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ARGUMENTS IN FAVOR OF A RELIGIOUS COPING PATTERN IN
TERMINALLY ILL PATIENTS

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Abstract: A patient suffering from a severe illness that is entering its terminal stage is forced to develop a coping process. Of all the coping patterns, the religious one stands out as being a psychological resource available to all patients regardless of culture, learning, and any age. Religious coping interacts with other values or practices of society, for example the model of a society that takes care of its elder members among family or in an institutionalized environment or the way the health system offers or not psychological support for a terminally ill patient. Health care providers should have at least some psychological coping patterns training because not all patterns of religious coping are equally effective, and some have been described as increasing the level of stress or producing other negative psychological effects on the patient. This article aims to review the complex models of religious coping that are unanimously accepted in psychooncology, arguments in favor of religious coping, the types of patients that use this model, ethical dilemmas that could be reinterpreted using religious arguments. Finally, we will also discuss the need of Romanian patients to embrace a religious coping in case of an incurable illness, and also the support that they can receive from both curative and palliative health care providers.

Key Words: coping, religious coping, spirituality, palliative care, terminally ill patients, cancer, spiritual needs, decision making at the end of life

Psychological adjustment of a terminal patient

The clinical approach for individuals facing a crisis (terminal illness) implies his analysis in a social, cultural, domestic and also religious context¹. The psychological and spiritual support given to patients facing a life-changing crisis such as reaching the terminal phase of an illness is based on the analysis and streamlining of his psychological adjustment as well as supporting the patient when they are faced with decisions regarding his clinical situation (deciding to start a palliative treatment, or to discontinue a treatment considered ineffective, or not treating a symptom and finding a meaning in suffering, even determining the place where the patients might desire to spend their final days). This moment, when faced with decision making in the terminal stage of an illness is where medicine, psychology and bioethics overlap; this is where controversies and dilemmas are born. But before we analyze these dilemmas we need to present, in brief, the main patterns of psychological adjustment as well as the multitude of bio-psycho-social problems caused by severe illness (near-terminal phase) in patients' lives, towards which the patient must develop a psychological adjustment process.

According to the common psychooncologic point of view, *coping* is a sum of behaviors and cognitive activities that appear in response to a "predicament", an overwhelming event of life, with the aim of overcoming that event. These "response behaviors" developed by the patient following the disclosure of the diagnosis/prognosis arise as a subconscious means of psychologically fighting. These psychological answers' aim is to minimize the disturbance in the life of patients produced either by the disclosure of the diagnosis and beginning of treatment or the overwhelming news that there is no cure, just palliative treatment. By effectiveness in alleviating the negative psychological consequences, coping can be functional (efficient, adaptative, effective), lowering levels of stress, anxiety and depression or dysfunctional (inefficient, not adaptative, ineffective), which is associated with unfavorable evolution of disease and an elevated level of stress².

The effective coping patterns for terminal patients are accepting the prognosis/diagnosis, positive thinking, engaging the "unseen enemy", represented by disease, in combat, accepting support from peers, taking into account every possibility for evolution of the disease, identifying their own resources and using them, reinterpretation of the disease as having positive connotations (cognitive reconstruction), reacquisition of religious valences at the start of the terminal stage, and the search for support in religion/spirituality. Examples of inefficient coping developed by patients with severe illness include negating the existence of the disease or diagnosis (if this persists for prolonged periods of time), anger, alienating people who could provide support (resource-people) by the

patient, hiding the truth, depression, interpreting the disease as Divinity punishment, loss of faith in the Divinity³.

An important feature of cancer patient coping is its dynamic nature. To contract an incurable disease and to enter terminal state is not a single event, but a chain of events that interconnect. The psychological adjustment process starts upon suspicion of the diagnosis, continues after the confirmation (at this time most patients suffer an emotional shock) and continues with the beginning of treatment, it is modified after complete remission (if the case consists of a malign illness) or with relapse and start of the terminal stage. The dynamic nature refers to the constant change of the stress factor towards which the patient must develop an adjustment process, but also to the effectiveness of the coping process. If an adjustment mechanism is effective at a certain point it does not mean that it will be as effective at a different point in the evolution of disease. For example denial represents functional coping upon disclosure of the diagnosis, but it becomes dysfunctional on long term.⁴.

Severe illness and the start of terminal phase have repercussions on all aspects of the patients' lives which develop psychological adjustment mechanisms for each of the repercussions. These can be *personal* (the feeling of loss in one's personal life, failure to reach certain life goals, depending physically and psychologically on other people, self blame for the onset of disease, uselessness), *domestic* (loss of family life, guilt towards the family members for not contributing to the material and spiritual well-being of the family), *social* (loss of social life being stigmatized). Last but not least, *financial problems* arise (costs of medical tests or treatments, the patient must retire, and the income is diminished due to low efficiency or retirement) or *dissatisfaction towards the health care system*⁵. Today, most terminal patients also confront stress factors related to the continuous change of the Romanian medical system, that is well known for its many weak points (human and material resources) The inequities that exist in the system that raise many debates on medical ethics are sources of stress for the patients. They live in a time when responsibility for the performance of the medical system is transferred between organizations and the authorities tend to rely more on the individual responsibility of the patient, further burdening them financially and psychologically⁶.

A person's coping ability develops based on their psychological resources. The latter can be internal (a patient's personality can inspire fighting spirit, humor) or external (resource-people, their profession, workplace, social context, material situation). Religion is one of the resources that these individuals most frequently turn to; this aspect is more intense and frequent at patients who find themselves in existential extreme situations, like an incurable disease in a terminal phase.

Terminal patients' coping: why a religious pattern?

As far back as Freud and Durkheim, sociology has tried to define the main role of religion in human existence. It is certain that people attribute different purposes to religion: lowering of anxiety caused by unforeseen events⁷, impulse self-control⁸, reinterpretation of physical and psychological suffering and the search for meaning in suffering, membership, interaction and the search for support in a religious community.⁹

Among the coping strategies utilized by different people, religious coping is one of the top most frequent. When patients are faced with adversities, like severe, life-threatening illness they frequently turn to the soul's closest means of adjustment, spirituality and religion. Among the consequences of religious coping psychologists usually count: the discovery of a meaning or cause that the patient attributes to the disease, comfort, sense of belonging to a community, the solution to their problems and spiritual orientation.¹⁰

Studies have proved that there is a correlation between spirituality, religiousness and a drop in morbidity and mortality, an improvement in mental and physical health, the choice of a healthier lifestyle, with a decrease in the necessity to call medical services, streamlining of coping, an increase in wellness, a decrease in stress and disease prevention¹¹.

KI Pargament, one of the most prolific psychologists that have studied religious coping with disease has sketched the portrait of the patients that develop this kind of coping from many angles. This author has demonstrated that during the counseling process for a patient, it is more important to answer certain questions about this psychological adjustment mechanism than to see if the patient adopts a religious coping mechanism¹²:

Religious coping motivation. People who have an internal control locus¹³ on past events (interpret them as a consequence of their own deeds), have an internal motivation for practicing religion, and have higher levels of self-esteem and psychologically adjust effectively. People who have an external control locus perceive stressful events and circumstances of life as beyond their capability for control. These individuals are motivated by guilt, anxiety and external pressure into practicing religion and religious coping. Studies have shown that a patient's control locus is influenced by the culture and religion of the patient in terminal phase. Protestant patients from northern European and North-American countries have adopted an internal control locus while Catholics in Spain have adopted an external control locus when participating in the study¹⁴.

Most often religious coping was conceived as being centered on emotion (being a method of dealing with negative emotion), but it also has cognitive components (reevaluation of the meaning of a disease in light of

spirituality) and also behavioral components (prayer). This turns out to be an addaptative and active coping pattern, useful in dealing with adversity and especially disease¹⁵.

The way of practicing religion, the means of religious expression can consist of rituals, experience and interhuman relations. This influences an individual's nervous system. In the last decades of the 20th century there have been studies of clinical neurology that have proven the existence of religious practices (meditation, prayer, contemplative activities, slow rituals accompanied by calm, monotonous, melodious speech) that cause the sympathetic nervous system to relax and therefore decrease muscle tone and heart rate, lower blood pressure and modify certain brain waves, all these having an anxiolytic and anti-stress effect. By contrast, there are religious practices that can stimulate the sympathetic nervous system, especially during religious rituals that cause a rhythmic stimulation of visual, auditive and kinesthetic receptors; this can cause an increase in distress levels for patients that are under tense situations¹⁶.

The way a patient practices religious coping is important, as is flexibility in thinking and in practicing religion; there is a great difference between the effectiveness of coping for rigid patience, that dwell on certain interpretations and practices and the effectiveness of a flexible person who is capable of cognitive reconstructing, of reinterpreting past events, of rediscovering new religious aspects after the event of a reserved prognosis or diagnosis.

In his classification of religious coping patterns, K.I. Pargament¹⁷ has proposed three subtypes: *collaborative*, *Self-Directing* and *Deferring*. The first subtype is a coping mechanism where the control over a situation is shared between the person and the Divinity; *Self-Directing* coping advocates the person's direct control over the situation, while not contesting the existence of the Divine, and the *Differing* subtype pleads for complete Divine control over the situations.

The development of one of these subtypes of coping depends on the degree of religiousness. People with a high degree of religiousness have a tendency to develop a *Differing* type coping system, while less religious people adapt according to a more *Collaborative* subtype, the latter being the most commonly found among patients in the USA, which also correlates with a better status of mental health (KI Pargament¹⁸). Studies on terminal patients have shown that the types of *Collaboration* and *Self-Directing* represent effective coping patterns¹⁹.

Of the three religious coping subtypes presented earlier patients have proven most often to adopt a *differing* coping system style, the patients "surrender" control over the situation they consider as out of control to the Divinity. The moment when a patient adopts a religious coping mechanism was included by Pargament in his definition of religious awareness²⁰.

In a different classification of religious coping, Pargament identified nine strategies, the first five of which are effective coping patterns and the last four are ineffective coping strategies:

1. Beneficial evaluation, redefining the stress agent as potentially beneficial (discovering new religious aspects).
2. Self-Directing religious coping, searching for control by means of personal actions, while experiencing a feeling of spiritual protection.
3. Collaborative religious coping, searching for control in a collaborative partnership with the Divine.
4. The search for spiritual support, the search for comfort and reassurance in the love and protection of the Divinity.
5. Searching for psychological support among the church and religious community representatives.
6. Religious waiting (passive): waiting for the Divinity to take control over the situation.
7. Evaluating the stress agent as a punishment, redefining the stress agent as a punishment from the Divinity.
8. Interpersonal religious dissatisfaction, expressing confusion and dissatisfaction in regard to church representatives or members of the religious community.
9. Spiritual dissatisfaction. Expressing confusion and dissatisfaction in regard to relationship with the Divinity²¹

An important psychological adjustment model in terminal patient studies that include religious coping is described by Elisabeth Kübler Ross, unanimously recognized in psychooncology. Interviewing two hundred of incurable patients, the author has defined five stages of psychological adjustment to terminal stage, one of which being a religious coping pattern, but spirituality and religion have implications in almost all of the five adjustment stages. Some of these steps can be more or less visible, and their order might be different, also some represent effective coping while others might be examples of ineffective coping.

The first stage is *denial*, this represents avoiding thoughts about the severe diagnosis or prognosis. The patient is tempted to believe that the doctor is wrong and that it is possible for the results to belong to a different patient; they have the tendency to get a number of second opinions, insisting that the tests be repeated. This stage is prone to generate conflict between the patients and the health care team, which can interpret the patients' denial and the wish to repeat the tests and get a second opinion as an insult to their professionalism and medical knowledge. Short term denial is effective coping, while long term denial is ineffective²². An important role in overcoming this stage can be played by the spiritual counselor, hospital priest or the patient's priest who could advise him/her to be more tolerant and accepting the situation or to look

for spiritual meaning in the appearance of the disease (if this intervention is accepted by the patient)²³.

The second stage of psychological adjustment is *anger*; this stage being under a series of symbolical questions: “Why is this happening to me? What am I guilty of?”. The patient considers that it is not fair that this destiny is applied to him/her while other members of society (often people with antisocial or antichristian behavior) are healthy. This stage also has religious implications; the patients sometimes develop a feeling of anger and protest against the Divinity, questioning the divine justice and feeling that their fate is unjust. In consequence, the patients develop an angry and accusing behavior against everyone around them: family, friends, medical staff, and other patients. Although apparently the patient wishes to keep these conflicts alive, in fact he is going through an ineffective coping stage that has the purpose of attracting attention and support to them. This is a delicate moment for the doctor-patient interaction where, if the doctor doesn’t show empathy and knowledge of these coping types conflicts are born as well as breaches of medical ethic. Here is another stage where the counselor/priest can intervene spiritually and listen to the patients and grant them the attention and guide them to calm and understanding as well as a different interpretation of the meaning of this disease²⁴.

Bargaining with the Divinity is the third stage; here the patients make “deals” with the Divinity, with the purpose of prolonging their existence while offering good deeds in return. This represents a religious coping stage. The patients wish to prolong their existence for a certain reason, and to participate in a happy family event (a child’s wedding, being reunited with a family member they have not seen in years). Usually the patients add the premise that they will never ask for anything again if God or faith will grant them this. This is usually not true as they will express countless other wishes, proposing more and more deals through internal dialogue. Bartering is an effective religious coping stage, its beneficial nature having multiple aspects: it is a process of becoming, of spiritual enlightenment, of reconciliation with the people around the patients following the conflicts started in the anger step, of active attitude because the patients develop a purpose for the future (they start fighting for the things they ask from the Divinity)²⁵.

Depression is the fourth stage of the Kubler Ross model. There are two types of depression of the severely ill patient, reactive depression (which is secondary to disclosure of diagnosis and caused by the loss the patients feel) and death preparing depression, which is a period of meditation and a psychological adjustment step, by means of which the patients separate themselves from this world and start weighing their lives’ achievements, and accept their fate. While the reactive depression is an ineffective coping stage, the death preparing depression is an effective stage, desirable for terminal patients; after this stage the patients’ passing comes

with feelings of peace, acceptance, and inner tranquility. This is a stage that interacts with religious coping mechanisms and the spiritual or religious approach is very important, the priest or guidance counselor being able to provide support for the patients, while respecting the practices of the religion they embrace²⁶.

The final stage of the Kubler Ross model is *acceptance*. In this stage, the pain has passed, the fight for prolonging life is over and what follows is a time that one of Elisabeth Kubler Ross's patients had suggestively named "the end before the great journey". This is a time for the patients' families to show great compassion, psychological help and support to ease the patients' overcoming of difficulties. Here too the priest has an important role in preparing the patients for their life's end and accepting and discovering new spiritual horizons, thus becoming an acceptance of the destiny the Divine has provided²⁷.

These psychological adjustment stages can be experienced by the family as the patient is experiencing them, which is why it is important that hospice care is provided so the family is involved medically and spiritually.

Who and where develops religious coping to severe illness?

Patients that invest more in their religious life develop a psychological well-being, a higher degree of satisfaction in life, more optimism and better health, in other words have a greater chance to develop effective coping in extreme situations. The development of an effective psychological adjustment system is also influenced by a person's culture and by historical factors. Often national or religious minorities develop religious based psychological adjustment mechanisms. A study done in the USA has proven that adult Afro-Americans adjust more effectively to severe illness because they have better religious psychological support from their church. This support has developed over time because of the oppression they were subjected to on the North-American continent (slavery, racial discrimination, living away from their home country)

Another question asked in literature was if *patients accept the approach that spiritual/religious counseling provides and in what situations*; one of the key principles of a psychological intervention is that it needs to be accepted or even desired by the patient²⁸. To answer this question clinical trials have been conducted especially in west European countries and on the American continent; the conclusions were in favor of a holistic approach to severely ill patients (medical and spiritual/religious approach). One study conducted in the USA on number of 921 patients (who were questioned upon presenting to their physicians) had the goal of developing a holistic approach focused on evaluating the patient's spiritual/religious needs. For this, the following points were studied: to

what extent are the patients open to a spiritual approach or religious beliefs; if, and at what time, they would desire that their doctor communicate with them about the religious implications of the illness; creating a predictive model on which patients would most desire a spiritual approach. The results have shown that 83% of the respondents wish to be confronted by their doctors with spiritual aspects under the following circumstances: in case of life-threatening illness, in case of severe illness or in case of loss of a loved one. Of the patients that desire to discuss spiritual problems with doctors, 87% desire that their doctors understand how their fate influences their own coping with the illness, 85% wish their doctor to understand them on a personal level, not just based on their physical problems, and 83% wish their doctor to understand how their decision making process works. Patients' opinion is that only after they understand what their religious beliefs are, the doctors could show genuine compassion, and encourage realistic hope about the prognosis as well as advice the patients how to look after themselves and individualize the treatment for each and every patient in case of unforeseen complications or at least guide them to a spiritual counselor. Patients that are liable to change the therapeutical approach are more often women than men and Caucasians rather than Africa-Americans. Asked why they would like a religious interaction with their doctors about one third of the patients answered that they would like to pray with the doctors, and another third would like the doctors to listen to them speaking about their spiritual values. Applying logistic regression has proven that the patients who desire predominantly religious discussions with their doctors are of ages 30 to 64, those who think that spirituality and religion might modify their decision-making process in regard to their illness, those who believe that certain religious beliefs give them hope when they are confronted with a severe illness and those who consider themselves as more spiritual on a scale from 1 to 5. Worth mentioning is the fact that most patients have declared that religion changes their decision-making process in regard to dying and death and also the beginning of artificial measures to sustain life.²⁹

The results of studies on the impact of religious coping of terminal patients have suggested an increase in the quality of life they live after following this pattern³⁰. Furthermore religious coping offers a frame of reference for the existence and reason for a life-threatening and potentially deadly illness³¹. A study conducted on a group of 69 cancer patients under palliative radiotherapy has reported that patient spirituality and religious coping is positively correlated in a statistically significant way with an increase in quality of life. 85% of the patients thought that doctors and nurses should pay attention to their spiritual needs³².

Patients in Romania – leaning towards religious coping?

Romania is a country where religious beliefs represent one of the most fundamental values of the citizens. Even in ancient times in this geographic space, the Christian church has been involved in village life, in family life and in solving everyday problems as well as in supporting followers in the three important moments in life: birth, marriage, and death³³. During the 45 years of communism, when the public speech was based on atheism, the religious faith of the Romanian people has been tested but not destroyed, and after the 1989 revolution religion was again supported by the state³⁴. As shown by Iloaie, even in the 21st century Christian faith offers many milestones so that contemporary man can rediscover it as a real help in decision-making³⁵.

Norris and Inglehart, quoted by Șandor, situates Romania among the most religious countries in the world, using two parameters to measure religiousness, frequency of prayer and frequency of places of worship. Therefore Romania is situated in the neighbourhood of the most religious countries on Earth (Ireland, USA, Uganda, Phillipines), and among the orthodox countries it shares first place with Greece. Religious life is important or very important for the majority of the citizens of Romania. Two thirds of Romanian citizens base their life on religious beliefs (a higher percentage than other European countries), prayer is a very common practice. The same study proves that the church has the role of solving most types of problems that arise in Romanians' lives³⁶. Taking into account these arguments regarding the degree of religiousness of the Romanian people it is obvious that in case of an unforeseen life-threatening event (cancer, entering terminal stage) Romanian patients will resort to religious psychological adjustment patterns. There are however few clinical psychology studies that confirm this hypothesis.

A study conducted on a lot of 100 patients with acute leukemia being treated at the Hematology Clinic in Cluj proves that for 89% of patients religion is one of the main resources mobilized in the "spiritual fight" against the illness. Analyzing the main psychological resources of the patients which have been mobilized against leukemia, religious belief ranked number four (by number of patients that develop leukemia coping based on this resource), ranking higher was family (especially life partners) the psychological support group and psychologist, and after religion the following resources were found: acquisition of a future goal, doctor, other patients, medical personnel, work colleagues and friends.

Analyzing the crossing of Kubler Ross stages (for psychological adjustment to cancer diagnosis) by the patients in the lot described earlier, 64% of subjects have confirmed that they had made a "deal" with the Divinity, effective religious coping stage. The favors they asked from the Divinity were mostly tied to family in 38% of cases, professional career

(7% of patients). 2% of patients had requested the divinity to allow them to carry out a pilgrimage to holy places, and 17% refused to reveal the subject of the deal. Elisabeth Kubler Ross in her reference paper where she defined the five steps to psychological adjustment states that the bargaining step was the hardest to emphasize, only counselors and priests (chaplains) being able to coax it out. Many of the patients of the study done in Cluj have spontaneously admitted during the interview, without being asked, the crossing of this threshold. Could this be a general trait of Romanian patients, this openness regarding their spiritual life and religious experiences?³⁷

Taking into account these arguments, it is easy to conclude that, as opposed to western societies (where religion is unpopular among the psychological resources³⁸), to the cancer patients in Romania, religion is one of the most important spiritual resources. With this in mind it becomes necessary to realize the importance of the spiritual/religious counseling of patients with severe illness, cancer and terminal patients. Unfortunately very few hospitals in Romania have a psychologist on their staff, and theologians are not in the specialist teams that have outlined the National Public Health Strategy, although they carry weight in bioethics³⁹. There are nongovernmental organizations in Romania that offer social and medical services; these organizations show potential in granting spiritual counseling for these categories of patients⁴⁰. On the other hand, in hospitals throughout Romania there are orthodox priests (because the majority of population -86.5%- is orthodox⁴¹) Based on the observations gathered over a period of 6 years at the Oncologic Institute of Cluj, where a psychological support group for cancer patients was held, we have concluded that the priests that give spiritual counseling to chronically ill patients with severe illnesses or terminal patients in hospitals do not have the necessary training to understand the specific psychological problems these patients are facing, and to counsel these patients. Some of these hospital priests and parish priests have oriented these patients towards ineffective religious coping mechanisms, towards interpreting the illness as a divinity punishment or accepting it along with destiny with passiveness. Observing the recurrence of these religious coping patterns developed under the guidance of multiple orthodox, Greek-catholic and Roman-catholic priests in Transylvania, the two counselors of the mentioned psychological support group started wondering whether this was the essence of Christian dogma⁴². The conclusions of a study meant to clarify these aspects will be presented here. Human suffering, when induced by illness must bring about reconciliation with the past and the Divinity, to ease the conscience and to guide patients to confession. Suffering intensifies the patients' ability to pray, bringing them closer to the Divinity, as this transforms suffering into values. Illness can also be interpreted as mystical divine lessons, a silent but pressing call to piety, humbleness and the search for salvation as well as for healing. The coping

model recommended by the Christian tradition is an active one. This coping model is exemplified by a fragment of the Holy Unction Prayer in which Christ said “Every time you fall, get up and you will find salvation” this is undoubtedly a plea for action, not passiveness. Fatalism, passive acceptance of an illness, taken to its extreme “what is said is done” does not reflect the essence of Christian tradition. Christian dogma recommends a collaborative attitude towards the Divinity in facing a problem. The unilateral interpretation of illness as punishment does not represent the correct attitude, and is not recommended for priests who offer spiritual aid in hospitals.⁴³

The implications of religious concepts and religious coping in the decision-making at the end-of-life

There are certain “classical” ethical dilemmas that appear at terminal patients that can be debated from a religious standpoint, taking into account the interpretation offered by theologians to physical suffering or can be overcome using religious coping patterns. This is especially true for end-of-life decisions, the choice whether or not to follow an aggressive/intense treatment during the last few days of life; at the start of palliative treatment, for people who could make decisions for unconscious patients and the degree of autonomy that should be granted to patients, a.s.o.

These ethical dilemmas are interpreted from different standpoints by specialists in different fields like allopathic medicine specialists, bioethicists, theologians. Often, these three categories of specialists propose different explanations and solutions for the ethical dilemmas that arise at the end of life; this difference in opinion arises from the different explanation they give to physical suffering and illness.

All these different sciences have in common their aim of improving the quality of life of the patient, but even the definition of quality of life differs from one point of view to the other.

From a medical standpoint, when referring to a terminal patient, maintaining the quality of life represents the disappearance of symptoms (especially pain) and maintaining a physical and social comfort level⁴⁴. However, Christianity does not exclude suffering. In the Christian orthodox faith “this is a reality that our Savior Christ did not deny, did not suppress, but assumed it. The love of one’s kind is expressed by helping them bear the pain until the terminal patient surrenders to God, and then they shall be the result of a natural process and, to the limit of their ability, fully conscious and aware”⁴⁵.

The orthodox space shares the view that a life with no quality or dignity is one that lacks a meaning for suffering and eschatological finality, the life without God⁴⁶. Life is sacred, and its quality results from its sacred nature, not the other way around. Here, “good death” or quality of

life are considered to be “centered on the love of God and neighbor rather than on personal comfort”⁴⁷.

The Catholics have an “economic” concept of suffering as temporary punishment for a sin. Suffering erases the temporary punishment that would otherwise be consumed in purgatory⁴⁸. While the West maintains a juridical understanding of sin, the Eastern Church has a therapeutic understanding recognizing the importance of being free of the effects of past sin after an honest repentance. Every time he truly repents and is forgiven during Confession, the Christian is given a full pardon. “Our suffering is born with patience... it can help us learn humility and to heal the effects of sin. Therefore the role of suffering must be understood therapeutically, not legally”⁴⁹.

In conclusion, the biblical understanding is that physical suffering brings about spiritual benefits, therefore the terminal patients’ suffering can be interpreted and understood as a divine act in human life⁵⁰.

Bioethicists are inclined to allow each patient to define their own acceptable level of quality of life from a bio-psycho-social and spiritual level, each patient experiencing his own level of suffering, that he is willing to accept. Keeping this into consideration, a doctor can explain why a patient with spiritual and religious values on which religious coping is based, does not wish to have the treatment of his/her symptomatology to be a priority, but the presence of a priest or to spend the last few moments of their life among family and not in a highly equipped hospital. Taking into account the light Christianity sheds on suffering, we can see why the attitude of patients who rely on religious coping rather than palliative stay in a hospital, a medical act that is often considered and proposed by palliative medicine specialists to terminal patients with severe symptoms which can not be controlled with classic medication⁵¹.

The four basic principles of bioethics (patient autonomy, principle of nonmaleficence, principle of beneficence, principle of justice) are unavoidably interconnected with spiritual values as well as religious ones that take precedence for every patient or culture and with each patient’s own psychological adjustment. In the American culture, autonomy and beneficence take precedence over the other two, as the American approach leans towards utilitarianism. The same model of autonomy respect is present in North European countries and Anglo Saxon ones (including Canada, Australia, and New Zealand). According to this model of doctor-patient communication and of medical care the patient is informed about his/her medical situation, the relatives being included in the decision-making process only if the patient expressly wishes this. In Europe, and predominantly in southern or Latin countries the concept of patient autonomy is overshadowed by the traditional view that important decisions (especially those that are related to the death of a “senior” of the family) are made within the family or by the family as a whole; this fact is often at odds with legislation. These countries have a more traditionalist

model of approaching a terminal patient. They are cared for among family and the entire family enjoys the support of the religious community they are a part of. Thus we see a religious coping model of the family as a whole, where the psychological resources are the people and their relationship to the priest. This is the case in Italy, Spain, Greece, Romania, Ex-Soviet Union countries, Japan and the Philippines⁵². It is hard to establish which would be the ideal model for decision-making and what is the degree of autonomy that should be offered to the patient. It is certain that religious patients wish rather a decision-making model in which the family is involved. A decision that comes from the sphere of bioethics to aid the patient is represented by the advance directive, a juridical tool that can be used to stipulate in advance the approach the patient wishes to explore in case of severe or terminal illness⁵³.

Maintaining patient autonomy and the psychological approach complementary to medical treatment is also found in the opinion of the Romanian Orthodox Church and expressed as a plea for maintaining the dignity of the terminal patient: “the patient should be granted the freedom to decide about the treatment of a terminal illness and should be shown solidarity and compassion by those around him (family, friends, medical staff), and they should be administered the adequate medication to relieve physical and psychological suffering (that could prove unbearable and dehumanizing), so that they can die with a maximum of consciousness and a minimum of pain”⁵⁴.

Another controversial concept intensely debated by palliative care specialists, worldwide associations of chronic illness sufferers, legal representatives and church representatives is the use/uselessness of an end-of-life medical treatment. This issue has generated famous discussions that were shown by the media world-wide and which ended up in court. From a strictly medical standpoint a useless treatment is an approach that “brings no benefits to the patient, prolonging the death process”⁵⁵. The main ethical problems related to the concept of uselessness refer to whether or not to resuscitate a terminal patient, whether or not to administer food/fluids artificially and whether or not to disconnect the artificial breathing machines. Of course the ethical dilemma is caused by the fact that it is hard to pinpoint who should make this decision, the doctor?, the family?, the patient?, an ethics committee?

An interesting original study was conducted on a number of 345 patients with terminal cancer, most of them Christian; it has proven that patients who develop an effective religious coping mechanism desire an intensive medical treatment when close to death (resuscitation, artificial ventilation, hydration and food). There are a series of explanations for this attitude. The patients desire aggressive treatment because they believe in miracles even if the doctors explain the limits of medicine and their situation in an objective manner, they hope for a therapeutical intervention of the divinity. Furthermore, these patients solicit

aggressive, costly, risky treatment with uncertain results believing in healing from God. One form of effective religious coping is collaboration with the Divinity with the purpose of conquering the illness and of transformation (enlightenment) through suffering. The patients that give a spiritual meaning to suffering can endure more aggressive and painful treatments at the end of their life. The patients that develop religious coping are less inclined to accept a palliative therapeutical attitude and to discontinue an aggressive cancer treatment, interpreting this as abandonment of their spiritual life, as an acceptance of the limitations of medicine and as a wait for death. Religious patients can consider palliative care as abandoning the Divinity, before the Divinity has abandoned them. A negative consequence of intensive end-of-life therapy is a painful death due to scientific/medical procedures (tracheal intubation, defibrillation, resuscitation, the multitude of injectable drugs and their side-effects etc.). This painful death can have negative psychological repercussions on the family and the medical team taking care of the patient, like burnout syndrome or pathological mourning. The results of this study do not negate the existence and the reality that some terminal patients experience as they develop effective religious coping pattern that accept the end of their life with feelings of calm, inner peace, without wanting intensive life support during their last hours or days.

Other studies have shown that among the spiritual reasons for which the patients preferred intensive life support measures, is the the belief that only God knows the moment of a person's death⁵⁶.

Another study in which cancer patients in late stages had developed effective religious coping, shows that they were less receptive to the idea of not being resuscitated, considering the order "do not resuscitate" as immoral⁵⁷.

Adopting an aggressive therapeutic attitude at the end of one's life is supported by theologians who are adepts of the sanctity of life, who are in favor of all medical interventions that preserve life (as opposed to the theologians who advocate the quality of life⁵⁸). The advocates of the sanctity of life use the official statements of leaders of the Christian Church as arguments; one example is the statement of Pope Pius XII in "49 Acta Apostolica Sedis 1027" where he considers the preservation of life even in case of severe illness "a right and a duty of the doctor"⁵⁹, the declaration of Vatican in 2007 was formulated following the numerous trials in the USA regarding the discontinuation of life-support for patients in irreversible coma „the removal of the tubes through which the patients in a persistent vegetative state are fed is an immoral act"⁶⁰. The Romanian Orthodox Church is also an advocate of the sanctity of life: „loving one's neighbor does not mean ending their life out of mercy to help him avoid the pain, but in helping them to endure the pain until he surrenders to God, a time that must remain the result of a natural process and, as much as possible in good conscience and consciousness. Our duty, and especially

the doctors' duty is to be in service of life until its end, but man is alive even when he is in the terminal stages of physical life"⁶¹. On this topic, the Russian Orthodox Church recommends that resuscitation and life support be administered to terminal patients in case they have clearly expressed the desire for this. If the patients have not expressed this desire, it is recommended that they not be resuscitated or artificially fed and hydrated when terminal.⁶².

Instead of conclusions

It is unanimously accepted that terminal and severely ill patients can rely on religious psychological adjustment patterns. This type of coping can be facilitated by meeting patients half-way with a qualified personnel. The entire medical care team should be made aware of the existence of these psychological adjustment patterns, as well as the consequences, be they negative or positive, of religious coping, the most important being closely tied to end-of-life decision-making.

Whenever it is possible from an administrative and human resources standpoint, it is recommended that in the health care team for terminal patients should be included also a counseling specialist with studies in spiritual/religious counseling, who could recognize the inefficient coping patterns and could provide spiritual support as well as counseling the patients in regard to their coping strategies. These spiritual counseling specialists can be either theology graduates who also have an education in counseling, or psychologists or psychiatrists who have learned about religious psychological adjustment.

Applying these elements of religious coping to terminal patients also refers to discussing them with the members of the religious community that offer counseling to the general public or help to care for terminal patients among family.

The failure in satisfying the spiritual needs of the terminal patients may lead to a spiritual crisis at the end of their life. This spiritual crisis is often described by the grieving families of the patients using the expression "he/she didn't die in peace", even though the patient suffered no pain or suffering at the end of his life. This spiritual crisis can have negative consequences on the patients' family, friends and relatives who can, as a result, develop pathological psychological reactions.

Providing spiritual support to terminally ill patients is an important component to the holistic care which they must receive. This therapeutical approach is recommended to be performed by a multidisciplinary team (doctor, nurse, orderly, spiritual/psychological counselor, physiotherapist) and to be adapted to each patient in particular. The patient must be approached alone, or with family, following their own wishes, and often, the family needs support as well, in

order to facilitate their dealing with the stress factor represented by the impending death of one of its' members.

Notes:

¹ **Acknowledgements:** This paper is a part of POSDRU/89/1.5/61879 Project co-financed from European Social Fund through Human Resources Development Sectorial Operational Program 2007-2013.

² Stacie Spencer et al., "Psychological and Social Factors in Adaptation", in *Psycho-Oncology*, ed. Jimmie C. Holland (New York: Oxford University Press, 1998), 211-212.

³ The examples shown here are taken from specialized literature as well as from the author's 9 year experience as a psychological counselor at the hematology section of the Oncological Institute in Cluj. Andrada Pârvu and Petrov Ljubomir, "Risk factors for ineffective coping in acute leukemia patients", *Hematologica - The Hematology Journal* 95(s2) (2010):190.

⁴ Andrada Pârvu, "Aspecte ale copingului la diagnosticul malign", in *Psihologia Sănătății*, vol.5, ed Eugen Avram (București: Editura Universitară, 2011), 33-66.

⁵ Cristian Vlădescu et al. „Un sistem sanitar centrat pe nevoile cetățeanului”, *Revista Română de Bioetică*, Vol.8, Nr.2 (2010): 7-16.

⁶ An ample and pertinent analysis of ethical and social responsibility of the organizations involved in the decision making in the Romanian medical system was done by Frunză. Sandu Frunză, „Ethical responsibility and social responsibility of organizations involved in the public health system”, *Revista de cercetare și intervenție socială*, vol. 32 (2011):159-171. In another paper, the author proposes a social responsibility model for ethical and adequate distribution of resources in the medical field. Sandu Frunză, „On the need for a model of social responsibility and public action as an ethical base for adequate, ethical and efficient resource allocation in the public health system of Romania”, *Revista de cercetare și intervenție socială*, vol. 33 (2011):187-192. Also, when analyzing the social inequality and inequity of the Romanian health care system Vasile Astărăstoae pointed out the need for an ethical analysis of the entire system. Vasile Astărăstoae, „Is an ethical analysis of the Romanian Healthcare system necessary?”, *Revista Română de Bioetică*, 8 (2010): 3-4. See also: Liviu Oprea, „Ethical Issues associated with social inequalities in health care”, *Revista Română de Bioetică*, 2 (2010): 3-6.

⁷ Milton Friedman and Steve Rholes, “Religious fundamentalism and terror management”, *International Journal for the Psychology of Religion* 18 (2008): 36-50.

⁸ Peter L. Benson, „Religion and substance use”, in *Religion and mental health*, ed. John F. Schumaker (New York: Oxford University Press, 1992), 211-15.

⁹ Claudia-Iulia Dragănescu and Ana-Maria Dima, „Religiozitatea și sănătatea psihică”, in *Psihologia Sănătății*, vol. 5, ed. Eugen Avram (București: Editura Universitară, 2011), 152-155.

¹⁰ Kenneth I Pargament, *The psychology of religion and coping: Theory, research, and practice* (New York: Guilford Press, 1997), 136. See also Maria Karekla, Marios Constantinou, “Religious Coping and Cancer: Proposing an Acceptance and Commitment Therapy Approach”, *Cognitive and Behavioral Practice* 17 (2010): 371-79.

¹¹ Gary McCord, et al., "Discussing Spirituality With Patients: A Rational and Ethical Approach", *Annals of Family Medicine*, 24 (2004): 356-361.

¹² The analysis of different aspects of religious coping is entitled: "The Why's, How's, When's, Who's and Where's of Religion". Kenneth I. Pargament, „Is religion good for your health? It depends” (paper presented to Heritage Foundation Meeting, Washington DC, USA, December 3, 2008)

http://site.heritage.org/research/features/religiouspracticeinamerica/pdf/Pargament_HeritagePaper.pdf

¹³ The control locus represents a psychological concept that means the perception of a certain individual of the factors that cause certain events in his/her life and his capability of influencing those events. Kenneth I. Pargament, „Is religion good for your health? It depends”, 3-4. See also Juan Núñez Olarte, "Cultural Issues and Ethical Dilemmas in Palliative and End-of-Life Care in Spain", *Cancer Control*, 8 (2001): 47-48.

¹⁴ The explanation given by Olart and all. refers to the countries where the Latin cultural model applies, where family unity and decision making is emphasized. Núñez Olarte, "Cultural Issues and Ethical Dilemmas in Palliative and End-of-Life Care in Spain", 48-52.

¹⁵ Karekla Maria and Marios Constantinou, "Religious Coping and Cancer: Proposing an Acceptance and Commitment Therapy Approach", 371-381.

¹⁶ Dragănescu, „Religiozitatea și sănătatea psihică”, 152-155.

¹⁷ Kenneth I Pargament, et al, "Religion and the problem-solving process: Three styles of coping", *Journal for the Scientific Study of Religion* 27 (1988): 90-104.

¹⁸ Pargament, „Is religion good for your health? It depends”, 5-6.

¹⁹ Thomas V. Merluzzi, et al., "Self-efficacy for coping with cancer: revision of the Cancer Behavior Inventory (version 2.0)", *Psycho-Oncology*, 10 (2001): 206-217.

²⁰ Religious awareness represents, in Pargament's view, "applying the correct religious resource at the right place at the right time", a relatively ambiguous definition because a person that has not been exposed to the stress factor can have a different interpretation of "the correct resource", "the right time" and "the right place". Pargament, „Is religion good for your health? It depends”, 6-7.

²¹ Dragănescu, „Religiozitatea și sănătatea psihică”, 152-155.

²² Elisabeth Kübler Ross, *Despre moarte și a muri* (București: Elena francisc Publishing, 2008), 69-84. See also Andrada Pârvu, „Optimizarea transfuziilor sanguine (aspecte legate de crearea unui model predictiv al necasarului transfuzional și de consilierea psihologică a pacienților leucemici politransfuzati)”(PhD thesis, UMF „Iuliu Hațieganu” Cluj-Napoca, 2009), 64-79.

²³ Kübler Ross, *Despre moarte și a muri*, 69-84.

²⁴ Kübler Ross, *Despre moarte și a muri*, 85-130, See also Pârvu "Aspecte ale copingului la diagnosticul malign", 45-46.

²⁵ Kübler Ross, *Despre moarte și a muri*, 131-135, See also Pârvu "Aspecte ale copingului la diagnosticul malign", 45-46.

²⁶ Kübler Ross, *Despre moarte și a muri*, 136-173.

²⁷ Kübler Ross, *Despre moarte și a muri*, 174-211, See also Pârvu "Aspecte ale copingului la diagnosticul malign", 45-46.

²⁸ Jacqueline Barus-Michel et al., „Abordarea clinică”, in *Crize. Abordare psihosocială clinică*, ed. Jacqueline Barus-Michel, Florence Giust-Desprairies, Luc Ride 1 (Iași: Polirom, 1997), 209-213.

²⁹ McCord, "Discussing Spirituality With Patients: A Rational and Ethical Approach", 356-359.

³⁰ Johanna J Mytko and Sara J Knight, "Body, mind and spirit: Towards the integration of religiosity and spirituality in cancer quality of life research", *Psycho-Oncology*, 8(1999): 439-450.

³¹ Timothy Daaleman and Leon Vandecreek, "Placing religion and spirituality at end of life care", *Journal of the American Medical Association*, 284 (2000): 2514-2517.

³² Mounica Vallurupalli et al., "The Role of Spirituality and Religious Coping in the Quality of Life of Patients with Advanced Cancer Receiving Palliative Radiation Therapy", *Journal of Supportive Oncology*, XX (2011):1-4, doi:10.1016/j.suponc.2011.09.003

³³ A historical perspective on the role that the church has had since from the middle age, through the secularization, and up to the modern era in the lives of Romanians can be found in Ioan Bolovan and Sorina Paula Bolovan, "From Tradition to Modernization, Church and the Transylvanian Romanian Family in the Modern Era", *Journal for the Study of Religions and Ideologies* vol. 7 Issue 20 (2008): 107-121.

³⁴ A large analysis of the values and religiousness of Romania was published by Sorin Șandor in 2008. Sorin Dan Șandor and Marciana Popescu, "Religiosity and values in Romania", *Transylvanian Review of Administrative Sciences*, 22E (2008): 171-180.

³⁵ Ștefan Iloaie, "Biotechnology and Faith. Relativism in the Postmodern Moral. A Christian-Orthodox Approach", *Journal for the Study of Religions and Ideologies*, vol. 8, Issue 22 (2009): 32-58.

³⁶ Sorin Dan Șandor reviews data from the World Values Survey 2005, a study published by Norris and Inglehart in 2003. Șandor, "Religiosity and values in Romania", 173.

³⁷ This is a reference to a doctorate study based on 100 semistructured interviews of patients with acute leukemia admitted for treatment in the Hematology Clinic in Cluj between November 2008 and May 2009. The interviews were conducted by a hematologist with studies in psychological counseling. Pârveu, "Optimizarea transfuziilor sanguine (aspecte legate de crearea unui model predictiv al necesarului transfuzional și de consilierea psihologică a pacienților leucemici politransfuzati)", 175-244. See also Kübler Ross, *Despre moarte și a muri*, 131-135.

³⁸ One of the most well known psychooncology volumes features in its psychological resources chapter a study on the psychological resources of American patients when receiving the malignancy diagnosis. For most patients the most important resource was the financial one because this could offer them better medical insurance or access to a better treatment. At this stage religion occupied only a fringe role as a psychological resource. Spencer, "Psychological and Social Factors in Adaptation", 212.

³⁹ Attention to the alarming state of things has already been drawn by Frunza, 2009. Sandu Frunză, "On the need for a model of social responsibility and public action as an ethical base for adequate, ethical and efficient resource allocation in the public health system of Romania", 186. The idea of ethics autonomy towards religion can also be found in Mihaela Frunză and Sandu Frunză, "Ethics, superstition and laicization of the public sphere", *Journal for the Study of Religions and Ideologies*. Vol. 8 Issue 23 (2009):13-15.

⁴⁰ Cojocaru emphasizes the important role of religion in the social services and medical system in Romania, by classifying the organizations that could provide religious assistance to patients. Daniela Cojocaru et al., „The Role of Religion in the System of Social and Medical Services in Post-Communism Romania”, *Journal for the Study of Religions and Ideologies*, vol. 10 Issue 28 (2011): 65-83.

⁴¹ Șandor, „Religiosity and values in Romania”, 173.

⁴² The research described here is based on observations taken on the psychological support group for malignant patients during 6 years and is included in the PhD thesis. Pârveu, „Optimizarea transfuziilor sanguine (aspecte legate de crearea unui model predictiv al necesarului transfuzional și de consilierea psihologică a pacienților leucemici politransfuzati), 232-248.

⁴³ Andrada Pârveu et al., „Adaptarea psihologică religioasă a pacienților- beneficii și controversate” (paper presented at The XI th National Congress of Clinical and Transfusional Hematology, Sinaia, Romania, October 13-16, 2011).

⁴⁴ Iustin Lupu, „Calitatea vieții în sănătate. Definiții și instrumente de evaluare”, *Calitatea Vieții*, XVII, 1-2 (2006): 1.

⁴⁵ Biserica Ortodoxă Română. “Opera social-filantropică, Bioetica. Euthanasia.” http://www.patriarhia.ro/ro/opera_social_filantropica/bioetica_2.html

⁴⁶ Ștefan Iloaie, *Cultura vieții: aspecte morale în bioetică*, (Cluj-Napoca: Renașterea, 2009), 85.

⁴⁷ Tristram Engelhardt jr., *Fundamentele bioeticii creștine. Perspectiva ortodoxă* (Sibiu: Deisis, 2005), 436.

⁴⁸ The canons and decrees of the Concil of Trident Pr. Prof. Dr. Dumitru Stăniloae et al., „Teologia Dogmatică în Biserica Ortodoxă Română în trecut și astăzi”, *Ortodoxia XXIII*, 3 (1971): 309-365.

⁴⁹ Engelhardt jr., *Fundamentele bioeticii creștine. Perspectiva ortodoxă*, 410.

⁵⁰ Eniko Skolka, “Principii etice fundamentale și considerații medicale referitoare la problematica intervențiilor medicale de scurtare intenționată a duratei vieții în fază terminală”, in *Aspecte ale asistenței bolnavului aflat în stadiu terminal. Posibilități, limite și dileme fundamentale*, ed. Eniko Skolka (Cluj-Napoca: Casa Cărții de Știință, 2004), 69.

⁵¹ Daniela Moșoiu, *ABC-ul medicinei paliative* (Brașov: Lux Libris, 1999), 9-97.

⁵² Núñez Olarte, “Cultural Issues and Ethical Dilemmas in Palliative and End-of-Life Care in Spain”, 47-52.

⁵³ Eniko Skolka, “Advanced Directives”, in *Aspecte ale asistenței bolnavului aflat în stadiu terminal. Posibilități, limite și dileme fundamentale*, ed. Eniko Skolka (Cluj-Napoca: Casa Cărții de Știință, 2004), 103-106.

⁵⁴ Biserica Ortodoxă Română. “Opera social-filantropică, Bioetica. Euthanasia.” http://www.patriarhia.ro/ro/opera_social_filantropica/bioetica_2.html

⁵⁵ The notion of futility of end-life medical treatment is one of the most controversial in the field of palliative medicine. Mary Whitmer et al., “Medical futility. A paradigm as Old as Hippocrates”, *Dimensions of Critical Care Nursing* 28,2 (2009): 68.

⁵⁶ Andrea Phelps et al., „Religious Coping and Use of Intensive Life-Prolonging Care Near Death in Patients With Advanced Cancer”, *Journal of American Medical Association* 11, 301 (2009): 1145-46.

⁵⁷ Phelps, „Religious Coping and Use of Intensive Life-Prolonging Care Near Death in Patients With Advanced Cancer”, 1143-46.

⁵⁸ Whitmer, “Medical futility. A paradigm as Old as Hippocrates”, 68-70.

⁵⁹Bela Almoș Trif et al., „Puncte de vedere teologice privind euthanasia”, in *Euthanasia, suicidul asistat, eugenia*, ed. Bela Almoș Trif, Vasile Astărăstoae, Liviu Cocora (București: Infomedica, 2002), 201-208.

⁶⁰ Whitmer, „Medical futility. A paradigm as Old as Hippocrates”, 68.

⁶¹ Biserica Ortodoxă Română. „Opera social-filantropică, Bioetica. Euthanasia”. http://www.patriarhia.ro/ro/opera_social_filantropica/bioetica_2.html

⁶² Russian Orthodox Church. Official Web Site of the Department for External Church Relation, “Problems of Bioethics”, <http://www.mospat.ru/en/documents/ustav/>

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