INTERNATIONAL CONFERENCE ON SPIRITUALITY AND PSYCHOLOGY 2018

13-15 MARCH 2018

BANGKOK

THAILAND

CONFERENCE PROCEEDINGS

Tomorrow People Organization

Dušana Vukasovića 73, Belgrade, Serbia

www.tomorrowpeople.org

Proceedings of international conference:

"INTERNATIONAL CONFERENCE ON SPIRITUALITY AND PSYCHOLOGY 2018"

Editors: Tomorrow People Organization
Dušana Vukasovića 73
11070 Belgrade, Serbia

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Producer: Tomorrow People Organization

Publisher: Tomorrow People Organization

Quantity: 200 copies

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A Look at the Meaning of Life through Psychologists Jung and Yalom

Amoneeta Beckstein, PhD
Webster University Thailand
Department of Psychology

Abstract

It seems important and natural for human beings to search for meaning and attempt to make sense of their often seemingly senseless lives. This topic is relevant to academics and mental health practitioners who are likely to assist others in meaning making. This paper aims to encourage such practitioners to self-reflect on the meaning of life for themselves to then further assist any clients who may be searching for meaning. This paper does this via exploration of relevant writings by two psychologists, Irvin Yalom and Carl Jung, from different theoretical backgrounds. Consensus between the two is mainly emphasized.

A Look at the Meaning of Life through Psychologists Jung and Yalom

Since the beginning of time it seems that humans, including philosophers such as Aristotle and Kant, have searched for the meaning of life (Metz, 2013), something to make sense of our existence to help stave off the thought that we might simply just exist and then die without a purpose. Many ask, what is the point of it all? (Kinnier, 2001). Do we just suffer and then die for naught? Since these are pressing questions for many people, it would make sense for academics, and particularly practitioners such as therapists and counseling psychologists, to explore this topic themselves as they are very likely to meet with clients who will be struggling with these concerns. While this paper may benefit anyone, its main focus is to encourage practitioners to self-reflect in order to find meaning in their own lives and assist their clients to do the same. This paper examines what two theorists from two different theoretical perspectives in psychology, Carl Jung (an analytical psychologist) and Irvin Yalom (an existential psychologist) have to say about the meaning of life. This paper explores their writings on the topic and how their thinking sometimes converges and sometimes diverges while showing more evidence of the former.

Let's start with what Carl Jung (1967) says about the meaning of life. Jung talks about life being split into two stages that we go through. In the first half, people's time is generally filled up with "necessary" preparation for the future through education, work, and often starting and taking care of a family. During this time, our energies tend to be externally focused on goals. Next, we start focusing inwardly and go through what Jung termed an *individuation process*. This stage often starts in middle age and could begin as a transition that could be challenging for many and has been termed the "midlife crisis" by the popular media. This transition occurs as people become more psychologically mature. During this time, we tend to ask existential like questions such as, "Who am I?" and "What is my purpose?" According to Jung, if we do not find some kind of meaning in our lives, we are more apt to experience psychopathology, meaning our distress goes up and functioning goes down. Since meaninglessness does not allow people to achieve their fullest potential; Jung equates it to neurosis. People might end up becoming more spiritual or more in touch with themselves during the second life stage and experience "ego ascension." However, others might go in the other direction and become shallow. This is when we stereotypically see men buying sports cars and women getting plastic surgery.

Another idea of Jung's that relates to meaning of life is called *synchronicity*, a term that he coined (Jung, 1967). This is where we try to make sense of two seemingly unrelated events. This meaning-making strategy helps people understand their life and feel more in control of it. From this author's personal observations of people in general and therapy clients in particular, it seems that we like to be able to make sense of why things happen and feel bothered by things that simply do not make logical sense to us. This possibly could be innate because babies, for example, will stare longer at an object that appears to be doing something unnatural or impossible (Aslin, 2007), such as a pencil hanging from the ceiling on an invisible thread. Jung goes back and forth in his discussion of meaning and meaninglessness. He seems to come to the conclusion that both exist in our lives but adds that he hopes that meaning will win over meaninglessness.

Jung seemed to have been one of the first positive psychologists, even before this field officially emerged; positive psychology has been defined as "the study of the conditions and processes that contribute to the flourishing or optimal functioning of people" (Gable & Haidt, 2005). Jung seems to fit into this field because he really had an optimistic view of life; furthermore, the study of the meaning of life also seems to fit nicely into this field. Jung (1967) stressed the importance of striving more, especially when it came to working with people with psychopathology. Jung disagreed with Freud (Freud, Strachey, & Freud, 1963)

that ridding ourselves or our clients of neuroses is enough. Rather, he thinks that it becomes necessary to go far beyond that to individuation, self-actualization, and achieving our highest potentials—basically living full lives, which to this author means living meaningful lives.

Jung himself was a meaning seeker. This is probably why he read so voraciously and why he went on *nekyias* (Jung, 1967), something that could be akin to vision quests. During these *nekyias,* he would sometimes spend days searching for inner meaning while unconscious or semi-conscious. A lot of what Jung talked about such as the collective unconscious, *nekyias,* alchemy, and explorations of the spirit world may seem a little off kilter and unscientific, however it seems likely that an exploration of these phenomena can help individuals make meaning of their lives, especially when many things that occur are hard to explain rationally. The fact that science has not been able to explain something *yet* does not make it untrue. It is likely that during this exploration and looking inward we can gain knowledge of ourselves through the shadowy connections with Jung's archetypes of our collective unconscious (these connections happen through endopsychic functions) which could help bring meaning to our lives.

A therapy approach called the mythopoetic approach was developed based on an adaptation of Jung's ideas that helps clients explore meaning in their lives (Flood, Gardiner, Pease, & Pringle, 2007). This approach makes use of the analysis of texts, dreams, experiences, and the aforementioned synchronicities (Jung, 1967) in order to make meaning often through the narration of stories. Some of the goals are to help people become more self-reflective and increase their capacity for living, which leads into what comes next: the exploration of the meaning of life through existentialism.

A basic tenet of existentialism is that we are not born into a world with meaning; rather, we begin to make meaning through our existence in the world (Crowell, S., 2015; Existentialism, n.d.). Without any meaning making, we become anxious therefore it becomes necessary to make sense of our world in order to lessen our state of anxiety. This relates closely to Plato's (517 BCE) concept of the Allegory of the Cave which talks about how we do not really see reality as it really is; rather, we see the shadows on the walls of the cave which is a watered down, fuzzy version of reality that we try to make meaning of. This seems to be similar to Jung's archetypes which are not clear either but help us make meaning and understand ourselves in the larger reality.

Victor Frankl, another existentialist, wrote the book *Man's Search for Meaning,* which, as can be seen from the title, is about the meaning of life (Frankl, 1963). Frankl lived through the atrocities of the Holocaust and was still able to make meaning out of that experience. Frankl concludes that, in order to make meaning, man (*sic*) must make meaning out of everyday experiences. He says that, despite what happens to us, we always have the choice to decide how we feel and react to it by choosing our attitudes. He advocates that people need to find a purpose to their lives in order to make them meaningful. The purpose he found for himself was to help others find purpose in their own lives.

Lastly, this leads us to what Yalom (1980), an existential psychotherapist, says about the meaning of life. Yalom posits two different definitions of meaning, cosmic meaning and personal or terrestrial meaning. Cosmic meaning is more about the bigger picture of how humankind fits into the universe. It tries to make overarching meaning of the larger patterns in the universe that are magical or spiritual. Terrestrial meaning is closer to home because it asks about the meaning of individuals' lives, thereby making it more personal. Yalom agrees with Jung in that people need to make meaning of their lives: "The human being seems to require meaning" (p. 422). We seem to be comforted by the fact that we have some purpose and therefore have a reason to continue living. Without meaning, it becomes hard to have the will to continue as can be seen with the cancer patients Yalom (1980) counseled and the

Holocaust prisoners that Frankl (1963) spoke of, both of whom had worse prognoses if they believed that their lives had no meaning.

Yalom (1980) lists six of the things that help us feel like we have a purpose in our lives. The first is *altruism*, the giving of ourselves to help others. The next is *dedication to a cause* which makes us feel like we are contributing to something greater than ourselves. This also includes an altruistic piece, but in addition it helps us lose ourselves in something else, taking our focus off ourselves which makes it easier to stave off thoughts of death and ideas that there is no point in anything that we do. *Creativity* is the third one. This helps us feel like we might be leaving something for the future, a kind of legacy. Yalom points out that creativity does not have to be limited to what we traditionally think of as the arts; instead it can extend to almost everything in life. The next point is about *the hedonistic solution* which basically says that if you enjoy life and all its pleasures to the fullest then life will have more meaning for you. The next meaning making idea is that of *self-actualization* which allows people to really live up to their fullest potential. Jung (1967) also discussed this in detail and seems to be in full agreement with Yalom. The next way of discovering a purpose and meaning to our life is through *self-transcendence*, the going above and beyond oneself to understanding higher meanings. This is when we no longer focus on ourselves but rather focus on larger goals such as solving world hunger or ending racism or smaller goals of helping others individually. Yalom points out that self-transcendence can look different as people go through the life cycle and experience different meaning at different developmental stages of their lives with meaning gradually evolving as we progress through life. As might be seen from this discussion of concepts that help us find meaning in life, many of them overlap and contribute to each other.

In conclusion, it seems clear that the search for meaning in life is an important issue for people and academics in general and for counseling psychologists in particular. If psychologists are able to deal with some of these existential questions about their own lives, they will be better equipped to help their clients, many of whom will undoubtedly be doing their own searching for meaning. This paper explored the meaning of life from two theoretical perspectives and found some areas where they agreed and some areas where they disagreed. It appears that there is enough agreement to give psychologists some guidelines to assist them in finding meaning in their own lives and the lives of their clients. If psychologists are able to address some of these existential questions about their own lives, they will be better equipped to assist their clients, many of whom will undoubtedly be doing their own searching for meaning.

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ENTRAIN YOUR BRAIN – TAKE CONTROL OVER ANXIETY

by

Dr. Anthony Rhodes PhD.

Psychology Department Coordinator

Department of Arts and Sciences

Webster University Thailand

Abstract

This paper examined the effects of Complementary and Alternative Medicine (CAM) interventions within the context of escalating anxiety disorders in the world today. The psychophysiological and neurological symptoms of anxiety and rising healthcare costs of treatment were discussed. Energy medicine (EM) was highlighted as a viable alternative to traditional healthcare. This paper explained how entrainment plays a vital role in understanding the endogenous process of healing through CAM modalities such as Reiki. Reiki treatments were used as an example of how the intentionality of Reiki practitioners employ the use of EM principles and entrainment to emit biofield energy that specifically targets anxiety affected cortical regions of the cerebral cortex to promote fear extinction and a reduction in state anxiety.

Keywords: *Energy medicine, biofield, entrainment, Reiki, anxiogenic blockages, homeostasis*

Introduction

Are we too "plugged in" today? There's no question we are living in rapidly changing times. The ubiquitous hi-tech milieu in which we live and work today is clearly the engine that is driving change today as well as virtually every facet of our daily lives at an unprecedented pace.

In today's modern, multifaceted and hi-tech environment, we are often compelled to meet market expectations to stay relevant and to simply survive the escalating cost of living. Unfortunately, the persistent pressures to perform in the fast lane of life is proving to be costly, resulting in debilitating emotions such as excessive fear, stress and anxiety. The exhausting pace of stressful living under inherent time constraints and agendas, while overstimulated by sociocultural demands to "act now" has resulted in an alarming pandemic increase in psychophysiological disorders and substance abuse among gender, ethnic and age groups.

Research suggests that one of the most prevalent psychophysiological outcomes of our stressful lifestyles is the astonishing increase in anxiety disorders. Anxiety disorders have become so widespread that some have referred to this current phenomenon as the "New Age of Anxiety" (Spielberger, 1983).

Anxiety disorders are now the most common psychological disorders in the world today. The World Health Organization reported that between 1990 and 2013, clinical cases of depression and/or anxiety increased worldwide by nearly fifty percent (WHO, 2017). It is estimated that 40 million adults in the United States suffer from some form of debilitating anxiety disorder (Anxiety and Depression Association of America [ADAA], 2014).

Emerging data suggests the increasing demands and pace of modern life also has a profound negative effect on the body's intrinsic ability to maintain normative homeostatic balance and effectively function at optimum health and well-being (Brady and Sinha, 2005). Negative affective states can have a profound effect upon immunologic response and distribution of hormones such as cortisol and epinephrine, which are diffused during periods of high stress and anxiety (Bauer-Wu & Decker, 2002). Clinically diagnosed psychotic patients with anxiety disorders and intrusive thoughts experience increased immune dysfunction and a significant reduction in lymphocytes, which are white blood cells that determine the specificity of immune response to infection, illness and disease. Sleep disturbances caused by excessive anxiety have also been associated with reduced T and NK cell counts (small and large lymphocytes, respectively) and high cortisol profiles which typically result in a cascade of immunologic dysfunctions (Keicolt-Glaser et al., 2002).

Moreover, anxiety often exists in a comorbid condition with other psychological maladies such as panic attacks and depression. In terms of escalating mood disorders, depression is among the most common mood disorders encountered in the world today. Globally, the World Health Organization (WHO) claims depression is reaching epidemic levels. They estimate by 2030 the amount of disability and life lost from depression will surpass that from war, accidents, cancer, stroke, and heart disease (Lepine and Briley, 2011). Anxiety disorders are a precursor to this alarming prediction.

Not only are anxiety disorders taking their toll upon millions of sufferers, they also impose a substantial financial burden upon society. A 2007 estimate of the annual cost of treating anxiety disorders was $36.8 billion or approximately $1374 annually per adult, which is nearly one fourth of annual $148 billion total cost of mental health treatment in the United States (Soni, 2007). Notably half of the annual expenditure for the treatment of anxiety disorders or approximately $18.4 billion

was for psychotropic medications. An online survey of 770 respondents who sought a health professional for anxiety, depression, stress, nervousness or lack of sleep indicated individuals were 3 times more likely to receive prescription medication than psychological therapy (Anxiety and Depression Association of America [ADDA], 2004).

Conventional treatment protocols for anxiety disorders may entail prescriptions for one or more psychotropic medications depending on an individual's comorbidity with other psychological disorders (e.g., depression). Unfortunately, comorbidity is much more common than exceptional, especially with individuals suffering from severe anxiety disorders. (Zamorski & Ward, 2000). Some of the typical side effects of these prescription medications include drowsiness, tiredness, decreased learning ability, sexual dysfunction, low blood pressure, memory loss, addiction, weight gain, cardiovascular risk, nausea, dizziness, vertigo, and headaches (ADAA, 2014).

As traditional healthcare costs continue to escalate, more patients are becoming disillusioned with the quality of conventional healthcare. Thus, many individuals have journeyed on a health quest elsewhere in search of valid treatment alternatives for a variety of reasons. Dewar, Gregg, White and Lander (2009) suggest many patients are at variance with prescription medications because of the severity of their mood-altering side effects and their personal fear of vulnerability to drug dependency. Moreover, some patients view conventional medical treatment as too authoritarian leaving them with a disconcerting lack of autonomy and empowerment regarding their healthcare options (Astin, 1998; Barnes, Powell-Griner, McFann, & Nahin, 2004).

Complementary and Alternative Medicine (CAM) has become a viable option for those who are seeking more personalized, cost effective and holistic healthcare. Astin (1998) suggests that CAM has become more attractive to patients who view unconventional and alternative treatment methods as more compatible with their personal values and worldview perspectives, as well as their affinity for more natural approaches to combating pain, psychological dysfunction, illness and disease.

It's noteworthy that survey research involving 1035 respondents indicated the second most cited health condition for which clients sought CAM treatments in addition to pain was anxiety (Astin, 1998). Furthermore, individuals who suffer from anxiety disorders were twice as likely as those with other health problems to seek alternative healthcare.

Energy Medicine Defined

Many of the CAM modalities today are based upon the ubiquitous premise that biosystems of the human body function on the propagation of electromagnetic energy. Every living organism can be seen both as a physical body and as a network of complex energy fields. These fields permeate space, are constantly interacting with the environment, and interface with physical cellular systems. One of Einstein's greatest insights was to realize that matter and energy are different forms of the same phenomena, as in his equation $E = mc^2$. Scientists have verified and charted many of the electromagnetic fields comprising the human energy field or biofield using diagnostic instruments (fMRI, Positron Emission Tomography (PET), Electroencephalogram, Electrocardiogram, etc.).

Most ancient civilizations understood the universe to be a vast ocean of energy, intelligence and consciousness. Like an individual wave within that ocean, each living being contains an animating vital energy or life force. Variously called Chi/Qi (China), Ki (Japan), Prana (India), Ka (Ancient Egypt), Pneuma (Greece), Ruah (Hebrew), Spiritus (Latin), Wakan (Lakota), Ashe (West Africa), and Mana (Polynesia), the vital energy that flows through all living beings is essential for life and good health. Much of ancient and traditional art depicts human figures surrounded by an energetic

aura or halo – evidence that earlier ages and artists were aware of luminous energy fields surrounding the physical body.

Ancient wisdom from many cultures views the human energy field as a spectrum of energies from the most subtle (transcendent energies) to the densest (the physical body). This hierarchy of energetic fields interpenetrates and interacts with the physical body, influencing cellular functionality. These dynamic patterns of energy are the equivalent of energetic blueprints and specific energetic signatures functioning as an intelligent guidance system that maintains health and balance.

The theory of energy medicine (EM) espouses several conceptualizations based upon its' foundational axiom that a biofield, local field and energetic pathways exist around and within the human body (NCCAM, 2012). A second axiom purports that biofield energies permeate and sustain all life, but may be significantly influenced by psychosocial, physiological, transcendent and affective states.

Science of Energy Medicine

Newtonian (classical) physics scientifically defined the "mechanisms" by which the universe works. Inferred in the principles of classical physics is that the universe is a giant clockwork mechanism with physical elements engaging with other physical elements. In this perception, matter is all that matters (hence the emphasis on materialism). The human body is perceived as a matter-based "vehicle" and to fix it, you need to use material parts (i.e. drugs). Newtonian principles imply that we can understand the nature of life by taking the body's mechanism apart and studying its bits and pieces (a process called reductionism). With an awareness of the machine's molecular nuts and bolts, one would have knowledge of how to adjust the body's chemistry, thus controling its operation (a principle known as determinism).

Enter quantum physics, the century-old "new" science that has recently been introduced into the realm of the biomedical sciences. These new insights are profoundly changing our perception and understanding of the mechanics of life and wellness. A century ago a group of "young thinkers," which included Einstein, Planck and Heisenberg revealed that atoms were not really physical bits of matter but are actually made out of focused vortices of immaterial energy. Subatomic energy vortices are intimately entangled with the invisible energy matrix of the universe, collectively referred to as the Unified Field Theory.

A field is defined as an area within which a "force" exerts an influence at every point. Everything in the universe's field is entangled in the same energy matrix at every point. Without an understanding of entanglement, studying individual parts and pieces (reductionism) will never fully reveal how things work. An understanding of the universe will only come about through holism, not reductionism. According to biophysics health issues of a patient do not necessarily originate as internal failures of cells, tissues and organs only. The new physics recognizes that the invisible forces (signals) in the field are a 100X more efficient in controlling biological functions than are chemical signals. Quantum physics reveals that heretofore-unrecognized environmental information in the form of energy fields profoundly impacts the behavior and function of biological molecules (Chergui, 2006). The nature and behavior of this invisible life-shaping force is functionally indistinguishable from the organizing "vital force" originally described by vitalist philosophers.

A neuroimaging device called the Superconducting Quantum Interference Device (SQUID) is now being used in cardiology with functional Magnetic Field Imaging (fMFI) to measure the biomagnetic field emanating from the heart for diagnostic risk assessment (Oschman, 2002). Research indicates the cardio bioelectric field produces the strongest electrical current in the human body and can be measured by SQUID technology several feet from the skin surface (McCraty et al., 1998).

Fundamentally, cardiac and brain waves form a coherent electromagnetic wave entrainment with other anatomic electromagnetic (EM) frequencies and thus form a collective biofield wave pattern with a unique energy signature (Denner, 2009). This biofield energy signature is open, dynamic, nonlinear and self-organizing. It modulates according to the intentionality, psychophysiological and cognitive state of an individual's current disposition and environment (Rubik, 2002; Oschman, 2002; Wisneski & Anderson, 2009).

The Science of Unitary Beings

One of the strongest proponents of EM within the nursing profession was Martha Rogers, who served as head of the department of nursing at New York University for 23 years. She was honored as Professor Emeritus at NYU in 1979 and inducted into the American Nurses Association Hall of Fame shortly after her death in 1994. Rogers is mostly known for developing the theory of The Science of Unitary Beings for implementation within the nursing profession for patient caregiving (Rogers, 1994).

According to Rogers, an individual and the environment are defined as having a unified nature that mutually evolves in a continuous and complex energy exchange. These ontological concepts espoused by Rogers in her many publications and professional leadership were clearly ahead of her time by formulating a biophysics model as opposed to the biochemical paradigm so prevalent today in medical science and practice.

Roger's theory of The Science of Unitary Beings reflects two theoretical approaches to understanding core basis of physical reality:

1. Einstein's theory of special relativity ($E = mc^2$), which postulates that matter and energy are intertwined and inseparable quantities in continuous motion.

2. The theory of EM which rests on the assumption that energy fields are the fundamental basis of all living things.

Rogers posits that there are essentially two energy fields, the human energy field (HEF) and the environmental energy field (EEF). The HEF is an "irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from the knowledge of the parts" (Rogers, 1994, p. 3). Rogers believed that human beings are intrinsically a unified whole that constitutes more than the sum of its parts.

1. The concept of openness postulates that an individual and the environment constitute a dynamic open system integrally bound into a unified nature that mutually evolves in a continuous, inseparable, mutable and complex energy exchange. In other words, all living things including matter itself are united in a continuous wave entrainment of vibrational energy patterns like an orchestra producing a chord coherence of melodious sound comprised of unique pitches, tones, harmonies and sub-harmonies.

2. The concept of pandimensionality describes the present reality as a nonlinear domain without spatial or temporal constraints. Roger's theory of pandimensionality reflects the basic principles of Einstein's theory of special relativity which posits that time and space are inseparable wave patterns that create an appearance of matter and reality within a universal, multidimensional and limitless space-time continuum. The concept of pandimensionality supports the EM precept that energy is universal and multidimensional.

3. The concept of pattern is intrinsic and unique to every individual's energy field within its own unique environmental field or surroundings. Each energy matrix has a unique signature pattern and by understanding these patterns one can identify illness, disease, even stress or anxiety. This concept is paramount in this study and useful for Reiki practitioners who are intuitively trained to discern energetic disharmony or blockages in a client psychophysiological condition during treatment interventions.

Closely aligned with the above concepts are Rogers' three heuristic Principles of Homeodynamics that form the ontological framework for her theory of the unitary human being.

1. Principle of Integrality states that all human beings and their environment are in constant relational interaction such that as one's energy field modulates change it produces a corresponding change in the environment. This principle has been used extensively in oncology and nursing care. From an EM perspective, previous research indicates manipulating the energetic environment through the propagation of biofield energy may elicit effective and lasting change in a client's health and well being (Tsang et al., 2007; Bowden et al., 2010; Bowden et al., 2011; Marcus, Blazek-O'Neill, & Kopar, 2012).

2. Principle of Helicy states that human and environmental field patterns are diverse and unpredictable. According to Rogers, since both fields possess openness, as one field changes so may the integrity of the energy field of another. However, change may occur without the influence of another which indicates that an intrinsic and self-organized re-patterning may occur and be beneficial to another individual by facilitating healing outcomes. This resounds with similarity to a Reiki practitioner's bioenergy influence upon a clients' energy field for healing outcomes.

3. Principle of Resonancy suggests that both human and environmental wave patterns are in a constant state of flux and modulate from lower to higher frequency vibrations. This principle will be further explained in terms of the theta wave band and the Schumann resonance.

Rogers' definitive principles and concepts espoused in the Science of the Unitary Human Beings (Rogers, 1994) closely relates to the theory of energy medicine and thus underscores the theoretical basis for EM treatment interventions.

The Science of the Body's Energy Field

Proponents advocate that the concept of biofield energy is grounded in the laws of electromagnetism. Ampère's fundamental law of physics states that electrical currents propagating through conductive substances also produce unobstructed magnetic fields in the surrounding space.

Furthermore, according to Faraday's Law of Induction these resultant electromagnetic fields are concentrically amplified through coherent and resonant wave entrainment in the surrounding space and emanate from the human body in a ripple-like effect at the speed of light (Wisneski & Anderson, 2005). Magnetic Resonance Imaging (MRI) and electroencephalogram technologies commonly used in clinical diagnosis today have established that the brain and heart produce and emanate bioelectric waveforms which can be recorded and measured with electrodes attached to the body's surface.

The vascular network of the circulatory system is the chief conductor of heart and brain waves in superposition with bioelectric frequencies from other anatomic structures (Oschman, 2000). These coherent EM biofield frequencies are somewhat analogous to a musical score that produces a chorus of sound with multiple sub-harmonics which modulate in time and space (Rubik, 2002).

Energy Dysfunction

Thus, the above scientific evidence suggests the human body is embedded with rhythmic and coherent electromagnetic vibrational frequencies that proliferate throughout the neural pathways of the central (CNS) and autonomic nervous systems (ANS) to assist in self-regulating and self-monitoring all anatomical systems and structures. This endogenous, nonlinear and dynamic EM biofield is critical to facilitating bio-regulatory functions of the human body, as well as exchanging information with the environment through energetic biofeedback loops to conceptualize and initiate contextually responsive behavior.

When biofield energy systems become disrupted or hyperpolarized, the causal effect may elicit psychological distress and dysfunction, as well as intrinsic vulnerability to pain, illness and disease (Fazzino, Griffin, McNulty, & Fitzpatrick, 2010). These disruptions are often referred to as blockages by EM practitioners in specific energetic centers amidst a network of proximal and distal neural connectivity.

Diseased tissue emits its own unique energy signature, which differs from the energy emitted by surrounding healthy cells. The energy signatures that pass through our bodies travel through space as invisible waves that resemble ripples on a pond. If you drop a pebble into a pond, the "energy" carried in the falling pebble (due to the force of gravity pulling on its mass) is transmitted to the water. The ripples generated by the pebble are actually energy waves passing through the water.

If more than one pebble is thrown into the water at the same time, the spreading ripples (energy waves) from each source can interfere with each other, forming composite waves where two or more ripples converge. That interference can be either constructive (energy-amplifying) or destructive (energy-deflating).

Dropping two pebbles of the same size, from the same height, and at the same time, coordinates the wave action of their ripples. The ripples from each pebble converge on each other. Where the ripples overlap, the combined power of the interacting waves is doubled, a phenomenon referred to as constructive interference, or harmonic resonance or entrainment.

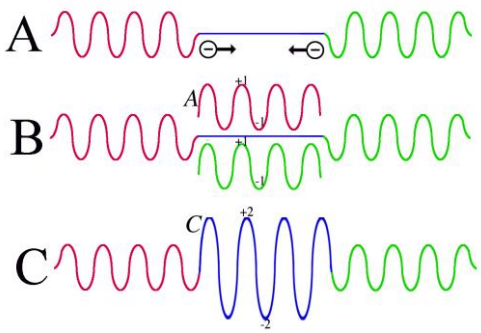

Figure 1: ***Constructive Coherence or Entrainment***

Constructive Coherence or Entrainment.

In Figure 1 above, two sets of ripples are moving across the surface of water toward each other. As illustrated, both wave A and B are moving toward each other with their ripples in phase, in this case both waves are going up and down at the same time. Their cycle patterns are aligned. The waves merge together at the interface where two ripples meet. To illustrate the consequence of this merger, the waves are drawn with one above the other in figure 2. Where the amplitude of A is +1, the amplitude of B is also +1. Add the two together, and the resulting amplitude of the composite wave at that point is +2. Likewise, where A is –1 so is B, together the total amplitude will be –2. The resulting higher amplitude composite wave is illustrated in 3.

When the dropping of the pebbles is not coordinated, their energy waves are out of sync. As one wave is going up, the other is going down. At the point of convergence these out of sync energy waves cancel each other. Instead of a doubling of the energy where the ripples interfere with each other, the water is calm . . . there is no energy wave. This phenomenon of canceling energy waves is called destructive interference.

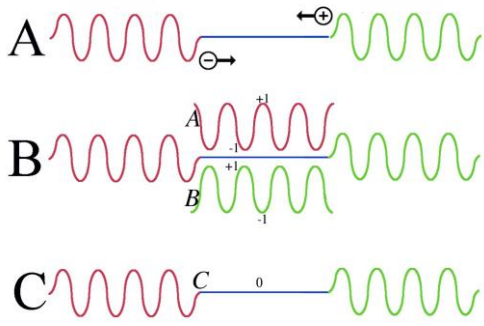

Figure 2: ***Destructive Interference***

Destructive Interference

In Figure 2 above, the ripples derived from first pebble, labeled as Wave A, are moving from left to right. Wave B, moving right to left, represents the ripples from a second pebble dropped shortly after the first. Since the pebbles did not hit the water at the same time, the waves will not be aligned when they merge at the interface, they will be "out of phase." In the illustration, Wave A is leading with a negative amplitude, and Wave B is leading with a positive amplitude. Where they meet in figure 2, the waves are mirror-images of each other, the high amplitude (+1) of one wave is aligned with the low amplitude (-1) of the other, and vice versa. As shown in 3, the amplitude values of each wave cancel each other out, so that the composite wave having 0 amplitude is no wave at all . . . it's flat!

The behavior of energy waves is important for biomedicine because vibrational frequencies can alter the physical and chemical properties of an atom as surely as physical signals like histamine and estrogen. Because atoms are in constant motion, which you can measure by their vibration, they create wave patterns similar to the expanding ripples from the thrown pebbles. Each atom is unique because the distribution of its negative and positive charges, coupled with its spin rate, generates a specific vibration or frequency pattern (Oschman 2000).

The new science reveals that constructive and destructive energy fields are one of the primary determinants that control the conformation in proteins. Simply energy signals are directly connected with the control of protein conformation changes that are expressed as behavior (life). Since proteins also control, via epigenetics, gene activity, science must recognize the primary role of energy medicine in influencing behavior and gene activity.

Entrainment and the Transfer of Reiki Biofield Information

As explained above, entrainment is basically defined as the interphase locking of two or more oscillators (Oschman, 1997). Intrinsic biofield oscillations can be perturbed by an external oscillator and synchronize or entrain with the rhythmic stimulus as endogenous biofield wave patterns cycle in phase in much the same way our sleep-wake rhythm is synchronized to a 24-hour circadian cycle. Understanding the dynamics of entrainment is essential to defining the theory and practice of bioenergy transfer which serves as a theoretical basis for all EM treatments such as Reiki. Moreover, entrained neural networks are essential to enhancing psychoneuroimmunology theory and homeostasis.

Rhythmic heartbeats, breathing, brain wave oscillations, the circadian 24-hour light and dark cycle, etc. are just a few examples of rhythmic and measurable cycles intrinsic to all living things (Glass, 2001). The human body is comprised of a complex nexus of dynamic neural action potentials that can produce an electrostatic biofield that can be detected on the body surface with neuroimaging devices such as functional magnetic resonance imaging (fMRI), electrocardiography (ECG), electroencephalogram (EEG), and electromyography (EMG) (Baldwin & Hammerschlag, 2014). Scientists have also developed superconducting detectors called SQUIDS (superconducting quantum interference devices) that can detect magnetic fields one billionth the size of the earth's magnetic field. Neuromagnetometers contain up to 275 SQUIDS to measure regional brain activity that accompanies the perception and performance of various stimuli (Carlson, 2013). These diagnostic instruments are used to measure and determine indices of health and illness represented as electromagnetic oscillations and sub-frequencies of the brain's architecture and other vital organs. This suggests that biosystems exchange biological information externally with the environment via innervated neural structures (Rubik, 2002; Thut, Schyns, & Gross, 2011; Oschman, 2002).

Numerous studies have been conducted on direct neural stimulation of cortical regions of the brain by a periodic external force to investigate the dynamic routing and gating of neural networks throughout phase entrainment process. Thut et al. (2011) conducted several quantitative experiments with repetitive Transcranial Magnetic Stimulation (rTMS), a non-invasive device placed at a small distance outside the skull that produces electrical pulses that emanate penetrating magnetic fields into brain tissue to determine the response activation of neurons in the parietal cortex. Their findings indicated rTMS entrained with alpha brain waves (see Table 1) as measured with EEG recordings, but only as a result of transient and calibrated adjustments to specific biological brain rhythms (Thut et al., 2011). Furthermore, the ability of rTMS to excite or interfere with specific brain cortices was dependent upon the strength and pattern of the external rhythmic stimulation.

Entrained oscillations are not only relegated to localized regions of brain but propagate and vary rhythmically throughout the central and autonomic nervous systems, as well as vascular and connective tissues of the human body (Glass, 2001). Buzsáki and Draguhn (2004) proposed that brain activity consists of micro and macro levels of neural oscillators interacting at various harmonic and sub-harmonic frequencies. The comprehensive and hierarchical nature of entrained frequency bands underscores its holistic capability to innervate resting potentials of cellular membranes to promote homeostasis (Baldwin, Wagers, & Schwartz, 2008).

Entrainment and Reiki Treatments

According to the National Center for Complementary and Alternative Medicine, Reiki therapy is a CAM treatment modality "intended to affect energy fields that purportedly surround and penetrate the human body" (NCCAM, 2012, p. 1) through various ethereal energy centers located at specific areas throughout the body. Reiki assumes that an external force (Ki) emanates through specific hand placements by a Reiki practitioner unto the client. The professional popularity of Reiki has also grown significantly since 1991 when it was estimated there were approximately 300,000 Reiki teachers and over 2 million practitioners worldwide (Rand, 1991). In recent years, Reiki bioenergy therapy has increasingly gained favor in the medical community as a conjunctive complement to conventional medical practice in many healthcare facilities across the United States. Research studies have shown variable results in measuring the electromagnetic fields produced in the hands of Reiki practitioners.

Zimmerman (1990) conducted research using SQUID technology to measure the electromagnetic field emanating from the hands of Therapeutic Touch practitioners in an "adequately" shielded room to eliminate other confounding electromagnetic effects. Four of 7 healers in the experiment indicated significant frequency changes emitted from their hands during treatment applications.

In a recent study using more sophisticated SQUID technology, researchers sought to measure the electromagnetic biofield in the hearts and hands of three Reiki practitioners with more than 10 years experience at five-minute intervals from baseline, and in two different experimental protocols of sending Reiki to a participant in another room, and sending Reiki energy through non-physical contact to a participant on the other side the treatment room (Baldwin, Rand, & Schwartz, 2013). The treatment room was magnetically shielded from any potential confounding electromagnetic noise. Contrary to the previous experiment, the results did not indicate statistically significant high intensity electromagnetic fields emanating from the heart or hands of the Reiki practitioners.

Baldwin et al. (2013) suggests the magnetic shielding of the room may have blocked the earth's magnetic field radiation called the Schumann resonance (SR) from entering the room which can

also entrain with a practitioner's intrinsic brain oscillations to facilitate energy coherence and healing. The SR is the geomagnetic field between the ionosphere and the earth's surface with an average extremely low frequency (ELF) range of 7-10 Hz. The SR is comparable to brain wave periodicity but is often modulated by solar and lunar positioning which can result in a cascade of micro-pulsations that range from 1 - 40 Hz (Oschman, 1997).

However, in a recent study Ventura, Saroka, and Persinger (2014) used EEG technology without magnetic shielding to measure brain wave entrainment between sending and receiving partners in nine Reiki and sham pairs by conducting a non-contact Reiki distance healing treatment separated in rooms at a distance of 50 meters apart (164 feet). An interesting cerebral effect yielded two salient results: 1) entrainment for the Reiki pairings was statistically significant at the left temporal lobe region in the theta band (4-7 Hz), a band and brain region involved in recalling pleasant, high intensity memories (Buchanan, Tranel, & Adolphs, 2006; Holz et al., 2010) and 2) entrainment was statistically significant for the Reiki pairs in the right hemisphere of the brain in the gamma band (40 Hz).

The right hemisphere has been shown to summon visual-spatial, working memory and affective responses in recognizing non-linear realities in an unconscious parallel processing system (Danielian, 2010; Turk et al., 2002). When short-term working memory representations match with new visual-spatial information, entrainment between gamma and theta bands is strongest in the right hemisphere (Holz et al., 2010). If gamma and theta bands entrain into a constructive interference pattern, their phase coherence forms a greater amplitude and wave intensity (Winter, Steinberg, & Attwood, 2014; Holz et al., 2010).

Ventura et al. (2014) posit that since both the theta and SR average frequency is 8 Hz, it's reasonable to assume that SR in coherence with the theta band is also involved in summoning various levels of consciousness. The authors, citing valid research, also suggest the right hemisphere is more sensitive to the SR (Mulligan, 2010; as cited in Ventura et al., 2014, p. 13) referring to its synchrony to gamma activity and super positioning in quantum coherence with the theta band (Ventura et al., 2014). It's also important to note that gamma and theta bands are often associated with meditative states, which is typically the cognitive and transcendent mental state for Reiki practitioners during a standard Reiki treatment (Cahn & Polich, 2006; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004).

Reiki Energy and Anxiogenic Neural Blockages

Severe to extremely severe state anxiety alters normal functioning of several cortical regions of the brain. Although it is widely recognized that ominous stimuli commonly invoke a normal threat response, chronic traumatic stress can lead to anxiety disorders such as generalized anxiety disorder, post traumatic stress syndrome (PTSD), panic attacks, etc., thus altering the brain's intercommunication network between vital neural structures (Kolassa & Elbert, 2007).

The medial prefrontal cortex (mPFC) has emerged in brain research as the primary cortical structure recruited during high-levels of anxiety (Likhtik et al., 2014). The mPFC interprets contextual anxiogenic information and functions to inhibit fear and anxiety behavior through a holistic neural circuitry with other subcortical structures. More specifically, the mPFC inhibits fear conditioning in the amygdala, a neural structure which receives sensory and memory stimulus of impending threat or danger (Davidson, 2002). It relays this information to immune system neural structures that mediate various psychophysiological expressions of fear and anxiety, such as facial expression, elevated blood pressure, decreased salivary cortisol (IgA), lower skin temperature and skin

conductance response (Wardell & Engebretson, 2001).

Research also indicates that the ventral (lower) hippocampus (vHPC) is involved in contextualized memory formation and interacts with the mPFC in modulating anxiety related behavior (Adhikari, Topiwala, & Gordon, 2010). Therefore, the neural underpinnings of the mPFC, amygdala and vHPC play a significant role in regulating fear conditioning, anxiety related behavior and memory processes. It has been posited that anxiety related disturbances of these cortical brain structures cause the emergence of anxiety disorders such as GAD and PTSD (Kolassa et al., 2010).

Recent research on the concept of dynamic wave entrainment within these neural structures has recently emerged with some fascinating results. Experimental studies on mice exposed to anxiogenic environments indicated synchronization of all three anxiety modulating structures mentioned above in the theta frequency range (Table 1) (Adhikari et al., 2010; Likhtik et al., 2014). This suggests the entrainment process in Reiki treatments involves the theta band as a content management mechanism to transmit bioinformation from the Reiki practitioner to neural structures within the participant. The constructive coherence effect catalyzes resting potentials on cell membranes to assist in restoring regulatory functionality of the anxiety and fear neural circuitry (Kolassa and Elbert, 2007; Kolassa et al., 2010).

Table 1. Electroencephalogram measures of brainwave frequencies

Delta	1-4 Hz	Deep sleep and certain brain disorders.
Theta	4-8 Hz	Light sleep, creativity, insight, and some emotional stresses including disappointment and frustration.
Alpha	8-12 Hz	Normal state of mind, reflecting a calm and peaceful yet alert state.
Beta	13-21 Hz	Seen over frontal portions of the brain during intense mental activity and/or anxiety higher frequencies (up to 50 Hz) noted during intense nervous activation and tension.

Note: From "*The Science of Energy Therapies and Contemplative Practice: A conceptual review and the application of zero balancing*", by S.S. Denner, 2009, *Holistic Nursing Practice, 23*(6), p. 315.

Reiki practitioners often speak about blockages that hinder the flow of bioenergy, but from a psychophysiological perspective what exactly are they? Kolassa and Elbert (2007) suggest that neural fear networks are developed during times of severe stress, anxiety and trauma. During a situational event that is perceived as threatening or dangerous, state anxiety increases, and a neurological response is stored in short term memory. Repeated anxiogenic events are integrated with the neural correlates of existing fear networks, and subsequently strengthened through long term potentiation and stored in long term memory, thus creating a "building block" effect (Kolassa et al., 2010).

Sousa (2000) refers to these powerful emotional or traumatic neural building blocks as "flashbulb" memories. In the presence of anxiogenic stimulus, the retrieval and recall ability of flashbulb memories is typically elevated and precise. These fear network building blocks disrupt the functionality of the anxiety related vHPC, mPFC and amygdala cortical structures which over time may lead to more severe and long-term anxiety related disorders.

This research lends support for the process of exogenous energy synchronizations with fear networks to catalyze cue-based retrieval of building block memories consciously or unconsciously within the cerebral structures of the participant. It suggests that a Reiki practitioner's intentionality and propagation of biofield energy in theta band oscillations facilitates and the delivers the transfer of bioinformational content encoded in waveforms to subcortical targets of hyperpolarized cell membranes of the disrupted fear and anxiety neural circuitry of the mPFC, vHPC and amygdala. Rubik (2002) posits that the participant's decoding and biologic response to the entrainment of resonant frequencies also involves other field parameters such as polarization, specific waveforms and intensities, and the patterns and length of time exposure.

Conclusion

In summary, the above information regarding the entrainment of biofield energy through Reiki treatments lends support to research suggesting extremely low frequency (ELF) electromagnetic fields stimulate endogenous biochemical processes within the brain. The resultant biologic response to anxiogenic events innervates cellular action potentials to normalize anxiety related neural circuitry for fear discrimination and extinction of endogenous fear network building blocks (Likhtik et al., 2014, Oschman, 1997). This entire process is holistic in nature and summons a cascade of neural intercommunications with the immune and endocrine biosystems throughout the human body to reestablish the dynamic equilibrium of homeostasis for optimum health and well being (Rubik, 2002).

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Exploring Scientific Spirituality

Author : Neha Tripathi
Co-author : Dr. Piyush Gupta
Affiliation of the author : Cancer Aid Society

Abstract

"Spiritual Care is to be fully utilized as a resource in provision of clinical care, education of future healthcare leaders & advancement of the science and practice of medicine". It's about integrating patient's spiritual beliefs into their care, addressing sensitive medical issues facing seriously ill patients and supporting health care professionals in their provision of compassionate care. It also includes various dimensions of Palliative medicine such as depression, desire for death, will to live & dignity at the end of life.

Spiritual care gives motivation to provide compassionate care that is sensitive to types of emotional and mental distress that accompany mental illness. During illness it becomes important to understand how the relationship works.

I could recollect an incident when I met Madam Julie Adams, the Cancer patient in advance stages with few weeks of life, at Washington DC during the Summer Institute who was in the stage of denial for the treatment but wanted to live without bothering her family. It was difficult to read her mind however I initiated the conversation as the group leader involving physicians, Chaplin, palliative care giver and social worker in my group. While other found it difficult to break the ice. I left my place, went to hold her cold hand after which she felt a bit relaxed and shared concerns. She was depressed due to his son's sudden death and worried about her family as the treatment. She was not sure that after treatment she will be fine or her life will get shorter starving the family, however got relaxed finally. In the feedback session she specially mentioned about me appreciating the touch therapy and posed for the photograph happily on my request.

Patients want their caregivers to talk with them on spiritual needs to address their spiritual issues but only very few actually having these conversations with their physicians.

Exploring the Relationship between Social Marginalization, Meaning in Life, and Mindfulness:
A Mixed-Methods Approach

Zvi J. Bellin, Karla Papula, Jessica Youseffi, & Mark Kurai
John F. Kennedy University

Abstract

This mixed-method study looked at the relationship between marginalization, meaning in life, and mindfulness. Study 1 explored the empirical relationship between three constructs (N = 106). Marginalization correlated negatively with meaning in life and with mindfulness. Meaning in life and mindfulness showed a positive correlation. Mindfulness, in part, explained the relationship between marginalization and meaning in life. This suggests that mindfulness can be a helpful intervention for marginalized people who experience a sense of meaning frustration.

In study 2, eight participants with marginalized identities in the U.S. were interviewed to understand how mindfulness has impacted their sense of meaning in life. Three themes are discussed: community, practices, and core teachings. The article concludes with recommendations for mental health practitioners and a discussion of limitations and directions for further research.

Keywords: marginalization, meaning in life, mindfulness, self-compassion, narrative analysis

Exploring the Relationship between Social Marginalization, Meaning in Life, and Mindfulness: A Mixed-Methods Approach

In U.S. society, people of color and LGBTQ people struggle to connect with a sense of meaning in life (Bailey, Williams, & Favors, 2014; Nadal & Mendoza, 2014), what Frankl (1984) termed meaning frustration. When one's environment fails to provide access to meaning, or worse still, rejects the notion of one's right to meaning, the person may experience meaning frustration. The findings from Bellin's (2017) study explored the ways in which marginalized people re-experience and retell their life stories, and how this phenomenon helps them shift from a sense of oppression to a sense of liberation. Through the retelling the participants were able to connect to an integrated sense of meaning in life.

Through that study, which investigated how therapy can aid one in the journey of meaning making, an unexpected theme arose that was not included in the published article. The findings implied the usefulness of mindfulness in helping people to navigate their experiences of marginalization towards meaning in life. More specifically, participants reported that mindfulness helped them connect their personal meaning struggles with universal human suffering, enabled them to tolerate distressing emotions that stemmed from marginalization, and supported them to discern when and how they wanted to respond to marginalization. These cultivated abilities translated into connection with life meaning. Building upon Bellin (2017), the purpose of this study was to empirically capture the relationship between marginalization, meaning in life, and mindfulness, and to explore the potential benefits of mindfulness practice for people with marginalized identities, specifically to help them connect with a sense of meaning in life.

We asked the following two quantitative-oriented questions: *(1) What is the relation between marginalization and meaning in life? (2) Does mindfulness impact the relation between marginalization and meaning in life?* Additionally, we posed the following qualitative-oriented question: *(3) How do people of color and/or LGBTQ people (historically marginalized groups in the US) who have a consistent mindfulness practice use their mindfulness skills/states to connect with a sense of meaning in life despite, or in light, of their experiences of being marginalized?* Before explaining our mixed-method approach to answer these questions, we will explain the theory behind the three main concepts of the study as we used them throughout our research.

Bridging Social Marginalization, Meaning in Life, and Mindfulness

Marginalization. Social marginalization due to race/ethnicity, gender identity, and sexual orientation has been shown to have a detrimental impact on both physical and mental health (David, 2014). For example, individuals who belong to historically marginalized groups in the United States experience higher rates of suicidality (Peter & Taylor, 2014), stigmatized addiction (National Institute on Drug Abuse, 2003), and a general sense of powerlessness (Thomas & González-Prendes, 2009).

According to the minority stress theory (Meyer, 2003), mental health disparities exist for individuals who belong to historically marginalized groups due to the cumulative impact of long-term day-to-day stress caused by social stigma (Skinta & Curtin, 2016). Minority stress may range from overt acts of violence and harassment to subtle forms of discrimination, such as microaggressions, which are, "unconscious and unintentional

expressions of bias and prejudice toward socially devalued groups" (Sue, 2010). These stigmatizing experiences can cause emotional dysregulation, which in turn leads to an array of psychopathological outcomes, such as anxiety or substance use (Skinta, 2014). Internalized oppression, where members of the oppressed group unconsciously apply negative stigma of their own identity to themselves, is a particularly harmful manifestation of minority stress, and can have a negative effect on mental and physical wellbeing (Meyer, 2003; Skinta & Curtin, 2016). In this study, we were particularly interested in how the experiences of marginalization negatively impact meaning in life (Bailey, Williams, & Favors, 2014; Nadal & Mendoza, 2014).

Meaning in Life. Viktor Frankl (1946/1963, 1969), coined the term the "will to meaning," which he defined as the fundamental human drive to find meaning in life. According to Frankl (1963), meaning in life is the primary motivation for living, and its absence is associated with diminished functioning and quality of life (Frankl, 1946/1984). Another foundational point about meaning in life is that it is a function of human embodiment (Johnson, 2007). Johnson reasoned that meaning is embodied and constructed from the interaction between a person's body and their environment. In this holistic framework, meaning emerges as we engage with the images, feelings, qualities, and emotions somatically evoked during our encounters with the world.

Park & Folkman's (1997) meaning making model also suggested that meaning is ubiquitous, impacting social, emotional, and physical well-being. Their model highlights two categories: global meaning, which represents an individual's general orienting system, and situational meaning, the meaning made in a situational context based on one's global meaning system. Park & Folkman conceived of a dynamic process whereby we are always appraising situational meaning for its goodness-of-fit to our global meaning. Mostly, situational meaning assimilates easily into global meaning. At times, global meaning must change in order to accommodate situational meaning. Similar to meaning frustration, situational meaning and global meaning can be locked at odds with each other in a state of rumination.

Meaning in life as a psychological construct has since been empirically validated as an important contributor to multiple wellbeing indicators (Heintzelman & King, 2014; Siegel, 2013) including, higher quality of life (Krause, 2007), and general health (Steger, Mann, Michels, & Cooper, 2009), while being negatively correlated with psychological disorders including depression and anxiety (Mascaro & Rosen, 2005; Owens, Steger, Whitesell, & Herrera, 2009; Steger & Kashdan, 2009). It would reasonably follow that the stress of marginalization, with its internalized impact, could significantly frustrate one's sense of life meaning.

Steger (2012) defined meaning as, "the web of connections, understandings, and interpretations that help us comprehend our experience and formulate plans directing our energies to the achievement of our desired future. Meaning provides us with the sense that our lives matter, that they make sense, and that they are more than the sum of our seconds, days, and years" (p.65). Steger's definition incorporates the complexity and conceptual range of the meaning in life as a construct, including its immersive and transcendent facets, as well as the cognitive, social, and interpersonal elements.

Bellin (2013) similarly highlighted two key dimensions of meaning in life in order to grasp the the full picture of the construct: meaning through doing and meaning through being in the world. Meaning through doing is an action-oriented construct and focuses on future

achievement and goal setting (Schulenberg & Melton, 2010), whereas meaning through being involves one's ever present sense of dignity and belonging (Bellin, 2017). Therefore, meaning in life is more than what a person achieves in the world, as it is tied to a readily accessible sense of one's existence mattering.

Meaning frustration. Researchers have found that the experience of social marginalization can have a negative impact on an individual's sense of meaning in life (Bailey, Williams, & Favors, 2014; Nadal & Mendoza, 2014). This is likened to what Frankl (1984) termed meaning frustration, which is the experience of seeking out, but not being able to connect to, one's meaning in life. Internalized oppression may cause meaning frustration by reducing an individual's self-esteem, self-worth, or belief in one's capacity to initiate meaningful change in one's life (Corrigan, Larson & Rüsch, 2009). Marginalization may also cause individuals to give up on their search for meaning in life after repeatedly being frustrated by their attempted pursuits. This is similar to the behavioral phenomena of learned helplessness, which occurs after a person repeatedly endures painful and unavoidable stimuli, and learns that they are helpless and so they give up trying to change anything (Teodorescu & Erev, 2014).

While individuals from historically marginalized groups first experience meaning frustration, they can still access and develop a deep sense of meaning in life, especially when challenges are viewed as personally meaningful (Bronk, 2014). Indeed, findings from Bellin's (2017) previous study revealed the ways in which marginalized people re-experience and retell their life stories, which helps them shift from a sense of oppression to a sense of liberation and increased their sense of meaning.

Frankl (1959) highlighted how connecting to a greater sense of meaning can help people bear and transcend any amount of suffering by giving us the psychological resources to persevere (Steger, Kashdan, 2013). As Frankl (1959) put it, "it is not suffering per se but suffering without meaning that is devastating to the individual" (p. 288). This theory applies to people of color, LGBTQ people, and among others who historically experience social oppression and marginalization, and highlights the importance of connecting to meaning in these communities. In this study, we were interested to see how mindfulness can help marginalized people connect with a sense of meaning in life.

Mindfulness. Mindfulness is a vast system of knowledge and practice that spans religion, philosophy, neuroscience, and other fields. In our study, given our collective social-location, we were most influenced by a particular stream of mindfulness that extends from a specific Buddhist tradition. The mindfulness literature available to the West in large part stems from a particular insight-oriented practice, known as Vipassana (Anālayo, 2003). The teachings of Vipassana were brought to the West by a cadre of Western-born teachers who spent time in Burmese and Thai monasteries, learning with teachers from the Buddhist Theravada tradition (Fronsdal, 2001; Kornfield, 2010). Though there is no single approach to Vipassana mindfulness, there is an underlying theme of paying loving attention to whatever arises in one's present moment, enabling a clear witnessing of the nature of reality (Yang, 2017). This clear witnessing is likened to waking up and connecting to a sense of real happiness that is not contingent upon changing causes and conditions (Salzberg, 2011). In his interpretation of a primary Theravada text, the Satipaṭṭhāna Sutta, Anālayo (2003) reviewed the first foundation of mindfulness of the body. In this foundation, the Buddha invited practitioners to investigate the nature of reality, suffering, impermanence, and experience of a self, through the experience of our somatic embodiment.

Mindfulness as focused attention and open monitoring. Generally, mindfulness includes a variety of practices that involve two distinct elements: focused attention (FA) and open monitoring (OM) (Lutz, Slagter, Dunne, and Davidson, 2008). FA is when a practitioner of mindfulness chooses a specific object, physical or conceptual, for sustained attention. A common focus or anchor is the breath. In FA anchored on the breath, practitioners focus their attention on their breath coming in and out of their body. When the attention wavers away from the breath, practitioners will return their attention to the breath as soon as they notice that their attention has lapsed. With a more collected attention, practitioners can open their awareness to whatever arises in their sense experience (including thinking) without emotional reactivity. Lutz, Slagter, Dunne, and Davidson refer to this widening of attention as open monitoring (OA). Practitioners report a lessening of the sense of a separate self as they witness the ebb and flow of life's sensations occurring. The potential in OM is to lessen the reactivity that causes suffering.

Mindfulness and self-compassion. Previous research has demonstrated a meaningful relationship between the distinct practice of mindfulness and that of self-compassion (Neff, 2003). While mindfulness practices tend to emphasize cultivating attention, self-compassion practices aim specifically to cultivate a sense of loving kindness towards one's own experience, and eventually all beings (Salzberg, 1995; Fronsdal, 2001). Self-compassion practices generally include repetition of phrases, such as, *May all beings be free of suffering and the causes of suffering.* The practitioner intends to embody the phrases while mustering a genuine emotional response to the phrase. The inclusion of heart-centered self-compassion practices counterbalances the more impersonal nature of mindful observing, especially as transmitted in the Western world (Fronsdal, 2001). Together, mindfulness and compassion yield a loving witness and way of being towards the suffering encountered in the world.

The importance of mindfulness in community. Finally, we make brief mention of the importance of community in mindfulness practice. The recognition that mindfulness is not a self-serving endeavour, but a socially connected experience, has recently become a more pronounced teaching in Western Vipassana (Yang, 2017). Considered one of the Three Refuges in Buddhism, spiritual community, or sangha, holds the practice together and keeps the wisdom alive and relevant from one generation to the next. According to Ajahn Chah (2006), the Thai teacher who inspired many of today's Western-born Vipassana teachers, the community is the site where the morality of the mindfulness tradition is cultivated. The moral roots of mindfulness can be somewhat neglected in the Western pursuit of mindfulness. As explored above, one's sense of community rejection or acceptance can highly influence their sense of meaning in life, tying together this theme of sangha through the main three concepts of this study. With our main concepts explicated, we turn now to our mixed-method exploration.

Mixed-Methods Exploration of Social Marginalization, Meaning in Life, and Mindfulness

In the current research, we began by providing empirical evidence for the relation between social marginalization, meaning in life, and mindfulness. Based on previous anecdotal evidence (Manuel, 2015; Yang, 2017), we expected to find a robust relation between marginalization and decreased meaning in life as well as mindfulness. Next, we expanded on the quantitative findings of Study 1 by providing qualitative evidence of the effect that practicing mindfulness has on meaning in life among members of historically marginalized groups in the U.S. (people of color, LGBTQ). Our research questions are:

(1) What is the relation between marginalization and meaning in life? (2) Does mindfulness impact the relation between marginalization and meaning in life? (3) How do people of color and/or LGBTQ people (historically marginalized groups in the US) who have a consistent mindfulness practice use their mindfulness skills/states to connect with a sense of meaning in life despite, or in light, of their experiences of being marginalized?

Study 1: Exploring the Relation Between Marginalization, Meaning in Life, and Mindfulness

Study 1 tested the association between being a member of a marginalized group, the presence of meaning in life, and being mindful. We expected to find that the constructs would show a significant relationship with each other - namely that marginalization would negatively correlate with meaning in life and mindfulness, and that meaning in life and mindfulness would show a positive correlation. We also hypothesized to find that if a marginalized person experiences lower meaning in life, mindfulness and common humanity can serve to raise meaning in life.

Method

Participants and procedure. Participants were recruited through outreach to the wider community via listservs, social media, mindfulness organizations, and other social organizations. Anyone over 18-years-old and living in the U.S., was able to take this survey, whether they identified as part of a marginalized group or not, and whether they had a mindfulness practice. As an incentive the PI donated $1 per participant to the People of Color scholarship fund at Spirit Rock Meditation Center.

Based on an a priori power analysis, we determined a minimum sample size of 120 participants to be sufficient (power = .95 at $|r| = .30$; Faul, Erdfelder, Lang, & Buchner, 2007). In total, 135 participants began the survey study. After excluding incomplete surveys, the final sample was comprised of 106 adults over the age of 18 years. All analyses were conducted using the available data for the measures included in the analysis, and so the sample size varies slightly from analysis to analysis. For our primary analysis, this sample provided 91% power to detect effects assuming the average effect size in social and personality psychology, and a 5% Type I error rate.

Following are a series of tables that show the diversity in our sample in regards to gender identity, sexual orientation, race/ethnicity, and age.

Gender Identity	**Percent of Participants**
Woman	64.2
Man	21.7
Genderqueer	7.5
Transman	4.7
Other	2 (Participants wrote in “Pansexual,” “Trans-attracted man”)

Table 1. Demographic breakdown by gender identity.

Sexual Orientation	Percent of Participants
Straight	62.3
Queer	17.9
Bisexual	7.5
Gay	6.6
Lesbian	3.8
Other	1.9 (Participants wrote in “non binary,” “Two-Spirit.”)

Table 2. Demographic breakdown by sexual orientation.

Race/Ethnicity	Percent of Participants
White	61.3
African American/Black/African Descent	10.4
Latino/Latina/Latinx	7.5
Other	6.6 (Participants wrote in “Jewish,” “European/white,” “Native American/White”)
Biracial/Multiethnic	4.7
Far East Asian	2.8
South Asian/Indian	2.8
Southeast Asian/Filipino	1.9
Native American/First Nation	0.9
Middle Eastern	0.9

Table 3. Demographic breakdown by race/ethnicity

In addition to race/ethnicity and sexual orientation/gender identity, participants identified with other historically marginalized identifiers, including women, identifying with a specific religion (Jewish, Muslim, or Catholic), overweight, and disabled. 87.7% of participants identified with at least one historically marginalized group in the U.S.

Age	Percent of Participants
18-21	0.9
22-25	2.8
26-30	14.2

31-40	27.4
41-50	26.4
51-65	26.4
66-75	1.9

Table 4. Demographic breakdown by age.

Mindfulness demographics. When asked about years practicing in general, (on and off, rather than consistently), participants responded with an average of 4.02 years (SD = 1.62). In terms of years consistently practicing mindfulness, the mean was 2.92 years (SD = 1.69). When asked about hours of formal practice per week, participants averaged 4.01 hours (SD = 5.71). The following Table 5 provides data for mindfulness community membership:

Regular Community Participant	**Percent of Participants**
Yes	17
No	58.5
True in the past, but no longer	24.5

Table 5. Demographic breakdown by regular mindfulness community participation.

Procedure. After providing informed consent, participants were directed to the online survey. Demographic questions were completed before measures of marginalization, meaning in life, and mindfulness. At the conclusion of the survey, we ended with a reflection on affirmation (*Please list one characteristic/quality that you value about yourself. For example: courageous, grounded, inspiring to others, etc… In 2 or 3 sentences please share why you chose the above characteristic/quality.*), and provided national resources for social support and networking.

Measures

Marginalization. Two separate measures were used to capture different aspects of the subjective experience of marginalization. First, to assess the self-perceptions of social rank and relative social standing the Social Comparison Scale (SCS; Allan, & Gilbert, 1995) was used. The SCS covers judgements concerned with rank, attractiveness, and how well the person thinks they 'fit in' with others in society. We chose this scale because it captures the sense that one feels marginalized, grounded in their own perspective, as they move through their lives. The SCS uses a semantic differential methodology--each item asks participants to make a general comparison of themselves in relation to other people by rating themselves along a ten-point bipolar scale (e.g., *In relationship to others I feel: Incompetent-More competent*). Low scores point to feelings of inferiority and general low rank self-perceptions. For brevity, we included three of the 11 items that were relevant to our hypotheses: (1) Left out - Accepted, (2) Different - Same, and, (3) An outsider - An insider; further, we were interested in capturing the dynamics of power in marginalization and added (4) Powerless - Powerful to the this scale (α = .85, M = 5.69, SD = 1.87).

Additionally, we considered negative positive regard as an important aspect of marginalization. To assess negative positive regard, participants completed the 8-item Other as Shamer Scale (OSS; Matos, Pinto-Gouveia, Gilbert, Duarte, & Figueiredo, 2015). Participants indicated how frequently they experience negative positive regard (e.g., "I feel

other people see me as not quite good enough") using 5-point scales (0 = Never to 4 = Almost Always) (α = .86, M = 2.01, SD = .74).

Meaning in Life. Meaning in life was assessed using the Meaning in Life Questionnaire (MLQ; Steger, Frazier, Oishi, and Kaler, 2006). The MLQ is composed of two separate, though negatively correlated five-item subscales that assess the search for meaning (e.g. 'I am looking for something that makes my life feel meaningful') and the presence of meaning (e.g. 'I understand my life's meaning'). Items are rated on a 5-point scale anchored at *not at all true* to *very true*. We will only report on data concerning the presence of meaning subscale since we are concerned with experiencing meaning, not searching for meaning (α_{presence} = .90, M_{presence} = 3.91, SD_{presence} = .87).

Mindfulness. Mindfulness was measured using the Five Facets of Mindfulness Questionnaire (FFM; Williams, Dalgleish, Karl, & Kuyken, 2014), and one subscale from the Self-Compassion Scale, Common Humanity (CH). Both scales are scored on a 5-point Likert scale anchored at *not at all true* to *very true*. For the FFMQ, we only used the highest loaded item for each subscale, thereby shortening the questionnaire to 5 questions: (1) I perceive my feelings and emotions without having to react to them. (Nonreactivity to Inner Experience subscale), (2) I pay attention to (physical/bodily) sensations, such as the wind in my hair or sun on my face. (pain/pleasure) (Observing subscale), (3) I find myself doing things without paying attention. (Acting with Awareness subscale), (4) I think some of my emotions are bad or inappropriate and I shouldn't feel them. (Nonjudging of Inner Experience subscale), and (5) I have trouble thinking of the right words to express how I feel about things. (Describing subscale). Sample size considerations prevented us from examining each facet of mindfulness independently in our primary analyses so the 5 items were averaged together to form an index of mindfulness where higher values indicate a person was more mindful (α= .68, M = 3.53, SD = .71).

Given previous research on marginalized populations (Bellin, 2017), we were most interested in the aspect of self-compassion related to perceiving one's suffering as part of the human experience. This aspect is captured by the Common Humanity subscale of the Self-Compassion Scale: (1) When things are going badly for me, I see the difficulties as part of life that everyone goes through; (2) When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am; (3) When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people; (4) I try to see my failings as part of the human condition (α= .89, M = 3.37, SD = 1.10).

Results

What is the relationship between marginalization and finding meaning in life?

Correlations between our variables of interest are presented in Table 6. As predicted, there was a positive correlation between meaning in life and both FFM (r = .55, p < .001) and CH (r = .43, p < .001). Looking at marginalization as negative positive regard (OSS), we see negative correlations with both of the mindfulness measures, FFM (r = -.37, p<.001), and CH (r = -.29, p < .001). OSS also correlates negatively with meaning in life (r = -.41, p < .001). The SCS only correlated weakly with CH (r = -.23, p < .05). Because of the absence of correlation between SCS and the other scales, we did not include the SCS in further exploration. CH and FFM are related but separate constructs (r = .50, p < .001).

Scales	1	2	3	4	5
1. Marginalized Identities (SCS)	_				
2. Negative Public Regard (OSS)	.40**	_			
3. Mindfulness (FFM)	-.07	-.37**	_		
4. Common Humanity (CH)	-.23*	-.29**	.50**	_	
5. Presence of Meaning	-.16	-.41**	.55**	.43**	_

Table 6. Intercorrelations between marginalization scales, mindfulness scales, and presence of meaning subscale. *Note:* * $p < .05$. ** $p < .01$

Correlational evidence suggested that the strongest predictors of presence of meaning in life were negative public regard, mindfulness, and common humanity. Subsequently, we tested a model in which the relation between negative public regard and presence of meaning in life was mediated by perceived mindfulness (FFM) and common humanity (CH) by examining the overall significance of the indirect effect (i.e., the path through the mediators) using Hayes' (2013) PROCESS SPSS macro with 5,000 bias-corrected bootstraps. Bootstrapping is a non-parametric resampling procedure that is used for testing mediation and provides greater statistical power and precision than Baron and Kenny's (1986) steps in testing mediation (e.g., MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002; Preacher & Hayes, 2004). If zero falls outside the confidence interval, the indirect effect is deemed significant and mediation can be said to be present. As predicted, perceived mindfulness (FFM) partially mediated the relation between negative public regard and presence of meaning in life $\beta_{indirect} = -0.17$, 95% CI [-0.32, -0.07]. In contrast, common humanity was not as significant a mediator $\beta_{indirect} = -0.06$, 95% CI [-0.19, 0.00]. The direct effect of negative public regard on presence of meaning remained significant $\beta_{direct} = -0.25$, $p = .04$, 95% CI [-0.48, -0.02], suggesting (perhaps unsurprisingly) that the relation between negative public regard and presence of meaning in life is not fully explained by idiosyncratic differences in mindfulness.

Discussion

The results of Study 1 demonstrate that marginalization (in the form of negative public regard) can significantly reduce the understanding that one's life has meaning, in part, because these negative experiences decrease mindfulness. It is surprising that perceiving one's suffering as part of the human experience, common humanity, did not show a similar effect. A larger sample size would provide more statistical power to examine this effect. Still, these results suggest that one strategy for countering the negative impact of marginalization on meaning in life is to adopt a mindfulness practice. Indeed, there are numerous memoirs of socially marginalized practitioners who found meaning in life through mindfulness (For examples, see Manuel, 2015 and Yang, 2017). In the next study, we expand on how mindfulness can support meaning in life among marginalized people.

Study 2: Revealing and Honoring the Stories of Marginalization, Mindfulness, and Meaning in Life

Procedure

Our qualitative-oriented research question was: *How do people of color and/or LGBTQ people (historically marginalized groups in the US) who have a consistent mindfulness practice use their mindfulness skills/states to connect with a sense of meaning in life despite, or in light, of their experiences of being marginalized? ("Consistent" for this study is 2 years of practicing 3 times per week. An example of skills is concentration practice, and an example of state is having a concentrated mind.)* We used a semi-structured interview with 8 participants, and were informed by grounded theory and narrative analysis for this study's analysis. Both are discussed in further detail below.

Before the semi-structured interview, participants were offered a short form to read that explained informed consent. The interviews were recorded and transcribed by members of the research team. Using grounded theory (Charmaz, 2006), the narratives were coded for emergent themes. A password protected cloud-based program, Dedoose, (http://www.dedoose.com/) was used to organize the data, codes, and emerging themes.

The following questions were used to establish if the participants met our inclusion criteria for the study:

1. How old are you?
2. Do you currently identify, or have you in the past identified as being marginalized by society? For the purpose of this study, marginalized is described as experiencing yourself on the outskirts of inclusion within a society that you live in.
3. If yes, do you experience this marginalization due to a core part of your identity as it relates to your race, ethnicity, sexual orientation, and/or gender identity?
4. Do you have an active mindfulness practice that has been continuous for at least 2 years? (Active in this study means performing intentional behaviors that cultivate mindfulness at least 3 times a week.)

Due to the personal nature of the study, we offered the following referrals for low-fee counseling services if needed:

1. Center for Holistic Counseling - 2501 Harrison St, Oakland, CA 94612
   (510) 444-3344
2. The Pacific Center (LGBTQ)- 2712 Telegraph Ave, Berkeley, CA 94705
   (510) 548-8283
3. Concord Community Counseling Center - 2702 Clayton Rd Suite 200, Concord, CA 94519
   (925) 798-9240
4. Women's Daytime Drop-in Center – 2218 Acton St., Berkeley, CA, 94702 (510) 548-2884
5. Sunnyvale Community Counseling Center - 572 Dunholme Way, Sunnyvale, CA 94087
   (408) 524-4900

Upon successful meeting of the criteria, a follow up interview was held in person. The main semi-structured interview consisted of the follow questions:

1. What parts of your identity do you consider to be marginalized by society at large?
2. Please describe your mindfulness practice. How/why did you start practicing? How do you understand mindfulness? Do you have a mindfulness community?
3. Can you share a story where you encountered your marginalized identity/ies during your formal mindfulness practice? (For example, felt emotions around being marginalized,

confronted by a memory of being marginalized, etc…) How did that encounter impact your sense of belonging, coherence, or connection with purpose in life?

3a. How did you use your mindfulness skills/state to meet the experience shared above? (An example of skills is concentration practice, and an example of state is having a concentrated mind.)

4. Can you share a story when mindfulness helped you cope with the negative impact of marginalization in your life? What helped you to successfully navigate the challenges that are exemplified in the story you just shared?

5. Can you share a story when mindfulness helped you feel a sense of belonging, coherence, or connection with purpose in life? What pieces of mindfulness practice was most supportive to you?

6. How might mindfulness around marginalization (personally and in society at large) influence your sense of belonging, coherence, and/or search for purpose in life?

7. How has mindfulness changed your perspective of your experience of marginalization? The experience of others?

8. What other questions are important to ask you in order to understand how mindfulness has helped you successfully connect to a sense of belonging, coherence, or connection with purpose in life?

Within the longer interview, the following follow up prompts were used to help facilitate sharing:

1. Can you tell me more about that experience?
2. How did that experience with mindfulness help you to connect with purpose in life?
3. What words, phrases, or metaphors might you use to describe your current relationship with your marginalized identity(ies)?

After the data was transcribed and analyzed, we crafted an individualized summary letter for each participant that touched on the key themes that we gathered from that participant's interview. We shared the letter with that participant and allowed them to offer any feedback or reflections.

Participants

Aiming for saturation, the researchers interviewed 8 participants. Participants were adults between the ages of 26-72 who identify as being marginalized in normative U.S society because of a core identifier (race/ethnicity, and/or sexual orientation/gender identity). All the participants were living near the Bay Area, California at the time of the interview. Additionally, participants had a consistent mindfulness practice that had been continuous for at least 2 years, engaging in intentional mindfulness practice at least 3 times a week. The following Table 6 summarizes pertinent participant demographics.

Pseudonym	**Age**	**Marginalized Identifier(s)**	**Self Reported Race**	**Self Reported Sexuality/Gender**
Kelly	28	Sexual Orientation/Gender Identity	Caucasian	Queer/Genderqueer
Cricket	63	Sexual Orientation	Caucasian	Gay/ Cisgender Male
Tom	72	Sexual Orientation/Race	Asian or Pacific Islander (Filipino) /	Gay/Cisgender Male

			Caucasian	
Richard	64	Sexual Orientation/Race/ Refugee	Asian (Vietnamese)	Gay/Bisexual/ Cisgender Male
Michelle	36	Sexual Orientation/Cultural Outsider	Caucasian	Queer/Cisgender Female
Bob	53	Sexual Orientation/Race/ Spiritual Identity	African American	Gay/Cisgender Male
Kim	29	Race/Ethnicity/ Gender Identity/ Immigrant/Person of Color	Asian (Indian)	Straight/ Cisgender Female
Tara	26	Race/ Class/Person of Color	Hispanic (Latina)	Straight/Cisgender Female

Table 6. Demographics of 8 participants interviewed for our study.

Data Analysis

After the interviews were transcribed, we divided the analytical process amongst the three members of the qualitative research team. We read the transcriptions while playing back the recording of the interviews to reconnect with the text. Using narrative analysis as our guide, we read the transcriptions carefully taking into, "consideration the entire story and focuse[d] on its content" (Lieblich, Tuval-Mashiach, & Zilber,1998, p. 15).

In narrative analysis, the process for coding the narratives is dependent on the interpretation and theoretical context of the reader. We were guided by our research questions and theoretical framework, as described above in the introduction. We focused on stories that exemplified how different aspects of mindfulness practice related to the participants' sense of meaning, especially as it related to their marginalized identity(ies). We used a cloud based software (dedoose.com) to store the transcripts, analysis memos, and to keep track of the coding process. We employed the constant comparison method associated with grounded theory (Charmaz, 2006) to organize the narratives into 143 codes. We then consolidated the codes into three themes, presented below.

Assuring Quality

In order to increase quality we used the research team as a small group to discuss research coding and theme building throughout the process. Having multiple readers allowed for various interpretations about the texts, and added to the transparency of the study. As mentioned above, each participant was given a summary letter that contained key themes from their interview. We further consulted the authenticity criteria of Guba and Lincoln (1994) and the quality guidelines put out by the National Institutes of Health (2001), and the National Centre for Social Research in the United Kingdom (Spencer, Ritchie, Lewis, & Dillon, 2003).

Note on the qualitative research team. For the sake of transparency it is important to share that this research team was formed through the Holistic Research Center at John K. Kennedy in the Bay Area, CA. Our team consists of one Assistant Professor in the Holistic Counseling Psychology department (Jewish European-descent American male), one recent alumna (Jewish Middle-Eastern descent, British female) , and one current student (European-descent, American female). All three of us identify within the Queer spectrum, and all practice and have studied mindfulness. We are also all trained and experienced to varying degrees as mental health clinicians.

We want to acknowledge our sociocultural and educational position in being able choose which facets of mindfulness (that have been transmuted from Eastern culture to Western culture) to include in this paper. Separating mindfulness from its spiritual lineage in order to investigate empirical constructs can pose a problem of colonization. We have done our best to honor the home of this topic, though our exploration is no doubt a cultural interpretation based on our Western bias.

Findings

Below we discuss the three themes that were crafted from the Grounded Theory/Narrative Research analysis of the transcripts. The themes are People, Practices, and Philosophies. In the People theme we discuss aspects of participants' experience in their mindfulness communities. In Practices we discuss specific mindfulness techniques and tools that were highlighted by participants. In Philosophies, we explore the common teachings that participants shared. Each theme offers an important look at an aspect of mindfulness that marginalized individuals employed and/or encountered that helped them connect to a sense of meaning in life.

People. This theme will investigate the interactions between participants and practitioners in their mindfulness communities. More specifically, it will explore how participants' sense of safety impacted their experience of marginalization, ability to utilize mindfulness tools, and make meaning in the present moment. Porges' (2004) Polyvagal theory demonstrates the importance of a safe community in cultivating the social engagement system. A sense of safety allows for autonomic nervous system regulation, an ability to connect and engage with others in the present moment, and therefore the capacity to integrate and make meaning in the here and now (Johnson, 2017). Safe, inclusive, communities that welcome all parts of people can help develop resiliency by increasing the state one's body can stay in before it recruits defensive strategies, also referred to as the window of tolerance or range of autonomic state (Porges, 2011). In the following excerpt, Kelly, who uses they/them pronouns, discussed their physiological response to the experience of danger and invisibility, as their non-binary gender identity was dismissed by a practitioner in her mindfulness community.

"I feel totally invisible right now. And it was this visceral, surge through my body, of like, oh my god, I don't belong here, and wanting to say something but then not wanting to because I was so triggered. It was this really intense like physical, emotional rush through the body…I mean there was such a sense of panic. It was a really crowded day in the hall, like I was in the middle and there was no way out. So, there was this sense of wanting to escape but not being able to." Kelly's adaptive neurophysiological response demonstrated a diminished state in which they were successfully defending against an immobilizing environmental threat ("surge through my body…"). Their ability to stay with and sense into their somatic activation in a self compassionate and non-grasping way, exhibits how mindfulness

community can offer the felt sense of belonging that is a foundation for one's sense of meaning (Johnson, 2007).

We can understand Kelly's experience as a microinvalidation, a form of microaggression in which communications, "exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of certain groups" (Sue, 2010, p. 37). The affective consequences include but are not limited to, a feeling of confusion, rejection, shame, not belonging, uncomfortability, helplessness, invalidation, anger and being misunderstood. This particular form of microaggression may be especially harmful due to its tendency to subtly deny the reality of the other's experiences. Another participant's (Cricket) encounter with a practitioner demonstrates the emotional pain that often accompanies the experience of a microinvalidation.

He describes his relationship with this practitioner, "I just remember trying to talk to this one teacher who I have a good relationship with and just he really trying hard to bridge… to make me feel comfortable. He was so awkward, and it was so painful. The assumptions and questions that he asked, I mean it was kind of like going to this great doctor but this doctor doesn't have a clue of what's going on with you. That heterosexual lens is so dominant that unless they have some contact with a gay person, they have no [idea]… I don't think he really thought about it at all. And I just remember feeling kind of like that all of the time in those meetings. If I ever said anything, I just felt super vulnerable in the beginning. Just because of the isolation." His words bring to light, one example of his mindfulness community mirroring rejection (Bellin, 2017), and thus potentially blocking his ability to make meaning. Cricket's marginalized parts were not reflected back to him by his practitioner, and this seemed to contribute to his sense of separateness and painful vulnerability. Johnson (2007) suggests that the body is the gateway to making meaning of our experience. We imagine that Cricket's ability to make meaning through foremost, a perceived bodily safety, is being challenged by his sense of invisibility in his community.

In contrast to the impact of an underrepresentation of identity in community, some participants reported their mindfulness communities mirroring acceptance, which contributed to a sense of belonging and safety. Bob described his experience of transcending limiting beliefs through the acceptance of his community,

> My experience at the residential retreat was kind of eye opening because I didn't realize I had so many negative voices in my head. And I can't tell you exactly what they said, just in general it was a sense of not being worthy. And so, one of the things that came out of being in the two sitting groups is they've done practices that sort of help you come to terms with those voices and whatever else may be in your past. There was a practice we did called 'Shadow Work' where we were supposed to make peace with our shadow side and one of the ways we did that was they had this thing called, 'The Tunnel of Love.' It was basically two lines of people and you would walk blindfolded down the line and people would say affirming things to you, things that they felt you might need to hear. And that was really an emotional experience because I think without consciousness we don't make room for that and we're not used to hearing those voices, they are so counter to the voices we hear in our heads, taking up residence and causing us distress. But I remember that, specifically as being an affirming experience.

Bob's narration directs us to the conclusion that an accepting community cultivates safety cues which activate the social engagement system and therefore allow for an ability to

connect to and receive love from others. Yang (2017) so eloquently described the experience of internalizing a safe community in the following quote, "As practice expands from the personal to the collective, from the internal to the external, from the particular to the universal, it comes to embody the value of inclusion of all things, of all people and of all differences. All of our experiences are invited and belong; none of us is marginalized or excluded. In that way, we are being invited to create beautiful and Beloved Communities," (p.79). These qualitative patterns imply that somatic safety which comes from a supportive mindfulness community could help promote the effective use of mindfulness practices, which will be discussed in the next section.

Practices. This theme will explore the practices used to cultivate mindfulness and their impact on participants' experiences of marginalization and connection to meaning in life. We identified three core types of mindfulness practices: focused attention, open monitoring, and loving-kindness/compassion.

Focused attention. This practice is a type of concentration meditation. Attention can be directed on an internal object, such as the breath or bodily sensation, or on an external object, such as a sound or image (Kabat-Zinn, 1990). Most participants in our study had a regular routine of focused attention practice. For example, Cricket spoke about sitting everyday for approximately 45-minutes. In describing his experience, Cricket said, "I liked sitting for longer periods of time, because I liked, you know, how you feel when you get concentrated. I like the calmness and stillness that can happen when you start sitting. Basically, you become quite altered." Focused sitting practice offered Cricket an opportunity to connect to his somatic experience, which resulted in an aware and calm mind. Cricket later remarked how he believed this regular practice was necessary as it prevented him from developing mental health issues, such as depression. As mentioned in the previous theme, our bodily senses form the basis of the meaning which make and shape the perception of our experience (Johnson, 2007). It can be surmised that practices that deepen somatic awareness contribute to one's sense of meaning in life. Additionally, contact with the self, such as on a somatic or emotional level, has been linked to increased feelings that life has meaning (Debats, Drost & Hansen, 1995).

Focused attention also served as a coping mechanism when participants experienced strong emotions. For example, Bob shared, "When I feel stress or anxiety I tell myself, 'you need to stop for a minute and take three deep cleansing breaths and just let everything go and then come back to the moment and ask what is it I need to do now instead of being scattered.'" Bob's practice of focusing on and slowing down his breath helped him alter his distressed physiological and emotional experience. Mindfulness tools that bring collected attention to direct somatic experience can shape how practitioners experience and make meaning.

Open monitoring. This practice involves bringing an open awareness to a wide array of internal or external objects (Germer, Siegel & Fulton, 2013). For example, a person may practice open monitoring by noting the various emotions and thoughts arising moment to moment.

Bob discussed his practice of witnessing his thoughts during formal sitting practice at a residential retreat. "When we're silent it all comes up and you hear the voices say whatever they say. I think for me it was, 'I'm not good enough,' for whatever reason. 'I'm not good enough because I'm gay, I'm not good enough because I'm black." Bob's open monitoring meditation practice was an eye-opening experience for him as he was able to notice the

unconscious stream of negative self-talk around his marginalized identities. Bob further shared, “It took two and a half days though, and being in silence for me to adjust to all the background noise in my head, and then after the two and half days I began to question or make peace with the voices, but it was the beginning of the process. I sort of got used to them being there, and what they would tell us is things would come up, feelings would come up, thoughts would come and they will go away. Try not to hold onto them, just note it.” For Bob, formal meditation practice and the retreat setting helped him train his attention and quieten the internal and external distractions so that he could hear the constant negative stream of voices in his mind. Following this first step of developing awareness, Bob was able to choose how to consciously address these negative voices. For marginalized individuals, open monitoring can offer more distance and perspective on their thoughts and feelings, which alters the meaning they makes of their experience (Germer, Siegel & Fulton, 2013). Following Park and Folkman’s (1997) meaning making framework, open monitoring practice can offer marginalized individuals an opportunity to question and revise their unhealthy and harmful global meaning framework, i.e. negative beliefs about the world and themselves.

Several participants also spoke about how they used open monitoring in their informal day-to-day practice, such as by paying attention to feelings and thoughts as they arise. Informal practice of open monitoring can help individuals, “cultivate equanimity in the midst of random and unexpected life events” (Germer, Siegel & Fulton, 2013, p.18). This mindfulness skill was highlighted as a useful tool when dealing with marginalizing experiences. For example, Kim shared,

> Like last night going to a yoga class at a prestigious gym and they're all white people, I’m the only one who is not, and I’m thinking in my mind that I’m not supposed to be in this room, I’m not supposed to be doing this practice of yoga even though people are saying ‘namaste’ and using my language. There’s still something off. But tapping into, ‘I do belong here,’ and being able to recognize that pattern of thinking rather than getting caught up in it and preventing me from doing the things I want to do.

Kim’s practice of informal open monitoring allowed her to notice her negative core beliefs and then consciously shift her global meaning (self-concept) from the belief that she does not belong because she is not white, to the belief that she does belong. The change in her global meaning in turn shifted her situational meaning (the interpretation of events), and allowed her to feel welcome at the gym . This is another example of how mindfulness practice can alter one’s sense of meaning despite the negative core beliefs internalized as a result of one’s marginalized identities.

Additionally, Kim highlighted how this practice of observing her thoughts and feelings gave her more control, as she noted, “being able to catch when it’s becoming a cycle, and being able to stop it and say enough, that’s not needed.” Mindfulness helped Kim gain more agency in the situation as she was able to control her mind’s chatter and choose how to refocus her attention, rather than running on autopilot. According to Frank (1972) this ability to choose, even in acts as small as the focus of one’s attention, is an essential component of meaning in life.

Loving-kindness/compassion. These practices are designed to foster sensitivity to the suffering of the self and others, as well as the cultivation of goodwill to all beings (Kolts, 2016). These practices are said to emotionally warm up the experience of meditation by focusing on tender, caring, and soothing qualities, which can be particularly helpful in making meaning out of emotional difficulty (Germer, Siegel & Fulton, 2013).

Tara shared how she practices self-compassion. “I have a big victim identity narrative from my internalized belief system, so instead of seeing myself as a terrible little thing, there is as sense of a precious thing that is suffering and is scared, that does not feel empowered.” Compassion practice enabled Tara to direct love and support to herself. Self-compassion practices can connect practitioners to a sense of meaning through being, i.e. that they have value and that their life matters (Bellin, 2017). Additionally, the presence of self-compassion has been associated with promoting meaning in life (Phillips & Ferguson, 2013).

Tara further shared how this practice enabled her to see the universality of her suffering. “If I interact with it in myself, get familiar with texture, flavor, and repetitive nature, I become more sensitive to it and recognize it is happening all around me. It has really opened up my heart in terms of empathy and compassion. It makes me feel we are all in this together.” By being more sensitive to her own suffering, Tara was also able to feel a greater sense of connection to, and belonging with, other people, as well as compassion for their suffering. The cultivation of compassion is connected with meaning in life as it may engender a sense purpose and responsibility to alleviate the suffering of others (Frankl, 1986). This sense of interconnection and belonging that arises through compassion practices can also help individuals overcome their feelings of separation and isolation due to their marginalized identities, and is associated with enhanced perception of meaning in life (Lambert, Stillman, Hicks, Kamble, Baumeister & Fincham 2013). Tara’s description also demonstrates the sensuality of meaning-making (Johnson, 2007), as mindfulness enables her to connect to the felt-sense of belonging through her body.

Compassion and loving kindness practice also helped participants open to receiving love and compassion from others. For example, Kelly shared, “part of my practice is to let in love and support and to feel it, and not have the body and the mind tense against letting in care.” Kelly brought up a story about a time they shared their feelings relating to their marginalized gender and sexual-orientation identity in a meditation group they attend. Kelly shared, “after that group I connected with the teacher that was leading that group and just felt this moment of compassion from her... There was no literal agenda or sense of self. It was just this pure embodiment of compassion that I was able to meet and receive in a way that I'm not usually able to, especially from someone that doesn't identity the way that I do.” Kelly practiced letting in love, not only by being vulnerable, but by then receiving the compassion from their teacher and other practitioners. Though Kelly’s marginalized experienced made it difficult for them to receive compassion from others who are different for fear of misunderstanding, their practice helped them take in love and meaningfully connect to others. This skill appeared to transform their relationship to themselves and others. This demonstrates how compassion practice may connect the marginalized individuals to a sense of meaning as it allows them to transcend the limitations of their own self and identity and to feel part of a larger entity (Aron, Aron, Norman, 2001). Below we will discuss how participants encountered these practices through specific teachings and philosophies.

Philosophies. This theme will explore the philosophical points that underlie the interviews, focusing on the mindfulness teachings that helped participants connect with a sense of meaning in life as they struggled with their experience of marginalization. All of the participants that were interviewed had been heavily influenced by a particular stream of insight-oriented Buddhism, known as Vipassana (Anālayo, 2003). As mentioned above, there is no one single approach to Vipassana. There is though an underlying theme of paying loving attention to whatever arises in one’s present moment enabling a clear witnessing of the nature of reality (Salzberg, 2011; Yang, 2017). A common outcome described in mindfulness

teachings is that with practice comes a sense of interconnectedness with humanity and with all life.

Interconnectedness. Cricket shared the following, "we're really just moments of consciousness that are arising and passing and just this idea of interconnection on some levels doesn't make sense to me, but I'll have these moments when this separation I feel, kind of like this hard separation, isn't that hard, and I can feel super connected to the world." In this quotation Cricket explained how the teaching of interconnection, and his experience of interconnection, through practice has helped to soften the harshness of the marginalization he experiences in his life as a gay man. He expressed that he does not always understand the idea of interconnection, but somehow the teaching of interconnection has made it possible for him to periodically feel a sense of connection to the world. From an expanded understanding of meaning in life, as we laid out above, we connect this sense of interconnection with the foundational elements of belonging and being affirmation that are crucial to one's sense of meaning in life. Cricket's quotation also introduces another key point in our philosophy theme, the recognition of a caring inner witness, or third-person observer.

Caring observer. Bob reflected on his mindfulness retreat experiences that, "the most important thing [the teachers] tried to enlighten us with was the third person observer, which is where you pretend you're not you but someone observing you, and that is how I got to a place of allowing the feelings to ebb and flow and not holding onto them, which became more of a formative practice that bit of knowledge of stepping out of yourself to watch yourself." Bob's internalization of teachings about a third person observer allowed him to watch the impermanent and ever-changing flow of feelings, thoughts, and sensations. From a philosophical standpoint, Bob was witnessing how the ingredients of what makes up a sense of solid separate self are actually quite dynamic and are not at all steadfast, as they are always ebbing and flowing (Anālayo, 2003). The malleability of the sense of a separate self is important to sustained meaning in life, because meaning in life is also a dynamic process rather than a set template (Bellin, 2015). Thus, we surmise that Bob's sense of meaning in life shifts from a socially marginalized self to an ever-present flow of experience which transcends and includes his personal life narrative. Ultimately, this leads one to, as Bob expressed later in his interview, "hold yourself with compassion." Compassion is a final philosophical component that appeared in multiple interviews.

Compassion. On the facet of compassion as it connects to meaning in life, Tara shared, "I am inspired by Buddhist philosophy, and the bodhisattva path, where you are committed to end the suffering for all beings. We are all in this together, struggling and doing our best. I am not separate. It feels so much better to have that. When feelings of [competition] or that I am an outsider come up, I identity with it for less time, and recognize that there is some larger truth." And, "Not only do I have mindfulness practice, but I feel blessed with the buddhist teachings, and teachings like … the Divine Mother, more compassion teachings. I can sit in these really uncomfortable places and huge amounts of love come up. From that there is lot of tenderness and support."

Tara's quotations summed up this theme on philosophical teachings that helped participants connect to meaning in life in the face of marginalization. She shared about how compassion teachings of the bodhisattva path and the Divine Mother inspired a cycle of witnessing the discomfort within herself and others with a third person observer quality, which cultivated a sense of interconnectivity and compassion. The presence of compassion for herself, and for all beings, allowed her to sit lovingly with more suffering. This ability

seemed to wake up a larger sense of purpose to care for the suffering that she encounters from marginalization.

Discussion - Study 2

The qualitative part of our investigation addressed the following question: *How do people of color and/or LGBTQ people (historically marginalized groups in the US) who have a consistent mindfulness practice use their mindfulness skills/states to connect with a sense of meaning in life despite, or in light, of their experiences of being marginalized?* The presentation of our themes above demonstrated how despite the negative impact of marginalization on social identity, mindfulness community, practices, and teachings, can facilitate a sense of meaning in life. Below, we reintegrate our findings with our theoretical framework, exploring Park & Folkman's (1997) model of meaning appraisal, the sensuality of meaning making through mindfulness of the body (Johnson, 2007), and the function of community to help us wake up to a higher sense of purpose (Yang, 2017).

Mindfulness Impact on Situational & Global Meaning

Our participants talked about how they felt limited and trapped by their experience of marginalization, and the accompanying isolation, emotional pain, and lack of a sense of belonging. Park & Folkman's (1997) model helped us make sense of their experiences by looking through a meaning making lens. Their model distinguished global meaning (the beliefs, goals, and feelings related to self, other, and the universe) from situational meaning (the meaning that we assign to specific experiences based on the global meaning framework). Our findings suggest that the situational meaning that people ascribe to their marginalized identities can be impacted by mindfulness communities, practices, and philosophies. The stories we heard shared many mindfulness-related moments of situational meaning challenging global meaning. The constant situational meaning appraisal within the conditions of community mirroring acceptance, practices of loving attention, and teachings connected to waking up, seem to have enabled a reinterpretation of once rejected identities. By immersing in mindfulness, marginalized people can shift their global meaning, which may include the negative beliefs about their identities, without minimizing the pain or struggle of their journeys.

Meaning and the Body

Our participants' experiences displayed a relationship between meaning making and the first foundation of mindfulness, the body (Anālayo, 2003). Their accounts suggest, as Johnson (2007) proposed, that meaning is made through the sensuality of experience. The way we somatically experience ourselves and our environments impacts the ways that we appraise the meaning of those interactions. Gently bringing our attention to sensations and emotions in the body as they arise and pass away, and directing loving kindness to our experience of the body are foundations of mindfulness (Fronsdal, 2001). Our participants used these mindfulness practices and teaches, often within the container of community, to connect to their bodily experience, which became the bedrock from which their meaning was made in the moment.

This emergent pattern from our qualitative inquiry also invites a deeper investigation into the potential role of the body in healing the marginalized experience. Manual (2015), also maintaining that meaning is made through our body, suggested that through mindfulness practice, we may come to experience our somatic embodiment as both conditional and boundless. She offered the idea that wisdom is not enough to heal the wounds of the marginalized. Microaggressions, outright aggressions and internalized shame, represent deep somatic wounds that are too often held in the bodies of those who are socially marginalized. Our findings propose that creating a mindful and meaningful relationship with the body in the context of community, practice, and philosophy, may be an important element in both healing emotional and physiological wounds.

Identity in Community

We observed in participants' personal narratives that bringing mindful awareness to their internal and external experience in the context of a "safe-enough" community, impacted the way that they experienced their marginalized identities. Yang (2017) discussed the necessity of acknowledging cultural differences in cultivating the experience of being "safe-enough" in community. The word "safe-enough" is used to acknowledge that most social spaces are not totally safe for people that identify as marginalized. He described the conditions of a community and their impact on one's ability to experience their body as open and receptive to healing. He wrote, "Spiritual explorations require intimacy and tenderness, and it is very hard to relax into what is an open, vulnerable state when our defenses already have to be in place to protect from the injuries and traumas caused by unconsciousness and patterns embedded in the dominant culture," (Yang, p.68). His sentiment reminds us that having a "safe-enough" space, a community container to hold all of our experiences, especially those experiences that land outside of the dominant cultural narrative, is fundamental in creating trust to deactivate our defenses and open us up to collective healing.

When participants were able to witness the ebb and flow of their experience within an accepting and inclusive community, they were able to feel liberated, to some extent, from a sense of rejection. Their stories supported the idea that community acceptance and compassion allows for self-acceptance and self-compassion. One common form of transcendence was through a larger sense of collective purpose and meaning that still held their marginalization with compassion.

General Discussion and Conclusion

Our mixed-methods approach explored in depth the relationship between marginalization, meaning in life, and mindfulness. We conclude with a summary of our combined findings with mental health practitioners in mind. In brief, we found that meaning in life and mindfulness/common humanity are connected, and that marginalization (as experienced by negative positive regard) also shows a significant relationship with mindfulness/common humanity. While mindfulness can lead to an expanded sense of meaning and purpose, meaning in life can provide a strong existential foundation for mindful and compassionate witnessing of one's life. Our data also showed that the relationship between marginalization and meaning in life, can be explained, in part, by mindfulness (though not common humanity). We conclude from this that mindfulness can be helpful for people who experience marginalization, to a certain degree, by helping them connect with a sense of meaning in life.

In the U.S. today mindfulness can be found with greater frequency in many different setting, including the psychotherapy office. Our qualitative study serves as a reminder that for

mindfulness to have an impact in assisting marginalized people connect to meaning in life, therapists have to consider the communities, practices, and foundational philosophies from which mindfulness is gleaned. Each piece is important to the mindfulness puzzle.

Mindfulness as a cultivator of life meaning is best practiced among a supportive community that knows how to be proactive about diversity and inclusion. Yang's (2017) book, *Awakening Together*, is an excellent guide to consider diversity in community. Mindfulness of the body can be an important focus to help a practitioner establish intimacy with their somatic-sensual experience of themselves and the world. We add a note of reminder here about the trauma that is often stored in the body, thus mindful exploration of the body should be done with care and compassion.

If therapists do assert themselves in positions of offering mindfulness in a clinical setting, we recommend referring clients to supportive mindfulness communities (online or in-person), deeply engaging in mindfulness/self-compassion practices themselves, and taking up some foundational study of core cultural teachings from which mindfulness has emerged.

Limitations and Next Steps

The major limitation of our study was the low sample size. Potentially, and as a direction for future research, with an increased sample size we could have obtained enough power to be certain about our results when it came to the subscale of common humanity. Greater power will allow for the investigation of which facets of mindfulness are most helpful. Indeed, a future study can look at the Self-Compassion Scale as a whole, and other possible contributing factors, such as social support, and personality.

We also are aware that mindfulness, even within Buddhism alone, varies greatly between different cultures and schools of thought. Thus, future research might include interviews of practitioners from a variety of mindfulness communities, including perhaps different religions that have contemplative practices that similarly cultivate mindfulness. We attempted to honor the richness of the traditions from which mindfulness grows out of, though we are ever aware that we are making cultural interpretations that might misguide from the original intention of the people that grew these teachings and practices.

As a final thematic next step, we were intrigued by the connection between body and community that emerged in this study as a foundation of meaning in life. Future research might investigate the impact on meaning in life by marginalization from a socio-somatic experience. Furthermore, researchers can explore the empirical relationship and thematic underpinnings of the body making meaning through loving and mindful attention in the face of sustained adversity.

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Identifying Intuitive Footprints™
Interpreting the Physical Sensations left by Emotions Around You

Nora Truscello

Many years ago, I noticed subtle energy beings existed around my body during meditation or when doing high level spiritual work while assisting other people. It was necessary to distinguish if these were safe, helpful energy beings or were they harmful dangerous energy beings. So I decided to use a technique learned years earlier to distinguish what emotion was fueling the being around my body, was it joy or anger. Once the energies around me during meditation could be identified as harmful (angry) or safe (joy), it left the question open, can one distinguish energies around them when not in an altered state. I believe you can, and I call these energies Intuitive Footprints ™.

Intuitive Footprints™ are energetic signatures, which are felt on our body, informing us of the emotions present. One can read the expression on a person's face, hear the tone of their voice, notice body language and make a good judgement on a person's emotional state. But what if there is a natural internal way the observer can tell a person's state, even if they could not see or hear the other person. Imagine the difference it would make for a patient if their psychologist could identify the underlying emotions the patients feeling, but may not be able to express. The benefits of identifying intuitive footprints are just being discovered. Intuitive footprints do not act as lie detectors, but if someone is angry and putting on a fake front, it would be helpful to know.

I welcome the opportunity to present my theory of the existence of "Intuitive Footprints", these energetic signatures that identify another person's emotional state. These personal intuitive footprints, when identifying the same emotion, are felt differently by those receiving the information. For example, when testing for the emotion "joy", each person in the room will feel the intuitive footprint in a different way on their body. One person will feel a brush down their right arm, another, a tug on their left ear, and so on. When the tests are run over and over, each person always gets the same signal for the same emotion. This makes most,

not all, intuitive footprints unique to each person, like our voices and facial structure are unique to each of us. Intuitive footprints were never previously distinguished because almost no two are exactly alike for every person.

However, there are a few intuitive footprints that are felt by all people in the same way, not uniquely as is the norm, called universal intuitive footprints. One example of a universal intuitive footprint is the “gut feeling.” Most every adult can identify with their gut feeling. We all learn the hard way when we don’t listen to our gut feeling in the pit of our stomach, and we move forward ignoring the warning. Realizing there are a few universal intuitive footprints, it beckons, are there more that simply have not been identified.

By discussing the universal intuitive footprints, giving the few examples, students begin to realize there are energetic signatures that provide us information, which we simply overlook in our high tech world. Once students are comfortable with the universal intuitive footprint, it helps them to understand there are many personal intuitive footprints that just need to be identified by an individual. Once you identify the intuitive footprints you open the door to an innate ability which is no longer dormant.

It is my belief the key to understanding and mastering intuition, or gut feelings, is to be able to identify this subtle energy on your own body and interpret these energies correctly. I look forward to the opportunity to explain in detail how to identify them, and how to compile your own personal library of intuitive footprints distinct to your own body.

Islamic Spirituality and Mental Health

Author:

Name : Mohammed Junaid KA
Studying at : Co-ordination of Islamic Colleges
(Recognized by: Al Azhar Islamic University,Cairo,Egypt
And Member of International Islamic Universities League)
: University Of Calicut,Kerala-India
Position : The Chief Editor of AL BASMA English Magazine
(Published By:KKHM islamic & Arts College,Kerala-India) 2015-2017

Abstract

Introduction:

Every religion are declaring their own spiritual life methods. If the men who believe in a religion keeping their religion's spiritual rules, they can reach the peak of happiness in this modern world with no depressions and stresses at all. So, the spirituality that being put forward by religions is very necessary to be analyzed. Here, I hope to present the spirituality of the religion ISLAM and its rewards on mental health.
Iam dividing this paper into three chapters.

Chapter 1:

In islamic percpective a spiritual life has not been set aside from mainstream of the society. Islamic spirituality is the suitable habits and practices in all walks of life.In the first chapter I would like to describe the Islamic worships like Ablution(wudu), prostration (swalath), Meditation(zikr), Fasting(saum) and handovering of Gifts(hadhya) and their benefits on mental health. Also the comparison study between the health of people following the Islamic spirituality and those who are not following.

Chapter 2:

Here, the explanations of orders of the Holly Quran and the commands of prophet muhammed (PBUH). Then the mental health theories that can be derived from the orders and commands mentioned above.

Chapter 3:

In the last chapter, the life of prophet Muhammed (PBUH) and other Islamic concepts which help to avoid psychiatric disorders. And the comparison between modern psychology and Islamic Psychology.

Research Methodology:

- Books & Magazines
- Interviews
- Internet

The spirituality of all religions gives more and more mental health to humans and it gives physical health also. The analyze about these spiritualties is very necessary in our modern world. Here, we are discussing about the spirituality in Islam and mental health gets from it through three chapters.

CHAPTER-1

Islamic Worships and Mental Health

Ablution

Ablution is the washing the esteemed parts of body. It involves washing the hands, mouth,nostils,arms,head and feet with water. It is compulsory for all obligatory islamic worships. The prophet muhammed (PBUH) teaches the living always with ablution as the symbol of real Muslim. Arabic word of ablution is wudu. The Quran says " for god loves those who turn to him constantly and he loves those who keep themselves pure and clean". And the prophet (PBUH) said that "cleanliness is the half of faith" . according to a Muslim, the cleanliness by ablution is very compulsory five times in a day.

The purification of body strengthens the soul which ultimately bring close to god. It is to be noted that Muslims wash their hands before rinsing their mouth, ensuring that they rinse their mouth with clean water. During the ablution, Muslims rinse their mouth in order to remove food particles and bacteria from the mouth. Most of them prefer miswak before ablution. Miswak is a natural tooth brush made from a twig or root of the tree which has its own antiseptic properties. The prophet muhammed (PBUH) recommended ablution before going to bed. Yoga experts also encourage washing of hands,arms,legs,eyes,mouth and genitals before sleep with cool water for a deep sleep. These like the ablution refreshes our body.

The physical purity gives more health and interest to perform an activity. And also the purity of body give the happiness to the mind. So, the prophet (PBUH) recommended to perform ablution during the time of sadness and angry. The studying with the ablution is more energetic to grasp the classes and lessons in the case of students. There are many physical health also getting by ablution. Some examples are here. They are, washing nose prevents from microbic diseases, washing arms activates blood circulation, washing hands prevents from pneumonia, rinsing mouth prevents systematic diseases cause by oral infection.

These are the reasons why islam empasizes on purity, as it is the basic part of faith in islam. But, many Muslims are unaware about the psychological and physical benefits of ablution.

Namaz and Zikr (Meditation)

Once the prophet muhammed (PBUH) asked to his companions that "is there any dirtiness on the body of who baths five times in a day?" the companions answered 'o…messenger of god, there is no dirty remains'. Then the prophet (PBUH) proclaimed that "like that, there is no any dirty in the heart of namzi who performs namaz five times in a day"

The namaz is the activity it centralizes the mind process to a definite thing. it is god. If a man performing the namaz with thoughtfully about god, then his mind is filling with that thought. Thus, in all the walks of his life he keeps that thought.. so, he cannot do what god is hating it.

We know that, the hypnotism is a trance state characterized by extreme suggestibility, relaxation and heightened imagination. The subject is feeling by suggestions with unconscious mind. Namaz is also like that. Islamic laws recommended to look to a definite point (sujood place) in the all times of namz. Namazi recitates the Quran and some special prayers, when he feels its meanings. Then he can reach to the thoughts about the go. Thus, his minds to be filled with love of god. So, the Holy Quran says "The Namaz preserves from lewdness and iniquity, but verily remembrance of god is more important. And God knows what you do"(surah al ankabooth-45) .

There is great correlation between Namaz and Yoga. Yoga rejuvenates the mechanism of body and mind. In our modern world, physicians are suggesting yoga therapy for most of diseases and to order the thought process as well as a cost-effective solution. It helps to restore harmony among various components of life style-physical,social,emotional,spiritual,mental and psychological. The system provides psychological and emotional well being.

Zikr is also an activity in which recitating the name of god with fully thought about god. So, Namaz and Zikr are the best forms of meditation. Meditation is defined as the uninterrupted flow of mind towards a particular object. Namaz and Zikr are the best stress buster and tension reliever modules. These two are providing ultimate satisfaction and peace to the mind, thus save us from many diseases and disorders. It enhances concentration and reduces the level of depression.

Fasting (saum)

In the terminology of islamic law, fasting means to abstain from eating, drinking and sexual relations during daylight hours. Many physical benefits of fasting are discussed since earlier by physicians. Psychological benefits are there are also there. Mood management is main benefit of fasting . when food is scarce our bodies release chemicals to help protect our brains from the negative effects.

Fasting involves controlling what we say and do. Being aware of these feelings will help us control ourselves. Self awareness is important for physiological well being. Because, it prevents us from acting in ways that we may regret. Self control is a trait of mature and emotionally healthy people. That self control gets from fasting.

However, it is clear that fasting can change brain chemistry, mood and mental functioning to the point of reducing risk for neurodegenerative disorders. Fasting increases self esteem. Self esteem is how we feel about ourselves. A high self esteem directly relates to our happiness. Each day that we fast, we feel a sense of triumph. Fasting is not only are we obeying the command of god, but we are also gaining mastery over our physical desires.

Gifting (hadhya)

Hadhya is one of the good manners that maintains and strengthens relations between the giver and the recipient. Based on this, giving to one of your relatives may be better than giving charity. Because, it is more befitting to uphold the ties of kinship. The same may apply if you give a gift to a friend of yours. Because that will strengthen the bonds of love between you. The prophet muhammed(PBUH) said : " Exchange gifts, as that will lead to increasing your love to one another" (sahih al bukhari). This words mean that giving gifts may generate and increase love.

In the words of the psychologists, giving gifts is seen as a social, cultural and economic experience. Gifts allow people to express their feelings and build on relationships without the use of language. Shaking hands between two person gives a positive energy to mind like hadhya. So, islam involved the hadhya as a great worship.

So, the Islamic worships gave more mental health to those who follows its laws. They are reaching to thought of god through it. They are hating what the hates. That mental health leads their life to success. Suicide and other life destroying activities are very less among Islamic person comparing with others.

CHAPTER-2

Quranic & Prophetic Approaches In Mental Health

The mental health

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience. Mental health is the capacity to express our emotions and adapt to a range of demands.

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". It was previously stated that there was no one "official" definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined.

In the mid-19th century, William Sweetzer was the first to clearly define the term "mental hygiene", which can be seen as the precursor to contemporary approaches to work on promoting positive mental health.Isaac Ray, one of thirteen founders of the American Psychiatric Association, further defined mental hygiene as an art to preserve the mind against incidents and influences which would inhibit or destroy its energy, quality or development.

At the beginning of the 20th century, Clifford Beers founded the National Committee for Mental Hygiene and opened the first outpatient mental health clinic in the United States.

In Quran and hadees

The Quran describes the way in which Allah should be worshipped. The Sunna includes all the known sayings, advices, and actions of Prophet Mohammed, his decisions, and his responses to life situations and to philosophical and legal questions, which usually derived from what's called Hadith.

The Quran and hadees are remedy for various diseases and makes people believe in healing. Quran is the holy book that the god sent to his messenger prophet Muhammed (PBUH), in the believe of Muslims. There are many examples in the Qur'an and Hadith of the virtues of a positive mental attitude, perseverance and optimism in the face of adversity. However, did you know that patience and a positive outlook on life are two of the greatest healing tools that you can

use?

The Qur'an says, "Give glad tidings to those who exercise patience when struck with adversity and say, Indeed, we belong to God and to Him is our return.' Such ones receive blessings and mercy of their Lord, and such are the guided ones"(surah al baqara-155). According to the findings of modern science, it appears that this mercy may often come in the form of improved health

Many emotional disorders today result from people being focused on or preoccupied with their own petty issues. Islam says that a cure for such narcissistic tendencies is to transcend the self, put trust in Allah (PBUH) and be concerned with loving and helping others. These attitudes are also the very fabric, which holds families, communities and nations together.

There is much wisdom in the Prophet's (PBUH) statement (narrated by Abu Hurayrah), "The strong [person] is not the one who overcomes the people by his strength, but the strong [person] is the one who controls himself while in anger." In fact, staying patient and calm is key to physical strength. It produces calm and health to practice saying, "Alhamdulillah" for what we have and for what we are faced with. We should try to keep our home and work environments peaceful and as free from stress as possible. One way we can counteract the effects of stress are to simply be aware of the stress we are encountering, and to consume sufficient nutrients and supplements such as herbs.

If we completely ignore the relationship between mental and physical health, we are missing an important detail in the picture of personal health. And, as in most health problems, practicing prevention is superior to finding a cure. Therefore, the best manner to avoid having negative attitudes and emotions control our bodies is simply to practice the wisdoms that we have been given throughout the Qur'an and Hadith. We should say, "Alhamdulillah"(praise to god) for what we have; "Insha'Allah"(as the decision of god) for what we intend; and, "Subhana' Allah"(glorifying the god) when we see something exciting or amazing. We should remember to say, Astaghfir'Allah"(o...god, forgive my sins) when we lose our tempers or become weak, and most importantly, "Allahu Akbar"(the god is great) when we are faced with the challenges of life. These five phrases, said regularly, are like taking a multi-vitamin for holistic health.

If the man loves another one he may feel bitter from him. But the god done a lot of boons to man. So, the disappointment from the god has no scope. Thus, the thoughts and loves the god gave more happiness. The Holy Quran says that: "Tranquility is getting by thought about the God"

The difficulties in the life and happiness is not eternal. The quranic verses give this positive thought: "so, surely with every hardship there is ease; surely, with every hardship there is ease".(surah al sharh-5,6)

Another concept of islam is in understand the in doing the activities. Someone who knew his potential, his skills, and his position well, he will be able to work well too, and it is a sign of healthy mental. On the contrary a man who is forced to occupy certain positions in the work with sufficient capacity then it will lead to distress, which in turn brings mental illness to him. Word of Allah: "That they may eat of the fruit, and from what is cultivated by

their hands. So will they not be thankful?". Prophet Muhammad(PBUH): "Better food eaten by a person is food that comes from his own efforts, because the Prophet Dawud also eat from his own work." (Sahih Al-Bukhari). Mentally healthy person is a person who receives his own condition, regarded to physical condition, position, potential or ability, because they are grace from God, to test the quality of human labor. There are two types of grace given to man by God, namely: (1) natural (pure) character, such as the condition of the posture, beauty/ handsomeness or ugliness, he was born in a particular family, and so on. Healthy human would be grateful for these gifts without questioning why God created like that, because behind their posture there is hidden wisdom; (2) arranged (kasbi) character, such as how to utilize fat posture at work or a career, how to function the aggressive character, and so on. A healthy human being will certainly mobilize all his resources optimally to achieve the desired objectives.

The other sign of mental health is the willingness to receive all the advantages and shortcomings of others, so that he is able to get along and adjust to others. The attitude developed such a love for a fellow brother as he loves himself (Sahih Al Bukhari and Muslim), a mutual help, grindstones, compassion, and foster . Word of God: "And do not be jealous of what God gave you more than others. (because) for men there is a portion of on what they earn, and for women (also) there is a portion of what they have earned, and ask for Allah His bounty portion. Indeed, God knows all things. (surah Al-Nisa' - 32).

A person's mental health is characterized by the ability to sort through and consider the action that will be performed. If the action was purely for sexual gratification, then the soul must be refrained, however, if for worship or piety to Allah SWT. It should be done as good as possible. The despicable acts can cause psychological problems, while a good deed will lead to the maintenance of the mental health.

In the view of the Qur'an, man has three aspects of human totality former that can be distinguished firmly, but it certainly can not be separated. The three aspects are jismiah aspects (physical, biological), Nafsiah aspects (mental, psychological) and ruhiah aspects (spiritual, transcendental). Jismiah aspect is the biological physical organ of human with its devices. The biological physical organ is composed of elements of earth, water, fire and air and it is the most perfect form compared with other creatures, called a concrete form and given them soul as the life energy that can sense various feeling, such as pain, heat, sweet, thirst, hunger and sexual pleasure. Nafsiah aspect is the overall quality of the typical human, in the form of thoughts, feelings, will and freedom, whose existence is among jismiah aspects and ruhiyah aspects. Spiritual aspect is the spiritual sublime potential of the human mind which is nature in a man that comes from the spirit of God and the transcendental creatures because this function appears on the dimension of pure nature.

The prophetic approach on gratitude is important to study. It is that the companion of prophet (PBUH) Abu Huraira reported: The Messenger of Allah(PBUH), said, "If one of you looks at those blessed over him in wealth and appearance, then let him look at those below him." In another narration, the Prophet(PBUH) said: "Do not look to those above you, lest you view the favors of the God as trivial." From these thoughts people gets a mind to thank the god without disappointment on what he lost.

According to attachment theory by John Bowlby, we know that having a secure attachment has been linked to the over-all wellbeing, coping, better mental health outcomes, enhanced self-esteem, and stronger relationship functioning. Thus, having a "healthy

attachment" to God would also be linked to better psychological functioning: "… And whosoever puts his trust in the God, then He will suffice him…" [Quran, 65:3]. So, the Quran and Hadees is not only saying about the heaven and hell. But also it lightening to man for his successful life.

CHAPTER-3

Modern Psychology and Islamic Psychology

Here, we are discussing about

- The Psychologists in Islam and their contribution
- Psychological intervention of Prophet Muhammed (PBUH)
- The comparison between modern psychology and Islamic psychology

Muslim Psychologists and their contribution

- **Imam Ghazali**

In Islamic psychology, al-Ghazali discussed the concept of the self and the causes of its misery and happiness. He described the self using four terms: Qalb (heart), Ruh (spirit), Nafs (soul) and 'Aql (intellect). He stated that "the self has an inherent yearning for an ideal, which it strives to realize and it is endowed with qualities to help realize it." He further stated that the self has motor and sensory motives for fulfilling its bodily needs. He wrote that the motor motives comprise of propensities and impulses, and further divided the propensities into two types: appetite and anger. He wrote that appetite urges hunger, thirst, and sexual craving, while anger takes the form of rage, indignation and revenge. He further wrote that impulse resides in the muscles, nerves, and tissues, and moves the organs to "fulfill the propensities."

Al-Ghazali was one of the first to divide the sensory motives (apprehension) into five external senses (the classical senses of hearing, sight, smell, taste and touch) and five internal senses: common sense (Hiss Mushtarik) which synthesizes sensuous impressions carried to the brain while giving meaning to them; imagination (Takhayyul) which enables someone to retain mental images from experience; reflection (Tafakkur) which brings together relevant thoughts and associates or dissociates them as it considers fit but has no power to create anything new which is not already present in the mind; recollection (Tadhakkur) which remembers the outer form of objects in memory and recollects the meaning; and the memory (Hafiza) where impressions received through the senses are stored.

He stated that there are two types of diseases: physical and spiritual. He considered the latter to be more dangerous, resulting from "ignorance and deviation from God", and listed the spiritual diseases as: self-centeredness; addiction to wealth, fame and social status; and ignorance, cowardice, cruelty, lust, waswas (doubt), malevolence, calumny, envy, deception, and greed. To overcome these spiritual weaknesses, al-Ghazali suggested the therapy of opposites ("use of imagination in pursuing the opposite"), such as ignorance & learning, or hate & love. He described the personality as an "integration of spiritual and bodily forces" and believed that "closeness to God is equivalent to normality whereas distance from God

leads to abnormality."
Al-Ghazali argued that human beings occupy a position "midway between animals and angels and his distinguishing quality is knowledge." He argues that a human can either rise to "the level of the angels with the help of knowledge" or fall to "the levels of animals by letting his anger and lust dominate him." He also argued that Ilm al-Batin (esotericism) is fard (incumbent) and advised Tazkiya Nafs (self-purification). He also noted that "good conduct can only develop from within and does not need total destruction of natural propensities".

- **Ibn Sina**

In psychology and the neurosciences, Ibn Sina was a pioneer of neuropsychiatry. He first described numerous neuropsychiatric conditions, including hallucination, insomnia, mania, nightmare, melancholia, dementia, epilepsy, paralysis, stroke, vertigo and tremor.

Ibn Sina was also a pioneer in psychophysiology and psychosomatic medicine. He recognized 'physiological psychology' in the treatment of illnesses involving emotions, and developed a system for associating changes in the pulse rate with inner feelings, which is seen as an anticipation of the word association test attributed to Carl Jung.

Ibn Sina is reported to have treated a very ill patient by "feeling the patient's pulse and reciting aloud to him the names of provinces, districts, towns, streets, and people." He noticed how the patient's pulse increased when certain names were mentioned, from which Avicenna deduced that the patient was in love with a girl whose home Ibn Sina was "able to locate by the digital examination." Ibn Sina advised the patient to marry the girl he is in love with, and the patient soon recovered from his illness after his marriage.
Ibn Sina noted the close relationship between emotions and the physical condition and felt that music had a definite physical and psychological effect on patients. Of the many psychological disorders that he described in the Qanun(laws), one is of unusual interest: love sickness! Ibn Sina is reputed to have diagnosed this condition in a Prince in Jurjan who lay sick and whose malady had baffled local doctors. Ibn Sina noted a fluttering in the Prince's pulse when the address and name of his beloved were mentioned. The great doctor had a simple remedy: unite the sufferer with the beloved.

- **Al Kindi**

He was the first great Arab philosopher. As an Islamic psychologist, al-Kindi was a pioneer in experimental psychology. He was the first to use the method of experiment in psychology, which led to his discovery that sensation is proportionate to the stimulus. He was also the earliest to realize the therapeutic value of music and attempted to cure a quadriplegic boy using music therapy.

He also dealt with psychology in several other treatises: On Sleep and Dreams (a treatise on dream interpretation), First Philosophy, and Eradication of Sorrow. In the latter, he described sorrow as "a spiritual (Nafsani) grief caused by loss of loved ones or personal belongings, or by failure in obtaining what one lusts after" and then added: "If causes of pain are discernable, the cures can be found." He recommended that "if we do not tolerate losing or dislike being deprived of what is dear to us, then we should seek after riches in the world of the intellect. In it we should treasure our precious and cherished gains where they can never be dispossessed…for that which is owned by our senses could easily be taken away from us." He also stated that "sorrow is not within us we bring it upon ourselves." He

developed cognitive methods to combat depression and discussed the intellectual operations of human beings.

- **Al Farabi**

In psychology, Al-Farabi's Social Psychology and Model City were the first treatises to deal with social psychology. He stated that "an isolated individual could not achieve all the perfections by himself, without the aid of other individuals." He wrote that it is the "innate disposition of every man to join another human being or other men in the labor he ought to perform." He concluded that in order to "achieve what he can of that perfection, every man needs to stay in the neighborhood of others and associate with them.

His work on the Cause of Dreams, which appeared as chapter 24 of his Book of Opinions of the people of the Ideal City, was a treatise on dreams, in which he was the first to distinguish between dream interpretation and the nature and causes of dreams.

Al-Farabi wrote more than 80 books on different topics. According to him man is composed of two principles : Body and soul. His theory of human nature is dualistic. Body and soul have no essential connections with each other.

Psychological intervention of Prophet Muhammed (PBUH)

The prophet(PBUH) teaches us to express the peace with every person. He gave warning through his commands that ‘don’t keep silence with friends than three days’. Two people should use the expression of peace and security to address each other. Thus Islam taught Muslims to say ‘Peace be upon you’ and replaced all other forms of greeting.

In this small greeting is hidden an excellent and comprehensive prayer, kindness and affection for the young, and respect and attention for the elders.

Almighty employs the same greeting in the Glorious Qur’an to address His beloved Prophets as a mark of His favour and esteem on them.

The intervention of prophet Muhammed (PBUH) is very amazing and we achieve from it many psychological facts. The style of commands of him is reported by his companions as a different behavior. Once a companion came to him and ask permission to do sex with a woman. The prophet (PBUH) asked to him as reply: “ Are you ready to do sex with your mother or sister?”. The companion replied that: ‘No, I cannot think about it’. The Prophet said that: “The woman you are greedy to do sex with her, she is a mother and sister of another person”. The companion says after all ‘ since I heard it from Prophet, prostitute became more hateful activity in my mind’. This is only an example of prophetic psychology. This type of psychological practices are seen in the life of Prophet Muhammed (PBUH).

Prophet Muhammad(PBUH) was compassionate and gentle towards all people. He used to treat everyone in a good way and he always wished goodness for them. His noble manners are an example for us all. The God praised him saying (what

means): And verily, you (O Muhammad (PBUH)) are on an exalted standard of character. [Quran 68:4]

The Prophet(PBUH), was known of being very kind and affectionate towards children. He(PBUH) used to carry them, kiss them, and even weep when they died. He(PBUH) used to instruct his companions, may The God be pleased with them, to be kind to them, choose good names for them when they are born, and bring them up well. The children also used to love the Prophet (PBUH) to the extent that Zayd Ibn Haarithah preferred living with him than living with his parents.

Ever since the very beginning of the Islamic call, many children were bright and influential during the lifetime of the Prophet(PBUH). For example, 'Ali Ibn Abu Taalib, may Allaah be pleases with him, embraced Islam when he was only ten years old. Zayd Ibn Thaabit, may Allaah be pleased with him, was one of the scribes who used to write down the Quran while he was still young. Anas Ibn Malik, may The God be pleased with him, was the servant who was entrusted him with the secrets of the Prophet(PBUH), although he was just ten years old.

Many children later became caliphs, commanders and scholars thanks to the Prophet's(PBUH) constant encouragement, care for their talents, and guidance to the straight path. When The Prophet was prostrating infront of God his two grandsons start to play by sitting on his shoulder, then prophet (PBUH) prolonged his prostrate for their playing. These like, so many activities of Prophet (PBUH) are seen in his history.

Modern Psychology and Islamic Psychology

In some cases, researchers have hypothesized the possibility of Freud or Jung being influenced by the Qur'an or other religious texts (Abu-Raiya, 2014), attempting to lend further credibility to a western theory having little relation to Islamic thought. While this may not indicate a strong alignment with earlier iterations of psychotherapy, several authors have shown how Islamic beliefs are in fact in line with the theoretical underpinnings of more recent psychological models such as Cognitive Behavioral Therapy (CBT). CBT are generally consistent with their belief systems in most areas including personal and religious values (Naeem, Gobbi, Ayub, & Kingdon, 2009). Whereas CBT is more of a therapeutic modality and less of a paradigmatic framework, it offers considerable flexibility for practitioners to adapt to clients' own personal and religious values. In a similar vein, Beshai, Clark, and Dobson (2013) discussed concordance and dissonance between the philosophical underpinnings of CBT and Islam, and state that "the beliefs of some modern Islamic sects and more secular Muslims fit exceptionally well with the humanistic underpinnings of CBT" (p.205). This highlights the possibility that while more religiously oriented Muslims may in fact need or want more explicitly religious solutions to psychological issues, for a large population of the Muslim community, the approach of CBT is compatible with an Islamic orientation in general.

As with the Ancient Greek psychology, it is important to remember that the Muslim scholars did not have a specific term for psychology and did not identify themselves as psychologists. Islamic scholars did not practice the discipline in the modern sense of the word and wrapped it together with their standard, holistic approach to medical matters.

However, their work on studying the mind and proposing treatments for mental conditions is extremely important, and underpins many of our modern techniques, even if many of the theories are couched in philosophical and theological terms. Whilst many Islamic scholars contributed to the history of psychology, and the work of others lies forgotten in the depths of time, a few great minds deserve their place amongst the greatest modern psychologists.

CONCLUSION

All the religions leads the followers to the successful life and better mental health through their own spirituality. If we becoming ready to study that, we can know about it. Here, I described shortly about the spirituality of Islam and the positive energy gets from that spirituality. I understand that as I studied about Islam, Islam is the religion which hopes the successful life of man in all the walks of his life in both psychologically and physiologically. In Islamic perspective a spiritual life has not been set aside from mainstream of the society. Islamic spirituality is the suitable habits and practices in all walks of life.

PAST LIFE REGRESSION THERAPY

FOR HERE AND NOW HEALING

A clinical psycho-spiritual approach

Pilar Ocampo, PhD.

Founder and Director of the Gestalt Center Oaxaca, Oaxaca Mexico

Abstract

In this article the author shares her journey through via psychology and how she comes to encounter spirituality to enrich her work as a psychologist and psychotherapist.

She explains the impact of psycho-spiritual stress, the symptoms that manifest, the long term consequences of these, the difficulty in treating this type of stress with traditional psychotherapy and the need to explore other pathways to access ways to treat these patients.

She presents detailed schemes of psycho-spiritual work and it delves deep into past life regression therapy from an integral clinical viewpoint, as a resource for the healing of physical, emotional, and relational symptoms that affect the present functioning of the patient, which they have not been able to resolve with traditional psychotherapy.

She concludes with the importance of following up on discoveries obtained with this technique, with a psychotherapeutic focus, as well as with professional preparation and ethics by those that utilize this resource, so that it becomes truly beneficial to the patients.

Clinical psychology has been my passion for as long as I can remember; understanding why things are was another, but nothing has captivated me more than trying to understand the why and what for, of human suffering and this has led me to explore this subject through varies pathways.

I grew up in a catholic family that believed that things happened "by God's will", and that way of thinking worked for some time, until I began to notice the marked differences in the human journey; the tragedies that some lived compared to the peaceful existence of others, and then, that God seemed to me unjust and even tyrannical. Not being able to find justifiable answers that made any sense to me or that went beyond a tenet of faith, began to distance me more and more from the guilt driven religion imposed on me by the nuns from my elementary school. However, the need to believe in something bigger than me never truly extinguished and it was then that I began to practice mindful prayer instead of faith based prayer, and I began conversing instead of supplicating or asking for something with that *Been* that did not fit into rigid teachings, nor within the vision of fear that I had known until then and thus, the need was met for some time but was never fully satisfied.

Inserting myself in the world of clinical psychology, the theories of personality development and psychopathology, subsequently gave me answers to understanding the human mind and how some things occur and I became impassioned with delving deeper into it.

The study of Gestalt Therapy opened a great door to the healing possibilities of a profound human encounter and for 25 years I have been on this journey, on which I continue to be marveled by the impact that is made when one feels profoundly and truly accepted by another and I am grateful to be a witness of how this contributes permanently to the recovery of self-worth and the strength to take risks from via the expansion of consciousness and in doing so, promoting a position of higher responsibility towards life.

However, I have also been witness over and over again, to patients whose progress has been very limited, who move from one paradigm to another with periods of brief improvement and who continue to present affective reoccurrences, physical symptomatology and with relational schemes that shows certain modifications but lacking major permanence; as if they only make temporary adjustments to a preexisting life design in which the tools provided through psychotherapy only permeate to a certain point.

This type of patient tends to have been victim to much abuse from what I call unscrupulous "Merchants of wellbeing", who find in the desperate responses of these individual's a fertile ground for personal gain. I have been witness to individuals who have suffered fiduciary abuse, as well as psychological and physical abuse from "spiritual guides" or "healers" that offer paths or shortcuts to the search for spirituality and surprisingly fill their pockets with the money that comes from desperation, ignorance, and the need for spirituality that has been absent from the lives of these individuals.

This is an undeniable reality, the need to find answers for those things which we do not understand, to believe in something, and it is also proven that the absence of a belief system makes a person fragile and vulnerable and more prone to being easily manipulated.

In my search for answers to these observations, I came across the Pentagram that S. Ginger (1987) presents, which proposes that the bases of the human being is composed of a physical part and a spiritual part (Figure 1) and both areas provide strength or fragility on which the other areas, affective, social, and mental are built upon.

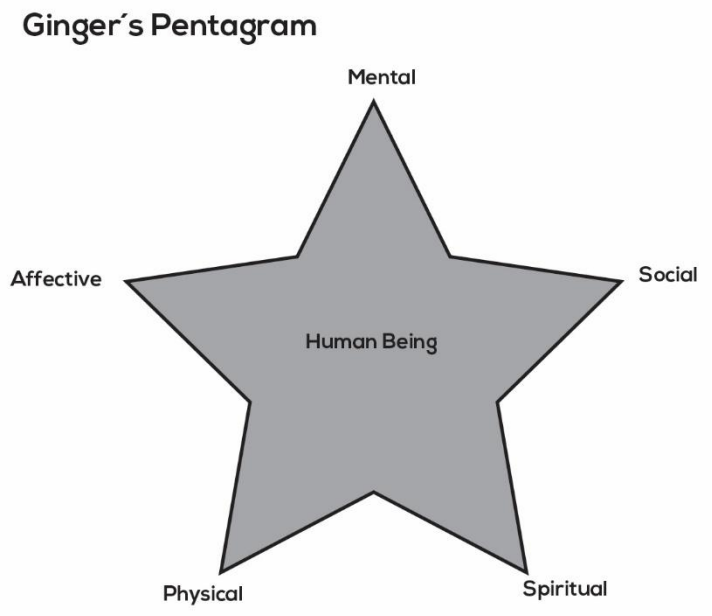

Fig. 1: Ginger's Pentagram

This proposal leads me to a profound refection; if this base makes an important impact on the structure of the human being, then it is important to amplify the consciousness in these areas to strengthen the relationship exists between the conscious and responsibility.

Based on my clinical experience as a psychotherapist, these observations lead me to propose 3 types of consciousness and two levels of responsibility (Figure 2) where we can work on in a very specific way.

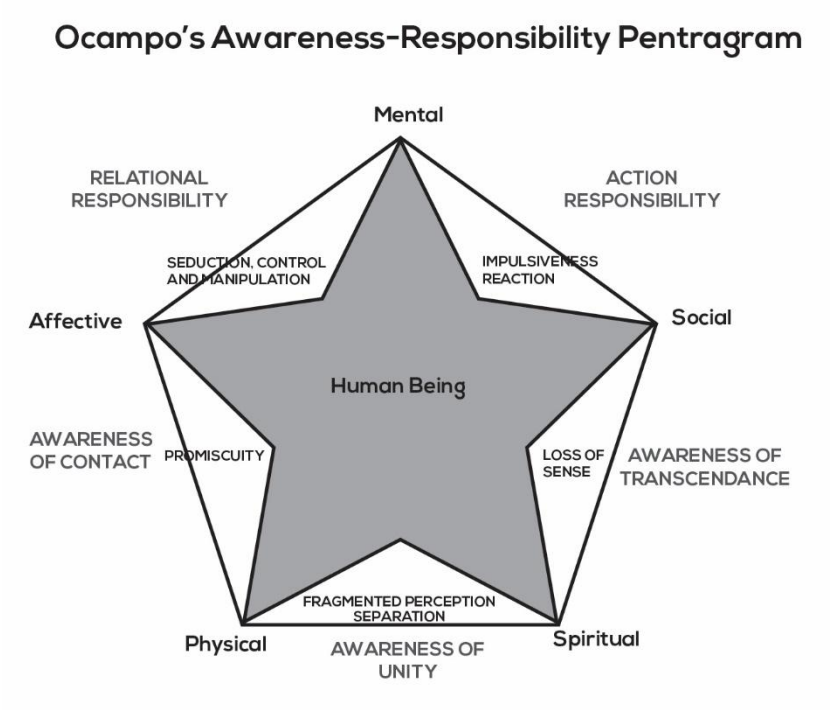

Fig.2: Ocampo's Awareness-Responsibility Pentagram

Said proposal was published in my book "Reencuentro con la esencia"; in this book I state that the bases of a permanent expansion of consciousness is the Consciousness of Unity and this can only be reached once we assume full contact with our bodies and with our spiritual part, making stronger these legs on which the pentagram is built. "Only from this can a bond be made to support existence… if we do not reestablish the bond with our spirituality, we may be able to modify the blueprints for behavior, however the resolution for an existential agenda will not come about." (Ocampo, 2013)

Based on observations and analysis of long term cases, I have been able to conclude that the major barrier to a full and permanent change for a human being comes from lack of contact with its spiritual part; by this I mean a contact with a spirituality that has a personal sense, that provides answers to profound existential questions and that redirects this person's existence on this earth after feeling a sense of being lost.

This need is not present with the same urgency in all individuals and some do manage to obtain a real, profound and permanent resolution to existential situations via psychotherapy or the practice of some discipline. In this article I am only referring to those individuals who for some reason, after searching in many places, continue being unable to remain in a harmonious existence.

The term Psycho-spiritual Stress is a term that has been taking on strength and presence in the clinical world; from the Mayo Clinic[1] to the UIA[2] have included this as part of the areas to work on the human being.

One of the definitions of Psycho-spiritual Stress given by Dr. Joel Friedman (2013) is: "A crisis of values, meaning and purpose; effort without pleasure, in regard to a job that is productive, satisfying, with meaning and which motivates; a misalignment with central personal values."

This vision caught my attention because the last sentence in the definition gave more sense to my observations. As long as a person has a base of spiritual beliefs, whatever they may be, function as support; it is precisely at that moment that these beliefs misalign for some reason, that psycho-spiritual stress emerges and with it the conscious or unconscious search for answers; which can range from participation in various disciplines, to generating of symptoms that cannot be resolved through any other means, as in the case of the individuals I described earlier in this article.

We would be then, referring to the individuals that are victims of psycho-spiritual stress, on occasions chronic with temporary periods of remission, who have sought palliative treatment but not in a profound manner; as long as they do not treat the true origin of their stress, there will be no resolution that moves them towards eliminating the long-term suffering, whatever the area in which it is being felt.

What is psycho-spiritual stress?

We could define psycho-spiritual stress as the tension resulting from the disconnection of schemes from the fundamental beliefs that give answers to all inevitable situations in life and that cease to be useful in as much to explain or in giving a reason to nurture a strength that is necessary to manage the inevitability of daily life.

This disconnection may be temporary or indefinite and could be resolved or could develop into physical, psychological, and /or relational symptoms that could remiss temporarily but will reoccur at some point in the life of the person.

From another point of view, psycho-spiritual stress may surge due to a need to redesign the spiritual paradigms that give answers to the inevitable; in other words, a need to find answers to new questions that arise at any given moment in our life journey. The need can surge at any time in our existence and can be treated temporarily or permanently. It is thanks to this need that is present in human being, that has given way for science to move closer to spirituality to find that they are not separate entities but rather part of the same reality.

There exist countless proposals that give way to understanding, and after reviewing many of these in depth; as humanist psychotherapist, I believe in the importance of individuality and individuating, and consider that there is no road more transforming than that which a human

[1] Mayoclinic.org
[2] Uia.org

being walks with his own feet and in which he finds the answers that his deepest being is searching for.

The relationships that exist between the mind and the soul, and its impact on mental health is a topic that Barret (2016) deepens with his proposal of the seven levels of consciousness and the 3 states of evolution of the souls (Fig.3)

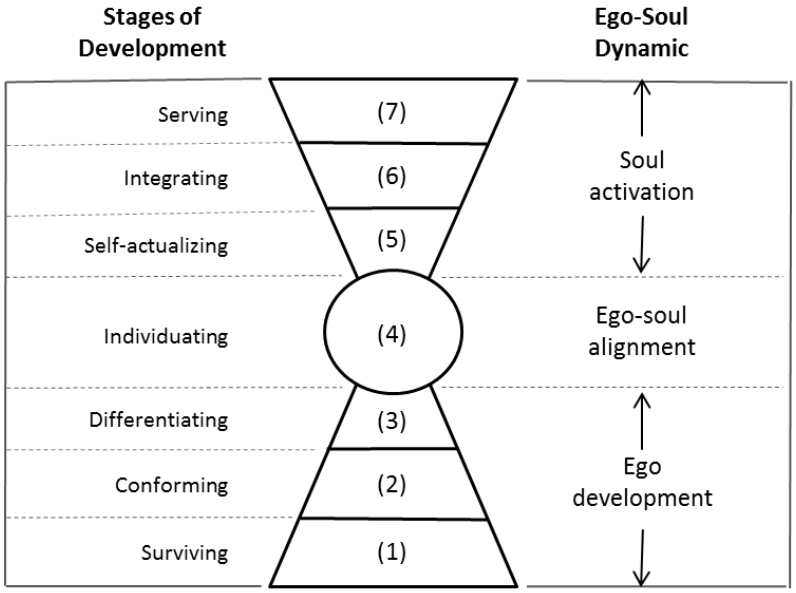

Fig. 3: The Seven Stages of Psychological Development and three evolutionary stages of the ego-soul dynamic. (Barret, 2016)

In this scheme the activation of the soul that Barret proposes, comes after the alignment of the Ego and the Soul during the individuation process.

This called my attention in a powerful way because this leads us to believe that self-actualization, which is a process clearly described by Maslow, would only be possible after this alignment has a place and it is precisely then that the proposal of Past Life Regression Therapy comes into play (PLRT).

The principal promoter of this technique in the West is Dr. Brian Weiss, North American doctor of psychiatry who has dedicated the last 30 years of his life to the investigation of this phenomenon and its impact on physical, emotional, and relational health of patients. “Understanding takes us to freedom, to joy, to a personal relationship, to maintain better relations; to happiness” (Weiss, 2016)

Past Life Regression Therapy is a technique which is accessed with clinical hypnosis, it intends for the patient to return to the moment where the symptoms first originated; the healing effect is attained once the amplification of the consciousness is obtained and the person understands the lesson implied for the symptom; since it is considered that these are ways the human being has, to amplify consciousness in order to progress towards spiritual development.

Therefore, regression has an important impact on the psyche of the individual when it takes place and the person encounters material related to their moment in life; in my clinical experience, what gives way to the evolution, is not only finding material and information, but also the application and management of this data in the Here and Now, which is after all where the patient is existing.

As a clinical psychologist and psychotherapist, my goal is not to discover who the person was but rather how can they benefit in the present, not only physically but also relational, from this information. And it is there where psychotherapy and Past Life Regression Therapy cross paths and take on meaning for me, giving origin to what I call *The Spiritual Practice in the Here and Now*.

The Spiritual Practice in the Here and Now

To discover who we were, and to make a regression to a past life to discover that my mother was my sister or my worst enemy, does not provide anything other than the risk of justifying dysfunctional emotions and reactions when facing a situation or person; this type of work is advantageous, if it is managed as a healing tool and if what is sought is to encompass healing for the patient as a whole, it must be accompanied with a psychotherapy process that also works in the psyche's present existence.

Past Life Regression Therapy provides information that allows the person to understand, through a broader vision their existence in the universe; also helps to understand the stories to which they are conformed and how they manifest in their present life, seeking to promote an understanding that has not been obtained in previous lives in order to resolve existential issues and move along their spiritual grown and development.

Psychotherapy works directly on the psyche of the individual, which in the end, even if it is a summary of different stories and previous lives, lives in the present, and it is only here and now that the necessary adjustments can be made so their existence can be fulfilling and their relationships nurturing.

In my experience, a psychotherapist lacking of a psycho-spiritual vision has a serious barrier to delving into the amplification of the consciousness of his/her patients, since it is only within the sphere of spirituality where a human being finds a true sense of transcendence and the motivation necessary to develop the virtues that Seligman pointed out in the development of Positive Psychology.

If what we want are human beings with higher consciousness and a more universal responsibility that goes beyond the ego, we must turn to the exploration of the spirituality as a fundamental part of the human structure.

Psychologist and psychotherapists, require more tools that promote the breaking off of narcissistic paradigms that serve only to promote isolation and egoism, loneliness and illness in their different manifestations.

Advantages of Past Life Regression Therapy

Past Life Regression Therapy promotes a series of advantages that impact the psycho-spiritual development in the following manner:

1. Holistic vision. Everything forms part of the whole. Separation is an illusion because we are all connected to one source.
2. It substitutes the paradigm of punishment for that of learning.
3. An evolutionary vision. A process of constant spiritual evolution.
4. Existential purpose: Individual, relational and universal.
5. The soul's immortality.
6. Eliminates the concept of bad or good.
7. Introduces the concept of free will and events of destiny, which promotes a position of existential responsibility empowering selectivity, temperance and resignation.

However, there are risks in Past Life Regression Therapy when practiced by persons who have no clinical or psychotherapeutic experience, who work more in favor of curiosity than healing, and they do not work to give new significance to current relationships, the risks are minimal compared with the benefits.

Conclusion

How has it been possible to analyze throughout this article, Past Life Regression Therapy is a very useful tool to promote the alignment of the current existence with that of immortal spiritual existence, promoting in this manner an amplification of universal consciousness and providing the basis from which it is possible to construct a full, nurturing, and responsible life; fundamentally centered on the Here and Now.

The past should be remembered to understand the present, and then released so that the Here and Now can be lived fully; being that it is only in this existence where the priority missions can be found for the most significant learning that the soul requires for its evolution.

Past Life Regression Therapy, without a psychotherapeutic process, it is a mere hypnotic strategy, however, if guided by a capable clinical professional, it can be the most powerful tool for the existential assigning of new significance of this and future lives of the person and with those with whom they share their existence.

In summary, psychotherapy accompanies the mind in search for answers of its conflicts in its life story; Past Life Regression Therapy accompanies the soul on seeking answers throughout its eternal story.

Pilar Ocampo is founder and director, since 1993, of the Centro Gestalt Oaxaca, a postgraduate psychotherapy training institute, the only one in Mexico training exclusively psychologists as gestaltherapists. She holds a Ph.D. in psychotherapy, another one in education, a Doctor Honoris Causa and has been recognized with the Sapientiae Award for Educative Excellence in 2014 and in 2017 as Gestalt Figure of Mexico for the Mexican Association of Gestalt Therapy. As an international trainer, she leads workshops in many countries and as an author she has published seven books, the most recent *Haz-Siendo Gestalt* (Being-Doing Gestalt) which describes the schemes that she has being developing and using as a trainer for the past 20 years.

Address for correspondence: pilar_ocampo@yahoo.com

Website: www.pilarocampoonline.com

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Post Abandonment Psychological Adaptation among Elderly in North India

Aditi Gupta, Junior Research Fellow,

Defence Institute of Psychological Research, DRDO, India

Abstract

Traditional Family System in India presupposes that elderly parents live with children throughout life. The trend has changed in last decade as more old age care shelters and retirement homes have mushroomed in urban dwellings. While much research focuses on the negative consequences of challenges in old age, the present study investigates psychological adaptability of abandoned elderly in old age homes of Delhi-NCR. The administration of Post Traumatic Growth Inventory, Connor-Davidson Resilience Inventory and Semi Structured Interviews with 50 elderly has demonstrated remarkable psychological adaptation among older adults. It is also observed that 72% residents reported that they would not return to their homes if given choice, but 100% residents do not wish that anyone in their family be sent to institution for elderly care. The demographics and causes of living at Old age home are examined along with reason for this discrepancy and late adulthood concerns. The analysis was done using frequency table and percentage statistics for quantitative data and narrative analysis of five factors of PTGI for qualitative data.

Keywords: Abandoned elderly, Psychological adaptation, Posttraumatic growth, Resilience, Old age.

Indian Elderly: Then and Now

One of the major concerns of the demographic transitions throughout the world is the ageing population. According to Population Census 2011 there are nearly 104 million elderly persons (aged 60 years or above) in India. The projections for population over 60 years in next four censuses are: 133.32 million (2021), 178.59 million (2031), 236.01 million (2041) and 300.96 million (2051).

Providing care for the aged has never been a problem in India where a value based joint family system was dominant. This family structure has been the socio-economic backbone of the average Indian (Shah, 1998) and one of the most important institutions. India is still characterized by its traditional ways of living where several generations live jointly within the same household. The families share responsibility of looking after elderly and providing them emotional, psychological, medical and financial support. Elderlies have always been revered and lived with families till the end of their lives. Their advices have been received with respect and their council on matters of daily life and social world considered important.

However, present day India is starkly different in that regard. Globalization, coupled with materialistic attitude and transformation in social, economic and demographic factors have resulted to increase in the neglect of the elderly. It is apparent from the deterioration in relationships of elderly with next generation or with their children, relatives and other members of the community. With the increasing influence of modernization and new life styles resulting in transitional change in value system in recent times, the 'joint family' is breaking down into several scattered nuclear families (Shah, 1998). Change in family structure and contemporary changes in the psycho-social matrix and values often compel the elderly to live alone or to shift from their own homes to some institutions or old age homes (Dotty,1992; Hedge et al., 2012; Kumar et al,2012; Mishra,2008 & Mudey et al., 2011).

The trend is evident as more old age care shelters and retirement homes have mushroomed in last few decades. Indian society is no longer Parent-oriented. In such a scenario, elderly care is no longer how it used to be, and various notions that were taken for granted in their regard, like their medical and emotional needs as being responsibility of family are no longer as true as they used to be. Conventionally in India, old age was viewed as twilight years, that had challenges and advantages of its own. A person often retires from his professional responsibilities and there is sometimes psychological void that needs filling as one arena of social engagement is cut back, they find themselves in new roles like grand-parenting where the new generation grows up by learning virtues and family tradition from the old ones. They also learn to accept decline in physical strength , mental stamina and financial status. Old age is often earmarked for spiritual endeavours, where they delve into queries of life meaning, death and afterlife concerns. They oftentimes also have to face trauma and grieve the loss of their loved one due to old age and death, which brings them more close to realization of their own mortality. These are a few developmental challenges that are a given for Indian elderly. However, through it all, the psychological scaffold of family and spiritual base characterized by any religious inclination helps to navigate challenges of late adulthood and old age.

Conceptualization of Abandonment as a trauma

Abandonment is defined as deserting a dependent person with the intent to leave them unattended at a place for such a time period as may be likely to endanger their health and welfare. The advanced years undoubtedly require more financial and emotional expenditure. Abandonment becomes more complex as elderly in India are mostly dependent on their off-springs for increased support in both aspects. Rarely are they psychologically prepared for negligence to the extent that they are forced out of their homes to live away from family. Cumming and Henry (1961) theorized in Disengagement theory about natural and normal withdrawl from social roles and activities and an increasing preoccupation with self with counterpart offered by Havinghurst's Activity theory (1948) wherein elderly can substitute new roles for those lost in old age. The issue of abandonment throws normal trajectory into turmoil as both identity as parent and possible bonds with progeny are lost to the person. Thus disengagement from social roles is not compensated by conventional Indian elderly roles like grand-parenting and decision maker. Their helplessness and vulnerability at this stage is not only deeply saddening, it is traumatic. Calhoun and Tedeschi (2006) argue that an event can be considered truly traumatic if it disrupts the personal narrative. If a person refers to a negative event as a watershed that divides a life into "before and after" the event, it has been truly traumatic. Abandonment often comes with intense cognitive demand to adjust to new environment along with bewilderment at being bereft from family support system. The aftermath of abandonment often cleaves the life narratives into 'one when they stayed with family' and 'the life after that'.

Resilience and Post Abandonment Growth

A lot of literature is invested on the negative outcomes of elderly living in OAH and shelter houses (Ashish, 2016; Kumar, Das & Rautela, 2012; Bagga,2002) has casted light on late life depression (Pilania et al. 2013) and low quality of life (Gupta, Mohan, Tiwari, Singh & Singh, 2014). Unfortunately, researches aimed to explore deficits may sometimes reinforce stereotypes of overall decline and passivity. But, human neuroplasticity is not limited to early childhood. Understanding that this adaptability extends well into adulthood have lead researchers to expand their studies of resilience beyond the early years. Gerontological findings substantiates that despite unfortunate circumstances and situations, elderly population has just as much potency for resilience and growth as any other section of the demographics. Tornstam's (1989) theorization of Gerotranscendence focuses that the very process of living into old age encompasses shift in meta-perspective from a materialistic and rational vision to a more cosmic and transcendent one, normally followed by an increase in life satisfaction, despite nature of adversities faced. In a research on abandoned Filipino elderly respondents, a four-part process emerged describing R.O.P.E. to Cope theory of Abandonment which describes the progression from the resisting, occupying, pondering and embracing phases towards successful coping. (de Guzman, Lacsamana, Lagac, Laguador, Lapid & Lee, 2012).

Given the likelihood that they have experienced multiple stressful events, Lerner and Gignac (1992) point out that old age does not necessarily bring about depression, and that even the aged who cope well are not distorting or denying the painful realities of their lives. They imply that wisdom of the aged is 'growth' that has gone beyond successful coping with losses and pain. Instead, life experience, including the painful aspects, has been used among certain elderly to create an identity that brings contentment in later life through 're-centering' process of self-discovery and affirmation. Understanding how the elderly view their own lived experiences and identifying the factors that help them cope and grow can be helpful in assisting elderly in their path to achieving an improved life and a happier perspective on it despite abandonment by family.

Method

Sampling

Purposive Sampling was employed to collect data from 50 individuals (N=50; Male = 12 and Female = 38) and study design employed was Cross Sectional Exploratory Study in Old age homes in Delhi and Faridabad, urban districts in North India

Assessment Tool

Semi-structured Interview Performa was read out to solicit demographics, reasons for living in OAH, present life concerns and enquiries regarding them shifting back home if given a choice.

Post Traumatic Growth Inventory (PTGI) (Calhoun and Tedeschi,1999), a psychological instrument having 21 items to access the degree to which change occurs in life as a result of crises. The Five factors of PTGI are Factor 1 (Relating to Others), Factor 2 (New Possibilities), Factor 3 (Personal Strengths), Factor 4 (Spiritual Change) and Factor 5 (Appreciation of Life). The basic premise was that unconsented relocation in Old Age home is a traumatic event.

Connor –Davidson Resilience Scale (CD-RISK) (Connor and Davidson, 2003), a psychological instrument having 25 items to assess resilience , operationalized as "ability to thrive in the face of adversity".

Inclusion Criteria: (a)elderly aged 58 (for females) and 60 (for males) and above residing in Old age homes for at least 1 year (b) relocation was unconsented (c) give verbal consent to record the interview (d) able to understand, comprehend and reply to questions

Exclusion Criteria: (a) physical problem interfering with interview like hearing impairment

(b) did not consent to record the interview

Procedure

The consent was taken from 3 OAH authorities to interview the inmates. A total of 52 residents were approached but 2 were excluded as per inclusion/exclusion criteria. After initial rapport building and seeking verbal consent, items of Connor-Davidson Resilience scale was read out and explained in Hindi to which responses were marked by the researcher. Thereafter, a brief interview was taken from which answers to interview performa were elicited. Finally, administration of Post traumatic growth inventory was done in similar manner as previous scale. Many times, the items had to be repeated again to ensure they were heard clearly and understood before responses were taken. On average, time spent with each participant was about 1.5 hour to 2 hours.

Data Analysis

The socio-demographics, inventory and scale scores, reasons for staying away from the family and issues of their concern were tabulated on the basis of frequency and percentage. The data from transcribed interview was analysed to detect recurring patterns across narratives. Pearson correlation for each factor of PTGI with resilience scale and demographics to explore if significant correlation emerged using SPSS.

Results

Table 1

Socio-demographic profile including Gender, Age, Marital Status, Number of children, Duration of stay, modes of financial assistance and number of personal visits they had in last one year.

Socio-demographic variables		**Gender**		Total (N=50) 100%
		Male (N= 12) 24%	Female (N=38) 76%	
Age	58- 68	5	22	27
	68-80	4	12	16
	80 and above	3	4	7
Marital status	Spouse Living	6	9	15
	Spouse Dead	6	29	35
No. of Children	Nil	1	4	5
	1-3	8	19	27
	More than 3	3	15	18
Duration of Stay	Up to 2 years	2	1	3
	2-5 years	0	17	17
	6-10 years	5	11	16
	More than 10 years	5	9	14
Financial Assistance	Family	2	8	10
	Pension or Life saving	4	8	12
	Self	2	3	5
	Nil	4	19	23
Personal Visits	Nil	6	19	25
	1-12	2	14	16
	More than 12	4	5	9

The inspection of above table indicates that mean age of the sample was 69.09 years. Socio-demographic details showed that most of OAH s residents were female (76%) and widows (76.3%)aged between 59 to 69 (57.89%). 46% of the inmates had no financial assistance and 50 % had not been visited by family even once.

Table 2

Frequency table for reasons of staying away from family

S. No.	Reason	Frequency
1	Children working away and do not wish to relocate parents	7
2	Misbehavior by son and daughter-in-law	16
3	Poverty/ No financial support /No home	13
4	Children do not wish to keep due to physical illness or psychiatric issues	9
5	Fighting among other family members (mainly on money matters)	3
6	Other	2

Table 2 provides frequency table for reasons of staying away from family .Among the factors that compelled the OAHs residents for residing in old age homes, the most common reason was Misbehaviour by son and daughter in law (32%). This ranged from forcing to do household chores to beating and life threats. The second most common reason for relocation was Poverty (26%), wherein, due to dire financial situation, family members opted to send elderly to OAH to relieve themselves of some economic strain.

Table 3

Frequency table of issues of their concern as told by elderly

S. No.	Issues of concern	Frequency
1	Afterlife concerns (What will happen to soul after death, how family will grieve their death)	13
2	Nature of Death (When and how death will take place, if it will be painful, who will be around when death takes place and what will be done with the body)	18
3	Deteriorating health and associated problems	17
4	Financial constraints	5
5	Family Troubles	4
6	Depression, Loneliness and Insecurity	16
7	Missing out on Grandchildren	8

Investigation of the above table casts light on the issues that bothered them or musings they mostly engaged in. The most common among these were nature of death, that delved into when and how death will take place, if it will be painful, who will be around when death takes place and what will be done with the body . It may be noted that the concerns regarding death and afterlife did not lead to anxiety or unrest in most elderly. Mostly, they were dispassionate third person accounts. Distress mainly revolved around Deteriorating health and depression. It was observed that feelings of depression often co-existed with extreme loneliness, general worthlessness and insecurities.

Table 4

Consolidated score on PTGI with Pearson correlation with CD-RISK and selected demographics

PTGI Scale	**Resilience Scale**	**Percentage Obtained Score/ Maximum score**	**Demographic Profile**		
			Duration of stay	**No. of personal visits**	**No. of children**
Factor 1	0.325*	78.11%	0.204	0.428**	0.244
Factor 2	0.492**	71.12%	0.177	0.539**	-0.064
Factor 3	0.233	83.9%	0.199	0.508**	0.024
Factor 4	0.416**	89.6%	0.308*	0.341*	0.314
Factor 5	0.551**	64.8%	0.175	0.477**	0.009
Total PTGI scale	0.585**	76.74%	0.292*	0.671**	0.160

*- Correlation is significant at 0.05 level, **- Correlation is significant at 0.01 level

Inspection of the above table reveals that each factor, except Personal strength (Factor 3) of PTGI is significantly correlated with CD-RISK. Significant correlations between Total PTGI score and CD-RISK imply that higher resilience is related to higher post-traumatic growth. Furthermore, duration of stay is positively correlated with Factor 4 (Spiritual change) and total PTGI score significantly. Number of personal visits has significant positive correlations with all factors as well as total PTGI score. No correlation between number of children and any of the factors is important in light of traditional belief of "more the children, better the old age" owing to which, people often have more children in hope of having better support system in old age. The PTGI results substantiated with narratives portray an emergence of coping model similar, yet not identical to R.O.P.E. to cope model (de Guzman et al., 2012) beginning from resisting and progressing through passive tolerance, accepting novel environment through active engagement, to ultimately growth among the abandoned elderly.

Discussion

Conventionally, living in old age home is perceived negatively by Indian society, both for inhabitant and the family. A resident is seen as pitiable for having been abandoned or reproach for failing in dutiful parenting and thus being sent away whereas the family is seen with blame for not catering to old members' need in their most vulnerable years. Many inmates found refuge in OAH after enduring years of neglect or abuse. Participant Bholi Sakhi, a 70 year old widow sustained years of beating by her son and daughter-in-law before being left in the OAH when due to deteriorating health, she could no longer do household chores. Sat Paul was found on a train station platform, disoriented and soiled. He retired as a Principal of Government school. His son, despite several correspondences refuses to take him back after the father transferred property to his son. Sitara Devi was left in the middle of the road as her son and daughter-in-law drove away leaving her stranded in a new town where they took her for temple visit. All the participants in the study had life incidents that caused extreme psychological distress and endured chronic stress. The narratives of life divided between "before and after" (Calhoun and Tedeschi, 2006) being left by family were salient in almost all the participants, irrespective of duration of stay. Nonetheless, the "after" phase of life indicated resilient processes and post traumatic growth. This can be expanded to assert that the societal view that regards geriatrics as a period of decline may not be congruent to the views of elderly people themselves and how they live. On the contrary, studies find that older adults are capable of high resilience despite socio-economic background, personal experience and declining health (Macleod, Musich, Hawkins, Alsgaard & Wicker, 2016). Not only do they have potential to "adapt well in the face of adversity, trauma, tragedy, threats or significant sources of stress" or "bounce back" from difficult experience, their struggle with adversity can result in genuine and meaningful changes to the individual identity and outlook on life (Tedeschi and Calhoun,2004). The participants' narratives were analysed in view of the five domains outlined in the inventory.

Factor I, Relating to Others, mainly dealt with perceptions about how connected they felt to other people in their life and surrounding. The factor has great implication in determining social support system and intimacy with co-inhabitants. The significant correlation with resilience scale ($r=0.325, p<0.01$) consolidated score percentage demonstrated high percentage of 78.11% which is substantiated by narrative as well. The usual trajectory of residents was solitude to deal with new environment that ranged to as long as 3 to 6 months, followed by bonding initially with same gendered people with greater proximity (room-mates) to about 6-7 members by the end of first year. Death of close mate in OAH would be very psychologically distressing and collective bereavement was reported to strengthen bonding. Generally, it was observed that scores in Factor I were significantly higher for inmates who had more personal visits in last one year ($r=0.428, p< 0.05$ *level)*. Participants reported that common dining room, living room for formal interaction between inmates, support at the time of health crises and collective grieving when a resident dies creates a bond of trust and affection, that makes them comfortable to rely on others and resolve to be of assistance to them at the time of need.

The Factor II, New Possibilities, delved into unexplored opportunities that came up as a result of their new situation. The factor had significant correlation with Resilience ($r=0.492, p< 0.01$) and percentage of 71.12% corroborating elderly reporting development of new interests like knitting and weaving, which contributed in financial gains also. Some had started working by teaching children from locality, distributing medicine in nearby dispensary, or being members of welfare society. In a research by Hrostowskis and Rehner (2012), older adult survivors of Hurricane Katrina described developing a new interest in life through their novel experiences that contributed in resilience. The interests of residents in present study, however, were confined to restricted premises as they usually did not prefer to delve outside of OAH campus. Nonetheless, they looked forward to school students' visit or devotional activities like hymn singing (bhajan mandli) within the premises.

Factor III, Personal Strengths, encompassed feelings of self-reliance, confidence to handle things, self-assurance and robustness. Participants exhibited high percentage of 83.9% on this factor but the correlation with resilience scale did not emerge out to be significant. The interview data reflected change in perception of self from being a 'victim' of trauma to being a 'survivor' of trauma. Verbatim like " *uss gam se ubhar gaye, ab koi aur dukh se dar nahi lagta"* [(I) overcame that sorrow, now any other sorrow does not scare me] reflects a sense of self reliance akin to "If I can survive this, I can handle anything" (Aldwin, Levenson & Spiro,1994). The interviews reflect that females demonstrated high self-reliance and personal growth than males, who tended to be more bitter. It may be due to patriarchal notion in India, where male abandonment and subsequent refuge in OAH was seen as greater failure, and thus, more damaging of self-assurance than for females. However, low correlation with resilience may be due to dissonance between perception regarding personal strengths and opportunities to behave in similar manner. Limited choices, physical and financial constraints, and strict schedules to adhere sometimes leave no avenue to test personal competence area in action arena.

Factor IV, Spiritual Change was significantly correlated with resilience scale ($r= 0.416, p<0.01$).Typically, there is more religious inclination during old age, and thus indicative of high score. Many elderly reported that the spiritual change they underwent living away from family could not have been possible if they were still living with children, as physical isolation from children facilitated in closeness with their 'God'. Also, they found respite from intentional trauma inflicted by loved ones by strengthening their spiritual base. Regular spiritual discourses and hymn singing (bhajan mandli) practices provided platform for religious activities and engage in spiritual dialogue. A general rumination with God in context of afterlife was seen mostly in elderly females, with strong belief that greater engrossment in religious thoughts would result in better afterlife and attain *moksha.* (salvation). In a similar research on community dwelling older women of San Diego, spirituality was significantly associated with higher resilience, lower income, lower education and lower likelihood of being married or in committed relationship (Vahia, Depp, Palmer, Fellows, Golshan, Thompson, Allison & Jetse,2011). The demographics share much similarity with participants of present study, which point to the poignant role of spirituality in promoting resilience possibly to greater degree in persons with lower income and educational level.

The narratives around Factor V, Appreciation of Life were mostly ambiguous, reflected in comparatively low percentage of 64.8%, despite significant correlation with Resilience scale ($r= 0.551, p<0.01$) The factor aims at exploring prioritization and value setting of life. Many participants confided that the abandonment still eclipsed much happiness in life, where absence of family was more prominent than being alive. The theme of death and afterlife often dominated the interviews, where life was seen as a milestone to cross to reach the next existential stage.

A consolidated percentage of total PTGI scale was 76.74% and significantly correlated with the Resilience scale ($r=0.585^{**}, p<0.01$). A general temporal shift was observed from disengagement in initial period of stay to eventual gerotranscendence implied by 'redefinition of reality'. When asked if they would go back to families if given a choice, 72% residents responded in negation. Upon further elaboration, the underlying motivations were not out of negative affect like bitterness or fear. Residents reported having 'forged' new families and a life they wish to choose over the previous one. The narratives aligned with Schroots (1995a, 1995b) dynamic system of ageing, gerodynamincs. He postulated that far-from-equilibrium systems can pass a critical point- the transformation point – and create order out of disorder through a process of self-organization and applied the metatheoretical viewpoint on ageing of living systems who can show a progressive trend towards order despite nonlinear series of transformation. It is further aided by response to question of wishing their family members living in OAH, to which 100% responded in negative. The explanation that irrespective of how they coped from abandonment, inclination to see the family undergo same event was appalling to all, stands testimony to parental affection as well as a gerodynamic system in elderly which progresses from disorder in the wake of abandonment towards order demonstrated by positive virtues

like forgiveness and post traumatic growth. The narratives also demonstrated the shift from hurt and anguish in the wake of separation to more transcendental discernments, for which, resolution with the 'traumatizing agent', be it children or extended family, was seen indispensable. Current life situation was accepted as part of one's destiny (*kismet*) rather than fault on part of children or failure on part of the society.

Conclusion

Recent demographic trends, lifestyles and work patterns may be contributing to a situation where Indian elderly find themselves isolated after a lifetime in a culture that stresses the value of extended family and family support. In a collectivistic culture like India, that boasts to respect and honor our elders, the problem of abandoned elderly in OAH is very real social problem. The perception of abandoned elderly being problematic continues to drive policy and practice. (Noosorn & Kanokthets,2015) However, understanding that adaptability extends well into adulthood is necessary to formulate well informed interventions. Elderly, despite the traumatic experiences are engaging in reconstruction of personal and social schemas that would equip them psychologically to cope, accept and ultimately grow to live a rewarding life. The present study demonstrated that resilience and post traumatic growth takes place in later years as well.

The limitations must also be acknowledged. The study involved only those elderly who could communicate and did not suffer from any physiological condition that restricted effective interaction. In conclusion, increased attention to provide personal engagement opportunities and promoting health can be focus for elderly policies on the basis of research findings. Appropriate intervention strategies, based on older people social context and lifestyle, and emphasis of spiritual beliefs should be considered while policy planning.

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SOCIAL SUPPORT, PHYSICAL HEALTH STATUS, AND PERSONALITY OF SENIOR CITIZENS IN ILIGAN CITY: BASIS FOR INTERVENTION PROGRAM

Jucelyn T. Arizo, MAEd
Julius A. Felicidario, PH.D, RGC
Saint Michael's College
Quezon Avenue, Iligan City
Philippines

Abstract

This study aimed to determine the social support, physical health status, and personality among the three hundred eighty four (384) senior citizens in Iligan City. It specifically set sight in determining the difference between the social support, physical health status and personality of the respondents. Descriptive-correlation research design was employed utilizing a standardized questionnaire on social support comprising various scales on appraisal, tangible, self-esteem and belonging. Physical health status was also determined using the common old age identified illnesses coming from habit-forming drugs or substance, treatment for addiction, and medical consultation or treatment during past two years. Personality on the other hand is examined in terms of their high tendency to possess intrapersonal, interpersonal, stress management, adaptability, general mode, and positive impression traits. Results were then analyzed using, frequency and percentage distribution, Mean and Standard Deviation, T-test and one way ANOVA or F-test. Findings revealed that there is a significant difference between the respondents' social support, physical health status, and personality level when grouped according to their profile. Accordingly, findings also exhibited result that implicates significant relationship between respondents' social support when analyzed according to their personality, social support with their physical health status, as well as their personality in relation to their physical health status. Thus, familial and societal traditional support deemed importance to live a quality of life.

Keywords: senior citizen, social support, personality, physical health status

Introduction

The cultures of respect for elderly in the Philippines has always been observed of Filipino societies and laid a high regard on conserving the dignity of our older person and put them in a dignified place in society. The elderly were the source of wisdom, customs and traditions. Thus, their contributions in the enhancement of economic development, policies in government, family and values, refinement in education, and preservation of religion cannot be disregarded (Carlos, 2009).

In view of the characteristic of modern world, the family culture of taking care of the elderly has dramatically changing. The accumulated knowledge of the elderly is rarely viewed as the source of wisdom – it is commonly regarded as something archaic and obsolete. Many elderly people who suffered from age-related illnesses, which are indigent and lack of family and social support systems which is needed in the twilight of their lives. They are one of the most neglected members of society (Philstar, 2016).

Moreover, the traditional patriarchal familial relationships have been gradually disappearing, the elderly have lost the halo of wisdom and their social prestige has been degraded. Family is very important for the elderly, since it represents a natural framework of life and death. However, for an old person's quality of life it is especially important and well integrated, accepted, surrounded by love and respect and not rejected (Pesic, 2007).

It has been observed that many older adults lose their ability to live independently because of limited mobility, chronic pain, frailty or lack of social support and physical problems that require some form of long-term care. In addition, older people are more likely to experience events such as bereavement, a drop in socioeconomic status with retirement, or a disability. All of these factors can result in isolation, loss of independence, loneliness and depression (WHO, 2016).

Indeed, a propose to aging, Erikson (1963) that an individual grow older (65+ yrs.) and become senior citizens, one tend to slow down in productivity and explore life as a retired person. It is during this time that one contemplates the accomplishments and can develop integrity in oneself as leading to a successful life. Erik Erikson believed if a person see one's life as unproductive, feel guilt about the past, or feel that one did not accomplish the life goals, the person become dissatisfied with life and develop despair, often leading to depression and hopelessness. Success in this stage will lead to the virtue of wisdom. Wisdom enables a person to look back on their life with a sense of closure and completeness. (McLeod, 2013).

In view of the above, the researcher felt the need to conduct this study to help the senior citizens of Iligan City in sustaining and regaining their productivity, self-worth and attain ego integrity. The researcher deemed to explore in three domains such as social support, physical health status and personality. This paper provides a glimpse on the emerging issues and concerns which are faced by the senior citizens in the year 2017. It also aims to recommend a call for action to properly address critical situations and complexities brought about by the ageing in Iligan City. An intervention program for senior citizens is designed to proactively respond to the social needs, physical health condition and personality development among seniors in Iligan City.

Methods

This study attempted to assess the Social Support, Physical Health Status and Personality of senior citizens in Iligan City.

The succeeding diagram (Figure 1) shows the conceptual framework of this study, and places emphasis on the relationship of factors such as the demographic profile, social support physical health status and personality of senior citizens in Iligan City.

Moreover, the independent variables will be hypothesized to affect the dependent variables and will be measured by using standardized tools. The responses of the respondents were considered essential factors in the research in addressing concerns about social support, physical health status and personality of senior citizens. Similarly, it provides a positive outlook that would serves as an important aspect in developing a more appropriate intervention program.

In the demographic profile, sex is considered being female or male. Age of the respondents is referred to as length of life one has existed. Educational attainment is included in finding their knowledge and competencies. Monthly income is considered believing to have impact to their living condition, and living status is included in the study as another relevant factor as it finds differences to respondents social support, physical health status, and personality.

Social Support is a variable that seeks to understand the nature and causes of individual behavior in social situations and this is measured in terms of appraisal- is a scale that allows someone to make informed decisions on his own. Tangible support refers to physical assistance provided by others in occurring and challenging situations. Self-esteem measures the self-awareness and lastly, belonging means which is an acceptance as a member or part of the group or family and considered as most important in seeing the value in life and in coping with intensely painful emotions. Physical health status delves only in terms of their medical consultations or treatment and symptoms for the past two years for various illnesses specified in the questionnaire.

Personality is another variable investigated in this study it includes Intrapersonal which is an assessment of the inner self. Indicative of an individual who has good self-understanding and who is achieving well up to this point in his life. Another one is the Interpersonal scale which indicates social adeptness, ability to understand others, and interact and relate well with people. Moreover, Stress-management scale indicates an enhanced ability to withstand adverse events and stressful situations. Furthermore, Adaptability is to tested to review the flexibility, problem solving scales and examines how successful one is in coping with environmental demands based on one's ability to effectively size up and deal with problematic situations. The components on General Mode Optimism and Happiness measure one's general feeling of contentment and overall outlook on life. The last subscale is Positive Impressions which indicates a tendency towards overly positive self-presentation. Finally, an Intervention scheme is designed as an output of this investigation based on the findings on social support, physical health status and personality of the respondents which would serve as a model in designing appropriate programs for the senior citizens in Iligan City.

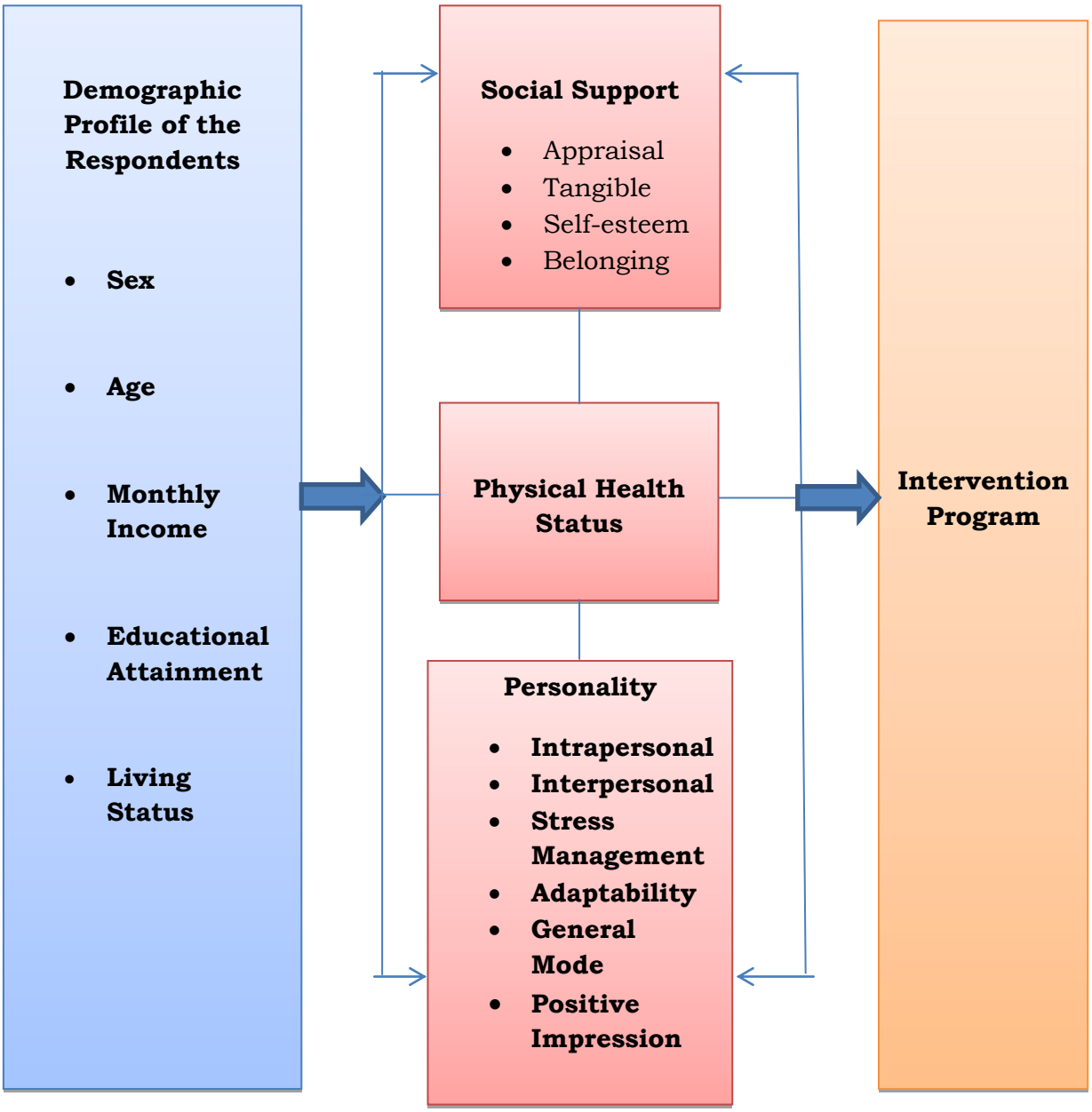


Figure 1. Research Paradigm of the Study

Statement of the Problem

This study aims to find out the social support, health status, and personality of the senior citizens in IIigan City in the year 2016. Specifically, the researcher seeks to answer the following questions:

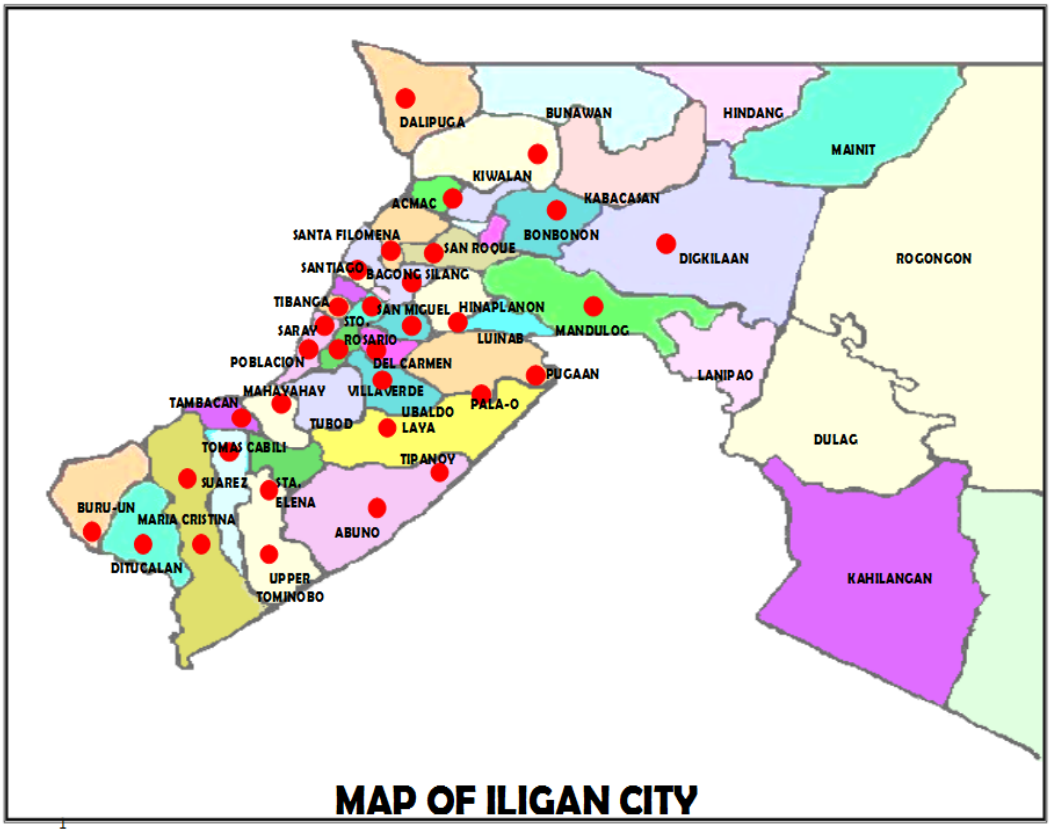
1. What is the demographic profile of the respondents in terms of:
    - 1.1. Sex
    - 1.2. Age
    - 1.3. Monthly Family Income
    - 1.4. Educational Attainment
    - 1.5. Living Status
2. What is the level of social support of the respondents in terms of :
    - 2.1. Appraisal support;
    - 2.2. Tangible support;
    - 2.3. Self-esteem support;
    - 2.4. Belonging support?
3. Is there a significant difference on the level of social support when grouped according to their profile?
4. What is the physical health status of the respondents?
5. Is there a significant difference on the level of health status of the respondents when grouped according to their profile?
6. What is the personality level of the respondents in terms of:
    - 6.1. Intrapersonal;
    - 6.2. Interpersonal;
    - 6.3. Stress Management;
    - 6.4. Adaptability;
    - 6.5. General Mode and;
    - 6.6. Positive Impression?
7. Is there a significant difference on the personality level of the respondents when grouped according to their profile?
8. Is there a significant relationship between the level of social support of the respondents and their physical health status?
9. Is there a significant relationship between the level of health status and personality of the respondents?
10. What intervention program shall be designed for the senior Citizens in Iligan City based on the findings of the study?

Methodology

This study utilized descriptive-correlation design since it deals with the analysis of the relationship of the profile and the level of social support and their physical health status and the relationship of between the physical health status and personality of the respondents. The correlational design was utilized to establish the relationship between independent variables and dependent variables.

The study was conducted in thirty –five (35) Barangays in Iligan City. A highly urbanized city in the Northern Mindanao region, Philippines. It is geographically located within the province of Lanao del Norte but administered independently from the province. It was once part of Central Mindanao (Region 12) until the province was moved under Northern Mindanao (Region 10) in 2001. Iligan has a total land area of 81,337 square kilometers (314.04 sq mi), making it one of the 10 largest cities in the Philippines in terms of land area.

The respondents of this study were three hundred eighty four (384) senior citizens. These were drawn from 19,339 legally registered in the Office of the Senior Citizens (OSCA). They were residing in the thirty five (35) barangays in Iligan City. As define in Republic Act (R.A) No. 9257, section 2, they were those whose age was sixty (60) years old and above.The formula of Slovin was utilized for the sample size:



Instruments Used

In obtaining the desired data of this study, the following instruments were utilized: Demographic Profile Sheet Questionnaire**.** This was constructed by the researcher. It was utilized to gather information on the respondent's profile for sex, gender, living status, family income, and educational attainment.

Social Support Evaluation Tool. This was the questionnaire-check lists used by the researcher in identifying the specific needs of the senior citizens of Iligan City. The standardized support evaluation tool is developed by Sarason, I.G., Levine, H.M., Basham, R.B., et al. (1983) and was designed to measure social support among old aged individuals in

which others affect person's responses to stressful events. The questionnaire consisted of forty (40) statements concerning the availability of potential social resources. The items were counterbalanced for desirability, that half of the items were positive statements about social relationships while the other halves were negative statements, Items subscale: tangible, appraisal, and self-esteem.

Each of these components is evaluated using the four-point scale: 1=definitely false, 2=probably false, 3=probably true and 4=definitely true. The score per area is obtaining by adding the weights of their choices item covered in the said area. Items that make up under the Appraisal support subscale are 1,6,11,17,19,22,26,30,36, and 38. Items 2, 9, 14, 16,18,23,29, 33, 35, and 39 make up the Tangible support. Lastly, items 3, 4, 8,13,20,24,28,32,37, and 40 make up the Self-esteem support.

Health Status Evaluation Tool. The tool is designed to determine the status of the respondent's physical health. The indicators included were the senior citizen's present physical health condition, history of illness for the past two(2) years, and/ or weather he/she has undergone medical examination, hospitalization and laboratory test or diagnostic test. The questionnaire consist of tree (3) statements with 13 subs question in item number two (2) and the (10) sub questions in item number three (3). The items covered in this tool were patterned after the Philam Life Guide to application for insurance.

Personality Evaluation Tool. Standardized tool is employed by using Bar-On model in measuring personality for the respondents. It consists of statements that provide opportunity to describe oneself by indicating the degree to which each statement is true. There are five possible responses to each sentence. 1- Very seldom or not true of, 2- seldom true of me, 3-sometimes true of me, 4-often true of me and 5-very often true of me or true of me. The scales that measured are: Intrapersonal, Interpersonal, Stress Management, adaptability and general mode.

Scoring System

The study established scoring system to determine the respondent's level in each of the domains. Likert scale was employed for the social support and personality. The scoring system used:

Social Support	**Personality**
1.00-1.75*= definitely false*	***1.00-1.79****=very seldom or not true of me*
1.76-2.50 *=probably false*	***1.80-2.59****=seldom true of me*
2.51-3.25*= probably true*	***2.60-3.39****-sometimes true of me*
3.26-400 *definitely true*	***3.40-4.19****-often true of me*
	4.20-5.00*-very often true of me or true of me*

Statistical Treatment of the Data

The following statistical measures were employed to treat the data gathered in the study with the aid of the Statistical Package for Social Sciences (SPSS):

Frequency and Percentage Distribution. These tools were used to describe the respondents' characteristics in terms of sex, age, living status, family income, educational

attainment, social support, physical health status and personality of senior citizens in Iligan City.

Mean and Standard Deviation. This was employed to get the level of social support, health status and personality of the senior citizens in Iligan City.

T-test and One Way ANOVA or F-test. This was employed to determine the significant difference and its relationship between the means of the respondents' level of social support, health status, personality when grouped according to their sex, age, family monthly income, educational attainment and living arrangement.

Correlation. This was used to measure the significant relationship between the level of social support of the respondents and their physical health status and significant relationship between the level of health status and personality of the respondents.

Findings

1. As revealed, 62.50% of the respondents were females.
2. Majority of the respondents were in the ages of 65-69 years old.
3. The vast numbers of living status fall under living with their family.
4. Most of the respondents were living below poverty line as based to their family income which was P5, 000.00 or below.
5. In terms of educational attainment, 21.40% of the respondents had not finished their elementary education.
6. For appraisal, the total weighted mean was 2.4 with a description as low. Indicator like *there is no one to feel comfortable to talk about intimate personal problem* reported as very low in social support in terms of appraisal. Low in appraisal find difficulties with regards to specific stressful encounters and coping strategies used. Thus, there is need to alleviate strongly when it comes to coping strategies to aid their specific stressful encounter.
7. For tangible, the total weighted mean is 2.49 and interpreted as low. The indicator that gained lowest mean is if I had to go out of town for a few weeks, it would be difficult to find someone. Low in tangible support usually experienced problem in handling certain life events which lead to depression and negative morale.
8. For self-esteem, the overall weighted mean is 2.70 and interpreted as high. The indicator which had the highest mean is *most people I know think highly of me and I am more satisfied with my life than most people are with theirs*. High in self-esteem is capable of measuring both positive and negative feelings about the self and enhanced initiative and pleasant feelings. Certainly, the respondents experienced feel good about themselves.
9. For belonging, the overall weighted mean is 2.22. This is referred as low. "No one I know would throw a birthday party for me and *if I needed some help in moving to a new house or apartment, I would have hard time finding someone to help me*" are the indicators which gained very low compared to other items. The low in belonging, experience poor in affection and recognition between people and being taken in and accepted as part of a group. It also relates to being poor in approved of and accepted by society in general. To belong is most important in seeing value in life and in coping with intensely painful emotions. More so, the experiences of personal

involvement in a system or environment is needed so that individual feels themselves to be an integral part of the system of the environment

10. Results reveal in that respondents' sex has no significant difference on their level of social support with a corresponding P-value on each social support scale that range from 0.177 to 0.594. However, Social Support Scale on respondents' Tangible Support reveals contradicting results from both sexes wherein female respondents shows high tendency to be able to easily find concrete and direct ways of assistance from other people while male respondents on the other hand possess the opposite result.
11. Respondents' level of social support when analyzed according to their age. Results reveal that there is a significant difference in their level of social support specifically in areas concerning appraisal and self-esteem in relation with their age.
12. In terms of living status, results reveal that there is no significant difference in their level of social support even if their various living status is being considered.
13. There is no significant difference in their level of social support in relation with their family monthly income.
14. Results reveal that there is a significant difference in terms of educational status and it plays important factors to the social support they obtain from their peers.
15. It is being emphasized, only 79 or 20.60 % who ever taken habit-forming drugs or substance of alcoholic drinks too excess, or had advice or treatment for such habit or other addiction.
16. For medical consultation or treatment, diabetes, cancer, tumor, or blood diseases with 164 or 42.70 % constitutes the greater frequency followed by lungs or respiratory disease having 147 or 38.30%. 145 or 37.80% had medical consultation pertaining to heart or blood vessels.
17. With regards to suffering from signs and symptoms of different illnesses in the past two years, 279 or 72.70% claimed that they had experienced unusual pain in any part of the body (Arthritis). It is followed by 228 or 59.40% who undergone medical examination, and 216 0r 56.20% who experienced loss of weight for the past two years. 48 or 12.50% constitute the least number of respondents who had experienced blood-spitting.
18. Results reveal that respondents' sex has no significant difference on their health condition however; several health concerns with higher prevalence to women reveal significant differences.
19. Respondents' age has no significant difference on their health condition specifically in condition concerning their kidney or urinary system and abnormality in breathing and the most age group who commonly acquired these problems are those who are in 70-74 years old.
20. There is no significant difference on the respondents' health status in relation to their living status however; health status concerning dizziness and unusual body pain has significant difference for those who are living with their children.
21. There is a significant difference between the two specifically in health areas concerning dizziness, urination and bowel movement, health laboratory concern with their internal organs, and abnormality in breathing. The above-mentioned health concerns are the most encountered problems by seniors whose monthly income from a single peso to only five thousand pesos.
22. There is a significant difference between the respondents' educational attainment and to their health status. It implies that education has a great effect to person's health.

23. The over-all weighted mean of Intrapersonal is 2.76 and labeled as moderate. Noted among other indicators, I tend to explode with anger easily and I'm impulsive were gathered greatest weighted mean.
24. The over-all weighted mean of Interpersonal is 2.82 moderate.
25. "*I like helping people"* is the indicator which earned the highest weighted mean compared to other items.
26. It can be gleaned in the study that the over weighted mean of Stress - Management is 3.10 and interpreted as moderate. "I believe in my ability to handle most upsetting problems, when facing a problem, the first thing I do is to stop and think. Are the indicators which gained high weighted mean among others.
27. The data revealed that the over-all weighted mean of Adaptability is 3.29 and the description is moderate. "I generally expect things will turn out all right, despite setbacks from time to time and I don't have bad day" are the indicators that get a high weighted mean compared to others.
28. The study revealed that in terms of General Mode over all weighted mean is 3.00 and indicated as moderate. "I believe that I can stay on the top of tough situations and my close relationship means a lot to me and to my friends," are the strength with a high description.
29. In terms of respondents perceived level of personality in terms of positive impressions, the data indicate a tendency towards overly positive self-presentation. The overall weighted mean is 3.32 and the description is moderate. "I am satisfied with my life. I care what happens to other people. And I don't do anything bad in my life are the indicators which had high description.
30. The data reveal that there is a significant difference when it is analyzed in accordance to their gender specifically in the following scale namely: Stress Management, General Mood, Intrapersonal, and Positive Impression. In general, such result implies that almost all of the respondents already have better understanding of their emotional and social functioning in life.
31. As what the result revealed, there is a significant difference on the respondents' age and personality level specifically in interpersonal scale which implies that seniors under the age bracket of 80 to 89 years old shows high tendency of being good with people and thrive in social interactions. They are good at reading, empathize and understanding others. They are good at working with others and have many friends.
32. 33. There is a significant difference on the respondents' educational background and personality level specifically in intrapersonal scale.
33. The study revealed that there is a significant difference on the respondents' income particularly those who are earning below the average wage to the type of personality they possess – introvert.
34. With regards to the possible relationship between the respondents' health status and social support, and thus it reveals that there is a significant relationship. Specifically health concerns with urination and bowel movement, illnesses involvement laboratory test, and blood spitting are common problems faced with elders who lack social support in appraisal, tangible, and self-esteem. Hence, such results are consistent with the earlier discussion on the respondents' health status when it was analyzed according to their profile.
35. Findings indicate that there is quite great relationship between the level of physical health status and personality. To sum it up, results would tell us that all aspect of the older people personality profile has an effect to their health.

Conclusion

Majority of the senior citizens in Iligan City are living with their family and are living below poverty line. Their level of social support in terms of appraisal, tangible, and belonging appears low. Self-esteem is high which describes the way they feel about themselves, strength, weaknesses emotions, and their effect on others. They are conscious and concern to their physical health, they go through medical consultation, had been subjected to laboratory or other diagnostic test, making them physically healthy.

Moreover, they are aware of their own personal strength and weaknesses, capable to interact with others and form agreeable relationship, they cope up with stress effectively, rarely impatient, and rarely overreact or lose control, adjust emotions, thoughts and behavior in dynamic environment and changing conditions. Optimism is somewhat elevated, and maintains positive attitudes. Thus, the senior citizens in Iligan City are able to manage the different occurring situation.

Furthermore, their level of social support specifically differs in the areas concerning appraisal and self-esteem in relation with their age. This is also true in terms of their educational status which plays as an important factor to the social support they obtain from their peers.

Finally, the respondents' health status and social support, specifically, health concerns with urination and bowel movement, illnesses involvement laboratory test, and blood spitting are common problems faced by elders who lack social support in in appraisal, tangible, and self-esteem.

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"Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts through Mindfulness & Emotional Intelligence in Bangkok, Thailand"

By Ms. Bhavna Khemlani

(Lecturer/ Academic & Creative Writing Coach / Author/ Reiki Master- Teacher / NLP Practitioner)

Acknowledgements

Our lifestyle, state of mind, and emotional status can affect our performance and our health. Understanding and exploring the transitions in the Health Care Systems in Bangkok are mandatory. How we acknowledge our emotions and our influence by people also reflects in the state our well-being.

This research has been a journey of awareness and an inspiring exploration of the Health Care understanding in the times of Uncertainty in Bangkok, Thailand. Expressing Gratitude to all the experts who were part of this research, making the study interesting, and sharing real life experiences and views. Your valuable time is appreciated and humbly acknowledge information shared.

The awareness of Emotional Intelligence and changes in the Health industry in Thailand shared by Dr. Davin Narula, Mrs. Rasee Govindani, Ms. Anette Pollner, and Dr. Anand Sachamuneewongse has given a valuable insight about quality health services, well-being, experience, and expressing possible changes and integration of services in the health industry**.**

Gratitude and the study will surely facilitate the wisdom of the Heart and well-being.

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Abstract

This research focuses on the Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts through Mindfulness & Emotional Intelligence in Bangkok, Thailand. The researcher was keen to explore, analyze, and bring awareness of how experts manage emotional intelligence and mindfulness in the fields of Health care, and structural transitions during the times of uncertainty.

The objectives of this research were whether the regular practice of Guided Mindful Meditation/training could improve patients' emotional intelligence. To distinguish the effect of pressure from the internal and external environment of health system in Bangkok. To evaluate the differences of between practitioners, experts, and doctors on various practices and handling structural transitions in the Health Care systems in Times of Uncertainty. To bring awareness on valuable techniques and resources for practitioners, doctors, and patients to creating Balance & practicing Mindfulness in their daily life. To analyze the shared experience of Mindfulness performed by the four experts in this research.

In conclusion, all four experts fulfilled the questions and answered all questionnaires of Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10. Dr. Davin, Mrs. Rasee, Ms. Anette, and Dr. Anand were aware of their emotional intelligence in terms of thoughts, environment, mood, and there are situations that may bring some difficulties to deal with the internal state, however, they tend to find a suitable approach to deal with it. Dr. Anand did not usually focus on emotional intelligence and mindfulness approaches and this research guided him to reflect on several aspects that relate to him and his work in a deeper perspective.

In contrast, when the face to face audio interview was conducted the insightful sharing on various aspects of uncertainty, transitions, mindfulness, and emotional intelligence was expressed. The challenges in the health industry with having less doctors and advance equipment in the public sector was acknowledged by Dr. Anand and Ms. Anette. Dr. Davin on NLP and how neuro programming and mindfulness programmes can be utilized in medical training, educating patients through awareness, and in daily practice of one's life. Mrs. Rasee & Ms. Anette stressed on integration of alternative/complementary healing/therapies with hospitals and having counselors on call to provide emotional; and moral support to patients and people working in the hospitals in both provide and public hospitals. There is a need to bring awareness in acknowledging emotional intelligence, mindfulness, and integration of balance through neuro programming that can enhance people from all walks related to the health industry. The essential approaches to emotional, mental, physical, and spiritual practices are needed throughout the Nation which will progress in every way.

Furthermore, emotional intelligence should be taught at schools for children to acknowledge how the feel and speak about it. Further research encourages to be explored in rural areas and other clinics and hospitals on emotional intelligence and mindfulness training.

Future studies can apply mindfulness training approaches on doctors and staff at the hospitals to test the efficacy of before and after practicing the mindfulness programme. It will be efficient to check the brain waves of before and after the practice of mindfulness training to check progress.

Keywords: structural transitions, health care systems, uncertainty, mindfulness, stress, balance, emotional intelligence, Bangkok, Thailand

Chapter 1

Introduction

1.1 Background

Health care systems have an immense and valued responsibility to bring awareness and make available right medical care for the entire nation. Over the years, with the advancement of technology and the marketing of medical tourism various types of health care facilities and services have been advertised. Nevertheless, during the times of structural transitions there is growing awareness of disadvantages and issues faced during the times of uncertainty.

Government health care and any other product or service managed by government is the foundation of any nation. The core values of products and services reveal, restore, revive, and help progress a nation's economy, well-being, investment, and generations of populations within a nation.

With reference to Today online news, Thailand is facing various challenges in the health care system. As stated in May 2017, "the Federation of Physicians and Nurses released a table showing 18 state hospitals were suffering deficits. For instance, Pranangklao Hospital had a deficit of 355 million baht, Saraburi Hospital was 322 million baht in the red, and Uttaradit Hospital suffered a deficit to the tune of 277 million baht. The hospital deficit is just the tip of the iceberg. There have been concerns in the healthcare system that need to be urgently reformed," said the president of the Federation of Physicians and Nurses of regional and general hospitals, Pradit Chaiyabud," (Today Online, 2017).

State hospitals get income from three sources: The state Budget; operators of three healthcare schemes, namely the universal healthcare scheme, civil servants healthcare scheme and social security scheme; and money earned by hospital operators themselves, such as donations. Contributions from the universal coverage (UC) scheme account for the largest portion of state hospitals' income. Hospitals normally receive an annual Budget of about 80 million baht, depending on the size and population of the district. The NHSO also dispenses money according to the number of patients suffering specific illnesses, such as kidney failure or heart disease, (Today Online, 2017).

The challenge for the NHSO is how to manage the budget efficiently with limited funds and an ageing society. Moreover, civil society groups have urged the government to invest more in healthcare because it is a matter of long-term human security. According to Mr Viroj Na Ranong who is a research director for the health economics and agriculture sector at the Thailand Development Research Institute, his study reveals that the health expenditure of low-income countries is approximately 4 per cent of GDP compared to 8 to 13 per cent for high-income countries. Health expenditure in the US is 15-17 per cent. The civil service healthcare scheme is more expensive, because its finances are based on open-end funding, meaning beneficiaries can get expensive drugs and treatment, (Today Online, 2017).

On the other hand, with reference to the cover story about Health care on life support published by Bangkok Post in November 2017 by Paritta Wangkiat, Thailand's healthcare scheme is most critical since 2002. For over ten years the scheme has been praised all over the world in providing healthcare access to over 48 million and filling the gap left by the social security scheme and civil service welfare. Going back to the 1980s, there was an ambition to establish health care for all after witnessing the experiences of patients who could not afford medical treatment. The capitation method also allows government to fund universal coverage within its capacity limit.

Furthermore, in relation to a research under the American Psychosomatic Society on behavioral medicine conducted on examining the Alterations in Brain and Immune Function

produced by Mindfulness Meditation by Davidson, Richard J. PhD; Kabat-Zinn, Jon PhD; Schumacher, Jessica MS; Rosenkranz, Melissa BA; Muller, Daniel MD, PhD; Santorelli, Saki F. EdD; Urbanowski, Ferris MA; Harrington, Anne PhD; Bonus, Katherine MA; Sheridan, John F. PhD, 2003 revealed that the short program in mindfulness meditation does produce positive and demonstrates effects on brain and immune function. Moreover, various studies shows stress-related health problems are responsible for up to 80% of visits to the doctor and account for the third highest health care expenditures, behind only heart disease and cancer. But few doctors actually share to patients about how to reduce stress. Mind-body practices like yoga and meditation have been shown to reduce your body's stress response by strengthening your relaxation response and lowering stress hormones like cortisol. Additionally, Harvard Health publications reveal the several different mind-body approaches, including meditation, yoga, mindfulness, cognitive behavioral skills, and positive psychology result in relaxation and reduction of medical services. With this the understanding of Emotional Intelligence and Mindfulness practitioners in the health industry can improve their health as well as their clients/patients.

This research study emphasizes and explores the demographics structural changes, healthcare transitions, alternative healing approaches, challenges faced during the time of uncertainty, assess experiences of experts in the Health Care system in Bangkok, Thailand. This study will enable respond to needs on the increasing of specific issues and pressure within the internal and external environment of health system in Bangkok, Thailand. Additionally, to understand more about how practitioners working in the Health Care industry are aware of their own emotional state before treating or providing any kind of service to their clients/patients.

Mindful training has been adopted in some primary schools and local universities in Thailand; however, the need for Mindful training is becoming a growing necessity which more schools, universities (local & international, private or public) should utilize this to bring awareness so students of all ages can find a balance from within and external factors.

Mindful training and bringing awareness in the Health Care Systems is very much needed to assess and making sure that service provided is being delivered from the expert is emotionally and mentally satisfied. Moreover, emotional intelligence is one of the five pillar, as stated by Daniel Goleman published his famous book "Emotional intelligence: why it can matter more than IQ." The increasing awareness of mental health and a concern with emotional intelligence are rapidly attaining significance as fundamental issues for the twenty-first century. Educators, therapists, and parents have become more anxious about how to enhance their children's emotional intelligence and this does not stop there. Teenagers and young adults need it as this effects their productivity, increases stress, and may increase emotional, physical, and mental issues which may lead to serious illnesses.

As a result, the present study is conducted using a qualitative and quantitative research method. Difficulties in Emotion Regulation Scale (DERS) Serenity Programme consisting 36 statements on various aspects of emotions and how one feels and what one does about it using the calculation in percentage - Higher scores suggest greater problems with emotion regulation will be assesses as the experts being interviewed will fill in the questionnaires. The Philadelphia Mindfulness Scale (PHLMS) and the Global Health PROMIS 10 questionnaire is also being completed to bring awareness about the experts. The present study is designed to assess and analyze the structural transitions in the health cares in times of uncertainty in Bangkok, Thailand.

1.2 Research Objectives

The researcher is interested in the way body and mind is being taken of, and how experts in the fields of Health care mange the structural transitions during the times of uncertainty.

For this research the research objectives formulated are:

1. To determine whether the regular practice of Guided Mindful Meditation/training could improve patients' emotional intelligence.
2. To distinguish the effect of pressure from the internal and external environment of health system in Bangkok.
3. To evaluate the differences of between practitioners, experts, and doctors on various practices and handling structural transitions in the Health Care systems in Times of Uncertainty.
4. To bring awareness on valuable techniques and resources for practitioners, doctors, and patients to creating Balance & practicing Mindfulness in their daily life.
5. To analyze the shared experience of Mindfulness performed by the four experts in this research.

1.3 Rationale of Study

The researcher is aware of numerous cases that come her way and the need to start to understand how to deal and mindfulness training is essential for everyone in all working industries. With experience of being an Educator, Author, Academic and Creative Writing Coach, Reiki Energetic Master Teacher, and practicing Raja Yoga Meditation for many years conducting a research to facilitate options and resources is significant for providing the right Social and Emotional Learning (SEL) as a process that clearly develops life skills. It is an integrated approach that can support many people in self-awareness and management on handling emotions and behavior skillfully. Where service is being provided to clients and patients the balance of the service provider is as important.

1.4 Brief view on Methodology

In the global phenomena where various materials are published and many types of services are available to promote medical tourism understanding the challenges and bringing awareness to imitate a reform in the health system is vital. Hence, the researcher will conduct a Quantitative & Qualitative Research where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire will be answered to accomplish the objectives about the Health Industry, Challenges, Health Care Financing, Health Care Management through email and meeting with the researcher.

The first participant is Mr. Dr. Davin Narula who is the Hospital Director of Sukumvit Hospital, Bangkok, Thailand who will be sharing about Mindfulness, Emotional Intelligence and the changes in the Health Care system and emergency treatment in Bangkok over the years. Dr. Davin completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The second participant **is** Mrs. Rasee Govindani, who is a certified birth doula with DONA International and a postpartum doula and childbirth educator in process of being certified by

Childbirth International. She is also a Gottman Institute Bringing Baby Home Educator who has taught the English childbirth education classes at Bumrungrad International Hospital from 2011 until 2016. She has attended over 100 births in Bangkok hospitals. She is also a breast cancer survivor who was treated at Bumrungrad International and currently being followed at Chulalongkorn Hospital. Along with a fellow breast cancer fighter she started Beyond Boobs, a source for information and support for breast cancer fighters and survivors in Bangkok (Facebook link to Beyond Boobs: www.facebook.com/beyondboobsbangkok). Mrs. Rasee completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The third participant is Ms. Anette Pollner a senior Counselor at NCS Counseling Center, Bangkok who also completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The fourth participant was Dr. Anand Sachamuneewongse, Orthopedic Surgeon at Samrong General Hospital, Bangkok, Thailand who will be sharing about Mindfulness, Emotional Intelligence and the changes in the Health Care system and emergency treatment in Bangkok over the years. Dr. Anand completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The four expert participants from different areas of the Health industry will accomplish the principal objectives of the research topic and assess experiences in the transitions of the health systems, where knowing more about the organizational structure and responsibilities to cope with the existing system in the health industry. Mindfulness draws upon the recent convergence of modern science and it is the cultivation of both attention skills and emotional balance. Therefore, an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS) a 20 item, bi-dimensional measure assessing distinct components of present-centered awareness and acceptance that both is based on clinical and non-clinical samples, Emotional Intelligence (DERS) questionnaire on Difficulties in Emotion Regulation Scale (DERS) Serenity Programme consisting 36 statements on various aspects of emotions and how one feels and what one does about it using the calculation in percentage - Higher scores suggest greater problems with emotion regulation will be assessed as the four experts being interviewed will fill in the questionnaires., and the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered. The research is undertaken from 2017 and to be completed by February 2018.

1.5 Possible Outcomes

The digital age has swept people into a new cult of modernization. The emphasizes on psychospiritual education, compassion, and subjects related to energy is very much required to bring healing/cures to people suffering from illness, sicknesses, depression, stress, and also offer insights to various ways balance life through a better quality of life and positive thinking. Possible outcomes for this research are:

1. Participant with a high emotional intelligence scores will show a greater change on applying the DERS scores in Emotion Regulation, mindfulness scale, and a great focus on their work tasks.
2. Mindful Meditation will be acknowledged to all four experts and understand the benefits. It does not encourage any Religious activity neither does it violate any policy or regulation of the clinic/hospital.
3. The research encourages more educators, educational institutions, international schools, and local alternative healing centres/clinics/hospitals to collaborate and/or introduce sources and platforms to find resolutions that elevate the coping of Emotional Intelligence and embracing Mindfulness approaches & alternative healing therapies for working with patients and the four experts.
4. The findings will encourage a wellness programme of Mindfulness in hospitals and/or collaboration of experts in Mindfulness to develop suitable courses and practice of Mindful activities for the hospitals.

1.6 Limitations of the Study

The results also depend on how the participants of this study understand the factors and deal with factors that bring awareness to his/her life and bring a change in his/her quality of life. Some limitations of this study are:

1. The research is limited to Bangkok geographically.
2. There was a challenge on how much and whether the experts would be able to share as many aspects on structural transitions in the health care systems and provide suggestions in times of uncertainty from their perspectives. There is privacy and the researcher cannot monitor the experts but trust in what they share with due respect of their years of experience and work with reputable health corporations.
3. The participants perform their duties and follow the protocols of the place they work in. With due respect and privacy of the place suggestions offered were based on their experience and observation over the years, hence, they faced boundaries of what can be done and what cannot be done.

Chapter 2

Review of Literature

2.1 Health Care System & Challenges in Thailand

Thailand's health insurance system is the product of reforms that have played out over the last thirty years. The Medical Welfare Scheme (MWS), started in 1975, was the first program to provide health care to the poor. However, over the years The Thai health system has undergone a remarkable transformation. Additionally, objectives of Thailand's health reform include achieving universal health insurance coverage with an acceptable level of benefits, limiting the growth of health spending, promoting efficient health care delivery, allocating more health resources to the poor and to rural areas, and maintaining the health system's capacity to supply services. The financial sustainability of Thailand's health system is affected by factors that are common across countries. Use of health services is expected to increase, driven by an aging population, rising national income, and the growth of medical technology. Revenue to pay for that rising trend in demand is less certain, affected by changes in the work force over time and competing demands for revenue in the government's budgeting process, (Ministry of Public Health, Thailand, 2007).

Alternatively, The Kingdom of Thailand has its own system of traditional medicine called "Thai traditional medicine" (TTM). It originated during the Sukhothai period (1238-1377) and developed in parallel with the country as a means of national health care until the early 20th century. The "Practice of the Arts of Healing Act B.E. 2542" defines Thai traditional medicine as "the practice of the art of healing that is based on Thai traditional knowledge or textbooks that have been passed on and developed from generation to generation, or based on the education from academic institutes that the Professional Committee approved," (Archanuparp S. 1987). The causes of illness According to TTM, human illness can be caused by the following factors: 1. Supernatural power, e.g., ancestor's soul, powerful spirit of the forest, evil spirits, and punishment from a heavenly spirit of those who misbehave. 2. Power of Nature, e.g., imbalance in the four elements of the body, imbalance of heat and cold, and imbalance of the body's equilibrium. 3. Power of the universe, e.g., positive and negative influences from the sun, the moon and the stars on human health. 4. Kimijati, which may be considered the equivalent of microorganisms or parasites in modern medicine. Furthermore, the influence of Western medicine, which was introduced into Thailand by missionaries and Western physicians starting in the reign of King Rama III, gradually increased. In 1888, Siriraj Hospital, the first Western-style hospital and medical school, was officially opened. Initially, both TTM and modern medical services were provided and the medical school that taught both disciplines of medicine was established in 1889, (Subcharoen, P. 2003). In addition, the hospital also initiated a health tourism programme for tourists to join various health promotion programmes, i.e., health food, exercise, Thai massage, herbal steam baths, meditation, yoga training, learning about holistic medicine and TTM, and to visit various tourist attractions in Prachinburi Province, (Ministry of Public Health, 2004).

Thailand's health care system needs improvements. There are several areas that could be enhanced as there are problems with the system in the urban areas, but they are even worse in the rural areas. The rural areas have problems with the amount of time the doctors are there, and also the means of transportation to the clinics. The accessibility of doctors can be a lack of service and the choice of doctors wanting to be there in relation to the package they are offered could possibly influence their interest to work at rural areas.

In turn, doctors work for so many hours and if something comes up after their appointment, it could be very difficult to contact a specific doctor. This is because they could be in a different hospital or rural location with other patients. Another concern is that Thailand does not have effective emergency transportation system. The lack of number of ambulances, emergency situations can often lead to serious problems due to heavy traffic. In November 2006, a reform was made and the health programme was called the Universal Coverage Scheme. The Universal Coverage Scheme gives completely free health care (without restrictions) to any Thai citizen who does not have the Civil Servant Medical Benefit or the Compulsory Social Security Schemes, (Hoontrakul, Duangporn, 2008).

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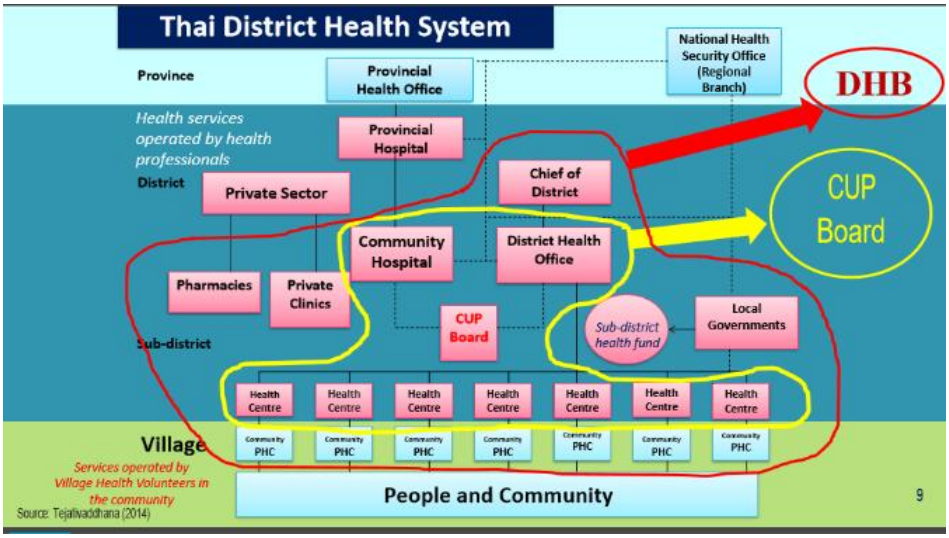
As follows, the Thais need a better emergency transportation system in the urban areas that will be able to bypass traffic. A special lane for emergency vehicles. To fix the problem with patients not being able to get ahold of their doctors after their appointments, the doctors could improve their means of communication. They could get more improved cellular service, or have specialty doctors on call. This would increase the accessibility of the doctors and improve the process of medication, curing, and also attend to mindful needs in various locations in Thailand. However, in its extensive networks of Provinces there are hospitals and health structures of a relatively good standard within some 700 districts that have responded well in reducing the prevalence of communicable diseases (Saelee D, Tiptaengtae Sh, Tonsuthepweerawong C, Yana T, 2014).

Figure 2.1: Thai District Health System



Source: Tejativaddhana, P., Briggs, D. & Tonglor, R (2016)

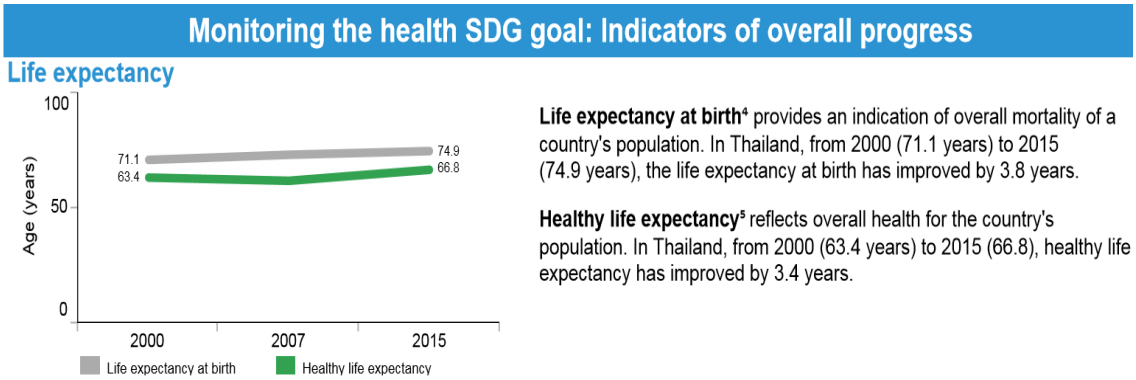
According to Chularat Sae (2015), publication in The Nation newspaper Nurses and doctors at public hospitals are apparently under stress trying to manage time so all the patients can see a doctor. The unequal distribution of doctors at state compared to private hospitals and the problem is more acute. Long queues are normal at state hospitals. The more famous the hospital, the longer the queue. Only those with enough money can skip these long queues by seeking medical services from private hospitals.

Thus, to address this visible problem, it's significant to develop the right standards and requirements for the hospital doctors, nurses, staff, and patients. It is quite obvious the ignorance of Emotional Intelligence is not being taken care of and if the doctors, nurses and/or practitioners are stressful, how will the right needs of the patients and clients be met.

2.2 Demographic Structures for Health Care in Thailand

With reference to the World Health Organization Southeast Asia (2017), the life expectancy at birth and health life expectancy of Thailand has improved over the years as shown in figure 2.2.

Figure 2.2: Life Expectancy in Thailand 2000-2015



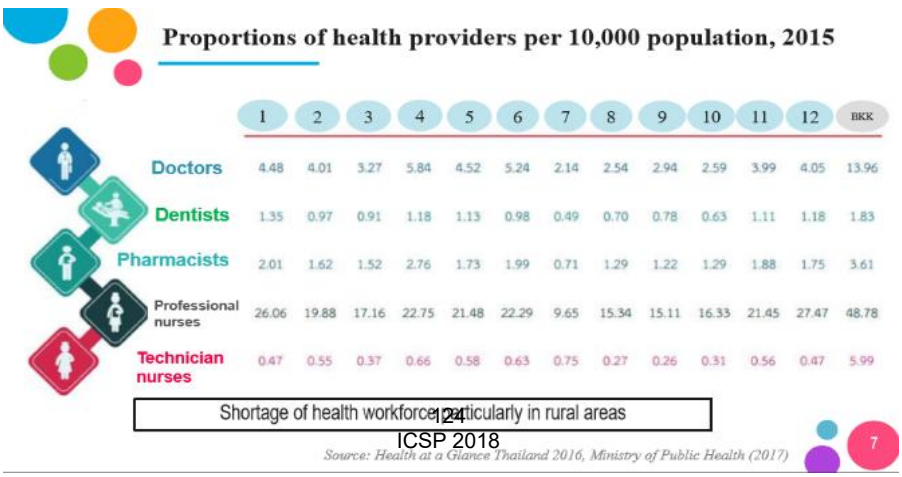
Source: World Health Organization Southeast Asia (2017)

Moreover, Thailand faces challenges to further improve its education and health-care systems to various demographics with aspects of environmental damage from its rapid growth. The country has made impressive progress in providing education and health care to most of the population. Nevertheless, significant inconsistencies remain, particularly for poorer households and between rural and urban areas that need to be addressed. Education quality needs to be improved, principally the quality of teachers, and rising health-care costs need to be contained through reforms to improve efficiency in the delivery of services (Lathapipat, Dilaka 2011). Thailand also needs to address environmental damage from past growth and achieve greener growth in the future by reducing carbon emissions and other forms of pollution to the changing needs of demographics and the learning of new health practitioners.

Also, there is health inequality problems concerning care for the dependent elderly who require constant care because of their fragile health status. Strengthening and necessary development of current reforms are needed to gain greater access to health-care services in an affordable manner. The government should attempt to improve awareness among the public, especially the poor and underprivileged, about the existence of the health insurance system and its services. This is important for the elder demographics to gain awareness about the transitions in the health system of Thailand. In contrast, the registration system for foreign workers needs to be improved so that they can get access to health services at an affordable fee (Jitsuchon, Somchai 2012b).

On the other hand, as reflected from figure 2.3, the proportion of health providers in Thailand are lesser in the rural areas.

Figure 2.3: Proportion of health providers per 10,000 population, 2015 Thailand



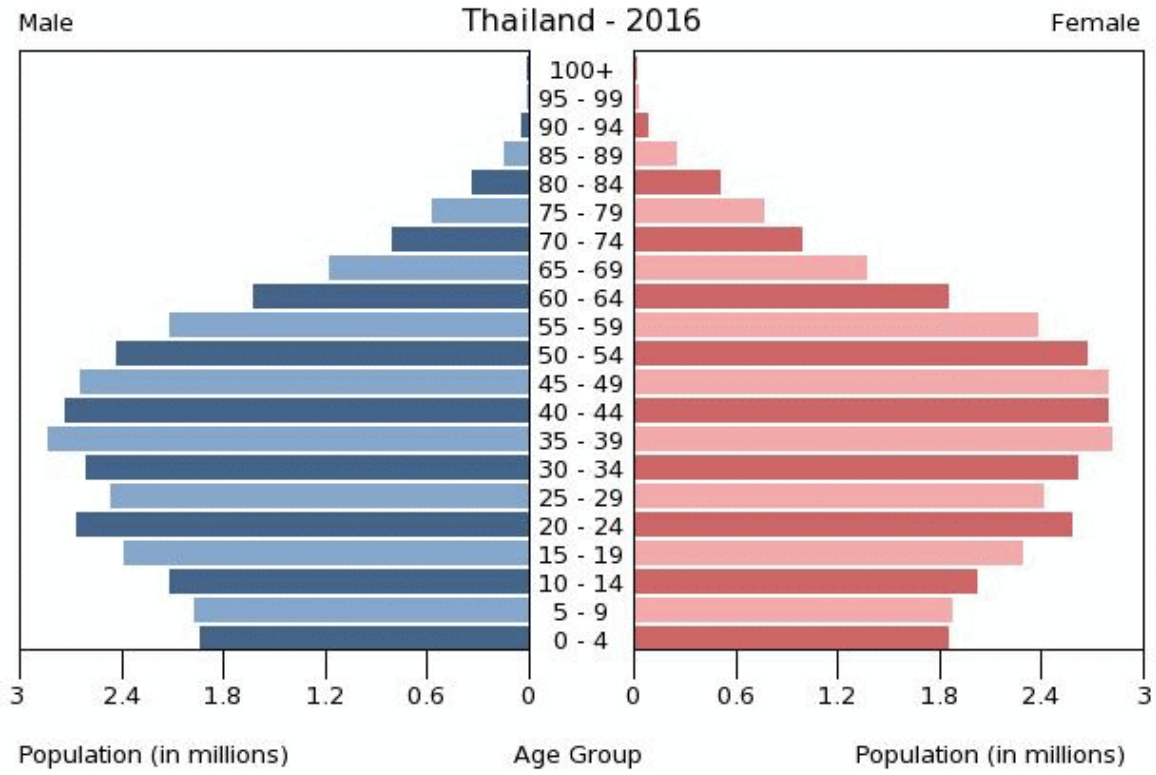
Source: Ministry of Public Health (2016)

The changes in the health policies have benefitted many and also affected many in the negative way. With the growing population in Thailand and the modern influence of social media, lifestyle, not appropriate consumption of healthy resources, sicknesses, illnesses, and manipulation of peers and/or society can also lead to inadequacy of understand the changes in the health system which some people may think its political and ignore the reforms and don't update themselves. The transitions in the policy and during the time in uncertainties have favoured private hospitals, drug companies and medical tourism. This can be a leading threat to universal healthcare.

A population pyramid of Thailand in 2016 published by Central Intelligence Agency, illustrated in Figure 2.4 represents the age and sex structure of a country's population and shows the male and female populations broken down into 5-year age groups represented as horizontal bars along the vertical axis, with the youngest age groups at the bottom and the oldest at the top. The shape of the population pyramid gradually evolves over time based on fertility, mortality, and international migration trends. The Age structure is 0-14 years**:** 17.18% (male 6,000,434/female 5,714,464), 15-24 years: 14.47% (male 5,030,930/female 4,839,931), 25-54 years: 46.5% (male 15,678,250/female 16,038,155), 55-64 years**:** 11.64% (male 3,728,028/female 4,208,624), 65 years and over**:** 10.21% (male 3,047,938/female 3,914,070) (2016 est, (CIA World Factbook, (2017).

It is understood that the age structure of a population affects a nation's key socioeconomic issues. Thailand increase with young populations need to invest more in schools, while the older populations need to invest more in the health sector. This can help in determining affordable and suitable packages from public and private hospitals. However, the concern here is to also understand the practitioners, the pressure, and long working hours which need to be taken care of.

Figure 2.4: Population Pyramid of Thailand in 2016



Source: CIA World Factbook, (2017)

2.3 Mindful Training & Alternative Healing Approaches

In various literature and researches, findings have revealed a positive relationship between mindfulness and Emotional Intelligence (Baer et al., 2006; Brown & Ryan, 2003). Since the objective of Mindful Meditation is to enhance the level of mindfulness, it can significantly facilitate the development of EQ. First, regularly practicing MM can enhance the ability to understand one's own emotions (Brown, Ryan, & Creswell, 2007). Since the meditation training requires practitioners to closely observe their thoughts and feelings moment-to-moment without any judgment or interference, practitioners tend to develop a higher tendency to be aware of their emotional state and change than those who do not. This contribution is supported by a study conducted by Feldman, Hayes, Kumar, Greeson, and Laurenceau (2007), which found that the level of mindfulness was associated positively with more clarity of feelings, attention to feelings, and lower distraction.

Furthermore, Feldman et al. (2007) found that people with a higher level of mindfulness tended to recover quickly from emotional distress compared with those with a lower level of mindfulness. Moreover, research found that practicing MM could heighten one's meta-cognitive ability (Zeidan, Johnson, Diamond, David, & Goolkasian, 2010), which is considered a higher-level cognitive ability that allows individuals to monitor and control their thought process (Flavell, 1987). In the same manner, Gundlach, Martinko, and Douglas (2003) suggested, "without an awareness or willingness to decipher and understand how one produces beliefs about his/her own work capability, it will be difficult to explain, understand, or improve existing self-efficacy levels."

Moreover, people who regularly practice Mindful Meditation can easily develop the ability to detect and understand the emotions of others. In particular, being mindful allows individual to better focus their attention on how other people around them are feeling (Brown et al., 2007), which subsequently helps them decipher emotional cues of others more accurately

(Krasner et al., 2009). Thus, practicing Mindful Meditation can significantly enhance the ability of individuals to regulate and control their emotions (Cahn & Polich, 2006).

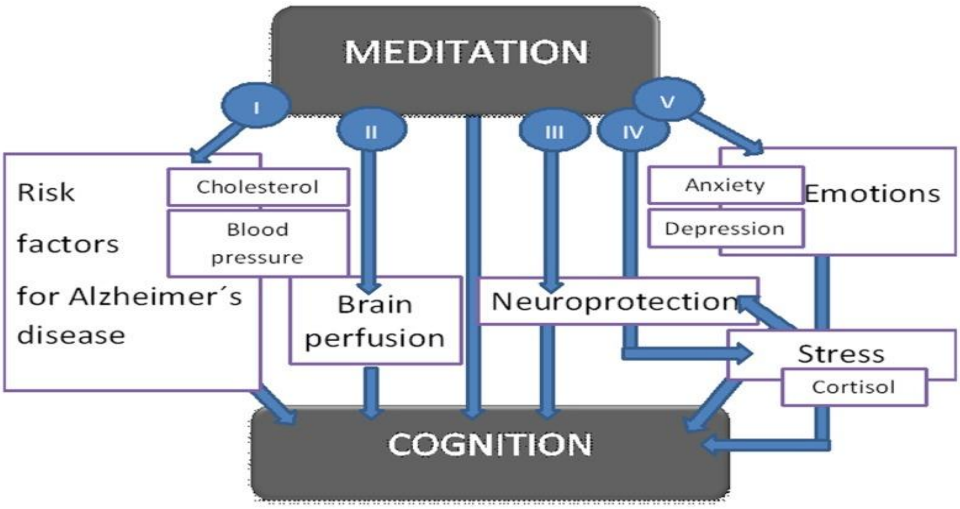
Other possibilities of non-pharmacological interventions are based on various meditation techniques. The impact of meditation on human health has been recently a subject of great scientific interest. The effect of these techniques has been studied from different perspectives (depression, anxiety disorders, eating disorders, addictions, and disorders caused by the use of psychoactive drugs) (Ospina et al., 2007; Balaji et al., 2012; Khanna and Greeson, 2013; Lakhan and Schofield, 2013). The impact of meditation on stress reduction, the prevention of psychosomatic disorders, blood pressure, and other cardiovascular diseases is a subject of several studies as well (Barnes et al., 2001; Grossman et al., 2004). Meditation can help with chronic pain and musculoskeletal disorders, respiratory diseases, and dermatological problems. It may be beneficial as a support of the immune system or as a symptomatic treatment of cancer (Ospina et al., 2007).

Mindfulness practice includes a number of meditational techniques, such as activities focused on breath and physical awareness or using metaphors enlightening the essence of mindfulness. All these techniques have a common goal, which is expanding a subject's mindfulness – i.e., the ability to focus on the present moment and to perceive without any judgment or choice current internal or external impulses, which are emerging at a given moment of consciousness. Mindfulness thus allows one to stay "above" the particular content of thoughts, emotions, or imaginations and enables one to become aware of the process of consciousness itself (Kabat-Zinn, 2005). There are many psychotherapeutic schools and approaches, which use the techniques based on the concept of mindfulness, for example, Gestalt therapy or Morit's therapy. There are several new areas combining a mindfulness approach with cognitively behavioral therapy, such as mindfulness-based cognitive therapy, dialectical behavior therapy, and acceptance and commitment therapy (Germer et al., 2005).

An evaluation by Chiesa et al. (2011) suggested a significant improvement of selective and executive attention in early stages of meditation, which aims at cultivating focused attention. Non-focused, long-term attention can be improved during following stages of meditation, which are characterized by non-judgmental observation of external and internal stimuli. Besides, this technique can increase the capacity of working memory and several executive functions.

Figure 2.5 illustrates ways how meditation impacts cognitive functions. The figure represents an example of how meditation can help patients with Alzheimer's. The effect of meditation on cognition is both direct and indirect (I–V): meditation positively influences hypercholesterolemia and hypertension which represent risk factors for Alzheimer's disease (I). Further it increases cerebral blood flow (II) and has a protective effect on the cortical thickness (III). Meditation further reduces stress (IV), anxiety, and depression (V). All these mechanisms lead to better cognitive functions.

Figure 2.5: Suggested influence of meditation on cognitive functions



Source: Rafał Marciniak, Katerina Sheardova, Pavla Čermáková, Daniel Hudeček, Rastislav Šumec, and Jakub Hort (2014)

In contrast, Complementary and alternative medicine (CAM) or alternative healing approaches from Reiki Energetic Healing, Acupuncture, various Meditation approaches, Aromatherapy, Ayurveda remedies, Nature therapy, Ozone therapy, detox, chelation therapy, cupping, naturopathy and much more. CAM practices are seen as forming part of traditional medical practices that have historical roots in the developing world. They have remained marginalized in the West because they have been looked down upon as traditional medicine and regarded, despite the increased interest in recent years, as alternatives to the Western model of medicine (Zhang, 2002). Moreover, the increase with various researches and collective support to alternative healing methods is increasing globally. With this awareness, it's important to sustain the healthier approaches than to increase consumption of medicines with high risk of side effects.

2.4 Emotional Intelligence and Difficulties in Emotion Regulation Scale (DERS) – Serenity programme

In 2006, a research conducted on Chulalongkorn medical students' in enhancing emotional skills of medical students was a valuable insight to understanding emotional intelligence for doctors. The results showed that having hobbies, participating in supplementary activities and genuine need to be doctor associated with high emotional intelligent scores may be helpful for evaluation and development of emotional intelligence in medical students. The human brain contains two minds and two different kinds of intelligence: rational and emotional. These two fundamentally different modes of consciousness interact to constitute our mental life. The emotional and rational minds are semi-independent faculties (Wongpiromsarn Y, Lotrakul P, Inseeyong V, Chaninyuthwong V, Suwanmaitree S, Wanitrommanee K, Sukmak K, Usaha S, Thongngen A 2002). They operate in tandem most of the time: emotion contributes to, and informs the operations of the rational mind, which refines and sometimes vetoes the inputs of these two partners interact well. Therefore, both E.Q and I.Q abilities enhance each other. Reflecting the Thai culture, there is a high social expectation of a "Doctor". There is not only a requirement of a knowledgeable doctor but also a need of a doctor who is empathetic, has devotion toward patients, high morality, and high degree of tolerance, good communication skills, and good self-control. Understanding the emotional intelligence of a doctor during the practice of being a medical student may be essential for

developing emotional and intellectual growth so the future doctors can assess emotional quotient during the practice and study as Chulalongkorn medical students.

The questionnaire used in the study was established by a team of Thai psychiatrists and psychologists based on Thai culture that emphasized goodness, mindfulness, peace, happiness as well as competency. People who recognized their feelings and aims in life would set a direction to progress and handled their emotions properly (Suppapitiporn S, Kanchanatawan B, Tangwongchai S 2006).

On the other hand, Gundlach et al. (2003) argued that emotional awareness and emotional regulation are considered key factors that facilitate the perception of self efficacy because they prevent individuals from being tampered by their negative emotion when making causal attribution between their abilities and outcomes. Nevertheless, Tsai, Chen, and Liu (2007) argued that a positive mood not only makes people easily recall an outstanding performance that they had in the past, but it also enhances their positive feelings about their past performance, thereby allowing them to raise expectation about their ability. Plus, their study conducted on employees and supervisors from insurance companies in Taiwan also found a strong positive relationship between positive mood and task-specific self-efficacy measure (Tsai et al., 2007).

Mayor and Salovey (1997) suggested that EQ consists of four functions. First, appraisal and expression of emotion in the self refers to the ability to understand one's own deep emotions and be able to express them naturally. Second, appraisal and expression of emotion in others refers to the ability to perceive and understand the emotions of other people (Goleman, 1995). Third, regulation of emotion in the self refers to the ability to control one's own emotion, which is crucial for an individual to recover quickly when experiencing a negative emotion. Fourth, using emotion to facilitate decision making represents the ability to direct one's own emotions to help improve performance.

In Thailand, Department of Mental Health (MOH) has classified the emotional intelligence (EI) into three categories. Firstly, "Intelligence" signifies one's awareness, motivation, and ability to cope with problems. Secondly, "Goodness" indicates the ability of controlling oneself such as emotions and desires. Lastly, "Happiness" implies the ability of living happily, being proud of oneself (Ramajitti Institute and Rajanukul, 2007).

In contrast, a survey conducted by The Shepell·fgi Research Group (2008), over 40% of call center agents deal with angry clients every day. They are often victims of verbal aggression from clients or find themselves in a state of emotional dissonance, for instance, they have to maintain a professional, helpful and caring attitude while feeling angry, sad or diminished. Such emotional labor may in part explain why there are significantly more emotional problems, such as anxiety and depression, in call centers than in other workplaces (19% vs 15%; The Shepell·fgi Research Group). These statistics indicate that there is a need for interventions that could help promote mental health and the use of effective emotion regulation strategies among call center employees.

As for this research Emotion regulation was assessed with six subscales of the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004; Labbé, Côté, Gosselin, & Dagenais, 2012), nonacceptance of emotional responses (6 items), difficulties engaging in goal-directed (5 items), impulse control difficulties (6 items), lack of emotional awareness subscale (6 items), limited access to emotion regulation strategies (8 items), and lack of emotional clarity (5 items). The DERS was developed to assess difficulties in emotion regulation. The lack of emotional awareness subscale reflects an inattention to, and lack of awareness of, emotional responses (e.g., "When I'm upset, I take time to figure out what I'm really feeling", reverse scored), while the impulse control difficulties reflects difficulties remaining in control of one's behavior when experiencing negative emotions (e.g., "When I'm upset, I have difficulty controlling my behaviors"). Higher scores for each subscale

indicate greater difficulties in emotion regulation (i.e., more emotion dysregulation). With the brief explanation stated, this makes it clear and an opportunity for the experts' part of this research to monitor and reflect the emotional regulation.

2.5 Mindfulness scale (PHLMS) & Global Health PROMIS 10

This researched used the The Philadelphia Mindfulness Scale (PHLMS) (Cardaciotto et al. 2008) which is 20-item, bi-dimensional measure assessing distinct components of present-centered awareness and acceptance that is based on both clinical and non-clinical samples without any meditation experience. Awareness items assess noticing or observing of internal and external experiences. Acceptance items assess non-judging and openness to experience and refraining from attempts to escape or avoid them. The assessment of present-moment awareness and acceptance which is valuable to practitioners working in the health industry. Clients and patients are regularly visiting and each one of them have different diagnosis and/or visit for a specific purpose. With this, the research can gain an insight on the present-moment awareness and acceptance of themselves and the situation they are dealing with at that point. For example, 'I am aware of what thoughts are passing through my mind. When someone asks how I'm feeling, I can identify my emotions easily. I tell myself that I shouldn't have certain thought' are some statements asked where the experts can reflect and reconnect with their state of mind and emotions on how they deal with a stressful environment being mindful and/or find it a challenge to do so.

On the other hand, Global Health- PROMIS Global Health (10 items) was used to know about the expert's health condition. This can support the research on emotional regulation, stress and mindfulness working in the hospital and/or clinic. This also enables understanding that during the times of uncertainty how one manages with being aware of self-health and well-being. Questions were asked under subscales of physical and mental health. For instance, "would you say your health is, quality of life, physical health, how would you rate your mental health, including your mood and your ability to think?" are some of the questions from the ten items. Hence, the use of these questionnaires are essential for this research study to establish a valuable insight of practitioners.

Neuroimaging studies have begun to explore the neural mechanisms underlying mindfulness meditation practice with techniques such as EEG (Slagter et al., 2007) and functional MRI (Farb et al., 2007; Lutz et al., 2008; Farb et al., 2010; Goldin and Gross, 2010). Various researches have revealed and show insight on how neural systems are modifiable networks and changes in the neural structure can occur in adults as a result of training. Since the early 1980s, mindfulness meditation has increasingly found a place in mainstream health care and medicine because of evidence that it's good for emotional and physical health. For instance, helping to reduce anxiety, stress, depression, chronic pain, psoriasis, headache, high blood pressure, and high cholesterol. Some studies suggest that it can improve immune function.

Chapter 3
Methodology

This is a qualitative research method research where four experts from the Health industry will participate in bringing awareness and valuable information.

3.1 Target population and Sample size

The researcher conducted a mix of a quantitative (brief) and qualitative research (more focus) where an in-depth- interview face to face, open ended questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management through email and Emotional Intelligence (DERS) questionnaire with four participants where answered.

The first participant was Dr. Davin Narula who is the Hospital Director of Sukumvit Hospital, Bangkok, Thailand who will be sharing about Mindfulness, Emotional Intelligence and the changes in the Health Care system and emergency treatment in Bangkok over the years. Dr. Davin completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The second participant was Mrs. Rasee Govindani, who is a certified birth doula with DONA International and a postpartum doula and childbirth educator in process of being certified by Childbirth International. She is also a Gottman Institute Bringing Baby Home Educator who has taught the English childbirth education classes at Bumrungrad International Hospital from 2011 until 2016. She has attended over 100 births in Bangkok hospitals. She is also a breast cancer survivor who was treated at Bumrungrad International and currently being followed at Chulalongkorn Hospital. Along with a fellow breast cancer fighter she started Beyond Boobs, a source for information and support for breast cancer fighters and survivors in Bangkok (Facebook link to Beyond Boobs: www.facebook.com/beyondboobsbangkok). Mrs. Rasee completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The third participant was Ms. Anette Pollner a senior Counselor at NCS Counseling Center, Bangkok who also completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The fourth participant was Dr. Anand Sachamuneewongse, Orthopedic Surgeon at Samrong General Hospital, Bangkok, Thailand who will be sharing about Mindfulness, Emotional Intelligence and the changes in the Health Care system and emergency treatment in Bangkok over the years. Dr. Anand completed the Quantitative & Qualitative Research requirements where an in-depth- interview face to face, open ended questionnaire, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10 questionnaire about the Health Industry, Challenges, Health Care Financing, Health Care Management was answered.

The four expert participants from different areas of the Health industry provided an insight to the principal objective of the research topic and assess experiences in the transitions of the health systems, where knowing more about the organizational structure and responsibilities to cope with the existing system in the health industry. Mindfulness draws upon the recent convergence of modern science and it is the cultivation of both attention skills and emotional balance. Therefore, the questionnaire on Difficulties in Emotion Regulation Scale (DERS) Serenity Programme consisting 36 statements on various aspects of emotions and how one feels and what one does about it using the calculation in percentage - Higher scores suggest greater problems with emotion regulation will be assessed as the four experts being interviewed will fill in the questionnaires.

3.2 Questionnaire Design

Quantitative part:

All questionnaires are in English. The questionnaire given to them is on the Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, The Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10. The questionnaire can be seen in the Appendix 1.

Qualitative part – Open ended Questionnaire and Face to Face Interview questions

Questionnaire survey through email was an open ended questionnaire about the Health Industry, Challenges, Health Care Financing, and Health Care Management with *eight main questions* that would accomplish the objectives. Questions such as, Health Systems may be perceived as a specific institutional involvement in the implementation of tasks related to the maintenance and improvement of a patient's health. What are your views and opinion on this with the job you do? What are the challenges you face when it comes to sharing knowledge and information to the patient? What is it that you can say, want to say, or don't want to share/say to the patient when dealing with their health issues/service given to them? How do you deal and what are the current pressures within the internal & external environment of health systems in Bangkok, Thailand? What are the changes/transitions in the health care system and management and how has that affected you? In times of uncertainty what approaches do you take? Share about your daily work responsibilities. What are your views on Alternative healing therapies? Is it important to be Mindful and be aware of Emotional Intelligence? Please share your views. What would you like to change about the Bangkok health care system & anything you feel needs changes in the place you work to have better approaches to enhance healthcare management and communication? Is there or has been a health problem you dealt or is dealing with? How did or are you coping with it? Do you apply the similar approaches with your patients?

Face to Face audio recorded interview consisted of four main questions: Has this research been beneficial for you? Give your views on answering the questionnaire on Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS); Are you able to understand more about Emotional Intelligence & Mindfulness? Share your experience; Have you meditated or taken and alternative healing before? How did you feel and what you recommend to people concerned about health or dealing with health problems? What are your views on reforming, and/or developing a new horizon to Bangkok's Health care system and management?

3.3 Research Method

The research method was a mix of qualitative and quantitative approach. Descriptive tables, analysis showing the four different Emotional Intelligence Regulation Scale & Mindfulness scores by the four experts were applied. The qualitative questionnaires and face to face interviews audio recording were analyzed and is shown in the Appendix 1.

3.4 Formulated Hypotheses

1. There is an impact of Difficulties in Emotion Regulation Scale (DERS) – Serenity programme on performing hospital/clinic duties.
2. There is an influence of being Mindful when performing hospital/clinic duties.
3. Not being aware of emotional, mental, and physical stress can affect productivity and service provider.
4. Doctors and professionals working in the clinic/hospitals are aware about Emotional Intelligence and Structural Transitions in the Health Care Systems in Thailand.
5. There is awareness in emotional regulation pattern.

Chapter 4

Research Findings and Analysis

Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts through Mindfulness & Emotional Intelligence in Bangkok, Thailand is significant and a mandatory study for any health industry in the global space. The research findings and analysis shared and answered by four expert participants were taken into consideration through Quantitative (descriptive) and Qualitative Study.

4.1 Research Findings of Quantitative Study

For Quantitative requirements difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS) were answered by the four experts.

Table 4.1 below shows the differences in scores and how each expert answered the Global Health PROMIS 10, Emotion regulation scale (DERS), and The Philadelphia mindfulness scale (PHLMS). In relation to the health scores, the four experts' scores are quite similar. The global physical health score of Dr. Davin: 13, Mrs. Rasee: 14, Ms. Anette: 13, & Dr. Anand: 12 depict that each of them are healthy and aware of their health status with regular check-up. On the other hand, with the global mental health score two experts have the same score (Mrs. Rasee and Ms. Anette 16), Dr. Davin has the highest score (17) and Dr. Anand with the lowest (13). This depicts that Dr. Davin, Mrs. Rasee, & Ms. Anette have their scores more towards very good as for Dr. Anand as good mental health. This shows that all the experts' have good physical and mental health.

Moreover, regarding emotion regulation each expert have similar scores in terms of non-acceptance of emotional responses, difficulties engaging in goal directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity. From the table it shows that all four experts do not have a problem and almost never have a problem not accepting emotional responses and only sometimes based on a situation may feel so. In terms, of difficulties engaging in goal-directed tasks when upset sometimes have some difficulties and about half the time may have difficulty in engaging in goal directed tasks but almost always can get things done.

Regarding, impulse control difficulties, Dr. Davin, Mrs. Rasee, & Dr. Anand can control their behaviors and seldom become out of control. However, Ms. Anette sometimes may have difficulty controlling her behavior. This shows that the participants are in awareness of their emotions and know how to control and when to voice out. When it comes to lack of emotional awareness all participants are emotionally aware about their feelings and know how to acknowledge their emotions. Ms. Anette scores the highest with being aware of her emotions and pays attention on how she feels and believes that are feelings are valid and important. Additionally, regarding to limited access to emotion regulation strategies, all four participants do not feel they limited access to emotion regulation strategies. Ms. Rasee may feel it sometimes based on an unexpected case; however, Ms. Anette, D. Davin, Dr. Anand do not feel overwhelmed too easily, do not believe that they will end up feeling very depressed. This shows all four participants can manage their emotions and do not jump into conclusions about their emotions. There will be times when they may take some time to feel better about a situation, but in most cases they are fine.

In relation to the lack of emotional clarity, three participants (Dr. Davin, Mrs. Rasee, & Dr. Anand) have emotional clarity almost always and almost never feel they have no idea about they feel. In contrast, Ms. Anette may sometimes have difficulty in making sense out of her

feelings and sometimes has no idea how she feels about a situation. This shows that all four experts have clarity almost always about their emotions.

Conversely, regarding mindfulness scale, in reflection to the awareness score all four experts are aware (mindful) about their emotions and conscious about their thoughts. Conversely, Dr. Anand's score is slightly lesser showing that there might be times he may not be aware (mindful) about his emotions at all times and about his thoughts at all times. However, this does not mean that the participants are not aware of their emotions. In relation to the acceptance score, Dr. Anand's has the highest score depicting that he is more acceptable (mindful) about his emotions, mood, feelings, and aware of how the air feels against his face. Dr. Davin, Mrs. Rasee, and Ms. Anette have similar scores depicting they accept and are mindful about their emotions and thoughts.

Table 4.1: Scores of Global Health PROMIS 10, Difficulties in Emotion regulation scale (DERS), and The Philadelphia mindfulness scale (PHLMS).

	Questions	**Dr. Davin**	**Mrs. Rasee**	**Ms. Anette**	**Dr. Anand**
Global Health PROMIS 10 Scale 1-5 for health Scale 1-10 for pain					
Global physical health score	Global 03: In general, how would you rate your physical health? Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair? Global 07: How would you rate your pain in average? Global 08: How would you rate your fatigue on average?	Raw Score: 13 T-score: 42.3	Raw Score: 14 T-Score: 44.9	Raw Score: 13 T:Score: 42.3	Raw Score: 12 T-Score: 39.8
Global mental health score	Global 02: In general, how would you say your quality of life is: Global 04: In general, how would you rate your mental health, including your mood and your mobility to think? Global 05: In general, how would you rate your satisfaction with your social activities and relationships? Global 10: How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Raw Score: 17 T-Score: 56.0	Raw Score: 16 T-Score: 53.3	Raw Score: 16 T-Score: 53.3	Raw Score: 13 T-Score: 45.8
	Questions can be seen in	**Dr. Davin**	**Mrs. Rasee**	**Ms. Anette**	**Dr.**

	Appendix 1				Anand
Difficulties in Emotion Regulation Scale (DERS)					
1.Non-acceptance of emotional responses (NONACCEPT) SCORE		11	7	6	8
2. Difficulties engaging in goal directed behavior (GOALS) SCORE		8	13	15	13
3. Impulse control difficulties (IMPULSE) SCORE		9	10	13	9
4. Lack of emotional awareness (AWARE) SCORE		26	27	30	26
5. Limited access to emotion regulation strategies (STRATEGIES) SCORE		13	18	15	15
6. Lack of emotional clarity (CLARITY) SCORE		12	11	14	11
Mindfulness-Philadelphia Mindfulness Scale (PHLMS)					
Awareness Score		42	45	50	39
Acceptance Score		25	25	21	31

4.2 Analysis of Qualitative Study

In relation to the Qualitative study, open ended questions and a face to face audio recorded interview was conducted.

The first participant is Mr. Dr. Davin Narula who is the Hospital Director and Internal Medicine Specialist of Sukumvit Hospital, Bangkok, who is above 45 years old. His years of expertise and currently in the late 60s of age has enables him to see changes, potential in the

young specialists, and provide insightful knowledge. He usually sleeps early by 10:00 pm and he surely likes his job. He usually discusses his daily stress with his voice and believes in one's thought process applying the NLP approach in dealing with stress and emotions. His view on Neuro-linguistic programming thinking approach enhances and enables a person to change perception, it's scientific, logical, guide to communication, psychotherapy, and behavior through neurological process in a positive way where one has the ability and will power to change the thought process which can in turn change the cell system in decoding and become fixated on any thought that can cause stress.. He believes and practices sleeping early and waking up early.

When asked: *Health Systems may be perceived as a specific institutional involvement in the implementation of tasks related to the maintenance and improvement of a patient's health. What are your views and opinion on this with the job you do?* Dr. Davin's feedback was prevention beats treatment, health promotion is the key approach where education on health and self-care is better than consistent consumption of medication. However, this may vary depending on any patient with serious illnesses and chronic diseases. Through education life will be better physically, mentally, and emotionally. Positive thinking can help in cell repair and people should become more aware of this.

When asked: *What are the challenges you face when it comes to sharing knowledge and information to the patient? What is it that you can say, want to say, or don't want to share/say to the patient when dealing with their health issues/service given to them?* Dr. Davin's feedback was he shares with his patient. The only problem he faces is sometimes it can get time consuming and next patient may get upset. At times, patients may not appreciate honesty.

When asked: *How do you deal and what are the current pressures within the internal & external environment of health systems in Bangkok, Thailand?* Dr. Davin's feedback was to keep updated with new studies and resources that are created by health experts, Harvard, and many more. External pressure can be the patient's stubbornness. Also, when there is a psychological problem doctors would send patients to the psychiatrist where in many cases may not be needed. Hospitals need to have better care on wellness through communication (counselling, NLP approach development, listening to patients, etc) and see the severity then it can be guided, and recommended to another approach.

When asked: *What are the changes/transitions in the health care system and management and how has that affected you?* Dr. Davin's feedback was on emphasizing the transitions in technology where patients embrace individual treatment with the help of medical knowledge in the internet. Artificial Intelligence is enhancing and has transformed the medical industry with various types of cures, surgeries, and science is being researched and taken more seriously in present times with the help of information technology.

When asked: *In times of uncertainty what approaches do you take? Share about your daily work responsibilities.* Dr. Davin's feedback was he discusses with his family members and people around him. He never discusses patients' information as they are always kept confidential.

When asked: *What are your views on Alternative healing therapies? Is it important to be Mindful and be aware of Emotional Intelligence? Please share your views.* Dr. Davin's feedback was his trust in knowledge, studies, research, and meditation. Emotional stability plays a role on physical health as well. There is a difficulty in healing the body if the mind is not ready and not healthy as well. Being mindful is essential and meditation surely helps.

When asked: *What would you like to change about the Bangkok health care system & anything you feel needs changes in the place you work to have better approaches to enhance healthcare management and communication?* Dr. Davin's feedback was emphasis on Time.

Having time for patients is effective and providing a meditation class may restore and help patients. Patients appreciate time given to them.

When asked: *Is there or has been a health problem you dealt or is dealing with? How did or are you coping with it? Do you apply the similar approaches with your patients?* Dr. Davin's feedback was on focusing on all aspects from medical, social, and spiritual conducts to gain the most benefit in health.

In relation to the face to face audio recorded interview which consisted of four main questions: *Has this research been beneficial for you? Give your views on answering the questionnaire on Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS); Are you able to understand more about Emotional Intelligence & Mindfulness? Share your experience; Have you meditated or taken and alternative healing before? How did you feel and what you recommend to people concerned about health or dealing with health problems? What are your views on reforming, and/or developing a new horizon to Bangkok's Health care system and management?*

Dr. Davin's views and feedback was that it's important to be professional and with the help of journals and various researches one can be mindful as well as become aware of being emotionally intelligent. He stated, 'we have a very interesting network in our brains and when we have repetitive thoughts in increases our cells with those thoughts slowly covering up our brain with thoughts that are not needed in a couple of days feeling depressed. However, if one goes in a positive way, one can also change the thought process and the cells can change from feeling depressed to happiness through the neuro network programming in the brain.' He expresses the motivation behind a research conducted like this for Bangkok and sees this as a benefit that can bring awareness to many people. However, the questionnaires can be good, but it may leave out many aspects of a situation, so based on certain situations the answers may vary. With this research and interview he has been able to share many aspects and sees this as the opportunity to understand more about being mindful and be aware of emotional intelligence.

He suggests and emphasizes on three factors: sleep, exercise, and energy. Sleeping between 10pm-4pm is the best time for body/cell repair (for instance tissue repair, growth hormone – melatonin is produced, blood supply to the muscles, and energy is restored etc) and this is a significant period of time where every person should embrace and become aware of. With the current lifestyle and consumption of unhealthy intakes affects the patterns of sleep. More people put work as a priority where there is no balance and that constant thought of wanting to complete work and sleeping late also affects sleep patterns.

The body needs oxygen and energy needs to be restored so that one can perform at the best in every way. Hence, exercise is important, 150 minutes per week or 30 minutes five times a week will help oxygen flow in the entire body system. Energy is vital for human physiology. God food given by nature is mandatory, which means fruits and vegetables are essential for the diet. There is nothing extra as all the elements the body cells need are in the fruits and vegetables that can help in stem cells. Stress cannot be seen but felt, thus, energy and other aspects need to be taken into consideration.

With regard to mindfulness and emotional intelligence in the context where people do sleep and exercise yet face problems. Dr. Davin's addressed aspects on spiritual requirements practicing a positive lifestyle, believing in the presence of God/Divine where people should understand the spiritual aspects of the context written in the religious books to assist in embracing a positive lifestyle. Many people don't understand and are not aware of the spiritual aspects or guidance shared by masters. Having gratitude every day and not asking

what one does not have but thanking about what one has brings about an amazing positive change and a fulfillment of goals can be achieved. On the other hand, meditation is important and a proven fact by various researches and scientists on how the approach and practice helps in cell repair, brain function and neurology. Meditation if guided properly and understood clearly can surely benefit anyone in many ways; for instance, if a person is overworked can always feel better after a thirty – sixty minutes meditation. Meditation is a growing awareness and is being practiced over centuries where people are becoming aware at present times and people should practice it as it helps in positive thinking, cell repair, healing, and being healthy. Medication only is not always the only way but utilizing sleep, conserving energy, exercise, and meditation is effective.

When concerns about society, norms, and how hospitals can add meditation as a mindful program where addressed Dr. Davin was impressed and saw this as a great aspect of concern. He encouraged if the right people would develop programs and propose to the hospitals there could be a possibility of acknowledging the approach for well-being programs. Moreover, studying medicine is a big step and medical schools apply medicine to treat. For psychological concerns patients are sent to the psychiatrist and medical practitioners' don't treat them. Emotional intelligence and being mindful is not very much addressed and he agrees with the researcher that if the combination of approaches are being proposed and taught this could be quite beneficial for the health industry not only for patients but for people working in the health industry. He encouraged with the fact that if society understands about this more there would definitely be a huge change in the health industry. He looks forward to integrate two ways into the health programs as this has never been thought and taught in medical schools. Medical schools focused more on treatments and medication to befit the drug industry. Certain aspects people don't talk about to avoid conflicts which is an ethical dilemma. Hence, emotional intelligence, psychology and mindfulness programs are needed with medication too.

The second participant **is** Mrs. Rasee Govindani is Self-employed birth and postpartum doula and childbirth educator aged between 36-40 years. She self-employed, but support women at whichever hospital they birth at; mainly her clients birth at Samitivej, Sukumvit and Bumrungrad International. Having worked since year 2010 she has gained the expert knowledge and experience. Usually she sleeps early around 10 pm, however, it depends on the day. She likes her job very much so.

She stated that, **'**stress and emotions are two different things. She does not often let herself become stressed. If she feels overwhelmed, she considers the situation and fixes what she can, then let go of the rest. She is not the one to dwell on the things she cannot control or change. If she needs to unwind she likes to read or watch a movie or TV show or go window shopping. She is a bit of an emotional eater so she likes comfort food and sometimes a glass of wine. As for emotions, she knows that feelings come and go, and just because she feels something in the moment, it does not accurately reflect reality. She likes to feel my emotions and she don't shut them out, run away from them, and does not overthink them.'

In relation to sleep disturbance from work being called often called in the middle of the night to attend a birth. She only take on two to three clients a month so the sleepless nights are limited. It takes her a few days to recover from overnight births. She sleeps a little more for a couple of days and does not do a lot during the day and being used to this as part of her job.

When asked: *Health Systems may be perceived as a specific institutional involvement in the implementation of tasks related to the maintenance and improvement of a patient's health. What are your views and opinion on this with the job you do?* Mrs. Rasee's feedback was on how she supports a couple during pregnancy as well as during labor and birth. This means

that, during pregnancy, she talks to a pregnant client about food, exercise, sleep, and how she can prepare her body (and mind) for labor. A normal labor and birth begins with a healthy woman; how she takes care of her body can impact how her pregnancy progresses, how her labor unfolds, and how well she recovers in the postpartum. She also focuses on her mental well-being and try to make sure that she's in a good place in her head as well as in her relationship with her partner. Mrs. Rasee supports that both aspects are important when entering into labor.

As a postpartum doula she tries to make sure that her client, who has just given birth and is likely breastfeeding, continues to eat healthily and takes care of herself by sleeping as much as she can, taking time to herself each day, and eventually, moving her body in a way that is comfortable for her. She also checks in with her client emotionally during this time as hormonal changes can affect how she feels immediately postpartum as well as in the coming days and weeks. Most women will experience the "baby blues" and a small amount will go on to develop postpartum depression. She reminds women of what is normal and what isn't so she can continue to be supported in an appropriate way.

As a childbirth educator she does the combination of what she has already covered and tries to prepare a pregnant woman physically, mentally, and emotionally for the journey ahead.

When asked: *What are the challenges you face when it comes to sharing knowledge and information to the patient? What is it that you can say, want to say, or don't want to share/say to the patient when dealing with their health issues/service given to them?* Mrs. Rasee's Feedback was she wears many hats and each has limitations so it depends on the services she is providing a client. As a doula she shares only what she feels is relevant to the client and what she wants to know. Information is kept as positive as possible while also making sure the client knows everything she needs to know to make the right decisions for herself in the hospital during labor and birth. She does not share negative outcomes and does not make things too personal. She does not her own birth story (which was negative). Her job is to support her client in achieving the birth she wants, even if it's not the birth Mrs. Rasee would choose for herself. She will talk through her choices with her client (if she wants) and give her the risks and benefits of each option that is (or may be) presented to her by her doctor or medical team, but ultimately she will make the choice that's right for her.

As a childbirth educator her job is to give all the information provide evidence-based childbirth education to couples who are planning all sorts of births: natural, medicated, surgical, and so on. She gives pros and cons for all choices available and tries to be as objective as she can. She shares her personal choices and stories of births she has attended as examples and "possibilities."

When asked: *How do you deal and what are the current pressures within the internal & external environment of health systems in Bangkok, Thailand?* Mrs. Rasee's feedback was in in Thailand doctors have all the power and most Thai patients do what the doctors tell them to do, without doing any of their own research or asking questions about risks and benefits. Doctors are also not used to explaining or defending their decisions. She works with a lot of foreigners who, in their home countries, are used to being able to ask questions, get second opinions, and say no to procedures they are not comfortable with, and so on. So there's always a need for balance when she works with clients. She makes sure all her clients understand the hierarchy in Thai hospitals and how best to navigate that. It usually comes down to choosing the right care provider who is used to supporting foreign patients and understands their culture. At the same time she has to remind her clients that this is not their home country and things will be different. Hence, there's always that pressure of making sure that everyone gets what they want and everyone feels safe with the decisions made.

As a survivor of breast cancer, she definitely felt the pressure of doing what her doctors wanted her to do, without questioning them. But she also learned through her diagnosis and

treatment that she had to advocate for myself, that she had to ask the questions, and that she was entitled to information.

When asked: *What are the changes/transitions in the health care system and management and how has that affected you?* Mrs. Rasee's feedback was when it comes to pregnancy and birth, as time goes on, women are treated as patients who are sick rather than women who are experiencing a very normal biological process. It's as if women don't know how to be pregnant and birth babies anymore without doctors managing their entire beings. This means, for her, that women no longer have an instinct about their bodies. They no longer trust their bodies to work. She has to remind them that they are made to birth their babies while their doctors remind them how "dangerous" birth is and how women need their doctors' help to give birth. There's definitely conflict between how she perceive birth and how it is managed by the medical institutions.

There's also a rush to medicate every symptom. As a mother she sees this when her daughter is sick, usually with the common cold. She believes in her body's ability to fight these, but when she is unsure, such as if her fever lingers too long or she's struggling to be comfortable, She knows that there is only one or two doctors that she can take her to who will not automatically prescribe a number of medication she really doesn't need. Same goes for pregnancy and birth. Spotting during pregnancy? Here's progesterone. Having contractions? Here's magnesium. Let's not forget iron and calcium supplements as well as prenatal vitamins—all things that women don't necessarily need if they are eating well. This is just one more way of telling women that their bodies are simply not enough.

When asked: *In times of uncertainty what approaches do you take? Share about your daily work responsibilities.* Mrs. Rasee's feedback was her job is uncertain. Not every woman labors the same way and not every birth goes the same way so she always tries to be open to being surprised. She tries to remember that nothing is permanent and nothing stays the same and it is significant to learn to go with the flow. She holds on to the core things that are important to her-her daughter, family, health, work--and those anchor her when everything else is uncertain.

Her routine varies from day to day. The morning is for getting her daughter fed and dressed and sent off to school. She might have a full day of meetings with potential clients, contracted clients, clients who have given birth, and so on. Sometimes she teaches private classes and postpartum/breastfeeding support. When she does not have those she usually stays home to catch up with other work or emails or so on. Then she picks her daughter up from school and they go to whatever activity she has or they go play or go home and hang out until dinnertime. She might work after she's asleep, but usually it's her time to watch Netflix or read.

When asked: *What are your views on Alternative healing therapies? Is it important to be Mindful and be aware of Emotional Intelligence? Please share your views.* Mrs. Rasee's feedback was that there is a strong mind-body connection and she thinks a positive outlook and attitude can only be helpful in living life, especially when dealing with illness. But does believe that having a positive outlook can cure sickness? No. she believes in medicine. She believes in science. But she also believes in miracles and sometimes wonderful, unexplainable things happen. There's no telling what can make someone "feel" better, which can lead them to be stronger or healthier or more willing to fight. She is open to most things.

She doesn't believe in "alternative" as much as "complementary." She thinks that acupuncture, homeopathy, reiki, and the like can be helpful along with "conventional" medicine. (Which really is just medicine.) She knows many people that have benefitted from acupuncture and chiropractic care, and there is more and more research on these. Anything without real research she views with a grain of salt. She is happy for clients to try whatever they like, as long as it's not going to hurt them. She does not believe, say, substituting

chemotherapy with energy work if you have cancer. What she does know and what science has shown people is mindfulness and living life with gratitude does something to a person's brain to make one happier and healthier. So she does believe it is important to find the good in even the worst places.

When asked: *What would you like to change about the Bangkok health care system & anything you feel needs changes in the place you work to have better approaches to enhance healthcare management and communication?* Mrs. Rasee's feedback was she thinks Bangkok hospitals could benefit from a more integrated approach to healthcare, in every field. For example, a medical doctor being willing to work with other doctors as well as practitioners of complementary therapies, so a patient is offered all options to improve their health. There's also quite a bit of competition between doctors in the same field so it's nearly impossible to get objective second opinions at the same hospital. Doctors need to become a little more professional and realize that the objective is to help the patient.

Doctors need to learn to explain things better and go over actuals risks and benefits of procedures as well as offer alternatives rather than tell the patient that this is their only choice and discourage questions. Consent is considered given even before it's really asked for. A patient has the right to understand the risks and benefits or procedures and medication. They have the right to do research. They have the right to more opinions. And they have the right to say no.

Additionally, in some fields Bangkok is keeping up with the rest of the world, such as oncology, and obstetrics are years and years behind current research and practices. For example, family-centered Cesarean sections, where babies are allowed to be skin-to-skin with their mothers immediately after surgery and there is no separation of mother and baby. Even in the "best" hospitals, this is considered outrageous. There is also a fail to mothers of premature babies by not encouraging kangaroo care and breastfeeding. They know better, but fail to do better.

When asked: *Is there or has been a health problem you dealt or is dealing with? How did or are you coping with it? Do you apply the similar approaches with your patients?* Mrs. Rasee's feedback was sharing about when she was diagnosed with breast cancer in June of 2016 and underwent surgery (a mastectomy of my right breast), chemotherapy, and radiation. She is currently on hormone therapy. She has come through the worst of it and life will forever be different, but she take things one day at a time and does not worry too much about the future that is not in her control. Some days are better than others. Some days she can handle her worries and fears better than other days.

Cancer and childbirth are very different things, but as she has always said that labor and birth are very mental, getting through cancer was also that way for her. She tried to stay positive and count her blessings, even on the worst days. She did not believe that would make her healthier, but it made dealing with treatment easier. It helped her find joy in between the difficult moments. She learned to be her own advocate when she was sick so she encourages her clients to do the same, to ask for what they want and fight for what's important to them. To research and ask questions and get expert opinions.

With reference to the face to face audio recorded interview which consisted of four main questions: *Has this research been beneficial for you? Give your views on answering the questionnaire on Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS); Are you able to understand more about Emotional Intelligence & Mindfulness? Share your experience; Have you meditated or taken and alternative healing before? How did you feel and what you recommend to people concerned about health or dealing with health problems? What are*

your views on reforming, and/or developing a new horizon to Bangkok's Health care system and management?

Mrs. Rasee's views and feedback on this research was positive. The research made her think more about the work she does and how she does not view it as work and not medical related. This was a good reflection when questionnaires were answered and the process gone through or what approaches are being utilized for her clients. Her life is busy and usually from one client to the other. As part of labor, understanding emotional intelligence is mandatory and having labelled those helps people to understand better. When it comes her own emotional intelligence she is a good compartmentalizer and focuses on the work she does and does not take things to her heart as the work she does cannot be seen that way. There will be days where there is a hard birth and she would talk it through or have a good cry when she is at home. She has been very good in separating her emotions and her clients' emotions. She has taken her work seriously and never mixed the two. As for alternative healing or meditation she does breathing exercises and as doulas she tells her clients about relaxation (guided and visualization), mindfulness, and breathing exercises. When she walks into her room she always relaxes her mind and clears her head for a fresh start and being at peace.

On the other hand, the transition in the health industry with alternative healing or complementary medicine has emerged over the years with better access for clients/patients. For instance, back then there were less Reiki practitioners, Tapping, NLP, EFT, Chiropractors, and many more, but at present times this is much more available. This is not integrated with the hospital system, conventional medicine and is separated. It would be better if it was integrated. There is much more research and information available online now for side effects of chemotherapy for cancer patients and acupuncture helps with those side effects. As a cancer survivor, she has seen the changes and noticed the changes over years. It will always be good if there is a team to support the person and have integrated approaches. Doctors don't do much of the referrals so doulas usually end up making referrals for chiropractor care and acupuncture for the clients. She encouraged researches conducted like this for data and she believes in researches where it can benefit many people with valuable insight.

She shared her experience on how she managed emotions and days she broke down during the time she had breast cancer where she had to find balance between her, her work, and daughter with the help of her good friend who reminded her that her emotions where not real but based on the situation and how it can change. Emotion changes, they are not real and are not concrete. She embraced her emotions at that very moment and knew it will change eventually. She is not the person who would block her emotions and also tells her clients to not rationalize their emotions and they would feel exactly what they feel and it was fine to feel emotional. An emotional state is not a lifetime conclusion but a situational outcome. The sad will surely go away and there is no need justify. Sadness is not bad and how should one be happy if one does not know sadness.

The third participant is Ms. Anette Pollner a senior Counselor at NCS Counseling Center, Bangkok who is above 45 years old and been part of the health industry for 20 years. She usually sleeps at around 1:00-2:00am and likes her job. As a counselor dealing with stress and emotions is part of her training and is still part of her practice to work on her own issues. She does that through her own personal mindfulness practice, through creative writing and through Jungian/Gestalt dream work. She also has therapy and therapy supervision sessions. Over the years, she has become more aware. She tracks her emotions and reactions – this is especially important in order to be aware of what some people call counter-transference, where the therapist projects their own issues on to the client.

Countertransference is a dangerous dynamic and not at all helpful for the client, and can only be managed through constant self-exploration and self-awareness. She attended many group trainings in the US, at Esalen and at the Process Work Institute in Portland, Esalen, where she learned a lot about herself and about group dynamics, personal dynamics and communication. She also led creative writing and dream work groups on a regular basis, and that also helps her to understand herself.

When there is a life crisis or when she is sick, she gets scared and sometimes angry, like everyone else. Sometimes that's very natural and appropriate. She does not try to avoid or bury unwanted emotions, she tries to explore them and what they can tell her about herself. She deals with stress and emotions (and welcomes all emotions) by engaging with them and trying to understand them. She also tries not to add on extra stress by expecting to 'fix' all this. Some things are very difficult to deal with and tries to show herself compassion.

Ms. Anette's expressed how she is one of those people who can sleep in almost any situation. The only times when she was unable to sleep because of stress was on the night before surgery, or when her partner broke up with her, or when someone close to her was dying. And when she didn't know if her Thai visa would be renewed or if she would be deported.

Moreover, when she studied to be a counselor she worked on the night shift, the so-called 'graveyard shift' from midnight to 8AM at a large international investment bank in London. She surprised herself by how easy it was for her to switch to a night shift. She has always been a night person and does her best creative work after 10PM. Until recently, she found it difficult to get up early in the morning, so she mostly sees clients after 10AM, and often until 9PM/10PM which works out very well for those many clients who are working and cannot see a counselor during 'normal' office hours.

In turn, some of her friends who are geneticists at Cambridge University, the gene for attachment to the Circadian cycle (day/night cycle) is strongly switched on (has to be awake in the day and has to sleep at night), weakly switched on (usually night person) or even switched off at all. Hers probably hardly there and is very flexible with sleeping.

When asked: *Health Systems may be perceived as a specific institutional involvement in the implementation of tasks related to the maintenance and improvement of a patient's health. What are your views and opinion on this with the job you do?* Ms. Anette's feedback was for most of her adult life she lived, studied and worked in the UK with its public health system, the NHS. Before that she lived in Germany which has a mandatory public health insurance system which also means that almost everybody is covered. She believes that this is vital to individual health and to the health of a society.

Unfortunately, in Thailand, the public health system is not easy to access for foreigners and many foreigners have either no health insurance or their insurance doesn't cover mental health. This means that they have to pay for their own therapy. On the other hand, in the UK the public health system also doesn't cover mental health issues very well and she paid for all her own therapy both as a counseling student and before, as an 'ordinary' client working out her issues, out of her own pocket. But it was definitely worth it.

NCS Counseling Center offers people a discount for the sessions if they don't have a lot of money. This can sometimes be tricky since she has to rely on clients being honest with her and it has happened once or twice that a client has tried to take advantage of NCS. But generally, she want people to be able to come as she lives on what she earns. She would very much prefer to have a regular salary and the center to work out the finances.

When asked: *What are the challenges you face when it comes to sharing knowledge and information to the patient? What is it that you can say, want to say, or don't want to share/say to the patient when dealing with their health issues/service given to them?* Ms.

Anette's feedback was counseling and psychotherapy are client-centered. In other words, the client is in charge of their healing process.

It is her job to enable the client to understand themselves better and to find ways of healing themselves. Therefore, it would be inconceivable to her not to share knowledge and information about the client's situation or mental health condition with them. On the contrary, she tries to explore it together with them as much as possible and encourage them to find out more for themselves.

She does explains how counseling works in general, what kind of counseling school she personally belong to (humanistic/integrative), and how the counseling center operates. She also explain whatever issues come up and some of the theories about psychology, psychotherapy and sometimes even sociology, politics, social studies etc. In all of this, she follows the client's lead. Some people want a lot of explanation. Others prefer to follow their immediate experience and probable google the rest at home. She would never even consider withholding information of any kind that is relevant to the client.

Counseling is confidential and information about the client is only shared with her clinical supervisor. Nobody else has access to the information except of course the client themselves.

When asked: *How do you deal and what are the current pressures within the internal & external environment of health systems in Bangkok, Thailand?* Ms. Anette's feedback was that main issues are the fact that most clients have to finance the counseling themselves, the lack of 'modern' psychiatrists in Bangkok, and the preponderance of the American 'medical' system of mental health, which means that hospital psychiatrists and even general doctors over-prescribe anti-depressives and anti-anxiety drugs. This would not happen so much in Europe where she was trained and where she grew up.

Talking therapies for Thais are not part of the general health system in Thailand which is very disappointing. They do have many Thai clients but they are mostly well-educated, wealthy, and have often spent parts of their lives outside Thailand. The main issue in her view is a lack of Thai counselors and psychotherapists who do NOT practice according to the American medical model but focus on the talking therapies.

Another huge issue is the lack of a suicide prevention hotline (the English language version of the Thai Samaritans is only a 'callback' system where someone will call you back within a week!) and the way suicidal patients are treated at Thai hospitals. There were cases where hospitals refused to accept suicidal patients.

On the other hand, hospitals with dedicated psychiatric units have frequently not cooperated very well with them and other counseling centres.

When asked: *What are the changes/transitions in the health care system and management and how has that affected you.* Ms. Anette's feedback was there is not much change since it is operated outside the system as a private health centre and has worked in Thailand for 9 years now.

When asked: *In times of uncertainty what approaches do you take? Share about your daily work responsibilities.* Ms. Anette's responsibility is to her clients and to be the very best counselor she can be and help them to process their psychological and emotional issues.

Sometimes she feels uncertainty, but she works it out together with her client. She can get a lot of feedback from them, directly or indirectly through body language and behavior. The one thing that is difficult for her in the context of a private counseling centre is the issue of short notice cancellations.

The counseling centre has a policy of a 24 hour cancellation notice period and if someone cancels within less than 24 hours, the session has to be paid. This is absolutely necessary or the centre would have to close.

When asked: *What are your views on Alternative healing therapies? Is it important to be Mindful and be aware of Emotional Intelligence? Please share your views* Ms. Anette's feedback was she practices mindfulness and other forms of meditation every day. To her, this is one aspect of the deeper psychological work she does, also every day, and also links in with her creative life as a writer and creative writing coach.

She believes working on her underlying issues is very important, not just for therapists, but also for other health practitioners. The relationship with the client/patient is a form of therapeutic relationship, and affects the healing process enormously. In England, she also worked as a staff counselor at Bart's hospital in London where most of the clients were nurses and hospital staff (excluding doctors who had their own service). She experienced there firsthand how stressful the lives of hospital staff were, how difficult the dynamics in the workplace could be, and how it affected the patients. Sadly, this service has suffered greatly from funding cutbacks since then

When asked: *What would you like to change about the Bangkok health care system & anything you feel needs changes in the place you work to have better approaches to enhance healthcare management and communication?* Ms. Anette's feedback was for about 2 years, the centre had access to a very good Thai psychiatrist who worked at various hospitals in Bangkok and had studied in the US. He was very supportive of talking therapies, came twice monthly for intervision meetings and worked with those clients who needed psychiatric help.

The centre never had a psychiatrist like this before or since – and he went back to the US. Thus, that's what we need. Generally Thailand needs more education in the value of talking therapies and more access to them.

When asked: *Is there or has been a health problem you dealt or is dealing with? How did or are you coping with it? Do you apply the similar approaches with your patients?* Ms. Anette's feedback was she has had a number of health issues during her time in Thailand.

She dealt with them in the Thai health system – with varying success and varying levels of stress. Some of her experiences were excellent, others were very bad. Since she deals with mental health, there is no direct way she can apply this to her own work, except to remember that every client is a person, a person with a life, a life history, with emotions, with complex life circumstances. A person who deserves my help and respect. Being seriously ill is very frightening.

Interestingly, there is one sentence she remembers from a young Thai dentist who she only saw once. She said, 'I learned to treat every patient as if they were my own family member.' She would never forget that. Of course, in psychotherapy we cannot treat own family members. But clients are unique human beings who deserve respect and positive regard.

In relation to the face to face audio recorded interview which consisted of four main questions: *Has this research been beneficial for you? Give your views on answering the questionnaire on Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS); Are you able to understand more about Emotional Intelligence & Mindfulness? Share your experience; Have you meditated or taken and alternative healing before? How did you feel and what you recommend to people concerned about health or dealing with health problems? What are your views on reforming, and/or developing a new horizon to Bangkok's Health care system and management?*

Ms. Anette's views and feedback on this research was positive and certainly encourages more works like this being produced to help enhance various health practices and well-being programmes. She found it interesting to write down her thoughts and reflect on it. As a counsellor she deals with uncertainty all the time. The clients are always in uncertainty and the tolerance level in psychotherapy is much more. Most of the clients are private clients so she does not work directly with the hospital. Understanding about emotional intelligence and being mindful is a prerequisite for counselling and psychotherapy. One must be self-aware, non-judgmental, and not project to them becoming useful to the clients. In contrast, it is difficult to reflect something so profound like mindfulness in a questionnaire. Also for meditation it is more of a free form, thus, it cannot be answered specifically in a questionnaire. Some questions may not be suitable for a mindful activity and it is situational. Mindfulness cannot be measured completely with questions used like that.

In relation to emotional intelligence and mindfulness as a practical practice is better and she was under therapy for five years before seeing her first client. She worked with her deep issues first before meeting her clients. Psychotherapy also works with mindfulness and she even works on dream patterns, visualization, and deeper work is being done like meditation where one gets into this zone where one does not connect with time and space. Being a creative person enables her to use her own materials in an imaginative way and help the clients.

Ms. Anette has embraced various approaches in her life. She has done various workshops and trainings over the world and done meditation. She has also done the shamanic journey, mindfulness workshops in various aspects, and classic meditation. She likes the aspect of mindfulness where it connects one with sensory inputs and directs you to being in the moment and not worrying about the future which is very similar with Gestalt therapy. Mindfulness has become aware over the recent years and with the western influence through research, workshops, and promoting it. Mindfulness needs to connect with the life one lives and not just a practice once in a while, let's be mindful for ten minutes or a trend people like to follow. It is an everyday individual practice. Meditation is not about being calm but connecting with the world inside a person and the world outside a person through a deep process and being in the moment. Being in the moment is not an easy thing and for many therapies that is a practice.

From experience she has noticed that many people are guilty about the past and anxious about the future. What is missing is living in the moment. Everything is either a memory or a fantasy. This is where meditation and creativity comes in where it helps in being in the moment. Also, when dreaming, that is also being totally in the moment. Personally she believes being calm is not the case but connecting to reality is very important. Emotions are very important and one must feel what one feels and being calm in a state of happiness or sadness can be a problem as emotions are to be shown or expressed. Even when going through a surgery at that point a person is quite scared and their emotions are justified. Nurses lack the knowledge and counseling to connect with the patients where they should be able to communicate with the patient rather than telling the patient not to be afraid when the patient will be afraid. It is a natural situation that should be addressed properly and acknowledge the patients feeling especially with the terminally ill. Doctors and nurses should have training programmes to learn how to acknowledge and communicate with patients. This is very important for nurses and doctors and can benefit hospitals. Sometimes, assumptions are made based on statistics and it's necessary for doctors in Thailand to become aware and connect with patients so it can help in the treatment process.

Long walks in the parks and nature therapy is very important. In Japan this is a very important approach and Thailand should adopt this approach in the healing process. Listening

to the sounds of the nature is essential for human physiology and health. The public hospitals and private hospitals in Thailand are very different. Private hospitals have more services and public hospitals don't. Personally she feels that hospitals should have counselors on call so they can always see the patient and provide emotional support to patients and staff. Having experienced working as a counselor in a hospital in London, nurses' sick rate is very high as nursing jobs are very stressful. It is because of the hierarchy and when they are sick they would stay home and sometimes nurses would bully each other. Then counseling services were offered for nurses which was a great opportunity and one nurse came for counseling and she learnt that that nurse was the bully. Once they admitted the problem there was healing provided which was good and counseling is very important. In public hospitals in Thailand nurses are very much in charge and some very old nurses have worked in hospitals for a very long time and empowerment is needed. It's important to see how the main nurses run certain department which can be good and some bad. Hence, empowerment and counseling services is very much needed to enhance a better service and healing for nurses too. This will become a health benefit and invest in better machines for public hospitals in Thailand to provide a better healing atmosphere for everyone.

The fourth participant was Dr. Anand Sachamuneewongse, Orthopedic Surgeon at Samrong General Hospital, Bangkok aged between 30-35 years of age has been in the health industry for seven years. He usually sleeps late around 1:00am and likes his job. He expressed that stress cannot be avoided especially when patient's complication arises. He usually keeps his stress to himself; however, does consult and/or discuss with co-workers and family members. When overwhelmed with stress or emotions he would usually exercise or play sports.

When asked: *Health Systems may be perceived as a specific institutional involvement in the implementation of tasks related to the maintenance and improvement of a patient's health. What are your views and opinion on this with the job you do?* Dr. Anand's feedback on this aspects suggests that even though patient's improvement and maintenance for health is the main role, he believes that the health system consists of interconnected institutions and individuals that have a role not only to restore and maintain but to also educate the community regarding disease prevention knowledge and activities.

When asked: *What are the challenges you face when it comes to sharing knowledge and information to the patient? What is it that you can say, want to say, or don't want to share/say to the patient when dealing with their health issues/service given to them?* Dr. Anand's feedback was apart from the actual treatment communication is a significant part. When it comes to dealing with patient's emotions and understanding there is no straightforward guideline to follow. On the other hand, one of the challenges that are faced that nowadays there is an easy access to resources and patients will be doing some research and read about their conditions before coming to the hospital. Sometimes, the information read will contradict with what they have read and that may cause some problem along the course of their treatment. In such cases telling them they are wrong can cause conflicts which can delay or affect the outcome of the treatment. All the doctor can do is to provide unbiased evidence and information that can help them make the decision in relation to the treatment choices. Also, government funding is limited and many people cannot afford treatments and updated equipment are needed.

When asked: *How do you deal and what are the current pressures within the internal & external environment of health systems in Bangkok, Thailand?* Dr. Anand's feedback was one of the main pressures in the internal environment is the increase in patients in the tertiary health care center including both inpatients and outpatients. For the outpatients department there are limited number of doctors and patients have to wait for a long period of time for their treatment. For inpatients department the number of beds and operating room available often causes delay for surgical treatment and prolong hospital stay. These problems are

caused by the external environment factors which is due to the insufficient government funding. He deals with this problem by communicating with the patients and give them the information about the current situation to avoid conflicts.

When asked: *What are the changes/transitions in the health care system and management and how has that affected you?* Dr. Anand's feedback was on the awareness of the updated equipment in the teaching hospitals and doctors have better access to research database. Patients have easier access to health care services due to advance referral systems and communication methods. Content over the internal can easily go viral and the sue rate has increased over the years. In order to avoid public conflicts or law suits, patients are usually recommended specialized physicians in tertiary care center without no proper initial treatment and because of this the number of the patients in the tertiary care center are increasing.

When asked: *In times of uncertainty what approaches do you take? Share about your daily work responsibilities.* Dr. Anand's feedback was he discusses with his family members and consults with other seniors at work if necessary.

When asked: *What are your views on Alternative healing therapies? Is it important to be Mindful and be aware of Emotional Intelligence? Please share your views.* Dr. Anand's feedback was on having limited experience on Alternative healing therapies. He is not against it and does encourage patients to take alternative healing of their choice as long as it does not harm them physically. He thinks that it's important for patients to be mindful and be aware of their emotional intelligence.

When asked: *What would you like to change about the Bangkok health care system & anything you feel needs changes in the place you work to have better approaches to enhance healthcare management and communication?* Dr. Anand's feedback was on limited government funding and inadequacy of resources in the rural areas. With not enough equipment and physicians to investigate or perform treatments patients are then referred to the tertiary care center where the number is increased with insufficient resources and causes delay for the treatment.

When asked: *Is there or has been a health problem you dealt or is dealing with? How did or are you coping with it? Do you apply the similar approaches with your patients?* Dr. Anand's feedback shared his experience in being affected with chronic back pain which affected his work performance. Instead of getting rid of the pain with medication he tried physical therapy and exercise which helped him reduce the pain and improve symptoms. He applies similar approach with his patients so it can help them with reducing the pain and improve the symptoms.

With reference to the face to face audio recorded interview which consisted of four main questions: *Has this research been beneficial for you? Give your views on answering the questionnaire on Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS); Are you able to understand more about Emotional Intelligence & Mindfulness? Share your experience; Have you meditated or taken and alternative healing before? How did you feel and what you recommend to people concerned about health or dealing with health problems? What are your views on reforming, and/or developing a new horizon to Bangkok's Health care system and management?*

Dr. Anand's views and feedback on a research conducted like this is very interesting. He never thought about emotional intelligence and being mindful and through the questionnaires and research process it helped him understand and become aware about being mindful. There were times when things can be stressful and he usually focuses on the root cause and finds a

solution. He exercises and listens to music to reduce stress and find a solution. His patients usually embrace religious beliefs to stay mindful and their thinking process for Thai people. The questions addressed in the mindfulness scale are fine; however, in every situation things are dealt differently and a deeper approach is needed outside the questionnaire. During his training years, in the case of emergency and the patient dies there is no straight protocol but right facts and information is given to the family to share the news. Emotions are taken into consideration and enough information is given for emotional support leaving out an elaborated information that can affect them emotionally and mentally. At that particular time the situation is quite delicate and avoiding a blame game or pointing out any hesitance that was taken at that point.

He has never meditated and does advice his patients to practice the approach. He does consider to take meditation and nature therapy into consideration. Alternative healing like Ayurveda and acupuncture is good. From his experience working in public hospitals is that people versus the doctors as there were patients and less doctors which was the main problem because there was a delay in treatment and less beds for patients. Many patients did get anxious and with not enough equipment affects the patients in the tertiary care center. Paramedic systems in Thailand is needed to be monitored and improvement is very much needed. Even though there has been some improvement, the government should take all this into consideration to help the country's well-being and emotional intelligence should be trained and practitioners and staff should be educated about these aspects.

Chapter 5

Conclusion and Future Research

This research study emphasized and explored the demographics structural changes, healthcare transitions, alternative healing approaches, challenges faced during the time of uncertainty, assess experiences of experts in the Health Care system in Bangkok, Thailand. Additionally, to understand more about how practitioners working in the Health Care industry are aware of their own emotional state before treating or providing any kind of service to their clients/patients a qualitative and quantitative research study was developed to accomplish the objectives.

5.1 Conclusion

In relation to the objectives below suitable questions were developed to justify the research study.

1. To determine whether the regular practice of Guided Mindful Meditation/training could improve patients' emotional intelligence.
2. To distinguish the effect of pressure from the internal and external environment of health system in Bangkok.
3. To evaluate the differences of between practitioners, experts, and doctors on various practices and handling structural transitions in the Health Care systems in Times of Uncertainty.
4. To bring awareness on valuable techniques and resources for practitioners, doctors, and patients to creating Balance & practicing Mindfulness in their daily life.
5. To analyze the shared experience of Mindfulness performed by the four experts in this research.

In conclusion, all four experts fulfilled the questions and answered all questionnaires on the Philadelphia Mindfulness Scale (PHLMS), Emotional Intelligence (DERS) questionnaire, & the Global Health PROMIS 10. Dr. Davin, Mrs. Rasee, Ms. Anette, and Dr. Anand are aware of their emotional intelligence in terms of thoughts, environment, mood, and there are situations that may bring some difficulties to deal with the internal state, however, they tend to find the suitable way to deal with it. Dr. Anand did not usually focus on emotional intelligence and mindfulness terminologies and this research guided him to reflect on several aspects that relate to him and his work in a deeper perspective.

In contrast, when the face to face audio interview was conducted the insightful sharing on various aspects of uncertainty, transitions, mindfulness, and emotional intelligence was expressed. The challenges in the health industry with having less doctors and advance equipment in the public sector was acknowledged by Dr. Anand and Ms. Anette. Dr. Davin on NLP and how neuro programming and mindfulness programmes can be utilized in medical training, educating patients through awareness, and in daily practice of one's life. Mrs. Rasee & Ms. Anette stressed on integration of alternative/complementary healing/therapies with hospitals and having counselors on call to provide emotional; and moral support to patients and people working in the hospitals in both provide and public hospitals. Many psychotherapeutic schools and approaches, which use the techniques based on the concept of mindfulness, for example, Gestalt therapy or Morit's therapy, which was addressed by Ms. Anette as she had practiced these during her training. Detailed answers can be read in the analysis part and the answers relate to the current situation stated in the literature review. Due to limited funding and a well-developed health care systems people in the rural areas and people in the lower social status do face difficulties in having suitable medications.

There is a need to bring awareness in acknowledging emotional intelligence, mindfulness, and integration of balance through neuro programming that can enhance people from all walks related to the health industry. The essential approaches to emotional, mental, physical, and spiritual practices are needed throughout the Nation which will progress in every way. It is not only the profits that need to be focused on but the implementation of integrated programmes that nurture every person as their very right to health benefits.

The understanding of how mindfulness training and emotional intelligence programmes enhance brain waves and human physiology has been researched and with this research it will certainly help anyone reading the perspective of experts in the health industry. Furthermore, emotional intelligence should be taught at schools for children to acknowledge how the feel and speak about it. Often, people feel guilty of how they feel or people around them make them feel guilty and direct them to be quiet about it and/or not being able to speak the truth. Being mindful is a necessary resource everyone can embrace. This research does acknowledge that if hospitals would introduce guided mindful meditation or training is could improve patients' emotional intelligence, there is an effect of pressure from the internal and external environment of the health system, and different practitioners experience different challenges and structural transitions. Conversely, every participant practices mindfulness differently and in some cases mindfulness is not even thought about which in this case because of this research it encourages the partipants to reflect and consider various approaches to mindfulness training.

5.2 Future Research

The research was limited to Bangkok geographically. There was a challenge on how much and whether the experts would be able to share as many aspects on structural transitions in the health care systems and provide suggestions in times of uncertainty from their perspectives. The participants perform their duties and follow the protocols of the place they work in. With due respect and privacy of the place suggestions offered were based on their experience and observation over the years, hence, they faced boundaries of what can be done and what cannot be done.

Further research encourages to be explored in rural areas and other clinics and hospitals on emotional intelligence and mindfulness training. Future studies can apply mindfulness training approaches on doctors and staff at the hospitals to test the efficacy of before and after practicing the mindfulness programme. It will be efficient to check the brain waves of before and after the practice of mindfulness training to check progress.

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Appendix 1

Questionnaire for Qualitative Research – Open ended question survey

Dear Participant:

I am conducting a "Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts in Bangkok, Thailand," *for Frontiers Public Health Journal.* This research only enhances and brings awareness on *being Mindful to develop Emotional Intelligence and Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts (2018).*

Thank you for your assistance with this study and survey. By completing this survey, you are granting me permission to analyze and present your answers and comments in research paper to be published. This research is completed by the Lecturer of Bangkok School of Management, Bangkok University & Reiki Master Teacher -Practitioner. Your contribution enables many health practitioners and people working in the health services to understand how important it's to understand mind, body, and spirit, and to reduce/overcome stress and improve well-being. Thank you for your time and assistance with this survey.

Please read the information carefully and ask questions about anything you don't understand. The purpose of this study is to explore your expert experiences through interpreting Difficulties in Emotion Regulation Scale (DERS) questionnaire, Global Health & being Mindful (PHLMS).

Statement of Consent:

I have read the above information and have sufficient information to make a decision about participating in this study. I consent to participate in the study. For any questions you can email: bhav_k@hotmail.com

Signature of Participant: …….

Signature of Researcher: …….

Section 1: Participant's Form

Name: ……

Place of work and position: ……

Age: ☐ 30–35 years ☐ 36-40 years ☐ 41-45 years ☐ above 45 years

Which hospital/clinic do you work in? …….

How many years have you been part of the health industry? …….

Do you sleep early or late? …… What time do you sleep? ……

Do you like your job? ……

1. <u>How do you deal with your stress and emotions?</u>

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2. Do you face sleep disturbance because of your work? How do you deal with having the right amount of sleep?

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Part 1: Open end Questionnaire

Dear Participant:

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Question 1

Health Systems maybe perceived as a specific institutional involvement in the implementation of tasks related to the maintenance and improvement of a patient's health. What are your views and opinion on this with the job you do?

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Question 2

What are the challenges you face when it comes to sharing knowledge and information to the patient? What is it that you can say, want to say, or don't want to share/say to the patient when dealing with their health issues/service given to them?

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Question 3

How do you deal and what are the current pressures within the internal & external environment of health systems in Bangkok, Thailand?

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Question 4

What are the changes/transitions in the health care system and management and how has that affected you.

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Question 5

In times of uncertainty what approaches do you take? Share about your daily work responsibilities

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Question 6

What are your views on Alternative healing therapies? Is it important to be Mindful and be aware of Emotional Intelligence? Please share your views

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Question 7

What would you like to change about the Bangkok health care system & anything you feel needs changes in the place you work to have better approaches to enhance healthcare management and communication?

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Question 8

Is there or has been a health problem you dealt or is dealing with? How did or are you coping with it? Do you apply the similar approaches with your patients?

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Part 2:

Face to Face Interview Questions for Qualitative Research

Dear Participant:

I am conducting a "Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts in Bangkok, Thailand," *for Frontiers Public Health Journal.* This research only enhances and brings awareness on *being Mindful to develop Emotional Intelligence and Structural Transitions in the Health Care Systems in Times of Uncertainty – Exploring views by Experts (2018).*

Thank you for your assistance with this study and survey. By completing this survey, you are granting me permission to analyze and present your answers and comments in research paper to be published. This research is completed by the Lecturer of Bangkok School of Management, Bangkok University & Reiki Master Practitioner. Your contribution enables many health practitioners and people working in the health services to understand how important it's to understand mind, body, and spirit, and to reduce/overcome stress and improve well-being. Thank you for your time and assistance with this survey.

Questions for Participant:

Question 1: Has this research been beneficial for you? Give your views on answering the questionnaire on Difficulties in Emotion Regulation Scale (DERS) – Serenity programme, Global Health & the Philadelphia Mindfulness Scale (PHLMS)

Question 2: Are you able to understand more about Emotional Intelligence & Mindfulness? Share your experience

Question 3: Have you meditated or taken and alternative healing before? How did you feel and what you recommend to people concerned about health or dealing with health problems?

Question 4: What are your views on reforming, and/or developing a new horizon to Bangkok's Health care system and management?

Answer all the questions under each part

Part 3: Print the questionnaires sent in the email

Global Health PROMIS 10

Difficulties in Emotion Regulation Scale (DERS) – Serenity programme

The Philadelphia Mindfulness Scale (PHLMS)

***Global Health*- PROMIS Global Health (10) SF**

	Please respond to each item by marking <u>one box per row</u>	**Excellent**	**Very good**	**Good**	**Fair**	**Poor**
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A Little**	**Not At All**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	In the past 7 days	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Glob	How often have you been bothered by	☐	☐	☐	☐	☐

al10	emotional problems such as feeling anxious, depressed or irritable?	5	4	3	2	1
		None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global08	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global07	How would you rate your pain on average?	☐☐ 0 No Pain ☐☐ 1 ☐☐ 2 ☐☐ 3 ☐☐ 4 ☐☐ 5 ☐☐ 6 ☐☐ 7 ☐☐ 8 ☐☐ 9 ☐☐ 10 Worst Imaginable Pain				

Scoring:

Re-code Global07. The recoded score ranges from 1 to 5.
(5=0 No pain; 4=1; 4=2; 4=3; 3=4; 3=5; 3=6; 2=7; 2=8; 2=9; 1=10 Worst pain imaginable)

After recoding, the
Global Physical Health score = SUM responses to G03 + G06 + G07 + G08.
Global Mental Health score = SUM G02 + G04 + G05 + Global10.

TOTALS	**Raw Score**	**T-Score**
Global Physical Health		
Global Mental Health		

PROMIS GLOBAL SF (10)

Physical Short Form Conversion Table		
Raw.Score	**T.Score**	**SE***
4	16.2	4.8
5	19.9	4.7
6	23.5	4.5
7	26.7	4.3
8	29.6	4.2
9	32.4	4.2
10	34.9	4.1
11	37.4	4.1
12	39.8	4.1
13	42.3	4.2
14	44.9	4.3
15	47.7	4.4
16	50.8	4.6
17	54.1	4.7
18	57.7	4.9
19	61.9	5.2
20	67.7	5.9

*SE = Standard Error

Mental Short Form Conversion Table		
Raw.Score	**T.Score**	**SE***
4	21.2	4.6
5	25.1	4.1
6	28.4	3.9
7	31.3	3.7
8	33.8	3.7
9	36.3	3.7
10	38.8	3.6
11	41.1	3.6
12	43.5	3.6
13	45.8	3.6
14	48.3	3.7
15	50.8	3.7
16	53.3	3.7
17	56.0	3.8
18	59.0	3.9
19	62.5	4.2
20	67.6	5.3

*SE = Standard Error

Hays, R. D., Bjorner, J. B., Revicki, D. A., Spritzer, K. L., & Cella, D. (2009). Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. *Quality of Life Research, 18*(7), 873-880.

1	2	3	4	5
Almost never (0-10%)	Sometimes (11-35%)	About half the time (36-65%)	Most of the time (66-90%)	Almost always (91-100%)

Difficulties in Emotion Regulation Scale (DERS)

Identifier Date

Please indicate how often the following 36 statements apply to you by writing the appropriate number from the scale above (1 – 5) in the box alongside each item.

1 I am clear about my feelings (R)

2 I pay attention to how I feel (R)

3 I experience my emotions as overwhelming and out of control

4 I have no idea how I am feeling

5 I have difficulty making sense out of my feelings

6 I am attentive to my feelings (R)

7 I

know exactly how I am feeling (R)

8 I care about what I am feeling (R)

9 I am confused about how I feel

10 When I'm upset, I acknowledge my emotions (R)

11 When I'm upset, I become angry with myself for feeling that way

12 When I'm upset, I become embarrassed for feeling that way

1	2	3	4	5
Almost never (0-10%)	Sometimes (11-35%)	About half the time (36-65%)	Most of the time (66-90%)	Almost always (91-100%)

13	When I'm upset, I have difficulty getting work done	☐
14	When I'm upset, I become out of control	☐
15	When I'm upset, I believe that I will remain that way for a long time	☐
16	When I'm upset, I believe that I'll end up feeling very depressed	☐
17	When I'm upset, I believe that my feelings are valid and important (R)	☐
18	When I'm upset, I have difficulty focusing on other things	☐
19	When I'm upset, I feel out of control	☐
20	When I'm upset, I can still get things done (R)	☐
21	When I'm upset, I feel ashamed with myself for feeling that way	☐
22	When I'm upset, I know that I can find a way to eventually feel better (R)	☐
23	When I'm upset, I feel like I am weak	☐
24	When I'm upset, I feel like I can remain in control of my behaviours (R)	☐
25	When I'm upset, I feel guilty for feeling that way	☐
26	When I'm upset, I have difficulty concentrating	☐
27	When I'm upset, I have difficulty controlling my behaviours	☐

1	2	3	4	5
Almost never (0-10%)	Sometimes (11-35%)	About half the time (36-65%)	Most of the time (66-90%)	Almost always (91-100%)

28	When I'm upset, I believe that there is nothing I can do to make myself feel better	☐
29	When I'm upset, I become irritated with myself for feeling that way	☐
30	When I'm upset, I start to feel very bad about myself	☐
31	When I'm upset, I believe that wallowing in it is all I can do	☐
32	When I'm upset, I lose control over my behaviours	☐
33	When I'm upset, I have difficulty thinking about anything else	☐
34	When I'm upset, I take time to figure out what I'm really feeling (R)	☐
35	When I'm upset, it takes me a long time to feel better	☐
36	When I'm upset, my emotions feel overwhelming	☐

Privacy - please note - this form does not transmit any information about you or your assessment scores If you wish to keep your results, you must print this document These results are intended as a guide to your health and are presented for educational purposes only They are not intended to be a clinical diagnosis If you are concerned in any way about your health, please consult with a qualified health professional.

Gratz, K.L. & Roemer, E. Multidimensional Assessment of Emotion Regulation and Dysregulation: Development, Factor Structure, and Initial Validation of the Difficulties in Emotion Regulation Scale. Journal of Psychopathology and Behavioral Assessment, 26: 1, pp. 41-54.

1	2	3	4	5
Almost never (0-10%)	Sometimes (11-35%)	About half the time (36-65%)	Most of the time (66-90%)	Almost always (91-100%)

SCORING THE DERS

The DERS is a brief, 36-item self-report questionnaire designed to assess multiple aspects of emotional dysregulation. Reverse-scored items are numbered 1, 2, 6, 7, 8, 10, 17, 20, 22, 24 and 34. Higher scores suggest greater problems with emotion regulation. The measure yields a total score (SUM) as well as scores on six sub-scales:

1. Non-acceptance of emotional responses (NONACCEPT)
2. Difficulties engaging in goal directed behaviour (GOALS)
3. Impulse control difficulties (IMPULSE)
4. Lack of emotional awareness (AWARE)
5. Limited access to emotion regulation strategies (STRATEGIES)
6. Lack of emotional clarity (CLARITY)

1: Nonacceptance of Emotional Responses (NONACCEPT)

25) When I'm upset, I feel guilty for feeling that way

21) When I'm upset, I feel ashamed with myself for feeling that way
12) When I'm upset, I become embarrassed for feeling that way

11) When I'm upset, I become angry with myself for feeling that way
29) When I'm upset, I become irritated with myself for feeling that way
23) When I'm upset, I feel like I am weak
Total:

2: Difficulties Engaging in Goal-Directed (GOALS)

26) When I'm upset, I have difficulty concentrating

18) When I'm upset, I have difficulty focusing on other things
13) When I'm upset, I have difficulty getting work done

33) When I'm upset, I have difficulty thinking about anything
else 20) When I'm upset, I can still get things done (R)
Total:

1	2	3	4	5
Almost never (0-10%)	Sometimes (11-35%)	About half the time (36-65%)	Most of the time (66-90%)	Almost always (91-100%)

3: Impulse Control Difficulties (IMPULSE)

32) When I'm upset, I lose control over my behaviours

27) When I'm upset, I have difficulty controlling my behaviours 14) When I'm upset, I become out of control

19) When I'm upset, I feel out of control

3) I experience my emotions as overwhelming and out of control

24) When I'm upset, I feel like I can remain in control of my behaviours (R)
Total:

4: Lack of Emotional Awareness (AWARE)

6) I am attentive to my feelings (R)

2) I pay attention to how I feel (R)

10) When I'm upset, I acknowledge my emotions (R)

17) When I'm upset, I believe that my feelings are valid and important
(R) 8) I care about what I am feeling (R)

34) When I'm upset, I take time to figure out what I'm really feeling (R)
Total:

5: Limited Access to Emotion Regulation Strategies (STRATEGIES)

16) When I'm upset, I believe that I'll end up feeling very depressed
15) When I'm upset, I believe that I will remain that way for a long time 31) When I'm upset, I believe that wallowing in it is all I can do

35) When I'm upset, it takes me a long time to feel better

28) When I'm upset, I believe that there is nothing I can do to make myself feel better
22) When I'm upset, I know that I can find a way to eventually feel better (R)

36) When I'm upset, my emotions feel overwhelming
30) When I'm upset, I start to feel very bad about myself
Total:

6: Lack of Emotional Clarity (CLARITY)

5) I have difficulty making sense out of my feelings 4) I have no idea how I am feeling

9) I am confused about how I feel

7) I know exactly how I am feeling (R)

1) I am clear about my feelings (R)
Total:

Mindfulness- **Philadelphia Mindfulness Scale** (PHLMS)

Please select how often you experienced each of the following statements within the past week.		**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
PHLMS1	I am aware of what thoughts are passing through my mind. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS2	I try to distract myself when I feel unpleasant emotions. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS3	When talking with other people, I am aware of their facial and body expressions. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS4	There are aspects of myself I don't want to think about. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS5	When I shower, I am aware of how the water is running over my body. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS6	I try to stay busy to keep thoughts or feelings from coming to mind. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS7	When I am startled, I notice what is going on inside my body. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS8	I wish I could control my emotions more easily. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS9	When I walk outside, I am aware of smells or how the air feels against my face. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS10	I tell myself that I shouldn't have certain thoughts. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS11	When someone asks how I am feeling, I can identify my emotions easily. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS12	There are things I try not to think about. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS13	I am aware of thoughts I'm having when my mood changes. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS14	I tell myself that I shouldn't feel sad. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS15	I notice changes inside my body, like my heart beating faster or my muscles getting tense. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS16	If there is something I don't want to think about, I'll try many things to get it out of my mind. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS17	Whenever my emotions change, I am conscious of them immediately. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS18	I try to put my problems out of mind. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS19	When talking with other people, I am aware of the emotions I am experiencing. (Aw)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PHLMS20	When I have a bad memory, I try to distract myself to make it go away. (Ac)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Scoring the PHMS:
Awareness Subscale: items 1, 3, 5,7,9,11,13,15,17,19
Acceptance Subscale: items 2,4,6,8,10,12,14,16,18,20

	My total	My item average
PHMS -TOTAL		
Awareness		
Acceptance		

Comments on PHMS:

Cardaciotto, L., Herbert, J. D., Forman, E. M., Moitra, E., & Farrow, V. (2008). "The Assessment of Present-Moment Awareness and Acceptance: The Philadelphia Mindfulness Scale." Assessment, *15 (2), 204-223.*

Therapy Sans Therapist: Overcoming Anxiety, Depression and PTSD

Dr. Margaret Trey
Center for Traumatic Stress Research at Xavier University of Louisiana, USA

Abstract / Program Guide

An increasing number of counselors/therapists are bringing Eastern meditative practices into the therapy room and introducing them to clients. Likewise, the presenter began to integrate Falun Gong (also known as Falun Dafa) into her therapeutic work back in 2001. Falun Gong, dubbed 'Chinese yoga', is an ancient Chinese spiritual cultivation system with elements from Buddhist and Taoist philosophies. Various studies have demonstrated that Falun Gong is beneficial for overall mind, body, and spiritual improvement—in reducing anxiety, stress, and a myriad of physical and psycho-emotional issues. A recent study by the presenter showed that the majority of respondents, who are health professionals, introduced Falun Gong to their clients. Using case examples, the presenter illustrates the mindful practice of Falun Gong as an antidote for overcoming anxiety, depression, and post-traumatic stress disorder. The presentation endeavors to throw light how this ancient self-cultivation discipline can serve as an intervention or self-help strategy to spark off self-healing and self-recovery for those seeking the path less travelled. This D-I-Y cultivation aspect of Falun Gong, with its concept of looking within to examine oneself, is akin to being 'in therapy without the therapist.'
(188 words)

Presenter bio:

Dr. Margaret Trey, researcher and author of *The Mindful Practice of Falun Gong: Meditation for Health, Wellness and Beyond*, adopts an integrative approach toward helping others. She holds a doctorate degree in counseling from The University of South Australia. Curiosity and a passion for antiquated wisdom enthused Dr. Trey to train in different modalities—traditional Chinese medicine, shiatsu, yoga, Vipassana meditation, food as medicine, and Falun Gong in 1997. Since 2001, Dr. Trey has focused on the study of the effects of Falun Gong by exploring counselor burnout with Falun Gong as an intervention strategy. During the same year, she began integrating Falun Gong into her counseling work and inspired her to investigate the health-wellness effects of Falun Gong as part of her doctoral research and current ongoing studies. Dr. Trey has presented on her research findings on Falun Gong at various international conferences, including in Cairns, Australia, Bangkok, Thailand, Singapore, and at the American Counseling Association annual conference in Montreal, Canada. To date, she has facilitated two Falun Gong seminars at Xavier University of Louisiana.
(176 words)

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Thinking Beyond the Horizon in Health Care Delivery – Case Study

Names of Authors:
Dr. K. Venkataramanan, Ph. D.,
Dr. Ajay P. Sankhe, M.D., Pediatrics

Affiliations of Authors: Bhaktivedanta Hospital & Research Institute, Mira Road, Mumbai, India

Case-Study – Thinking Beyond the Horizon in Health Care Delivery

"A patient coming to the hospital gives us an opportunity to serve: by treating a patient, we are not doing a favor to him, the patient is doing a favor to us by giving us an opportunity to serve" – **Mahatama Gandhi**

Steve Jobs of Apple often speaks about "Making a dent in the universe". But what does it take to do so? To find out one need not have to go to Cupertino, California. Just go to the western suburbs of Mumbai, Mira Road, you will find 'Bhaktivedanta Hospital & Research Institute' a 20 year old institution, that is truly had made a dent in the healthcare delivery with the concept of "Thinking beyond the horizon"

Here patient is not another bed number and there is an unwritten pledge to ensure 'health for all' & 'help for all' by mobilizing "all for health". It reminds us of "Declaration on health development in South-East Asia region in the 21st Century" by the Ministers of Health of Countries at their 15th Meeting in Bangkok, Thailand in August 1997. The declaration is founded on the principle of human rights, equity, social justice and the centrality of health to sustainable development. It identifies the challenges of addressing inequalities in health by creating an enabling environment and ensuring health services for all. It also resolved to strengthen the capacity and regional solidarity to further the same.

The then Director General of WHO, Gro Harlen Brundland rightly observed that, the way the health systems are designed, managed and financed, affect people's lives and livelihood. The difference between a well-performing health provider/ system and one that is failing can be measured in mortality, dis-ability, impoverishment, humiliation and despair.

Science and Technology advancement may have provided opportunities for improved diagnostic and treatment but, the escalating nature of diseases and growing dissatisfaction is a great cause of concern in healthcare delivery. Also, the dramatic recovery of patients from hopeless condition, from the medical view point, has always been an unresolved mystery. This indicates a missing link.

Contribution of spirituality to health has been accepted but not yet defined with clarity. Leigh Tremaine posted that "**Spiritual health can be defined** as our integration with the greater whole of life and is measured by the degree that we honor our interconnectedness with all things". Leigh adds "Developing good spiritual health releases inner suffering and adds deeper meaning and value to our lives. It also increases our compassion towards others, builds strong community and improves our ability to live sustainably. [1]

India's real wealth and also that of South East Asia's uniqueness is not just in the technical knowledge that they possess but in their God consciousness and the cultural heritage they have acquired and inherited from the Vedas and Spiritual Support Systems. By being God Conscious, one can transcend all sufferings in the human society. Modern man is moving in a godless direction and with each passing day, people are experiencing the ill effects of such misdirected civilization.

Spiritual Health

- There has been a growing awareness of what Arnold Toynbee referred to as a **"spiritual vacuum"** in many parts of the world, especially in the industrialized countries in the West. A vacuum that led to widespread psychological insecurity" with the consequent deleterious effects on mental and physical -health.

- In May 1983, at the Thirty-sixth World Health Assembly, in discussion of the issue, at that Assembly, the question of the "spiritual dimension" was raised and discussed at some length.[2] Later the initiative came in the form of a draft resolution from twenty-two countries from different regions and with different religious beliefs.[3] The Director-General concluded his reflections by saying that "it can justly be claimed that people's ennobling ideas have not only stimulated worldwide action for health but have also given to health, as defined by WHO's Constitution, an added spiritual dimension".
- The Executive Board concurred with the analysis and conclusions of the Director-General and recommended to the Health Assembly to note the Board's conclusion.[4]
- In May 1984, the Thirty-seventh World Health Assembly took the historic decision to adopt resolution WHA37.13, which made the "spiritual dimension" part and parcel of WHO Member States' strategies for health.[5]
- Fourteen years later, the special group of the WHO Executive Board for the review of the Constitution proposed that the preamble be modified to read:[6]

  "Health is a dynamic state of complete physical,
  mental, spiritual and social well-being and not
  merely the absence of disease or infirmity"
- In January 1998, the Executive Board endorsed this proposal of the Special Group and adopted resolution EB 10 1.R2 recommending the World Health Assembly to modify the preamble of the Constitution accordingly.[7]

It is a sheer coincidence that Bhaktivedanta Hospital inaugurated on 11th January 1998 initiated the "Spiritual dimension to health" from day one.

Related Trends in Spirituality and Management:

- Harold Quinton and Professor Ian I. Mitroff in their extensive research with over 200 leaders of organizations found that spirituality is one of the most important determinants of organizational performance. People who are more spiritually involved achieve better results.[8]
- In the World Economic Forum at Davos, where 2000 power brokers gathered, discussed on "Spiritual anchors for the new millennium" and "The future of meditation in a networked economy.[9]
- "After intelligence quotient (IQ) and emotional quotient (EQ), it is now the turn of the spiritual quotient (SQ). Western authors like Danah Zohar and Ian Mitchell are increasingly considering spiritual intelligence as the most important attribute of a human being and the foundation for both IQ and EQ. Corporates are also increasingly falling on spiritual awakening programs, retreats, ethic camps, soul searching camps and transcendental meditation workshops for the spiritual development of their employees. The renewed interest in spiritual training can be traced to the rigors and complexities of the modern, competitive working environment, which breed stress, tension and complexes among employees".[10]
- A study done by Mckinsey in Australia found the productivity peaking up and employee turnover reduced, when the company incorporated spiritual tools in programs conducted for the employees. A growing number of companies are aware of the inherent benefits of helping the employees open up their expression of spirit, the whole being, and complete life in the workplace.[11]

- Harvard trained Tom Chappell sees two reasons for the move toward increased corporate spirituality. One is employees' need for meaning. The other reason is old-fashioned bottom line.[12]
- The Association for Spirit at Work is a non-profit association of people and organizations who are interested in the study and practice of spirituality in the workplace. The mission of this organization, based at USA is to provide community, education for those who are integrating their work and their spirituality.[13]
- It is important to note that Maslow's (1943-1954) 5 Stage Model has been expanded to include Cognitive and Aesthetic Needs (Maslow, 1970a) and later Transcendence Needs (Maslow, 1970b): Both developed during 1960's & 1970's. Transcendence Needs & Self-Actualization Needs include the need for personal growth and discovery, i.e., present throughout a person's life. In Self-Actualization, a person comes to find a meaning to life that is important to them.

The classic case of thinking beyond the horizon:

Way back in 1993, a group of young doctors opened a 10 bed Medical Facility, more of a nursing home/ polyclinic model in the western suburbs of Mumbai. Prior to this, when they were doing their post-graduations from the reputed medical colleges of Mumbai, they used to conduct free medical camps with a three pronged approach - Medical treatment to patients, feeding them by providing food and making them comfortable by counseling and prayers. Thus the seed of paradigm shift was planted – treatment for the body, mind and soul. However, the question was, whether it can be carried out in a full-fledged health care Institution and if so how?

Subsequently, on 11th January 1998, Bhaktivedanta Hospital got inaugurated with 100 odd beds and over 400+ staff. It continued to provide the quality treatment at affordable cost, mostly free or subsidized. Despite all the good intentions, high quality service, the hospital was trying to figure out the ultimate pulse of the patient to improve their satisfaction. Several brain-storming sessions took place to identify and establish the missing link .

Thus the mission of Bhaktivedanta Hospital & Research Institute was carved out, "With love and devotion we will offer everyone a modern, scientific, holistic health-care service based on the true awareness and understanding of the needs of the body, mind and the soul."

The decisive step in this direction was taken after lot of deliberation; the **'Department of Spiritual Care'** was setup under the guidance of His Holiness Radhanath Swami – A well-known Spiritual Teacher and an Acclaimed Author, who is the main inspiration behind this project.

The USP

In healthcare delivery are we selling something? In fact No! If so, how can we look beyond the horizon to define our USP. Thus the Unique Selling Proposition got redefined as Unique **Service** Proposition. Spiritual Care department became Our USP. The department of spiritual care commenced with one HOD and three supporting staff and counselors. Two nurses were attached to the department as spiritual care nurses. Now it has grown to 25 staff and many others supporting as volunteers. The entire spiritual care ,is non-sectarian and is based on 4 key principles, viz., Compassion, Truthfulness, Self-discipline & Cleanliness.

The Goal of Spiritual Care

To help establish a paradigm shift in 21st Century healthcare- from a focus on the treatment of disease state, to the promotion of wellness of communities, families and individuals that is patient-centered and community-based. To that end, we propose the following:

1. Reincorporation of the traditional Vedic knowledge and Spiritual science of healing into the modern science of healthcare – embracing body, mind, spirit with the closer involvement of medical community.
2. Restoration of a healthy relationship with the Lord, environment and natural way of living encompassing a holistic approach.
3. Management of the treatment of disease with emphasis on lifestyle changes, with focus on behaviors and self-responsibility.
4. Integration of the effective and proven complementary and alternative disciplines of medicine and to encourage structured research in this direction
5. Proposing transition from the current health care delivery model to one of collaboration, partnership and with deeper understanding of human needs.
6. Reduce the cost and improve outcomes in healthcare by bringing in mind set changes in health care delivery by incorporating the Spiritual Care learning in the medical and para-medical education as proper structured curriculum.
7. Recognition of a fundamental belief that Unconditional Love is life's most powerful healer and to study the correlation and effectiveness of counseling and such healing, on the patients based on the **Principle of Inclusiveness – 'Sanatana Dharma'.**
8. Encourage and support counseling using M-A-T-C-H Formula and document the entire process of Spiritual Care for wider application in Health Care Delivery including internal / external and environmental health promotion.

Department of Spiritual Care at Bhaktivedanta Hospital & Research Institute is unique in several ways

- First of its kind in the field of medicine as a department. Spiritual & Emotional well-being of a person plays an important role in the overall health.
- Spiritual Care Support System helps in addressing the physical, emotional, mental & spiritual needs of:
    - Patients
    - Patient's Relatives
    - Staff
    - Medical Practitioners
    - Suppliers
    - Contractors
    - Well-wishers/ Donors
    - General public & Others

Key Aspects of Spiritual Health in Bhaktivedanta Hospital [14]

- Spirituality in hospital is nothing but accepting patient as a person with his/ her dignity.
- It is meeting the needs of the patients with so much warmth and affection.
- It is treating the patient beyond his physical symptoms.
- It is giving holistic care to the patients and their families.
- It is helping the patient and their family to understand their role in the entire healing process of the patient.
- It is diverting the attention of the patients and their family from the disease and helping them to focus on the source of health, the Lord.
- It is neutralizing the negative energy in the patients and relatives and charging them with tremendous positive energy by chanting the holy name, reading or listening the holy books etc.
- It is giving up all the unethical practices in health care and deal with a pure consciousness.
- It is helping the patients and their families to see beyond the suffering and thus bring a new light in their lives.
- It is providing a peaceful and prayerful atmosphere in the hospital. It is making their stay in the hospital as pleasant as possible.
- It is the responsibility of the entire hospital team of hospital staff.
- It is accepting the soul of the patients and giving a soul- soul care with a divine touch.
- It is eliminating the distracting or discomforting elements from the patient and providing with soul nourishing items to the patients.
- It is providing an opportunity to the patients to open up their hearts to a confidential person and giving them words of wisdom.
- It is helping the patients to appreciate their own religion and help them to follow the spiritual practices according to the teaching of their own religion.
- It is cultivating higher moral and ethical values in the management of the hospital as well as in the life of the patients and the staff.
- It is bringing the best out of the people, whether it is patient or staff.

Application of Spiritual Care:

Spiritual Ambience	A soothing peaceful environment conducive for healing including display of spiritual painting
Sanctified Diet	Karma free food – cooked with love and devotion and offered to The Lord
Prayers	4 times a day at the beginning of each shift to motivate & enrich the staff & our stakeholders. "Prayer is the most commonly used non-drug method of controlling pain"
Mantra meditation	All the patients, patient's relatives and staff are uplifted by playing Mantras – 24 hours, which enters the sub-conscious mind and helps in reducing stress and facilitates faster recovery.
The Lord on Wheels	The Lord's Chariot is daily taken at the bed-side of the patients which gives an opportunity to the patient and their relatives to offer prayers to the Lord.
Temple & Prayer Hall	The hospital also has a temple/ prayer hall wherein staff/ doctors/ patients and their relatives come, take Darshan and offer prayers.
Stress busters	We regularly conduct dramas, festivals, weekly programs as and other employee integration activities which in turn benefit the patients & relatives
ISO 9001-2008	Certification for Spiritual Care Support Systems & Processes
Counseling	Daily one-to-one counseling to the patients and their relatives. The representatives of spiritual care department go to the bed-side of patients and read spiritual literatures to sooth and enlighten them with spiritual wisdom.
Garbha-Samskar program	Garbha-Samskar program is offered to pregnant women right from the conception, till birth & lactation. This helps to conceive a baby with good values and spiritual character.
Spiritual Retreats	An opportunity for staff, patients & their relatives, doctors, suppliers and well-wishers to visit holy places to get enriched
Spiritual Care in Nursing	A unique program for nurses, in our institution as well as in other institutions/ nursing schools
End-of-life Care	For patients in their last stages of life & their relatives
Spiritual Care Support System for Palliative Care	For terminally-ill patients and their family members
Maitri System	Building friendship - where every staff has at least 1 friend and they meet regularly to shares their concerns.
Spiritual Gyms	Spiritual Gyms through weekly 2 programs (Prabhat-Jagruti & Sandhya-Jagruti) for doctors & staff.
Employee integration	Through festivals and dining together
Appreciations and celebration	Appreciations and celebration after the daily prayers to improve communication and visibility
Journey of Self-Discovery	A 6 days unique program for patients, staff & general public. It systematically covers topics like: - Happiness on Sale - The God mystery - Who am I? - Why bad things happen to good people? - Is world an unfair place? - Life Apps, etc.
Youth Forum	To train the youth in values and culture

Research Initiatives:

<table>
<tr>
<td>Spiritual Care Research in Oncology [15]</td>
<td>

Spiritual Care Therapy in Cancer Patients and Their Caregivers
Recruited 100 Cancer Patients undergoing surgery and their 150 caregivers (n=250), followed for 6 Months following discharge
Mercy, Austerity, Truthfulness, Cleanliness, Holy Name (MATCH) guideline Spiritual care regime during admission periods:

Counseling 30 min daily
Reading 15 min, 2 times a day
Chanting 15 min, 2 times a day

Study Team: Onco-surgeon, Spiritual Counselor, Research staff
Study Parameters-

Functional Assessment of Cancer Therapy - General (FACT-G) Questionnaire
Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp) Questionnaire
Brief Patient Health Questionnaire (Brief PHQ)
Structured life style questionnaire

Key Results

General Well-being (Physical, Social, Emotional and functional) was improved by 64% in cancer patients and 61% in their caregivers during 6 months
Spiritual Well Being was improved by 60% in cancer patients and 53% in their caregivers during 6 months

Table 1 FACT-G and FACIT-Sp scores between the study participants
<table>
<tr><th>Visit time points</th><th>Admission</th><th>Discharge</th><th>Follow-up 1 (2 months)</th><th>Follow-up 2 (4 months)</th><th>Follow-up 3 (6 months)</th></tr>
<tr><td>FACT-G in patients</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mean (SD)</td><td>59.9 (26)</td><td>88.1 (17)</td><td>88.1 (19.2)</td><td>92.9 (19.5)</td><td>98.1 (15.8)</td></tr>
<tr><td>FACIT-Sp in patients</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mean (SD)</td><td>28.5 (13.3)</td><td>42.5 (5.6)</td><td>42.6 (6.6)</td><td>43.5 (6.8)</td><td>45.4 (5)</td></tr>
<tr><td>FACT-G in patients' caregiver</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mean (SD)</td><td>60.3 (24.7)</td><td>90.2 (20.2)</td><td>95.6 (15.9)</td><td>97.7 (14.4)</td><td>98.1 (16.7)</td></tr>
<tr><td>FACIT-Sp in patients' caregivers</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mean (SD)</td><td>29.7 (11.4)</td><td>41.2 (8.4)</td><td>43.2 (6.9)</td><td>44.5 (5.7)</td><td>45.4 (4.8)</td></tr>
</table>
Statistical analysis: repeated measures ANOVA with post hoc Dunn's test—$P < 0.0001$

Published in 'Journal of religion and health'(PubMed Indexed) Nov 2016
</td>
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<tr>
<td>Spiritual Care Research in Psychology [16]</td>
<td>

Effect of Spiritual care on patients diagnosed with generalized anxiety and depression
Recruited 100 Patients: 2 Group randomization- Spiritual (50) and Control (50), Followed for 6 weeks, every 3 weekly
Study Duration- 6 Week
Spiritual care regime:

Spiritual Counseling 30 Min- Every 3 weekly
Spiritual Mantra Mediation (Audio) 15 Min – 2 times day for 6 Week

Study Team: Consultant Psychiatrist Spiritual Counselor, Spiritual Care Assistant Research staff

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Study Parameters-

Hamilton Anxiety Rating Scale (HAM-A)
Hamilton Depression Rating Scale (HAM-D)
WHO Quality of life questionnaire – Brief
Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp) Questionnaire

Key Results

HAMA (Anxiety)scores reduced by 45% in spiritual group in 6 weeks
HAMD (Depression) Anxiety)scores reduced by 55% in spiritual group in 6 weeks
Spiritual Well-being score increased by 27% in 6 weeks

Scores in the Spiritual group
<table>
<tr><th>Type of scores</th><th>Baseline [Mean (SD)]</th><th>Follow up visit 1- 3 Week [Mean (SD)]</th><th>Follow up visit 2-6 Week [Mean (SD)]</th><th>P-Value (Friedman test)</th></tr>
<tr><td>HAM-A</td><td>31 (10.6)</td><td>25.1 (11.3)</td><td>17.3 (8.1)</td><td>< 0.001*</td></tr>
<tr><td>HAM-D</td><td>22.6 (7.3)</td><td>14.1 (10.8)</td><td>9.4 (9.3)</td><td>< 0.001*</td></tr>
<tr><td>FACIT-Sp 12</td><td>26.9 (8.2)</td><td>28.9 (9.9)</td><td>33.8 (7.1)</td><td>>0.05</td></tr>
</table>
Published in ‘Psychology Health and Medicine’(PubMed Indexed) Feb 2017
</td></tr>
<tr><td>Spiritual Care Research in Cardiology</td><td>Efficacy of spiritual care therapy in patients undergoing Percutaneous Transluminal Coronary Angioplasty

Recruited 100 Patients: 2 Group randomization- Spiritual (50) and Control (50)
Spiritual care regime: Spiritual Counseling and Holy Chants before angioplasty and 14 days post angioplasty
Statistically significant lower Depression score during study period and shorter length of hospital stay in Spiritual Group - under Publication
</td></tr>
<tr><td>Spiritual Care - Dialysis and Diabetes Mellitus</td><td>Ongoing research</td></tr>
</table>

Other Related Research Findings:

The initial findings released by 'Search Institute', a Minneapolis-based independent research group. [17]	• "A project involving 7000 youth in the age of 12-25 years in 17 countries, spanning over 2 years reveal that 75% believe in God or higher power. Some 55% felt their spirituality has increased over past two or three years." • 41% of the American youth said, "It means believing that there is a purpose to life and 33% believe in God". • For Indian youngsters, spirituality means being true to one-self and engage in a range of practices to nurture spiritual growth. • "There is a growing recognition that spiritual development is an important, if complex, dimension of the life that must better understood and nurtured within a holistic understanding of youth development".
Spirituality and health: an initial proposal to incorporate spiritual health in health impact assessment [18]	• Spirituality belongs to a differing school of thought with entirely different assumptions: it is an emergent property of a complex living system and exists only when such a system is examined in a holistic manner.

A report on application of Spirituality in Healthcare at Bhaktivedanta Hospital - by Sister Catherine (Institute of Health Management Research – Jaipur) [14] brilliantly bring out the following aspects:

The benefits of spiritual care explained by the patients

Response	Frequency	Percentage
Mental peace	25	50
Presence of God in life	15	30
New direction in life	5	10
Speedy recovery	5	10
Total	**50**	**100**

Opinion of the Staff about Spiritual Care Provided for the Patients

Response	Frequency	Percentage
Healthy soul accelerates the cure of unhealthy body	30	43
Spiritual care helps to bring patients close to God, the ultimate healer.	12	17
Enables the patients to open up to the treatment better.	11	16
If the patient is spiritually satisfied, their mind will be happy and then the body remains well.	10	14
Helps to understand the meaning of life.	7	10
Total	**70**	**100**

Patients' opinion about application of spiritual care in all hospitals

Response	Frequency	Percentage
Spiritual care makes the hospital complete	24	48
Provides mental peace	15	30
Helps to accept the disease	6	12
Supports in the speedy recovery	5	10
Total	**50**	**100**

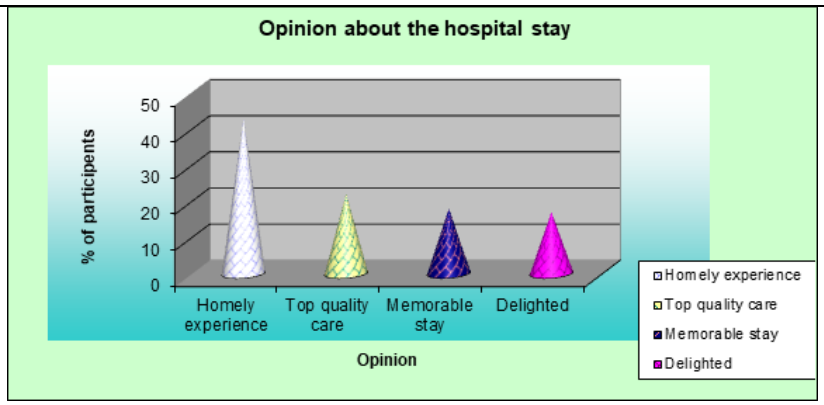
The Best Aspect Of Bhaktivedanta Hospital According to the Patients

Response	Frequency	Percentage
Caring and dedicated staff	26	52
Cleanliness	15	30
Prayerful atmosphere	9	18
Total	**50**	**100**

Opinion about the hospital

Opinion	Percentage
Excellent neatness and cleanliness	32
It is a holy hospital even felt like a temple	25
Well organized hospital	22
A hospital with an excellent blend of modern Science and Spiritual Care.	21
Total	**100**

Opinion about the stay in the hospital



Opinion about the staff

Opinion	Percentage
Excellent care with real warmth	32
There was not a single instance of negligence	22
Staff of this hospital has gone beyond their mere duty, they provides the service with devotion.	18
We felt as they are our family members	16
Well disciplined, polite and compassionate staff	12
Total	**100**

Opinion about the spiritual care provided to the patients and family

Opinion	Percentage
Peace of mind.	45
Speedy recovery	18
Faith in God increased	15
New direction in life	12
Total	**100**

A study of Consumer Buying Behavior towards Healthcare Services offered by hospital in Mira-Bhayander [19]

- Response for Top-of-the-mind recall for Bhaktivedanta Hospital – 76.2%, i.e., 762 patients out of 1000
- Out of 583 respondents who visited the hospital, 81.47% rated the hospital good/ excellent for the spiritual ambience and environment, 82.84% considered the quality of treatment as good and excellent, 81.64% were happy about the quality of treatment and 73.41% rated the staff responsiveness as good/ excellent.

Management by Spirituality (MBS) [20]

In the Thesis entitled "Management by Spirituality (MBS) An Integrated Approach to Management" the researcher, who is also one of the authors of this Case study introduces the concept of Management By Spirituality – MBS and in the conclusion lists the possible implementation strategies for organizations.

- A department of Spiritual Care can be functional with volunteers and interested managers. This can cater to the patients, staff, clients, suppliers, etc.
- Concepts like spiritual gym can be introduced with audio/ video facility and counselors to enable staff and other stake holders to access and avail the benefits of MBS.
- Business/ Medical schools ought to be championing MBS. The trainers can add courses/ topics that combine ancient wisdom with needs of modern medicines.
- Just like Continuous Medical Education (CMEs) for medical professionals, Continuous Professional Development programs (CPDs) for managers and others, MBS should be introduced as Continuous Spiritual Sessions (CSS) to drill down the message and for transformation. These sessions should be practical, interactive sessions rather than just philosophy.
- On the similar lines of Corporate Social Responsibility (CSR) activities, employees should be motivated to have Corporate Spiritual Support Responsibility (CSSR) activities for self.
- Just like chartered accountant for audit, cost accountant for cost audit, the culture of spiritual audit should be introduced in organization with the help of certified MBS professionals.

Effects of MBS to various aspects of organization:

Indicators of MBS	**No**	**Percentage**
Reduced Conflict	21	10.5
High customer satisfaction	34	17
Continuous Creativity	16	8
Connectedness	36	18
Interdependence	49	24.5
Joy	12	6
Healthy Life Style	32	16
Total	**200**	**100**

The managers surveyed strongly felt the need for MBS in organizations. When asked about the indicators as to how , they would like to measure the effects of MBS in the organization, the results correlated with the objectives of the study: - 24.5% responded for Interdependence, 18% for Connectedness, 17% for high customer satisfaction and 16% healthy life style topped the rank and cover almost 75% of the indicators. Thus MBS application is expected to improve the HR and bring in, interdependence & connectedness which is the key to success of the organizations.

Spiritual Care Acceptance

Spiritual Care also has a significant effect on the improved turn-over of patients. In 1998, Bhaktivedanta Hospital served 53,647 out patients and 4,222 indoor patients. In 2016, it served 2,28,183 out patients and 19,819 indoor patients. This is a significant growth considering other healthcare facilities that have come-up in the near vicinity. The USP- Unique Service Proposition, continues to be Spiritual Care and it is well accepted by the community. The institute also got **NABH Accreditation** – The Assurance of Quality and is now being recognized for its USP

Awards Won:

Bhaktivedanta Hospital has won more than 20 awards in the recent years. Organizations like KPMG, E&Y, etc. evaluated various aspects of the functioning. Few of the top awards include:

1. **Trendsetter Award in Patient Wellbeing & Quality Care** by Times of India in association with New India Assurance Co. Ltd

2. **Social Initiative Award 2017** – FICCI Healthcare Awards - Evaluated by ENY
3. **Skill Development Award 2017** (Caregiver Course) – FICCI Healthcare Awards - Evaluated by ENY
4. **CSR Impact Awards 2017** received for Skilling Farmers, Women & Youth – NGOBox.
5. **Sach Bharat Samman Award** for Ethics, Transparency and Spirituality at Work by Assocham, Times Group & SREI Foundation
6. **Best Oncology & Palliative Care Service Provider** by AmeriCares India Foundation
7. World CSR Congress presents **Best Social Enterprise Award 2014** was given for social innovation & sustainable enterprise in the health care industry by World CSR congress in Mumbai.

Conclusion:

Healthcare delivery is a comprehensive process which includes the treatment for the body, mind and Soul. There is a strong evidence based link between the treatment for the body and the mind as given above. We cannot treat only the body leaving the mind and soul. Thus a holistic approach is the need. While WHO talks of three dimensions – Physical, Mental & Social, it is high time that Spiritual Health is added as a part of the definition of health i.e.fourth dimension. The disease pattern is changing from communicable diseases to non-communicable diseases; from major health threats like cancer to mental illness. Deviating from spiritual support system seems to be the missing prescription.

Hospitals can save big bucks by putting chaplains on their health care teams. Surprised? Hospitals are beginning to recognize that spiritual well-being can be crucial to the healing process. The Rev. George Frank, director of pastoral care at Victory Memorial Hospital in Waukegan, Illinois, says, "I don't think you can separate the physical from the emotional and spiritual. People are whole people. You can't treat the body without there being a spiritual or emotional impact."

Let this case-study be an eye-opener for all health professionals and healthcare organizations to adapt spiritual care support system in the best possible way. Grounded in reality but armed with tools to implement the Spiritual Support System - SSS Formula, the soul leaders are bound to initiate the healthy debate and deeper appreciation of this process.

Bhaktivedanta Hospital & Research Institute in Mumbai has set an example for others to follow in this direction. Hence it is of prime importance that healthcare institutions and other institutions as well, adopt spiritual care in management. Soon WHO will have no option but lay more emphasis on Spiritual Health to combat the growing threat of mental illness, which is devouring the youth and adults as well.

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UNIVERSAL FACE THEORY, a theory of happiness

Susheel Kamotra

Websites : www.universalfacetheory.com ; www.mezbahn.com

Mr. Susheel Kamotra
Founder & CEO, Mezbahn (Malaysia) Sdn Bhd
Kuala Lumpur, Malaysia

Susheel Kamotra, nickname Tinu, was born on 22nd October 1962 in Jammu, India. He is a Civil Engineer and has more than thirty two (32) years of professional experience in project management business largely in the construction industry, and has worked on large different projects in India since 1985, and in Malaysia since 1995. He holds many credentials with many professional bodies including Chartered Engineer (Civil) from India, and Project Management Professional (PMP) from PMI, USA. He has MBA in Construction Business from International Islamic University Malaysia, IIUM. He has worked with multinationals in India and Malaysia out which he remained associated with French companies now under Vinci Group for more than twenty (20) years. In 2002, he established his company M/s Mezbahn (Malaysia) Sdn Bhd and had been providing services to leading international companies on various projects in Malaysia and overseas. He has self published his maiden book title "Universal Face Theory" in July 2017. He lives with his family in Kuala Lumpur, Malaysia.

Based on this year's theme, to remind ourselves that we all are connected, one of a kind, creative, but still a part of the whole. The Oneness.

ABSTRACT:

Key Words: Self-realization, Innovation, Sacred Geometry, The God Particle, Science, Religion, Spirituality, Consciousness, Philosophy, Art & Culture, Yoga, Educational Psychology, Happiness, Managing the witness inside us.

The purpose of publishing Universal Face Theory, a theory of happiness, is to create a complete understanding of our existence in a broader sense to everyone present on earth, but the most importantly to our younger generation to enhance their happiness in life.

It connects you with a tool you were born with to remain in a state of self-exuberance, always. In other words, a self-realized person at the much early age of one's life can stay contended and free from stressful corrupt practices, violence, and hatred. Self-realization can help someone gain a sense of life meaning as Infinite Being.

The theory innovatively uses simple project management tools (PMBOK, PMI), and already established theories in science, philosophy, religion and faith, and knits historical data since 3200 B.C.E. to give clarity on The Mind and Matter Forms of GOD presented in an integrated I-chart to explain "Who We Are" and the purpose of our existence in the universe.

Nine years of research work is based on old documented religious scriptures, ancient symbols, philosophies and wisdom, established scientific theories, art and literature, internet source and throws clarity on the living in the present to enhance productivity, and eventually contribute towards making a country great.

It also throws another perspective (theory) on the famous art painting of the last supper as what message the great master Da Vinci wanted to convey. It also gives a logical explanation on the ancient secret of living in the present, which you can never forget in life. That awareness makes you Kalki Avatar. That is the mantra to live life with true happiness in the present, a definition of NOW.

As an output to its application, Universal Face Theory creates a peaceful road map for the world economies to reduce growing debt and achieve their long-term goals. The implementation of Universal Face Theory will make people more ethical and contended, which will enhance productivity, growth, and happiness. Eventually it leads to increase country's happiness index.

UNIVERSAL FACE THEORY: INTRODUCTION

In his book " A BRIEF HISTORY OF TIME", Stephen Hawkins posed a challenge to discover a complete theory to know the mind of God and purpose of our existence to explain why it is that the Universe and we exist.

There have been many theories derived from the subject by many people coming from different sciences, philosophies, religions and faiths. While science is still working to discover the truth, others talk about the same aspects, in various ways.

Science accepted four physical theories of existence revolving around four forces namely Gravity, Electromagnetism, Weak Nuclear Force and Strong Nuclear Force. The much talked about fifth element, the Consciousness, is the topic of discussions amongst the scientists and research scholars. Consciousness is also known as the intelligence or knowledge or awareness of the meaning and purpose of life.

Finding the meaning and purpose of life is something that renders fulfillment and peace to any individual. If this concept is ingrained by parents into their children, during early years of life, it can go a long way to creating a meaningful life.

As a parent, there are a lot of things that we need to convey to our kids so that they stay happy, contended and find a purpose in life. Telling them about birds, and bees are one aspect, but, developing them into 'self-realized human beings' at very young age is not an easy task. This is where Universal Face Theory comes into the picture.

The questions that arise are:
1) When and how do children become self-aware?
2) How can Universal Face Theory help you achieve the goal of instilling self-realization into a six year old child?
3) How do we test this theory?

Universal Face Theory is a simple unified theory that mixes already established theories of science, philosophy, faith and religion, and explains our existence in a simple project management style. Everything around us has a purpose, and this theory gives a clear understanding of the events around us, and of our existence.

The idea is a unique blend with the order of nature to cheer every moment of change on action path and to keep us grounded and spiritually connected to the universe and all others surrounding us in the circle of life.

This theory is an attempt to answer all aspects of diverse questions a human mind can think of. If it does not answer your question from any field whether it is science, art, philosophy, religion or faith or personal etc then it is no longer a universal theory. Its after years of research work by the author and its application on various scenario from household to the corporate world and from the wall street to the world politics, it is finally ready to be revealed in form of a book, artwork and a documentary film to make people's life better.

What is the purpose of publishing face theory?

The purpose of publishing face theory is to create a complete understanding of our existence in a broader sense to everyone present on earth, but the most importantly to a six-year-old child. This innovative concept, if planted in a child, at an early age, and nurtured with systematic educational development until the child achieves the age of thirteen, will train him/her to remain conscious in every moment of the surrounding environment.

After that throughout their life, his/her mind is not influenced by any adverse energy. The universal face theory will equip children to be alive at every moment to take correct decisions, even in the most unfavorable condition.

With conscious awareness or self- conscious introspection in every moment, one can identify the ethical issues involved in one's actions and inactions whereby it brings a natural borderless order of development in the world, not necessarily measured by the economic parameters of that region.

So, in other words, a self-realized person at the much early age of one's life; can stay contended; and free from stressful corrupt practices, violence, and hatred. Self- realization can help someone gain a sense of life meaning.

In project management terms, we are unaware of our scope as we are born. Our intellect grows with our age but still unaware of our scope which changes every moment with the influence of our stakeholders around us. We do not realize that the stakeholders are our parents, families, friends, relatives, neighborhood and the country we live in that shapes our future. We are like in a natural obligatory social form of a contract with unknown scope and have to manage variations every moment in our life.

Universal Face Theory, as unified theory helps breakaway the old notions of inherited conditioned web and shakes you with the new perspectives and understanding of life with examples of already accepted theories of science, ancient philosophies, symbols, art form, literature and metaphors.

As an output to its application, Universal Face Theory creates a peaceful road map for the world economies to reduce growing debt and achieve their long-term goals given increasing unrest due to geopolitical, racial and religion related tensions worldwide.

In our world of over seven billion people, the human controlled managerial functions are under threat by growing automation of algorithms and artificial intelligence. Many existing jobs are starting to disappear and there is a greater need for the people to understand and prepare themselves for the competitive future job market scenario. Self-interest multiplied by awakened intellect and energy awareness shape the people to enhance their interests in energetic and creative ways.

Here again, Universal Face Theory would help people remain evolved and united, as communities and this would bring a quantum shift in the human way of life. A theory that empowers individuals to understand themselves much faster to make appropriate choices for their happiness first and for the sake of happiness of their loved ones and society.

Ancient scriptures talk about telepathy, teleportation, simultaneously living in multiple dimensions of individual enlightened souls. Presently we think of self-realization only after retirement when our body and mind are conditioned by the outer world. Early self-realization would help humans

explore hidden inner intelligence as we would have more time in hand to practice, discover and cherish the hidden treasures of the Universe within by maximizing the power of our neural network.

This theory is a tribute to the great minds of our time and the living legends, philosophers, mentors, spiritual masters, gurus, teachers, politicians whose selfless works have inspired the author to embark this beautiful journey of finding the reasons as why he survived this day to make an attempt to this noble challenge.

The implementation of Universal Face Theory will make people more ethical and contended, which will enhance productivity, growth, and happiness. It will also make people less corrupt. Thus we need to implement of this theory (Knowledge) amongst the masses especially young children as national/ global policy in the primary education system to eradicate corruption, balance resources to enhance productivity, and spread happiness all around the world with a human touch.

SIX (6) MAJOR TAKES FROM THIS THEORY:

1) Universal Face Theory "connects you with the happiness tool you were born with." And that awareness leads you to become a self-realized person in the shortest span of time.

2) Clear understanding of Universal Face Theory brings inner peace and freedom, enhances your happiness span in life, and makes you ethical, contended and free from any bondage for rest of your life.

3) You get awareness of the application of various other tools to live in the present always, with your available choices; and how to manage the witnessing part of your Inner-Self. You master the art of becoming your own Guru; as a result you become more productive, successful and come out victorious in every task.

4) The above awareness re-establishes the disconnect the elderly parents may have with their new-age children or grand children, especially the diasporas or the migrant families with school going children trying to make a living in the new environment.

5) The sheer understanding of the underlying basic concepts this theory brings a quantum shift in our response to a situation and gives you control over your response.

6) The theory unlocks our unique, innovative thought process, and makes us realize that we are part of the same universe as Infinite Being and connected as One World Family in the Circle of Life.

The book, Universal Face Theory, a theory of happiness is an outcome of author’s nine (9) years of research work, a quest to find an unified theory, an expression that vibrates and binds everything within us as an individual, and with families / societies / countries within the circles of life, and connected with the Universe.
Likewise in science (E=mc2), philosophically or psychologically we can say that "JAI GURU DEV" is the single most appropriate expression of the Universe that binds us all with current and ancient teachings / knowledge presented in various religions, cultures since 3200 B.C.E., that are presented in form of I-Chart in the book.

"JAIGURUDEV is the expression of Living in the Present."

UNIVERSAL FACE THEORY – MAIN CONCEPT

With application of scientific knowledge; considering the example of the north and the south poles of mother earth as the big bang and the big crunch of the universe where laws of science hold good; I applied the above concept with a simple project management principle to our body/our face considering as a sphere with two earlobes being the start and finish ends of a project life cycle. Thus I created a time scale along x-axis. Then along y-axis, I connected the above concept within lifecycle in economic terms of demand and supply as curves of our face generating positive and negative attributes along y-axis to make a sense to find an equilibrium/balance in life moments within the realm of ancient spiritual knowledge and wisdom.

Expanding the above concept in third dimension in 3D within the face gives clarity on the witnessing part of us in the whole consciousness. Within our face we can imagine either a colosseum or amphitheaters or a stadium or home or a great natural landscape or whatever happening place you can imagine. Here we can differentiate "the mind and matter forms of God" residing within each one of us, as we are the manifestation of the same source. Here we can measure Consciousness and relate to various states of our Happiness. In fact the above concept applies to each living cell in our body. Primordial Universal sound AUM is the key example.

But here for clear understanding of the common people on discussion table with the scientists, philosophers and spiritual masters, we apply the above concept to our Face.

This concept is Universal, and Eternal. And hence I gave the name "Universal Face Theory."

And with the result... I believe we have a breakthrough discovery, similar like the concept of gravity, "the tool that we were born with to remain always in state of complete awareness, happiness and freedom." And this tool is our face, the chalice of life between the two earlobes. Many call life is a game. Thus in our life, during those playing moments, it does not matter whether we lose or win, as long as we are on the righteous, ethical path and play the game in the spirit of the game, the trophy, which I call here as the chalice of life, that mother nature has built in us as our face, remains with us always. This awareness will bring a quantum shift the way we live our lives, and respond in any situation.

All laws of science hold good, all teachings and knowledge of various scriptures, religions, and philosophies in literature or art form since ancient times more than 5000 B.C.E. hold good within Universal Face Theory. I have been trying and perfecting it for you so that a common man without scientific and philosophical knowledge can grasp and understand it completely.

Now it's the time for you to apply and test it. Start with your own self.

Finally now we can say that we have "Theory Of Everything" that a common man can understand and we all common people, philosophers, scientists, spiritual masters, project managers be able to take part in the discussion of the question of why it is that we and the universe exist.

The conclusion of this discussion in context with universal face theory would be the ultimate triumph of human reason and a befitting tribute to all our ancestors, masters, philosophers, scientists especially Stephen Hawking who desired this question be answered in his life time.

See the videos and you will get more clarity. More videos for other modules are under development and we will start education campaign with "Seminar of Life Series."
www.universalfacetheory.com ; www.mezbahn.com

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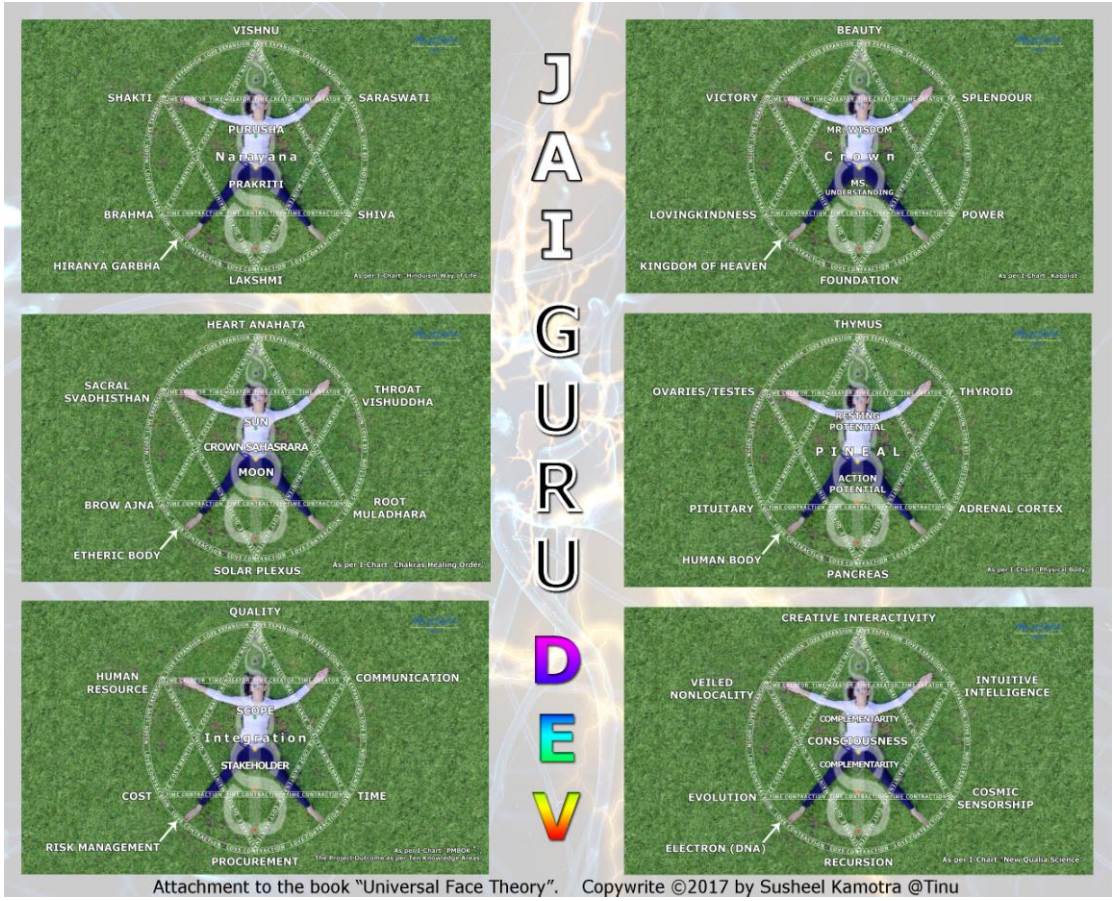
QUALITY
HUMAN RESOURCE
COMMUNICATION
SCOPE
Integration
STAKEHOLDER
COST
TIME
RISK MANAGEMENT
PROCUREMENT
As per I-Chart "PMBOK ⁵",
The Project Outcome as per Ten Knowledge Areas.


VISHNU
SHAKTI
SARASWATI
PURUSHA
Narayana
PRAKRITI
BRAHMA
SHIVA
HIRANYA GARBHA
LAKSHMI
BEAUTY
VICTORY
SPLENDOUR
MR. WISDOM
Crown
MS. UNDERSTANDING
LOVINGKINDNESS
POWER
KINGDOM OF HEAVEN
FOUNDATION
HEART ANAHATA
SACRAL SVADHISTHAN
THROAT VISHUDDHA
SUN
CROWN SAHASRARA
MOON
BROW AJNA
ROOT MULADHARA
ETHERIC BODY
SOLAR PLEXUS
THYMUS
OVARIES/TESTES
THYROID
RESTING POTENTIAL
PINEAL
ACTION POTENTIAL
PITUITARY
ADRENAL CORTEX
HUMAN BODY
PANCREAS
QUALITY
HUMAN RESOURCE
COMMUNICATION
SCOPE
Integration
STAKEHOLDER
COST
TIME
RISK MANAGEMENT
PROCUREMENT
CREATIVE INTERACTIVITY
VEILED NONLOCALITY
INTUITIVE INTELLIGENCE
COMPLEMENTARITY
CONSCIOUSNESS
COMPLEMENTARITY
EVOLUTION
COSMIC SENSORSHIP
ELECTRON (DNA)
RECURSION
JAI GURU DEV
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UNIVERSAL FACE THEORY - A COMPARISON CHART FOR I, WHO ARE YOU? TAT TVAM : THAT THOU ART : YOU ART THAT : YOU ART GOD

manifestation of G O D

CLASSIFICATION	ITEMS	HINDUISM WAY OF LIFE 3200 B.C.E.	KABALIST 1700 B.C.E.	WORLD RELIGIONS ETHICS (DHARMA)	CHAKRAS HEALING ORDER OF 1400 B.C.E.	PHYSICAL BODY MEDICAL SCIENCE	PMI PMBOK® 2000 A.D.	ONE WORLD FAMILY VASUDAIVAH KATUMBHAKAM PRESENT DAY - 4000 AD	UNIVERSAL FACE THEORY	NEW QUALIA SCIENCE THE SCIENCE OF CONSCIOUSNESS
MIND FORM OF gOD	1	NARAYANA (SAKSHI)	CROWN	KNOWLEDGE THE INNOCENT THE WITNESSING	CROWN SAHASRARA CHAKRA	PINEAL: produces melatonin and regulates body clock	INTEGRATION	SILENCE CONSCIOUSNESS INNOCENCE THE DANCE OF NATARAJA	J	CONSCIOUSNESS (COSMIC SELF)
	2	PURUSHA (KALKI)	MR. WISDOM	PATIENCE *YANG*	SUN CHANNEL IDA-PINGALA NADI	RESTING POTENTIAL NEURAL NETWORK	SCOPE	KALKI/PUNNU/MICKEY	A	COMPLEMENTARITY
	3	PRAKRITI (SAISHA)	MS. UNDERSTANDING	INTELLECT *YIN*	MOON CHANNEL SUSHUMNA NADI	ACTION POTENTIAL NEURAL NETWORK	STAKE HOLDER REQUIREMENTS	SAISHA/SASSI/MOUSE	I	
MATTER FORM OF gOD **g**	4	BRAHMA (Generator)	LOVINGKINDNESS	MIND	BROW AJNA CHAKRA	PITUITARY: helps metabolism, growth and other harmones connected with giving birth.	COST	INNOVATIVE, UNIQUE FORM	G	EVOLUTION
o	5	SARASWATI	SPLENDOUR	SURRENDER	THROAT VISHUDDHA CHAKRA	THYROID: controls metabolism and affects physical and mental development.	COMMUNICATION	KNOWLEDGE, DEVOTION	U	INTUITIVE INTELLIGENCE*
	6	VISHNU (Operator)	BEAUTY	HEART	HEART ANAHATA CHAKRA	THYMUS: building a strong immunity from pain and disease.	QUALITY	VIBRATION	R	CREATIVE INTERACTIVITY
d	7	LAKSHMI	FOUNDATION	JUSTICE & TRUTH	SOLAR PLEXUS MANIPURA CHAKRA	PANCREAS: processes sugar and controls digestion.	PROCUREMENT	CONTENTMENT SOCIAL DIVIDEND INTERNATIONALISATION OF COSTS	U	RECURSION
	8	SHAKTI	VICTORY	BODY	SACRAL SVADHISTHANA CHAKRA	OVARIES/TESTES : reproductive organs, control sexual development.	HUMAN RESOURCE	LOVE AND SURRENDER	D	VEILED NONLOCALITY
	9	SHIVA (Destroyer)	POWER	LOVE	ROOT MULADHARA CHAKRA	ADRENAL CORTEX: the fight-or-flight function of the kidneys is activated.	TIME	RIGHTEOUSNESS, SERVICE	E	COSMIC SENSORSHIP
MANIFESTED FORM	10	HIRANYA GARBHA	KINGDOM OF HEAVEN	SOUL / SPIRIT / ENERGY	ETHERIC BODY	HUMAN BODY	RISK MANAGEMENT	SKY-AIR-EARTH-WATER-FIRE	V COSMIC WOMB	ELECTRON (DNA)

NOTE : THERE ARE SIMILARITIES IN THE KNOWLEDGE POINTS STATED IN HINDUISM, CHRISTANITY, BUDDHISM, CHINESE, JAINISM, ISLAM, SIKHISM AND VARIOUS OTHER RELIGIONS & CULTURES.
The metaphors used are KALKI/SAISHA/SASSI/PUNNU/MICKEY/MOUSE for better understanding by the children. "All above are author's own interpretations"

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ABOVE SUMMARY POINTS ARE ADOPTED FROM THE AUTHOR'S BOOK, APPENDIX 2, RELEASED IN 2017

INTUITIVE INTELLIGENCE* ADDED BY SUSHEEL KAMOTRA

INTERNATIONAL CONFERENCE ON SPIRITUALITY AND PSYCHOLOGY 2018
13-15 MARCH 2018
BANGKOK, THAILAND
CONFERENCE PROCEEDINGS

ISBN 978-86-87043-56-5
