

Program to Enhance Well-being and Psychospiritual Understanding Implications in Indian Medical Care Perspective



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ABSTRACT

Background: Spirituality is an important dimension of life. The medical practitioner's well-being is an under-appreciated priority in India. As research on spirituality is minimal, this study attempts to introduce an online 6-week Eastern spirituality-based educational program for physicians. The primary aim was to see the effects of the intervention on the well-being of the participants. The secondary aim was to form an opinion about an extension to medical practice.

Materials and methods: A total of 60 medical practitioners were randomized into two groups—one attended the spirituality sessions while the other placebo “self-care” sessions. Quantitative outcome measures were Warwick-Edinburg Mental Well-being Scale (WEMWBS) and World Health Organization (WHO) Well-being Index (WHO-5) noted pre and postprogram. Qualitative data was collected to support the quantitative outcomes. Statistical tests used were unpaired and paired t-tests for quantitative data. A 5-point Likert scale and Cochran's Q test were used for the qualitative data.

Results: In the spirituality group, postsession WEMWBS and WHO-5 scores improved with $p < 0.0001$ and $p = 0.0033$, respectively. Regarding qualitative data, 94.44% of physicians “agreed/strongly agreed” in favor of the benefits of sessions with $p = 0.0242$ and $Q = 5.0793$. A total of 86.67% of physicians felt the sessions have helped them to understand other's spirituality-related problems and made them more confident to discuss spirituality with others.

Conclusion: The online Eastern spirituality program had a positive impact on the well-being of Indian medical practitioners. There appears to be a potential for extension to the medical care setting. The results need to be substantiated by further studies.

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INTRODUCTION

Spirituality is an important dimension of human existence. Spirituality is a complex construct made up of multiple aspects as diverse as beliefs, rituals, coping, relationship with the transcendent, the meaning of life, and much more.¹ Previously spirituality was thought to unfold within a religious context but now it is a separate construct itself. Eastern spirituality is a distinct entity with practically no similarity with its Western counterpart. In the extended biopsychosocial model of medical care, spirituality forms the fourth dimension.² In this research work, we refer to spirituality as “the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred.” (United States Consensus Committee 2009).³

Spirituality plays a prime role in the lives of millions of Indians. There is a wide variation in the ways spirituality is understood and practiced throughout India. In the Indian scenario, eastern spirituality is not a single entity but an assembly of concepts, affiliations, practices, cultural influences,

and perspectives influencing day-to-day lives. Spirituality can help one to find hope, purpose, and meaning in life and improve emotional adjustment.⁴ A high proportion of doctors in India experience occupational stress and depression.⁵ The clinician's well-being is an underappreciated priority in this subcontinent. Indian physicians may find spirituality significant and fulfilling in their own lives.⁶ In addition to achieving personal well-being, there can be a unique benefit of spirituality for physicians. A better psychospiritual understanding may help them to support their patients to find meaning and acceptance amid their suffering.⁷ The medical training in India neither involves spirituality nor any structured programs available to orient physicians to Eastern spirituality. But nearly 90% of medical institutions in Western countries have something about spirituality in their curricula.⁸ Unfortunately, the Western psychospiritual educational models have no practical implications from the Indian perspective. The lack of understanding, unavailability of training, personal reservations, and apprehension in addressing spiritual issues make Indian physicians stressed, uncomfortable, and

insecure in real-life situations. Being a very sensitive and emotionally charged issue, research with practical application of Eastern spirituality-based interventions in the Indian medical care perspective remains limited.

The researchers are physicians with in-depth knowledge of spirituality and this study is an early attempt to introduce a semi-structured time-limited Eastern spirituality-based educational group program for the peers. An online mode of delivery that can be attended from home, clinic, or hospital was deliberately chosen to respect the time management aspect of professionally burdened Indian physicians. The primary aim of the study was to see the effects of the program on the well-being of participants using the WEMWBS and WHO Well-being Index (WHO-5). Qualitative data was used to support the quantitative outcomes and indirectly reflect the psychospiritual understanding. The secondary aim was to form an opinion about an extension to medical practice settings.

MATERIALS AND METHODS

Study Design and Setting

This prospective randomized trial was conducted from October to December 2021. The study was conducted by a medical institution in collaboration with a meditation center based in West Bengal, India. Institutional Ethical Approval was obtained and the study was registered in the Clinical Trial Registry of India.

Sample Size Calculation

From the previous available studies using WEMWBS and WHO-5, we calculated our sample size to detect a standard deviation (SD) of 8.6 and 14.2 of the expected difference

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of means in the above scales, respectively, with a power of 80% to detect this difference using unpaired *t*-test and paired *t*-test with type I error (α) of <5%. The calculated minimum sample size in each group was 26 using WEMWBS and 21 using WHO-5. The overall minimum size in each group was 26 using both instruments. Hence, we started our study with 60 participants.

Study Participants

The physicians and practitioners involved in primary care were informed about the study. Those interested to attend the program were asked to contact the study coordinators. A total of 60 participants were recruited based on inclusion and exclusion criteria. Inclusion criteria—(1) age 18–65 years, (2) have access to an electronic device with an internet connection, and (3) not suffering from any psychiatric illness. Exclusion criteria—(1) have a significant medical illness or comorbidity and (2) have previous experience of attending an Eastern spirituality course.

Informed consent was obtained from all participants *via* e-mails. The participants were subjected to an online interview with a clinical psychologist to exclude any significant mental health issues which escaped screening. If found, they were not included in the study. The participants were randomized into two groups. Group S attended online spirituality sessions while Group C attended “self-care” sessions (Flowchart 1). The “self-care” sessions were placebo sessions with the same facilitator

of similar duration, excluding the concepts of Spirituality. It included discussions on ways of dealing with professional stress, the importance of taking work breaks, effective ways of utilization of spare time, and different relaxation techniques. Candidates of Group C were later offered to join the online spirituality sessions after the study period, which is beyond the scope of the present discussion.

INTERVENTION

The educational program was an online 6-week psychospiritual intervention. The goal was to use spirituality to develop positive spiritual coping and achieve wellness in life. A nonreligious, secular method was adopted based on the core principles of Hinduism and Buddhism, devoid of any particular rituals. The focus of the intervention was to help participants understand their problems from a spiritual perspective, to gain a greater sense of hope, accept responsibility for their actions, and to experience a sense of self-worth. Positive virtues like compassion, gratitude, and acceptance were advised to be applied in daily life situations. Compassion was given utmost importance as it helps to promote well-being. Group activities included informal talk, discussions, and meditations. Daily 10 minutes of home practice of meditations were encouraged as it produced a calming effect. A physician having adept knowledge of spirituality and meditations served as a facilitator. There

were six online group sessions in the program each of 1.5 hours duration every week. The details of the program are given in Table 1. At the end of the session, participants were encouraged to share their experiences and newer understanding regarding spirituality. The participants maintained a daily practice log and were monitored by the facilitator through a social media app. Any participant experiencing any discomfort/side effects was instructed to report to the facilitator.

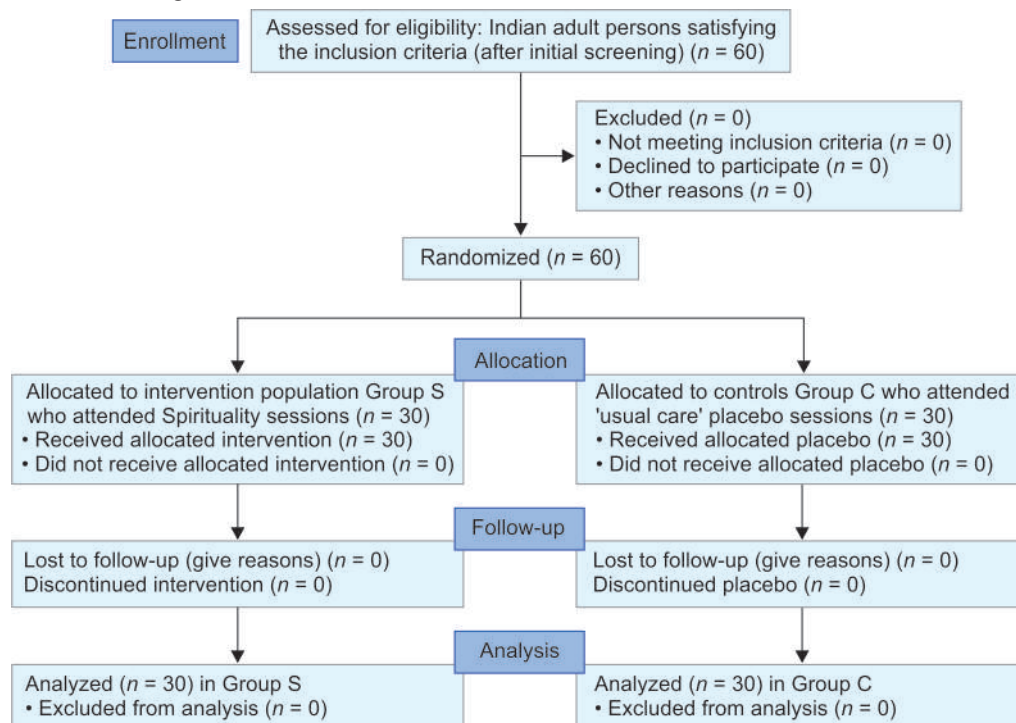
OUTCOME VARIABLES

Demographic data was collected before the program. The data of the participants included the person's age, gender, and religious affiliation. In terms of religious affiliation, all the participants were incidentally found to be Hindus. Quantitative variables were noted twice, before, and after the program. Qualitative data was collected from Group S at the end of the program. All the data were collected *via* e-mails. The researcher who noted the outcome variables had no idea of the patient's allocation and the intervention received.

Quantitative Variables

The researchers wanted to explore the well-being of the physicians, mostly the psychological aspect. WEMWBS is a measure of mental well-being focusing on positive aspects of mental health. WEMWBS is a tool commonly used in previous studies

Flowchart 1: CONSORT 2010 flow diagram



on spirituality.⁹ In addition, the 5-item World Health Organization Well-Being Index (WHO-5) was used to assess subjective psychological well-being.¹⁰

Qualitative Variable

A questionnaire was formed with six questions—(1) this spirituality course is helpful to deal with my life problems, (2) this spirituality course is helpful to reach my peace of mind, (3) this spirituality course has made my concepts more clear, (4) this spirituality course has made me more confident to discuss spirituality with others, (5) this spirituality course is helpful to understand others' spirituality-related problems, and (6) spirituality course like this is very much needed for the well-being of our society. The responses are noted on a 5-point Likert scale—strongly disagree = 1, disagree = 2,

neither disagree nor agree = 3, agree = 4, and strongly agree = 5.

Statistical Analysis

Data from WEMWBS and WHO-5 scales were treated as continuous. Data were tested for equality of variance using Levene's test. Normality was tested using the Shapiro–Wilk test. The analysis of continuous data was performed using unpaired and paired *t*-tests. Baseline characteristics (age and sex) were tested using unpaired *t*-tests for age and Chi-squared (χ^2) test. Qualitative data *via* a 5-point Likert scale was collected in response to a 6-point questionnaire in Group M postsession. This Likert scale was analyzed *via* dichotomous division: “agree/strongly agree” and “neither agree nor disagree/disagree” and interpreted *via* Cochran's *Q* test. The statistical software used was Statistical Package for the Social Sciences statistics

for Windows 7® version 18.0.0 (Chicago, Illinois 60606-6412), GraphPad Prism® InStat version 5.0 (California 92037-3219) and Microsoft® Office Excel 2010 (Washington: Microsoft). Results were presented in mean (SD) and percentage format. $p < 0.05$ was considered statistically significant.

RESULTS

Baseline characteristics (age and sex) were similar between the cases (Group S) compared to the controls (Group C) (Table 2).

Quantitative Variables

By unpaired *t*-test, the mean scores in Group S when compared to Group C in postsession increased significantly in both WEMWBS and WHO-5 scales with $p < 0.0001$ and $p = 0.0033$, respectively. Effect size (measured by Cohen's *d*) was $d = 1.2827$ for WEMWBS and $d = 0.7909$ for WHO-5, respectively (Table 3).

Within Group S comparison by paired *t*-test showed that the postsession scores increased significantly in both WEMWBS and WHO-5 scales with $p < 0.0001$ in each respectively. Effect size (measured by Cohen's *d*) was $d = 1.0025$ for WEMWBS and $d = 0.7290$ for WHO-5, respectively (Table 3).

The difference in mean scores in Group S was not significant when compared to Group C before the session by unpaired *t*-test; as also within Group C pre and postsession comparison by paired *t*-test.

Qualitative Variables

The Group S postsession 6-point questionnaire yielded the following results—only two responses out of 30 (6.67%) to questions 3 and 4; and four responses out of 30 (13.33%) to question 5 have remained “neither agree nor disagree.” Only two responses out of 30 (6.67%) “disagreed” only in question four of the postsession questionnaire (Fig. 1). Around 100% of responses (30/30) to questions 1, 2, and 6 have either “agreed” or “strongly agreed” in favor of meditation sessions. A total of 86.67% of responses (26/30) to questions 4 and 5 and 93.33% of responses (28/30) to question 3 have either “agreed” or “strongly agreed” in favor of spirituality sessions (Fig. 1).

Overall 94.44% (170/180) of responses have either “agreed” or “strongly agreed” to all questions taken cumulatively and only 5.56% (10/180) of responses have either remained “neither agree nor disagree” or “disagreed” with the postsession questions. The above dichotomous proportions, when compared by nonparametric Cochran's *Q* test showed that the proportion of responses (94.44%) who “agreed/strongly agreed” in favor of spirituality session was significantly greater

Table 1: Overview of the 6-week, semi-structured Eastern spirituality-based educational programme

Week	Topic	Description
1	Introduction	Facilitator gave group members an overview of the topics to be discussed in the programme. Motivates the participants to understand that Spirituality can be a helpful tool in the way of daily life
2	Discussion on positive virtues in spirituality	Explanation of core virtues in spirituality like compassion, gratitude, and acceptance
3	Discussion on the application of virtues and misconceptions in spirituality	Discussion on the application of the virtues in modern life. Understanding the misconceptions and ritualistic constructs that prevail in the society
4	Discussion on emotional regulation and how to handle crisis	Explore positive spiritual strategies that can be used to handle crisis situations in life. Understanding positive spiritual coping of difficult situations
5	Discussion on connectedness to self and the greater meaning of life	Explanation of the concept of connectedness to self and understanding a greater meaning in life by realizing this connectedness
6	Conclusion and sum-up	The facilitator review all the topics covered and solicit feedback from group members

Table 2: Demographic characteristics (age and sex) of participants

	Group S (N = 30)	Group C (N = 30)	Group S vs C
Age			Unpaired <i>t</i>
Mean years (SD)	43.5667 (9.6443)	42.4333 (9.9192)	$p = 0.6553$ $t = 0.4487$ Degree of freedom (df) = 58 95% confidence interval (CI) = -3.92 – 6.19 $d = 0.1158$
Sex			Chi-square (χ^2)
Number (percentage)	Males = 24 (80.00%) Female = 6 (20.00 %)	Males = 21 (70.00%) Female = 9 (30.00 %)	$p = 0.3710$ $\chi^2 = 0.8000$ df = 1

Columns 2 and 3 show age (mean (SD) years) and sex (male/female) for Group S (case group) and Group C (control group), respectively. Column 4 shows the *p*-value of the unpaired *t*-test comparison of the mean age of Groups S and C prior to the beginning of the session and also the *p*-value of χ^2 test of the sex distribution of Groups S and C prior to the beginning of the session.

Table 3: Representation of WEMWBS and WHO Well-being Index (WHO-5) Scores pre and postsession in Group S and Group C

	Group S (N = 30) Mean (SD)	Group C (N = 30) Mean (SD)	Group S vs C presession	Group S vs C postsession	Group S (pre vs postsession)	Group C (pre vs postsession)
WEMWBS			Unpaired t	Unpaired t	Paired t	Paired t
Presession	50.1333 (9.1942)	49.3000 (8.9178)	$p = 0.7229$ $t = 0.3564$ $df = 58$	$p < 0.0001^*$ $t = 4.9680$ $df = 58$	$p < 0.0001^*$ $t = 5.2332$ $df = 29$	$p = 0.2649$ $t = 1.1369$ $df = 29$
Postsession	58.2667 (6.8628)	48.7667 (7.9119)	95%CI = -3.85–5.51 $d = 0.0920$	95%CI = 5.67–13.33 $d = 1.2827^{**}$	95%CI = -11.31 to -4.95 $d = 1.0025^{**}$	95%CI = -0.43–1.49 $d = 0.0632$
WHO-5						
Presession	62.9333 (15.1109)	61.0667 (13.9331)	$p = 0.6208$ $t = 0.4974$ $df = 58$	$p = 0.0033^*$ $t = 3.0635$ $df = 58$	$p < 0.0001^*$ $t = 4.8478$ $df = 29$	$p = 0.2458$ $t = 1.1846$ $df = 29$
Postsession	74.0000 (15.2496)	61.8667 (15.4289)	95%CI = -5.65–9.38 $d = 0.1284$	95%CI = 4.21–20.06 $d = 0.7909^{**}$	95%CI = -15.74 to -6.40 $d = 0.7290$	95%CI = -2.18–0.58 $d = 0.0544$

Columns 2 and 3 show the presession and postsession mean (SD) scores of WEMWBS and WHO-5 scores for Group S (case group) and Group C (control group), respectively. Column 4 shows the p -value of unpaired t -test comparison of Groups S and C prior to the beginning of the session. Column 5 shows the p -value of the unpaired t -test comparison of Groups S and C after the session. Column 6 shows within group S paired t -test comparison pre vs postsession. Column 7 shows within Group C paired t -test comparison pre vs postsession. * p -values are statistically significant. **Cohen's d values have a large effect size.

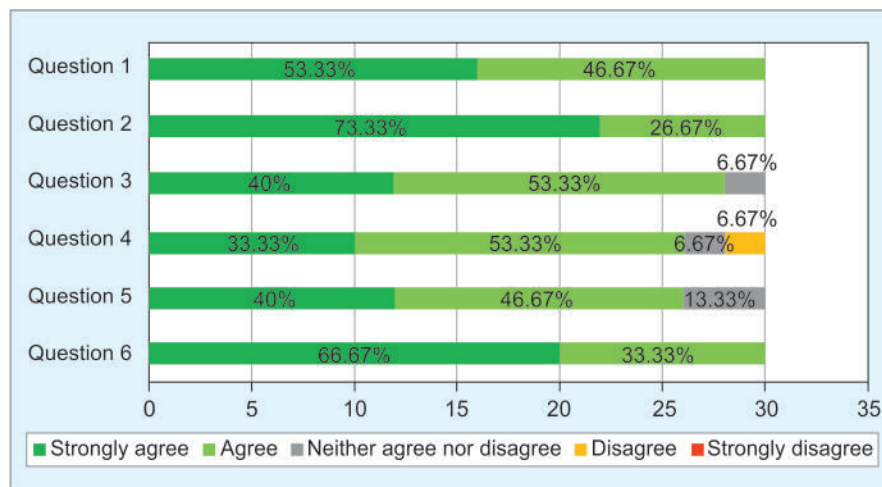


Fig. 1: Post session responses of participants regarding their views of the spirituality program

than to proportion (5.56%) who remained "neither agree nor disagree/disagreed" with $p = 0.0242$ and $Q = 5.0793$.

No discomfort/side effects were reported by the participants.

DISCUSSION

The primary aim of the study was to see the effects of an online Eastern spirituality-based program on the well-being of the participants. The postsession mean scores of both WEMWBS and WHO-5 in the spirituality group improved significantly with $p < 0.0001$ and $p = 0.0033$, respectively compared to control groups. So the spirituality program significantly affected the well-being of the physicians.

The qualitative data asked about making the spiritual concepts clearer, getting the confidence to discuss spirituality with others, and understanding others' spirituality-related problems. A major proportion (94.44%) of participants "agreed/strongly agreed" in favor of the benefits of a spiritual educational program with $p = 0.0242$ and $Q = 5.0793$. While 86.67% of physicians felt the sessions have helped them to understand other's spirituality-related problems and made them more confident to discuss spirituality with others. The secondary aim was a scope of extension to medical practice settings. It is difficult to form a definitive opinion with the parameters studied in this particular research work but the quantitative and qualitative

outcomes indirectly see a potential for extension to medical practice settings.

The study results are in line with previous studies conducted in other countries. A study concluded that spirituality among healthy individuals was associated with higher health-related quality of life.¹¹ Even in persons with chronic health problems spirituality can be beneficial.¹² Previous study results on physicians are quite encouraging. There are possible protective associations of certain dimensions of spirituality on the maladaptive behaviors of physicians.¹³ Spirituality-based wellness practices for physicians can negate negative behavioral effects of the profession.¹⁴ Attention to health including spiritual health helps physicians to protect against burnout and enhances both coping and caregiving abilities.¹⁵ A review comments that the better spiritual well-being of resident physicians was associated with a better sense of work accomplishment, overall health, decreased burnout, and depressive symptoms.¹⁶ A systemic review showed consistent independent associations between spiritual well-being and quality of life.¹⁷ Another systemic review found Spirituality to have benefited by improving quality of life and promoting health behaviors.¹⁸

Eastern Spirituality as a Distinct Construct

Eastern spirituality differs significantly from spirituality practiced in the Western world. In Eastern spirituality, the concept of human

existence is based on the understanding that the human soul is from the divine. Life is a continuum and the purpose of life is liberation from the surroundings (māya) of this world and union with the divine. Here death is not a termination of existence but a passage to the divine. The core principles of spirituality are “union with the divine,” “being at peace,” and “preserving dignity.” The core aspects of Indian spirituality were included in the program, but a lot of concepts were not covered as considered confusing or superfluous. It is practically not possible for a simple 6-week program to capture all the diverse dimensions of Eastern spirituality.

INDIAN MEDICAL CARE AND SPIRITUALITY

There is a paucity of literature and a lack of understanding about the interplay of Spirituality with health and medicine in the Indian scenario. Traditionally Western modern medicine did not incorporate spirituality, and it was considered a symptom of mental illness. Many practitioners of modern medicine in India still consider patients’ beliefs and practices as irrelevant and as problematic superstitions.¹⁹ Now in medical literature, there is a growing appreciation of the impact of spirituality on health as well as influencing recovery from illness.²⁰ The unfamiliarity of Indian healthcare providers with spirituality is compromising the holistic goal of healthcare. A lot of Indian medical professionals still consider religion and spirituality synonymous. Programs incorporating spirituality into clinical practice are available in Western countries.² But the use of chaplains, pastors, and priests for spirituality is not a practical idea in the Indian scenario.²¹ Turning to ritualistic religious practitioners for healthcare needs can be no less than a disaster. Negative religious coping can lead to greater spiritual distress, including greater anxiety, depression, and lower self-esteem.²² So a group of physicians with adept spiritual understanding needs to come up with psychospiritual interventions and training for healthcare providers. In our study, the online sessions could be easily accessed, the medical practitioners felt motivated to complete the 6-week duration program, the queries could be addressed by virtual interactions, and the program was highly valued by the participants as evidenced by the lack of dropouts and postprogram written feedbacks. The challenges faced by the researchers were lack of uniformity in

spiritual literature, difficulty in the conversion of philosophical concepts to a semi-structured format, difficulty in time management by the attendees (busy practitioners), and keeping the physicians involved in placebo sessions.

Limitations

This study is an initial attempt with several limitations. The participants showed interest to participate which may have influenced the results. This study only reflects the effects of spirituality on the well-being of the participants. The multi-dimensional measures of spirituality as outcome variables could not be included in this early study.²³ The improvement in psychospiritual understanding could not be quantitatively measured in this research work. This study could not look deeply into possible mechanisms of association between spirituality and well-being. Being conducted on apparently healthy practitioners, the researchers were in no position to comment on the interaction of spirituality in individuals with psychological/psychiatric conditions. The secular program only dealt with core values of spirituality common to Hinduism and Buddhism. The participants being all followers of Hinduism incidentally, the results may not be equally replicated in religiously diverse Indian communities. The online sessions were only accessible to those who had electronic devices with internet connections.

Despite these limitations, this program provides a rudimentary framework to guide future work on Eastern spirituality in the Indian medical fraternity. This intervention can be a forerunner of more structured and standardized programs or curriculums custom-made for the healthcare community. This study opens up new gateways for further research on the integration of spirituality with medical care in the Indian context toward achieving a holistic healthcare goal.

CONCLUSION

The online Eastern spirituality-based educational program shows promising results in influencing the well-being of Indian medical practitioners. There appears a potential for extension to medical care practice. Further studies will be needed to substantiate the results.

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