Brief Summary of Stages of Selfhood and Faith Development (James Fowler)
Fowler, J.W. (1981). <u>Stages of Faith</u>, New York: Harper and Row.

Disclaimer: In no way does Fowler suggest that a person characterized by one of the less developed stages is any less a person than one described by a more developed stage

For Fowler:
Belief- Assenting intellectually to concepts or propositions as set forth in religious doctrines and creeds
Faith-A quality of the person, not of the system, an orientation of the total person giving purpose and goals to one's hopes and strivings, thoughts and actions.
While beliefs divide, faith unites.

For Fowler: Erik Erikson, Lawrence Kohlberg, and Jean Piaget were most influential

Primal Faith and the Incorporative Self
In utero, Infancy through first two years of life
Pre-language sense of trust and loyalty with the environment
Pre-images of powerful and trustworthy ultimacy
Trust vs. mistrust (Erikson)
No distinction between self and environment; self and those providing primary care
With time, able to sense the caregiver will return without undue anxiety
The culture of "mothering"….if not met, child is serious emotional risk

Intuitive-Projective Faith (Early Childhood, 2-6) and the Impulsive Self
Imagination, stimulated by stories, gestures, and symbols, and not yet controlled by logical thinking, combines with perception and feelings to create long-lasting images that represent both the protective and threatening powers surrounding one's life. The penumbra of mystery invades the child's life. Fantasy and make belief and not readily distinguished from reality.

Mythic-Literal Faith (Childhood, 7-11, and beyond), and the Imperial Self
The developing ability to think logically helps one order the world with categories of causality, space, and time; to enter into the perspectives of others; and to capture life meaning in stories. One sees the world through the structures of one's needs, interests, and wishes. The Imperial self longs for independence rooted in self confidence and self-esteem.

Synthetic-Conventional Faith (Adolescence and Beyond, 11-13), and the Interpersonal Self

This was a *watershed* in faith development for Fowler: young person uses logic and hypothetical thinking to construct and evaluate ideas. New cognitive abilities make mutual perspective-taking possible and enable one to integrate diverse self-images into a coherent identity. A persona and largely unreflective synthesis of beliefs and values evolves to support identity and to unite one in emotional solidarity with others.

Individuative-Reflective Faith (young adulthood and beyond), and the Institutional Self
Critical reflection upon one's beliefs and values, utilizing third person perspective taking; understanding of the self and others as a part of a social system; the internalization of authority and the assumption of responsibility for making explicit choices of ideology and lifestyle open the way for critically self-aware commitments in relationship and vocation. Stage of demythologizing. (This and the previous stage: 60%)

Conjunctive Faith (Early Mid-life and beyond), the Inter-Individuative Self
The embrace of polarities in one's life, an alertness to paradox, and the need for multiple interpretations of reality mark this stage.   Implies a rejoining or a union o that which previously has been separated.   Marked by being porous and permeable. Symbol and story, metaphor and myth (from one's own traditions and others') are newly appreciated as vehicles for expressing truth.

Universalizing Faith (Mid-life and beyond), the God –grounded self
Beyond paradox and polarities, person in this stage are grounded in a oneness with the power of being. Their visions and commitments free them for a passionate yet detached spending of the self in love, devoted to overcoming division, oppression and violence, and in effective anticipatory response to an in breaking commonwealth of love and justice. (Fowler's list of examples includes Lincoln, Gandhi, Mother Teresa, MLK, JR.) "Greatness of commitment and vision often coexists with great blind spots and limitations."

ARTICLE ONE
Koenig, H.G. (2002). A commentary: The role of religion and spirituality at the end of life. *The Gerontologist, 42*, Special Issue III, 20-23

Background
The issue of control…..controlling the circumstances of our dying
A cohort of 75 million "baby boomers" will reach age 65 and expand the current 35-million member elderly population to more that 80 million by mid 2000s. By 2011, the need for health services by an elderly, chronically ill population will soar. By 2030-2050, there will be only 2 working persons for every retired person (requiring support).
Health Care in the future:
Hospitals will be intensive care units

The sick will be stabilized and sent to nursing homes; there will be enormous waiting lists.
The dying will more than likely die in their homes in their communities, the burden falling on family members
In the case of the lack of family members, aging baby boomers could be forced to spend their last days on the streets and in the parks
Bottom line: less and less ability to control the circumstances of their dying

Religion and Spirituality
Religion gives many a renewed sense of "internal" control; faith allows the ability to give up control and instead trust God to control the circumstances. Belief plays a strong role in terms of the physical, psychological, social and spiritual aspects of dying.

Examination of the physical, psychological, social and spiritual needs of five groups: the dying person, the family, the health care provider, the nonreligious dying person, and the dying person without family.

The Dying Person
Relief of symptoms the first priority: pain, breathlessness, constipation, insomnia.
Enabling the patient to stay as alert as possible during the last days while achieving physical comfort
Relieve depression, anxiety, psychotic symptoms that may interfere with relationships
Address feelings of loneliness, isolation, and abandonment, to include spiritual abandonment
Meet spiritual needs: making peace with self, others, Other; finding meaning; forgiving others and receiving forgiveness; accepting what one has (has not) accomplished and become; saying goodbye. (aka, the "tasks" of dying).
Fears: Judgment/punishment; religious turmoil; abandonment by God; questioning God's love for them; questioning the power of God to help them; feeling abandoned by their religious community; belief that the devil caused the illness.
Also, there is the fear by many that the dying person is not "saved"

The Family
How to help the patient complete the tasks of dying
Need for health care professionals to assist them with the equipment needs and respite from caregiver roles
Support to let go of the patient and cope with the grief of the expected loss
How to cope with the guilt over imagined or real failings in relationship with patient
Such inabilities to cope often spur the request for more technical treatment
Best predictors of adaptation in family members: strong base of social contacts and self-reported religious faith

80% of the elderly are members of some church setting; how does the religious community provide bereavement support after the funeral?

The Health Care Provider
Providing a nurturing and caring community for the dying and their family
How do we help the patient and family to achieve "healing" during the final days?
The emotional and spiritual needs of health care providers must be addressed so that they are better able to meet the physical, spiritual, and emotional needs of the dying patients and family members
Health care professionals with negative experiences of dying in their families may transfer this to future patient care situations
Health care professionals with tortured spiritual lives find it very difficult to address the spiritual needs of patients/families…….ie, the inability to be "fully present" to the patient and the family
Point of fact: the health care provider has the same vulnerabilities, neurotic needs, and unfulfilled hopes and dreams as patients who are dying.
Health care professionals adopt and adapt ways to prevent selves from being emotionally overwhelmed for the pain of repeated contacts with the dying

The Nonreligious Dying Person (10-15% of Americans)
Similar to the religious in terms of needing physical symptoms controlled
How do non-religious persons cope with death? Little research in this area.
30% of Americans are not members of religious communities---absence of this potential base of support
Family, if religious, have difficulties providing care to one who lacks the same base for communication (and vice versa)…..places additional burden on health care providers to meet the needs of the dying and the families in order to compensate for the lack of religious resources
Spiritual needs of the non-religious: finding meaning and purpose; forgiving and receiving forgiveness; maintaining hope; saying goodbye; and coming to terms with what might occur after death.

The Dying Person without Family
No one else but the health care provider to help with emotional and spiritual areas of care, especially if no religious community to provide help and resources

ARTICLE TWO
Hart, A., Kohlwes, J., Deyo, R., Rhodes, L.A., and Bowen, D.J. (2003). Hospice patients' attitudes regarding spiritual discussions with their doctors. *American Journal of Hospice and Palliative Medicine, 20*(135), 135-139.

<u>Introduction</u>
Increasing discussions of spirituality in patient care helps to guide patient choices and can help to better define their illness or disease
This study is from the Pacific Northwest (most others from the Midwest or the Southeast)
One of the few studies that have examined hospice patients' attitudes regarding spiritual discussions with their physicians in the medical setting

Study: 3 objectives:
1. To explore the desires of hospice patients in the NW to discuss spiritual issues with their physicians;
2. To explore the type of spiritual issues hospice patients may want physicians to address;
3. To explore the appropriate time and setting for spiritual discussions to be initiated by physicians.

<u>Methods</u>
Ethnography; open-ended questions; meaning; recurrent themes
16 terminally ill patients enrolled in 2 Seattle area hospice programs
Exclusion: impaired hearing, speech, or cognition, too frail
11 patients interviewed in their homes; two in a hospice center, one in a convent infirmary
Length of interview ranged from 15minutes to 2.5 hours
Open ended question categories: living with illness, religion and spirituality, patient-physician relationships
Dominate themes from the NUDIST program (non-numerical unstructured data indexing searching and theorizing) software program

<u>Results</u>
Patient characteristics
6 males
9 females
Age range 63-86, mean 74.5

4 major themes
Treating the whole person
Treating with sensitivity
Favorable attitudes toward religious and spiritual discussions
No preaching (preferred a "non-aggressive" manner)

11 of the 15 favored physician inquiry about their spiritual beliefs; only two said that their physicians asked about this area of care; the 11 indicated that the physician would know when it was right to introduce such discussions.

CARE Spiritual assessment tool
C Do you Consider yourself to be a spiritual or religious person?
A Are you A ctive in any religious or spiritual community?
R Are there any spiritual or religious practices/beliefs that R elate to your views about health and/ or your health care needs?
E Are there any religious or spiritual conflicts that might be affecting you E motional health?....Are you concerned about religious or spiritual matters in your E veryday affairs?

FICA SPIRITUAL ASSESSMENT ACRONYM
F   Faith, belief, meaning
I   Importance and Influence
C   Community
A   Address/Action in Care