethical reasons.

Caroline had two terminal illnesses, namely Cancer and HIV/AIDS. The first interview and four therapy sessions were conducted at her house. The remaining four sessions were held when she was admitted at the local provincial government hospital where she passed on soon after the last session. Caroline regarded herself as spiritual, with strong beliefs in God. She stated that she was brought up by Christian values since she was young.

The second participant, Nomsa was much more stable, in terms of health condition, compared to Caroline. She introduced herself as a *sangoma* (a Zulu/Xhosa word for a divine healer or traditional doctor). She stated that she had a dual belief in God and ancestors and that she and her husband are both *sangomas*.

4.2 The phenomenological-hermeneutic explication of the participants' experiences.

The themes that emerged from the data processing were grouped into two broad fields of experiences. In the first instance, themes resulting from the initial, pre-treatment interview that was aimed at assessing the participants' level of spirituality (as one of the inclusion criteria), as well as determining the extent of the impact of terminal illness in the participants' lives, are discussed. In the second instance, themes emerging from the discussion of the participants' experiences of spiritually focused therapy techniques (SFT) are discussed. Themes emerging from the pre-treatment phase are discussed first. The record of the course of therapy sessions has been placed as an appendix to this manuscript (Appendix D: SFT sessions). This serves as a context in which to locate the general aim as well as the participants' experiences thereafter. In terms of the participants' evaluation of the impact of their illness and the level of their spirituality, the following eleven themes were identified:

4.2.1 Belief in a higher power: a source of coping and support

> Me, I believe in God, you see; so, no matter what happens to me I pray, you see. When I pray I feel as if something has eased up on my shoulders, and I feel ok.

These were Caroline's words who further stated that, over and above praying, she reads holly scriptures from the bible to make her feel better. Although she was unable to attend church service, due to being confined at home by illness, Caroline said she believes in God's power and in prayer, hence she teaches her children about God, "...I always teach my children and say to them they must go to church, even if I can't go due to ill-health". Caroline's behaviour confirms the claim made by many authors (Breitbart et al., 2004; Cole, 2005; Cole & Pargament, 1999; Kaye & Raghavan, 2002) that strengthening one's spiritual connection becomes a valuable coping resource for terminally ill people.

Nomsa, on the other hand, regarded herself as a spiritual person who believes in ancestors and works as a *sangoma* (traditional doctor/divine healer). While Caroline attributed her

wellbeing to God and prayer, Nomsa strongly hailed her ancestors as her higher power who literally resurrected her from the dead in hospital last year (2007). She said she and her husband burn incense to convey their requests and ask for good health from the ancestors. She said, in times of difficulties, she sometimes consults with other *sangomas* to give her guidance as to what to do. This happened last year, soon after the near-death incident at the hospital, where doctors were convinced that she was dead. She said that her ancestors woke her up, to the surprise of doctors, at the hospital. After this incident, she and her husband knew that they had to perform some ritual to the ancestors, asking for forgiveness for the wrongs she had done, as well as to ask for good/long health. To go to this process she "... consulted another *sangoma* to get clarity as to how exactly to go about performing the ritual. I then went to my parents' house and performed the ritual, after which I became well immediately". Nomsa's cultural practice is consistent with that of many other South African Blacks which, as discussed in chapter 2, has been supported and encouraged by many authors (Chemane, 2004; Edwards, 2004; Leach et al., 2003; Mill, 2001; Nyembe, 2002a; Okello & Ekblad, 2006; Romero-Daza, 2002; Ross, 2008). This is one of the things that define community psychology (i.e. practices that influence community behaviour) in these communities (Chemane, 2004).

4.2.2 Social disconnectedness

Both participants reported a certain level of being disconnected from the social network, which added to the felt strain of their terminal illnesses. Nomsa's case is different, however, in that, since her illness is currently well controlled by antiretroviral treatment (ARV's), she is not in pain nor confined to her house. Caroline's situation was however worse. She was really suffering, with excruciating pain, due to cancer, and some days were worse than others. Nomsa reported that she didn't really like to talk to people about her situation due to fear that they would make her a laughing stock. Caroline seemed to be in a similar position:

> I don't have support, except one friend to whom I tell my problems. My family is scattered and bad people. They are the kind of people who like to gossip and make my problems a laughing stock; so I can't tell my problems to them, you see.

The participants were obviously afraid of being stigmatised for having HIV/AIDS. This finding is consistent with Kokach's (2000) contention that the real suffering for terminally ill patients is mostly due to them being socially disconnected rather than being in physical pain. In the end stages of her life, Caroline was unhappy about being away from her family, to the extent that she would cry when she spoke about it. The social disconnection was aggravated by the stigma placed on her due to having HIV/AIDS. She was experiencing this stigmatisation from her extended family, which sent her indirect messages that she deserved to be punished for contracting the disease. Again Kokach (2000) supports this finding. Other authors in the literature have also indicated the role played by stigma in the problem of social disconnectedness (Martin, 1994; Nyawose, 2004). The literature indicates that the effects of stigma are worse for women, compared to their male counterparts (Broun, 1999). This is due to the fact that, for this social category, HIV/AIDS is associated with promiscuous and immoral behaviour (Demmer, 2007a; Mill, 2001). People living with HIV/AIDS are even isolated by their families of origin or extended families ((Ironson, Solomon et al., 1995). This was clearly the case in Caroline's family, "...when the news reached my family, it was as if I was someone who didn't carry herself appropriately, whereas that was not the case". This left her with very little options in terms of social network to reach out to, because her only real support were her two sisters who lived more than a thousand kilometres away. The fact that both her parents are deceased added to the problem. Nomsa's mother-in-law lived close by to her but, again due to poor relationship between them, she could not seek her support, leaving Nomsa and her whole family lacking social support.

4.2.3 Terminal illness evokes existential concerns

Existential themes of fear of death and anxiety about who will take care of children after their parents' death were noted from both participants. This finding is supported by

literature (Chibnall et al., 2002; Cole & Pargament, 1999; Farber et al., 2003; Kelly et al., 2006). In the case of Caroline, both her children's fathers are HIV positive. She was hoping that the father of her older child (daughter) would take care of his daughter after she (Caroline) dies. However, she lost hope in him too, "…I was thinking he will look after Yolanda (name altered); now he says he is also sick. I think I am better, yes, I believe that God will not take me as yet". Caroline also talked about her fear of death. At times she even bargained with God not to take her yet, while she was still trying to put things right, to ensure that she leaves her children in a good position. Towards her last days, while in hospital bed, Caroline was observed to be very scared, clearly expressing her fear of death: (irritable, with a voice close to crying) "I am sick brother, people are dying; I want to go home now!". Nomsa too expressed existential anxieties about the welfare of her children after her death:

> Right now I have anxiety about what will happen to my children should my husband and I die as he is also HIV positive, because she (her mother-in-law) does not like them (children). I can't even draw up a will because I don't know who will take care of my children!

It was clear that, while both participants were experiencing annihilation anxiety (fear of death), they were also concerned about the wellbeing of their loved ones after their death.

4.2.4 Psychiatric symptoms co-morbid with terminal illness

Caroline was in so much pain that her sleep pattern was often disrupted, "Sometimes I wake up too early. At other times I am awake by 2 a.m. while the children are asleep. I only fall asleep at five a.m." She reported other signs of depression such as poor appetite, being irritable towards her children, significant weight loss, inappropriate guilt, fatigue, and suicide ideation. The co-morbidity of terminal illnesses and psychiatric symptoms in Caroline's case has been widely reported in the literature (Cooperman & Simoni, 2005; McDaniel, & Blalock, 2000; Yi et al., 2006). Living alone appeared to intensify Caroline's suicidality, "When I am alone I sometimes think of hanging myself. But then I

think about who will take care of my two children." This finding is again consistent with observations in the literature, which have cited social isolation as a strong predictor of suicidality (Cooperman & Simoni, 2005). Caroline's depressive symptoms did not, however, meet the duration criterion to warrant a full diagnosis of major depressive disorder, "...it doesn't last long, it just happens at certain times, especially when I am alone or when I struggle with sleep". The phenomenology of her symptoms appeared to meet the diagnostic criteria of Adjustment Disorder with Depressed Mood, Chronic. Despite this co-morbid presentation, Caroline still believed in the power of God, which somewhat reduced the suicide thoughts, "...I also think that I shouldn't kill myself because, while God gives me an opportunity to look after my children I must. Perhaps, by God's grace, I will be ok again." Cooperman and Simoni's (2005) research study similarly revealed that a strong spiritual connection tends to be a deterrent to suicidal thoughts.

4.2.5 Spiritual struggles/Dysfunctional spiritual beliefs

> I accepted religion, but I was violent. There is a day when I didn't accept it. I was admitted in the hospital when this one congregation from the Universal Church came. When they tried to lay hands on me I refused and told them to leave."

These were Caroline's words explaining spiritual struggles she had experienced due to her terminal illness. Upon being asked if she had ever questioned the presence of God, Caroline said "I do ask those questions. Sometimes I pray and the pain goes away, sometimes it doesn't; because I do have severe pains from time to time." Caroline's faith might have been weakened by the fact that, due to illness, she was unable to attend church service, "...I last attended church service in 2006." Both Caroline and Nomsa reported having perceived their illnesses as punishment from their higher power. Caroline said:

> When I became sick I was asking myself: what have I done, you understand. Again when I got the second one I asked Him again, how I will deal with these

> terminal illnesses. But I tried to accept them because they are in my body. I thought may be it's the way God is punishing me, I don't know.

Nomsa sounded certain that her illness was punishment by her spirituality:

> Yes I did experience difficulties with my spirituality. The ancestors were punishing me by giving me this illness. They said I do not want to listen; I am a stubborn person because I was supposed to have performed certain rituals in my father's kraal as required if one is given the gift of being a *sangoma*. This ritual, which involves the slaughtering of animals, was not performed.

Caroline also reported intermittent experiences of existential vacuum (i.e. loss of meaning in life). When she was asked whether she ever had thoughts that her life is meaningless, Caroline said that she sometimes did, "That comes to mind sometimes. But then it passes and then I become ok again, and then it comes back again"

The above finding appears to be consistent with the claims in the literature, stating that the diagnosis of terminal illness results in serious agitation of one's level of spirituality (Cotton et al., 2006; Ironson, Stuetzle et al., 2006; Szaflarski et al., 2006; Vance, 2006). Many studies have found that the diagnosis of AIDS results in an increase of the level of spirituality for most people living with this disease (Ironson, Stuetzle et al., 2006; Szaflarski et al., 2006; Vance, 2006). However, this was not supported by the present study, which, in the case of Caroline in particular, could be due to the advanced stages at which the illnesses were diagnosed, resulting in her finding it difficult to accept her situation. Both participants had not undergone psychotherapeutic intervention, which could have also been another factor.

4.2.6 Unresolved relational problems

Unresolved relational problems may sometimes result in one becoming mentally attached to those figures, not letting go of resentments. This may result in rumination, as it is

evident in Caroline's case, which may in turn exacerbate depressive symptoms, causing sleepless nights, "There are so many things I think about, because this person who infected me with this disease (her son's father) told me that he would destroy me. I didn't know how he would do it." This has resulted in Caroline having difficulty accepting her HIV status:

> What bothers me the most is this thing of being HIV positive. The cancer thing does not worry me that much. What makes me angry is that the person who infected me with this virus didn't tell me, he only told me that he would destroy me. I didn't know how he would destroy me, something like that.

Nomsa's unresolved relational problems with her mother-in-law were one of the main problems that made her agree to participate in the current research, hoping to get a chance to process related underlying feelings.

> ...my main problem is that, as I am married now, the proper Xhosa cultural procedures were not followed. My husband did not pay the *lobola* to my parents as a cultural requirement, which has caused animosity between my parents and his, especially his mother. His mother is the main culprit who has stalled the whole procedure, and she and my parents do not get along at all.

Nomsa explicitly verbalised ill-feelings against her mother-in-law, saying that she is holding a grudge because "...initially she promised to help my husband pay *lobola*, seeing that he was not working; but eventually she wanted nothing to do with my family." *Lobola* refers to the payment (in monetary or cattle terms) made by the groom to the bride's family as a Zulu/Xhosa culture, before the couple can be formally married.

The above HIV-related worries about issues that include unresolved relational problems, problems relating to how HIV was contracted and poor social support have been cited in the literature as highly discriminative for psychiatric symptoms such as depression (Chibnall et al., 2002; Yi et al., 2006). Caroline's depressive symptoms could be partly

attributed to her constant worry about her ex-boyfriend, whom she was accusing of infecting her with AIDS. Such negative emotions, according to the literature, may weaken immunity, leading one to being susceptible to opportunistic diseases, which may be particularly detrimental for people with HIV/AIDS (Cohen & Herbert, 1996; Dane, 2000; Tsigos & Chrousos, 2002).

4.2.7 The whole family is feeling the stress of illness

Results of this research revealed that the distress of terminal illness is not only felt by the patient. Members of the family may also be dealing with their own frustrations of having to put up with the temper and irritability of the patient, resulting in lack of tolerance for each other. This seemed to be the case between Caroline and her daughter, Yolanda:

> At times I struggle with my daughter's school needs. When she comes from school and tells me that I am required to pay so much, I say to myself: when I was still working I wasn't struggling like this. So these things worry me. Even the other one at times (her son) I can see that he is sick, and there is no one to help me, I help myself, you see. At times Yolanda wants help with her school work and I find that I can't help her. This hurts me. Because when I deal with her, she becomes angry and irritable and I also become angry and irritable. No one has time for the other here in this room.

This quote indicates that Caroline's terminal illness has caused emotional and financial strain. Apparently, Caroline finds it difficult to accept the fact that she has lost, not only her physical identity but, her identity with the role of being a financial provider in the family. The findings in other studies in the literature have also confirmed this finding (Demmer, 2007a; Farber et al., 2003; Hedge & Sherr, 1995; Holt et al., 1999; Lindsey et al., 2003; Williams & Stafford, 1991). Most studies have concentrated on the pain and existential struggles that patients themselves grapple with, leaving the other family members outside of the research.

4.2.8 Guilt or self blame

The expression of guilt was noted from both participants. Nomsa blamed herself for not listening to her parents and for dating her husband in the first place:

> I constantly blame myself. If only I didn't date him at all I would not have landed into this mess. I also got so carried away about our affair that I agreed to leave school in standard 9 in stead of finishing school. If only I finished school I would be working right now rather than struggling so much financially.

Caroline, on the other hand, blamed herself for making bad relationship choices, saying had she agreed to marry the one man who appeared serious to settle in a stable relationship she wouldn't be suffering as she was. She blamed herself for allowing herself to be lured by her son's father who lied that he would marry her, only to dump her for another woman in the end. She said:

> ...there was a guy I was dating in Paris (not real place), who wanted to marry me. We had a minor disagreement and I ended up leaving him and started dating this person thinking that he was better than the other guy in Paris. So he (the second one) was busy talking about marriage, meanwhile he knew that he would marry somebody else. So yes I do blame myself for that, yes, something like that.

In his study, Cunningham (2005) found that terminally ill patients grapple with existential concerns of forgiveness and guilt. Cunningham's findings are consistent with those of the current study. Other authors, as stated earlier, have observed that guilt is greater for women living with AIDS compared to their male counterparts, a difference that has been attributed to the culturally scripted roles assigned to women by society (Broun, 1999; Demmer, 2007b; Holt et al., 1999; Krakauer & Newbery, 2007).

4.2.9 Belief in the power of western medicine

The results revealed that both participants strongly believed in the power of western medicine. This was unexpected from Nomsa who practices as a *sangoma*. She reported that she even went to the extent of making a special request to her ancestors to allow her to use this medicine or else she would die:

> Initially, when I was due to start the ARV program, hospital files kept getting lost and mixed up. This strange occurrence resulted in a delay in the start of the program. Traditional doctors told me that my blood is not made to use this kind of medicine. They said I am not supposed to take ARV's. But I told them that I will have to take them (ARV's) in order to live. I also made a special request to the ancestors that I must be allowed to take them or else I will die. I believe they have helped me; hence yes I am using them.

Caroline also strongly stressed her preference of western over traditional medicine "Eh, what I like right now is exactly what is happening, to be under doctors, not under the traditional healers." The above quotes indicate that the two participants followed certain criteria to make their decision to choose what type of treatment to use (that is, traditional or western). In the case of Nomsa, for example, for other ailments she supports and largely uses traditional herbs. However, she took a decision to only use ARV's for AIDS treatment, based on her belief (which led her to negotiate with her ancestors) that such treatment alone would be effective. This finding is consistent with the claims in the literature, which have revealed that people use certain criteria to decide whether to use or not to use alternative medicine (Bishop et al., 2007; Kremer et al., 2006)

4.2.10 Spirituality is subjective and private

Nomsa believed that different people who regard themselves as spiritual are not necessarily experiencing the same spirituality "...some of the things we do are not the same because we listen to different spiritualities." Nomsa's claim is consistent with some

of the definitions of spirituality, which have stressed the subjective, private nature of this construct (Bartoli, 2007; Grof, 1998; Helminiak, 2001).

4.2.11 Dual spiritual beliefs

Although it is unusual, it is not unheard of for someone in the African culture to be both a *sangoma* and a church-goer at the same time (Edwards, 2004). Most traditional doctors, however, do not necessarily attend church even though most of them do believe in the presence of a Creator who is the Father of all creation. Nomsa seemed to be an exception. She said "...We use traditional medicine as directed by our spiritual leaders (ancestors). I also believe in God." She said in the past, before she was diagnosed with HIV/AIDS, she used to be, not only a visitor at church but, a card carrying member who wore uniform. However, she was disappointed by her church members who did not visit her when she became ill. Hence she said "I have decided that my health and my life are not dependent on me going to church. I can be connected to Him by just praying privately in my own home." This finding confirms Krakauer and Newbery's (2007) findings, which indicated that traditional and western practices are not necessarily mutually exclusive. One church known as Shembe for example, in South Africa (Krakauer & Newbery, 2007), combines the western church and traditional practices and has massive membership following as a result. There have been calls for the medical fraternity to adopt a similar practice, of viewing western ways of treatment as complementary rather than mutually opposing extremes (Chemane, 2004; Edwards, 2004; Leach et al., 2003; Mill, 2001; Nyembe, 2002a; Okello & Ekblad, 2006; Romero-Daza, 2002; Ross, 2008). Lessons may, perhaps, be learnt from the practices of Shembe and Zionist churches as advocated by Krakauer and Newbery (2007).

SECTION B

4.3 Participants' experiences of spiritually focused therapy (SFT)

The evaluation of the participants' experience of SFT was done at the end of the six session period. However, participants were asked to share their experiences of each relaxation exercise. Here they were asked to comment on their experiences and comfort level in doing the exercise; to state whether they were able to relax as well as to follow the researcher' suggestions. After the sixth session, participants were asked unstructured, open-ended questions about their experiences of the psychotherapeutic intervention as a whole, their experiences of meaning-based type of approach, problems they experienced with any of the techniques, if any, and any SFT technique they benefited the most from, if any. As it was mentioned earlier, it was not possible to elicit most of this information from Caroline, due to her health condition in the end.

4.3.1 The power of guided imagery in deep relaxation

The transpersonal exploration achieved by the use of guided imagery in deep relaxation assisted Nomsa to gain insight into the workings of the psyche. During the last session, Nomsa was guided through the process of asking for forgiveness from her father while in trance (deep relaxation). This was something that had troubled her very much emotionally; something she had never thought she could get herself to do and be at peace with. This exercise in transpersonal exploration assisted her to, as Walsh and Vaughan (1993) put it, face her fears and discover a wonderful tool she has within her. When she was asked what her experience was and whether she had connected with her father she said "We connected well. I didn't know that something like this can happen, where you talk with someone who is absent but you feel his presence." Nomsa was happy to have discovered this powerful tool and believed that it would be the answer to help her deal with emotional problems "...now I am feeling a lot better because, if I have emotional problems I can do that visualisation exercise." Nomsa further said "I found that the

human mind is powerful; because I never knew that if I have a problem I can deal with it and get rid of negativity using my imagination and visualisation."

Guided imagery also brought about a sense of self-transcendence, where Nomsa felt happy beyond expression in trance "I felt as if I am dreaming, and so happy in a way I cannot describe." Nomsa also found that her mental creativity was enhanced "Yes, I observed that my mind is capable of creating a person without them coming to me physically. For example, that dialogue I had with my parents in trance was very powerful."

The above finding indicates the power of meditation or deep relaxation. According to Knight (1990), meditation enhances psychological wellbeing. The research finding revealed that deep relaxation put the participants into contact with deep-seated or repressed emotions so as to uncover and process them experientially. This was particularly noted with Nomsa, who abreacted as a result of connecting with her repressed emotions. This finding is consistent across contexts as Knight (1990) similarly found that meditative experiences were able to put participants into contact with their feelings of anxiety, anger, sadness and unworthiness. Caroline expressed a sense of being closer to God as well as feeling physically strong when she prayed. Kaye and Raghavan (2002) reported similar findings with their participants who reported that meditation and prayer provided them with strength and acted as a coping resource.

In Knight (1997) and Oberholzer's (1996) studies, participants spontaneously regressed to past-life. Both these studies were conducted over a period of more than three years. In the current research however, neither of the participants spontaneously regressed to past-life transpersonal phenomena. Knight (1997, p. Xii) defines past-life as "...the experience of transcendence of consensual reality and boundaries of space-time." The time period over which the present study was conducted could explain this. Secondly, the participants had only just begun meditative exercises and had not yet mastered the exercise to routinely practice it on their own.

4.3.2 Forgiveness brings relief

Both Caroline and Nomsa verbalised that the exercise on forgiveness brought about relief and a feeling of being lighter after doing it. When she was asked how she felt about it, Caroline said "It was helpful; I felt ok and lighter after doing it." Immediately after the exercise of asking for forgiveness from her parents in deep relaxation Nomsa said "Yew, I feel so relieved and peaceful." Like Caroline, she expressed a feeling of relief and being light "...I feel like a big boulder has been taken off my shoulders now, I feel lighter." She perceived it almost as a miracle "...I didn't know that you can work on forgiving them or dropping resentments without actually talking to them in person. So, the way I understand it now, it is easy, because it doesn't matter if he is still holding a grudge against you, as long as you can make yourself alright inside." Wood and Fox (2005) have similarly stated that one can set oneself free by means of self-forgiveness, regardless of whether the other party is willing or not to settle the disagreement. Forgiveness done on an empty chair basis or even in deep relaxation through guided imagery can speed up the process of forgiveness or pave the way for face to face request for forgiveness as Nomsa put it "Now when I go to them, it will be easy because I will be free and have no fear."

Nomsa's statements above confirms the literature's emphasis of the healing power of forgiveness through its ability to free an individual from being plugged-in or connected to the negativity of the past (W.R. Miller, 1999; West, 2000; Wood and Fox, 2005). Kaut (2002) argues that the process of self forgiveness brings about a sense of psychological healing (Kaut, 2002). In her study of past-life as transpersonal phenomena, Oberholzer (1996) similarly concluded that working through forgiveness of self and others brings about healing. In Nomsa's case, this was achieved both by psycho-education and transpersonal means.

4.3.3 Transpersonal exploration through dream imagery

Walsh and Vaughan (1993) contend that transpersonal exploration through dreams can be very powerful in facilitating psychological healing. A dream can help an individual to

bypass ordinary consciousness and access unconscious material so that internal conflicts can be worked through. Such exploration is transpersonal inasmuch as it transcends or goes beyond the ego or the usual self to access the repressed material. As it was observed in Nomsa's case, dream work can strengthen spiritual beliefs. The dream that Nomsa had, where she and her husband met a wise man who appeared to convey the message that they were in the right track by challenging the unreasonable demands made to them by their higher power, served as an anchor for Nomsa and enhanced what had already been done in therapy with the researcher. After this dream was further interpreted in therapy, Nomsa expressed hope that her life was headed for success and that it was going in the right direction. She also learnt how to approach dream imagery in an attempt to interpret it.

4.3.4 Social closeness leads to psychological wellbeing

During the therapy sessions the researcher had psycho-educated both participants about the psychological benefits that social closeness can bring about. Caroline had started working on it by strengthening friendship with an old friend of hers who was a teacher. This is the one friend who kept visiting Caroline even when her own sisters and family were not doing it as regularly as she would have liked. Asked if this had benefited her in any way Caroline said "It has helped me a lot with my mental health."

Nomsa was beginning to make changes in her immediate family to improve social connectedness. She said "I have begun it here in my immediate family with my husband." She further said:

> I think it will be helpful, because if people you care about are distant, that can affect your health, making you ruminate. It's nice to see that your family care about you no matter what problems you have they are close to you. So if I can work at improving relationships I will be happy and free in my heart.

These participants' claims about the effects of social closeness on them are consistent with those that have been made in the literature (Ashton et al., 2005)

4.3.5 Deep relaxation/hypnosis works as pain inoculation

Both participants reported heightened awareness of some body sensations during the hypnotic state. This experience is not unusual in transpersonal psychotherapy i.e. therapy done after inducing hypnosis or altered states of consciousness (Zimberoff, 1997). Body sensations may be indicative of blocked energy in those parts of the body. In Caroline's case, it sounded like the breathing exercise during relaxation had resulted in the movement of such blocked energy from her upper extremity to the lower extremity of her body as she said, "I felt heaviness coming down from the upper body extremity to the knees." This movement was followed by a feeling of peace and relaxation when she was resting peacefully in her safe place as supported by her statement when she said, "I felt safe in that place; it was like there is a cool breeze coming down, as if I see a blue sky." She further said, "It was very nice; the cool breeze was relaxing." Nomsa also became aware of body pain, which faded with the process of relaxation:

> As you told me to fix my eyes on the spot on the ceiling, I felt this painful lump I was talking about in my chest. As you went on talking to me about breathing I felt it fading away. When you suggested that I must invite a wise person I saw my husband just appearing in front of my eyes. I felt so relaxed and peaceful. My husband and I were talking so calmly. I felt as if my chest was full of all the things that have been bothering me; but when we sat down and I asked him questions as you suggested I felt relieved, as if all the negativity is fading away, leaving peace and tranquillity inside me.

The above vignettes show that deep relaxation can be an effective coping strategy once a person learns to practice it. It can help one cope better with pain by reducing focus on pain while focusing attention on a peaceful, relaxing experience, which is inversely correlated to pain. In support of this argument, Corr and Corr (1983) contend that psycho-

educating patients on how to reduce the focus of concentration from pain to other things can be very effective in helping them to cope with pain. Similar findings are reported by Cunningham (2005). One of his participants stated that meditation resulted in a momentary disappearance of pain on his hip and neck. This means that meditation or an exercise in guided imagery in deep relaxation may result in positive distraction from body pains.

4.3.6 SFT: A sacred space for participants to deal with emotions and to heal

The participants gained insight about how one should surrender some of one's issues to the higher power, while shouldering those that are in one's control. Nomsa felt enlightened:

> This has helped me realise that I can table my problems and my frustrations to my ancestors without fear that I am burdening them. They want things done in a certain way but there is no money; I have to think of ways to get money. While I believe that they will help me and indeed they have done so many times, I believe that I must do my part. Now I am able to divide things in terms of whose control they are, whereas I didn't do so before.

This vignette indicates that, while spirituality is private and subjective, dysfunctional beliefs can still be challenged in psychotherapy. Nomsa has learnt that ancestors (and by extension God) help those who help themselves. One has to be clear about which issues are in one's control and which ones are to be surrendered to one's higher power. Nomsa also believed that SFT sessions helped her know more about how her psyche works so that she can use it to work for her "…I know that I can use my visualisation as a tool to create what I want and solve my problems."

Despite her deteriorating condition, Caroline found SFT sessions beneficial "After our sessions with you I always feel alright and relieved." Nomsa expressed a similar feeling "What I can say is that the fact that I was able to talk about things that bother me helped

to take the burden off my shoulders." This was helpful to Nomsa in view of her lack of social support as well as her personality style of bottling things up "Talking about my problems helped me a lot because I was not someone who talks about my problems. Now I know that talking about my problems brings relief." About the relaxation exercise Nomsa said "I found that it is good; because after doing the exercise I feel relaxed and lighter; even panic and fear disappear." She also gained an understanding about how to deal with negative emotions. She said, "At times you find that you have something that's bothering you inside but you are scared to express it; once you gather courage and open up, you feel a relief emotionally." During the 5th session, Nomsa relived (abreacted) her past negative experiences so vividly that the process had to be continued in the next session. She was contained, assisted to process her feelings and properly sealed so as to be able to function without being disorientated, but the session had to be ended as the abreaction happened by the end of the session. Because of this, the next and final session had to be on the next day.

The above vignettes show the effects of SFT on the psychological wellbeing of the participants. Both participants gained insight into the workings of their inner worlds and realized that the inner experiences are as real as the outer experiences. Hence Nomsa remarked, "...I never knew that if I have a problem I can deal with it and get rid of negativity using my imagination and visualisation." Knight (1990) refers to this realisation as an indication of personal growth, which in turn indicates that the self has been enhanced. Knight (1990, p. 18) defines personal growth as "...the transformation of consciousness and the expansion of awareness to all levels within the psyche as well as the integration and unity of these levels and identities".

During the hypnotherapy sessions (i.e. therapy in deep relaxation), the participants reported an experience of peace and deep relaxation. Similar findings were reported by Cunningham's (2005) participants during meditation exercises. This, according to Knight (1990) is a subtle revelation of the occurrence of transpersonal self. Knight (1990, p. 17) defines transpersonal self as, "... the self-sense that transcends egoic and existential identifications". Transpersonal experiences that support Knight's description were also

noted in the contents of Nomsa's dream. However, what was evident in this study does not warrant a claim of a complete development of transpersonal self as this would take much more to develop than just a few meditative sessions of spiritually focused therapy as was the case in the present study (Knight, 1990). The present study focused on a sample of terminally ill patients' experiences of spiritually augmented psychotherapy, whereas Knight's (1990) study focused on meditative experiences of a sample of learners. Therefore, the similarity of the findings between these two research studies indicates the transferability of findings across contexts (Terre Blanche & Durrheim, 1999).

Cole's (2005) and Cole and Pargament's (1999) studies revealed that surrendering some of the problems to the transcendant's control, as Nomsa was now doing, relieved the burden off the participants' shoulders. She also found that facilitating a spiritual connection with the higher power served as pain inoculation while facilitating closeness with God or higher power. These findings were also confirmed by the present study. Cole's study also revealed that cancer may result in loss of a sense of identity and self worth. This was found in the case of Caroline, who complained about losing her sense of financial independence due to illness. She also complained of having lost her weight, showing the researcher her old photo's as proof of this, which was very painful to her.

The SFT in Cole's (2005) study resulted in stabilisation of depression. This finding was not supported by the present study. Caroline's depressive symptoms did not abate. This could be explained by the present study's short duration of the SFT intervention coupled with Caroline's poor social support as well as the stage of her illnesses at the time of research.

In the study on interactive guided imagery therapy with medical patients (Scherwitz et al., 2005), participants reported being able to relax, breathe deeply and follow instructions or hypnotherapy induction. Participants also reported an increased insight into the workings of their psyche (i.e. increased wisdom), and reduced anxiety and depression. These findings are consistent with those of the current study, except for their

findings on reduced depression, which has already been explained. These authors' findings also confirm the current study's finding on the co-morbidity of terminal illness with psychiatric symptoms (i.e. anxiety and depression).

4.3.7 Fear of death is dealt with

The talk about death makes people uncomfortable as it evokes their inner conflict of wanting to continue living despite their knowledge that their existence will end at some point (Nyembe, 2002b). This creates existential anxiety, making the death subject almost a taboo. When Nomsa was asked how it was for her when the researcher talked openly about her illness and death, she said:

> Initially it scared me and I thought that, since I am ill you think I will die tomorrow, hence I must sort out my things now. But as we went along I realised that no man, this thing is not like that; it's not that I will die now, just that I must know that putting things right while you still can is good practice because indeed I will die eventually. But yes, it scared me initially.

The above quote indicates that spiritually focused sessions helped Nomsa to confront and deal with her death fears. She further stated that talking openly about death helped her and her husband to feel at ease with the subject:

> Yes it helped me because now I talk about my illness freely even to my husband. We are able to talk about the future of my children after our death rather than avoiding the subject like before. Before, my husband would be scared when I talk about my illness, thinking that I will die tomorrow. Now he has no problem because he can see that I am physically and emotionally alright.

Kaut (2002) speaks about the spiritually focused therapist being a presence who provides a sacred space for the dying person to discuss her fears and hopes concerning existence beyond this life, helping her to find her personal meaning of life and existence. In the

present study, participants were afforded such sacred space and they used it to express their fears. Caroline expressed her fears about death. She was encouraged to talk freely and, with the help of the researcher, find meaning of her existence. Nomsa reached a point where she could see that her existence was meaningful and eventually found talking about death not as fear-provoking. Nomsa's diminished level of death anxiety was also reported in Cunningham's (2005) study. However, as Cunningham stated, it is difficult to determine the sustainability of this new perspective on death.

4.3.8 Improved insight into the development of psychopathology

In therapy, psycho-education about how one gets emotionally disturbed, how body and mind is connected and how one can change emotions by changing one's response (in terms of cognitions) to the stressors, was provided. This was based on the basic CBT principles of the development of psychopathology (Corey, 2005; W.R. Miller, 1999; Zimberoff, 1997). Responding to how this had impacted her, if at all, Nomsa responded by saying that:

> I used to think that, as I am sick, I will die. However, during the sessions you didn't tell me that I will die. You taught me that the thoughts and meaning I attach to my illness can make me feel sicker than I really am. Like that chest pain I was telling you about. If I am emotionally stressed I feel that pain more, but it goes away when I am emotionally ok. Yes, I never realised that my headache, for example, can be related to my automatic thoughts that I have about something. But now I know that there is a connection between my thoughts or worries and my bodily sensations. For example, this lump I have in my chest becomes noticeable if I am emotionally unwell; if I am well emotionally, I don't feel it.

The above vignette indicates that the separation of body and mind is only artificial as in practice they are connected. The presentation of primarily psychological/emotional problems as somatic complaints, known as psycho-somatisation, happens all the time (Zimberoff, 1997). The so-called 'tension headache', which Nomsa is referring to above,

is one of the common forms of psycho-somatisations in people experiencing psychological stress. Using psycho-education in therapy is one of the common techniques in CBT. Cunningham (2005), for example, psycho-educated cancer patients about common patterns of thinking that block spiritual experience and healing.

4.3.9 Spiritual disconnection due to existential anxiety and suffering

After determining what or who the participant's spiritual connection is, the researcher then asked the participant if she would like to invite her spiritual connection into her session for guidance and healing. The researcher would say, "If you would like to invite your spiritual connection to your session for guidance and healing, please raise your finger". If the participant's response is affirmative would then continued and said, "Feel the presence of your spiritual connection here with you." This could have provided a feeling of safety as well as wisdom to a person undergoing this process (Zimberoff, 1997). Caroline, however, reported that she did not feel the presence of her spiritual connection, God, during this exercise. It is possible that this was due to her serious health condition that she was beginning to be disconnected from her spirituality. This was during the first session of the therapeutic intervention. This was noted to be a trend throughout the period of therapy with her. Her existential anxieties and pains were taking too much of her time towards the end that she was struggling even to meditate as it was suggested. Furthermore, her existential struggles with forgiveness and anger towards her ex-boyfriend could also be distracters. Cunningham (2005, p. 184) reports similar findings with some of his participants and posits existential struggles with such questions as "why do bad things happen to good people" as a possible explanation.

However, when Caroline did take her attention away from pain and focused it towards God and praying, she did feel the difference. She said, "It (prayer) makes me feel alright, physically strong and connected to God." When she expressed a feeling of being disconnected from people, due to her family not visiting, Caroline was asked if this also results in her feeling rejected by God as well. She responded by saying, "No. I pray. Even yesterday Rhodes students came here and they prayed for me." She said the thought that

God has not deserted her make her feel better as she said, “I feel strong and ok.” This indicates that, being at peace with God and strengthening one’s spiritual connection with one’s transcendence, become important as one prepares to die (Kaut, 2002). Caroline even requested the researcher to pray for her in the end.

CHAPTER FIVE

CONCLUSION, IMPLICATIONS, EVALUATION AND RECOMMENDATIONS

Introduction

In this chapter, a summary of the major findings and the implications of the study are discussed. Research studies at postgraduate level should add value, both in body of research in general as well as in the lives of people in the human sciences in particular. This will be evaluated in this chapter by considering the strengths as well as the limitations of this research study, with a view to guide future research in this field.

5.1 Summary of the major findings

Both participants stated that believing in their higher power kept them going in their life path and acted as their support in the struggle to deal with their terminal illnesses. They also expressed a feeling of being socially disconnected, which made it difficult for them to cope with their illnesses. This feeling was even stronger for Caroline, who lived alone for the better part of the day while her children were at school. This meant that the two participants had ample time to ruminate over their illnesses and their entire situation, grappling with existential concerns such as guilt, unresolved relational problems of the past (i.e. struggling with forgiveness), doubting the presence of their higher power (spiritual struggles) as well as constant worry about the welfare of their children after their (participants') death. The study also showed that terminal illness can coexist with other depressive symptoms, which was evident in the case of Caroline. These symptoms were obviously secondary to the pain and suffering from cancer and they aggravated her emotional and existential struggles. Most research studies working with a sample of patients with terminal illness report about problems and existential struggles that such patients, as individuals, grapple with. Very little (Demmer, 2007a; Hedge & Sherr, 1995; Holt et al., 1999; Lindsey et al., 2003; Williams & Stafford, 1991) has been said about how this difficult situation affects the family as a whole. In this research it was found that

the terminal illness places a strain in the whole family as well. This was more so in the case of Caroline whose financial and personal identity had been lost as a result of her illnesses, particularly cancer. Her daughter was obviously struggling to accept the fact that her mother was dying. The findings also revealed that participants were partly blaming themselves for their illnesses. Caroline's situation was particularly more difficult in that the relatives were holding her responsible for contracting HIV/AIDS. Despite being Black South Africans, both participants believed in the power of western medicine to help them through their illnesses. This was particularly found to be surprising in Nomsa's case in view of her being a traditional doctor. It was also unusual to find her, being a traditional doctor, strongly believing in both God and ancestors.

The analysis of the participants' experiences of the spiritually focused therapy (SFT) revealed that the guided imagery exercises resulted in the participants gaining insight into the power of their psyche. Participants found that working on forgiveness of self and others brought about psychological relief. The work on dream imagery with Nomsa resulted in a transpersonal exploration that brought about a level of personal growth. Both participants were encouraged and helped in SFT sessions to work on reaching out to others for support and coping. Results reveal that participants made a start in this, which brought about some level of psychological wellbeing. The research findings indicated that the SFT sessions afforded participants a space to work on their emotional problems. They found that the relaxation exercises brought about feelings of relaxation and worked as a positive distraction from pain. One participant reported that fear of death diminished as a result of SFT sessions and that her insight into the development of psychopathology had improved, which made her cope better with her emotional problems. One participant was found to be struggling so much with death anxiety that she found it difficult to stay connected to her higher power, God.

5.2 The implications of the study

5.2.1 Theoretical implications

Using broad definitions of spirituality may be helpful in assisting practitioners to plan intervention strategies. Dictionary-like definitions are narrow and not helpful in planning a spiritually focused intervention. A broad definition ensures inclusion of even those existential struggles that are not expressed in known religious terms and hence have a potential risk of being dismissed as non spiritual. This was evident in the case of one participant who was a traditional doctor in the present study. As it was shown in chapter two, most traditional psychotherapeutic schools can be modified to incorporate spirituality as an adjunct or main focus of treatment. Transpersonal and existential approaches lend themselves more readily to this incorporation. More research is required to establish exactly which spiritual technique will benefit whom as there are many different techniques and they do not benefit all patients in the same way. The role of context – culture, idiosyncratic preferences, and the type and stage of terminal illness – needs to be taken into consideration in determining the types of techniques to use.

5.2.2 Research implications

There is a need to conduct more research with minority populations with unconventional forms of spiritual beliefs such as traditional healing and ancestral spirituality. In the South African context, the population of people that use traditional forms of healing are in the majority compared to countries like United States, for example. Secondly, Kellehear's (2000) call for further research on patients' spiritual needs in the social, psychological and physical areas, is supported. This would enhance our understanding of the extent of such needs and in so doing helping practitioners to pitch their intervention correctly. The concept of mind-body is well understood in the psychological arena. However, the argument that spiritual pain can express itself as body pain or exacerbate it, as Kellehear (2000) states, requires further empirical investigation. Lastly, the specific helpfulness of surrendering control to the patient's higher power to help ease their burden

requires further investigation. It was established in the current study, in support of Cole's (2005) findings, that such surrender not only decreases the emotional burden, but it also strengthens the spiritual connection.

5.2.3 Implications for clinical practice

Patients who are spiritual are more likely to participate in programs or interventions that address spiritual as well as psychological needs. Cognitive-Behavioural based therapy approaches can be helpful in providing patients with coping strategies to use to challenge and restructure their dysfunctional spiritual struggles. The findings of other research studies as well as of this research suggest that terminally ill patients are aware that cure has become out of question for them, while healing has become more important. This implies that treatment for them should be holistic, targeting body, mind and spirit. This obviously applies to patients who consider themselves spiritual. Comprehensive assessment of the patients' needs on intake becomes very important to aid in identifying the exact needs so that the intervention can be pitched accordingly. It also became evident in the present study that cancer patients' needs may be different from the needs of patients with HIV/AIDS as a terminal illness. Due to the recent discovery of ARV treatment, many people have begun to regard HIV/AIDS as just another chronic disease, which, when managed well, does not even warrant classification as terminal illness (Baer & Roberts, 2002; Holt et al., 1999; Hoy-Ellis & Fredriksen-Goldsen, 2007; Schneiderman, 1999).

Patients in advanced stages of cancer may be inaccessible for spiritually focused interventions, making the strengthening of spiritual connection with them extremely difficult. In the current study, the one participant who had cancer was also suffering from HIV/AIDS. This points to the co-morbidity of terminal illness with psychiatric disorders, which is consistent with the observations made in the literature (Cooperman & Simoni, 2005; McDaniel & Blalock, 2000; Yi et al., 2006). This study, like a plethora of others, has revealed that people with terminal illnesses grapple with existential concerns. In view of this, meaning-based intervention approaches may be beneficial to them. Lastly, the

present research study, which is consistent with other studies, has established that existential issues at the end of life tend to relate to fear of death, forgiveness, guilt, hope, dignified death, meaning and goals, communication and relationships. This finding has implications for the choice of spiritually focused intervention as well as the decision on the entire treatment plan by the practitioners.

5.3 Evaluation of the study

5.3.1 The strength of the study

Many of the available studies conducted on integrating spirituality and psychotherapy are based on surveys and interviews, without doing the actual spiritually focused intervention. The present study attempted to bridge this gap between theory and practice by providing the intervention and thereafter eliciting responses from participants regarding their experience of the intervention. This will hopefully add to a few available studies that explicate the patients' experiences. This will also aid with further research in this valuable resource, which will be particularly useful for the terminally ill patients. This study also investigated different types of spirituality, namely, Christianity and traditional/ancestral spiritualities. The latter has hopefully added to the body of research and clinical practice by providing an understanding regarding this type of spirituality as well as the type of spiritual struggles involved.

5.3.2 Limitations of the study

Sample size

Due to the size of the sample in this study, the findings are not generalisable to a larger population of terminally ill patients. However, the aim as said earlier, was not to generalise but to gain an understanding of the experiences of the participants after undergoing spiritually focused intervention. It can be further argued that, according to the qualitative rubric, transferability of the study may be possible. Transferability refers to

comparison of the contexts of each study to understand whether findings can be transferred from one context to another (Terre Blanche & Durrheim, 1999).

Lack of control

In the absence of a control group, it is difficult to attribute the benefits and improvements in the participants to the SFT. It is possible that just the attention given to the participants as well as being given a sacred space to express their emotional struggles was enough to bring a change, an improvement that could have been achieved by any other psychotherapy approach. However, according to the qualitative research logic, it could be argued that the results provided rich descriptions about how the SFT intervention influenced coping with terminal illness.

5.3.3 Aims of the study

The aim of the study was to determine the experiences of the participants in using spirituality in psychotherapy. The research findings of this study indicate that participants associated the SFT intervention with positive changes. Through such intervention, they were afforded an opportunity to identify and process their emotional, existential and spiritual struggles. In this regard then, the general aim of this study was realized.

5.4 Recommendations

5.4.1 Recommendations for caregivers

Caregivers need to know that, at the end of life, patients grapple with issues of hope, forgiveness, guilt and the ability to make meaning. Questions of dignified death and the knowledge that their loved ones will be taken care of are also important to address. Caregivers may assist by helping the patient cope better with the illness by facilitating the addressing of these issues. Secondly, caring for a terminally ill person may be emotionally draining and stressful. Hence caregivers may benefit by seeking

psychotherapy for stress management and coping. Those that are spiritual could benefit more from spiritually focused interventions.

5.4.2 Recommendations for psychotherapists and other mental health professionals

Psychotherapists and other mental health professionals need to assess patients holistically to establish the nature and the extent of needs. The researcher proposes that all professionals, not only spiritual leaders, can help patients address spiritual struggles to a certain extent, if needed by specific patients. This may mean just determining what the need or struggle is, giving patients permission to express all their needs freely. Psychologists have an ethical obligation to address all their clients' needs, even those that are spiritual. In the event of needs that are beyond their ability or scope of practice, they can refer further. It is also their ethical responsibility to seek further training in the areas where they are not competent. Literature has shown that the majority of clients that seek therapy are religious or spiritual (Abernethy et al., 2006; W. R. Miller, 1999; Wen-Shing, 2004). In view of this, it makes sense for psychotherapists to seek more training in spiritually focused therapy. The study findings in this research have shown that the caregivers of people with terminal illness struggle with emotional problems of their own as a result of caring for these patients. It is therefore recommended that caregivers be given psychotherapeutic counselling as well. In view of the fact that terminally ill persons struggle with problems of social disconnection, it may benefit patients to encourage that they join self help or social support groups. This may help them gain support and a resource for coping. Fellow worshippers for those patients that are religious may also provide such support. Psychotherapists should also examine themselves and be wary of countertransferential issues that may hamper their work as spiritually focused therapists. It may help them therefore to identify these issues and clear them out of the way so that such an important work can be done without any barriers. Results of this study have established that spirituality is subjective and private. The implication of this is that, spiritually focused interventions should be planed to address the needs of each individual rather than using them on a one-size-fit-all basis.

5.4.3 Recommendations for further research

The findings of this study have established that terminally ill patients struggle with relationships. In view of this, patients might benefit more if the spiritually focussed therapy is conducted on a group setting where group members serve as one another's support and coping resource.

Although it was not the intention to generalise the findings of this research to a larger population, using a larger sample may shed more light in terms of the participants' experiences of this type of intervention. Comparison with the current results may then become possible if the results of the current study are transferable. The psychotherapy sessions were too few and hence did not allow for personal and spiritual growth. For spiritual techniques such as meditation, beginners may need more than just a few sessions to master the technique.

Starting SFT intervention with a patient who was in the advanced stages of her terminal illness in this study proved limiting as she was almost inaccessible for help. It is recommended that future research consider starting SFT early, when patients are still accessible and hence able to benefit from the intervention.

5.5 Conclusion

As indicated in chapter three, this study set out to determine the two participants' experiences of spiritually focused psychotherapy (SFT). The research findings indicated that self-knowledge, coping strategies, healing and insight into the development of psychopathology were achieved. While it cannot be claimed that all this was due solely to SFT intervention, there is rich participant evidence that the intervention largely assisted the process of these achievements.

Both participants reported that, after calling upon their higher power for support and coping, they felt immediate relief from their physical and emotional distress. The findings also revealed that terminal illness resulted in the participants becoming socially disconnected. This was attributed to the stigma attached to HIV/AIDS in the case of both participants as well as, in Caroline's case, loss of identity as one of the existential elements that cancer patients grapple with. This is consistent with the findings of Cole (2005) as outlined in chapter two. Chapters one and two list a plethora of studies that have consistently shown that terminally ill patients grapple with existential and spiritual struggles. These findings were confirmed by this study, where, particularly in Caroline's case, the spiritual struggles such as doubting the presence of her higher power led to the weakening of her spiritual connection to God, resulting in her praying less as well as struggling to meditate. This weakening of spiritual connection in turn resulted in the failure to use her higher power as a source of support and coping. Her fear of death and physical agony took more of her time, resulting to her giving more time to her pain and existential struggles. Again this finding is consistent with Cunningham's (2005) findings as stated earlier.

Nursing a terminally ill patient may place a strain to the caregiver. Many studies, including this one, tend to focus on helping the terminally ill patient cope with the illness, while excluding the rest of the family. The findings of this study revealed that there is a need to review this tendency for future studies. The findings indicated that the whole family is affected by the stress brought about by terminal illness and therefore any

intervention provided should consider both the caregiver as well as the patient. Participants were found to be stuck in their past mistakes and harbouring feelings of guilt, finding it difficult to drop resentments towards those that have wronged them in the past and move on. This finding is consistent with the findings as stated in chapter two. Participants were psycho-educated about the role that negative emotions can play in the dysregulation of the immune system as it has been indicated in the literature. Furthermore, they were assisted in working through their guilt and forgiveness of themselves and others.

Participants' responses indicated that they benefited from meditation and guided imagery in deep relaxation. Nomsa was excited about the discovery of the powerful tool within her and stated that she would continue working on forgiveness using such a tool. She also realised, as did the other participant, that working on forgiveness this way made her feel lighter and it brought about a sense of relief. The participants also reported experiences of pain relief during the use of this exercise. This means that regular practice of this exercise may provide an effective strategy to help patients cope with pain.

The dream interpretation assisted Nomsa to work on refining her skills in dream imagery interpretation. Nomsa was used to communicating with her ancestors through dreams. Hence regarding dream imagery as something positive, with a healing potential, affirmed the legitimacy of her spiritual beliefs, rather than dismissing them as demons as other religions and western psychologies have done.

Spiritually focused therapy (SFT), as an intervention technique holds promise in assisting terminally ill patients in the future. In this study, both participants reported that SFT provided them with a sacred space to heal. One participant found that SFT reduced her fear of death, while her knowledge of the development of psychopathology improved.

Although further research is required to give more clarity on using SFT for clinical practice, this study provides some guidance to psychotherapists. A claim cannot be made that SFT is superior to other traditional therapeutic techniques or modalities. However,

the researcher is advancing an argument that there is a need for psychotherapists to assess their clients holistically, so that physical, emotional, and spiritual problems can be identified and treated holistically. The researcher, however, is not making a claim that SFT is for everyone. Patients who are spiritual and willing to explore their spiritual struggles in therapy may benefit from it. Hence a call is made for a comprehensive assessment during intake, so that where spiritual needs are present, therapy can be spiritually augmented to ensure that such needs or struggles are addressed.

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APPENDIX A: THREE RELAXATION SCRIPTS

i) DEEP RELAXATION/HYPNOTHERAPY SCRIPT

1. DEEP RELAXATION/HYPNOSIS: INDUCTION – **EYE FIXATION**

"Now focus your eyes on a spot up on the ceiling...keep your head straight...and just gently lift your eyes up to focus on the spot on the ceiling...Now take a nice deep breath in and hold it, hold it as long as you can, until you just can't hold it any more...now slowly let it out and feel a wave of relaxation from your head to your toes...Good, now take another deep breath in, continuing to stare at that spot ... hold it, hold it ... and, as you let it out feel that wonderful wave of relaxation from your head to your toes ... One more deep breath in and as you let it out ... feel yourself relaxing from your head to your toes ... You now begin to notice your eyelids blinking ... you can feel your eyelids blinking and tearing and wanting to close down. Just allow them to close down now and let yourself go deeper and deeper into relaxation ..."

2. DEEPENING TECHNIQUE – **THE ELEVATOR or THE STAIRCASE or THE GENTLY SLOPING HILLSIDE**

"Picture and imagine yourself in an elevator or on a staircase or on a gently sloping hillside somewhere out in nature, whichever is most comfortable to you ... (wait) ... There are ten levels going down ... each level that you go down, you become more and more relaxed ... When you get down to level number one, you will be all the way down to the bottom of relaxation ... the sound of my voice and the sound of the music will take you deeper and deeper into relaxation ... You're on level number **ten** now ... moving down to level number **nine** ... more and more relaxed ... letting go of all your thoughts and all cares ... more and more relaxed ... Moving on down to level number **eight** ... calm and relaxed, calm and relaxed ... Whenever conscious thoughts come into your mind, go back to the words, calm and relaxed, calm and relaxed to quiet those thoughts ... You're moving on down now to level number **seven** ... perhaps you can picture or

imagine those numbers as you go down the levels … Moving on down now to level number **six** … relaxing your mind as well as your body … more and more relaxed, deeper and deeper … Any sounds you hear are just the normal everyday sounds of living; they do not disturb or distract you in any way … they only serve to take you deeper into relaxation … You're moving down now to level number **five** … you're half way down now … feel your body becoming loose, limp and relaxed, just melting into the couch (or chair or mat) … Feel your muscles let go like noodles … loose and limp and relaxed … Moving on down now to level number **four** … going deeper and deeper, more and more relaxed … letting go of all your thoughts and cares … Moving down now to level number **three** … when you get to level number one, you will be all the way down to the bottom of relaxation … Moving down now to level number **two** … releasing, relaxing and letting go … more and more relaxed … Moving down to level number **one** … down to the very bottom of relaxation."

3. DEEPENING TECHNIQUE – **FAVOURITE, MOST RELAXING PLACE or NATURE/SAFE PLACE**

"Now let yourself go to one of your very favourite, most relaxing places. It may be a place out in nature … the beach … a lake … a place up in the mountains … a meadow … or perhaps it's a place in your own home or your backyard … When that place comes to you, just raise your finger"… (Wait for finger response. If no response after a few minutes then say, "If no place comes to you, raise your thumb." If they do, tell them "That is okay, one will come" and just continue.) … "Now let yourself just be there in your favourite place and begin to use all your senses to be there … Tell me now what place comes to you there … What do you like about it? … Visualise or imagine all your favourite scenery (or favourite things) surrounding you there … (wait) … notice the colours … the shapes … the textures … using all your senses to be there … Begin now to listen to your favourite sounds there (use examples from the person's place if possible) … listen to the sound of the water … or the birds … or the gentle breeze … (wait) … Now smell your favourite aromas there … perhaps the flowers or the fresh clean air … (wait) … Now just feel the familiar feelings there in your favourite place … Now bring your

thumb and forefinger together ... just touch the tips of your thumb and forefinger on the same hand together ... This is your anchor ... whenever you bring your thumb and forefinger together you will come right back to this place ... back to your favourite most relaxing place ... using all your senses to be there ... anytime you want to come back to this place, when you want to relax, just bring your thumb and forefinger together and you will be right back here ... Do you have a spiritual connection? What do you call that connection? If you would like to bring __________ into your session for guidance and protection, raise your finger now. (If yes) Okay, now feel your spiritual connection, (use the name they gave you) and bring ___________ here into your session for guidance and protection and healing. Okay, now let go of your anchor ... release your thumb and forefinger."

Adapted from: Heart-centered therapies training manual by The Wellness Institute, (n.d.)

(ii) CORRECTIVE VISUALISATION SCRIPT

Take a few minutes to relax. Recall a time when you spoke or acted in a way you now regret. As vividly as you can, imagine yourself back in that same situation. Visualise the place you were in and the people who were there. Recall what you were doing and how you felt. Then allow yourself to watch the scene unfold and watch yourself make the error and observe the consequences.

Now restart the visualisation from the beginning and again allow the scene to unfold. However, this time see yourself making a wiser choice and notice how you feel as you do so. For example, perhaps a friend made a hurtful comment and you flew into a rage and lashed back, thereby damaging the friendship. In replaying the scene you might see yourself taking three deep breaths and then making a joke about the comment. If you wish, you can replay the scene several times and try different types of skilful responses. Just a few minutes doing this exercise can bring a sense of healing, offer new insights, and begin to establish healthy new habits.

In a moment now I am going to count from 1 to 3. When I come to 3 you will come back to the room, feeling fresh and full of energy. **One,** the energy is coming back into your body now. **Two,** feeling nice, fresh and relaxed. **Three,** open your eyes, wide awake with lots and lots of energy.

(Say to the person out of trance "This exercise shows that our minds are wonderful tools. We can use them in any creative way we want. It also shows that we create our realities and hence feel the way we think")

Adapted from Walsh, 1999

(iii) ACTIVATING WISDOM FROM WITHIN/ EGO STRENGTHENING SCRIPT

Close your eyes and relax. Imagine yourself in a beautiful place, perhaps your favourite beach, mountain, or garden. See yourself there and enjoy the feelings this special place evokes. In just a moment you are going to invite into that place an extraordinarily wise person. It may be a great spiritual teacher, or it may be an unknown wise man or woman. Whoever it is, this person will embody qualities such as great wisdom, love, and complete acceptance of you just as you are. Invite this wise person into your place of beauty and introduce yourself. Take time to savour the experience of being in the presence of a person of deep wisdom and boundless love. Observe how it feels like to be with someone who understands and loves you completely! Observe your fears and defences melt into nothingness in the presence of someone who accepts you just the way you are.

Here is an opportunity to learn and get advice about anything that concerns you. Take a moment to think of the questions you would like to ask. Then ask your first question and wait quietly for the answer. There is no need to try to make anything happen. Simply relax and allow the wisdom within you to respond. When you are ready, ask your next question, wait for a response, and continue with any further questions. Next, ask the wise person if he or she has anything to tell you. Again, just relax and wait for an answer. Then ask if there are any questions the wise person has for you. Finally, ask the wise person if he or she will be available to you in the future at any time you request help or do this exercise. Then express your thanks for the gifts of this meeting.

Now imagine yourself beginning to merge with the wise person so that your bodies, hearts, and minds melt into one. Actually you already are one, because the sage and the qualities such as love and wisdom are creations and part of your own mind. Feel that you have absorbed the qualities of the wise person and explore the experience. What is it like to be wise? What does it feel like to be fearless and to have no need to defend yourself in any way? What is it like to feel boundless love and care for all people, including

yourself? And what does it feel like to accept and love yourself completely, just as you are? After you have savoured this experience, gently open your eyes. Try to make the transition slowly and gently so you can bring back the qualities you experienced.

(Say to the person, out of trance "Take a moment to reflect on the fact that these feelings – wisdom, fearlessness, love, and acceptance – are not new or foreign to you. They are actually aspects of yourself that you projected onto the wise person. True, these qualities are not fully developed or always accessible to you yet, but they are available and await your attention to grow and flourish. This exercise can be repeated whenever you wish to experience and nourish positive qualities. It can also be done when you need guidance with a difficult question or choice, and it is especially valuable during times of confusion")

Adapted from Walsh, 1999

APPENDIX B: CONSENT FORM

RHODES UNIVERSITY
DEPARTMENT OF PSYCHOLOGY

AGREEMENT
BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I (participant's name) ________________ agree to participate in the research project of (researcher's name) ________________ on integrating spirituality and psychotherapy.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Master's degree at Rhodes University.

2. The researcher is interested in participants' experiences of spiritually focused psychotherapy.

3. My participation will involve my responding to a maximum of four interviews which will take about 60 minutes and being a client in a minimum of six spiritually focused psychotherapy sessions of about 60 minutes each.

4. I will be asked to answer questions of a personal nature but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

5. I am invited to voice to the researcher any concerns I have about my participation in the study and to have these addressed to my satisfaction.

6. I am free to withdraw from the study at any time – however I commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation which I did not originally anticipate.

7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.

Signed on (Date):

Participant:

Researcher:

Witness:

APPENDIX C: SCHEDULE OF SEMI-STRUCTURED QUESTIONS

- Ask about participants' spiritual history.
- Determine the impact of participants' spiritual beliefs on their day-to-day lives and whether their beliefs have been harmful in any way.
- Ask each participant whether they consider themselves as a spiritual person
- Determine the place of spirituality in the participants' life in the face of their illness.
- Ask whether the participants are integrated in an organised spiritual community
- What role would participants like their doctor, nurse or therapist to assume in the domain of spirituality?
- Ask whether participants' sad feelings have affected their relationship with God/higher power/transcendent force OR
- Whether anything in their spiritual life has changed since they were diagnosed with their illness.
- The type of problems participants grapple with and whether these have been effectively addressed in therapy.
- Ask participants about their experiences of spiritually focused therapy (question to be asked during phase 3 of research).

APPENDIX D: SFT SESSIONS

Spiritually focused therapy (SFT) sessions

Sessions for each participant will be discussed separately. Caroline, due to the severity of her illness, required more than six therapy sessions that were initially planed. Hence she ended up having a total of eight SFT sessions. Sessions 7 and 8 were used for both evaluation and therapy and, owing to the deterioration of her health condition by this time, very few evaluation responses could be elicited. By contrast, Nomsa's condition was stable as she had responded very well to antiretroviral treatment. For that reason, there was no need to go beyond the initial treatment plan of six SFT sessions.

1. Caroline

Session #1

Mental status examination (MSE): Caroline appeared bright and alert. Her mood was euthymic with normal affect that was congruent to the mood. She engaged well with normal rate, flow and volume of speech. No perceptual disturbances were noted or reported.

Caroline used this session to express her emotional struggles. The researcher acted as a container or vessel for Caroline to express her feelings which were metaphors of her struggles. These included feelings of being unsupported by her children's fathers, being overwhelmed by her son's sickness and his demand for attention, and dealing with her son's anger, frustration and hatred. These stressors, according to Caroline, resulted in spiritual struggles, where she forgot to pray and read the bible. Her feelings were validated and normalised in the face of her illness. At this point, the idea of journal writing was introduced. This was coupled with daily record of dysfunctional thoughts based on cognitive-behavioural therapy (CBT) approach. Psycho-education was then given on the mind-body connection as well as the development of emotional disturbance

(basic CBT principles). Examples were made with what Caroline had given hitherto to demonstrate how one can challenge one's dysfunctional thinking and or emotions, which is one of the cognitive restructuring strategies in CBT. After this the researcher introduced relaxation as one of the spiritually focused therapy techniques that one can use to manage stress and to bring about other psychological benefits. Relaxation/hypnotic state was then induced using hypnotherapy script (see Appendix A i). Guided imagery to create a safe place and to strengthen Caroline's spiritual connection was done with her still in trance. After this exercise, Caroline was invited to share her experiences of the exercise. These will be discussed later under the 'participants' experiences of SFT' section.

Session #2

MSE: Caroline looked and reported to be a bit down today compared to last session, she engaged well.

Caroline's weekend had reportedly not been pleasant. Her friend had asked for her permission to have Yolanda visit her to help out at the function. Caroline had said yes but not meaning to. When she was alone, her son drank paraffin, resulting in her being very scared and began to have guilt feelings that people would think she is not a caring mother. Caroline had recorded this incident on the daily record of dysfunctional thoughts that she was given previously. However, she had not been able to challenge her own dysfunctional thinking. Using this form, she was shown in session how to do it by going through all the automatic thoughts she had had in her head at the time of the incident and how these were indirectly serving to maintain her emotional state. Using a role play, Caroline was guided to express her emotions to her friend (empty chair technique) in a non-abusive but assertive way. She was also instructed to express the feelings of being "upset" she had had at the time when her friend made this request "knowing very well that I am sick". This is a combination of behavioural and Gestalt approaches (i.e. assertive behaviour and connecting with past experiences to deal with unfinished business). Before the above paraffin incident, her son had behaved in a strange way,

leading Caroline to have existential anxieties of death. These feelings were also processed in the session. The session was closed by inducing hypnosis/deep relaxation. The ego strengthening technique (transactional analysis technique) was used, where it was suggested that Caroline invite a wise person into her safe place to seek answers to her mysteries. Meditation music was playing softly in the background while guided imagery to evoke wisdom from within was done. This technique was adapted from Walsh's (1999) technique (see Appendix A iii), with the researcher using his own words to make it relevant to the material presented in the session.

Session #3

MSE: Well groomed, relaxed, engaging well and looking bright and happy.

This session was held immediately after the weekend of the Mothers' Day. Caroline had been surprised by her daughter by giving her a gift and getting other people to phone her, saying good things to her. She also had her name being mentioned in the local radio station. Caroline reported a feeling of being socially connected which showed her the importance of reaching out to people for emotional wellbeing. This incident was then used in therapy to strengthen the relationship between emotions, cognitions and spirit (mind-body-spirit connection) using Caroline's words where she had reported feeling happy and well physically, spiritually and emotionally. Psycho-education about how negative emotions influence one's immune system was given. She was then psycho-educated about how to facilitate forgiveness as a way to free herself of resentment. This was practised by having Caroline express her resentments towards a particular parent (on empty chair basis) in Yolanda's school, with whom they had had a disagreement previously. This was repeated until Caroline could do it satisfactorily.

Session #4

MSE: Caroline was at home, looking agitated and sick, breathing with difficulty due to dyspnoea, still upset becoming angry as she explained what had happened over the weekend. Her child lying next to her, also sick and hence didn't go to school.

Caroline had become so sick over the weekend that her Hospice nurse had referred her to the local hospital. When she got to the hospital she insisted that her son be admitted as he too was sick but the nurses at the hospital had refused. This resulted in her storming out of the hospital with her child and returned home. On her way back she had experienced severe pain, walking a long distance from the hospital to the taxi rank. She experienced feelings of existential anxiety on her way to the taxi rank "I felt funny and scared because I don't know how one feels when one is dying" When she got back she told her daughter to write everything she needed her to do before she dies. Therapy focused on reflecting feelings of fear of death, facilitating expression of other existential anxieties – giving her permission to talk about death openly, encouraging separation of existential issues of control – differentiating things in her own control and those in God's control. Caroline was then psycho-educated on inducing self hypnosis so as to put herself into her safe place. She could use safe place to quiet her thoughts as well as a positive distraction from concentrating on pain. A bit of work on self forgiveness was also done. Caroline was encouraged to go to hospital as she was clearly too sick to be on her own at home.

Session #5

MSE: Looking really sick and frail in the hospital bed; pale in the face; talking with great difficulty due to dyspnoea; oxygen bottle near her; dysphoric and irritable mood.

Caroline expressed fear of death and feelings of being rejected and socially disconnected, saying people were being visited but her family hadn't been coming. She reported having been pleading with God not to take her before she had certain things sorted out. Therapy concentrated on containing and reflecting feelings, processing existential anxieties – together exploring available options to address immediate spiritual needs. Caroline was

invited to identify people she felt negative emotional attachments to, due to disagreements in the past. She mentioned her son's father at the top of her list. She was then invited to choose anyone she felt ready to express her anger to, so that she could pave a way to forgiveness. She chose her son's father and, through the researcher's guidance, she expressed her anger towards him, imagining his presence in the room and she cried. She was further encouraged to use the technique of inducing deep relaxation and putting herself into her safe place to help lessen her physical pain.

Session #6

MSE: Sick, in hospital bed; still struggling to breathe; looking brighter than yesterday.

Caroline was happy to hear that the researcher had contacted her sister and she had promised to come and stay with her (Caroline's) son. She reported that, after the previous session, she had thought about her son's father and had managed to put her resentments towards him behind her and she was now feeling at peace inside. Therapy concentrated on guilt feelings in order to facilitate self forgiveness. Caroline owned up her part that had kept the resentment between her and her son's father and forgave herself. She also identified other guilt feelings about her past mistakes and forgave herself. The death anxiety was greater after Caroline had seen one patient, who was also suffering from dyspnoea, dying in front of them (patients).

Session #7

MSE: Still in hospital; dyspnoea still troubling her; physically emaciated; talking with near crying and irritable voice but becoming more relaxed as session progressed.

The talking in this session was kept short, with long halts as Caroline was obviously in great pain. Immediately when the researcher and the nurse appeared in her sick room, Caroline's demeanour changed to near crying. When the researcher reflected on this presentation, Caroline verbalised being happy because she had been feeling socially

isolated hitherto, with nurses being perceived as not caring "They are only coming now that you are here". Hence there was a feeling of being also rejected by nurses. She said her sister hadn't visited in a week's time. Strong needs of being connected and surrounded by significant others in familiar surroundings were expressed, validated and processed. The researcher's visits were obviously perceived as a source of support and coping.

Session #8

MSE: Looking frail and emaciated; psychomotor retardation; very soft speech; sad mood; very sick; struggling with dyspnoea.

Caroline was now finding it very hard to be seen by her children in the above mental state. The session was kept short. Caroline was encouraged to concentrate on getting healed spiritually, even though still feeling weak physically due to pain and suffering. She complained that nurses do not talk about spiritual matters; they only concentrate on her physical condition. She said she would have liked them to also address her spiritual needs. While the researcher was about to leave, having said the goodbyes to see her in the next session, Caroline requested him to pray for her. The researcher held her arm and prayed. The researcher was touched by this request and it meant more to him when he arrived for the next session only to be told that he was 3 minutes too late as Caroline had just passed on 3 minutes before he came.

2. Nomsa

Session #1

MSE: Well groomed; smiling, presenting a happy face but looking down; reported to be scared due to what had happened at home; engaging well with normal rate, flow and volume of speech.

Nomsa reported unpleasant emotions due to a number of stressors at home including the fact that she and her husband were experiencing problems with the neighbours concerning the way they treat their patients. Police had gotten involved, placing a lot of strain in the family, with her 13-year old daughter being very anxious about what will happen to her family. Nomsa's husband had been arrested temporarily as a result of this. In the session, the researcher facilitated the uncovering of dysfunctional thinking patterns about Nomsa's situation. Therapy was meaning-based, helping Nomsa review her life and her record of treatment expertise. She was assisted to make a difference from the present ordeal and what she is capable of doing, treatment-wise. She said she knew that she and her husband had a good treatment track record, especially when it comes to the treatment of "*amafufunyane*" (similar to what used to be called hysteria). Psycho-education on how one becomes emotionally disturbed was given using the basic CBT principles. This was done by taking one particular incident where a group of parents had come to their house. Nomsa was invited to remember the thoughts that had popped into her mind then, the emotions that went with such thoughts and her behaviour thereafter or at the time.

Session #2

MSE: Well groomed; looking bright and ready for the session; euthymic mood with normal range of affect; engaging well with bright smiles.

Therapy in this session concentrated on listening, reflecting and validating emotional experience, doing cognitive restructuring of dysfunctional spiritual beliefs. Nomsa believed that she could not challenge her ancestors' unreasonable demands of wanting her and her husband to perform the Xhosa ritual they owed them. She and her husband believed that the problem of being estranged by their patients were indications that the ancestors were angry with them, hence they were punishing them. This was challenged in therapy, where Nomsa was told that she and her husband could communicate to their ancestors and explain their situation. After all, the ancestors, being a higher power, are supposed to know this already. The exercise of separating issues of control was done, with researcher exploring with Nomsa what was in her control, such as finding a job or starting to sell small things rather than relying on traditional healing only, which was obviously not doing well. Psycho-education about how emotional disturbance happens as well as how negative emotions may dysregulate one's immune system was given.

Session #3

MSE: Well groomed; looking a bit down today, verbalising feelings of frustration; normal speech.

Nomsa expressed feelings of being unsupported by her husband in many ways. She was struggling to get food for children but her husband was not showing concern. She found this very frustrating. Nomsa also reported lack of communication which left her frustrated as she didn't have friends to talk to. She also expressed her anxieties about the fact that there was no one to look after her children after her death. It became clear in this session that Nomsa had a lot of stressors and she was feeling overwhelmed. The lack of social connectedness was obviously adding to her psychological stresses. Therapy concentrated on exploring possibilities to address existential issues, easing up the burden of stressors by surrendering some to the transcendent's control while addressing those that are in her control. These issues were explored in the session. Ways of opening up communication lines between her and her husband were explored and role-played in the session. The issues of spiritual connection (the power one calls upon in times of

difficulties for support and strength) were explored. Nomsa said her spiritual connection was her ancestors. Meditation and hypnotherapy were introduced and explained to her. Psycho-education on psycho-somatisation, which is an indication of mind-body connection, was given. Nomsa was given homework of working on facilitating communication with her husband and talk about her anxieties about the welfare of children after their parents' death. She would do this following the guidelines as per the role-play above.

Session #4

MSE: Looking rather untidy today, coming straight from the garden; looking and reporting being in a good mood; engaging well with normal rate, flow and volume of speech.

Nomsa reported that she had been promised a temporary job of being a security guard. She was happy about this. However, she had lost money while going to pay for the security guard course and the family had interpreted this as the ancestors' expression of unhappiness about Nomsa going into the working industry. They believed that the ancestors were having a problem with the fact that she was going to be wearing trousers while doing the security guard job, something that is unacceptable by her ancestors. Nomsa discussed with her husband what was discussed in session 2 above about challenging unreasonable demands by the higher power. Based on this they decided to go and request her father-in-law to go to the kraal and speak to the ancestors on their behalf. After the discussion with her husband (before her father-in-law went to the kraal), Nomsa had a dream in which a wise man appeared and asked her and her husband to say their wishes. Nomsa asked for money and a job. While they were saying their wishes, there came a swamp of bees and Nomsa and her husband tried to run away but the sage told them to ignore this. After that a heavy rain came down (in the dream). Family interpreted this dream as meaning that they had to go to the kraal to talk to the ancestors as they had envisaged. Indeed after their father finished talking to the ancestors a heavy rain came and the family became hopeful that things were going to change for the better from then

on. The interpretation and the feelings of the family were validated in therapy. Alternative or expansion of the family's interpretation was explored in the session. Bees were interpreted as obstacles and hurdles they have endured (arrest of husband etc.) and rain as a symbol of hope for something good coming (rain makes plants grow). Psycho-education was further given about dream imagery and how these can be regarded as transpersonal level of consciousness that goes beyond the ordinary, egoic one. It was stressed that dreams can help us see beyond our ordinary awareness and become aware of other, higher levels of consciousness. Existential issues of control were again stressed, where finding a job and making money so the family can perform the rituals required, were classified as things in the family's control. Relaxation exercise was then done in which spiritual connection was facilitated and wisdom from within was evoked to strengthen Nomsa's wise adult ego state. Thereafter Nomsa shared her experience of the deep relaxation exercise.

Session #5

MSE: Well groomed; euthymic mood with congruent affect; normal speech.

Nomsa reported having made a chance to discuss her existential anxieties about the welfare of her children after her death. Her husband agreed to let children live with her family in view of the fact that her mother-in-law does not like her and her children. In this session, Nomsa expressed her spiritual struggles that had resulted in her stopping attending church. She was aggrieved because the members of her church had failed to visit and support her during her sickness. She had stopped attending but she regretted it because she was deriving support from attending church service. Nomsa also reported having been told by one church minister that God did not destine people to die nor experience pain. He then said if one prays hard one may live forever and never experience pain. This dysfunctional spiritual belief was challenged in therapy using CBT principles. The researcher invited Nomsa to look at the evidence supporting or disclaiming this claim. This showed that the belief was dysfunctional. The session was ended by engaging in a corrective visualisation and self forgiveness was done in trance

(see Appendix A ii). Nomsa immediately connected with repressed emotions of the past and severely abreacted. This was about her past mistakes and Nomsa came face-to-face with her father about her serious mistakes in the past. The researcher helped her process the emotions.

Session #6

MSE: Well groomed; alert with euthymic mood; normal affect, congruent to the mood; engaging well with normal rate, flow and volume of speech.

Psychotherapy in this session focused on listening, reflecting and validating Nomsa's emotional experience. Feelings were explored in view of this session being the last. Nomsa expressed a desire to go straight into hypnosis in order to deal with her unfinished business with her father as it started in the previous session. Guided imagery with Nomsa in trance was facilitated after inducing deep relaxation (Appendix A i: hypnotherapy script). The deepening technique into the safe place was facilitated and Nomsa invited to work on asking for forgiveness from her father. She was guided into this process step by step, using guided imagery. After this exercise, in which she became aware of the presence of her father and later her mother, the researcher led her to self forgiveness, suggesting that despite the mistakes she had made in the past, something positive did come about e.g. children, her father's grandchildren. This session was very powerful as Nomsa felt very happy having made peace with her parents, which to her felt very real.

At the end of the session Nomsa expressed a wish for her husband to get psychotherapy as he too was emotionally troubled. The Researcher directed her as to how to go about accessing this service from the local state hospital. He explained that, ethically it wouldn't be right for him to work with the researcher but he could definitely get help from the hospital free of charge.

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