

**AN EXPLORATION INTO MYSTICAL EXPERIENCE
IN THE CONTEXT OF HEALTH CARE**

by

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DECLARATION

I declare that **AN EXPLORATION INTO MYSTICAL EXPERIENCE IN THE CONTEXT OF HEALTH CARE** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any institution.

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Abstract

In this qualitative phenomenological study, the researcher interviewed 18 hospitalised patients and community members in rural Appalachia to learn about their mystical experiences in the context of health care. A loosely structured interview format addressed factors that initiate mystical experience and essential qualities of mystical experience. In addition, the researcher examined the nursing process, focusing on assessments and actions which supported the participants in sharing their experiences. The researcher also considered her response to being the recipient of these shared experiences. Data were analysed using the crystallisation/immersion method and concept mapping. Mystical experience was conceptualised as a *process* incorporating *initiation*, *occurrence*, *maturation*, and *integration* of mystical experience. Essential aspects of the mystical experience itself were found to include *sensory–motor perception*, *interaction with the supernatural*, *interaction with dead and living members of the family*, *conviction of reality*, *cognition*, *dynamic tension* and *emotional intensity*. Nursing actions which supported the participant included *listening* and *support*. The researcher's response to the participants' sharing their experiences included *tension*, *intimacy* and *empathy*, *sense of awe* and *autonomic responses*. In addition, the researcher developed an *appreciation of the mystical in everyday experience*.

KEY WORDS

Autonomic response, caring, ecstasy, entheogen, mysticism, mystical experience, religion, spirituality.

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Dedication

This thesis is dedicated to the memory of

my mother

Edith Schell Daubner

(1924 - 2001)

and

my father

Robert Foster Schell

(1917 - 1991)

*"There is a river that brings joy to the city of God, to the sacred house of
the most high." (Ps 46:4 TEV)*

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List of abbreviations

ADC	After death communication
ANCC	American Nurses Credentialing Center
APRN, BC	Advanced Practice Registered Nurse, Board Certified (Graduate level preparation and certification)
APA	American Psychological Association
DSM-IV	Diagnostic and Statistical Manual
HIPAA	Health Information Portability and Accountability Act
LPN	Licensed Practical Nurse (One year of technical training prior to licensure exam)
MDMA	3-4 methylenedioxymethamphetamine
M-Scale	Hood's Mysticism Scale
NDE	Near death experience
NANDA International	North American Nursing Diagnosis Association International
NIC	Nursing Intervention Classification
NOC	Nursing Outcome Classification
PCE	Pure consciousness events
RERC	Religious Experience Research Centre
RERU	Religious Experience Research Unit
RN	Registered Nurse (Two to four years of education prior to licensure exam)
SIMO	Short Index of Mystical Orientation
TEV	<i>Today's English Version</i> Bible translation
WV	West Virginia

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Chapter 1

Introduction and overview

1.1 INTRODUCTION

Spirituality in nursing is receiving increased emphasis as a fundamental aspect of holistic health care. Contemporary holistic nurses assert the right of individuals to receive care that “honors the body, mind, and spirit” (American Holistic Nursing Association 2005:1).

Spirituality is a complex aspect of the human condition, and for some – perhaps many – it includes mystical experiences. This research project explores mystical experience in the context of health care, encompassing not only the inpatient hospital setting, but also other settings in which the individual might be expected to receive nursing care or to communicate with a nurse. The focus of this research is on understanding and describing mystical phenomena experienced by participants as well as on exploring the role and experience of the nurse in supporting the individual who has had a mystreal experience.

This first chapter discusses nursing as a spiritual profession. Mysticism is introduced as an aspect of spirituality, and a case is made for the need of the nursing profession to understand mystical experience. The researcher’s interest in mystical experience is presented and the study area is described in detail. A working definition of the term mysticism is presented, and reference is made to related terminology used in the scholarly literature. Caring theory, especially Jean Watson’s *Theory of Human Science and Human Care* (1999), is identified as addressing aspects of spirituality that support the call for nursing research into mysticism.

To clarify the perspective from which the research is advanced, this chapter identifies epistemological and ontological assumptions as well as methodological assumptions about the research process. The tension between subjectivity and objectivity in qualitative research is briefly addressed. In this context, the *Torus Model of Mystical Experience* (Figure 1.3) is presented to clarify the researcher’s understanding of

mysticism as a concept, a conceptualisation that must be “set aside” (bracketed) during the research process.

Based on the call for nursing research into mystical experience, on the assumptions identified by the researcher, and on the *Torus Model of Mystical Experience* (Figure 1.3), the research problem is explicated; research questions are presented; and the significance of the research for the nursing profession is discussed. In addition, the scope and limitations of the research are considered.

The first chapter concludes with definitions of key terms used in the research and with an overview of the organisation of the thesis. Subsequent chapters present a review of the literature on mysticism and related concepts, a discussion of the methodology and research design of the proposed study, and a discussion of the findings and conclusions of the research study, with recommendations for nursing practice.

1.2 BACKGROUND OF THE STUDY

1.2.1 Nursing as a spiritual profession

As a profession, nursing has a legacy of concern for spirituality (Dolan, Fitzpatrick & Hermann 1983:43-85). Historically, nurses have served in religious orders as health care-givers; others have perceived their profession as a spiritual calling (Dock & Stewart 1938:43-56). The development of nursing theory has incorporated literature from the fields of theology, philosophy and transpersonal psychology, with its emphasis on human potential and consciousness. Each of these fields is relevant to spirituality.

The practice of holistic nursing care requires that nurses understand “the bio-psycho-social-spiritual dimensions of the person [and] integrate spirituality and reflection in their own lives” (American Holistic Nurses Association 2005:3). From a broader stance, spirituality is receiving increasing focus in health care and medicine (O’Connor 2001:33). Nurse researchers have studied some aspects of spirituality such as spiritual perspective (Haase, Britt, Coward, Leidy & Penn 1992; Long 1997) and self transcendence (Coward 1993 in Ellerman & Reed 2001; Emblen & Pesut 2001; Haase et al 1992). In addition, nurse researchers have addressed the spirituality of the nurse, especially from the perspective of caring (Burkhardt & Nagai-Jacobson 2002; Dolan et

al 1983; Helin & Lindström 2003; Long 1997; O'Brien 1999, 2001; Watson 1999a). Although nurses do not universally agree on a definition of spirituality (Burkhart & Solari-Twadell 2001:49), spirituality remains an important aspect of nursing care and a central concept in nursing science.

1.2.2 Nursing and mysticism

As the nursing profession has refined its theoretical tools, nursing diagnoses have been developed to address specific aspects of spiritual development (Cavendish, Luise, Horne, Bauer, Mendefindt, Gallo, Galvino & Kutza 2000:151). The North American Nursing Diagnosis Association International (NANDA International) has developed the nursing diagnosis, *Readiness for Enhanced Spiritual Well-being*. It is defined as “ability to experience and integrate meaning and purpose in life through a person’s connectedness with self, others, art, music, literature, or a power greater than oneself” (Wilkinson 2005:513). A *defining characteristic* identified for this diagnosis is “reports mystical experience” (Wilkinson 2005:13). The identification of mystical experience within a classification system used by nurses internationally suggests that this phenomenon exists in association with health care and not only is relevant to nursing care, but is also a spiritual condition that nurses are qualified to recognise and assess.

Mysticism has been referred to both obliquely and explicitly in nursing literature. Watson (1999a), for example, discusses several aspects of spirituality that are consistent with mysticism, such as metaphysics (1999a:37) and higher levels of consciousness (1999a:44). Mysticism is identified as an aspect of Florence Nightingale’s personal and professional spiritual development (Calabria & Macrae 1994:116, 118; Dossey 2000:33). It has also been considered as a fundamental aspect of the caring relationship in nursing (Helin & Lindström 2003:425).

1.2.3 Medicine and mysticism

The medical profession has also addressed the religious and spiritual experience of patients. The most recent version of the Diagnostic and Statistical Manual (DSM IV), developed by the American Psychiatric Association (APA), lists the diagnostic category: *Religious or Spiritual Problem*. This is identified as a “non-pathological” problem and includes mystical experience among its examples (Luckoff 1994

<http://www.virtualcs.com/dsm4/dsmrstoc.html> accessed 13/12/2004). This medical diagnosis is relevant to nurses working in psychiatric settings or in situations in which psychiatric diagnoses are involved.

1.2.4 Mysticism: relevancy to the nursing profession

As an aspect of human spirituality and a concern of the psychiatric profession, mystical experience is a concern for nurses. However, nursing literature infrequently addresses *mystical experiences*. Nursing literature and indeed much health care literature, generally addresses these experiences only tangentially. The paucity of such reference suggests either that patients and nurses are not usually perceived to be subject to mystical experiences, or that nurses do not have a framework for identifying and describing such experiences.

Working nurses, however, respond with interest and recognition when the subjects of mysticism and altered human consciousness are introduced. Patients and former patients also aver that they have had extraordinary experiences that may be interpreted as mystical experiences. Many personal accounts of mystical experience have been published (Baker 1951; Belanger 1938; Doherty 1977; Duff 1993; Richman 2000; St John of the Cross 1959; St Theresa of Avila 1961). *The Mystical Experience Registry* 2005 http://bodysoulanspirit.net/resources/links_etc/linksetc.shtml accessed 13/3/05) is an internet web site replete with personal accounts of mystical experiences. Mystical experiences are real and present in the lives of many people including in the lives of nurses and of those for whom they care.

The researcher herself has observed patients having what might be considered mystical experiences. In one case, a little boy, about ten years old, was hospitalised with a blocked ventricular-peritoneal shunt. After surgery to replace the shunt, he told his parents that he had seen Jesus, dressed in white, in the post-anesthesia recovery room. A girl of the same age, recovering from encephalitis, believed herself to be in labour and described in vivid detail the process of giving birth (to her mother's great consternation). A teenaged boy with metastatic cancer, bald from chemotherapy, spoke of no special experience, but his face glowed with radiance. An elderly woman on a long-term psychiatric unit recounted an out of body experience in which Jesus took her

from her kitchen, carried her up to heaven, and reassured her that her deceased father was in heaven.

The nursing profession has a call to develop an understanding of these and similar experiences in the context of health care. When nurses are formulating nursing diagnoses and giving care, they have an obligation to understand the characteristics of genuine mystical states of altered consciousness, because these altered experiences of human consciousness represent not only potential spiritual or religious problems, but also opportunities for spiritual growth, recovery and healing. Moreover, mystical experience may be concomitant with *entheogen* use (substances used to initiate mystical experience) or other conditions such as post-anesthesia delirium, drug intoxication, confusion, or psychosis, calling for a complex constellation of nursing interventions. In addition, nurses who seek to promote the patient's spiritual development require knowledge about *triggers* to mystical experience and knowledge of ways to support patients having mystical experiences.

From the viewpoint of the profession itself, it is important to affirm the potential for nurses themselves to have spiritual experiences – to develop spiritually as they witness the mystical experiences of their patients and as they themselves may experience related phenomena in the context of the caring relationship. Watson emphasises the importance of nurses attending to their own spiritual development or “soul work” as an aspect of “personal and human evolution” (Watson 1999b:152).

This study explores mystical experience occurring in the context of health care, its meaning for patients and community participants, the implications for nursing care, and the implications for the nurse involved in such care.

1.2.5 Description of the study area and its suitability for research into mysticism in the context of health care

A description of the State of West Virginia (WV) and its demographics is presented below, with emphasis on the three county study area. Health resources, health characteristics and spiritual patterns of the state and the study area are discussed. The rationale for selecting the study area and the study population is explained.

1.2.5.1 West Virginia demographics

The State of West Virginia is located in the mountainous area of the eastern United States of America. It is within the southern half of the nation. The population of the state is relatively homogenous, with 95% of West Virginia residents being white and English speaking. Residents tend to have less education than other Americans and a higher incidence of poverty. The state of West Virginia has a large elderly population. Approximately 30% of its inhabitants are over 65 years old (Highlights from Census 2000 Demographic Profiles 2004 http://factfinder.census.gov/servlet/SAFFacts?event+changeGeoContext&geo_id=04000U accessed 23/6/2004).

The three counties in the study area are Lewis County, Gilmer County, and Calhoun County. These counties are located in the North Central area of West Virginia. These counties may be found in Figure 1.1.



Figure 1.1
Map of West Virginia

(WV county map with county seats)

<http://www.callwva.com/maps/county-seats.cfm> 2004 accessed 23/7/2004)

The area contained within these three counties is exclusively rural and thinly populated. Population statistics and density may be seen in the following table, derived from United States census statistics (Quick Facts from the US Census Bureau 2004 <http://quickfacts.census.gov/qfd/ 2004> accessed 29/4/2004).

Table 1.1 Population density in three West Virginia counties

County	Estimated 2003 population	Land area (square miles)	Persons per square mile
Calhoun County	7 294	281	27
Gilmer County	7 037	340	21.1
Lewis County	17 148	382	44.3

West Virginia is wholly within the multi-state region called *Appalachia*, in the Appalachian Mountain range. For many years, the term *Appalachia* has had the connotation of isolation, rural poverty, under education, and resistance to change. This stereotype is slowly dissolving. Many West Virginians exhibit pride in their mountain cultural heritage.

1.2.5.2 Health resources in the three-county study area

The study area comprises three counties within the state of West Virginia (see Figure 1.1 for county locations.) The hospitals chosen for inclusion as study sites were Alpha Hospital, a 70-bed facility in Lewis County, and Beta Hospital, a 19-bed facility in Calhoun County. (The names of the hospitals have been changed in this report in order to protect the privacy of the participants.) Each is the sole general hospital in its county. Alpha Hospital in Lewis County offers medical surgical services and supports an emergency room, a six-bed intensive care unit, a labour and delivery unit, and a three-room surgery suite. Beta Hospital in Calhoun County is much smaller, and is designated a “Critical Access Hospital”. Critical Access Hospitals are designed to provide emergency care services and limited inpatient health care services to rural areas where health care resources are otherwise unavailable (Centers for Medicare and Medicaid Services 2005 http://questions.Cms.Hhs.Gov/cgi-bin/cmsghs.Cfg/php/enduser/stdadp.Php?P_faqid=3050&qse accessed 7/4/2005). Beta Hospital has an emergency room, a small inpatient medical unit, and is associated with a small nursing home unit for the elderly. Beta Hospital operates outpatient clinics in Calhoun County and Gilmer County.

Both of the hospitals selected for study draw patients from their own and surrounding counties, including Gilmer County, which lies between them and has no hospital of its own. Gilmer County does have, however, one nursing home with 62 beds, serving elderly and disabled adults.

Although the two hospitals selected for study are the only general hospitals in the three-county area, it should be noted that Lewis County is also the site of a 185 bed state psychiatric hospital serving citizens from the entire State of West Virginia. This hospital accepts only “court-committed” patients. These include forensic patients who are being assessed for competency to stand trial for criminal acts and patients who are “not guilty by reason of mental illness” of criminal acts, but who have been sentenced to hospitalisation in lieu of incarceration. This hospital is only marginally accessible as a health resource to local residents and is not included in the study.

1.2.5.3 Health characteristics of residents in the three-county study area

Lewis, Gilmer, and Calhoun Counties share similar, but not identical, health profiles. All three of these West Virginia counties exceed the national average for the United States in potential years of life lost before the age of 65, as well as in the incidence of unintentional injuries and sedentary lifestyle. Gilmer and Calhoun Counties exceed the national average in obesity, hypertension, and smokeless tobacco use (snuff and chewing tobacco). Lewis and Calhoun Counties exceed the national average in heart disease and cancer (WV Bureau of Public Health 2004 <http://www.wvdhhr.org/bph/profiles/> accessed 21/7/2004).

According to Jim Doria, West Virginia Acting Statistical Services Manager, the State of West Virginia has the greatest incidence of diabetes of any state in the United States. Diabetes morbidity is highest in the North Central region of the state, which includes the three-county study area (Conference Presentation 13th Annual WV Rural Health Conference 28/10/2005).

However, all three counties have a lower than average incidence of binge drinking, and all three fare better than the national average in terms of mothers receiving timely pre-natal care (WV Bureau of Public Health 2004 <http://www.wvdhhr.org/bph/profiles/> accessed 21/7/2004).

1.2.5.4 Religion and spirituality in West Virginia

Mystical experience may or may not be associated with religious practice or belief. However, religion is an important aspect of the West Virginia culture (Meitzen in Hill 1997:839). Maurer (1980) identifies five characteristics of religion in West Virginia:

- *Intensely personal relationship with God*
- *Independence*
- *The ability to withstand hardship and privation*
- *Ability to accept people as they are*
- *Joy* (Maurer 1980:177-179)

Maurer (1980:179) further explains what he means by *joy*:

The fifth characteristic of our religious heritage sets forth the tone of the gospel in song – Joy! How great and unspeakable the joy that bubbles up within and overflows the spirit-possessed soul. It's got to come out – the face beams the radiance of happiness in the Lord, and the buoyant heart rejoices. The feet, hands, and voice all join in paeon of praise. Happy in the Lord, cleansed and forgiven, new life, Hallelujah! Foot stomp'n', hand clappin', and whoopin' it up are all part of the liturgy of joy in our religious heritage (Maurer 1980:179).

The majority of Protestant churches in the southern United States are Baptist and Methodist (Hill 1988:192). This is also the pattern in West Virginia. Other denominations and spiritual traditions have a smaller presence in the state. Pentecostal churches may be independent or allied with denominations such as the Church of God. Episcopal (Anglican) and Roman Catholic churches exist throughout the state. Jehovah's Witnesses, Latter Day Saints, and Reformed Latter Day Saints also have established a presence. Orthodox churches, Christian Science churches and reading rooms, synagogues, and mosques are uncommon, but can be found in the urban centres of West Virginia. The Hare Krishna group has built one temple, the "Temple of Gold" in the north of the state in Moundsville

(New Vrindaban Community 2005 <http://www.newvrindaban.com> accessed 9/3/2005).

Organised New Age groups are somewhat rare, but there are two Spiritualist churches in West Virginia, one on Wheeling Island, in the north of the state, and one in Charleston, the state capital (Global Tuition 2005 <http://spiritualistchurches.net/america/westvirginia.html> accessed 3/8/2005). On the World Wide Web, nine covens, or related groups, report their presence in West Virginia. Most of these are in urban areas, but one, Deer Haven Grove (Keltrian Druid), is in Clarksburg, not far from Lewis County, a county included in the study area (The Witch's Voice 2005 http://www.witchvox.com/vn/gr/uswv_gra.html 2005 accessed 3/8/2005).

Based on the researcher's understanding, in the 1970s, West Virginia was a destination for "hippie" groups seeking alternate lifestyles, some affirming New Age beliefs or other nontraditional belief systems. In time, many of these individuals have become assimilated into the mainstream of the local culture. Those who were not assimilated may continue to hold beliefs consistent with New Age ideologies or other nontraditional systems. The sale of New Age jewelry and paraphernalia, as well as Christian goods, is common at commercial outlets.

In addition, although it is not part of a formal religious structure, the researcher notes a common belief that spirits of the dead walk on the earth and these spirits, identified as ghosts, are real. In West Virginia, there is a folklore tradition of telling ghost stories about persons who have been murdered or who have died unnatural deaths. Traditionally, the purpose of these stories has not been primarily recreation or entertainment; they are presented as real experiences of the supernatural (Musick 1965:xi-vi).

1.2.5.5 Religion and spirituality in the three-county study area

Religion and spirituality are deeply embedded in the lives of people in the study area. This is reflected in many aspects of daily life and is so taken for granted that it is not remarked upon. For example, large boards in the shape of a cross are nailed on the front of a barn that faces a main thoroughfare in Lewis County. The text says: JESUS

SAVES “HE DIED FOR YOU! ARE YOU LIVING FOR HIM?” The ends of the cross are marked with painted drops of red blood. Figure 1.2 depicts this display.



Figure 1.2
Roadside display

In Calhoun County, a series of roadside signs urge one to repent, reminding drivers that “the wages of sin is death”. The researcher notes that local residents are familiar with these signs and similar others, but that they evoke little comment. Such religious expressions are taken for granted.

Schools and other institutions reflect the integration of religion belief into daily life. Federal law prohibits not only prayer in the public schools, but also the teaching of religious doctrine. However, public sentiment informs school activities and curriculum with a subtle conservative Christian character. For example, (based on students’ comments to the researcher), in science classes in Gilmer County High School, evolution is discussed only cursorily, and birth control is addressed cautiously in health classes. In 1996, in Calhoun County, the Calhoun High School sports mascot, the “Red

Devil”, was challenged by local residents as being diabolical and unchristian. In the ensuing protest, one citizen, masked and dressed as a devil, disrupted a Calhoun County Board of Education meeting. His actions resulted in his arrest (State of West Virginia vs Thomas Berrill 1996 <http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=vv&vol=spring96%5C2350&invol=1> accessed 23/7/2005).

Each county has its own federally funded Senior Center offering daily congregate meals. These meals are preceded with prayer, and a regular activity at the centers is for the senior citizens to sing gospel songs together, their voices blending in poignant harmony. Church groups visit the nursing homes in Gilmer and Calhoun Counties every week.

Events such as the opening of a local museum or a graduation reception may incorporate the singing of gospel music by a special singer or group. State and local newspapers in the area frequently carry intense religious debates on the “letters to the editor” page. Common issues are the immorality of abortion, “evolution” (a pejorative reference to evolution), and the degree to which government should be involved in religion. Local news columns in area newspapers commonly report church activities and the Sunday service attendance at the reporters’ churches.

Churches in the three counties comprising the study area are primarily Baptist (various branches), Methodist, and “independent”. There are also Roman Catholic, Presbyterian, Seventh Day Adventist, Disciples of Christ, Church of God, and Episcopal Churches sparsely located in the area. There are several Kingdom Halls of Jehovah’s Witnesses. Within the three counties, there are no Orthodox, Lutheran, Quaker, Christian Science or Latter Day Saints churches, no synagogues, and no mosques. The researcher does not know of any churches in the study area or any of the contiguous counties that practice snake handling.

Not all people in Appalachia are religious (Welch in Leonard 1999:59-60), nor do all participate in organised religion (Gillespie 1982:26). Overall, however, conservative Christian religious beliefs and practices characterise the State of West Virginia, as well as the three-county study area. Religious belief and spirituality are acknowledged as an important aspect of everyday life.

The pervasiveness of spiritual and religious practices in the study area, the acceptance of personal spirituality and the cooperation of local health care facilities provided a background conducive to nursing research into mysticism in the context of health care.

1.2.6 Working definition of mystical experience

To clarify the research focus, a working definition of mystical experience follows: *A subjective experience of transcendent phenomena that are apprehended directly in human consciousness and that are not mediated by normal cognitive or sensory perceptual faculties.* This definition is designed by the researcher to be open and fluid so that experiences such as dreams, creative episodes, and even paranormal phenomena may be included. The researcher developed this definition as a point of departure for research because she sought to obtain an understanding of what such “mystical experiences” mean to recipients of nursing care; lay people who probably would not have a scholarly orientation. In addition, it should be noted that, in terms of the phenomenological approach underlying this study, that which is real is what appears *real* to the individual. Reality is individually constructed and experienced.

James (1929) is one of the earliest scholars to discuss mystical experience. His inclusive approach to mystical experience supports the broad working definition of mystical experience presented above. It is important to recognise that scholars such as Underhill (1974) define mystical experience narrowly, as “the science of ultimates, the science of union with the Absolute, and *nothing else ...*” (italics added) (Underhill 1974:6). Stace (1961) too, says that mystical experience “culminate(s) in the perception of, and union with, a Unity or One ...” (Stace 1961:62). Stace allows for the possibility of “borderline cases” in which some, but not all of the characteristics of mystical experience are manifested (Stace 1961:46). However, he explicitly excludes “visions and voices ... raptures, trances, and hyperemotionalism” ... as not *in themselves* being mystical experience (Stace 1961:46-51). But James acknowledges a range or “ladder” of mystical experiences, including a “deepened sense of the significance of a maxim or formula which occasionally sweeps over one”, déjà vu and dreamy states, and the effects of “intoxicants and anaesthetics” (James 1929:371-373). In section 1.9.1 the researcher’s conceptual definition of mysticism is discussed in greater detail.

1.2.7 Terminology associated with mysticism

Mystical experiences and related phenomena are described and discussed using various terminologies. Sometimes *ecstasy* is used as a term basically synonymous with *mysticism* (Greely 1974; Laski 1961). For others, *ecstasy* refers to a discrete aspect of the mystical experience. Nurse author Steeves (1987:114) uses the phrase *critical experience* to refer to a condition analogous to mystical experience. Atwater uses the term *near-death-like experience* to include *unitive experiences* (Atwater 2000:44).

Sometimes the phenomenon is uniquely designated by a particular theorist or faith tradition. Bucke (1969:1) calls it *cosmic consciousness*; Maslow (1964:19) calls it *peak experience*; Wilber (1993:179) refers to peek experiences and *one-taste*, (using Buddhist terminology). In the Orthodox Church tradition, Ware (1980:163) refers to *Heyschia* as “concentration combined with inward tranquility”. Sometimes the experience is simply called *religious experience* (Hay 1982:161).

Theologians often use the term *mysticism* to describe a special awareness of, or relationship with, deity. In contrast, secular authors sometimes use the term *ecstasy* to refer to a similar state that is not explicitly associated with religious interpretation or reference to deity. However, current literature rarely uses the term *ecstasy* in connection with mystical experience, as its primary association is now with 3-4 methylenedioxymethamphetamine (MDMA), an illicit drug nicknamed “ecstasy” (Levinthal 2005:137).

In this study, the terms *mysticism* and *mystical experience* are chosen for use as recognisable across a variety of disciplines and faith traditions. Such terms as *ecstasy*, *cosmic consciousness*, *peak experience*, and the like suggest subtle differences in meaning, but the use of a common terminology supports scholarly discussion of experiences that have fundamental similarities in that they all involve consciousness of transcendent phenomena unmediated by normal cognitive or sensory perceptual faculties.

1.2.8 Spirituality and mysticism in nursing theory

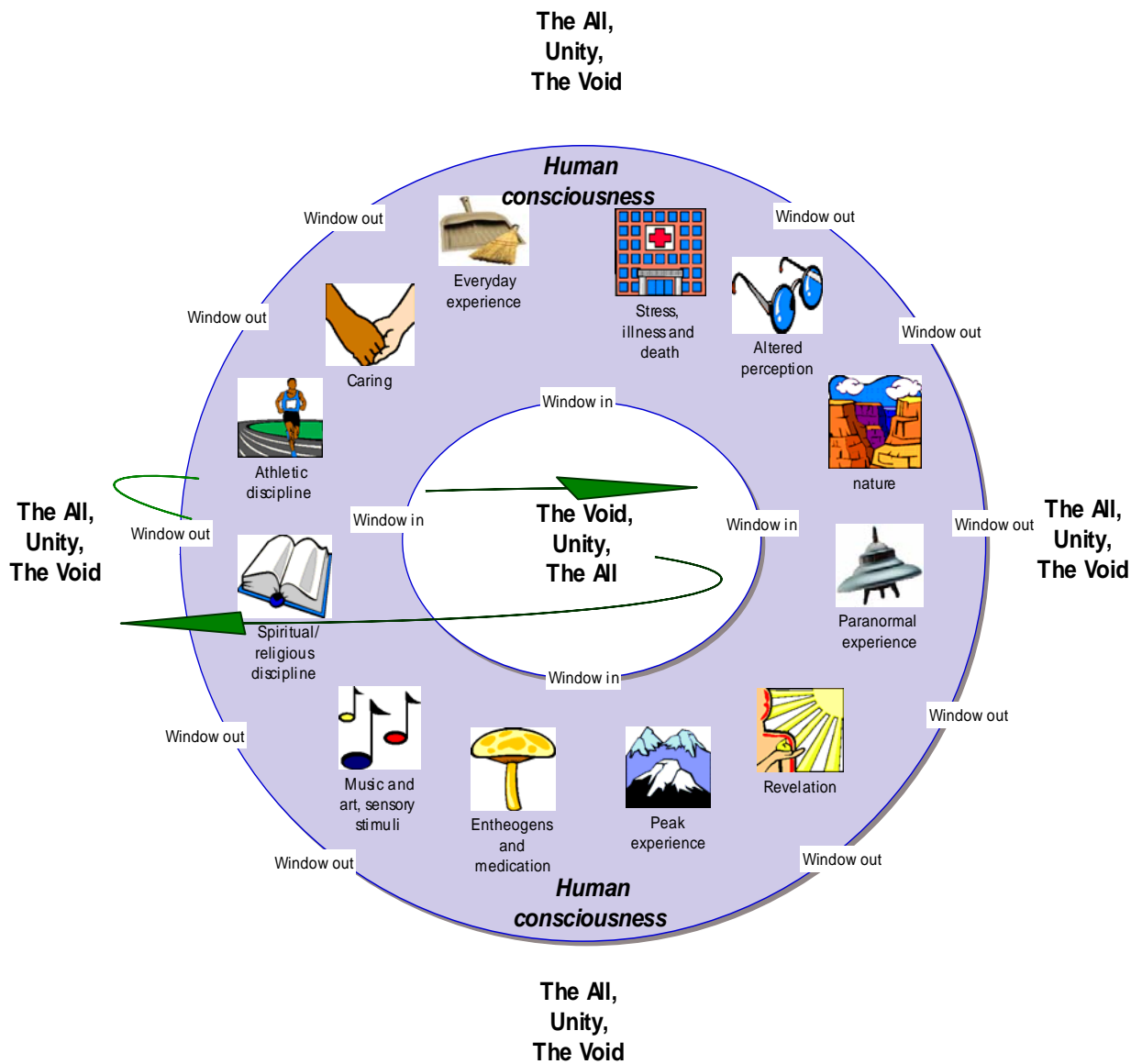
Nurses have constructed various theories to explain the role of the nurse and the needs and experiences of the patient. Contemporary nursing theories affirm a holistic understanding of humanity, but do not always address spirituality as such, nor the possibility of achieving mystical experience, either by the patient as person or the nurse as caregiver.

Among nursing theories of caring, Watson's (1999a) *Theory of Human Science and Human Care* is well suited to the exploration of mysticism in nursing, a process that requires a conceptual framework that specifically addresses and validates spirituality of the patient and the nurse. Jean Watson states: "My conception of life and personhood is tied to notions that one's soul possesses a body that is not confined by objective space and time" (Watson 1999a:45). Her affirmation of transcendence and self-actualisation makes the theory ideal for examining mysticism.

In addition, Watson's emphasis on relationship (Watson 1999a:66-68) supports the need for research to examine the nurse's interaction and response in addition to the mystical experience from the patient's perspective. Watson's caring theory, as well as other contemporary nursing theories, provide a context for developing nursing research about mystical experience.

1.2.9 Torus Model of Mystical Experience

The *Torus Model of Mystical Experience* (Figure 1.3) is presented below as a concept model developed by the researcher to add structure to the exploration of mystical experience. This model clarified the researcher's *initial* understanding of mystical experience and provided a framework for examining her thinking in comparison with others' discussions of mysticism.



Torus Model of Mystical Experience

Figure 1.3
Torus Model of Mystical Experience

In the *Torus Model of Mystical Experience* shown above (Figure 1.3), human consciousness is bounded within a fluid multidimensional torus, or doughnut shape, with a permeable conterminous boundary separating the individual from the world “outside the skin” and separating the individual from the deepest knowledge of his or her own inner existence. Mystical experience is access to perceptual windows, both inward and outward, on that conterminous boundary. Mystical experience lets individuals perceive what is real, beyond *and* within the integral self. The *Void*, the *All*, and *Unity* are terms that have been used to describe this reality. By stating the terms together, the researcher explicitly asserts the fundamental (albeit paradoxical) connection between the *Void*, the *All*, and *Unity*. For some, the *Void*, the *All*, and *Unity* may be experienced as the reality of God.

The space within the “hole” of a torus, or doughnut, is continuous with the space outside the ring. So it is with the reality perceived in mystical experience. Looking *out* is the same as looking *in*; the *Void* that is perceived when turning inward is *unified* and continuous with the *All* that is perceived when looking outward.

The graphic icons within the torus represent factors affecting human consciousness that may precede or accompany mystical experiences, giving access to windows both inward and outward. Inability to find the windows does not mean they are not there, nor does unwillingness to open them change what might be seen. Mystical experience is here conceptualised as available to *all*, given the right combination of circumstances and/or triggers.

The *Torus Model of Mystical Experience* (Figure 1.3) represents a preliminary understanding of mystical experience and sets the stage for conducting the current research in line with the phenomenological approach. In chapter 4, a *Concept Model of Mystical Experience* (Figure 4.1) is presented which reflects the research findings.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The researcher’s personal and clinical experience suggests that mystical experience is neither unusual nor limited to spiritual adepts. It is conceived as an extraordinary spiritual phenomenon, but one that is experienced in many circumstances, including illness and stress – situations where the nurse has a role. Yet little nursing literature

addresses mystical experience *per se* or the role of the nurse with regard to such circumstances.

Nurses need to have a clear understanding of the occurrence and quality of this phenomenon in the context of health care. Nurses need a means by which they can identify and describe such experiences, differentiate them from psychopathology, and provide personal and environmental support to patients having mystical experiences. In addition, it is important to understand what it means to the nurse to share in and support the patient having or recounting a mystical experience.

This research project explores mysticism within the context of health care, focusing on describing mysticism as it is experienced by patients and exploring the role of the nurse both as a caregiver with whom mystical phenomena are shared and as participant in mystical experience arising from the quality of the caring relationship.

1.4 RESEARCH QUESTIONS

This research focuses on several aspects of mystical experience in the context of health care. The emphasis is on mystical experience as it presents to the patient and on an exploration of the associated role of the nurse. Implications for the nurse himself or herself are also considered. The research questions follow:

- What factors accompany or precipitate mystical experiences?
- What is the meaning of the lived experience of mystical phenomena to patients experiencing it in the context of health stressors and/or hospitalisation?
- What nursing assessments and interventions support patients reporting mystical experiences?
- What is the subjective experience of the nurse sharing a patient's expression of mystical experience?

1.5 OBJECTIVES OF THE RESEARCH

In phenomenological terms, any object that can be known through experience can be said to be "in the world" (Husserl 1962:46). In Husserl's sense, mystical phenomena may be said to be *objects in the world*, but they cannot be measured or observed

directly; they can be known *only* through subjective experience. It is the subjective perception of mystical phenomena, the *meaning* of mystical experience to individuals that must be addressed for the researcher to gain understanding. Therefore, exploring mystical experience requires a phenomenological approach to research. According to Cohen, Kahn and Steeves (1987), the phenomenological approach encompasses the subjectivity of the individual and the intersubjectivity of the observer who affirms and shares the experience of the other. Cohen says that “the study of experience reveals consciousness” (Cohen 1987:31). This applies equally to the particular consciousness associated with mystical experience.

The purpose of this qualitative phenomenological study is to explore mystical experiences – known to occur throughout the lifespan in a variety of different circumstances (Hardy 1979:26-30) – in the context of health care and health related stressors. The research addresses the circumstances in which mystical experiences occur in relation to health care and stress and characterises participant perceptions of the phenomenon. Toward this end, the researcher interviewed participants who reported having had mystical experiences, both in the hospital setting and in other circumstances associated with significant physiological or psychological stressors. Based on analyses of these interviews, a description and structure of the phenomenon is developed, integrating Porter’s (1998:21) steps of phenomenological inquiry and the immersion/crystallisation technique of data analysis (Borkan 1999 in Crabtree & Miller 1999:179-194). The research includes examination and reflection of the researcher’s subjective responses when interviewing patients and hearing them share their experiences. From this examination and reflection, assessment and caring interventions that most facilitated the patients’ communication, comfort, and spiritual well-being are identified, and implications for the nursing role are discussed.

1.6 SIGNIFICANCE OF THE STUDY

Watson (1999a:21-22) points out that nurses see the world differently than traditional scientists. She advocates the experiential, qualitative approach to nursing research. Research which examines the quality of mystical experience and the nursing response promotes a goal important to nursing: “to help persons gain a higher degree of harmony within the mind, body, and soul which generates self knowledge, self-reverence, self-healing, and self-care processes ...” (Watson 1999a:49).

If nurses are to be effective carers, helping persons grow in “self knowledge, self reverence, self-healing and self-care” (Watson 1999a:49), they must be skilled in recognising and dealing with the full range of human experience. Mystical experience is an important aspect of spirituality, but currently nurses have limited resources to fully understand this dimension of spirituality and its implications for nursing care. The nursing profession will benefit from a knowledge base on which to found assessment and intervention for patients having mystical experiences. The profession will also gain an understanding of what such involvement means to the individual nurse and to the nurse’s own spiritual development.

Nursing knowledge comprises three modalities: clinical knowledge, conceptual knowledge, empirical knowledge (Schultz & Meleis 1988:217). Nursing literature and nursing knowledge in the area of mysticism are limited, despite occasional reference in the literature and a solitary identification in the nursing diagnosis *Readiness for Enhanced Spiritual Well-being* (Wilkinson 2005:513-514). This research is expected to contribute to the conceptual body of nursing knowledge regarding mysticism and to provide a foundation for future study. Chinn and Kramer (2004:146) note that empirical nursing practice is a source of evidence that may be used to identify descriptors or indicators of abstract concepts. They emphasise the importance of identifying those aspects of a concept that are actually present and available to the nurse in practice when developing concepts to be used in nursing diagnosis (Chin & Kramer 2004:149). In addition, they note that “nursing diagnostic criteria can be derived partially from criteria for a concept and vice versa” (Chin & Kramer 2004:148). Conceptual findings in this research are expected to derive from elements of nursing practice, to enrich spiritual nursing diagnoses, and to have wider application to the development of conceptual knowledge in nursing theory.

1.7 SCOPE AND LIMITATIONS

Mystical experience occurs across cultures. However, the scope of this research into mystical experience is limited to a narrow segment of the population: hospitalised patients in small, rural West Virginia hospitals and community participants in the study area. (Characteristics of the study area are described in detail in section 1.2.5.)

The findings have limited transferability due to religious, social, cultural and physical characteristics of the population studied. In addition, inasmuch as the population of hospitalised patients may be older than the general population, fewer individuals may be willing to share mystical experiences. Levin (1993:511) finds older adults to be less likely to report mystical experience as such, although Hay (1982:118) finds older adults more likely to report religious experiences.

Nonetheless, the experiences of the study population provide a basis for an initial examination of mystical experience in the context of health care. Similarly, the nurse researcher's own responses, while perhaps not typical of all nurses, provide a basis for initiating study of the nursing role. The current research is conceived a starting point for understanding mystical experiences in the context of health care.

1.8 FOUNDATIONS FOR THE RESEARCH PROCESS

Nursing research into mystical experience lends itself to qualitative methodology and a phenomenological approach. In phenomenological research, the researcher is usually expected to engage in phenomenological reduction, suspension of personal views, in order to "take the experience precisely as described" (Kleiman 2004:4). However, Schultz (1994:414) advocates an openly subjective approach to qualitative nursing research so that the researcher may fully confront his or her own perspective. The challenges Schultz identifies in the attempt to bracket are relevant to research into mysticism, which is personal and intense for both nurse and patient. Essentially, bracketing involves bringing to consciousness what the researcher knows and feels about the phenomenon being studied in an attempt to avoid this unduly influencing her interpretation of research data.

The researcher recognises that objectivity is a goal in phenomenological research, but also recognises the subjectivity inherent in the nurse-patient interactions. The researcher must acknowledge assumptions and subjective understanding of the concept of mystical experience before the research is initiated. In this regard, the following section identifies research assumptions. These foundational beliefs shape the research process and thus cannot be wholly bracketed, nor must they be. However, they must be identified, and the researcher must be willing to accept that they may be

modified as the research progresses. However, the researcher's subjective understanding of the research phenomenon must be bracketed to the extent possible.

The researcher must clarify personal beliefs about the concept under investigation: mysticism. The *Torus Model of Mystical Experience* (Figure 1.3) was developed to clarify the researcher's initial understanding. It represents the results of personal reflection and reading about the concept of mystical experience. This model represents a theoretical construct that was meant to be set aside – bracketed – during the research process, as it might or might not reflect the research findings.

1.8.1 Assumptions

Research assumptions may be construed as reflecting fundamental beliefs held to be true by the researcher. As such, they are inextricably bound to the research process (Lincoln & Guba 1985:161).

Mouton and Marais (1988:146-147) emphasise the importance of research commitments: the assumptions and preconceptions underlying research. Following Kuhn, they identify three areas of commitment to be considered during research: ontological commitments, theoretical-conceptual commitments, and methodological commitments. These are explicated respectively below in relation to the methodology, the research process, and (in Chapter 3) to the researcher and the participants.

1.8.1.1 Ontological assumptions

Ontological commitments and assumptions refer to an initial characterisation or understanding of the nature of the research object that is being explored, in this case, mystical experience (Mouton & Marais 1988:147). These assumptions do not predict expectations regarding research findings, but do validate the existence of the phenomenon. The *Torus Model of Mystical Experience* (Figure 1.3) serves as a source of assumptions in this regard. These assumptions follow.

- Mystical experience is part of the broader human lived experience.
- Objects presented to the mind are experiences and as such are *real*.

- There is a greater reality of which an individual may become aware, given heightened consciousness.
- Mystical experience and phenomena may fall in the realm of partial ineffability.
- Individuals can identify mystical experiences that they have had.
- Mystical phenomena are human experiences occurring in multiple settings and contexts, including health care.
- Mystical experience may occur spontaneously or may be initiated by a variety of circumstances or triggers.
- Mystical experiences may be brief and time limited or may be unfolding processes.
- Mystical experience may be religious or secular.
- Mystical phenomena have meaning for the persons experiencing them.
- Mystical experience is a way in which humans interface with a greater reality.
- Mystical experience is significant in the spiritual dimension of holistic functioning.
- The fundamental connection between the *Void*, the *All*, and *Unity* represent a paradoxical reality only partially recognised in human cognition.

1.8.1.2 Theoretical-conceptual assumptions

Theoretical-conceptual commitments are here constructed as epistemological assumptions concerning mysticism – as a knowable phenomenon and a phenomenon of knowing. The following assumptions reflect this stance.

- Mystical experience is a unique type of knowing, transcending cognitive, perceptual, and affective capability and competency.
- Mystical phenomena compel the experiencer to seek meaning and understanding in the experience.
- “Ineffable phenomena” have some elements that are subject to description and communication (Dienske 2002:3).
- Intersubjective meaning of mystical experience can be developed.
- What is logically inexplicable might be existentially (experientially) real and valid.

1.8.1.3 Methodical assumptions

The following assumptions refer to the philosophical and methodological beliefs on which the research is founded and which contribute to its scientific trustworthiness (Mouton & Marais 1988:147).

1.8.1.3.1 The methodology

- Phenomenological research is based on others' descriptions of their experiences (Giorgi 2000a:7), including mystical experiences.
- A transcendental phenomenological research approach can yield scientific understanding of mystical experience.
- Transcendental phenomenology offers a framework for integrating understanding of mystical experience with existing nursing theory.

1.8.1.3.2 The research process

- Phenomenological methods are inspirational (Porter 1998:22), and incorporate awareness of the process as an aesthetic endeavor (Sandelowski 1995:205; Watson 1999a:90).
- It is not possible to test the veracity of a participant's mystical experience with reference to objective measures, but it is possible to discern the meaning of the experience *to the participant* using phenomenological inquiry.
- A loosely structured "guided interview" is most appropriate for openness to the data (Field & Morse 1985:67).
- Interview transcripts, personal reflections of the researcher, and meta-research consideration of the research process: the temporal and spatial environment, attitudes towards the research by others, and the research process itself are all valid data resources.
- The immersion/crystallisation approach (Borkan 1999 in Crabtree & Miller 1999:179-194) is appropriate to analyse the research data.
- Themes and codes, and ultimately understanding, can be developed based on the research data.
- Eidetic reduction based on intuiting (Porter 1998:21) and immersion in the data yield scientifically viable description and structure of a phenomenon.

1.9 DEFINITIONS

The following definitions are those of key terms used in the research. In addition, these terms are presented to show that certain aspects of health care that might be taken for granted, such as the hospital environment and medications, must be considered anew as factors in the discussion and understanding of mystical experience. Although the definitions selected to determine terms used in this research reflect scholarly trends, they are not without controversy. Issues arising from the meanings given to the terms *spirituality* and *religion* are addressed following the definition of religion.

It is important to note that the definitions discussed below are developed from a variety of scholarly sources, including both nursing and nonnursing literature. This research is structured on understanding derived from the disciplines of psychology, sociology, religious studies, and the arts. Such a variety of sources must be utilised because mystical experience has been discussed only in a limited manner in the nursing literature. Some sources such as James (1929) are classical older works, others, such as Narayanasamy (2004) are recent. The study of spirituality and spiritual experiences develops over time, but newer resources do not “outdate” older ones. Classical works are fundamental to this nursing research. Both older and more recent works contribute to the development of research definitions.

1.9.1 Mystical experience

A subjective experience of transcendent phenomena that are apprehended directly in human consciousness and that are not mediated by normal cognitive or sensory perceptual faculties.

The above definition is the researcher’s working definition based on a broad review of the literature. The literature is more likely to contain characteristics of mystical experience than it is to contain explicit definitions. There is no agreement as to whether mystical experience is objectively true or not. Certainly, however, it can be said to be subjectively true to the individual. Normal pathways of cognition or perception are apparently bypassed, and the phenomenological content of the mystical experience is experienced as transcendent cognition, perception, and/or emotion. *Transcendence* in this context refers to content not normally accessible to the individual and is associated

with some higher truth, deeper understanding, or elevated emotion. (This is somewhat, but not wholly, different from Husserl's (1962:117) use of the term *transcendence* to refer to "the real nature of things" derived from phenomenological reduction.) The individual may refer to *the Void*, *Unity*, *the All*, *the One*, or *God* in an attempt to explain this transcendental awareness, although these terms are not used in a uniform fashion.

(In section 1.2.9, the *Torus Model of Mystical Experience* (Figure 1.3), the researcher discusses her own understanding of the interrelationship between *the Void*, *Unity*, and *the All*). For many, however, the experience is said to be ineffable, indescribable (James 1929:371). Most often the experience is perceived as positive, and often it results in an enduring change in the individual's understanding of reality. Although mysticism is often associated with religious belief and the experience of God, many mystical experiences described in the literature are purely secular and have neither reference to God nor any clear relationship to religious belief. They may, however, be said to be spiritual experiences.

The rather broad nature of the above definition will become evident as scholarly approaches to mystical experience are described in the review of the literature (Chapter 2). Many scholars propose clear boundaries for what is, and what is not, mystical experience. Even those who suggest a spectrum of experiences, such as James (1929:371-373), give somewhat explicit examples. But in qualitative research, it is necessary to be *open* and *receptive* to a variety of research findings from participants who are unlikely to have a scholarly orientation or familiarity with the literature of mysticism. Although it is necessary to have a clear idea of the research focus, the researcher did not want her preconceptions or the preconceptions of others to limit openness to the data. The use of a broad definition of the phenomenon promotes the qualitative approach to the research.

1.9.2 Triggers

Events and circumstances preceding, accompanying, and possibly initiating mystical experiences.

There is much discussion in the literature about the precipitants of mystical experience, although little is specific to the health care setting. However, experiences of altered health and the health care setting itself have elements that may precipitate mystical experience.

Some spontaneous mystical experiences are associated with bright light and certain types of sound, including music (Bhattacharya [Sa]; Tame 1984:42; Khan 1991:6) and rhythms (Khan 1991:151; Leuba 1972:11). It is important to note that the hospital environment embodies many sources of bright light and numerous rhythmic sounds such as monitors beeping and intravenous therapy devices pumping.

Spiritual practices and disciplines have long been associated with mystical experience. In the orthodox tradition, icons are venerated and are considered to reveal the spiritual world (Ware 1991:214). Other triggers include devotional practices (Kavanaugh & Rodriguez 1991:27; Medwick 1999:39, 42, 45), fasting (Leuba 1972:11), and bodily mortification (Flynn 1996:257-258). Pain is associated with mystical experience, apart from religious discipline (Watts 1958:105). Pain, fasting, and bodily discomfort are common corollaries of hospitalisation and illness.

Nature and beauty are commonly cited as spontaneous triggers to mystical experience (James 1929:386; Laski 1961:26). Although these terms usually refer to scenery and outdoor phenomena, it may also be appropriate to include in this category childbirth, noted as a trigger by Laski (1961:26), and dying, suggested by Roberts and Whall (1996:360), as they are both natural phenomena.

Numerous authors identify illness as a precipitant to mystical experience (Duff 1993:xv; Hollenback 1996:337; Medwick 1999:21; Richman 2000:84). This may be related to the association of illness with pain, fasting, sensory deprivation or overload and other features of hospitalisation and treatment, or to the inward focus that results from concern with one's health in a crisis.

1.9.3 Entheogen

Mind changing substance taken to enhance religious experience
(Smith 2000:xvi-xvii).

Prescribed medications and drugs individuals ingested for personal or cultural reasons may induce mystical experiences and can also be implicated in the occurrence of confusion, intensive care syndrome, and post-operative delirium. James (1929:378) notes that licit drugs are associated with altered levels of consciousness. The use of *ayahuasca* in Amazon religious ceremonies and *peyote* in Native American religious ceremonies is associated with mind altering experiences (Metzner 1999:19-29). Other "psychedelic" drugs are associated with initiatory rites for shamans (Harner 1973:xii). Although promotion of entheogen use is outside the province of nursing, the administration and monitoring of certain medications associated with altered consciousness is fully within the purview of nursing.

1.9.4 Spirituality

Beliefs and practices reflecting one's understanding of existence
and one's connectedness to reality beyond personal boundaries.

The above definition represents the researcher's summative definition of a term which has been defined variously in the nursing literature. Smith (1994:37) describes spirituality as encompassing four dimensions including confidence in the meaningfulness of life, commitment to actualisation, awareness of connectedness, and valuing the transcendent. Narayanasamy (2004:1140) presents a multidimensional understanding of spirituality, stating that it is "the essence of our being, giving meaning and purpose to our existence" and that it includes a "sense of personhood and individuality ... an inner source of power and energy", as well as connectedness and wholeness.

Long (1997:497) and Goddard (1995:808-815) conceive of spirituality somewhat differently, as energy. Dawson (1997:282), however, takes issue with their stance, arguing that it is inappropriate to attempt to describe spirituality using scientific terminology. Similar to Dawson but coming from a different perspective, Hall (1997:86)

argues for movement away from operational definitions of spirituality and spiritual assessment tools, toward greater openness to understanding of spiritual phenomena based on *what they mean to the patient*.

The definition of spirituality used in this research is purposefully left open, making reference primarily to *understanding* and *connectedness*. These terms occur repeatedly in the literature on spirituality and mysticism. *Understanding* and *connectedness* are seen as the core of spirituality and provide a modest, but workable framework for discussing spiritual experiences from the patient's own perspective, using the patient's own terminology.

1.9.5 Religion

Spiritual beliefs and practices reflecting one's understanding of existence and one's connectedness to reality beyond personal boundaries, based on belief about divinity, deities, or other supernatural agencies.

The researcher has purposely designed this definition to be open and general in deference to the recognition that the attributes of spirituality and religion overlap. Religion is here conceived as an aspect of personal spirituality rather than as an independently structured system of belief or worship.

1.9.5.1 Discussion of the differentiation between religion and spirituality

In much nursing literature, religion and religious practice are differentiated as separate and distinct from spirituality (Burkhart & Solari-Twadell 2001:45). However, not all scholars differentiate religion and spirituality. Non-nursing scholars such as Freud (1961), Jung (1933), and James (1929) use the term "religion" in a broad context. Freud (1961:11), for example, refers to religion as "illusion"; Jung (1933:76) refers to "invisible and unknowable things", and James (1929) asserts that "the word 'religion' can not stand for any single principle or essence ..." (James 1929:27), but arbitrarily describes it thus: "... *the feelings, acts and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they consider the divine*" (italics original) (James 1929:31-32). This suggests that religion is a concept that

encompasses more than beliefs and behaviors associated with a specific tradition or denomination and that it is not necessarily wholly distinct from spirituality.

Zinnbauer, Pargament, Cole, Mark, Butfer, Belavich, Hipp, Scott and Kadar (1997:2) point out that the differentiation of religion and spirituality is inconsistent in social science research and “impairs communication ... across other disciplines”. They note that although spirituality and religion have not been historically identified as exclusive concepts, “recent definitions of religion have become more narrow and less inclusive” (Zinnbauer et al 1997:2). Their research among a broad population of American participants who performed self ratings of religion and spirituality shows a correlation between the concepts, although one group of participants who defined themselves as “spiritual but not religious” was found to have a mildly negative reaction to the concept of religiousness. Personal meanings given to the terms *spirituality* and *religiousness* vary greatly (Zinnbauer et al 1997:8).

Zinnbauer et al (1997) point out some problems for practitioners who consider spirituality and religiousness to be separate and distinct. First, the more spiritually oriented focus of mental health practitioner groups may lead them to deemphasise or minimise religious perspectives held by clients. Second, by separating the concepts of religiousness and spirituality as though they are independent, or by valuing one above the other, research may be impaired. Last, there are implications for research in the field of “the social scientific study of religion”, if spirituality be considered wholly distinct from religion (Zinnbauer et al 1997:9). Zinnbauer et al (1997:9-10) assert the value of considering spirituality as an aspect of religion.

The above definitions of spirituality and religion do not fully address the concerns of Zinnbauer et al (1997). However, they provide a framework for pursuing the research and affirm the connection between spirituality and religion.

1.9.6 Transcendental phenomenology

A philosophical approach to scientific understanding based on data derived from experience available to consciousness, and what can be discovered by subjective reflection on this data (Moustakas 1994:45).

1.10 SUMMARY

The nursing profession has deep spiritual roots. Nurses themselves and patients are multidimensional, with spirituality being an important aspect of professional practice and holistic care. Nurses need to have a better understanding of mystical experience, an important aspect of spirituality. This need reflects contemporary trends in nursing theory, developments in nursing diagnosis, and holistic trends in medical care.

The research assumptions and the *Torus Model of Mystical Experience* (Figure 1.3) serve as a starting point for researching mystical experience in the context of health care.

1.11 OUTLINE OF THE STUDY

From this chapter onwards the thesis proceeds as follows:

Chapter1: Introduction and overview

Chapter 2: Review of the literature ¹

Chapter 3: Methodology and research design

Chapter 4: Presentation and discussion of the data

Chapter 5: Discussion and conclusions

¹ Note on the literature and literature review: In defining mysticism, the researcher turned to “classic” sources still referred to by contemporary authors as these are more in line with her initial conceptualisation of the concept “mysticism.” In the subsections of the literature review she attempted to give a chronologic overview within subsections and across subsections of major developments in the field of mysticism. The use of “outdated” sources should be view in the light hereof.

Chapter 2

Review of the literature

2.1 PURPOSE OF LITERATURE REVIEW IN QUALITATIVE RESEARCH

Research builds on the work of others and reflects various disciplinary perspectives. Mouton and Marais note that scientific research takes place within “research communities” (Mouton & Marais 1988:10-11). A review of the professional and research literature is part of the methodology of qualitative research (Moustakas 1994:111). An in-depth review of the literature also facilitates the process of bracketing, as paradoxical descriptions and analyses of mystical experience are encountered and considered. The researcher becomes less attached to personal beliefs and more open to the data derived from the research.

2.2 ORGANISATION AND SCOPE

This review of the literature encompasses scholarly and literary works on spirituality, mysticism, and nursing. Some associated literature on near death experience (NDE) is included when the content makes reference to unitive experience or other features of mystical experience.

The review of the literature begins with a history of the scholarly discussion of the spiritual dimensions of mystical experience. Multiple disciplines are represented, including philosophy, psychology and religious studies. The focus is on how mysticism is defined and characterised, how mystical experience is initiated, and how mystical experience has engendered controversy among contemporary scholars.

The next section examines biological, psychological and socio-political interpretations of mystical phenomena. The focus is on explanation of mystical experience as a factor of elements beyond personal spirituality. There is, of course, much overlap with the prior discussion of spirituality, but by separating out additional influences, mysticism is seen as a holistic phenomenon.

Following the above section, the review of the literature presents literary and narrative accounts of mystical experience, including straightforward narrative accounts of mystical experience in prose, poetry, and fiction. Younger (1990) asserts the value to nursing in examining literary works: "Through art one person receives another person's expression of feeling through hearing, sight or intuition and is capable of expressing the emotion that moved the other to express it. Thus, a major value of art is that as metaphor, it confronts one with reality" (Younger 1990:39).

The last section of the review of the literature discusses nursing theory and approaches to mystical experience. Nursing theories are examined to ascertain the degree to which they reflect on mystical experience as a concern of nursing; then, nursing literature directly discussing or making reference to mysticism is discussed. Nursing literature making reference to associated concepts such as serenity and transcendence is also included. In addition, nursing literature relating to NDE is discussed, for in some cases, these experiences have the characteristics of mystical experience.

Throughout the review of the literature, a common sub theme presents itself. Mystical experience is not the exclusive province of saints and scholars; it is accessible to many people, under many and different circumstances and conditions. Transcendent experiences may even occur as a corollary to everyday experience (Carse 1994:xi; Rahner 1966:50; Eklof 2003 http://www.cliftonunitarian.com/toddstalks/practical_mysticism.htm accessed 16/8/2005; Larkin 2004 <http://carmelnet.org/larkin/larkin041.pdf> accessed 26/1/2004) and as an aspect of human care (Watson 2005:7) and service (Deikman 2000:83-83). The review of the literature supports an understanding of mystical experience as relevant and accessible to nurses and patients.

2.3 SCHOLARLY DISCUSSION OF THE SPIRITUAL DIMENSIONS OF MYSTICAL EXPERIENCE

2.3.1 Modern mystical thought

The modern study of mysticism as a discrete phenomenon begins at the turn of the twentieth century. Richard Bucke (1969), a Canadian physician, wrote *Cosmic Consciousness* after an intense personal experience of illumination. His book, published in 1901, attempts to explain his experience and the experience of other mystics as

evidence of the natural evolution of the human intellect. Bucke (1969:1) defines Cosmic Consciousness as “a higher form of consciousness than that possessed by the ordinary man”. He believes that Cosmic Consciousness, or Cosmic Sense, occurs in males aged 30 to 40 who have superior moral sense and superior health. (Bucke, of course, writes unconsciously from the context of his age, but appears deliberately to exclude women.) Of his contemporaries having the qualification and experience for Cosmic Consciousness, Bucke frequently refers to poet Walt Whitman, known in later nursing literature as an American Civil War nurse (Dolan, Fitzpatrick & Hermann 1983:182-183).

Bucke notes a number of characteristics of the “Cosmic Sense”. He identifies the following:

- *The subjective light*
- *The moral elevation*
- *The intellectual illumination*
- *The sense of immortality*
- *The loss of the fear of death*
- *The loss of the sense of sin*
- *The suddenness, instantaneousness of the awakening*
- *The previous character of the man — intellectual, moral, and physical*
- *The age of illumination*
- *The added charm to the personality so that men and women are always (?) strongly attracted to the person [punctuation original]*
- *The transfiguration of the subject of the change as seen by others when the cosmic sense is actually present (Bucke 1969:79)*

Bucke was at one time Medical Superintendent of the Asylum for the Insane in London, Canada. Perhaps his experience with the mentally ill stimulated him to analyse the experience of mental illness *vis à vis* Cosmic Consciousness. He believes that insanity is “the breaking down of mental faculties, which are unstable because they are recent, and that it rests therefore on an evolution which is modern and still in progress ...” (Bucke 1969:58). Insanity then, is similar in origin, if not in result, to Cosmic Consciousness. A certain tension between mysticism and psychopathology is also seen in later literature (Lukoff 2000; Shorto 1999; Turner, Lukoff, Barnhouse & Lu 1995).

William James, an American psychologist who was familiar with Bucke's work (Bucke 1969:preface), subsequently explored mysticism in depth in the seminal work, *Varieties of Religious Experience* (1929), based on a series of lectures delivered in Edinburgh in 1901-1902. James does not identify himself as someone who has had any mystical experience. Unlike theological writers who write from orientation founded on a structured or denominational belief in divinity, James seeks to clarify the religious nature of the mystical experience from a psychological perspective. Religion for James, it may be recalled, does not refer to structured belief or the practices of a particular faith group. Rather, it refers to "the feelings, acts and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they consider the divine" (James 1929:31). James believes that all religion has its basis in mystical states of consciousness (James 1929:370). Without formulating a specific definition of mysticism, James does say that during mystical experience, "consciousness [is] possessed by the sense of being at once *excessive* and *identical* with the self: great enough to be God, inferior enough to be *me*" (James 1929:499, italics original). James discusses the qualities he ascribes to mystical states: ineffability (indescribability), noetic quality, transience, and passivity of the one having the experience (James 1929:371-372). For James, *noetic* means the experience exists in the mind or intellect. This meaning is subtly different from the phenomenologists' use of the term *noesis* to refer to intentionality and essence. James includes a range of phenomena in his conception of mysticism: sudden insights into the significance of words or phrases, *déjà vu* – like "dreamy states", trance states, and altered states of consciousness produced by alcohol or drugs such as nitrous oxide and chloroform (James 1929:373-384). He notes that nature experiences often trigger the mystical state of consciousness (James 1929:385). James's observations serve as a framework for subsequent authors, among them Underhill (1974) and Stace (1961), both pioneers in the study of mysticism.

Leuba, an American psychologist contemporary with James, writing in the 1920s, discusses mysticism with frequent reference to pathology. He divides mystical experience into two levels, with "lower mysticism" referring to "primitive" religious practices, in contrast to "higher mysticism" referring to Western European mystical experiences (Leuba 1972:47). He notes that the term *mysticism* may refer to any unusual or strange phenomenon, *or* may have the meaning of "union of the self with a larger-than-self" (Leuba 1972:1). (This is a cogent observation suggesting that there is significant variability in the use of the term *mysticism* among lay people and scholars.)

Leuba notes numerous physical triggers to what he calls *ecstasy*: “deprivations of food and sleep, isolation, even torture”, alcohol, narcotics, hallucinogens, and rhythmic body movements (Leuba 1979:11-15). Responses to such stimuli include altered sensory perception, altered cognition, including hallucinations, and altered emotions (Leuba 1979:27-29). Leuba discusses Christian mystics and notes additional motivations relevant to Christian mysticism: “the tendencies to Self-affirmation and the Need for Self- esteem” (Leuba 1979:120), “the Dread of Isolation; the Needs for Moral Support, for Affection, and for Peace in Passivity and in Activity” (Leuba 1979:122), “the Universalization of Socialization of the Individual Will” (Leuba 1979:127), and “the Sex-Impulse” (Leuba 1979:137) (letter cases original). Leuba expresses a certain respect for the spirituality of mystics, especially the Roman Catholic mystics, but the mystical experiences he describes are strongly mediated by physiological and psychological factors.

Leuba’s emphasis on sexuality and “auto-eroticism in grand mysticism” (Leuba 1979:143) prompted a vigorous response by Maréchal, a French Jesuit who objected to the sexual implications attributed to the Christian mystics (Maréchal 2004: 224-225) and asserts that Leuba seeks to discredit mysticism (Maréchal 2004:220). In addition, Maréchal challenges the religious significance of the “lower” forms of mysticism described by Leuba and criticises Leuba for equating “unconsciousness” with “the void” (Maréchal 2004:222-223).

For Maréchal, mysticism, both within and without Catholicism, “presents ... an *intuition of the divine*, or at the least of the *transcendent*” (Maréchal 2004:111). Maréchal examines Protestant mysticism, Yogism, Buddhism, Sufism, and Pantheism, the last of which, he says, is devoid of religious content (Maréchal 2004:12-116). However, without *fully* accepting the value of mystical experiences in other traditions, he affirms their commonalities with Catholic mysticism.

Evelyn Underhill is a British author writing from a Christian (Anglican) perspective in the 1940s. Like James, she believes that “[m]ysticism entails a definite psychological experience” (Underhill 1974:91). She also believes that mysticism is fundamental to religious experience (Underhill 1974:vii). Underhill refers to mysticism as “a direct encounter with absolute truth” (Underhill 1974:8). She states that it is “essentially a movement of the heart, seeking to transcend the limitations of the individual standpoint

and to surrender itself to ultimate reality ... purely from an instinct of love" (Underhill 1974:71). The experiences of religion, pain, and beauty are associated with mysticism (Underhill 1974:20). Although acknowledging James's characteristics of ineffability, noetic quality, transience, and passivity, she explicates the essential characteristics of mystical experience thus:

- *Active and practical*
- *Spiritual and transcendental experience of the "One"*
- *The "One" being an "Object of Love"*
- *Remaking of the self in union with the "One"* (Underhill 1974:81)

Underhill makes quite clear that in using the term *mysticism*, she rejects any association of mysticism with "occultism, dilute transcendentalism, vapid symbolism, and bad metaphysics" (Underhill 1974:xiv). Rather, she addresses genuine mystical experience as profound, real, and life enhancing.

Underhill explains mystical experience as introversion characterised by a sequence of "Recollection, Quiet and Contemplation" (Underhill 1974:309). It is a learned art that requires a spiritual discipline. The experience is described as a withdrawal from external stimuli and an approach to unity with God or the "One". Underhill describes ecstasy as an advanced aspect of mysticism, a distinction not made by some. She says that *ecstasy*, a trance-like state, "is the last phase of realized contemplation", a more profound sense of union with God and a complete separation from the world outside the self (Underhill 1974:358).

In the state of *ecstasy*, the subject is unconscious and unaware of external sensory stimuli. Underhill believes that bodily function is actually depressed during the trance or rapture, and that anaesthesia may occur (Underhill 1974:359). She notes that ecstasy may be stimulated by psychological conditions unrelated to mystical practice, such as hysteria. The experience is to be critically examined before it is considered to be from God (Underhill 1974:361). Underhill also notes that mystical experiences may be interspersed with periods of "Dark Nights", wherein the mystical experience cannot be achieved (Underhill 1974:380). The concept of the dark night associated with depression recurs later in the literature (Neumann 1995; O'Connor 2002).

Contemporary with Underhill, British novelist Huxley also contributes to the understanding of mystical and transcendent experiences. His dense work, *The perennial philosophy* (1970), advances his understanding of “the one divine Reality substantial to the manifold world of things and lives and minds” (Huxley 1970:viii). He believes that enlightened individuals across time and across cultures access this reality in a *common* experience (Huxley 1970:vii-ix).

American Abraham Maslow, writing in the 1960s, addresses mystical experience from the psychological perspective as the culminating experience of human development. He uses the term “peak experience” as synonymous with “core-religious”, mystical, or transcendent experiences (Maslow 1964:19). Maslow sees all these experiences as essentially the same and conceives of them as models of religious revelation (Maslow 1964:260). Such experiences answer the great questions of religion, but outside the framework of organised religion, a view that might be shared by those who describe themselves as “spiritual but not religious” (Fuller 2001:5). Maslow lists a number of aspects of reality that are perceived in peak experiences. An abbreviated list of these intrinsic values follows: truth, goodness, beauty, wholeness (unity), dichotomy-transcendence, aliveness, uniqueness, perfection, necessity, completeness, justice, order, simplicity, richness, effortlessness, playfulness, and self-sufficiency. The person experiencing these aspects of reality feels positive, awe- evoking emotions, including joy, ecstasy, and a sense of mystery (Maslow 1964:94-96).

Maslow is notable in that he is the first contemporary researcher to use interview techniques to qualify the characteristics of the peak experience in a sample of participants. He notes the difficulty of getting subjects to describe an experience usually referred to as ineffable, and indeed, reports problems in describing to the participants the type of experience he is researching. He finds the use of “poetic language” useful, noting that some people simply need to be given permission to talk about their peak experiences (Maslow 1964:84-89).

Perhaps the most influential analysis of mysticism in the twentieth century is carried out by British philosopher WT Stace (1961). In his work, he seeks not to define mysticism, but to determine the characteristics common to all mystical experiences. In addition, he examines an “argument for objectivity” of the mystical experience (Stace 1961:43). Stace concludes that mystical experience is subjective (Stace 1961:206) and not

necessarily the experience of absolute truth, despite similarities in descriptions of mystical experiences. This conclusion is critically examined by subsequent scholars, notably Corduan (1991) and Pike (1994). Stace specifically identifies “raptures, trances, hyper emotionalism” and sexual phenomena as features of mysticism that may be present, but that are not *intrinsic* to the mystical experience (Stace 1961:51-53).

In his analysis of common characteristics, Stace differentiates between extrovertive mysticism and introvertive mysticism (using Underhill’s [1974] terms). Although both types of experiences lead to the perception of unity, the introvertive experience results from an inward awareness; the extrovertive experience is initiated through the senses (Stace 1961:60-61). Extrovertive mystical experiences are usually, but not always, spontaneous, whereas introvertive experiences can be induced and replicated at will, although subject to “dry” periods. Stace believes that for some, the introvertive mystical state may become permanent.

Stace identifies qualitative differences between introvertive and extrovertive mystical experiences. The extrovertive experience involves a sense that all things are “One” and that the “One” truly exists as life in all things. However, in the introvertive experience, unity is apprehended rather in the sense of “pure consciousness” or the “Void” (Stace 1961:131). The extrovertive experience suggests a sense of subjective fullness and connectedness with all life; the introvertive experience suggests a sense of unitary consciousness and independence from time and space. Stace argues that the extrovertive experience is a lower level of the introvertive experience, rather than a different phenomenon (Stace 1961:132).

Characteristics common to all mystical experience as identified by Stace are as follows:

- Sense of objectivity or reality
- Blessedness, peace, etc
- Feeling of the holy, sacred, or divine
- Paradoxicality
- Alleged by mystics to be ineffable (Stace 1961:131-132)

In addition to identifying the characteristics of mystical experience, Stace also posits the “principle of causal indifference” (Stace 1961:29). He believes that spiritual discipline,

moral efforts, and ascetic practices can initiate mystical experience. He also describes an experience initiated by surgical convalescence (Stace 1961:83). Stace notes, too, that hallucinogenic drugs can initiate these experiences. Irrespective of the cause, he believes these experiences to be genuinely mystical, based on their characteristics. Characteristics, not causes, define mystical experience.

2.3.2 Veridicality of mystical experience

Much of the recent philosophical and religious debate about mysticism focuses on the phenomenological objectivity of mystical experience, and in particular, the ability of an individual to have an experience wherein he *truly* experiences God. Corduan (1991:125) believes that mysticism in Christendom validly reflects the indwelling of the Holy Spirit described in the New Testament. Ellwood, too, discusses mystical experience as an “encounter with ultimate divine reality” (Ellwood 1980:xi), although his own mystical experience was more one of pure transcendence than an encounter with the divine (Ellwood 1980:37). Pike (1994:116-153) argues in favor of the possibility of genuine theistic experience. He frames his arguments against the assertions of those such as Stace (1961:31-34) who believe that mystical experience is experienced, described, and interpreted in ways reflecting the individual’s cultural and religious background, and the assertion of Forgie (1994:7), who is not convinced of the possibility of theistic experience. The stance of both Stace and Forgie is that descriptions of theistic experiences are subjective interpretations – phenomena subjectively true, but not true experiences of God.

Katz (1992) and Cupitt (1998) also reject mystical experience as true experiences of God, each moving successively away from spiritual interpretation of mystical phenomena. They interpret mystical expressions as functions of words and language, rather than veridical experiences of God. Katz discusses mystical language as “literature”, “interpretation” (Katz 1992:4), and “power” (Katz 1992:21). Cupitt (1998) asserts that mystics are not truly describing transcendent experiences, but rather that they are radicals using language to challenge orthodox religious beliefs (Cupitt 1998:61).

The matter of veridicality of mystical experience appears to be a theoretical concern which must be considered against the *sense* of objectivity or reality which Stace

identifies as one of the characteristics of mystical experience (Stace 1961:131-132). In the current research, the *perception* of the participants is the research focus, rather than whether the experience is, or even can be, veridical in the sense used by Corduan (1991:125), Ellwood (1980:xi), or Pike (1994:116-153).

2.3.3 Mysticism and consciousness

The writing of American Ken Wilbur (1993) is the leading voice in the post-modern examination of altered consciousness. His work defies easy categorisation, embracing both Eastern and Western approaches, and reflects scholarly study, as well as disciplined personal practice of meditation and consciousness development. Wilbur describes mystical experience as the culmination of four stages of spiritual development. The first two stages are *Belief* and *Faith*. The third stage of spiritual development is *Direct experience*, which includes peak experiences, also called “peek experiences”. These are brief intense experiences which encompass nature mysticism, experiences of God, experiences of the void, and what he calls “a glimpse of One Taste” (Wilbur 1993:179-181). “One Taste” is a Buddhist term implying complete unity (Wilbur 1993:13). Wilbur also includes “plateau experiences” in the third stage of spiritual development. Plateau experiences are essentially peak experiences and other similar experiences which are sustained through disciplined spiritual exercise. For Wilbur, the fourth and highest stage of spiritual development is *Adaptation*. At this point, the individual has a “constant, permanent access to a given level of consciousness” (Wilbur 1993:181). This consciousness is present even in sleep and represents a rather singular level of human development (Wilbur 1993:181-183). Wilbur places mysticism in the context of disciplined spiritual practice; it is not spontaneous.

Forman (1990, 1998) and Deikman (2000) also discuss mystical experience as aspects of consciousness. Forman examines mystical experience against the constructivist model and says that during mystical experience, *Pure Consciousness Events* (PCE) occur, free from language systems and prior constructs (Forman 1990:4, 31).

Deikman (2000) takes a rather different approach to mysticism and consciousness. He discusses the concept of *deautomatisation*, a “shift toward a cognitive and perceptual experience that could be characterized as more ‘primitive’”. This loosening of attention and thought frees the mind to deal with abstractions. Sensory perceptions assume

greater prominence, and cognitive focus is enlarged (Deikman 2000:78-79). Although Deikman discusses *deautomatisation* in connection with meditative practices, he also suggests that the process may occur in association with the performance of “renunciation and service” activities, in which focus on the self is forgotten (Deikman 2000:83-84). Deikman’s identification of renunciation and service as antecedent to or associated with mystical experience is a theme that recurs in the religious literature, secular literature, and nursing literature with regard to the latter.

2.3.4 Mysticism in the Christian church tradition

The Western Christian church has been only partially receptive to mystical experience. Inge was a British scholar studying mysticism early in the twentieth century. Writing from an Anglican religious perspective, he details the history of Christian mysticism (Inge 1919 http://www.gutenberg.org/catalogue/world/readfile?fk_files=5986 accessed 23/7/2005), describing a movement whose leaders were sometimes not only seen to be at odds with the established church, as was Mechthild of Magdeburg, a Beguine of the early 13th century, but who were also regarded as heretics, as was Meister Eckhart, in the same time frame. Inge does not regard mysticism as a new phenomenon, and asserts that mystical expression is not always acceptable within society or by the Western church (Inge 1919). Inge’s observations raise the possibility that mystical experiences described by research participants might be received by their churches and pastoral caregivers with variable degrees of acceptance.

Inge’s assertions are borne out by others. Mystics such as St John of the Cross and Teresa of Avila faced challenges from the Inquisition, and although they were absolved of heresy, it was not without some difficulty (Medwick 1999:126-128,196). German mystic Meister Eckhart was condemned for heresy after his death (Ferguson 1977:50). Roman Catholic mystic Pierre Teilhard de Chardin was forbidden by the Roman Catholic Church to publish while he was living (Huxley 1962 in De Chardin 1962:13).

McKenzie agrees that the Roman Catholic Church is not fundamentally receptive to mystical experience and that reports of mystical experience are doubted and carefully scrutinised. When mystical experiences are evaluated in the context of possible canonisation of the experiencer, the focus is on the “orthodoxy of the experiences, not their reality” (McKenzie 1971:234-237).

In contrast, Rowell, a contemporary European Anglican bishop, states that the English church has a tradition of embracing mystical experience, noting famous mystics such as Julian of Norwich and Edward Pusey, a key figure in the Oxford Movement – the Catholic revival in Anglicanism (Rowell 2005:52). Indeed, Rowell identifies several other key persons in the Oxford Movement, Keble and Neale, as also having mystical character (Rowell 1983:27, 87, 100). Rowell's statements are put into perspective, however, when it is recalled that the Oxford Movement engendered intense religious and political controversy (Yoder 1985:46-47).

Contemporary Orthodox theologian Ware discusses mysticism as prominent in the Eastern Orthodox Church tradition but notes the 14th century "Hesychast Controversy" (Ware 1991:72). *Hesychia* is a term that "signifies concentration combined with inner tranquility" (Ware 1980:163). The controversy, however, encompasses more than a manner of prayer; it concerns one's ability to actually experience God's transcendence, without committing pantheistic heresy. At a time of political unrest, the Byzantine church came to partial resolution of the issue, based on St Gregory Palamas's distinction between the *energy* and the *essence* of God. It is orthodox to speak of knowing the *energy* of God, whereas it is impossible to know the *essence* of God (Hinnells 1984:147; Ware 1991:74-81).

Ware discusses *deification*, mystical union with God, as an important aspect of contemporary Orthodox Church theology (Ware 1991:236-237). It is not a remote possibility for the believer; "it is the normal goal for every Christian without exception" (*italics original*) (Ware 1991:240).

The "Jesus prayer" features prominently in the Orthodox tradition. This is the meditative repetition of the words "*Lord Jesus Christ, Son of God, have mercy on me a sinner*" (Hinnells 1984:147; Ware 1980:164). The repetition of this prayer in coordination with awareness of the heart beat forms the basis of a powerful spiritual discipline, movingly described in the anonymous spiritual memoir of an 19th century Russian pilgrim (*The Way of a Pilgrim* 1991:90).

2.3.5 Mysticism in other spiritual traditions

Many of the authors above are writing, consciously or unconsciously, about mystical experiences in a Christian or Western European/American context. They examine instances of expanded consciousness in Eastern cultures or indigenous cultures only superficially, if at all. The book *Mysticism east and west* by German theologian, Rudolph Otto (1958) enlarges this focus. He compares the Hindu metaphysics of Sankara to the writings of the medieval theologian Meister Eckhart, finding essential similarities (Otto 1958:262).

Waley (1958) presents a detailed discussion of Taoism, a Chinese philosophy reflecting Indian and possibly Greek influence (Waley 1958:109, 112-114). However, it is fundamentally a Chinese system developed by an unknown Quietist several hundred years before the Common Era (Waley 1958:86).

Merton, an American Trappist monk and mystic, has explored mystical experience across Asian cultures. He discusses the tranquility sought in Taoism. It is not a system of meditation or contemplation, but an emphasis on “non-action” as the path to happiness, a rejection of striving. He states:

If one is in harmony with Tao – the cosmic Tao, “Great Tao” – the answer will make itself clear when the time comes to act, for then one will act not according to the human and self-conscious mode of deliberation, but according to the divine and spontaneous mode of wu wei, which is the mode of action of Tao itself, and is therefore the source of all good (Merton 1965:24).

Taoism, in its turn, influenced the development of Zen Buddhism in Japan (Merton 1965:15). The Zen tradition is discussed extensively by Suzuki, a Japanese scholar who has helped familiarise the Western world with Zen practices. His works are important scholarly Western sources on Zen. Suzuki defines Zen as “discipline in enlightenment” (Suzuki 1973:5). Zen, also referred to as *satori*, is a function of both language and experience (Suzuki 1973:6-9) Suzuki observes that the Zen tradition has affected multiple aspects of Japanese culture (Suzuki 1973:21). Dürkheim, a German student of

Suzuki, further writes on the value of disciplined Zen practice for Western cultures and its compatibility with Christian spirituality (Dürkheim 1991:123-128).

The mysticism of Islam is receiving increased attention. *Sufism* is mystical practice in the tradition of Islam, and although it receives significant emphasis in contemporary mystical writing (al-Rawandi 2000; Chittick 1983; Gurian 2000; Housden 2002; Nicholson 1989), it is not always considered to be consistent with orthodox belief. Some Muslims say it is “infected” by Christian and Hindu beliefs and practices (Dalrymple 2004:2-4). Hinnells (1984:313) corroborates the influence of early Eastern Christian church on Sufism. Nonetheless, Sufism has played a role in contemporary social and political issues, especially in Western Africa (Ellis & Ter Haar 2004:67, 137; Ryan 2001:208).

Jewish mysticism (Kabbalah) also receives increasing emphasis (Besserman 1997; Epstein 2001; Hoffman 1992a; Jacobs 1990; Kushner 1994; Scholem 1974; Wasserman 1990). Kabbalah incorporates complex esoteric and theosophical elements in a system that has some elements of magic and the occult (Scholem 1974:3-5). Personal accounts of mystical experience are rare in this tradition of “hidden science”. Jewish mysticism does not emphasise *mystical union* with God, but rather *spiritual communion* (Jacobs 1990:1-2, 13-14, 160).

Erotic references feature in some Kabbalistic writings (Besserman 1997:105-107; Scholem 1994:160), and Besserman (1997:107) notes that female Kabbalists are rare. However, female entertainer Madonna is currently promoting a popular (and controversial) version of Kabbalah among celebrity friends (Barker 2004:1).

Some historical consideration of mysticism in indigenous cultures in areas such as North America and Northern Europe has focused on the role of shamans, considered as either charlatans or hysterics (Howells 1963:130-136). In contrast, French scholar Mircea Eliade’s work, *Shamanism: archaic techniques of ecstasy*, first published in 1964, is a comprehensive examination of shamanism considered as a religious phenomenon, across cultures (Eliade 1989:xi). Later authors such as Neumann (1995 http://home.adelphia.net/~drdick/divine_madness.html accessed 13/1/2003) also treat the role of the shaman with respect and differentiate the mediumistic function of the shaman from the experience of the mystic.

The most extensive examination of mysticism in an indigenous North American culture is American author Hollenback's (1996) in-depth treatment of the mystical experiences of Black Elk (1863-1950), a Native North American of the Lakota tribe. Black Elk was not a shaman, but he had a "Great Vision" at age nine during an episode of pain, leg swelling and paralysis (Hollenback 1996:327). He later shared his vision (Hollenback 1996:327-342) and became both an important leader in Native American history and a Roman Catholic missionary (Hollenback 1996:432-443). Hollenback compares Black Elk's experiences to the experiences of medieval mystics Teresa of Avila and Meister Eckhart. Hollenbeck includes emphasis on paranormal experiences and dreams as legitimate aspects of the mystical experience – in keeping with the quality of Black Elk's experience (Hollenback 1996:279). Hollenbeck's acceptance of paranormal experiences and dreams has sensitised the researcher to the potential for mystical experience associated with dreams and paranormal phenomena recounted by research participants.

Contemporary belief in power of the spirit world persists in the African continent (Ellis & Ter Haar 2004:51-52; The spirits that move Africa 2000:78). Communication with the spirit world may involve "dreams and visions or spirit possession" (Ellis & Ter Haar 2004:56). Ellis and Ter Haar (2004:57) distinguish "hyperkinetic" trance states and spirit possession from "hypokinetic" mystical states, but describe both as altered states of consciousness. Trance behaviors and ecstatic rituals may also be integrated into indigenous church ceremonies such as those of the church of the Apostles of John Maranke, with branches in central Africa (Jules-Rosette 1980:1-2). American psychologist Bynum (1999:xxv) argues that *all* contemporary religion has its roots in the "African unconscious" and "ancient mysticism". He traces Kundalini mysticism ("serpent power") to Africa, believing that it is foundational to the development of Voudoun, Candomble (an Afro-Brazilian cult), and Santería (a Cuban cult) (Bynum 1999:132-143; Hinnells 1984:24)) as well as the great religious traditions of the West (Bynum 1999:20).

Even though specific practices and interpretations vary, mystical experience occurs across cultures and spiritual traditions. Experiences are not always the same in such different contexts, but they are not incompatible with the researcher's definition of mystical experience (section 1.9.1).

2.4 RESEARCH EXPLORING CHARACTERISTICS OF MYSTICAL EXPERIENCE AND THOSE HAVING MYSTICAL EXPERIENCES

Research in mystical experience has moved from anecdotal compilations to early attempts at measurement, followed by the development of mysticism research tools and the exploration of entheogen use.

2.4.1 Measurement of mystical phenomena

Mystical experience is known to occur spontaneously, irrespective of spiritual discipline or entheogen use. The study of naturally induced mystical experience is a contemporary interest in research into mysticism. Research is carried out to determine the extent and characteristics of spontaneously occurring mystical or ecstasy experience in the general population. Research also addresses the concurrent use of hallucinogenic drugs as triggers. Other areas of focus include demographic traits of experiencers and the correlation of mystical experience with psychological variables.

In 1959, Australian physicist Raynor Johnson published a compilation of case histories of persons who reported having mystical experiences. He was followed by Marghanita Laski in 1961, who conducted a semi-formal survey among her friends and acquaintances in England and analysed published texts of mystical experience (Laski 1961:5-13). She analyses the experiences in terms of intensity and withdrawal experiences. These categories are roughly parallel to Stace's (1961) extrovertive and introvertive experiences. Laski is not writing from a religious perspective, and perhaps because of that, makes a especial attempt to identify *triggers* of mystical experience (Laski 1961:16). Her use of this term is probably the first in the literature. Johnson (1959:10), for example, speaks of "methods" for inducing awareness, but makes no attempt to categorise the phenomena that might induce mystical experience spontaneously. Laski's list of triggers is informative. In addition to expected factors such as nature, scenery, art and religion, she includes exercise, sexual love, and childbirth (Laski 1961:17).

Maslow (1964), as previously noted, interviewed subjects to determine whether they had had *peak experiences*, his term for a "core-religious" developmental concept carrying the implications of mysticism (Maslow 1964:73). He finds that with proper

questioning, many people report peak experiences. He has come to believe that those who did not report these experiences were those who were afraid of them or willfully forgot them, based on characteristics of their own personality structures (Maslow 1964:20).

Hardy began research into spiritual experiences in 1969, under the auspices of the Religious Experience Research Unit (RERU) at Oxford University in England (Hardy 1979: preface). Researchers at the RERU came from a variety of disciplines: theology, botany, zoology, and philosophy (Hardy 1979:preface). The group collected 3000 personal descriptions of spiritual experiences, based on self-submitted accounts and questionnaires (Hardy 1979:29). Although Hardy did not isolate mystical or ecstatic experiences from other experiences of “spiritual awareness” (Hardy 1979:29), the experiences and triggers he describes are similar to descriptions of mystical experience in other research. Among triggers, he identifies natural beauty, religious and devotional practices, depression, illness, and aesthetic experiences as the most common antecedents to spiritual experience (Hardy 1979:28).

Hardy’s research includes a preponderance of female participants whose ages range from adolescence to over 90 years (Hardy 1979:30). Hardy identifies several important aspects of spirituality derived from his research: “a feeling of transcendental reality”, “a sense of presence”, and “personalization” of one’s relationship with God (Hardy 1979:131-134). Supporting Huxley’s *Perennial philosophy* (1970), Hardy (1979:142) believes that his findings have broad applicability across cultures. The work of the RERU, renamed the Religious Experience Research Centre (RERC), has moved from Oxford to the University of Wales, (University of Wales Lampeter Department of Theology and Religious Studies 2005 http://www.lamp.ac.uk/trs_Main_pages/other_activities.htm accessed 4/4/2005).

In 1974, American Roman Catholic sociologist and priest, Andrew Greely, carried out a broad based population study of *ecstasy* experiences. (He uses the terms *ecstasy* and *mystical experience* interchangeably.) His results indicate that mysticism and related phenomena occur with relative frequency in the American population (Greely 1974:139-142). His work refers to the triggers identified by Laski, and he makes particular reference to the ecstasy of sexual union (Greely 1974:91-97).

Keutzer (1978) conducted a related, but more limited, research project, focusing on triggers of mystical experience among American college students. Her results are similar to Greely's (1974) and additionally show physical exercise to be a trigger. Among her sample, recreational drug use is found to be a significant trigger for mystical experience (Keutzer 1978:77). Exercise is noted in later literature as initiating mystical experience. "Runner's high" is a term associated with the spiritual experience of running (Prebish 1983:108).

Hay, a British zoologist, initially working with Hardy, conducted research into religious experience from a psychological perspective. Like Hardy, his focus is not limited to mystical experience; he seeks to understand a broad range of religious experiences across cultures, based on Wach's criteria for religious experience, which incorporate the concepts of *total involvement*, *reality*, and *transcendence* (Hay 1982:96). Hay's research in Nottingham, England, involved random interviews in which participants were asked questions to explore their awareness of some type of spiritual power or presence. Among the various experiences reported by his sample, he identifies certain patterns: brevity (usually less than 10 minutes), being alone, a preceding "neutral" or distressed emotional state, and a subsequent positive or peaceful emotional state (Hay 1982:131). Hay thinks these patterns of religious experience have similarities to mystical experience, even though they are not wholly like classical mystical experiences (Hay 1982:161). Hay identifies various influences and triggers, such as nature and cultural expectations (Hay 1982:202-204), and he notes the importance of subjective distress as an important antecedent to the experience in 50% of those surveyed (Hay 1982:204).

The contributions of the above researchers paved the way for Ralph Hood (1994), an American psychologist, to conduct sophisticated research into the nature of religious mystical experiences in the context of the psychology of religion. Hood (1994:11) rejects the "methodological atheism" he finds in some psychological research traditions and states that the "ontological issue of God's existence can no longer be ignored in the psychology of religion" (1994:18). His research draws on Stace's conceptualisation of mystical experience (Hood 1994:33-34) and is carried out using the Hood *Mysticism Scale* (M-Scale), which has been extensively evaluated and validated (Caird 1988; Hood, Watson, Ghrameleki, Bing, Davison & Williamson 2001; Reinert & Stiffler 1993). Although other scales of mystical and transcendent experience have been developed, such as the Short Index of Mystical Orientation (SIMO) (Francis & Loudon 2004), and

the Spiritual Transcendence Scale (Piedmont 2004 <http://www.evergreen.loyola.edu/~rpiedmont/STSR.htm> accessed 23/3/2004), none has achieved the prominence of Hood's M-Scale.

Under the M-Scale, mystical experience is structured as the interaction of three factors: introvertive mysticism, extrovertive mysticism, and interpretation (Hood 1994:34). The M-Scale is adapted to Christian and non-Christian traditions and can also be administered using purely secular terminology (Hood 1994:32-47). Hood finds that although there may be a "common core" of experience, interpretations vary across religious traditions (Hood 1994:47). This finding suggests that it is important to consider religious traditions in the study area.

Hood confirms that mystical experience is not uncommon and that it is more frequently reported by females (Hood 1994:157-158). He finds mystical experience to be associated with a measure of self-actualisation (Hood 1977:269).

Using Hood's M-Scale, Lazar researched the influence of ethnic and cultural variables on religious experiences of Israeli Jews from Ashkenazi, Sephardic, and Ethiopian backgrounds. Although religious background was similar in this sample of Orthodox Jews, cultural background is found to affect their religious motivation and interpretation of religious experiences, but not the unitive or extrovertive character of the experience (Lazar 2004:69-70).

Hood's research on anticipatory stress and setting stress as antecedents of mystical experience in a nature context is also relevant to considerations of mystical experience in the context of health care. Hood finds that "the interaction between anticipatory stress and setting stress apparently operates both ways – either stressful settings anticipated as nonstressful or nonstressful settings anticipated as stressful serve to elicit reports of mystical experience. Importantly, stress per se, whether setting or anticipatory, is *less* likely to elicit reports of mystical experience" (*italics added*) (Hood 1994:63).

In suggesting a direction for further research, Hood states that mystical experience is more than a function of linguistics. However, the ability to utilise appropriate language or communication modalities may influence an individual's ability to share mystical experience (Hood 1994:158). (This is surely a concern regarding any study population

and may have major methodological implications for research into mystical experience in the health care setting.) Hood's concern with the role of language in mystical experience reflects issues raised by Katz (1992) and Cupitt (1998).

2.4.2 Inquiry into the potential of entheogens to trigger mystical experience

Except for Bucke and Wilber, many scholars address mysticism and ecstasy from the outside. They do not claim to be mystics and do not share in the mystical experience, although James reports an incomplete and unfulfilling experience with nitrous oxide (James 1929:378). Entheogen use is a controversial factor that has received particular attention in the discussion of mystical experience.

It was for Aldous Huxley, in the mid 1950s, to experiment with mescaline, also known as peyote, (a drug originally used in Native American religious ceremonies), and to describe an experience of profoundly altered consciousness. Huxley's 1954 essay describing his beliefs, *The doors of perception (reprinted 2004)*, anticipated the "Psychedelic" movement, in which drug use became to be seen as a means of expanding human potential. Huxley believes that the urge towards self-transcendence is a basic human motivation and that the use of drugs such as mescaline offers ordinary people an opportunity safely to achieve transcendent experience (Huxley 2004:67). (This represents a change from his earlier thinking in which he stated that transcendent experiences are only "apprehended by those who have made themselves loving, pure in heart, and pure in spirit" [Huxley 1970:x]).

In 1957, RC Zaehner responded to Huxley's work rapidly and emphatically with the book *Mysticism sacred and profane* (1961). Zaehner, too, experimented with mescaline but found the experience unsatisfactory, despite dramatic sensory and emotional alterations. He does not believe that mescaline is able to trigger a genuine mystical experience, nor that Huxley had had a genuine religious experience (Zaehner 1961:226). He does concede that Huxley's experience may have had some elements of "nature mysticism", a phrase similar in meaning to Stace's extrovertive mysticism.

The American religious scholar, Huston Smith (2000), remains an articulate proponent of the use of entheogens to promote spiritual development, supporting Huxley's stand and disagreeing with Zaehner. He examines entheogen use from a historical,

psychological, and cross-religious perspective. Interestingly, he addresses the potential of disease processes such as infection and epilepsy to initiate brain changes paralleling the effects of entheogens, using as illustrations John Henry Newman's religious experiences while ill with typhoid fever and Dostoevsky's epileptic episodes (Smith 2000:107-111).

Smith's affirmation of the spiritual potentialities of entheogens is not a lone voice. A web site developed by the *Council on Spiritual Practices* quotes and makes reference to a number of popular and scholarly works in order to make "direct experience of the sacred available to more people" (Council on Spiritual Practices 2004 <http://www.csp.org/> accessed 27/10/2004). This web site has several sections focusing on the use of entheogens, drugs used to promote spiritual experiences.

Early writing about mysticism notes the use of spiritual disciplines such as fasting and bodily mortification. Drug use to induce trance states is known in shamanic practices in some cultures, but the deliberate use of hallucinogenic substances to artificially induce states of altered consciousness is a relatively recent theme in the study of mysticism.

Despite Zaehner's negative view of Huxley's work, for some time the therapeutic use of hallucinogens was believed to hold potential to promote human development and even to have therapeutic use in treating mental illness. Overall, however, this movement has been negatively affected by the drug culture of the 60s and 70s, and most recently, by the negative connotations of the drug referred to as "Ecstasy".

Some early research was carried out on the use of hallucinogens to promote human development and spirituality. The Good Friday Experiment is perhaps the most famous. In 1962, on Good Friday, a group of theology students in Massachusetts, USA, was given psilocybin by Harvard psychiatrist Walter Pahnke, to find if they would have mystical experiences. Their experiences were evaluated using Stace's characteristics of mystical experience. The experiment was limited, but according to Huston Smith, a participant, some of the students in the treatment group did indeed have mystical experiences. At least one student reported a strongly negative experience (Smith in Grob 2002:64-71).

Harold Abramson's (1967) book, *The Use of LSD in psychotherapy and alcoholism*, reports the use of LSD-25, a derivative of d-lysergic acid, as a therapeutic agent. Excerpts from the book, available on the internet site for the Council on Spiritual Practices 2004 (<http://www.csp.org> accessed 30/7/2004), describe variable results in the treatment of alcoholic patients and favourable results in psychotherapy. Because only limited excerpts of the book are available on the web site, it is difficult to evaluate the research findings. However, it illustrates the tenor of research in the 1960s.

Roberts (1999) reviews research to support his "Emxis hypothesis". He believes that entheogens can induce genuine mystical experiences and that mystical experiences so induced can have a positive effect on immune function. He looks at research in which salivary IgA is believed to be enhanced by factors associated with mystical experience and at instances in which spontaneous remission from disease is thought to be mediated by similar factors. Although he finds that stress reduction practices are linked to increases in IgA, he is not able to verify a relationship between mystical experience and increased IgA. In addition, he finds spontaneous remission of disease associated with spiritual or religious practices to be rare. Roberts does not abandon his hypothesis; rather, he suggests that there is a need for further research (Roberts 1999:139-147).

Winkelman (2001) also reviews a broad spectrum of literature to establish a therapeutic potential for hallucinogens, although he does not directly address mysticism. He finds that hallucinogens have an effect on serotonin function and on many aspects of brain function, possibly resulting in "integration of feelings with thought, enhancing insight" (Winkelman 2001:229). He also notes a variety of severe and unwelcome consequences of use, including death. Despite these drawbacks, he believes persistent social use of illegal hallucinogens reflects some "innate drive" (Winkelman 2001:231).

A recent study regarding the use of psilocybin to induce mystical experience has been carried out at the Johns Hopkins University School of Medicine by Griffiths, Richards, McCann and Jesse (2006 <http://springerlink.metapress.com/media/p3dgvmvuvq597tmxcd4p/contributions/v/2/1/7/v> accessed 31/7/2006). In a double blind study comparing psilocybin to methylphenidate hydrochloride and a placebo, Griffiths et al (2006:unpaginated) find that participants given psilocybin report having experiences with "marked similarities to classical mystical experience" and sustained effects. This

study may represent a renewal of empirical research interest in the ability of entheogens to induce mystical experience.

2.4.3 Inquiry into other factors underlying mystical experience

The research discussed above supports the existence of spiritual experiences and gives evidence that mystical experience is a profound aspect of spirituality, with great significance for the experiencer. These experiences are neither unusual nor restricted to a particular subgroup of the population.

An underlying question is this: apart from the meaning of the experience to the experiencer, does mystical experience result from some factor or combination of factors separate from, or in addition to, the spiritual or religious? Questions such as this do not challenge the significance of mystical experience; they merely look for underlying functional or pathological factors that may bring about mystical experience in association with particular triggers.

Triggers have also been discussed in the literature as actions or circumstances that can initiate genuine mystical experience. Triggers of many types have been identified as integral to mystical experience. The focus of this next discussion is the way in which triggers interface with broad holistic factors to bring about mystical experience.

2.4.3.1 Biological inquiry

Physiological changes feature in many descriptions of mystical experience. These include *altered sensory perception*, such as seeing a bright light, or a tunnel; *altered proprioception* such as a sense of floating above the body, a sense of movement forward or backward, or levitation; and *altered cognition* such as a sense of timelessness. Less commonly, slowed vital signs are reported. Sometimes stigmata (bleeding on the hands and other parts of the body recalling the wounds of Christ) are described as mystical manifestations. These changes may reflect underlying alterations in physiology such as normal variations in biological functioning, physiological attempts to restore homeostasis in the face of threats or pathophysiology.

2.4.3.1.1 *Functional interpretations*

Some experiences of mystical phenomena may be expressions of normal physiological functioning. D'Aquili and Newberg (2000) have developed a model they call the "Aesthetic-Religious Continuum". They recognise nine states of knowing, six of which relate to the perception of reality. Of these six states, three reflect drug use and psychopathology, but the other three derive from *stable* brain function. These more stable states include first, a "neutral" perception of reality, then, another state analogous to "Cosmic Consciousness", and finally, a state involving intense sad or negative perceptions of reality (D'Aquili & Newberg 2000:41-43).

Spiritual and mystical experiences are linked to coordinated functioning among the various lobes of the brain (D'Aquili & Newberg 2000:46). The temporal lobe has been suggested as the seat of mystical activity (Persinger 1983:1256). Research, of course, is difficult, as mystical experiences cannot always be summoned at will in the laboratory. However, Wulff (in Cardeña, Lynn & Krippner 2000:405-406) identifies several studies that support the belief that religious and mystical experience may originate in temporal lobe activity.

Among neurotransmitters, serotonin function has been positively associated with self-transcendence in normal males in a small Swedish study (Borg, Antree, Soderstrom & Farde 2003:1967), and a larger study in Korea, although the authors of the Korean study qualify their findings by noting the complexity of the relationship between personality and genetic traits (Ham, Kim, Choi, Cha, Choi & Lee 2004:4).

Research on meditation may be considered to have implications for mystical experience, but most such research has been designed to show the therapeutic *effects* of meditation, rather than the physiology underlying the practice. Canter (2003:1049-1050) discusses research on the effects of meditation on various illnesses, including asthma and hypertension, finding the research flawed and the results unimpressive.

2.4.3.1.2 *Neuropathology*

Sometimes specific disease processes, most commonly neurological disorders, are discussed as being causative of mystical experience. Spirituality in general has been

associated with epileptic signs (MacDonald & Holland 2002:785). Sacks (1985:160-161) cites the scotoma-like characteristics of St Hildegard's visions as evidence of epilepsy. Hansen and Brodtkorb (2003:667) describe "ecstatic seizures" in a small sample of patients, some with temporal lobe seizures and some with nonlocalised seizures. In some cases, the seizures could be induced at will by the patient.

Fenwick, Galliano, Coate, Rippere and Brown (1985) investigated mystical experience and traumatic brain trauma in a small study of 17 students. They address mystical experience broadly, in association with a wide array of psychic abilities and find that "support is provided for the hypothesis that the experiencing of 'psychic gifts' can be indirectly related in time to the occurrence of brain trauma" (Fenwick et al 1985:42). However, contrary to their expectations, they do not find an association with "non-dominant temporal dysfunction" (Fenwick et al 1985:42).

2.4.3.1.3 Hypoxia

Arzy, Idel, Landis and Blanke posit hypoxia as an important factor in high altitude mountain top revelations, such as the experiences of some of the great religious leaders (Arzy et al 2005:841). Blackmore associates oxygen deprivation and "noise in the visual cortex" with the tunnel vision and out-of-body experiences reported by persons claiming near death experiences (Blackmore 1991:41). Woerlee believes that tunnel and darkness perceptions in near death experiences can be linked to oxygen deprivation in the retina (Woerlee 2004:29).

Greyson (in Cardeña, Lynn & Krippner 2000:333-334) discusses Sabom's (1982) model of hypoxia-induced unconsciousness experienced by pilots undergoing rapid acceleration. Pilots' experiences include cognitive alterations and some aspects of near death experience, such as a sense of being out of the body and floating. The similarities of mystical experience and some aspects of near death experience have prompted discussion and research into physiological factors that may underlie both types of experience. Near death experiences share many characteristics with mystical experience, but are associated with grave disruptions in homeostasis.

2.4.3.2 Psychological inquiry/psychopathology

A continuing theme in the scholarly examination of mysticism is the discrimination between mysticism as religious experience and mysticism as pathology. The new diagnosis that has been developed for the *Diagnostic and statistical manual* (DSM IV), *Religious or Spiritual Problem*, has raised questions about the overlap between spiritual experience and pathology, as in, for example, the diagnosis of mania. In addition, spiritual beliefs and behaviors that may be acceptable in one culture may represent psychiatric illness in another (Turner et al 1995:441).

Although descriptions of mystical experience frequently include reports of personal growth and even self-actualisation (Maslow 1964), other reports suggest severe difficulties in functioning. Historically, mystics have exhibited behavior that has been described as hypersexual, hysterical or otherwise maladaptive. Some descriptions of mystical experience share similarities with descriptions of hallucinations. Such observations have prompted the examination of mystical experience as psychopathology. This, of course, overlaps with research into the physiological aspects of mysticism, as increasingly, psychiatric problems are considered to have multiple causative factors.

2.4.3.2.1 Hysteria

Leuba attributes some aspects of mystical experience to hysteria and sexual disorders (Leuba 1972:143, 191-193). In the 19th century, German physician Krafft-Ebing (1965) is not atypical of his contemporaries when he says, "Religious and sexual hyperaesthesia at the zenith of development show the same volume of intensity and the same quality of excitement, and may therefore under given circumstances, interchange" (Krafft-Ebing 1965:7). Even today, Epstein (2001:136) describes ecstatic practices of ultra Orthodox Hasidic Jews as having elements of hysteria.

2.4.3.2.2 Depression

Mystical experience is not commonly sustained without interruption. However, its absence may be associated with a profound sense of loss or grief. The term "dark night" may have been used first by St John of the Cross to describe this state, as illustrated by

the title of his great 16th century mystical work, *Dark night of the soul* (1959). Neumann (1995 http://home.adelphia.net/~drdick/divine_madness.html accessed 3/1/ 2003) considers the “dark night” experience associated with mysticism to be an “inevitable” corollary to the stages of mysticism.

O'Connor (2002:138, 143) too, associates depression with mystical experience, but urges careful assessment, as the interventions required for “dark night” depression are different from the interventions for depression unrelated to mystical experience. He states that the depression associated with the loss of ability to experience the intensity of mystical phenomena is less likely to impair functioning than ordinary depression, but causes the individual to feel “spiritually disoriented” (O'Connor 2002:138). O'Connor (2002:140) urges referral to pastoral caregivers, rather than psychologists, as best qualified to offer support.

2.4.3.2.3 *Psychosis*

Several authors examine the relationship between psychosis and mystical experience. Hood (1994:9) rejects the contention that mystical experience is pathological or infantile, although he notes that mystics may be subject to hallucinations as “accidental characteristics” of mystical experience. For Hood (1994:7-9), the loss of ego associated with mystical experience presupposes a mature, functional ego to begin with.

Neumann also asserts the psychological integrity of the mystic. He believes that the mystic has a balanced personality and an enhanced ability to relate with others. He notes that the visual experiences reported by mystics differ from the auditory hallucinations reported by psychotics (Neumann 2003 http://home.adelphia.net/~drdick/divine_madness.html accessed 13/1/ 2003).

Wapnick (in Woods 1980:325-337) explicitly compares mystical experience with schizophrenia by analysing the writings of St Theresa of Avila and Lara Jefferson's modern (1940) personal account of schizophrenic experience. He concludes that persons experiencing mysticism are more able to maintain conscious control of their actions and are more integrated socially than persons experiencing schizophrenia.

American Russell Shorto (1999) addresses this issue from another perspective. He believes that experiences deemed psychotic in the contemporary psychiatric setting may be more truly considered mystical experiences. Reviewing research carried out using the Hood M-Scale in a pastoral care study, Shorto says, “[I]f the mystic's experience is to be called religious, then so too should the psychotic's. Perhaps the real differences are exterior to the persons involved; we prefer to think of the one as religion and the other as mental illness ...” (Shorto 1999:173). Shorto suggests that both mystical and psychotic experience can be related to levels of dopamine and serotonin in the brain. However, he does not think that trying to examine a particular part of the brain or its function is a realistic approach to understanding the mystical experience; he believes it involves the entire organism (Shorto 1999:190-193).

Stahlman discusses the possibility of “mystical experience with psychotic features” (Stahlman 1992 http://www.well.com/user/elliotts/smse_schizo.html accessed 16/1/2004). However, most contemporary thinking supports the identification of mystical experience as a possible “spiritual problem” (Lukoff 2000 <http://www.virtualcs.com/dsm4/dsmrstoc.html> accessed 13/12/2004), rather than psychopathology.

2.4.4 Socio political inquiry

Social factors have been identified as relevant to mystical experience. In the Western culture, feminist and power issues are prominent. Mysticism also has been discussed as a factor of individual leadership or charisma.

The medicalised interpretation of mysticism as pathology in 19th century medical literature prompts Mazzoni (1996) to consider ecstatic religious experience as a feminist phenomenon. Mazzoni, an American professor of Romance languages, says that 19th century physicians, such as Charcot and Bourneville, made the diagnosis of hysteria when confronted with women's experiences of ecstasy and their manifestations of the stigmata. Hysteria was considered to be primarily a disorder of females (Mazzoni 1996:27). The physical disciplines used to achieve the mystical experience were associated with psychopathological masochism (Mazzoni 1996:209). Female religiosity could be perceived as hysterical and pathological by male physicians. Indeed, historically, mysticism and madness were seen as “dangerously similar” (Mazzoni 1996:10).

However, in medieval times, mystical and ecstasy experience may have provided the only platform for deeply religious women to express their spiritual experiences outside the confines of the home and family. Women generally not only had less access to religious and philosophical education, but also were prohibited by the church from hermeneutical exegesis (Hollywood 2002:9). Historically, the effect of pathologising mystical experience was to marginalise the religious experiences of women (Mazzoni 1996:33).

In contrast, Cox (1995) believes that the Pentecostal movement worldwide may provide new leadership opportunities for women. Cox describes the Pentecostal movement as supporting mystical experiences such as “visions, dreams and voices” and as providing a safe forum for church members to share such experiences. The Pentecostal movement provides an opportunity for “women preachers” to tell their story (Cox 1995:133). Cox identifies Kathryn Kuhlmann and Aimee Semple McPherson as women who assumed leadership in the Pentecostal movement, even though both had to establish their own ministries (Cox 1995:121, 137-138).

Others also have related mysticism to politics, leadership and power. Greeley identifies belief in Millennialism as “the most frequent form that political mysticism takes in the Christian tradition” (Greeley 1974:99) and notes that “Marx’s view of the classless society comes close to being a mystical vision, if it isn’t quite one” (Greeley 1974:100).

Dow (1978) analyses Weber’s work on charisma, finding Weber’s understanding of *ecstasy* (a concept analogous to mysticism) to be, quoting Weber, “a distinctive, subjective condition ... which represents charisma”, a key factor in authority and leadership (Dow 1978:84). Hollenback (1996:241), too, discusses empowerment as an important aspect of the phenomenon of mysticism across cultures and among various religious traditions. In the *Christian Science Monitor*, Cocks (2004 <http://www.csmonitor.com/2004/0227/p06s02-woaf.htm> accessed 7/4/2006) suggests an association between mystical religious beliefs and violence in a news commentary on political instability in Uganda.

2.4.5 Summary

Many modes of inquiry – biological, pathological, psychological, social and political – have been pursued in the attempt to explain mystical experience. No discipline has provided a definitive answer. It is important to recognise that even as mystical experience is explained as resulting from various factors, the reality of such phenomena to the experiencer remains unchanged. It is the character of mystical experience to remain intense and true to the one having the experience, regardless of the way it is initiated, or the way in which it is explained by others.

2.5 MYSTICAL EXPERIENCE IN LITERATURE

Fiction contains accounts of mystical experience that are instructive and represent considerable variety in the possibilities of experience. Poetry also addresses mystical themes.

2.5.1 Prose

In the novel *Lourdes*, French author Emile Zola (1897) discusses the prayerful ecstasy of a young girl, Marie, who travels to Lourdes to be healed of paralysis. Marie is described as like a vision of light and joy, “lovely in her ecstasy” to a dying woman who sees her (Zola 1987:112, vol 2). The repetition of prayers by Marie and the many pilgrims is intense and moving to the narrator, who observes Marie to be in ecstasy. Nonetheless, he is not convinced that any physical healing has occurred. He concedes, however, that Marie’s psychological healing of paralysis, hysterical in origin, is genuine. Zola expresses familiarity with Lourdes and the claims made for the miracles there. His novel may be an attempt to reconcile the events he observed there with his rational beliefs.

Mystical experience occurs in a novelette, *Worleys* (1936), by Baltimore, Maryland, poet laureate, Lizette Woodward Reese. The story concerns Adelaide, a little girl experiencing the end of the Civil War (1865) in the United States. Her father has just died of battle wounds, and her mother is broken with grief. The family has lost almost everything. At dusk the stars come out, and Mam Rachel (her loving mammy), sings a hymn. Adelaide lays a hand on her cat, Thomas Didymus, and “(a) vast and simple joy

possessed her" (Reese 1936:55). This abrupt end to the narrative leaves no doubt that bliss can arise from despair.

A popular American novel of the 1960s, *Heaven knows, Mr Allison* (Shaw 1963) asserts the reality and validity of mystical experience. The story involves two people stranded on a deserted island during World War II, attempting to survive against the elements and intermittent hostile Japanese forces. One character is a nun who exemplifies a meditative approach to coping, sometimes weakening, but never giving up her faith and her confidence that they are under the care of angels. At the end of the story, the nun hears an inexplicable voice guiding her to the far side of the island, leading to their rescue by American forces.

The second character is an American Marine, preoccupied with survival and lust for the nun. However, when the nun falls ill, the Marine cares for her gently and respectfully. Rendering this compassionate care changes him as a man, and eventually he comes to share in the nun's faith and vision. The process of giving care is transformative, and Shaw portrays the characters' mystical experience not only as giving meaning to struggle, but also as genuinely lifesaving.

Contemporary English author, Susan Howatch, writes a series of novels about Anglican clerics. One of the themes in her novels concerns using mystical talents in a responsible manner, especially in the ministry of healing. This is clearly defined in the novel, *Glamorous Powers* (Howatch 1988). Jonathon Darrow, a priest, is challenged to use his psychic and charismatic mystical abilities in a way that promotes his ministry, yet does not result in self-aggrandisement.

In a subsequent novel, *The Heartbreaker*, Howatch (2003) describes the struggles of Gavin, a prostitute, who is attempting to break away from a destructive and abusive lifestyle. Through a variety of circumstances, he comes into contact with the healing centre established by the son of the mystical priest, Jonathon Darrow. At one point, Gavin is assaulted and ends up in hospital. As he is put into an ambulance and begins to receive emergency care, he experiences the sensation of going down a long corridor or tunnel, into brilliant light. He has a series of revelations about his relationship with his girlfriend Suzanne and with God. Gavin narrates:

As I think of Suzanne and me, somehow being able to care for each other despite the soul-destroying abuse we've endured, I see the giant forces of joy, truth, beauty and love merge in a huge blaze of colour which blots out the dark, yet draws all the blackness back into itself so that everything is finally subsumed in that triumphant blaze and redeemed (Howatch 2003:379).

Although Howatch writes a great deal of popular fiction, her novels reflect thoughtful consideration of the nature of mysticism, its potential for misuse, and its relationship with healing.

Another recent novel, *The Monk Downstairs* (Farrington 2002), describes the relationship between Rebecca, a single mother, and Mike, a former monk who has just left the monastery because of doubts about his vocation. In a series of letters to a monk who is still in the monastery, Mike shares his thoughts about the contemplative life. Although he has had a mystical experience and had a well-developed devotional life in the monastery, he does not feel satisfied spiritually. As the novel progresses, Mike becomes involved in the life of his landlady, Rebecca, babysitting her daughter and supporting Rebecca through the crisis of her mother's catastrophic stroke and hospitalisation. In the final letter in the book, Mike discusses the *Spiritual Canticle* of St John of the Cross. He says that he finally understands the meaning of going "into the thicket" (Farrington 2002:261). To him, this means that spirituality and love are fully realised as practical challenges are suffered and embraced. Rebecca has a similar revelation, as she, only nominally religious, comes to feel deep peace and spiritual freedom sitting at the bedside of her dying mother. Although the author does not use the phrase, both characters seem to be experiencing the mysticism of everyday life. As in several of the other novels, caring is intrinsic to mystical experience.

In significant contrast to the above is the book, *Dreams of the N'dorobo*, by American author Gabelhouse (2003). It is an action novel set in Kenya. The protagonist, Gabe, seeks to master "dream walking", a form of self-psychokinesis. After study with an N'dorobo shaman, and the use of a local entheogen, Gabe is able to use his psychokinetic abilities to save the life of a visiting American vice president. The story alludes to the mystical potentialities of dream walking, but places considerable

emphasis on the political tactical advantages of being invisible and being able to transport oneself mystically, both for the purpose of saving life, and for murder.

Two other recent novels are worthy of mention, as they reflect popular interest in Sufism. Both are by American authors. *The American mystic* (Gurian 2000) describes the journey of Ben Brickman, an American student seeking enlightenment. He travels to Turkey in the fulfillment of his quest, finally becoming recognised as “The Magician” and as a long awaited messenger. Much of the tale reflects the Sufi tradition, but the author refers to a kaleidoscopic array of mystical traditions. Fundamental to the theme is the necessity for a disciplined life and the relevance of entheogen use for achieving mystical experience.

Chasing Rumi (Housden 2002) is short novel that intertwines Sufism and the Orthodox tradition. The protagonist is a Greek icon painter living in Florence, Italy. He has a mystical experience viewing Fra Angelico's paintings and eventually embarks on his own mystical quest. He finally becomes involved with dervishes of the Mevlevi order and embraces an understanding of love based on the Sufi writings of Rumi.

2.5.2 Poetry

Mystical themes are not uncommon in poetry. Gregory and Zaturenska (1957) note that “the vision of human contact with divine sources, though brief, is often within the province of poetic experience” (Gregory & Zaturenska 1957:xxiv-xxv). One contemporary poem is cited here to highlight mysticism as a function of caring and everyday experience. (American Civil War nurse Walt Whitman has also written poetry that has mystical overtones. His work is discussed in section 2.7.2.4, *The nurse as mystic*.)

Sr Maura, a Notre Dame Sister in Baltimore, Maryland, has published a short poem called “Footnote for a book of mystics” (1958). First, she notes the prevalence of the term *mystic* in literature, and then she adds a quiet but assertive stanza:

*One more thing – let this relevant detail
Be added to the mystics’ book:
The lay sister doling food to dissipated men
And finding Christ in every look* (Maura 1958:39).

The emphasis on face and service stresses the potential for everyday experience to engender mystical experience.

2.6 MYSTICAL EXPERIENCE IN NARRATIVE FORM

Numerous personal accounts of mysticism exist, expressed as narrative and sometimes poetry. Historical and contemporary accounts may be used to give depth to the understanding of mysticism and also to identify some of the varied circumstances in health and illness that may lead to mystical experience.

2.6.1 Historical and religious narratives

Historical accounts form the basis for many modern analyses of mysticism. For example, Theresa of Avila's *Interior castle* (1961) and the writings of St John of the Cross (1959) are cited by almost every contemporary writer on the subject of mysticism. Even though St John's and St Theresa's writings are based on their subjective experiences, they both have much to say about the practice of spiritual disciplines that lead to mystical experience, the qualities of genuine mystical experience, and the problems encountered along the way.

Members of modern religious orders also write powerful accounts of mysticism. *Canticle of love*, the autobiography of a Canadian nun in the Order of Jesus and Mary, tells the story of a talented and spiritual woman who increasingly drew nearer to Christ before she died of a painful illness (Belanger 1938). French Jesuit, de Chardin (1961; 1962), is an anthropologist and theologian whose work is permeated with mystical observations.

Mystical narratives are not limited to members of the major Christian denominations. American professor and author Dennis Covington, writes a book about Christian snake-handling cults in Southern Appalachia (1995). Members of snake-handling churches handle serpents and drink poison (strychnine) to demonstrate their faith in God. As Covington becomes familiar with the churches and their members, he experiences a broadening of his own spiritual perspective. The time finally comes when he feels called to handle a poisonous rattlesnake himself. Here is his description:

I turned to face the congregation and lifted the rattlesnake up toward the light ... I felt no fear. The snake seemed to be an extension of myself. And suddenly there seemed to be nothing in the room but me and the snake ... [A]ll faded to white. And I could not hear the earsplitting music. The air was silent and still and filled with that strong even light. I was losing myself by degrees ... The snake would be the last to go, and all I could see was the way its scales shimmered one last time in the light, and the way its head moved from side to side, searching for a way out. I knew then why the handlers took up serpents. There is power in the act of disappearing; there is victory in the loss of self (Covington 1995:169-170).

The contemporary Pentecostal Movement worldwide supports certain types of mystical phenomena. Members of the Pentecostal Movement participate in a religious culture that affirms glossolalia, visions, and dreams as valid spiritual experiences (Cox 1995:133).

2.6.2 Experiential narratives associated with life events

Contemporary narrative prose and poetry accounts of mysticism reflect experiences across the lifespan, as corollaries of ordinary experience and in association with journeys, illness, and death.

2.6.2.1 Mystical experience in youth

International journalist Gladys Baker (1951) describes an early experience which caused her to embark in a lifelong search for religious meaning. In her American childhood, one night, at bedtime, “a Figure appeared at the foot of my bed. He was clad in a pure white robe and surrounded by a radiant golden aura. He stood silently looking down at me, dark eyes filled with infinite tenderness and compassionate love. I can still recall that timeless instant of ineffable bliss”. Her parents dismiss the incident as a “vision ... which doesn’t happen to nice little girls” (Baker 1951:7). Baker has another transcendent experience at her father’s death. Standing at her father’s coffin, she has a sensation “as though I were suddenly lifted in angel’s hands and transported into a

completely deathless dimension". This is followed by a sense of illumination and inner happiness (Baker 1951:17).

The *Journal of Humanistic Psychology* published a poem describing another childhood mystical experience (Farmer 1997). It describes an eleven-year-old boy's experience in a barnyard. As Farmer watched the sun shine on rusty metal, he suddenly had an experience of enhanced awareness. He "saw that all around me was fluid harmonious movement, and everything that everything consisted of was one liquid pool of motion" (Farmer 1997:38). He does not tell anyone about his experience until he is an adult.

American psychologist Hoffman has collected more than 250 international accounts of spiritual experiences occurring in childhood and has sorted them into categories, such as "peak moments during intense or personalized prayer" and "spontaneous moments of bliss and ecstasy"(Hoffman 1992b:19, 20). He affirms the potential for "tremendous peak – even mystical – experiences during our early years" (Hoffman 1992b:175).

2.6.2.2 *Mysticism in everyday experience*

Gertrud Nelson (1986) is an American religious writer who describes mysticism in down-to-earth terms. She says, "Sometimes the sacred moments in our lives are deceptively simple" (Nelson 1986:16). She tells a story to support this. One day her teenage daughter bought a fat yam and showed it to her. It was not needed for their meal, but was so "lovely". Nelson comments, "The ordinary, not having been noticed by someone else, becomes wonderful ... the religious experience is the attaching connection that we make between the homely and the fantastic, both metaphorically and personally" (Nelson 1986:19). Here again, mysticism is an aspect of everyday experience.

Sarpong, a Catholic bishop in Ghana, discusses "everyday spirituality" in relation to his growing up experiences as a member of an extended family. Sarpong notes that for Africans, spirituality is integrated with all aspects of life (Sarpong 1986:4). So it is for him. He is deeply influenced by the examples of his elders' relationship to God, and their acceptance of God's will. He states, "Could I have been formed by better mystics?" (Sarpong 1986:11).

Carse, an American professor of history and religion, writes a personal, yet scholarly description of mystical awarenesses he has had in the course of his own “ordinary” experiences. He presents a wide variety of experiences, from teaching in the classroom, to sailing, to human interactions, that cause him to conclude that, “[t]here is mysticism in ordinary vision” (Carse 1994:63). In discussing the accessibility of mystical experience he says, “The heavens cannot open for the soul; they are already open ... through the whole course of our ordinary life, veils are dropping away” (Carse 1994:82-83). Carse notes, however, that mystical perception requires a shift from one’s normal ego focus (Carse 1994:83).

The potential for ordinary or everyday experience to be associated with mystical experience has particular implications for the current research. Episodes of illness and even surgery are often described as routine or ordinary. The act of giving care may also be considered ordinary for the nurse. *Yet, these experiences may have an element of mysticism.*

2.6.2.3 Mystical experience as journey

Several accounts of mystical experience present it as a journey, a real journey that leads to mystical understanding and a personal journey inward.

The anonymous author of *The Way of a Pilgrim* (1991) describes a 19th century Russian Pilgrim’s travels in search of authentic prayer. He finds it in the Hesychast tradition by continually repeating the Jesus prayer. Swander (2003) describes her travels through the deserts of New Mexico in search of mystical answers, after experiencing a disabling accident. *Tracks* (Davidson 1980), describing a woman’s trek across the Australian desert by camel, and *Richer by Asia* (Taylor 1964), describing the experiences of an American officer stationed in India and Ceylon during World War II, both recount journeys that incorporate mystical experience as unsought, but integral aspects of the authors’ travels.

2.6.2.4 Mystical experience associated with health stressors and death

Other accounts of mystical experience specifically reflect experiences with health stressors. Duff (1993), for example, has chronic fatigue syndrome and describes the spiritual aspects of dealing with her illness.

Another mystical experience is recounted by an eighty-nine-year-old resident of the Presbyterian Home in Towson, Maryland. In a collection of residents' writings, Fleagle contributes a selection called "Blessed Assurance", describing an experience that occurred when she was very ill as an infirmity patient in the nursing home. She describes an experience in which she felt herself to be looking down on her own body in the bed. There was light all around. She felt the presence of Jesus and perceived a comforting voice without sound. She is left with the enduring impression that "He is here" (Fleagle 1981:80-81).

Lee (2005), a Canadian patient with schizophrenia, discusses his experiences in dealing with visual and auditory hallucinations. Assisted by medication and cognitive behavioral therapy, he is able to deal with the more troubling of his symptoms. He notes that he experiences "connectedness with God" and extrasensory perception as an adjunct to his illness (Lee 2005:76). He says, "[A]lthough I live with schizophrenia I am also gifted with the richness that comes with the inner spiritual and mystical experiences and with the excitement and challenges that accompany all of life's activities" (Lee 2005:76).

A troubling account of mysticism based on an illness experience is that of Richman (2000), a British sociologist, who writes a description of his experience in an intensive care unit following surgery for a ruptured gallbladder, with subsequent complications. Richman was comatose for seven weeks, but recalls altered sensory perception and terrifying dreams, as well as paranoid and psychotic thinking. He later identifies his experiences as *Intensive Care Syndrome*. He works through these experiences by considering his dreams as shamanic forms of ecstasy and a search for self. He says he talked to the nursing staff about his dreams and their effects on him, but "neither the medical nor the nursing staff referred to it by name" (Richman 2000:95). Richmond was referred to a psychiatrist, "whose only concern was whether I was hearing voices"

(Richman 2000:96). After the experience, he develops a new sense of spirituality and says that nurses should address spirituality more explicitly (Richman 2000:84).

Also troubling as a narrative of mystical or quasi-mystical experience is *Silent soul: the miracles and mysteries of Audrey Santo* (Felix 2001). Audrey Santo is a young American woman who almost drowned when she was three years old. Although she survived, she retains little but brain stem function and requires assisted ventilation and total nursing care (Felix 2001:20-21). This young woman has become an object of cult attention. Cures are attributed to her, as well as unusual religious phenomena (Felix 2001:16-17). Religious objects in her home are found to be covered in mysterious oil (Felix 2001:114-115), and she is reported to exhibit the stigmata (Felix 2001:61) – bleeding on the hands and other parts of the body mirroring the wounds of Christ.

Felix raises the question of whether an unconscious person can be said to “make a decision to be a ‘victim soul’, a person who willingly takes on the suffering of others to help in the redemption of humanity” (Felix 2001:4). Forman (1990, 1998), Deikman (2000) and others discuss mystical experience as aspects of consciousness. The case of Audrey Santo, if she be considered a mystic, as Felix (2001) suggests throughout her book, challenges the relevance of consciousness.

Felix does not address the possibility that Audrey Santos may be the object of exploitation, although she notes that Roman Catholic clerics are uncomfortable with her semi-public display from her home (Felix 2001:60,126). (At one time, a window was cut in the wall of her residence so pilgrims could view her (Felix 2001:126). Nor does Felix address the possibility that the stigmata have been purposely inflicted by caregivers, although her report of “fresh wounds in her hands, feet, side and head ... purple streaks that zigzagged across her brow ... slashlike bruises all over her body (and) ... welts on top of her hands” (Felix 2001:77-78) could be considered consistent with abuse.

Numerous authors describe mystical experiences associated with the death of a loved one, such as that described by Baker (1951) above. Others, including Eadie (1992), describe their own near death experiences in mystical terms. Eadie is an American who writes a popular account of a near death experience associated with childbirth. Her detailed and joyful account includes angels, telepathy, tunnel phenomena, an out of body experience, and acquisition of knowledge of life after death (Eadie 1992:25-61).

Although Eadie states that she has experience as a licensed practical nurse (LPN) (Eadie 1994:29), her nursing perspective comprises only a limited aspect of the narrative. It cannot be said to contribute to the nursing literature, although it suggests that nurses are no different from others in their ability to have mystical experiences when they are ill.

These personal accounts reflect mystical experiences across the lifespan. The context for some is religious; for others it is secular. The experiences occur in varied circumstances, in health, illness, and near death.

2.6.2.5 Summary

The scholarly and narrative literature on mysticism gives ample evidence that it is an important spiritual concern and a pervasive aspect of the human condition. The meaning of the mystical experience is addressed by scholars, authors, and ordinary people. It exists not only as a religious phenomenon, but is present in all aspects of life, induced by spiritual discipline or spontaneously elicited by natural happenings and the stresses of life.

2.7 NURSING THEORY AND APPROACHES TO MYSTICAL EXPERIENCE

Nursing theories are here reviewed to consider whether they address spirituality, and their potential to support nursing research into mystical experience. The discussion of mystical experience in nursing research and other nursing literature is also considered.

2.7.1 Nursing theorists

Theorists such as Johnson, Henderson, Orem and King explicate the nature of person, health, environment, and nursing as key concepts, with less emphasis on spirituality. In Johnson's *System Theory*, the focus is on behavioral systems and balance (Holaday in Parker 2001:87); Henderson focuses on the unique function of the nurse (Gordon in Parker 2001:145); Orem focuses on self-care as a fundamental concept (Orem in Parker 2001:173); and King's emphasis is on goal attainment (King in Parker 2001:279).

Levine's *Conservation Model* does address spirituality as one of the cultural patterns characterising the environment. The goal of the *Conservation Model* is to "promote adaptation and to preserve wholeness". In addition, the role of the nurse is intended to recognise the self-awareness of the individual (Schaefer in Parker 2001:108-109). Mystical experience is not addressed, but is not inconsistent with Levine's model.

Rogers and Parse have developed theories more adaptable to discussion of spirituality and mysticism. Rogers places "unitary human being and environment" as the focus of nursing, and makes reference to the paranormal (Malinski in Parker 2001:195,198). Rogers does not discuss the concept of spirituality as such (Smith 1994:35), but Smith (1994:36-38) and Malinski (1994:12-18) find her principles of homeodynamics, resonancy, helicy, and integrality consistent with a theory of spirituality and transcendence. Further, based on Roger's principle of integrality, Malinski (1991:56-57) discusses spirituality and mysticism as identical concepts. Paranormal phenomena and altered aspects of consciousness are considered normal aspects of diverse field patterns (Malinski 2001:198).

Parse (in Parker 2001:229) addresses spirituality directly in her *Theory of Unitary Man*. Her nursing theory, which relies on both Rogers' theory and existential phenomenology, describes the term *human* as comprising "body-mind-spirit", and *health* as "a state of biological, psychological, social, and spiritual well being". Transcendence, a process underlying the process of human becoming, "is the process of reaching beyond self to the not-yet" (Parse in Parse, Coyne, & Smith 1985:12). This description of transcendence may be construed to be consistent with the possibility of mystical experience.

Newman's *Theory of Health as Expanding Consciousness* is also consistent with an understanding of mysticism. Newman conceptualises humans as energy fields, inseparable from the larger energy field that includes person, family, and community (Pharris in Parker 2001:266). According to Newman, "[t]he responsibility of the nurse is not to make people well, or to prevent their getting sick, but to assist people to recognise the power that is within them to move to higher levels of consciousness" (Newman 1978, quoted in Parker 2001:266). Newman's focus on consciousness has made the theory useful for nurse authors researching such themes as human awareness (O'Neill & Kenney 1998) and transformation (Neill 2002). Newman's theory

supports the need for nurses to gain a deeper understanding of the possibilities of human consciousness.

Theorists Boykin and Schoenhofer (in Parker 2001:393) have developed the theory of *Nursing as Caring*. They state, "Caring is an altruistic, active expression of love, and is the intentional and embodied recognition of value and connectedness." Although Boykin and Schoenhofer do not address the association, *connectedness* is a theme found repeatedly in mystical writing.

The *Humanistic Nursing Theory* of Paterson and Zderad offers another structure supporting the understanding of mystical experience. Their theory of nursing describes "peak experiences related to health and suffering in which the participants in the nursing situation are and become in accordance with their human potential" (Paterson & Zderad 1976:7 quoted by Kleiman in Parker 2001:154). Existentialism and phenomenology are incorporated into this theory, which examines the "call and response" interaction between the patient and the nurse (Kleiman in Parker 2001:154). The potential for mystical experience is not explicitly addressed, but it is implicit in this theory by the reference to *peak experiences*, a term used by Maslow (1964) as very similar to mystical experience.

Watson's *Theory of Human Science and Human Care* is uniquely suited to the exploration of mysticism in nursing, a process that requires a conceptual framework that specifically addresses and validates spirituality of the patient and the nurse. Jean Watson states, "My conception of life and personhood is tied to notions that one's soul possesses a body that is not confined by objective space and time" (1999a:45). Her affirmation of transcendence and self-actualisation supports research into mysticism in nursing.

Watson believes in an evolving human consciousness in which persons become "integral" with the universe rather than attempting to control it. This consciousness is transcendent, yet inward also, as persons become aware of archetypes that reflect real meaning. These archetypes represent a delicate play between Yin and Yang. Yang is reflected in the masculine medical model, whereas Yin is exemplified by the nurturing, feminine nursing model, which has as a fundamental component, human caring. Caring is intimately related to transcendent consciousness (Watson 1999b:51-152).

The caring relationship is described as a contact between nurse and patient, having “the potential to transcend time and space and the physical, concrete world as we generally view it in the nurse-patient relationship” (Watson 1999a:47).

Watson (1999a:51) identifies seven premises of her theory in *Nursing: human science and human care*. These premises assert the potential of the nurse to act as an agent in promoting spiritual growth. They also affirm the existence of the spirit or soul and the universality of love and caring. The last premise describes the phenomenological field as including “the individual’s frame of reference [*comprised of*] subjective internal relations and the meanings of objects, subjects, past, present, and future as perceived and experienced” (Watson 1999a:51). Mystical experience is therefore an aspect of the nurse’s and the patient’s phenomenological field and worthy of concern.

The shared interaction between patient and nurse is seen as creating a phenomenal field and a “spiritual union”. It is in this relational context that caring is seen as an art, where feeling becomes transformed through nursing intervention, and the patient is supported in “self-healing and discovery of inner power and control” (Watson 1999a:66-68).

Watson’s emphasis on relationship supports the need for research to examine not only the mystical experience from the patient’s perspective, but also the nurse’s interaction and response. Watson’s caring theory provides a context for developing nursing research about mystical experience.

2.7.2 Nursing literature

Among the health care disciplines, psychology has begun to discuss mystical experience and to address research into mysticism, but nursing, for the most part, addresses mysticism only obliquely. When addressing spirituality and related concepts, the nursing literature sometimes refers to phenomena and concepts that other authors have explicitly associated with mystical experience. Literature discussing the nursing role in supporting patient spirituality mentions the possibility of mystical phenomena, especially at the end of life. However, nursing literature addressing the mystical experience of patients, using the terminology of non-nursing literature is limited.

Some nurses describe mystical phenomena without identifying them this way. For example, Burkhart and Nagai-Jacobson (2002), in *Spirituality: living our connectedness*, describe the transformative experience of an alcoholic woman. While a patient in a rehabilitation center, the woman experiences altered consciousness concurrent with vivid visual phenomena. This results in an enduring and positive change in her spiritual perspective. The experience has mystical features, but they are not identified as such (Burkhart & Nagai-Jacobson 2002:156). Most often, nurses discuss mystical experience in association with other concepts.

2.7.2.1 Nursing literature discussing spiritual concepts related to mysticism

Several nurses mention mysticism in the context of other concepts. Roberts and Whall (1996:360) describe *serenity* as a concept occurring in developmental levels that can culminate in a mystical or ecstasy experience. They believe that serenity may result from meditative practices or end of life experiences.

Self-transcendence, a concept with some similarities to mysticism, is examined by Haase, Britt, Coward, Leidy, and Penn (1992), Ellerman and Reed (2001), Emblen and Pesut (2001) in British Columbia, and Coward (2003).

Haase et al (1992) analyse the relationship between the concepts spiritual perspective, hope, acceptance, and self-transcendence. Connectedness is seen as a theme within these concepts, and self-transcendence is seen as an achievable goal related to the other concepts (Haase et al 1992:146).

Ellerman and Reed (2001) state that self-transcendence is associated with an individual's ability to achieve a broadened perspective, a perspective that represents the crossing of self-boundaries, including transpersonal boundaries (Ellerman & Reed 2001:699). Self-transcendence is found to be inversely correlated with depression in middle-aged adults, especially men. It is seen as a developmental concept relevant to middle-aged adults and adults at the end of life (Ellerman & Reed 2001:711).

Emblen and Pesut (2001) find that patients can derive transcendent meaning from the experience of suffering. These authors believe that this can be facilitated by nursing assessment and interventions, and they develop a model for doing so. In this model, the

provision of comfort is seen as the most important nursing intervention in the category of experience and emotion. The authors also acknowledge the importance of aesthetic therapies and humor (Emblen & Pesut 2001:50).

Helin and Lindström (2003) also identify an association between suffering and personal transformation. They see the caring relationship as embodying a mystical dimension for both the patient and the nurse (Helin & Lindström 2003:425).

Coward (2003) finds that self-transcendence in breast cancer patients is facilitated by a support group and that patients report increased emotional well being. However, the positive results are not sustained subsequent to participation in the group (Coward 2003:297).

Nurses discussing self-transcendence are using a concept related to, but not identical with mystical experience. Self-transcendence implies challenging and overcoming personal boundaries and growing spiritually, but mystical experience, as defined in this study, additionally includes the experience of transcendent phenomena unmediated by normal cognitive or sensory perceptual channels.

2.7.2.2 Nursing literature addressing mystery and mystical phenomena

Cavendish, Luise, Horne, Bauer, Medefindt, Gallo, Calvino and Kutza (2000:155) discuss ways nurses can enhance the spirituality of well adults. They identify “connectedness” and “understanding the mystery” as salient themes. The role of the nurse in promoting spiritual development at important life events is addressed (Cavendish et al 2000:160).

Engelbreton (1996:100-108), in discussing nursing diagnosis in the spiritual domain, refers to the possibility that altered states of consciousness could be misinterpreted by the nurse as psychoses. She believes that nurses might ignore or deny “spiritual emergencies”, a category in which she includes altered states of consciousness, paranormal experiences, and near death experiences (NDE).

More often, however, the nursing literature on NDE fails to develop fully the association between NDE and spirituality or mysticism. Simpson (2001) performs a concept

analysis of NDE focusing on attributes (being dead, tunnel experiences, and return to life), antecedents, and consequences (Simpson 2001:522-523). Tutka presents a picture essay that is designed to “open the door to meaningful conversation” (Tutka 2001:65). Wimbush and Hardie discuss the support of the patient with a NDE, which is described as “a profoundly personal experience” (Wimbush & Hardie 2001:49).

James (2004) is an exception in relating NDE to spirituality. She notes that the NDE may involve “euphoria ... out of body experience – a separation of body and spirit ... tunnel experience ... an unearthly world of light .. .[and] the decision-making period – being involved in the decision to stay or return ...” (James 2004:30). She also notes that nurses and physicians are the ones most likely to be told about the NDE and relates this to the possibility of “promot[ing] a path of physical and spiritual health and well-being” (James 2004:33). James does not, however, characterise NDE as a mystical phenomenon.

Baumann and Englert (2003) analyse three views of spirituality in the literature of oncology nursing. One of these views they call “theologically inspired spirituality” (Baumann & Englert 2003:53). They describe mysticism as a dimension of this approach, using the term very much as Underhill and Stace do. They also refer to the Eastern mystical tradition. Baumann, a nurse, argues eloquently that the nurse must be a good listener. He wrote the article with his colleague Robert Englert, a religious teacher and therapist who later died of multiple myeloma.

Several other authors address mystical phenomena and spiritual needs in the context of end of life care. Hall (1997), writing about the nursing care of patients with terminal illness, notes that patients sometimes have “dramatic” spiritual experiences, including out of body and psychic phenomena. The experiences are not easy to talk about, but have great meaning for patients (Hall 1997:93-94). Forbes and Rosdahl (2003) also note that patients who are dying may have visions of bright lights, spiritual beings, and loved ones. They note the need for the nurse to support the patient and the family when these phenomena occur (Forbes & Rosdahl 2003:218). But a qualitative study in Scotland finds that when examining the spiritual needs of patients dying of lung cancer or heart failure, nurses give less spiritual support than patients themselves would like, and that nurses may even cause spiritual distress in their interpersonal dealings with patients (Murray, Kendall, Boyd, Worth & Benton 2004:44).

The nursing literature cited supports the belief that patients have spiritual experiences and spiritual needs. Phenomena such as visions and bright lights are sometimes mentioned, especially at the end of life, but are not necessarily linked to mysticism. Some authors discuss serenity, self-transcendence, and connectedness – concepts that may be associated with mystical experience. Rarely is mystical experience *per se* addressed by nurses writing about patients' spiritual experience. The most clearly identified aspects of the nursing role are for the nurse to provide comfort and support and to be a good listener.

2.7.2.3 *The nurse as mystic – historical and contemporary nursing literature*

Mystical phenomena experienced *by* some nurses in history can be inferred from the context and content of their writings, as well as, in some cases, the interpretations made by their biographers and others.

Dolan et al (1983) identify several famous monastic nurses: St Brigid of Ireland in the Fifth Century, St Radegonde of Germany in the Sixth Century and St Hilda of England in the Seventh Century. As monastics, it is possible that each may have had a well-developed spiritual discipline, perhaps including mystical experiences.

Hildegard of Bingen is described as a mystic, physician and healer in 12th century Germany. Maddocks (2001) speculates that as a young woman, Hildegard would have been trained in the infirmary in Disibodenberg, treating and caring for patients with a variety of diagnoses (Maddocks 2001:154). Hildegard had a series of mystical visions that are recorded as vivid pictures, incorporating falling stars and religious imagery (Maddocks 2001:55-62). (British neurologist Sacks says that the character of these visions is “indisputably migrainous”, although he affirms their value and significance [Sacks 1985:160-161]).

Another mystic of the 15th century, St Catherine of Genoa, is not known primarily as a nurse, but is recorded to have served as matron, or administrator, of a large hospital for six years (Leuba 1972:68-69).

The powerful mystic, St John of the Cross, served in his youth as a “nurse and alms-collector” in the hospital in Medina, Spain, in the 16th century. He is said to have had “a gift for compassion toward the sick” (Kavanaugh & Rodriguez 1991:10).

Nightingale’s writings about spirituality reflect the themes expressed by the great mystics, despite sometimes unconventional interpretations. She says, “God communicates with us by his nature actually becoming ours” (Calabria & Macrae 1994:118). Nightingale had an “awakening” at age 16 that profoundly influenced her life (Dossey 2000:33). Dossey traces Nightingale’s mystical development through five mystical phases as identified by Underhill: *Awakening*; *Purgation* (in young adulthood, as Nightingale defined her commitment to the care of the sick and separated herself from her personal inclinations); *Illumination* (as Nightingale grew in her professional career and carried out her great work at Scutari); *Surrender* (as she subsequently experienced trials of ill health and personal loss); and *Union* (as her writings at the end of life reflect peace and unity with God) (Dossey 2000:425).

Walt Whitman, an American poet, is recognised by Bucke (1969) as “the best, most perfect, example the world has so far had of the Cosmic Sense” (Bucke 1969:225). In 1862, Whitman traveled as a volunteer nurse to the American Civil War front in Virginia to care for his wounded brother. He stayed there until the war ended in 1865 (Morris 2000:47, 215). In 1865, Whitman published a series of poems called *Drum-Taps* about his experiences with wounded soldiers. Two of these poems have a spiritual quality suggesting mystical experience. One poem, *A sight in camp in the daybreak gray and dim*, describes an early morning walk through camp. The first stretcher Whitman sees holds a gaunt elderly man, the second a young man with “blooming” cheeks, but the third is a man with a serene countenance:

... a face nor child, nor old, very calm, as
of beautiful yellow-white ivory;
Young man I think I know you -
I think this is the face of Christ himself,
Dead and divine and brother of all, and here again he lies
(Whitman 1921:347-8).

In the poem, *The wound dresser*, Whitman recounts his duties caring for the wounded. This poem is dreamlike, yet intense, as Whitman tells of witnessing appalling wounds, changing dressings, and caring for the dying. As the poem ends, he says:

*I am faithful, I do not give out,
the fractur'd thigh, the knee, the wound in the abdomen,
These and more I dress with impassive hand, (yet deep in
my breast a fire, a burning flame)* (Whitman 1921:352).

The mystical experience of the contemporary nurse is addressed to a limited degree in the literature about nursing spirituality. The nursing literature varies from the perspective of understanding and even embracing shamanism to a Christian perspective of nursing as a mystical experience.

Krieger (1981), an American nurse, addresses the influence of shamanism in the history of holistic healing. She notes that shamanism is a natural development of women's healing and caring experience in prehistoric times (Krieger 1981:17-18). She describes the activities of shamans in native cultures as incorporating altered states of consciousness, including trance and ecstasy, and personal ascetic practices. Krieger notes that the shaman is uniquely qualified to deal with conditions arising from "soul loss" and that the shaman communicates directly with spirits during altered states of consciousness (Krieger 1981:23-24). Krieger places the practice of the shaman as healer in the context of holistic healing, but does not explain how this translates into contemporary nursing practice.

Engebretson (1996) and Fontaine (2000) validate the importance of the nurse understanding shamanistic practices in the context of the patient's culture and experience. Fontaine suggests sharing with clients that "shamanism offers a chance for contemplation" (Fontaine 2000:341). Engebretson asserts the value of "different[iating] ... religious ecstasy and shamanic journeying as different from psychotic hallucination" (Engebretson 1996:107). However, neither Engebretson nor Fontaine suggest that the nurse might adopt shamanic methods to deliver nursing care

In contrast, Forrest (2000) a nurse practicing in America, offers a different approach to shamanism in nursing as she details her personal growth in gerontological nursing.

While she was pursuing doctoral education, Forrest learned shamanic practices from Native American co-workers (Forrest 2000:34-38). Through this experience, Forrest finds that she is able to identify a new level of spirituality in Alzheimer's patients, which adds depth and meaning to her nursing care (Forrest 2006:194-197).

Nurse theorist Jean Watson relates a personal mystical experience. She had sustained a severe injury to her eye, necessitating protracted treatment. During her convalescence, her husband cared for her, and she was able to experience being the recipient of tender care. Tragically, after this, her husband killed himself. She is quoted in *Living our connectedness* (Burkhardt & Nagai-Jacobson 2002:181-184) as having had, during this stressful time, "mystical experiences where I had Biblical dreams".

Watson discusses the experience in detail in her recent publication, *Caring science as sacred science* (2005). She states that during the experience of receiving care, "I had this powerful cosmic moment when I felt that I had *Become love!* It was not a feeling of *being* loved, or being *in* love, I felt I WAS LOVE, and it was as if I realised that was what I had come here to remember" (Italics and capitalisation original) (Watson 2005:72-73).

Another personal perspective on mysticism is offered by O'Brien, a member of an American religious order. Writing from the Christian viewpoint, she discusses "the mysticism of everyday nursing" (O'Brien 1999:115). O'Brien relates this to the "mysticism of everyday life", a concept she says is described by Karl Rahner (Rahner, quoted in O'Brien 1999:115). The tone of O'Brien's (2001:11-13) writing is luminous as she describes nursing as fulfilling a covenant with Christ, a sacred relationship involving trust and commitment.

Finnish nurses Helin and Lindström (2003) examine mysticism in nursing in a discussion of the sacrificial role of the nurse. They note that Christian mysticism, especially of the medieval period, often incorporates a ministry of caring for the sick. This care is not peripheral to the development of mysticism; it is fundamental to it (Helin & Lindström 2003:418). The authors believe that in the caring relationship, the nurse sacrifices her stance of power and knowledge and meets with the patient in a very direct way. As the egoistic stance is relinquished and lost, the nurse may have experiences similar to Stace's (1961) introvertive mysticism and may experience God himself in the face of the patient. The nurse is not expected to forgo her knowledge or clinical skills;

rather, she is seen to be giving up the self-centered focus which these engender (Helin & Lindström 2003:422). Helin and Lindström clearly associate the experience of mysticism with the caring role of the nurse.

2.8 SUMMARY

Mysticism has been addressed from numerous perspectives in this review of the literature. It occurs in many spiritual traditions, although it is not uniformly accepted in these traditions. It has been the subject of religious, psychological, social, and biological inquiry. It has even been considered as a factor in politics. Numerous individuals from diverse backgrounds, in conditions of health, stress and illness, have recounted personal narratives of mystical experience, and it is present as a theme in prose and poetry.

The consideration of historical literature shows that mystical experience and nursing may be said to be linked, especially in nursing religious orders and in the spiritual development of Florence Nightingale. Contemporary nurses are beginning to discuss mystical experience. Although these expressions are not prominent in the nursing literature, they suggest that mysticism may be intrinsic to the ethos of nursing.

Chapter 3

Methodology and research design

3.1 OVERVIEW

In this study, the exploration into mystical experience builds on an understanding of phenomenological inquiry and nursing theory, incorporating general principles of qualitative research.

Van Manen (1990) notes the importance of distinguishing research methodology and research method. *Methodology* refers to theory and philosophy, the overall theoretical orientation that informs the research method and design. *Research method* refers to the techniques, procedures, and particular methods which evolve from the research methodology. The research design incorporates techniques, procedures, and methods that reflect the researcher's philosophical and theoretical stance (Van Manen 1990:27-29).

In section 3.2 of this chapter, phenomenology is discussed as a meta-theoretical and methodological approach. The focus is on Husserl's system of descriptive phenomenology – Transcendental Phenomenology. The compatibility of the phenomenological approach with the scientific pursuit of understanding spirituality and mysticism is addressed. Similarly, the potential of phenomenology to promote understanding of psychology, and by implication, mystical experience, is considered. Qualitative research and nursing theory, especially caring theory, are discussed as consistent with the phenomenological approach to understanding human experience.

A rationale is presented for the use of qualitative, rather than quantitative, research, and a descriptive, rather than interpretive, phenomenological approach in this research. Supporting this rationale, an understanding of patient and nurse in relationship is presented.

In section 3.3 of this chapter, the research design is discussed. Assumptions are presented about the nature of the researcher and the participants in qualitative

research. The research design reflects the researcher's understanding of patient and nurse as fellow partakers of reality.

The research design incorporates the phenomenological approach, nursing theory, and principles of qualitative research. After the identification of assumptions, reasons for identifying mysticism as a phenomenon of interest are presented, and bracketing is addressed. Then, steps in the actual research process are discussed: initiation of the research, with a discussion of demographics of the study area; research protocol; ethical considerations; data collection; and data analysis. Finally, issues of research trustworthiness are examined.

3.2 METHODOLOGY

3.2.1 Philosophical background of phenomenology as a basis for scientific inquiry and understanding

The development of phenomenology has been divided into different schools and different approaches, beginning in 18th century Germany and Austria. Descriptive phenomenology, as developed by Husserl, builds on the work of Franz Brentano and others, but Husserl's is the first explication of phenomenology as a "distinct method" (Moran & Moody 2002:11).

Husserl was not the first philosopher to use the term phenomenology, but he is acknowledged as a leader in the early German phenomenological movement (Spiegelberg 1971:73). Husserl (1962:191) describes phenomenology "as a descriptive theory of the essence of pure experiences". He conceives of phenomenology as not only a system of philosophy, but also as the science of experience. Husserl presents the phenomenological approach as a way to use experience given to consciousness as a means to gain understanding of facts (Husserl 1962:46). It is this focus on experience mediated by consciousness that characterises the phenomenological method. Consciousness must inevitably be consciousness "in the world", and therefore, the mind and body are not seen as separate (Cohen, Kahn & Steeves 2000:6). The character of consciousness as being always conscious of something is described as *intentionality* (Husserl 1962:109).

Husserl's approach begins with *epokhe* ("abstention") or bracketing in which preconceived judgments and understanding about the nature of things are set aside. This includes setting aside even beliefs about theory and science (Husserl 1962:99-100.) Husserl notes that consciousness itself is unaffected by *epokhe*, and indeed, has a "unique being of its own" (Husserl 1962:102). Consciousness, thus bracketed, is referred to as pure or "transcendental" consciousness (Husserl 1962:103). Husserl's approach is often called *transcendental phenomenology*.

Inquiry proceeds, based simply on experience given directly to consciousness, or *intuited*, but reduced of preconceived judgments or understanding (Husserl 1962:175). The intentional object of experience is the *noema*. The experience of the object, its *essential* meaning as interpreted directly to consciousness uncorrupted by prior expectation or interpretation, is *noesis* (Husserl 1962:237-238). *Intersubjectivity* is a term referring to "a plurality of subjectivities making up a community sharing a common world" (Spiegelberg 1984:747). The concept of intersubjectivity is important in the process of scientific inquiry, as it suggests that noetic meaning is not limited to one individual's experience, but may be shared.

Husserl believes that through the phenomenological process, "scientific descriptions" are developed (Husserl 1962:191). (Nurse researchers such as Drew (2001), Porter (1998), and Kleiman (2004) discuss the applicability of descriptive phenomenology to qualitative nursing research.)

Following Husserl, Heidegger, Dilthey and Gadamer further developed the school of hermeneutic phenomenology, which like Husserl's work, is influential in nursing research (Dowling 2004:3-5). In the hermeneutic method of phenomenology interpretation and meaning of experience are added to description (Cohen et al 2000:5).

A third school of phenomenology, the Dutch school, typified by Van Manen and Van Kaam, incorporates both descriptive and hermeneutic approaches (Dowling 2004:2). Although Husserl's transcendental phenomenology is seen as the basis for this research, some elements of later phenomenologists are incorporated.

3.2.2 Phenomenology as a basis for the scientific understanding of spirituality and mysticism

The phenomenological approach, with its strong emphasis on consciousness as a tool for understanding, has certain similarities to scholarly explanations of mystical experience. In each case, human consciousness is explicated as a way of knowing. Husserl's phenomenological approach (1962:49) presents essential insight as intuition; Laski (1961:280) emphasises inspiration as an important aspect of *ecstasy* (the term used by Laski as similar to *mysticism*). Phenomenological intuition and mystical inspiration may be conceived as parallel approaches to the search for understanding.

The phenomenological method has been used to develop understanding of multiple aspects of human experience. These experiences include lived space, lived body, lived time, and lived human relation (Van Manen 1990:101). Spirituality, as well as mystical experience itself, may be considered as lived human relation of self with a greater reality, a concern of phenomenologists that is expressed both explicitly and implicitly in some of their works. Several examples are presented below.

3.2.2.1 Husserl and spirituality

Husserl's writings reflect interest in the medieval mystics and Buddhism (Spiegelberg 1984:79-80). Although Husserl was not an outwardly religious person, he had a personal faith, keeping on his desk a New Testament that had been owned by his son (who died in World War I). He is reported to have had a "deathbed conversion". Spiegelberg notes, "his mind remained open for the religious phenomenon as for any other genuine experience" (Spiegelberg 1984:70). However, Husserl warns of the necessity to disconnect or bracket one's understanding of the "divine" or the "Absolute" when engaging in phenomenological inquiry (Husserl 1962:158). (In the study of mystical experience, this might imply that the researcher must be careful not to interpret phenomena as veridical experiences of God, but instead should be open to meaning and description as presented.)

Although Husserl's writing does not address mysticism as an object of study, Sodeika (in Baranova 2004 <http://www.cvrp.org/book/Series04/IVA-26/contents.htm> accessed 23/7/2005) has identified several parallels between Husserl's phenomenological

approach and the mysticism of the medieval theologian Meister Eckhart. Both react to the intellectual approach of their times. Meister Eckhart rejects scholasticism as being an academic technique rather than an appreciation of the mystery of faith; Husserl's approach is a response to "objectivism". Both Meister Eckhart and Husserl affirm the value of subjective experience (Sodeika 2004 in Baranova 2004:1-7). In addition, Sodeika finds similarity between Meister Eckhart's emphasis on "poverty of spirit" and Husserl's *epokhe* as the "*universal* condition of any absolute foundation" (italics original) (Sodeika 2004 in Baranova 2004:10). Both, he says lead to "pure experience" (Sodeika 2004 in Baranova 2004:11). Still, Husserl is not described as a mystic, yet his phenomenological approach is compatible with the study of mysticism and shares some similarities.

3.2.2.2 Hegel and spirituality

Hegel discusses spirituality and mysticism in evocative language:

For the mystical is not concealment of a secret, of ignorance, but consists of the self-knowing itself to be one with the divine being and that this, therefore, is revealed. Only the self is manifest to itself; or what is manifest is so, only in the immediate certainty of itself. But it is in this immediate certainty that the simple divine Being has been placed by the Cult; as a thing that can be used it not only has an existence that is seen, felt, smelt, tasted, but it is also an object of desire, and by being actually enjoyed becomes one with the self and thereby completely revealed to the self and manifest to it. That which is said to be manifest to Reason, to the heart, is in fact still secret, for it still lacks the certainty of objectivity and the certainty belonging to enjoyment, a certainty which in religion, however, is not merely immediate and unthinking, but is at the same time purely the certainty that is known by the self (Hegel 1977:437).

Hegel considers mysticism to be worthy of the phenomenologist's concern; it is presented as a form of esoteric knowing. He associates the mystical experience with sensory and emotional content, presenting the phenomenon as hidden, but real.

Bertrand Russell, when evaluating mysticism and logic, frequently refers to Hegel as a mystical phenomenologist (1917:10, 17), noting that a form of "logical" mysticism "dominates the reasoning of all the great mystical metaphysicians from ... Parmenides' day to that of Hegel and his modern disciples" (Russell 1917:7).

3.2.2.3 Heidegger and spirituality

Heidegger's thought has an affinity with several strands of mystical thinking. Heidegger personally knew Suzuki, the Japanese Zen scholar, and made efforts to translate Lao Tzu into German (European Graduate School 2005:2 <http://www.egs.edu/resources/heidegger.html> accessed 23/7/2005). Heidegger's thought reflects these influences in his development of the concept of *Gelassenheit*, "letting-be", or self-surrender, drawn from both medieval mystic Meister Eckhart (Moran & Mooney 2002:246) and Lao-Tzu (European Graduate School 2005:2 <http://www.egs.edu/resources/heidegger.html> accessed 23/7/2005).

Much of Heidegger's writing is based on the concept of *Dasein*. The term *Dasein* reflects a concept that, although it builds on Husserl's phenomenology, is somewhat newer in the phenomenological movement. *Dasein* refers to "being-in-the-world", the individual's inseparability from relationship with others and the world itself. Sabatino finds significant similarities in Heidegger's understanding of *Dasein* and the Buddhist tradition of *Pratitya Samutpada* (Sabatino 1999:1). *Dasein* may be compared to the Buddhist idea of *Pratitya Samutpada*, or equiprimordiality, in which everyone and every thing are related, and in which any one person or thing is nothing at all (Sabatino 1999:1-3). This may be said to reflect the emphasis on *connectedness*, often found in the literature on mysticism.

Heidegger is perhaps unique among the German phenomenologists in marrying both Eastern and Western mysticism with the phenomenological approach.

3.2.2.4 Stein and spirituality

Edith Stein was one of Husserl's students and one of his translators. She is considered both a phenomenologist (Moran & Moody 2002:229) and a mystic (Oben 1983:149). In addition to her philosophical work, Stein worked in a nursing capacity in World War I at Weisskirchen Hospital, providing care to Austrian soldiers (Oben 1983:142). Stein was Jewish, and, for some time, an atheist. She converted to Christianity after being inspired by the autobiography of St Teresa of Avila. Later, she joined the Carmelite religious order. She died at Auschwitz (Oben 1983:147). Her life and her work reflect integration of her phenomenological orientation with a complex spirituality (Ales-Bello 2002 <http://www.carmelite.com/saints/edith3.shtml> accessed 22/7/2005). Oben observes that Stein "maintains that we must understand the essence of our own spirit in order to understand all other phenomena" (Oben 1983:141). This would speak to the researcher's need to understand her own spiritual perspective before embarking on research about mystical experience.

3.2.2.5 Levinas and spirituality

Levinas is a French phenomenologist whose work, *Ethics and the face*, is highlighted in Jean Watson's book *Caring science as sacred science* (2005). For Levinas, seeing the face emphasises one's recognition of another's otherness. Building on Husserl and Descartes, Levinas discusses "the expression of this transformation of the idea of infinity conveyed by knowledge into Majesty approached as a face" (Levinas 1969 in Moran & Mooney 2002:528). Divinity discerned in the human face recurs as a theme in mystical and nursing literature (Whitman 1921:347-8; Maura 1958:39; Helin & Lindström 2003:422-423).

3.2.3 Phenomenology as a basis for the scientific understanding of psychology and implications for the understanding of spirituality and mysticism

The work of the phenomenologists is compatible with the scholarship of psychology. Spiegelberg notes similarities between Husserl's understanding of consciousness and American psychologist James's *Principles of psychology*. Husserl and James were contemporaries, although the degree to which each was familiar with the other's work is

unclear. Husserl is known to have read James, although James may or may not have heard of Husserl (Spiegelberg 1984:100-101).

Van Kaam (1969) is a modern psychologist who describes the use of existential phenomenology in psychological theory and research. Phenomenology is also applied in Gestalt therapy (Crocker 2001:1-5). Colaizzi (1978) emphasises phenomenology as integral to psychological research: “*Identification of phenomena must then, become the crucial first step in the psychological research, and must become the new hallmark of psychological methodology*” (italics original) (Colaizzi in Valle & King 1978:56-57).

Spiegelberg (1971) states that the phenomenological approach offers ways to “enrich” research in psychology and psychiatry: it draws attention to new or under-researched phenomena; it offers potential for understanding patterns and relationships among phenomena; and it offers new opportunities for verifying scientific findings (Spiegelberg 1971:362-363). These conclusions may be expanded to the venue of nursing research, especially nursing research on mystical experiences related to health care. It is on this basis, perhaps, that some nurses (Albaugh 2003; Hall 1997) have used the phenomenological method to explore the psychological aspects of spirituality. From a holistic nursing perspective, mysticism may be considered as a psychological and spiritual dimension of human experience.

3.2.4 Phenomenology as a basis for the scientific understanding of nursing and caring research

Husserl’s philosophy of phenomenology was first presented by Omery as a method for nursing research in 1983. Omery’s discussion of the method is identified as a significant influence on the development of qualitative research in nursing (Porter 1998:16-17). In reviewing Omery’s contribution, Porter discusses the inspirational nature of Husserl’s writing and the use of inspiration in phenomenological investigation (Porter 1998:16-28).

Phenomenological philosophy has been applied to nursing and caring theory and research, but not without some controversy. Barkway discusses Crotty’s indictment of nursing research which purports to use phenomenology as its basis. Crotty criticises such nursing research as lacking critical vigor and avers that patient descriptions of

phenomena are not the phenomena themselves (Barkway 2001:195). Priest (2004:1) notes that nurse researchers may have an inadequate understanding of phenomenology, and that misunderstanding affects the quality of research. Glazer (2001) criticises qualitative phenomenological research as “antiscientific” (Glazer 2001:196). In contrast, however, Giorgi states that although philosophical inquiry and scientific inquiry have different rules, phenomenology can be used appropriately for caring research (Giorgi 2000a:11-15). Nurse theorist Jean Watson advocates the use of phenomenological inquiry for caring studies (Watson 1999a:79-100). The burden is on the researcher to apply philosophical principles as they were intended, or to clearly indicate when and why an identified theory base has been adapted or changed.

The researcher acknowledges the potential misuse of the phenomenological method. In this study, it is seen as more than a tool or a simple method of data collection. The phenomenological approach is considered fundamental to the understanding of significant human experiences which are not accessible to other forms of research. Although Crotty may be correct that patient descriptions of phenomena are not the phenomena themselves, it is difficult to imagine any other way a nurse could get closer to the actual phenomenon of mystical experience in patients than by interacting with patients and sharing their descriptions.

Mystical experience could be measured with a quantitative scale, but such scales are not designed to reflect the impact of stress or illness, or to incorporate the role of the nurse. The phenomenological approach provides a basis for further study. The research is not conceived as an end in itself. Once completed, it may serve as a foundation for further qualitative and quantitative inquiry.

3.2.5 The phenomenological method

Husserl’s explication of phenomenology as science has been developed into structured methods of inquiry by subsequent philosophers, educators, psychologists, and nurse researchers. Different disciplines have developed variations of the phenomenological method. Qualitative nurse researchers have embraced the phenomenological method as uniquely applicable to nursing research, challenging, but satisfying (Donalek 2004:517).

As a philosophical historian, Spiegelberg (1984) identifies the following steps of the “phenomenological method”. His steps move beyond Husserl’s explication of descriptive phenomenology as given and include interpretation, as may be seen in step 7. These steps are:

- 1) *Investigating particular phenomena*
- 2) *Investigating general essences*
- 3) *Apprehending essential relationships among essences*
- 4) *Watching modes of appearing*
- 5) *Watching the constitution of phenomena in consciousness*
- 6) *Suspending belief in the existence of phenomena*
- 7) *Interpreting the meaning of phenomena* (Spiegelberg 1984:682)

Van Manen, an educator, describes the steps of hermeneutic research into lived experience. Although he identifies his approach as hermeneutic, the steps he identifies also apply to descriptive research. First, the researcher identifies a phenomenon of interest. Second, the researcher investigates the phenomenon as it is lived, rather than as it is conceptualised. Next, the researcher reflects on identified themes. Finally, the researcher describes the phenomenon in writing, remaining faithful to the original phenomenon and “balancing the phenomenon by considering the parts and whole” (Van Manen 1990:30-33).

Van Kaam discusses the phenomenological approach in psychotherapeutic research. The researcher begins with a research question and selects a “method of approach to the phenomenon”. This is followed by attention to explication of the phenomenon from the points of view of the researcher and the subjects. Van Kaam presents a method for the “scientific phase of the explication” that includes six operations: “listing and preliminary grouping, reduction, elimination, hypothetical identification, application, and final identification” (Van Kaam 1969:325). From this process, results are derived.

Giorgi is a psychologist who considers the application of phenomenology to research in the caring disciplines. He notes the contrast between using philosophical guidelines and scientific guidelines when carrying out phenomenological research. Using the term “scientific phenomenology”, Giorgi argues for using scientific guidelines in caring

research, (Giorgi 2000a:14). On this basis, he presents steps of the phenomenological approach. Giorgi describes this method as integrating “the phenomenological reduction, description, and search for essences” (Giorgi 1997:236). To render the process scientific, Giorgi adapts Spiegelberg’s (1984) steps emphasising, in addition, detailed concrete descriptions, the natural attitude of others, the researcher’s reduction, consideration of the researcher’s discipline orientation, and the search for “scientific” essences. Giorgi further discusses the steps he says are required in all qualitative research: “(1) collection of verbal data, (2) reading of the data, (3) breaking of the data into some kind of parts, (4) organisation and expression of the data from a disciplinary perspective, and (5) synthesis or summary of the data for purposes of communicating to the scholarly community” (Giorgi 1997:241). He believes that with modifications, these are appropriate steps for phenomenological inquiry. Giorgi’s emphasis on the scientific application of phenomenology offers a means to strengthen the quality of qualitative research into human caring.

Kleiman (2004), a nurse researcher, presents a template for descriptive phenomenological inquiry, making reference to Husserl, but relying also on Giorgi. Her template reflects a clear nursing orientation. In her template, Kleiman includes the identification of a conceptual framework, which is not uncommon in nursing research, but is potentially problematic in terms of bracketing. Data analysis is presented as a somewhat structured process, although “free imaginative variation” is incorporated. Kleiman notes the importance of maintaining the orientation to nursing. Her process is formulated as a series of components, rather than steps:

- 1) *Formulating the research question*
- 2) *Specifying the conceptual framework*
- 3) *Sample and method of selection (the purposeful, “snowball” technique is noted)*
- 4) *Theoretical design constructs*
- 5) *Concrete descriptions as data*
- 6) *Phenomenological reduction*
- 7) *Concrete descriptions of the phenomena of interest*
- 8) *Get a sense of the whole*
- 9) *Discriminate meaning units*
- 10) *Integrate meaning units*

- 11) *Disciplinary perspective (nursing)*
- 12) *Finding essential meanings*
- 13) *Elaboration of findings*
- 14) *Structure of the phenomenon of interest*
- 15) *Going back to the data* (Kleiman 2004:2-6).

Porter (1998), also a nurse researcher, returns to Husserl's writing directly to develop somewhat different steps for phenomenological research. Bracketing takes place early in the process. Porter gives explicit guidance for handling the data, once it is obtained.

The structure of this research project utilises Porter's steps integrated with modifications gleaned from variations of the research processes described above. The structure described below provides the basis for the research methodology discussed in section 3.3. Porter's steps are noted in italics. Bullets identify modifications developed by the researcher for the current study. Following is the framework of the research:

- 1) *Explore the diversity of one's consciousness* (Porter 1998:21)
 - Identify a phenomenon of interest (Van Manen 1990:30-33)
- 2) *Reflect on experiences* (Porter 1998:21)
- 3) *Bracket* (Porter 1998:21)
 - Develop a "working description of the phenomenon"
 - Review the literature
 - Initiate reflective journaling as an aid to bracketing (Wall, Glenn, Mitchinson & Poole 2004:1-7)
- 4) *Explore the participant's life world* (Porter 1998:21)
 - Identify sample (Kleiman 2004:2-6)
 - Continue personal reflective journaling during the research process.
- 5) *Intuit structures through descriptive analysis* (Porter 1998:21)
- 6) *Engage in intersubjective dialogue* (Porter 1998:21)
- 7) *Attempt to fill out the phenomenon (using cycling and integrating bracketed material)* (Porter 1998:21)

- Use immersion/crystallisation technique of data analysis (Borkan in Miller & Crabtree 1999) (consistent with steps 5, 6 and 7)
- 8) *Determine uses for phenomena and features* (Porter 1998:21)
- Describe mystical experience in the context of health care
 - Analyse the concept in relation to nursing diagnosis and develop recommendations for nursing process
 - Explore implications for the nursing role in the context of caring theory, incorporating disciplinary perspective (Kleiman 2004:2-6)

Porter's steps, *with the researcher's added modifications*, form the framework for this research project. The integration of these approaches and the similarity to other approaches to phenomenological research may be observed in the Table 3.1 below.

Table 3.1 Comparison of research methods

	Porter	Spiegelberg	Van Manem	Van Kaam	Giorgi	Kleiman
1) Explore the diversity of one's consciousness	Explore the diversity of one's consciousness	Investigating particular phenomena	Identify a phenomenon of interest			
-Identify phenomenon of interest		Investigating general essences		Identify the research question		Formulating the research question
2) Reflect on experiences	Reflect on experiences	Apprehending essential relationships among essences		Select a method of approach		
		Watching modes of appearing				Specify conceptual framework
		Watching the constitution of phenomena in consciousness				Sample selection
						Theoretical design constructs
						Concrete descriptions as data
3) Bracket	Bracket	Suspending belief in the existence of phenomena			Reduction	Phenomenological reduction
-Develop working description of the phenomena					Detailed concrete descriptions	
-Review the literature						
-Initiate reflective journaling (Wall et al, 2004)						
4) Explore the participant's life world	Explore the participant's life world		Investigate the phenomenon as it is lived	Attend to phenomenon from researcher and subject's point of view	Natural attitude of others	

	Porter	Spiegelberg	Van Manem	Van Kaam	Giorgi	Kleiman
-identify sample					Collection of verbal data	
-continue journaling						
5) Intuit structures through descriptive analysis	Intuit structures through descriptive analysis	Interpreting the meaning of phenomena		Scientific phase of explication	Reading of data	Concrete descriptions of phenomenon
6) Engage in intersubjective dialogue	Engage in intersubjective dialogue					
7) Attempt to fill out the phenomenon using cycling and integrating bracketed material	Attempt to fill out the phenomenon			-listing and preliminary grouping		Sense of the whole
-Use van der Wal's (2005) procedure for using a word processor for data analysis to support immersion/crystallisation.				Reduction	Breaking data into parts	Discriminate meaning unite
-Steps 5, 6, and 7 are consistent with immersion/crystallisation technique of data analysis (Borkan in Crabtree & Miller1999)				Elimination		Integrate meaning units
8) Determine use for phenomena and features	Determine use for phenomena and features			-hypothetical identification	Organise and express data from disciplinary perspective	Disciplinary perspective (Nursing)
-Describe mystical experience in the context of health care.			Describe the phenomenon in writing			Elaboration of findings
-Analyse the concept in relation to nursing diagnosis and develop recommendations for nursing process				-application		Structure phenomenon of interest
-Explore implications for the nursing role in the context of caring theory, incorporating disciplinary perspective (Kleiman 2004:2-6)				-final identification	Scholarly synthesis	Return to the data

3.2.6 Rationale for research decisions

Methodological decisions inform the steps of the research process. Frankel (1999:342) states that “[t]he research question should always determine the method, and not the other way”. This research employs not only the qualitative rather than the quantitative research approach, but also descriptive phenomenology rather than interpretive phenomenology. Reasoning for these research decisions is presented below, based on the research questions and an understanding of patient and nurse in relationship as fellow partakers of reality.

3.2.6.1 *The decision to use the qualitative approach, based on an ontology of the nurse-patient relationship*

Relatively little research has been carried out using the terms *mysticism* or *mystical experience*, especially as it relates to health care. The earliest research is quasi-quantitative research, using both formal and informal surveys (Laski 1961; Maslow 1964). There is no clear attempt to maintain objectivity. From these surveys, certain characteristics of mystical experience are identified. These early researchers started out with a preconceived idea of the mystical experience and selected responses consistent with their understanding for further analysis.

Some of the more recent ongoing research is more structured, using Hood's (1994) Mysticism Scale (M-Scale). Hood has developed a well-validated tool that reflects a specific understanding of spirituality and mystical experience in the psychology of religion.

Hood's quantitative approach is not used in this study for several reasons. The first reason has to do with the researcher's reluctance to use an impersonal tool to develop understanding of experience which is, to the patient, intense, emotion-laden, and perhaps life changing. Further, the M-Scale may not be well received by the study population. It requires a relatively high level of literacy and familiarity with Likert scale responses. The language makes specific reference to God, in one version, and uses "neutral" but possibly "New Age" sounding terms in another version (Hood et al 2001:34). In this research, the study population is defined by health care experience and not by religious affiliation and orientation. To select the most appropriate version of the scale for participants, religious affiliation and orientation would have to be ascertained first, the process itself adding a religious context to the research.

Second, the researcher wished to be entirely open to the patients' expression. This is best achieved by a qualitative approach, wherein the patient himself or herself is the guide to the interaction. This places a burden of intuition and reflectiveness on the researcher, but this is seen as the epitome of the nursing role. In this way, also, the nurse may examine her own approach, which is modified both by the patient's expression and by her own responses, changing as the interviews and research progress.

The qualitative approach used in this research reflects the researcher's understanding of the relationship of patient and nurse as fellow participants in the research process, as fellow participants in the healing relationship, and as fellow partakers of reality.

In the *Torus Model of Mystical Experience* (Figure 1.3) developed by the researcher, and described above, lines are drawn to indicate the individual's personal boundaries. These boundaries are described as fluid and permeable, but from a larger perspective, these lines or boundaries may represent something quite different.

An individual usually perceives himself to end at the edge of the skin. The external world seems to be separate – outside himself. And yet, if one looks at it another way, these lines at the edge of the skin may be seen as *connections* to what lies beyond, rather than *separators*. The skin that envelops the body is also an interactive organ interfacing with the environment. Humans are not separate entities.

That inward sense, in which all of a person's perceptions, thoughts, and emotions seem to be inside the head and heart, reflects an interaction with reality beyond perceived boundaries. This is not to say that everyone has the same perception of reality, but rather that all humans share in what is real, within and beyond the integral self. The nurse, then, cannot separate himself or herself wholly from the patient, and the patient cannot be seen as wholly other. This ontological conceptualisation negates a strictly quantitative approach to mystical experience, an experience that represents a challenge to perceived boundaries. The nurse must look and listen to herself as well as the patient, and she must look at her responses as well as the patient's utterances. And patients must allow the nurse into their own minds and hearts if they are to share these profound experiences.

The ontology of the nurse-patient relationship described above has similarities to the *healing relationship* for which Quinn, Smith, Ritenbaugh, Swanson and Watson (2003) propose a research agenda. Their conceptualisation of the *healing relationship* incorporates "those physical, mental, social, and spiritual processes of recovery, repair, renewal and transformation that increase wholeness" (Quinn, Smith, Ritenbaugh, Swanson & Watson 2003 in Watson 2005:147). Quinn et al (2003 in Watson 2005:147-177) have identified guidelines for researching the impact of the healing relationship in nursing. They recommend that research involving "questions related to the lived

experience of the healing relationship for the patient and the clinician” be carried out using qualitative research (Quinn et al 2005:161-167).

3.2.6.2 *The decision to employ descriptive phenomenology rather than hermeneutic phenomenology to support the qualitative approach*

Factors underlying the decision to employ a descriptive rather than interpretive phenomenological approach include the need for a nursing description of the phenomenon of mystical experience, consideration of bracketing, and certain practical considerations.

This research lends itself to the descriptive phenomenological approach. Nursing literature regarding patients’ mystical experience is somewhat limited. The phenomenon is recognised, but little discussed. Clearly, a rich thematic description of mystical experience in the context of health care is needed, as well as an understanding of the implications for the nursing role. The researcher wished to achieve a sense of immediacy in her interviews; the goal was to examine the mystical experience as it presented to the patient, in the purest sense of phenomenology, rather than interpretation, which might include analysis of possible meaning or implications. Giorgi notes that in descriptive phenomenology, “description is the articulation of the given as given”, and contrasts this with hermeneutic phenomenology in which meaning is developed by explanation and interpretation. He says that such additional factors are unnecessary, given a “sufficiently rich description” (Giorgi 1997:240). Kleiman also affirms the validity of descriptive phenomenological research against hermeneutic research with patients. She believes that the researcher must undertake the phenomenological reduction and analysis alone, and that the interpretative procedure of returning the data to subjects for further analysis would yield a “meta-reflective” rather than a “pre-reflective” description (Kleiman 2004:7).

The consideration of bracketing is another important factor to be considered when selecting descriptive phenomenology as a research approach. Dowling (2004) notes the emphasis on bracketing to be an important differentiation between the descriptive and the hermeneutic phenomenological approaches (Dowling 2004:2-3). The clear call for bracketing is characteristic of Husserlian descriptive phenomenology. The hermeneutic Heideggerian approach, in contrast, calls less for bracketing and more for

understanding and interpretation. The *attempt* to bracket is essential in this research. Although the researcher cannot divest the research act from all personal context, it is especially important in this research to recall Husserl's admonition to bracket one's understanding of the "divine" or the "Absolute" when engaging in phenomenological inquiry (Husserl 1962:158).

The researcher's subjectivity must be acknowledged (Schutz 1994:413-414), but subjective expectations and preconceptions must not colour the description of the phenomenon. Entire openness to what the patient has to say during the interview process is essential in order to develop a description of mystical experience as a patient phenomenon. (However, the researcher's perspective is not ignored. The researcher's journal entries and reflections subsequent to each interview are considered, as well as the researcher's reactions to the research process itself.)

In addition to the above concerns, certain aspects of the research setting limit the feasibility of hermeneutic phenomenological inquiry. Were the hermeneutic research approach to be used, participants would be invited to reflect on the researcher's findings, and follow up interviews would then be held to develop additional interpretation (Van Manen 1990:99). This could prove problematic in the selected hospital settings, where patient stays are brief, usually one to two days. Concerns for confidentiality, based on Health Information Portability and Accountability Act (HIPAA) regulations, which are strictly enforced in the hospital setting, also limit the researcher from obtaining personal information that would be necessary to contact patients after discharge.

The researcher seeks to understand and describe the meaning of mystical experiences in the context of health care, but fuller interpretation is indicated at a later time. The researcher believes that hermeneutic analysis must build on the initial foundation of identification and description of the phenomenon.

3.3 RESEARCH METHOD AND DESIGN

3.3.1 Overview

The proposed research method is a descriptive phenomenological (qualitative) examination of the subjective experience of mysticism. Mystical experience involves perceptions that are mediated by consciousness rather than by the organs of sense. It is not possible to test the veracity of a patient's mystical knowledge using objective measures; it is, however, possible to discern the meaning (without interpreting this meaning) of the experience *to the patient* using phenomenological inquiry. It is thus possible to examine the nursing response to the sharing of such experience. Assumptions, addressed below, undergird the plan of the research. Following assumptions, the research process is discussed in detail. After that, ethical concerns are discussed. Finally, concerns about the trustworthiness of the research are addressed.

3.3.2 Assumptions

The research design incorporates methodological assumptions about both the researcher and the participants. These assumptions, which are additional to the assumptions presented in Chapter 1, are listed below.

3.3.2.1 *The researcher*

The researcher assumes that:

- The researcher's consciousness is the primary instrument in data collection (Porter 1998:22), as is the researcher's conscience.
- The researcher is inseparable from the research process (Lincoln & Guba 1985:101; Porter 1998:22).
- Bracketing, in principle, is desirable and should be attempted, however, imperfectly.
- The experience of the researcher in the research process and the reflections of the researcher contribute to understanding the phenomenon under investigation.

3.3.2.2 The participants

The researcher assumes that:

- Human resources will provide the information sought about mystical experience.
- The pursuit of research understanding is a shared endeavor between the participant and the researcher. Patients are partners with the researcher in the attempt to construct the mystical experience (Lincoln & Guba 1985:101).
- Participants need not wholly understand the research process to contribute to understanding of the phenomenon under study. All participant contributions are potentially valuable.

3.3.3 Plan of the research project

Based on an adaptation of Porter's (1998) steps of the phenomenological research method, the plan of the research project is described below. First, *Exploring the diversity of one's consciousness* is discussed. Following this, *Bracketing*, and *Exploring the participant's life world/Identifying the sample* are discussed. The sections designated *Research protocol* and *Data collection* incorporate the processes of intuiting structures through descriptive analysis, engaging in intersubjective dialogue, and attempting to fill out the phenomenon. The section designated *Qualitative approach to the data* clarifies the process of data analysis in relation to the research protocol. Last, *Determining use for the phenomenon and features* are discussed, although this is examined in more detail in Chapter 4.

3.3.3.1 *Exploring the diversity of the researcher's consciousness; identification of a phenomenon of interest; reflection on experiences*

The researcher began the research process with a deep interest in the subject of mysticism. Her religious background led her at first to view it as a theological or religious phenomenon reserved for the spiritual elect. In her Master of Science study in the 1980s, the researcher chose the concept *ecstasy* to examine from the nursing perspective in a course on nursing theory. It was at this time that she became acquainted with the works of Laski (1961), who examines ecstasy experiences from a nonreligious perspective and Greeley (1974), who considers ecstasy as a cognitive

phenomenon. (The term *ecstasy* was in more common use in the 1960s and 1970s, as it had not begun to be associated with drug use.) At that time, although the nursing literature on mysticism was almost nonexistent, it became clear that ecstasy or mysticism could be understood as more than a religious phenomenon.

An initial reflection on the researcher's own experiences has been discussed in section 1.2.4. As the researcher considered patient experiences she observed in the clinical setting, among various age groups in a variety of acute and chronic settings, she came to believe that mystical experiences are not rare and do occur in the health care context.

Continued reflection on the researcher's own experiences brought to recollection personal phenomena that hint at transcendence, and perhaps mysticism: the sensation, as a small child, of lying prone on the carpet, feeling that the whole earth was under her, and that she was revolving with the earth itself; in adolescent years, after a dance class, an experience of profound rhythmicity and connectedness while listening to a band rehearsing Mason Williams's "Classical Gas"; in adult life, at a time of deep personal despair, a sense of bright and forward motion, and the sudden realisation that it was possible to "dance in the heart"; and later, as a professional nurse, a sense of wholeness and utter focus, when listening to an anxious mother talk about problems in her life.

The researcher also had the startling experience, several years ago, of learning from a distant cousin that four of her great great grandparents were members of a mystical religious community called the Harmony Society. The Harmony Society was a group of German Separatists who based their beliefs on millennialism, the mystical writings of Jacob Böhme, and other theosophical and esoteric works.

The society was led by George Rapp, who brought the group to the United States from southern Germany in the early nineteenth century (Versluis 1999:1 <http://esoteric.msu/Versliius.html> accessed 27/4/2005). Arndt (1972), a scholar of the Harmonists and their work, describes a communal group motivated by mystical beliefs, yet practical, innovative and industrious. The Harmonists built a series of thriving communities in the American wilderness and enjoyed social and economic success

(Arndt 1972:2-6) before internal dissention weakened the movement (Arndt 1972:521-577).

The researcher has come to view mystical experiences as phenomena that may be present, to some degree, everywhere and for everyone, if they but acknowledge them. Within the context of health care, the phenomenon of mystical experience is confirmed, but the nursing literature is relatively sparse. It was with a sense of excitement that the researcher first read the recent NANDA International nursing diagnosis, *Potential for Enhanced Spirituality*, and saw “*reports mystical experience*” (Wilkinson 2005:513-514) listed as a defining characteristic. This nursing diagnosis supports the need for a clearer understanding of mysticism in the context of health care.

Mysticism now presents itself to the researcher as a phenomenon which is as relevant to herself as it was to her forebears, and is relevant to herself as a nurse, and to all nurses. Entering into the research process has heightened her sensitivity to the possibility of mystical experience in herself and others, and she has developed an increased awareness of the mystical in everyday occurrences. The research process itself has taken on an almost ethereal sense at times.

3.3.3.2 Bracketing

In preparing for and conducting research, the researcher must bracket personal understanding of the phenomenon under consideration. Bracketing is an essential part of the process of phenomenological reduction (Husserl 1927:4). In this research, the *attempt* to bracket is recognised as a mandate, especially during the interview process. Speziale and Carpenter (2003:22) describe bracketing as “the cognitive process of putting aside one’s own beliefs, not making judgments about what one has observed or heard, and remaining open to the data as they are revealed”. (This process has similarities to Happold’s description of the mystic’s *Purgation of Self*, when pursuing the Mystic Way. *Purgation of Self* includes “detachment ... and death of the egocentric life” [Happold 1977:56].)

It is important that the researcher examine personal beliefs and attitudes so that they may be suspended during the research process. In the study of mysticism, this presents special challenges, inasmuch as religious symbols and spiritual beliefs may be so

deeply held that they are not even recognised as such; they reside deep in the human psyche (Jung 1933:122) and the collective unconscious (Jung 1968:41).

The researcher's religious and spiritual perspective is laid aside, as well as beliefs about the nature of health, illness, and patient experience. Yet the researcher must not shear so much from her perspective that she discards the caring stance of the nurse when interacting with patients, nor that she abandons empathy when communicating with them about their experiences. Rather, the approach is one of entire acceptance of what the participants say, and willingness to analyse the data with an open mind. This approach recalls certain lines in DH Lawrence's poem, "Song of a man who has come through". The poem begins: "Not I, not I, but the wind that blows through me!", and later continues: "Oh for the wonder that bubbles into my soul/I would be a good fountain, a good well-head, would blur no whisper, spoil no expression ..." (Aldington 1958:1158).

The researcher felt strong motivation to show acceptance and respect to the participants, although this was challenged when they expressed unfamiliar and even uncongenial beliefs. The occasional, but very vivid, discussions of hell and the devil were most troubling. Certain other aspects of belief inconsistent with the researcher's faith tradition also caused discomfort. These included what might be called a "folk belief" in ghosts, and the discussion of certain New Age practices. Still, the interviews were not a forum for theological debate. The researcher felt it inappropriate to contradict or counter firmly held beliefs, even though it became clear to her that some of the participants were dealing with unconventional, even frightening, belief systems. (Curiously, the researcher was quite comfortable with discussing glossalalia, "falling in the spirit", and even exploring arcane Biblical references. These discussions were found to be stimulating and enlightening, rather than unsettling, even though not necessarily familiar to her.)

Subsequent to each interview, the researcher looked at her own role and her own reactions. This was promoted by way of reflective journaling (Shutz 1994:416; Wall et al 2004:1-7), which was expected to contribute not only to the efficacy of bracketing, but also to the facilitation of movement between the nurse-interviewer and the nurse-researcher roles. Reflective journaling was undertaken before the first interview and continued throughout the research process.

A review of the professional and research literature is part of the method of preparing for qualitative research (Moustakas 1994:111). An in-depth review of the literature facilitates the process of bracketing, as paradoxical descriptions and analyses of mysticism are encountered and considered. The researcher's preconceived notions were challenged in the exploration of the literature, and the only thread that could be held continually was that there *is* something called mystical experience, or ecstasy, or cosmic consciousness, and that it *is* profound. Bracketing is not easily achieved. It is important to attend to Schutz's observation that "it is the skill and experience of the researcher as an individual, in interpretation and understanding, that will overcome bias and prejudice" (Moustakas 1994:414).

3.3.3.3 Exploring the participants' life world; identifying the sample

As the research was initiated, the study area was identified from which the participants would be drawn. Participants included hospitalised patients and members of the community, as well as several nurses.

3.3.3.3.1 Selection of the study population

The three county study area was identified as the focus for study because of the researcher's familiarity with the area, the accessibility of the hospitals, and the willingness of the nursing administration in the hospitals to facilitate research. The study area has been discussed in detail in section 1.2.5.

3.3.3.3.2 Inclusion criteria

A variation of purposive sampling was used to select participants for the study. Purposive or "*judgmental*" sampling involves the use of "special knowledge or expertise about some group to select subjects who represent this population" (Berg 2004:36). The explanation of the research and the initial inclusion criteria questions in the interview format helped the researcher identify participants who would have relevant experiences to share. Initially, patients who were hospitalised were chosen for study because it was hoped that they would be close to mystical experiences associated with the hospitalisation. In addition, the role of the nurse is clearly delineated in the hospital setting. It is usual for patients to discuss their experiences related to illness, health care,

and stress, in association with nursing assessment and history taking. However, it soon became evident that other participants might have relevant experiences they would be able to share. Therefore, the pool of potential participants was expanded to include others in the hospital setting, such as family and visitors, nurses, and members of the community who met the inclusion criteria.

Participants needed to be alert and able to talk about their experiences in order to be approached for inclusion in the study. Screening criteria for inclusion included several initial questions addressing the participants' experience of mystical or spiritual phenomena in the context of health care (see interview record in Appendix A). As other potential study participants were identified outside the hospital setting, based on local or participant referrals, they were also contacted, and, if they met the inclusion criteria, they were interviewed.

The fundamental inclusion factor was the participants' belief that they had had experiences relevant to the study, and their willingness to share those experiences. It is likely that some potential participants had had mystical experiences, but did not wish to share them, either because of privacy concerns or because of discomfort with sharing such an intense experience in a noisy interrupted setting. (The researcher encountered a higher likelihood of participation in Beta Hospital than Alpha Hospital. Beta Hospital was less busy than Alpha Hospital and patients at Beta Hospital were all in rooms *without* roommates. Most of the rooms at Alpha Hospital were occupied by two patients. The nurses and staff at Beta Hospital were generally supportive, but had limited insight into patients with complex psychological needs. The nurses at Alpha Hospital were very busy and expressed little interest in the research. They were wont to ignore the researcher when she asked for the census list. This attitude moderated, however, as the research progressed.)

In several cases, nurses volunteered interviews about experiences they had had. These nurses were interviewed, although they did not necessarily meet the specific inclusion criteria. If a nurse said, "I heard about your research, and I have an experience I want to tell you", then that nurse was offered the opportunity to participate in an interview. The researcher wanted to stay open to insights about the nursing role, and wished to show respect for the nurses who were aiding the research process.

In qualitative research, random selection of subjects is not a goal. Rather, an attempt is made to locate study participants who have experiential knowledge of the phenomenon under study (Field & Morse 1985:59). For this reason, a selection protocol was utilised that was flexible enough to accommodate additional participants suggested by hospital staff, colleagues and the participants themselves.

Table 3.2 shows the number of possible participants who were approached and the number that was found to have relevant experiences and who agreed to be interviewed.

Table 3.2 Potential participants approached and participants agreeing to be interviewed

Date and setting a = Alpha Hospital b = Beta Hospital c = Community	Number of potential participants approached or contacted	Number of participants expressing mystical or spiritual experience in the context of health care (patients, community members, and nurses) and agreeing to be interviewed
8/7/05 b	3 patients	1 patient
9/7/05 b	2 patients	0 patients
11/7/05 b	1 patient	0 patients
15/7/05 b	3 patients	3 patients
22/7/05 b	2 patients	2 patients
24/7/05 b	1 nurse	(1 nurse offered telephone interview)
28/7/05 b	4 patients	1 patient visitor—listed as patient for tabulation
29/7/05 c	1 nurse	(1 nurse offered interview and added personal experience data on 10/05)
12/8/05 b	2 patients 1 nurse	0 patients (1 nurse offered interview)
1/9/05 c	1 community member	(1 community member offered interview)
23/9/05 a	6 patients	0 patients
28/9/05 a	6 patients	1 patient
5/10/05 a	4 patients	3 patients (*1 not interviewed because of respiratory distress)
12/10/05 a	5 patients	1 patient
14/10/05 c	1 community member	(1 community member offered interview. Note: Community member was also an LPN, but offered <u>limited</u> discussion of nursing role.
4/11/05 a	10 patients	1 patient (patient was also an RN)
17/12/05 c	1 community member	(1 community member offered interview)
TOTAL Note that patients and community participants include an RN, an LPN, and another self identified nurse. However, the primary interview was not their nursing role, but rather their personal experiences.	N=54 48 Patients (31 Alpha Hosp 17 Beta Hosp) 3 Community participants 3 Nurses	N = 18/54 12 Patients (13-1 patient not interviewed) 3 Community participants 3 Nurses (interviewed as nurses) Note: Not counted separately are one community member who was a Licensed Practical Nurse (LPN), one patient who was a registered nurse (RN), and one patient who was a self identified, but unspecified, nurse)

3.3.3.3.3 *Exclusion criteria*

Primary exclusion criteria in the hospital setting were based on the identified needs and status of the patients. If the charge nurse indicated that a patient was seriously ill or under an isolation protocol, then that patient was not even approached for inclusion in the study. Patients who were sleeping, who were receiving nursing care, or who were using the telephone were likewise not approached when thus engaged. (This meant that some potentially productive interviews were probably missed.)

In one case, a patient receiving oxygen stated that he had had a mystical experience, but developed increasing shortness of breath as he spoke. A staff nurse entered his room to complete an admission assessment, and the researcher decided *not* to pursue an interview with him. The researcher considered the patient's assessment and care to have priority over the research.

Secondary exclusionary criteria included the inability of potential participants to understand the researcher's explanation of the study and communication deficits on the part of potential participants. Several patients responded that they had had mystical or spiritual experiences, but then began discussing unrelated or incomprehensible topics. For example, one middle-aged woman started to talk about spiritual experiences, but wandered from topic to topic, and appeared unable to focus on the explanation of the research. Other potential participants were either inarticulate or difficult to communicate with. An elderly man receiving oxygen by facemask responded with enthusiasm when the topic of mystical experience was broached. However, his speech was muffled and indistinct. Staff nurses told me that he often spoke of religion, but that he had a significant speech impediment, making his speech hard to understand even for those who knew him well. This man was thanked for his interest, but the full interview was not pursued.

A last small group of potential participants who were excluded were those persons who stated they had had spiritual experiences, but that they were *not* mystical, and those who said they had had dramatic experiences such as near death experiences that were *not* spiritual. They did not meet the screening criteria for inclusion. Table 3.3 shows the numbers of potential participants excluded from participation in the study and the reasons.

Table 3.3 Potential participants excluded from participation

Date and setting a = Alpha Hospital b = Beta Hospital	Number potential Participants approached or contacted	Number patient participants not identifying any mystical or spiritual experience in the context of health care	Number patient participants expressing spirituality but not mystical or spiritual experience in the context of health care	Number patient participants expressing unusual experience, such as out of body experience, but denying spiritual connection	Number patient participants who could not respond, who did not understand, or who could not speak clearly enough to be understood
8/7/05 b	3 patients	2 patients	0 patients	0 patients	0 patients
9/7/05 b	2 patients	1 patient	1 patient	0 patients	0 patients
11/7/05 b	1 patient	1 patient	0 patients	0 patients	0 patients
15/7/05 b	3 patients	0 patients	0 patients	0 patients	0 patients
22/7/05 b	2 patients	0 patients	1 patient	0 patients	0 patients
24/7/05 b	1 nurse				
28/7/05 b	4 patients	1 patient	0 patients	0 patients	2 patients
29/7/05 c	1 nurse				
12/8/05 b	2 patients 1 nurse	2 patients	0 patients	0 patients	0 patients
1/9/05 c	1 community member				
23/9/05 a	6 patients	4 patients	1 patient	0 patients	1 patient
28/9/05 a	6 patients	3 patients	0 patients	1 patient	1 patient
5/10/05 a	4 patients	0 patients	0 patients	0 patients	1 patient
12/10/05 a	5 patients	4 patients	0 patients	0 patients	0 patients
14/10/05 c	1 community member				
4/11/05 a	10 patients	7 patients	0 patients	1 patient	1 patient
17/12/05 c	1 community member				
TOTAL	N=54 48 Patients* (31 Alpha Hosp 17 Beta Hosp) 3 Community participants* 3 Nurses	25/48 patients	3/48 patients	2/48 patients	6/48 patients

*Note that patients and community participants include an RN, an LPN, and another self identified nurse. However, the primary interview focus was not their nursing roles, but rather their personal experiences.

3.3.3.4 Initiation of the research process

Initiation of the research involved preparation in the hospital and the community setting. After this preparation, interviews were carried out using a consistent procedure. The processes of preparation and the interview procedure are discussed below.

3.3.3.4.1 Preparation – hospitals

The researcher contacted the Directors of Nursing at Alpha Hospital and Beta Hospital about the possibility of pursuing research with patients in the facilities during the summer and fall months of 2005 (15 May to 15 December). Prior to initiating research, the researcher prepared packets of information that included the *Interview record/Personal reflection* form, a copy of the *Information/Permission* form, and a copy of the researcher's qualifications in the form of *Curriculum Vitae*. These are found in the Appendices A, B, C and D. These packets were made available to the hospital administrators, the Medical Directors, and the Directors of Nursing. According to each Director of Nursing, neither hospital has an internal research review board. Permission for nursing research is obtained directly from the Director of Nursing (in consultation with the hospital administrators). The researcher sought documentation of such permission in writing. Copies of the letters of permission are found in Appendix E. United States Health Insurance Portability and Accountability Act (HIPAA) regulations specify procedures to follow when conducting research. The research protocol was consistent with HIPAA requirements. Confirmation of the researcher's training in HIPAA requirements is found in Appendix F.

3.3.3.4.2 Preparation – community

The researcher also sent one e-mail message to the faculty and staff of the educational institution in which she is employed. This institution is centrally located in the study area, and the e-mail message represented a limited attempt to locate participants who were not currently hospitalised. This message, as well as administrative permission to use e-mail for this purpose in the researcher's workplace, is found in Appendix G. The researcher believed that in a small community the e-mail message would contribute to the snowball effect, publicising the research and possibly yielding additional participants. This process yielded two participants. An additional individual identified

himself as having had several mystical experiences but chose to exclude himself from the study because he did not feel that his experiences were related to stress or health factors of any kind. One further effect of the e-mail was to increase interest and cooperation with the study in the researcher's workplace.

3.3.3.4.3 Interview procedure

Each time interviews were attempted in the hospital setting; the researcher identified herself to the nurse manager or charge nurse on the medical-surgical unit and stated her plans. She asked for a patient census list and asked if any patients should not be interviewed, either because of their condition or because they were on isolation precautions. The census lists each patient's name and room number. The census at Alpha Hospital also includes age, admitting diagnosis, physician, source of payment, and length of stay. (Parts of this data, with patient and physician names deleted, were recorded for each patient with whom an interview was attempted.) The census list at Beta Hospital proved to be less comprehensive. Staff nurses at Beta Hospital seemed to prefer giving a verbal list of patients and room numbers, with some limited additional information. Since the census at Beta hospital was low, often less than six or seven patients, the verbal list was workable. The researcher also asked the nurse manager or charge nurse if any patients had reported mystical experiences. (The only patient who was reported as likely having had a mystical experience – at Beta hospital – denied it when asked.)

The researcher identified herself clearly on the patient care units as a nurse and a researcher by wearing a white laboratory jacket and a large nametag with her name, title, and UNISA affiliation, to clarify her nursing role. Because nurses in the United States are no longer required to wear caps or white uniforms, often patients do not know who is, and who is not, a nurse (Mason & Buhler-Wilkerson 2004:11) .

After preliminary communication with the nurse manager or charge nurse, the researcher conducted loosely structured, minimally guided interviews with patients meeting the inclusion criteria. Some structure is required when the interviewer knows the questions to ask, but wishes to remain open to a variety of possible responses (Morse & Fields 1995:94). Maslow, in researching the characteristics of "peak experiences" using interview techniques, notes the difficulty of getting subjects to

describe an experience usually referred to as ineffable, and indeed, reports problems in describing to the participants the type of experience he was researching. He finds the use of “poetic language” useful, and notes that some people simply need to be given permission to talk about their peak experiences (Maslow 1964:84).

In the hospital settings, the researcher first planned to interview any patient who was identified as possibly having had a mystical experience and then progressed through the census list, attempting as many interviews as practical for the day. The researcher interviewed participants using the format found in Appendix A. Typically, a session of interviewing yielded one or two usable interviews. Additional referrals were welcomed from patients, staff, and colleagues, reflecting the snowball effect, whereby one interview leads to others (Fields & Morse 1985:58). Although such referrals would have been welcome, the snowball effect did not prove to be a significant source of participants.

With the permission of the participant, the researcher digitally audio recorded most of the interviews. One patient declined to be recorded, but was willing for the researcher to take notes. Another interview was only partially recorded because of difficulties with the recording equipment. Also, one telephone interview offered by a nurse was not recorded because of the difficulty of doing so on the telephone, nor was written permission obtained for this interview. (Informed consent was obtained verbally.) Extensive notes were written for the interviews which were not audio recorded.

Informed consent and a signed permission form were obtained from all participants, except the telephone interview indicated above, and one interview of a nurse administrator. This interview was somewhat peripheral to the research, focusing on paranormal events at Beta hospital. The nurse administrator gave verbal consent (Appendix B) to be audio recorded, but stated she did not feel a need to sign a permission form.

After each interview, the researcher wrote down personal observations and reflections in a designated format that included specific provision for reflective journaling. This format, designated *Interview record/Personal reflections* is found in Appendix A. Additional entries, sometimes, but not always, relative to a specific interview, were also maintained in a separate journal. Reflective journaling is identified as a valuable tool in

phenomenological research, facilitating bracketing (Wall et al 2004:1-7) and developing the researcher's self-knowledge and perception (Shutz 1994:416).

At the end of the research day, the researcher told the nurse manager or charge nurse she was leaving the facility, returned the patient census list to be shredded (to maintain confidentiality), and provided a means of contact.

When interviews were conducted outside the hospital setting, the same interview procedure was followed. In the community settings the researcher did not wear a lab coat, and did not announce her presence or activity to anyone not associated with the interview.

3.3.3.5 Sample size

A total of 54 persons was personally contacted by the researcher. This yielded 11 interviews of hospitalised patients, one interview of a patient's family member who was visiting in the hospital, three interviews of persons in the community (not currently hospitalised) and three interviews of nurses who wished to contribute to the research. A total of 18 interviews forms the data base for this study.

The researcher's goal was to obtain at least ten interviews in which the patient described a mystical experience that occurred in a health care setting, or that was related to stress or an alteration in health. It was expected that a certain number of patients would report having had some type of mystical experience, using the broad definition in section 1.9.1; however, the patients reporting these experiences *in the context of health care* represented the sample for study. (The *context of health care* was interpreted broadly to include not only the inpatient hospital setting, but also other circumstances associated with physical or psychological stressors in which the individual and/or family member *might* receive nursing care or communicate with a nurse.) Interviews were conducted until the data approached saturation, and enough data were obtained for a complete description (Cohen et al 2000:12). Morse (1991:140) warns that saturation may be a myth, and that a new sample may reveal new information. Therefore, as many interviews as possible were undertaken, above a minimum number of ten interviews. A minimum sample size of ten is small, but is acceptable for qualitative research (Polit & Hungler 1999:299). Kvale (1996) notes, "In

current interview studies, the number of interviews tends to be around 15 ± 10 . This number may be due to a combination of the time and resources available for the investigation and of the laws of diminishing returns" (Kvale 1996:102). The 18 interviews obtained provided a rich data base.

3.3.3.6 Data collection

In this study, data are derived from several sources: audio recording of interviews with patients, interview transcripts, conversations with nurses and other colleagues, and the researcher's reflective journal. The interaction with patients is considered to be a source of data about the phenomenon of mysticism and also about the nursing role. Schultz notes that "[p]ersonal experience recorded and reflected upon can be itself an informant in research data ..." (Schutz 1994:416). Reflective journaling can also aid in bracketing (Wall et al 2004:1-7).

Interview questions purposefully were kept open. For example, specific religious denominational affiliation was not asked, as the question itself adds a religious context to the interaction – a context that may not reflect patient experience. The research focused on patients and what they had to say about mystical experiences, without interjecting the researcher's own experiences and interpretations. If asked, the researcher discussed her perspective briefly, attempting to remain neutral and to return the focus to the patient experience. The researcher believes that when the nurse gives information about herself in the research process, it may lead patients to express themselves in a way that they perceive as congruent with the researcher's expectations. However, occasionally the researcher shared limited personal information when she felt that it would demonstrate her understanding or acceptance of what the participant was saying.

Morse and Field (1995:94-96) discuss the principles of interview technique in qualitative research. Good listening techniques, honesty, and at times, a somewhat passive role are necessary. Kvale further observes that the interview process may be something of an art (Kvale 1996:13). The researcher expected the interview process to develop as the interviews were carried out. And this is what happened. The interview process moved from an early reliance on format to a process of just listening, with the interview tool as a simple reminder of the research focus.

At first, procedural matters were paramount. At times the researcher wondered if her responses were the best she could have made, if she were unnecessarily indulging in small talk, and if she were using the most appropriate language to initiate discussion. The researcher began to realise that her interventions were built on responses to the settings and the participants. In time, she developed a sense of the most useful interventions which supported patients sharing mystical experiences. For example, Purnell and Paulanka note the use of small talk to be appropriate to establish trust in interactions within the Appalachian culture. They also note, "Sensitive topics are best approached with indirect questions and suggestions" (Purnell & Paulanka 2005:48).

Even with the use of small talk, and an oblique approach, it was necessary to explain the purpose of the research and to obtain informed consent. It was a challenge for the researcher to explain the focus of the research. Maslow himself described the difficulty of explaining to research participants what he meant by *peak experiences* (Maslow 1964:84-89). The interviewer recorded a variety of questions which she tried to use, but in the end, the most productive (albeit wordy) way of explaining the research was this: *Have you ever had a mystical experience or unusual spiritual experience at a time of physical or mental stress or when you were receiving health care?*

The researcher found the term *mystical experience* by itself to be apparently puzzling for some. Occasionally she suggested related concepts, such as *experience of God*, *near death experience*, or *out of body experience*, but she tried to refrain from this as possibly leading participants towards particular responses. However, even when such related concepts were presented, they did not seem to be leading, rather serving to make clear that the researcher was interested in unusual spiritual experiences consistent with a broad definition of mysticism.

The most effective terminology proved to be the use of the paired phrase "*mystical experience or unusual spiritual experience*". While this does add to the defining characteristic terminology of "reports mystical experiences", in the nursing diagnosis Readiness for Enhanced Spiritual Well-Being, (Wilkinson 2005:513), the phrase served to clarify the research focus. It is difficult to say whether this paired phrase would be useful in other cultural settings, but the researcher suspects it might be. It was well understood by the study population. It should be noted that the broadness and inclusiveness of the initial questions also opened the possibility that experiences would

be included that could only be called mystical in the most generous meaning of the term.

Once the interviews were initiated, the researcher reflected on the language she used. Often when a participant made an intense statement, she would be perplexed at what would be the most appropriate response. She came to realise that any comment that indicated attentiveness and affirmation of the reality of the experience was acceptable, and that silence was also acceptable. Purnell and Paulanka (2005:48) note silence as being acceptable within the Appalachian culture.

The other side of silence is listening, and the researcher found that if she concentrated on listening, rather than coming up with the right response, the participants often shared more. In listening, she found that participants were able to share aspects of their experiences that were surprising and even troubling. Allen, in discussing spiritual direction, asserts the importance of *listening*, rather than *hearing* (Allen 1994:111). This recommendation seems equally relevant to nursing care. Baumann and Englert (2003:53) also affirm the importance of listening in spiritual nursing care. In addition to listening, the researcher also found it important to express verbally and nonverbally to the participants how much she valued their willingness to share, by quiet attentiveness and focus on the participants' stories.

Although listening is important in supporting patients expressing mystical experiences, the nurse must address the patient holistically, and sometimes, this means attending to other physical and psychological needs. The researcher was constrained by her role from actually giving care, but in several instances she requested support from the nursing staff, as when for example, a patient started vomiting uncontrollably, or an intravenous pump was malfunctioning. A patient who is vomiting is in no condition to discuss spirituality. In other instances, an interview was cut short, or a pause was made, because the patient was experiencing shortness of breath or prolonged coughing. Participants who were hospitalised were, in general, somewhat frail and weak, and the interviews required them to extend a limited supply of physical and emotional energy. The researcher made the patient's physical and psychological needs a priority over the expression of spiritual experience.

Figure 3.1 shows a diagram of the guided interview process.

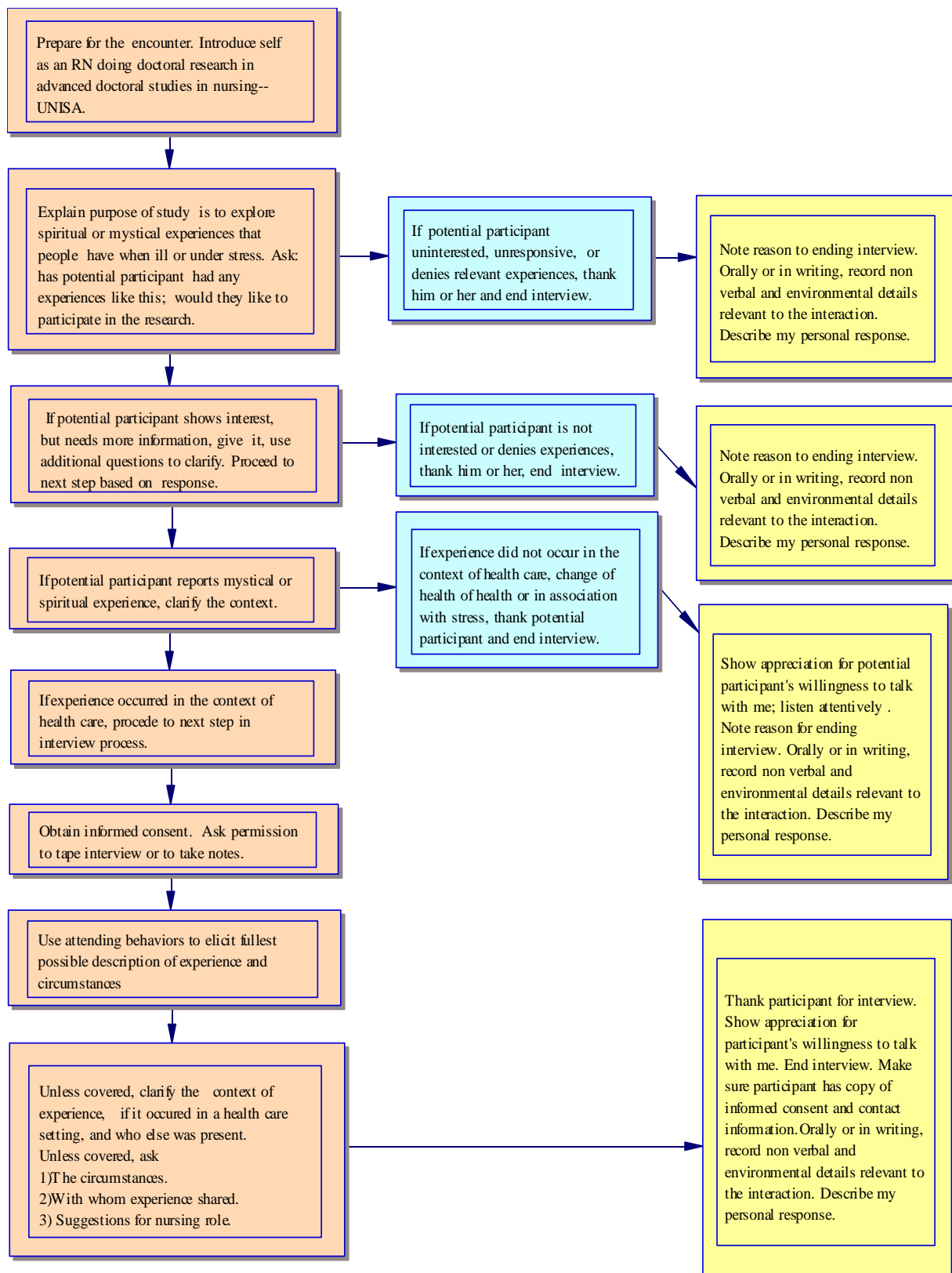


Figure 3.1
Interview process

The loosely structured steps of the guided interview procedure were designed to provide consistency in the patient encounter and to facilitate possible replication of the research with other patient populations (Field & Morse 1985:7). The steps in the process are detailed below. (Steps relevant to the *non-selection* of potential participants are italicised.)

- 1) Prepare for the encounter. Introduce myself as a Registered Nurse doing doctoral research with the University of South Africa.
- 2) Explain that the purpose of the study is to explore spiritual or mystical experiences that people have had when they were experiencing physical or emotional stress or when they were receiving health care. (Several introductory statements were attempted, but this statement, although wordy, seems to be best understood by participants.)
- 3) If potential participant expresses interest, but needs clarification, ask additional questions such as “Have you ever had a mystical experience or unusual spiritual experience associated with a change in your health or at a time of physical or psychological stress?”, or “Have you ever had an experience in which you felt that you were very close to a powerful spiritual force that seemed to lift you out of yourself?” (Greeley 1974:141). These additional questions use varying terminologies to which it is believed hospitalised patients are able to relate.
- 4) If the potential participant denies relevant experiences, is unresponsive or uninterested, note reason, thank him or her, and end interview. (If indicated, reassure that non-participation will have no effect on further health care.) Note reason for ending interview.
- 5) If potential participant describes having a mystical experience but denies its association with stress or any change in health, listen attentively showing appreciation for participant’s willingness to talk with interviewer, but do not proceed with interview. Reiterate focus on mystical experience in the context of health care and end interview. (If indicated, reassure that non-participation will have no effect on further health care.) Thank potential participant. Note reason for ending interview.

- 6) Offer participation in the research if participant says he or she has a mystical experience to share which occurred in the context of health care.
- 7) If participant is responsive and willing, obtain informed consent. Ask for permission to audio record interview or to take notes. Ask the patient to tell about himself or herself and why he or she is in the hospital (if indicated). Ask, "Would you tell me about your experience?" Use attending behaviors to elicit fullest possible description of experience and circumstances. If not addressed spontaneously, ask if the experience occurred at a time of mental or physical stress, if it occurred in a health care setting, and who else was present? If not addressed spontaneously, ask
 - The circumstances
 - With whom, if anyone, the participant shared the experience
 - Other comments about the experience and the nursing role

Use Interview Record to guide interview if data is not elicited spontaneously (see Appendix A).

- 8) Thank the participant. Reiterate the value of the participant's contribution. Make sure participant has copy of informed consent with signatures and contact information.
- 9) Record non-verbal and environmental details relevant to the interaction on the interview record.
- 10) Record personal reflections for each interaction on the interview record. (Add personal responses not associated with specific interviews to the reflective journal.)

3.3.3.7 Qualitative approach to the data

A method of data organisation and analysis developed by Van der Wal in South Africa was employed to support the identification of codes and themes, the circular approach to editing and the process of immersion/crystallisation. This method involves the use of

word processing software to organise data units and codes, in-depth analysis, and tabular categorisation of findings (Van der Wal 2005: personal communication). Inspiration 7.5 concept mapping software was also used to identify and develop patterns and relationships in the data findings.

Interviews were transcribed by a professional typist, adapting Morse and Fields' (1995:130-131) suggestions for interview transcription and formatting. Olympus transcription software was used to support the transcription process. The transcripts were proofread several times for accuracy and for the insertion of such factors as pauses, changes in tone, non-verbal behaviors, and environmental factors, including interruptions.

Each interview was identified by a designation "P" (participant) and a numeral. The numerals are derived from the recording software and have no special significance. (The original interview numerals generated by the Olympus recording software were retained to aid in the establishment of an audit trail.) When they were not recorded digitally, interviews were given a random, but sequential number in the sequence of interviews. As interviews were subsequently broken down into data units for analysis, each data unit was identified by the participant number and the number of the data unit. Thus **P33 12** refers to participant 33, data unit 12.

3.3.3.7.1 Coding and theme identification

Because there are no qualitative data in the field of mysticism research from which coding can be derived, original codes had to be developed by the researcher. According to Boyatzis (1998), using codes based on the raw data would require the researcher to design a theoretical framework that supported the code. Were the development of thematic codes to be based only on prior data and theory, the researcher might be restricted in identifying new data (Boyatzis 1998:30-31). The researcher believes that a theoretical construct of mysticism can be developed that integrates with contemporary nursing theories such as Watson's *Theory of Human Science and Human Care* (1985) and Paterson and Zderad's *Humanistic Nursing Theory* (Kleiman 2001 in Parker 2001).

Boyatzis (1998:62) notes the importance of correctly identifying the unit of analysis and the units of coding in qualitative research. The unit of analysis in this research is the

patient-nurse interaction, including both the content of the patient interview and the notes maintained by the researcher in the interview record and the reflective journal. Initially, using the inductive approach, codes and categories reflecting the content of the mystical experience were developed based on the raw data. Themes were identified as they became evident.

3.3.3.7.2 *Circular approach to editing*

Analysis incorporated an editing approach that involved reviewing the data over and over, during collection and subsequently. Porter emphasises the value of “recursive” and “cyclical” processes of data analysis (Porter 1998:22). This approach was fruitful in analysing mystical experience. This circular approach was utilised to help the researcher examine assumptions and biases and to lead to a depth of analysis otherwise unavailable (Porter 1998:22). *Initially*, each interview was read in full at least three times. During this process, data units were identified and matched with codes and categories. After this, the codes and categories were considered anew, and themes and patterns were identified. These themes were listed in an “analysis tool”, and relevant entries from *all* the interviews were reassembled together, organised under thematic headings. The process of reading and rereading the data was repeated multiple times.

The process of eliciting patterns was accompanied by tabulating interviews in which particular themes occurred. Sandelowski (2001:230) notes that in qualitative research, counting may be used to aid in identifying patterns.

The next step was to reassemble each interview from entries coded and categorised in the analysis tool, notes from interview records and the researcher’s journal. (Note that in reconstruction, the researcher’s statements and notes added later were italicised for clarity.) This process of reading, breaking out categories and themes and reassembly incorporated new understanding that grew with the data analysis.

3.3.3.7.3 *Immersion/crystallisation*

In further support of the recursive practices described above, analysis and interpretation of the data were carried out by means of the immersion/ crystallisation method. Immersion/crystallisation is seen by the researcher as an integrated approach to the

data from multiple directions, using the self, intimacy with the data, and technology, as an aid to thinking and analysis. Borkan (in Crabtree and Miller 1999) describes immersion/crystallisation as a process that seems uniquely appropriate to the study of mysticism. Borkan believes that the *self* is the critical tool in qualitative research. He validates the importance of “uncertainty, reflection, and experience” in a process that is meditative and almost spiritual at times (Borkan in Crabtree & Miller 1999:181). This approach involves the researcher’s “immersion” in the data. It requires rich data and field notes, a personality type suitable for the task, adequate time, the ability to reflect on the data and the researcher role, attention to process, and experience (Borkan in Crabtree & Miller 1999:181-182).

Borkan (in Crabtree & Miller 1999:183) identifies several phases of the Immersion/crystallisation process:

- Initial engagement with the topic/reflexivity
- Describing
- Crystallisation during data collection
- Immersion and illumination of emergent insights from collected data and texts
- Explication and creative synthesis
- Corroboration/legitimation and consideration of alternative interpretations
- Representing the account/recording (Borkan in Crabtree & Miller 1999:183)

This process is similar to the process that Parse (1985:19) calls “contemplative dwelling” with the data, the reading and rereading process that opens the researcher to overt and covert meanings. Reading and rereading the data is an important aspect of immersion (Cohen, Kahn & Steeves 2000:76). Concurrent with this reading and the assembly of an analysis tool, Inspiration 7.5 software was used to develop a concept map to explore and clarify the patterns and relationships among themes. This map was developed as a series of *crystals* representing themes which could be placed and moved to overlap or fit among other themes. Because the experience of mystical experience was increasingly revealed as integrated *process*, the use of arrows was minimised, as the researcher wished to identify relationships and interactions rather than linear cause and effect. The use of the concept map made it possible to integrate other aspects of the researcher’s experience, piece them in with the research data, or remove them as seemed relevant. Individual interviews, once reconstructed, were also

compared to the concept map to carry out “imaginative variation” and to look for exceptions.

The researcher also organised her thoughts in a power point slideshow. The graphic representation of ideas and relationships was then viewed with a fresh eye. The power point was modified as the depth of analysis increased.

Thus the progress of data analysis included reading and rereading, coding and classification, organisation of codes and classifications as themes, development of a concept map based on these themes, and reassembly of the data, all supported by the researcher’s in-depth analysis and development in understanding.

3.3.3.8 Determining use for the phenomenon and features

Porter (1998:21) discusses the need to determine use for the data. Based on the data analysis, a description of the mystical experience in the health care context was developed, with special attention to triggers and assessment factors accessible to the nurse. The circumstances and communication techniques most productive in supporting the patient as he or she shared the experience were identified, as well as concerns particular to the nurse. From the researcher’s interview records, field notes, and reflections and the patient transcripts, nursing assessment and interventions for patients experiencing mystical experiences were delineated, consistent with the nursing diagnosis, *Potential for Enhanced Spirituality* (Cavendish et al 2000).

Although not all theorists advocate the use of nursing diagnosis, NANDA International nomenclature is widely used in North America. The nursing diagnosis *Potential for Enhanced Spirituality* makes specific reference to mystical experience (Wilkinson 2005:513-514), and it is valuable for nurses to have a common understanding of the term in clinical use.

Consideration of the researcher’s reflective journaling, in addition to the interview data, provided a basis for considering the subjective experience of a nurse sharing a patient’s expression of mystical experience. Understanding the researcher’s subjective experience contributed to a richer appreciation of the nursing role and yielded suggestions for nursing interventions with patients. In addition, several interviews

contributed by nurses about their experiences also yielded useful data about the nursing role.

3.3.4 Ethical considerations

In qualitative research, the researcher must acknowledge the delicate play of power and control between researcher and participant (Fryer & Feather 1995 in Cassell & Symon 1995:233). Ethical considerations encompass the principles of autonomy, beneficence, nonmaleficence, and justice (Sullivan & Decker 2005:68-69). As potential ethical issues are identified, professional ethical guidelines provide direction for decision-making (Silverman 2001:55). Other important sources of guidance are Federal laws regarding privacy (Health Insurance Portability and Accountability Act – HIPAA) and the institutional guidelines that support HIPAA. Although there is some overlap, each of these standards and guidelines is considered below.

Autonomy, dignity and confidentiality are prominent concerns in the American Nursing Association *Code for Nurses* (2001) and the International Council for Nurses *Code for Nurses* (1973). Although qualitative research does not present quite the risks that may be associated with quantitative research, informed consent must be obtained from the participants, ensuring a measure of patient autonomy. Permission for research was also sought from the hospitals, based on the policies they identified. Dignity was embedded in the interview process, as patients were considered equal participants in the research undertaking and every one of their statements was considered worthy of attention and respect. The researcher addressed each participant by title, unless requested to do otherwise. Moustakas emphasises the dignity and importance of the participants' role in qualitative research. He refers to research participants as *coresearchers* and identifies the principle of *horisontalisation*, in which the investigator is “receptive to every statement of the coresearcher's experience, granting each comment equal value and encouraging a rhythmical flow between the research participant and the researcher” (Moustakas 1994:123). The researcher also considered the participants to be coresearchers, but did not use this term in the clinical setting, as it could have been confusing to the participants. However, the principle of horisontalisation was apt and was applied throughout the interviews.

Confidentiality was ensured, and informed consent was obtained using the form found in Appendix B. Interviews were carried out in as private a manner as possible and information elicited was not shared with others. Confidentiality in small communities is a significant concern. The researcher made particular efforts to keep field notes, audio files, and transcripts in a secure location. She gave directions to the typist and colleagues involved in reviewing the data that confidentiality must be maintained.

Federal HIPAA regulations impose a strict standard of privacy and confidentiality on anyone who has access to patient information. The HIPAA Privacy Rule research guidelines [45 CFR 164.501, 164.508, 164.512 (i)] require that identifiable health information of human subjects remains private and confidential. The requirements for the use of confidential information are detailed and rigid. However, they do allow “disclosure with individual authorisation” by the patient. Such patient authorisation allowing disclosure means that an institutional review board does not need to perform a waiver for the use of selected patient data *if* the patient has given permission for its use (United States Department of Health and Human Resources 2003:1-5 <http://www.hhs.gov/ocr/hipaa/guidelines/research.pdf> accessed 14/3/2005). The patient permission form in Appendix B identifies the limited patient information that was requested in order to obtain patient cooperation and consent and to validate to the hospitals that the researcher was not requesting access to protected patient records. Privacy is taken seriously by both Alpha Hospital and Beta Hospital, for violations of HIPAA have serious legal implications. Both hospitals issue privacy statements to each patient, and both fully support the standards of the HIPAA Privacy Rule. Privacy and autonomy are intrinsic to the overriding focus on the patient as a valued contributor in the research process, an individual worthy of dignity and respect.

The draft document of the *Faith Community Nursing: Scope and Standards of Practice* (2005) suggests valuable guidelines for research. Although this document makes reference to the American Nursing Association Code for Nurses (2001), it also specifies the scope of practice for the faith community nurse. Standard 12 states: “The faith community nurse integrates ethical provisions in all standards of practice.” (Faith Community Nursing 2005:21). Several of the *Measurement Criteria* listed for this standard are relevant to this research. These criteria state that the faith community nurse:

- *Acknowledges and respects patient's tenets of faith and spiritual belief system.*
- *Delivers care in a manner that preserves and protects patient autonomy, dignity, rights, spiritual beliefs and practices.*
- *Maintains a therapeutic and professional patient-nurse relationship with appropriate professional role boundaries.*
- *Demonstrates a commitment to practicing self-care, growing spiritually, managing stress, and remaining connected with a centered-self and others (Faith Community Nursing 2005:22).*

The value of these guidelines is that they address not only the ethical mandates of dignity, autonomy, and role boundary maintenance, but also the spiritual status of the patient and the nurse. The nurse as researcher must maintain respect for the patient as an autonomous spiritual being. (It is likely that the patients interviewed had religious and spiritual orientations different from those of the researcher. Her religious affiliation is with a denomination with a marginal presence in the study area, but one that has been the subject of national and international controversy.) The researcher refrained from sharing her beliefs, proselytising, or engaging in religious debate. Maintaining an open and respectful receptivity to the patient's expressions of spirituality and religious belief was essential.

The researcher did not ask participants their denominational affiliation. She did, however, address the spiritual effects of the mystical experience when patients did not bring this up spontaneously. The patient's response cued the researcher's interaction. The researcher was prepared to make pastoral care referrals if this seemed necessary. However, no such referrals were made, and in general, participants seemed to be dealing with their experiences capably.

The standards also address the spiritual well-being and self-care of the nurse. This is relevant to the proposed research. Interviews may involve stress for the researcher. The researcher was the recipient of personal and emotionally intense communications, yet had a mandate to analyse the content of these communications in a dispassionate manner. She also faced possible conflict in the research role. As researcher, she

projected the caring stance of the nurse, yet the research role limited her from actually rendering physical care.

Self-care for the researcher involved planning her time to allow for recreation and family and seeking the support of colleagues who share her interest in research. As she made the long drive to the hospitals to interview patients, the researcher listened to heartening music, such as that of the ecumenical French Taizé community.

Another source of ethical guidelines is the *Code of Ethics for Spiritual Guides* developed by the Council for Spiritual Practices, a group promoting “primary religious experience” (Council on Spiritual Practices 2004 <http://www.csp.org/> accessed 27/10/2004). This code is designed for spiritual practitioners such as ministers, pastors, curanderas, and shamans, and is relevant to a researcher investigating spiritual matters. Autonomy, dignity, confidentiality, and consent are identified as important standards. And, as in the *Faith Community Nurse Guidelines*, practitioners are advised to be tolerant and respectful of the beliefs of the persons with whom they work.

The Council for Spiritual Practices guidelines are particularly valuable in that they address the vulnerability of participants to the influence of the spiritual practitioner and to the influence of institutions and organisations. Professional integrity is mandated; the practitioner must make participants aware of the possible physical or psychological risks attendant on awakened spiritual practice. No physical risks were identified in this research, other than possible fatigue, but psychological stress could result from sharing and reviewing intense personal experiences. This possibility was clearly identified in the patient permission form in Appendix B. Had fatigue or stress occurred, the researcher was prepared to offer personal support and to end the interview if necessary. (One potential participant offered to participate, but was experiencing respiratory distress, so he was thanked for his interest, but not interviewed.)

The *Code of Ethics for Spiritual Guides* also notes that practitioners should “assist with only those practices for which they are qualified by personal training or education” (Council on Spiritual Practices 2004 <http://www.csp.org/> accessed 27/10/2004). The researcher’s graduate level preparation as a psychiatric liaison nurse was appropriate for the nursing support of patients expressing spiritual or psychological stress associated with hospitalisation and health care. Should specialised counseling have

been needed, each hospital had, on call, chaplains and psychologists associated with the medical staff. If it were indicated, these resources could have been identified to participants. The researcher did not, however, initiate referrals independently, nor did she identify any participants for whom this was a need.

A final guideline indicated most clearly in the *Code of Ethics for Spiritual Guides* (Council on Spiritual Practices 2004 <http://www.csp.org/> accessed 27/10/2004) is the call for peer review. The researcher identified several Advanced Practice Nurses who were prepared to offer guidance and feedback as the research progresses. One of them read every interview in its entirety and compared the interviews with the Concept Map of Mystical Experience (Figure 4.1) derived from the research findings. Several other colleagues voiced interest in the research and offered productive insights. Participant confidentiality, was, of course, maintained.

3.3.5 Evaluation – trustworthiness

The evaluation of qualitative research may use the terminology of quantitative research, *reliability* and *validity*, or it may be addressed using the term *trustworthiness*, as better reflecting the character of qualitative research. Cassell and Symon (1995:32), Polit and Hungler (1999:429), and Boyatiz (1998:31) discuss the evaluation of qualitative research using the terms *reliability* and *validity*. Lincoln and Guba, in contrast, refer primarily to *trustworthiness* (Lincoln & Guba 1985:289-331) as parallel to *internal validity* (Guba & Lincoln 1989:236). This discussion responds to both evaluation perspectives.

Lincoln and Guba (1985:328) explicate the factors that contribute to the *trustworthiness* of qualitative research as *credibility*, *transferability*, *dependability*, and *confirmability*. *Credibility* is enhanced by “prolonged engagement, persistent observation, and triangulation” (Lincoln & Guba 1985:301) as well as “peer debriefing ... negative case analysis ... progressive subjectivity ... [and] member checks” (Guba & Lincoln 1989:237-238). *Transferability*, which is “parallel to external validity or generalisability” (Guba & Lincoln 1989:241), is not brought about by means of a certain technique, but rather by providing a rich enough data base that a judgment may be made about its quality (Lincoln & Guba 1985:316). *Dependability*, analogous to *reliability* (Guba & Lincoln 1989:242), is described as a function of a potential auditing process, somewhat similar to the fiscal audit of a business (Lincoln & Guba 1985:317-318). This audit is also

described as a “confirmability audit” and is fundamental to establishing the *confirmability* of qualitative research. Guba and Lincoln compare confirmability to objectivity (Guba & Lincoln 1989:242). It requires a clearly defined “audit trail” in which the research data and decision-making processes can be reviewed and evaluated by someone outside the research process itself (Lincoln & Guba 1985: 318-320). A “data supplement” has been developed for this research project which could facilitate a subsequent confirmability audit. The numbering of individual data units also contributes towards this end.

Guba and Lincoln note that the above criteria used to evaluate qualitative research have counterparts in the concepts of *validity* and *reliability*. However, they point out that these are criteria of methods, and reflect the positivist model. They propose, in addition, several *authenticity criteria*, relating to “fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity” (Guba & Lincoln 1989:245-250). Authenticity criteria continue to receive emphasis in qualitative research (Guba & Lincoln 2005 in Denzin & Lincoln 2005:207-208).

3.3.5.1 Credibility

Credibility in this research reflects prolonged engagement and persistent observation by the researcher (Lincoln & Guba 1985:301). The researcher has been studying the literature on mysticism since the early 1980s. She has had a growing awareness of the potential of the health care environment to contribute to mystical experience. This research represents not a beginning, but rather a culmination of interest and engagement. The time spent in the clinical setting actually performing interviews encompassed six months. The time spent in planning and discussing the research concepts with peers and colleagues exceeded two years. The process was one of increasing immersion in the concept, until it seemed that the researcher lived in a continual ambience of mysticism. It seemed as though all of her diverse interests, her idiosyncrasies and her abilities came together as she progressed in this research. And yet, in the clinical setting, she maintained the stance of researcher, of onlooker, for to do otherwise, would be to “go native”, the process Lincoln and Guba (1985: 303-304) warn against, when self-awareness as investigator is lost. The researcher found, however, that she had a growing sense of privilege, of receiving great gifts, as patients, community members and nurses told their stories, and this sense she did not reject.

Credibility is enhanced by triangulation, peer debriefing, negative case analysis, progressive checking and member checking (Lincoln & Guba 1985:238-239, 305-309). Triangulation involves the use of a variety of data sources (Powers & Knapp 2006:180). The data derived from patient interviews and the reflective journal are compared to data gained from discussions with nursing staff and the professional literature discussing mystical experiences in the health care setting.

Interestingly, Janesick (2000) suggests that crystallisation is a better approach than triangulation in addressing qualitative research credibility. Crystallisation includes “incorporation of various disciplines as part of a multifaceted qualitative research design”. In reference to crystallisation, Janesick describes the value of journal keeping and other aspects of the arts (Janesick 2000 in Denzin & Lincoln 2000:391-2). The researcher’s journal was intrinsic to the research process, and the development of concept models was experienced as an aesthetically satisfying aspect of the investigation.

Peer debriefing is a valuable adjunct to qualitative research in which the researcher explores the research process with a peer who has an objective perspective (Lincoln & Guba 1985:308). Several of the researcher’s colleagues expressed interest in the research and were valuable sources of ongoing feedback.

Negative case analysis involves revising qualitative conclusions until every variation in data is explained (Lincoln & Guba 1985:309). This required that interviews be conducted in as much depth as possible and that the number of interviews be sufficient to approach saturation, so that important variations were not missed. Reconstructing each interview using the analysis tool was valuable for identifying negative cases and resulted in the revision of some themes as the data was analysed.

None of the themes identified in this research reflects the experience of all participants, but all the themes identified reflect the experiences of more than one participant. Tables of patterns are presented to show the incidence of themes among participants.

Progressive subjectivity is a way of monitoring and analysing changes in the researcher’s own understanding (Guba & Lincoln 1989:238). It was promoted by the reflective journaling process.

Member checking is the last factor of *credibility* to be addressed by Guba and Lincoln (1989:238-239). This involves returning to the participants to share conclusions (Guba & Lincoln 1989:238-239). During the interviews, the researcher summarised and clarified, but she made only limited attempts to return to the participants because of the demands for confidentiality imposed by the health care system.

3.3.5.2 *Transferability*

Transferability is brought about by the development of a rich data base (Lincoln & Guba 1985:316). The data base in this research includes 18 interviews, numerous notes of conversations with nurses and others about mystical experiences, and reflective journal entries.

The term *transferability* is associated with validity in qualitative research (Guba & Lincoln 1989:241). The term *transferability* suggests that the “findings are meaningful to other persons in similar situations” (Powers & Knapp 2006:181). In qualitative research, as in quantitative research, validity is a measure of whether the research is actually measuring or examining the concept it purports to measure or examine. However, in quantitative research, validity is most affected by the quality of the data interpretation (Cassell & Symon 1995:32). It is also affected by the credibility of the researcher (Polit & Hungler 1999:429), with credibility seen as both a function of the researcher’s credentials and the researcher’s prolonged engagement with the data. Credibility issues addressed above are relevant to the establishment of reliability and validity.

It should be noted that the willingness to be open to codes based on the raw data increases the validity of the research, as the researcher is close to the information itself (Boyatzis 1998:31). Codes and themes, with associated data, were shared with a nurse colleague to strengthen the measure of reliability.

3.3.5.3 *Dependability and confirmability*

Dependability and *confirmability* (Lincoln & Guba 1985:317-320) were addressed in this research by establishing an audit trail by which the research could be examined in the future. A *data supplement* was compiled which included

- Original interview transcripts
- Coded and analysed interviews
- Models and concept maps at various stages of development
- Coding tool (table of codes and themes)
- Analysis tool (data chunks sorted by theme)
- Reconstructed interviews
- Summary of conversations not meeting criteria for interview
- Final data displays with changes highlighted

These documents were organised to facilitate analysis and comparison. Digital recordings and records of emails and correspondence are also available as separate files. The interview notes, permission slips and reflective journal are not maintained in a digital format, but can be accessed if necessary.

Dependability is associated with reliability in qualitative research (Guba & Lincoln 1989:242). In qualitative research, reliability refers to the ability of the research to be replicated by a different researcher with the same population and to obtain the same result. However, absolute objectivity is not required. It *is* required that the researcher attempt to self-identify biases and assumptions and to set them aside if they might contaminate the data (bracketing) (Cassell & Symon 1995:30-31). Although each interview was different, the *standardised approach* to the patient interview was an attempt to increase the reliability and replicability of the research. The researcher continually examined her assumptions and attempted to set aside preunderstandings that might prevent an unbiased interpretation of the data. In addition, the circular approach to editing uncovered heretofore unrecognised assumptions with which the researcher dealt. Personal reflection was ongoing and was recorded in a section of the interview notes and the reflective journal.

3.3.5.4 Authenticity

The establishment of *authenticity criteria* as factors of validity is important in addition to the establishment of *credibility*, *transferability*, *dependability*, and *confirmability*. *Authenticity criteria* include “fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity” (Guba & Lincoln 1989:245-250). These

terms refer respectively to stakeholder (participant) involvement and “open negotiation”, respect for the participants’ constructions, supporting participants to understand other’s constructions, action on behalf of participants, and empowerment of participants (Guba & Lincoln 1989:245-250). In this research, the act of listening to participants’ experiences in an interested, open, and nonjudgmental way was seen as promoting empowerment. The researcher consistently sought to affirm the value and importance of each patient’s spiritual experience, *even when it did not fit directly within the guidelines of the research*. Some of the participants’ experiences included phenomena which were marginal to the research focus on mystical experience, but they were accepted as presented, and given full consideration in the process of data analysis. In addition, by specifically asking participants during the research process for suggestions for the nursing role, participants were given a direct voice in the research findings.

3.4 SUMMARY

The research methodology and design incorporate the phenomenological approach, nursing theory, and principles of qualitative research. The research process and interview procedure address ethical concerns and incorporate qualitative principles of trustworthiness. Analysis of the interview data provides the foundation for answering the research questions concerning the lived experience of mystical phenomena by patients in the context of health care and the role of the nurse in such instances.

Chapter 4

Presentation and discussion of the data

4.1 INTRODUCTION

The research project was initiated in accordance with the procedures described in Chapter 3. The hospitals in the study area proved amenable to the research, and several participants were also found in the community. The researcher's colleagues, and others, proved supportive and provided insights that were noted as *conversations* in the researcher's journal, rather than *interviews*. Reflective journaling was carried out throughout the interview process. The researcher's experience confirmed Borkan's assertion that the *self* is the critical tool in qualitative research. His identification of "uncertainty, reflection, and experience" was found to be fundamental to the research process (Borkan in Crabtree & Miller 1999:181). The research proved to be not only a process of data collection, but also a process of transformation for the researcher.

The following sections first present information about the participants, the interviews themselves, and conversations not meeting the criteria for interviews. Mystical experience is then presented as a *process* rather than a static phenomenon. This process is represented in the *Concept Map of Mystical Experience*, which is derived from the researcher's immersion in the data, and which informs the structure of the subsequent data presentation. The *Concept Model of Mystical Experience* (Figure 4.1) is compared to the researcher's earlier *Torus Model of Mystical Experience* (Figure 1.3) which was developed as a function of bracketing. The research questions are then revisited in relation to the *Concept Model of Mystical Experience* (Figure 4.1), data derived from the interviews and other conversations, and consideration of the researcher's reflective journal and interview notes.

4.2 OVERVIEW OF PARTICIPANTS AND THE INTERVIEW PROCESS

A total of 18 persons was interviewed for this study. Eleven were hospitalised patients, one was a visitor of a hospitalised child (counted as a patient for tabulation), three were members of the community, and three were nurses. Of the 11 hospitalised patients, one was a registered nurse, and another claimed to be a nurse, but the type of nurse was

not ascertained. One of the community members was a licensed practical nurse (LPN) with one year of training. (As the study progressed, the need to categorise participants as patients or community members or nurses seemed less important. A person's spiritual experience is not separated into a separate package labeled "patient"; rather it is part of the whole experience of being human.) The following tables present an overview of the interviews and characteristics of the participants and their experiences.

4.2.1 Overview of interview process

An overview of the interview process is exhibited in Table 4.1 below.

Table 4.1 Overview of interview process

Date and setting a = Alpha Hospital b = Beta Hospital c = Community	Number of potential participants approached or contacted	Number participants expressing mystical or spiritual experience in the context of health care (patients, community members, and nurses)	Number patient participants not identifying any mystical or spiritual experience in the context of health care	Number patient participants expressing spirituality but not mystical or spiritual experience in the context of health care	Number patient participants expressing unusual experience, such as out of body experience, but denying spiritual connection	Number patient participants who could not respond, who did not understand, or who could not speak clearly enough to be understood
8/7/05 b	3 patients	1 patient	2 patients	0 patients	0 patients	0 patients
9/7/05 b	2 patients	0 patients	1 patient	1 patient	0 patients	0 patients
11/7/05 b	1 patient	0 patients	1 patient	0 patients	0 patients	0 patients
15/7/05 b	3 patients	2 patients	1 patients	0 patients	0 patients	0 patients
22/7/05 b	2 patients	2 patients	0 patients	1 patient	0 patients	0 patients
24/7/05 b	1 nurse	(1 nurse offered telephone interview)				
28/7/05 b	4 patients	1 patient visitor – listed as patient for tabulation	1 patient	0 patients	0 patients	2 patients
29/7/05 c	1 nurse	(1 nurse offered interview and added personal experience data on 10/05)				
12/8/05 b	2 patients 1 nurse	0 patients (1 nurse offered interview)	2 patients	0 patients	0 patients	0 patients
27/8/05 b	1 patient	1 patient				
1/9/05 c	1 community member	(1 community member offered interview)				
23/9/05 a	6 patients	0 patients	4 patients	1 patient	0 patients	1 patient
28/9/05 a	6 patients	1 patient	3 patients	0 patients	1 patient	1 patient
5/10/05 a	4 patients	3 patients (1 not interviewed)	0 patients	0 patients	0 patients	1 patient

Date and setting a = Alpha Hospital b = Beta Hospital c = Community	Number of potential participants approached or contacted	Number participants expressing mystical or spiritual experience in the context of health care (patients, community members, and nurses)	Number patient participants not identifying any mystical or spiritual experience in the context of health care	Number patient participants expressing spirituality but not mystical or spiritual experience in the context of health care	Number patient participants expressing unusual experience, such as out of body experience, but denying spiritual connection	Number patient participants who could not respond, who did not understand, or who could not speak clearly enough to be understood
		<i>because of respiratory distress)</i>				
12/10/05 a	5 patients	1 patient	4 patients	0 patients	0 patients	0 patients
14/10/05 c	1 community member	(1 community member offered Interview). Note: Community member was also an LPN, but offered <u>limited</u> discussion of nursing role.				
4/11/05 a	10 patients	1 patient (patient was also an RN)	7 patients	0 patients	1 patient	1 patient
17/12/05 c	1 community member	(1 community member offered Interview)				
TOTAL Note that patients and community participants include an RN, an LPN, and another self-identified nurse . However, the primary interview was not their nursing role, but rather their personal experiences.	N=54 48 Patients (31 Alpha Hosp 17 Beta Hosp) 3 Commu- nity participants 3 Nurses	N == 18/54 12 Patients (13-1 patient not interviewed) 3 Community participants 3 Nurses (interviewed as nurses) Note: Not counted separately are one community member who was an LPN, one patient who was an RN, and one patient who was a self identified nurse)	26/48 patients	3/48 patients	2/48 patients	6/48 patients

4.2.2 Overview of participant demographics and experiences

An overview of participant demographics and experiences is shown in the following table. These demographic and statistical details are offered as a way of rounding out

understanding of the participants and the research, rather than as being intrinsic to understanding of the phenomenon of mystical experience itself. The experiences are described as expressed by the participants, using their terminology when possible and their attitudes toward the reality of the experiences.

Table 4.2 Overview of participant demographics and experiences

Code number	Set-ting	Date of interview	Age	Sex	Diagnosis at time of interview	Age at experience	Health factors associated with experience	Years since experience
Patient 33	B	6/7/05	82	F	Not specified	12, 52	Heart attack	70, 30
Participant 33 was a frail elderly woman, a retired school teacher, who recounted two experiences. The first was a sensation of floating and looking down at her parents at age 10 or 12 when she had scarlet fever. The second followed a heart attack at age 52. She had a sense of moving through a tunnel to a bright light and waiting family, but regretfully, she was made to return.								
Patient 36	B	15/7/05	59	M	Multiple Sclerosis, Rectal and internal bleed, legally blind	53	Not specified	6
Participant 36 was a 52 year old man. He recounted an experience he described as a “spiritual feeling”. It occurred near a Native American burial ground where he and friends were smoking marijuana. They experienced alterations in the electrical lighting and a persistent inability to keep their pipe lit, which they attributed to Native American influences.								
Patient 37	B	15/7/05	70	F	Broken foot, cancer, Diabetes mellitus Type II	68, ongoing	Grief	2, ongoing
Participant 37 was a pale, elderly woman who described visits from her deceased brother and other family during sleep. She called these experiences “visiting night”.								
Patient 39	B	22/7/05	76	F	Hepatitis C outpatient for platelets	22	Near miss auto accident	54
Participant 39 was an elderly woman who described an experience early in her marriage in which she was driving a car with inoperable brakes. Suddenly a powerful arm was seen to jerk the steering wheel to safety, averting a crash. This was thought to be an angel's arm.								
Patient 40	B	22/7/05	72	M	Not specified	1991-1992	Burst aorta	15
Participant 40 was an intense elderly man who recalled falling unconscious while using a chainsaw. He said he had a burst aorta and went in for surgery. He saw a glowing man in the brilliant operating room whom he identified as an angel. He believed he died three times. He moved between the pain and darkness of hell and the light three times.								
Nurse 41 (RN)	B	24/7/05	??	M	NA	Recent < 1 yr	Care of a dying patient	Recent < 1 yr
Participant 41 was a nurse who called the researcher at home to share an experience he had while working. He saw a tall blonde man enter the room of a dying patient. When the nurse entered the room, the man was nowhere to be seen, and the patient had expired. He thought the man might be an angel.								
Patient visitor 43	B	28/7/05	39	F	NA	10	Lightning strike	29
Participant 43 was in the hospital visiting her young nephew who was a patient. Her educational background was in teaching. She described an experience that happened when she was 10 or 12 years old at summer camp. She said she was hit by lightning and had an out of body sensation of floating. She felt a sense of peace when she returned to her body.								

Code number	Set-ting	Date of interview	Age	Sex	Diagnosis at time of interview	Age at experience	Health factors associated with experience	Years since experience
Nurse 44 (RN)	C	29/7/05	~ 45	F	Professional care, also personal grief	28	Care of a dying patient	17
Participant 44 was a nurse practitioner with graduate education in nursing. She volunteered to be interviewed when she heard about the research project. She described an experience which occurred years earlier as a home health nurse. She visited a patient dying of cancer. The atmosphere was disturbing as the family was drinking and partying in the room next to the dying patient, and the patient was screaming and struggling horribly. She believed that he was facing entry into hell as he lay dying. She felt she was in the presence of evil. In contrast, she described another patient who related a positive near death experience, and, some time later, she shared an after death vision of her own father.								
Nurse 46 (RN)	B	12/8//05	62	F	NA	ongoing		
Participant 46 was a nurse administrator with graduate education. She was willing to be interviewed about a ghost which is said to cause activity at Beta hospital prior to the death of a patient. She believed that electrical and mechanical disturbances experienced by the staff and herself were caused by a ghost, the spirit of someone who had died, and presaged a death in the facility.								
Patient 48	B	26/8//05	38	F	Cholelithiasis DM II	28	C section	10
Participant 48 was a pale, ill-appearing woman who described an experience which occurred when her daughter was delivered by Cesarean section. She saw and felt an angel at the head of the operating table and saw Jesus at the foot of the table. She recovered without pain, and her daughter survived a difficult birth.								
Non patient 49	C	1/9//05	29	F	Fatigue	23	Father's heart attack	6
Participant 49 was a staff member in an educational institution in the community. She described a precognitive dream in which she saw her father as a younger man, but bruised on his left side. It turned out that he had just been hospitalised with a heart attack.								
Patient 53	A	28/9//05	42	F	Cholelithiasis w/ Cholecystectomy	17	Post partum	25
Participant 53 was a jaundiced and ill-appearing woman who described several experiences of seeing and interacting with dead family members. In one instance, she saw her brother, who had just committed suicide, smiling and holding her newborn. He also appeared to her later to warn her of danger. She also communicates, on some level with her father and sister who are both dead.								
Patient 56	A	7/10//05	35	M	Cellulitis of leg	23	Stress and grief	12
Participant 56 was an obese man who was a bull dozer operator. He shared an experience of seeing his dead father. He had cared for his father before his death, and was troubled and unsettled at the time of the experience. His father appeared on the porch of his house during a dream, and reassured his son that he was in heaven and that he was at peace. After that, the participant was able to function normally. He and his wife referred to the experience as "the dream".								
Patient 58	A	7/10//05	47	F	Obstructive chronic bronchitis with acute exacerbation	17, continuous	Stress	30, ongoing
Participant 58 was an obese woman with an educational background in engineering, but currently unemployed. Her posture and appearance suggested respiratory insufficiency. She described sensing the presence of her sister and grandmother, both deceased, especially in times of stress. She also described communicating with ghosts and awareness of paranormal phenomena.								
Patient 59 (said she used to be a nurse)	A	12/10/05	52	F	Obstructive chronic bronchitis with acute exacerbation	47	Cardiac arrest	5
Participant 59 was a woman who said she had worked as a nurse but gave no details. She coughed frequently and showed other signs of respiratory distress. She described a "miracle experience". She had had a cardiac arrest five years ago. She described it an experience of brightness, beauty, and peace. She saw her dead father leading her by the hand. She regretted the return to life.								

Code number	Set-ting	Date of interview	Age	Sex	Diagnosis at time of interview	Age at experience	Health factors associated with experience	Years since experience
Non patient 61 (LPN)	C	14/10/05	34	F	NA Father had organ failure	Child witnessing father's story of incident in 1972	Organ failure	34
Participant 61 was an LPN who shared an experience about her father. When the participant was an infant, her father developed meningitis and later organ failure. He had a vision of angels and heard them singing hymns. He couldn't understand why his wife did not see the angels or hear the singing. Later he and his wife divorced, and he raised his daughter alone. His daughter thought that he cared little for life, and his only concern was to raise her. He died after she married and left home.								
Patient 62 (RN)	A	4/11/05	55	F	Venous embolism, thrombosis	50	Grief	5, ongoing
Participant 62 was a psychiatric nurse who was in the hospital as a patient. She told about her search for meaning after the death of her adolescent son. She called this "Possibilities". She believed that her son communicated with her in a variety of ways after death, and she believed that she had developed psychic abilities.								
Non patient 63	C	17/12/05	79	F	CHF	76	Massive heart attack	3
Participant 63 was a frail elderly woman living in the community. She shared several experiences. The most recent was a vivid vision of heaven subsequent to a heart attack three years ago. She saw Jesus, angels and family members, but was given a mission to return to save her son, who was not a Christian. She is so far unsuccessful, but believes that Jesus accepted her efforts. Many years earlier she had seen an angel in the operating room when she had surgery for a tubal pregnancy.								
Summary 18 participants			29-82	M=4 F=14		12-73		2-70

4.2.3 Conversations not meeting the criteria for interviews

A number of conversations which did not meet the criteria for interviews were held with hospitalised patients, colleagues and members of the community. Because the parties in the conversations did not give permission to participate in the research, details of the conversations are not cited in the sections on data analysis. However, the researcher's thoughts about the conversations were considered to be data and were recorded in the reflective journal.

4.3 MYSTICAL EXPERIENCE AS PROCESS

When the research process was initiated, the researcher expected to be able to identify essential characteristics of the mystical experiences described by the participants. Although these essential characteristics did present themselves, it became clear that the essences of the experience itself could not be isolated from preceding and

succeeding essential elements. Mystical experience in the context of health care does not occur as an isolated event, but rather represents a complex of factors and essential characteristics. The concept map below presents mystical experience as a *process* which begins in the individual's life world, occurs in consciousness, matures, and results in changes in the life world. As *process*, mystical experience may be considered to have four stages, but these should be seen as complex and interrelated, rather than strictly linear. These stages include *initiation*, *occurrence*, *maturation*, and *integration*.

4.3.1 Concept map of mystical experience

The Concept Map of Mystical Experience displayed in Figure 4.1, shows mystical experience conceptualised as a process forming, and formed, by interrelated crystals. The process of *initiation*, *occurrence*, *maturation* and *integration* is discussed in the narrative following the Figure 4.1.

4.3.1.1 Concept map – Initiation of mystical experience

Initiation of mystical experience is multifaceted. It includes the participant's life world prior to his or her identification of mystical experience – attitudes, behaviours and spiritual perspective. Initiation also includes a degree of consciousness on the part of the participant. In some cases the experience is conceived as dream; in others as occurring during operative anesthesia. Nonetheless, there is always an element of consciousness. (It is important to recognise that even during intraoperative anesthesia, subconscious awareness may occur [Lemone & Burke 2004:178, Smeltzer & Bare 2004:434].) Triggers also comprise a key aspect of the stage of initiation. Recalling the definition in section 1.9.2, triggers are *events and circumstances preceding, accompanying, and possibly initiating mystical experiences*. While cause and effect can not be inferred, triggers reported by participants included psychological and physical stressors, and exposure to psychoactive substances, including surgical anesthesia and marijuana.



Figure 4.1
Concept Map of Mystical Experience

Several nurses offering interviews reported experiences associated with rendering nursing care. Nursing care is explicitly associated with mystical experience by Helin and Lindström (2003:425) and O'Brien (1999:115). In the initiation phase in the *Concept Map of Mystical Experience* (Figure 4.1), nursing care is subsumed as “everyday experience”, which is associated with mystical experience by several authors (Carse 1994; Nelson 1986; Sarpong 1986). The term *everyday* should be understood to refer to experiences which occur during ordinary activities. This could include nursing care and other activities in which participants were engaged. But, although “everyday”, these activities should not be regarded as insignificant, for they may include instances of profound care and compassion.

4.3.1.2 Concept map – Occurrence of mystical experience

Occurrence is the stage in which the mystical experience presents to the individual's consciousness. Seven themes became evident in the analysis of the data. These themes include *sensory-motor perception*, *interaction with the supernatural*, *interaction with dead and/or living members of the family*, *conviction of reality*, *cognition*, *dynamic tension* and *emotional intensity*. These categories are not rigid, and the expression of one theme can in many cases be said to fit into more than one category.

Several of the themes encompass a greater range of experience than may be evident at first. Interaction with the supernatural includes awareness or interaction with the deity, with the circumstances of heaven and hell, and also with paranormal phenomena. No attempt is made to rank or separate these phenomena. Supernatural interaction connects with the theme of mission or purpose, as this was found to flow from the interaction with the deity or a family member “in heaven”.

The theme of emotional intensity includes both positive and negative emotions. Autonomic response is conceptualised as connected to both the theme of emotional intensity and dynamic tension. Autonomic responses include tears, erector pili enervation (gooseflesh) and the sensation of chills or coldness.

The interrelationship of the themes identified above is represented on the *Concept Map of Mystical Experience* (Figure 4.1) as connected crystals.

4.3.1.3 Concept map – Maturation of mystical experience

Mystical experience is not a discrete event which just occurs and then ends. It goes through processing subsequent to occurrence. The experience is reviewed and an attempt is made to affirm or validate it. The experience is interpreted and meaning is derived. A sense of ownership evolves for the experiencer, and often the experience is given a name.

When ownership is established, the experiencer lives with the experience, seeking further implications and attempting to fulfill the mission or purpose, if this has been part of the experience. Sharing or reporting the experience to friends, family, spiritual guides and even health care givers also grows from the basis of ownership. This sharing, in turn, prompts a response from others that is incorporated into understanding of the experience.

4.3.1.4 Concept map – Integration of mystical experience

Mystical experience and the maturation of the experience that follows are integrated into the experiencer's life world. Attitudes, behaviour and interactions with others, and spiritual perspective may all be affected by the experience in ways which may be seen as positive or negative by the experiencer.

4.3.1.5 Concept map – Summary

The *Concept Map of Mystical Experience* (Figure 4.1) addresses mystical experience as phenomenon and process, initiated in the life world, occurring in consciousness, maturing in the life world, and integrated into the life world.

4.4 DATA PRESENTATION

In the following sections, findings correlated with the research questions are presented for each facet of the concept map. Data displays are presented which show the numbers of interviews from which data was derived supporting identification of essential themes. The numbers are not meant to indicate the importance or relevance of a particular theme, but rather give a sense of the relative frequency with which it was

addressed by participants. The relationship of these themes is also shown on the Concept Map of Mystical Experience (Figure 4.1). Data displays show specific quotes from interviews that support the identification of themes.

Note that data displays include interview data from patients and community members as well as participants who were interviewed in their nursing roles. Interviews offered by nurses in the role of nurse, rather than patient or community member, are identified by the notation "NURSE". *Italics indicate notes made by the researcher, comments and additional notes providing clarity or explanation.* The researcher is identified as "I" (interviewer) in the interview transcripts. Participants are identified as "P". **Bold font used in the data presentations is used to emphasise key words in participant statements.** As noted earlier, in section 3.3.3.7, the numerals identifying each participant are derived from the recording software. They are sequential, but do not relate to the total number of participants. Thus **P33 12** refers to the participant designated 33 by the Olympus recording software and data unit 12.

The data presented below are complex and interrelated. It is recommended that with each of the following sections the reader refer to the accompanying *Concept Map of Mystical Experience* as an aid to following the crystalline, nonlinear structure of the data. In addition, after a specific data display, a cross reference is given relating the data to existing literature in the literature review. The reader is reminded that literature that relates to findings and "familiar concepts" directly related to mystical experience in nursing and health is virtually non-existent.

4.4.1 Initiation of mystical experience in the context of health care

This category answers the research question: *What factors accompany or precipitate mystical experiences?* The circled area in the concept map shown in Figure 4.2 relates to this research question.

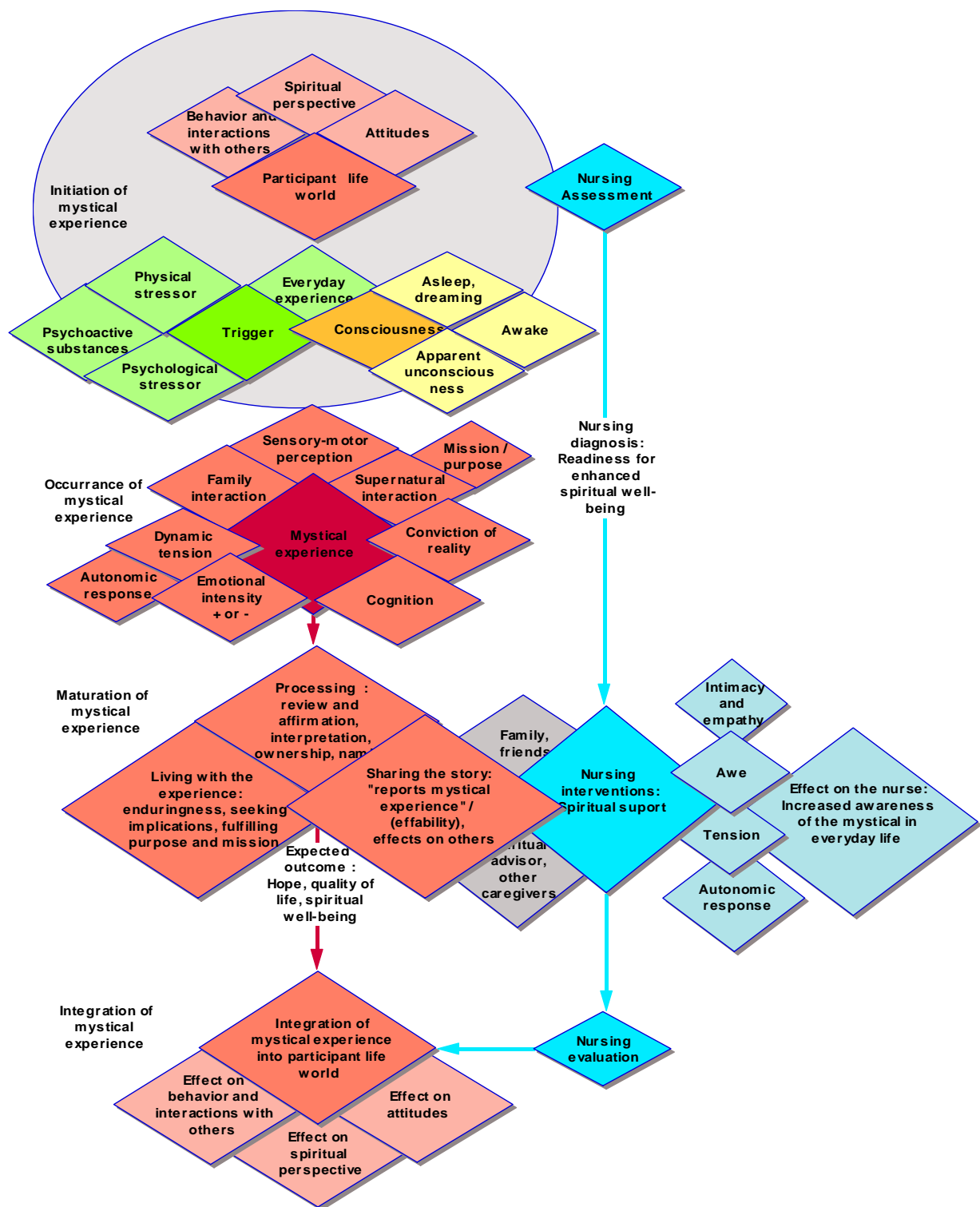


Figure 4.2
Concept Map of Mystical Experience:
What factors accompany or precipitate mystical experiences?

It is clear from the data that triggers to mystical experience do not occur randomly as external factors. In part, they derive from the individual's life world and reflect internal as well as external factors. The participants in this study reported psychological and physical stressors evenly. However, no one aspect of initiation can be considered key to the initiation of mystical experience in the context of health care. Data display 4.4.1 gives an overview of the patterns involved in initiation of a mystical experience as well as the "count" (the number of participants that contributed to a specific sub-category or attribute) and the data display in which data units are displayed.

Data display 4.4.1: Overview: Patterns of initiation		
Sub-category	Count	Data display
Participant Life world	3/18	4.4.1.1
Consciousness	6/18	4.4.1.2
Accompanying factor/trigger	7/18	4.4.1.3
-Physical stressors		
Accompanying factor/trigger	7/18	4.4.1.4
-Psychological stressors		
Accompanying factor/trigger	2/18	4.4.1.5
-Psychoactive substances and Entheogens		
Accompanying factor/trigger	2/18	4.4.1.6
-everyday experience		

4.4.1.1 Participant life world

Although the interviews were placed in the context of health care, many of the physical and psychological stressors that participants report are not clearly associated with illness or hospitalisation. For example, participant 43 reported being struck by lightning at summer camp when she was ten or twelve years old, but did not report receiving any care afterwards. Participant 58 had multiple health problems, but did not identify these physical problems as relevant when she described the psychic closeness she felt with dead relatives. She did report generic "stress", as did participant 49. Data display 4.4.1.1 illustrates statements associated with the participants' life worlds.

Data display 4.4.1.1:
Initiation: Participant life world

P49 5 ... how do I explain this? When I think stuff sometimes it happens. I don't know if it's like **ESP** or whether it's *deja vu* or what it is.

P62 42-43 You've got to understand that that period in my life, I wasn't too sure whether I was sane or not, **I just lost my baby**.

P58 20-22 I think, I mean I've always had, especially myself, **I've always believed that you can communicate with the dead**. You know the **spirits are still around** to help you and everything. Not everybody believes that.

4.4.1.2 Participant consciousness

Consciousness is identified as salient aspect of initiation. It can be said that the participants were, in some degree, conscious, enough so to have vivid perceptions and to remember them in detail. Considering their closeness to death, in some instances, and the likelihood that at least some of them were anaesthetised, this challenges the meaning of unconsciousness. The researcher asserts that either the experiences were retrospectively incorporated into prior events, or that, most likely, some consciousness is retained during anesthesia and near death experiences. Data display 4.4.1.2 shows participant statements illustrating some degree of consciousness during mystical experience.

Data display 4.4.1.2
Initiation: Participant consciousness

P33 15 Yeah, **I knew what was going on**, but I didn't really know, I thought I was having a dream or something

P37 11 I'm asleep **but I'm not asleep**.

P40 3-4 *So he worked cleaning the ice off the logs, the cutting logs, with a double sided axe. **Then he passed out in the mud.***

P49 6-8 ... one morning I woke up very agitated from a dream that I had and I could not go back to sleep. It was very haunting, the images. **I had a dream that my dad had had a heart attack**

P56 21-22 I went to bed and I had a dream. And in this dream, I was laying down in my bed at the house. **I could see myself laying in that bed in this dream**.

P61 6-7 And he, uh, but during this whole time and **once he kind of went into this vegetative state**, he could remember at some point in time, and I guess my mom was at his bedside he could remember seeing angels and singing hymns.

The contents of data display 4.4.1.2 also relates to section 2.3.3: Mysticism and consciousness.

4.4.1.3 Physical stressors

Several participants reported dramatic health crises. Participants 33, 40, 59, 63 described experiences in which they died and came back, or were very close to death. It is impossible retrospectively, to validate the accuracy of their recollections, but it would be true to say that these participants view their experiences as *near death experiences*.

Meningitis and scarlet fever were disease states noted by participants 33 and 61. Participants 40, 48 and 63 reported having experiences during surgery. For these participants, the stress of surgery was also associated with a degree of anxiety. Data display 4.4.1.3 shows some of the physical stressors experiences by the participants.

Data display 4.4.1.3 Initiation: Physical stressors/triggers

P33 16 I had a **heart attack** at home and I was lying on my sofa in a lot, in a lot, of **pain**, and I thought well I'm just **dying**. That's what I thought.

P40 6 "It was **being dead**" three times in nine hours and 45 minutes.

P43 3 And we were having a real bad storm, and **lightning** struck the sheet metal roof and went through the pipes and **struck me** and threw me back into a shower stall.

P63 60 When N took me to the hospital, I had **pneumonia**. And during the pneumonia, I had the **massive heart attack**.

P63 84 And there have been other incidents, and this I think he was showing me something. When N (daughter) was in third grade, third grade wasn't it [to N], I had an accident. My surgeon said he had never experienced such a situation. My doctor from Puerto Rico said he had one experience like that. The ovum passed into the tube, but the ovary didn't close. The pituitary didn't get the message for the ovary to close, and I was **hemorrhaging** all through the night. (*This was followed by **surgery** and a rapid recovery.*)

P59 16-17 When I first got sick. And I had a **heart attack** and I was **dead** before I hit the floor. So my son and my uncle **brought me back** once and then the EMS (*Emergency Medical Service*) and the doctors brought me back the second and third times.

P48 5-6 Well, it was November, November 15, of '95. I was getting ready to go in for surgery for **C-section**. And I was kind of a little bit scared. And that day, the night before had snowed almost like a foot or more. All the roads were blocked. We happened to have a dozer sitting there and his friend scraped the road and we got to the hospital.

P61 3, 5 **Meningitis. Streptococcus meningitis**. You understand he was the first patient cured of this at the C Clinic in 1972 ... Went completely to a **vegetative state**.

Leuba notes numerous physical triggers to what he calls *ecstasy*, “deprivations of food and sleep, isolation, even torture”, alcohol, narcotics, hallucinogens, and rhythmic body movements (Leuba 1979:11-15). These triggers are discussed in association with other triggers in section 2.3.1 on modern mystical thought.

4.4.1.4 Psychological stressors/triggers

Several participants described specific psychological stressors. Initially, some of these stressors did not appear to be specifically health related. However, the researcher decided to include as episodes of psychological stress the several experiences that reflected *fear* of imminent harm, even if actual injury did not occur. Participant 39 described an acute episode of fear when she believed that the car she was driving was going to crash. Participant 48 was anxious and fearful for her unborn child as she anticipated a Cesarean section.

Among the psychological stressors identified, grief is prominent. Participant 56 was incapacitated with grief after his father’s death. Participant 62 was devastated by the death of her adolescent son. For some of the participants, a specific loss was not identified, but a background of loss can be inferred. Participant 59 had a son who was murdered; participant 53 had several siblings who had committed suicide. Data display 4.4.1.4 shows the range of psychological stressors identified as triggers among the participants.

Data display 4.4.1.4 **Initiation: Psychological stressors/triggers**

P39 9-12 I approached the car that I expected to use as (*a brake*), you know that could have been an awful accident. This one would have hit this one and this one hit this one. And all of a sudden my car turned to the right, suddenly, very suddenly, and we went up in a curve and in to what stopped us was a brick building. And here comes a woman down the sidewalk with a baby in a baby carriage. **That was close.**

P49 32-34 No health problems at the time. Stress? [pause] I don’t know. Mostly **the most stress I was going through at the time was lack of sleep.** I was going back to college and working full time at the bank and going to school the whole time and it was a little bit stressful on my body. **I mean I was constantly worn down and very tired and never getting enough sleep.**

P56 16-19, 20-21 (*After my father’s death*) **I about went crazy. I was irritable.** My wife is a wonderful woman to put up with me. I still had to run the dozer and I didn’t care if it worked or **I didn’t care about nothing** ... I went to bed one night, and I said Lord I’ve

got to know if he's all right. I went to bed and I had a dream.

P62 9 P: Well on Christmas Eve, 2001, **my 19 year old son was killed in a motorcycle accident. And that was my traumatic stressor because you start looking for reasons why and you start looking for ways to cope.** So you go on a search. Hopefully you'll find something that will help you deal. And I think I did.

P58 9, 12 My sister died 11 years ago and my grandmother died October 17th in 82 ... I've never seen them, but especially **in times of stress**, you know, I've felt them with me.

P48 5-8 Well, it was November, November 15, of '95. I was getting ready to go in for surgery for C-section. And I was kind of a little bit scared. And that day, the night before had snowed almost like a foot or more. All the roads were blocked. We happened to have a dozer sitting there and his friend scraped the road and we got to the hospital. Well, after they prepped me and everything for the surgery, I was on a bed out in the hall and I was still in kind of **ascared and lonely**. I was the only one there. All I could see was a big clock. So I prayed that the Lord would be with me and everything would go smooth and the baby would be alright and everything.

P53 2 My baby was to be born in January and he was born on December 27. It's my brother that shot himself, on the 26th and my baby was born on the 27th ... And I was really close with my brother. We just met through G 'cause we had been separated in childhood. **And I was real upset because he was so close to me, and he couldn't see my baby.**

Although it is impossible to identify a single stressor as a trigger for these participants, the participants' experiences are supported by Hay's research. Hay notes the importance of subjective distress as an important antecedent to religious experience in those he surveyed (Hay 1982:204), although Hood finds "... stress per se, whether setting or anticipatory, is less likely to elicit reports of mystical experience" (Hood 1994:63). With regard to psychological stressors, the reader is referred to the groundbreaking work done by Maslow (1964 and later interpretations of this work) in section 2.3.1 as well as aspects of psychological inquiry into mystical experience such as hysteria (section 2.4.3.2.1) and psychosis (section 2.4.3.2.3).

4.4.1.5 Psycho-active substances and entheogens

Surgical anesthesia was only weakly identified by the participants as a trigger, although participant 48 remembered inhaled anesthesia.

Only one participant reported using a psychoactive substance. Participant 36 described a "spiritual experience" following the use of marijuana. Inasmuch as he currently has

multiple health problems, it is not unlikely that some of them were also present at the time of the experience he described. The data display below shows statements associating psychoactive substances as triggers to mystical experience.

Data display 4.4.1.5
Initiation: Psycho-active substances and entheogens
stressors/triggers

P36 12-13 And, these bunch was going to have a party and they had it at this house. And they were having a party and **they was smoking dope (marijuana)** and that guy said here, we'll just smoke this.

P48 9 I remember them giving me my **gas** to put me under ...

In this regard the reader is also referred to section 2.4.2 relating to inquiry into the potential of entheogens to trigger mystical experience

4.4.1.6 Everyday experiences

A word must be said about several responses made by nurses who reported experiences associated with nursing care. Nursing care is included here as “everyday experience”. In neither case was the experience anticipated; the nurse was only doing what was expected of him or her routinely. Nursing statements placing mystical experience in the context of everyday experiences are illustrated in data display 4.4.1.6 below.

Data display 4.4.1.6
Initiation: Everyday experiences

P41 NURSE 7-10 A “lady” had been admitted with cancer; Room___ (close to the nursing station). She was “there just to die ... she even knew, everyone knew”. One night I was by myself, doing **paperwork**, sitting with my back to the hallway, there were only 3 or 4 patients, around 3 AM ...

P44 NURSE 11-12 (Home health visit) So **we were going through the process of, you know, she washed him off and cleaned him up a little bit. He was wet.** And I had gotten somewhat, you know, attached to this man and very close to him and he and I had had some pretty intense conversations about life and where his life had gone and he had had a pretty rough and tumble life to say the least, and I really cared a lot about him.

Transcendent experiences may even occur as a corollary to everyday experience (Carse 1994:xi; Rahner 1966:50; Eklof 2003 <http://www.cliftonunitarian.com/toddstalks/practicalmysticism.htm> accessed 16/8/2005; Larkin 2004 <http://carmelnet.org/larkin/larkin041.pdf> accessed 26/1/2004) and as an aspect of human care (Watson 2005:7) and service (Deikman 2000:83-83).

Although it is impossible to identify a single stressor as a trigger for these participants, or even a cause and effect relationship with mystical experience, it is clear that the participants associate psychological and physical stresses and even everyday experience as precipitating factors to the mystical experiences they described. The participants' experiences are supported by Hay's research. Hay notes the importance of subjective distress as an important antecedent to religious experience in those he surveyed (Hay 1982:204), although Hood finds "... stress per se, whether setting or anticipatory, is less likely to elicit reports of mystical experience" (Hood 1994:63).

4.4.2 Occurrence, maturation, and integration of mystical experience in the context of health care

Subsequent to *initiation*, the process of mystical experience in the context of health care involves *occurrence*, *maturation*, and *integration*. These interrelated aspects comprise the essential meaning of mystical experience for participants. Each of these stages and associated themes is addressed in the following sub-sections. These sub-sections of the data answer the question: *What is the meaning of the lived experience of mystical phenomena to participants experiencing it in the context of health stressors and/or hospitalisation?* The circled area in the Concept Map of Mystical Experience shown below (Figure 4.3) illustrates findings relevant to this research question. (Some arrows are hidden as an artifact of the concept mapping software.)

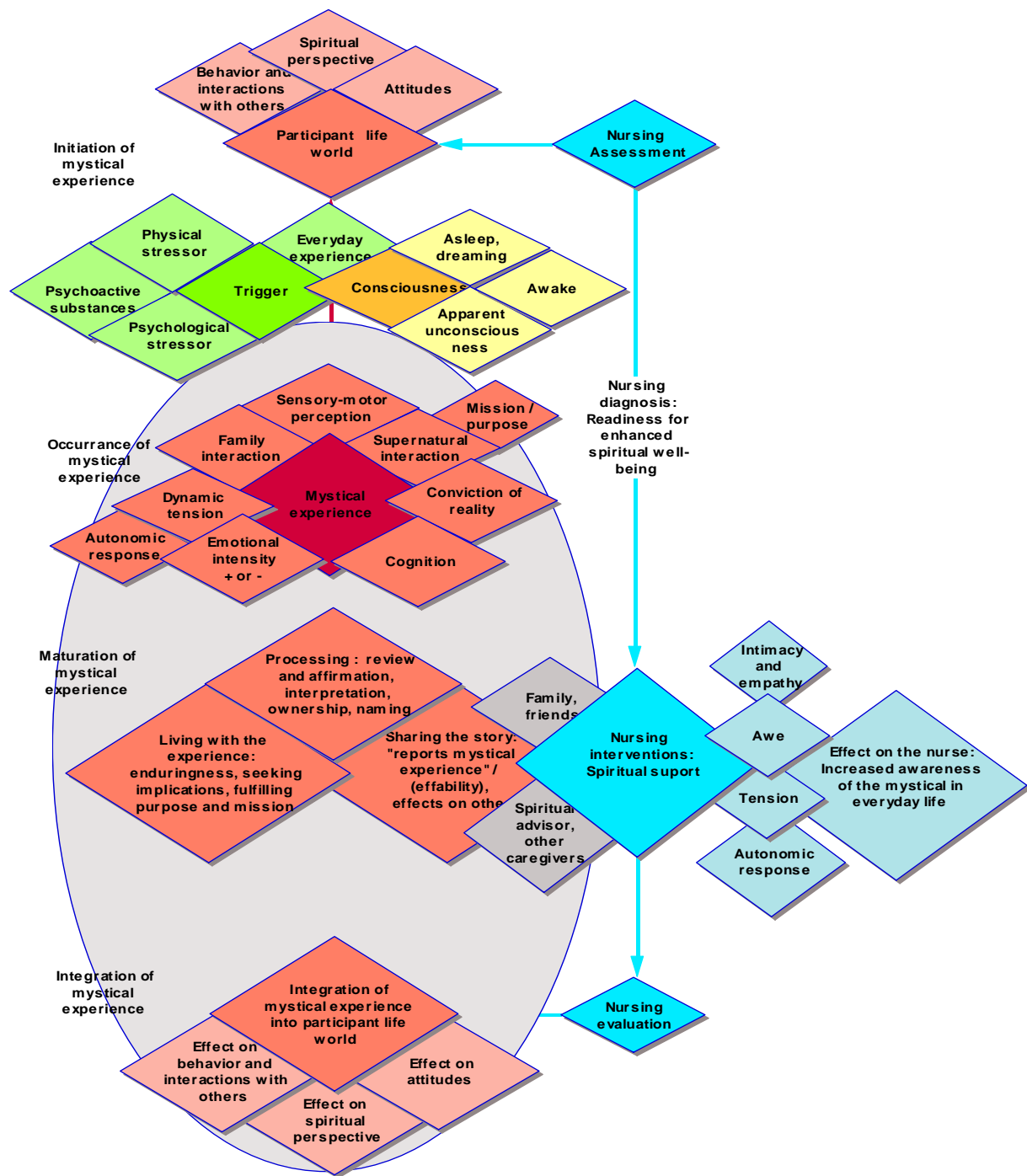


Figure 4.3

Concept Map of Mystical Experience:

What is the meaning of the lived experience of mystical phenomena to participants experiencing it in the context of health stressors and/or hospitalisation?

4.4.2.1 Occurrence

Occurrence involves two main features namely an account of events relating to the experience itself (such as contents) and reaction on reflection on the experience (such as emotional intensity, cognition and conviction of reality). Further, occurrence has multiple features: most commonly, interaction with the supernatural and vivid sensory motor perceptions. Interaction with dead and living family members and emotional intensity are also prominent. Accompanying these are dynamic tension, a conviction of reality, and elements of cognition. Data display 4.4.2.1 shows the number of participants describing these aspects of *occurrence*.

Data display 4.4.2.1: Overview: Patterns of occurrence		
Sub-category	Count	Data display
Interaction with the supernatural	13/18	4.4.2.1.1
Sensory motor perception	13/18	4.4.2. 1.2
Interaction with family	9/18	4.4.2. 1.3
Emotional intensity	10/18	4.4.2.1.4
		(Series)
Emotional intensity-Positive	9/18	4.4.2 1.4.1
Emotional intensity- Negative	7/18	4.4.2.1.4.2
Emotional intensity: Autonomic response:	6/18	4.4.2.1.4.3
Tears		
Emotional intensity: Autonomic response:	4/18	4.4.2.1.4.4
Sympathetic enervation		
Dynamic tension	9/18	4.4.2.1.5
Conviction of reality	8/18	4.4.2.1.6
Cognition	7/18	4.4.2.1.7

4.4.2.1.1 Interaction with the supernatural

Interaction with the supernatural frequently involved face to face interactions with God, angels and heaven, but also the devil and hell. Other supernatural beings and experiences were also reported.

Participants 39, 40, 41, 48, and 61 stated they saw angels. In the case of participant 39, the angel she described grabbed her steering wheel and saved her from a car crash. Participants 40 and 48 reported seeing angels near them during surgery. Participant 61 reported that her father saw angels during a “vegetative state”. Participant 41, a nurse, said he saw an angel walk into the room of a patient who was on the point of death.

Interactions with God, and the person of Jesus, were also common. Participant 48, although believing that the Bible says that one can not see God, vividly described Jesus at the foot of the operating table when she was having a Cesarean section. Participant 63 described Jesus reaching out his hand to bring her into heaven. Other participants referred to God as being intrinsic to the experience. For example, participant 40 said “God had mercy on me, has a purpose for me”. This reference to a personal purpose or mission from God was not unusual and was alluded to, directly or indirectly, by participants 40, 56, 61 and 63.

In addition to references to God and angels, there were references to heaven. Participant 59 and 63 described heaven vividly. Participant 56, in a conversation with his dead father, was given a poignant description of heaven: “This place is just like everybody said it was ... the sky is blue, and the grass is green” (P56 23-25).

Although less common, there were several references to the devil and hell. Throughout his interview, participant 40 described shuttling back and forth between heaven and hell during emergency surgery. Participant 44, a nurse, described an intense and unsettling sense of Satan’s presence at the bedside of a dying patient that she believed was facing hell.

References to paranormal beings and experiences were also encountered. Participant 36’s description of a spiritual experience involved interruption of electrical power that he believed was due to the influence of Indian (Native American) spirits. Participant 58 described multiple interactions with ghosts.

Participant 46, a nurse administrator, discussed the actions of a ghost thought to haunt Beta Hospital. The ghost is thought to cause electrical and mechanical disturbances prior to the death of a patient. (While not uniformly held, belief in this ghost was common among the staff at Beta Hospital. However, only participant 46 would agree to an interview.)

Data display 4.4.2.1.1 shows statements relating to interaction *with the supernatural*, including the conferral of a mission, as part of the occurrence of mystical experiences.

Data display 4.4.2.1.1:
Occurrence: Interaction with the supernatural

P36 12-18 ... that guy said here, we'll just smoke this. This one girl was Indian and she said no, you can't do that (*smoke the Indian pipe*) ... when they lit it, the electric went off ... every time they try to light it, the electric, the power would all go off.

I - Well, *so do you think the power went out because of the Indians being there or because of what they were smoking?*

P - Oh, no the Indians being there. They wasn't smoking that much. Those girls said they hadn't even smoked anything then, you know... But it's a regular **Indian peace pipe** and they found it up in there and when they built the dam and they said they were going to smoke it, well, they couldn't because every time they tried to fire it up, the power would leave.

P39 6-17 I went to put on my brakes, and there was nothing ... And all of a sudden my car turned to the right, suddenly, very suddenly, and we went up in a curve and in to what stopped us was a brick building. And here comes a woman down the sidewalk with a baby in a baby carriage. That was close. ... And I said B (husband) I'm sure grateful for you, to you for grabbing the steering wheel. He said, "I never touched the steering wheel." He was catching J (child); she was flying over the seat. I said, "but honey, I saw your arm on the steering wheel". He said, "M, I never touched that steering wheel". Well when we realised what had happened, I saw part of my **guardian angel**. Because B had on a long sleeve, (he wasn't in military uniform that day), plaid winter shirt. And had he grabbed the wheel, he would have grabbed it with his left hand. This was a **bare, ivory colored, powerful right arm** that grabbed the wheel at 2 o'clock.

P40 7 "God had mercy on me, has a purpose for me".

P40 8-12, 15 *He described going into the operating room. Said how he didn't have to be lifted to the table, he just moved right over. He said it was brightest in the operating room. Everyone glowed white, snow white, everyone" he remembers sitting up on the table. He said he saw a man behind the two surgeons. He didn't have wings. He was six or seven feet tall. He could describe him in detail all except the eyes. "it had to be an angel".*

P41 NURSE 11-20 I heard somebody walking up the hall...I didn't pay it any mind ...

I turned around and saw a tall **guy about 6'4", with long blond hair, well groomed, wearing a lab coat and dress pants** ... I said 'Can I help you, sir?' ... (He didn't answer); he rounded the bend ... I seen him go in Room___ ... I followed him into the room ... he was gone. (*He looked for the man in the room*). "The lady was drawing her last breath. Her husband was asleep. I don't know what or who it was; I think it may have been an **angel**."

P44 NURSE 23 And we would try and calm him and he was jerking and a lot of movement and we had this **heaviness** on us and we felt, I felt and then we later talked about it that I felt that I was in the midst of **evil**. I mean it was a true experience of fear, I wanted to leave. **It was like a spirit**, I know that sounds weird, but it was like **this spirit that was present**; it was there.

P44 NURSE 29 ... We knew we had experienced in our mind and I not come to this conclusion. I had come to my own conclusion and

she had too, but as believers we felt, I felt, I had just witnessed **Satan's presence**. I mean that was my feeling you know I mean whatever it was, **it was a powerful evilness that was there**.

P46 NURSE 3-5 And he (*the ghost*) manifests in, we'll be walking down the hall and a TV will come on in one of the rooms. First time it happened, next day a patient died on the floor. And we've had **lights**, be sitting at the nurses' station, and a call light will come on in a room in a room where there is no patient and the next day, somebody in long term care dies.

P46 NURSE 17 ... I think it's the **spirit of someone who died** in this facility who either didn't want to leave or isn't happy or something.

P48 18-22, 42-43 But I know it was **Jesus** there ... people tells me the Bible says nobody can see Jesus. I know in my heart that I seen him ... (*Jesus looked*) [k]ind of plain. **He wasn't skinny like I always thought he would be. His hair was waves like this, but it only come to here, not real long. And he had a beard. It looked like it was trimmed to me a little bit.** You seen these pictures of him with the... But the **angel** did not have wings if it was an angel. But she kind of, they was sort of a **mist**, it wasn't like a bright light glow, but it was just a little mist.

P56 23-25 I got up in this dream and I walked out on my front porch. There stood my [*deceased*] dad. He talked to me. He said what are you crying about. He said the old man's all right. I said, daddy, I was worried about you. He said you don't have to worry about me. He said this place (*heaven*) is just like everybody said it was. He said the sky is blue, and the grass is green.

P56 36-39 (*Mission is from father, not specifically a supernatural source, although his father had come from heaven*) he said you've got to go on. I'm with you all the time. He said just promise me one thing, you'll take care of your mother. I said I'll take care of her until she dies, Dad.

P58 23, 26-30 Well I will tell you I have lived in a house that had **ghosts** ... He didn't bother me. And I assume it was a **he**, just felt more like "**he**" type things. But each year, I lived there two years and, I was in college, and each year, it like he picked one roommate that he didn't particularly care for. Things like towels you know things that fall on their own fall in an arc. These would be things that go straight out and straight down. You know but it was not really, just in the kitchen. Now it was not knives or anything, but might be a glass might come out of the cupboard on occasion. I got it one time [*laugh*] in my bedroom, I could tell someone had been on my bed, and no one else had been in the household that day, none of the other roommates that I could tell, someone had sat on my bed and the last thing I did before I went to class was straighten up the room and I said, "Look obviously we both have to live here. I can't afford to live anywhere else and you apparently are stuck. Leave me alone." (*The ghost left her alone.*)

P59 89 And there's not little cubicles up there (*heaven*) for everybody, everybody goes that's sincere in their hearts, and is in **God's eyes** (*hard to understand*), everybody goes.

P61 6-7 And he, uh, but during this whole time and once he kind of went into this vegetative state, he could remember at some point in time, and I guess my mom was at his bedside he could remember seeing **angels** and singing hymns.

P63 13-14 I realised that was also the last that I remember of that episode in the hospital, and that is when I found myself reaching for **his hand** to take me in. It's **Jesus** himself.

P63 37-38 ... one night as I was praying, He (**Jesus**) reassured me that what I had done was what he had sent me to do. I had tried to save this soul (*her son*), that the rest was up to him being ready to accept him, and he then would take it from there. All that heavy burden lifted from my shoulders. I was relaxed. I cried and cried with N (daughter) and told her I don't feel that way anymore. I feel assured I tried and that's all he'd asked me to do.

P63 21, 23-24 (God) explained to me, I can't bring you in now because I still have work for you to do. And in doing this work you must remember to correct three flaws that you've grown up with in your character ... I was not interested in coming back here at all, although I love them dearly. He still explained to me that I have work for you to do.

P63 59 ... mine was kind of a special situation whereby **He** (*God*) saved my life many times during that period for a purpose, to try to save this other soul in my family. The rest are devout Christians.

P63 85 (*discussing a surgery many years earlier*) Oh yes. It wasn't the surgeon; it was Dr V, my family doctor. I insisted he be there if I was going through all this (*tubal pregnancy, hemorrhage, and surgery*) and he was, he stayed right there with me. He, at one point, he would always come pray with me. I was Catholic at the time, he was also and he would always come pray with me. And, this time when I first really realised **God** is showing me something here, **behind him stood an angel**. Angels do not have wings. I know it. Angels do not have wings.

With regard to mystical experience and the involvement of elements of the supernatural the reader is referred to section 2.3.2 on *Modern thought in mysticism* and section 2.3.2 on *Veridicality of mystical experience*. The position of the supernatural, referring both to deity and demons, as defining content of a mystical experience is presently still warmly debated.

4.4.2.1.2 *Sensory motor perception*

Sensory motor perception was a common aspect of participants' experiences. While some of the literature addresses factors of upness (the sensation of being above the perceptual field), or light, or tunnels, the researcher found sensory and motor *perception* itself to be the essence, and particulars of that perception to be variations.

Participant 59 was not able to articulate specifics, but she made a significant statement: "... I wasn't hallucinating. I know exactly where I was, what it looks like, how it smells, how it feels. I can feel it, I can taste it, I can smell it." (P59 84-85).

Although participants 33, 40 and 63 described brightness and light, other visual imagery was equally prominent. Participant 39 said she saw the bare arm of an angel who jerked her car steering wheel to safety. Participant 48 described an angel and Jesus standing by the table as she underwent a Cesarean section; participant 49 described the black and blue bruising she saw on her father's body as he experienced a heart attack; participant 63 described her glimpse of heaven – 24 karat gold pavements, houses with shutters made of gemstones.

Participant 43 described seeing herself, as from a distance, after being struck by lightning. Although the sense of seeing oneself from a distance is a common finding in near death experiences (Simpson 2001:522-523), participant 43 did not identify her experience as a near death experience. Pain was noted by participants 33 and 40. (This was part of occurrence but might also be seen as a trigger.) However, *freedom* from pain was reported by participant 48, even though she had had a Cesarean section. Sensory perceptions were varied. Many patients reported hearing music and the voices of family members. Participant 48 described the coldness she felt when she encountered a ghost.

In addition to sensory perceptions, participants described themselves as actively engaged in their experiences via motor perception. Motion and proprioception were identified; floating and moving through a tunnel by participant 33, floating, running and screaming by participant 43. Others described being touched or touching. Participant 37 stated she kissed her dead brother; participant 48 said she was kissed by an angel prior to surgery; participant 56 reported he touched his dead father's arm; and participant 63 said she felt Jesus touch her hand as he took her to heaven.

Data display 4.4.2.1.2 shows elements of *sensory perception* occurring in the participants' descriptions of mystical experience.

Data display: 4.4.2.1.2
Occurrence: Sensory motor perception

P33 10-13 When I was a ba ... little girl with scarlet fever, I was very ill. And I had found myself, I know that's what it was, at the time I didn't know what it was, but I know I had this experience of being around, **floating** around, and have my family, **seeing** all my family there, you know.

P33 16-22 I had a heart attack at home and I was lying on my sofa in a lot, in a lot, of pain, and I thought well I'm just dying. That's what I thought. And so, then **I went through this dark tunnel** and at the end of it was this wonderful **light** and I didn't, and they wouldn't let me in that light.

P37 22-25 ... this one last time my (deceased) brother came to see me, **I was coming up these steps**, and he was at this at this side room there and I thought well I'm going to go ahead on up to my room, and I thought he'd come out and I thought he said, well, there you are Betty, I've been waiting on you. **That sounded like him**, well M, I was going to my room. Well, I've been waiting on you. He said, and he was tickled to death to see me and I was on the second step and he come over and he stood down there and he looked up at me and we kind of exchanged a few words and I told him. He said, "I miss you"... **bent down and I kissed him right there on the temple** and he just smiled and that was about the end of that. And **I see him as plain as I can see him**.

P39 17 This was **a bare, ivory colored, powerful** right arm that grabbed the wheel at 2 o'clock.

P40 8-12 *He described going into the operating room. Said how he didn't have to be lifted to the table, **he just moved right over**. He said it was **brightest** in the operating room. "**Everyone glowed white, snow white, everyone**". He remembers sitting up on the table.*

P40 19 "the **pain** when you're dead is a thousand times worse than when you're living."

P41 NURSE 11-20 **I heard** somebody walking up the hall...I didn't pay it any mind ... I turned around and **saw a tall guy about 6'4"**, **with long blond hair, well groomed, wearing a lab coat and dress pants**.

P43 3-7, 11-13 ... it was like all of a sudden **I was up above everything, and I could see myself stand up and run through the building screaming**, and then I fell, and then right after I fell, it was like ... **I was back inside myself again. I wasn't up above any more** ... it was the weirdest thing. **I was just floating, and I could see myself running and screaming**.

P 46 NURSE 3-5, 17 And He manifests in, we'll be walking down the hall and a **TV will come on** in one of the rooms. First time it happened, next day a patient died on the floor. And we've had lights, be sitting at the nurses' station, and **a call light will come on** in a room in a room where there is no patient and the next day, somebody in long term care dies. ... I can think of at least five different occasions where he has done something and someone has died in the facility ... I think it's the spirit of someone who died in this facility who either didn't want to leave or isn't happy or something.

P46 NURSE 7- 9 My most famous experience of him (*the ghost*) was I was working with A. I locked the door (*of the bathroom*) and finished what I was doing and **unlocked the door and it wouldn't open, and it wouldn't open.** And I thought o.k. maybe it was just stuck. So I did it two or three times, wouldn't do nothing. Banged on the door and A said well turn it. I said I can't get out. She said turn the knob. I said I can't get out. I turned the knob and the door opened right up. And I would have thought well maybe that's a different problem with the door knob, but nobody else and it was a fairly new one, fairly new door period, nobody else had any problems with it after that, just that one time.

P46 NURSE 11-12 No. Alexander's not, to my knowledge no one has ever seen Alexander. **They have seen the results of Alexander (*the ghost*).**

P48 10-16 ... soon as he (the physician) thought I was under, he got real serious and started talking, so I went to sleep. And at some point during that I felt something moving my cheek *moves hand along cheek* like this just real easy and they had the arms strapped down there. And it was a woman that had long, kind of wavy; I don't now if it was blonde or grey hair. And **they kissed me, and I seen the doctors working on me at the foot of my bed** and I remember I don't know what it was, I was still scared a little bit ... and **there stood Jesus** and he just sat there and smiled at me.

P 48 23-34 They said they had never seen somebody go through a C-section that easy. **Hardly had any pain.**

P48 39 I wish I could explain it better **how he (*Jesus*) looked** and the peace, oh.

P56 23-24, 42 I got up in this dream and **I walked out on my front porch.** There stood my dad ... And **I grabbed him by the arm.**

P49 10 The whole left part of his body in my dream was black and blue like someone had beat him. **He was bruised on the left side in my dream.**

P58 12 I've never seen them (*deceased family members*), but especially in times of stress, you know, I've **felt** them with me.

P58 33 But you could really tell when he (*the ghost*) was really mad. You could walk into certain spaces in the house and **it just became very, very cold. It was like walking into a freezer. Going like from like 85 degrees to 30.**

P59 84-85 But I wasn't hallucinating. I know exactly where I was, what it **looks** like, how it **smells**, how it **feels**. I can **feel** it, I can **taste** it, I can **smell** it.

P63 17- 20 I was **reaching** for his hand to take me in also. Somebody was **holding** me ... it was a saint or an angel. (He) placed his hand on mine.

P63 39-42 Across the pavement, he's standing, and it is gold, its 24 Karat gold paved. He's standing there welcoming people in and directing them to the gates and, which, it's infinity. There is no limit to the space. Heaven is above where our solar system, all of our little planets and all are. The rest of it is heaven. All of that space. And the **music** in the background, you can't imagine. It's songs of praise, of course, but it's soft. It's there, it's everywhere, and the **music** is there.

P63 50-53 But to the right, I was there long enough; He gave me a **glimpse** of what we can expect of heaven ...but to my right was one of the mansions that's described in the Bible ...These shutters (*on the mansions*) are slabs of sapphires and rubies ...most of their buildings are stucco exterior and that bright sun out there shining on that white stucco kind of **glistens**. The exterior of the mansions I **saw** are like that. I feel it was diamond dust and uh, but the brilliance, of course the light is there, everything is lit beautifully, but the **brilliant** reflection of the light on these shutters and trim everywhere is in fabulous gemstones. But another thing that caught my eye was the clothing of the robes they were wearing. They were all wearing pure white robes and there was a soft glow about the material and also over their heads. I assume those were probably halos, but **the light also causes a glow, just a soft glow**, from this material.

Eadie's (1992:25-61) joyful account of mystical experience includes angels, telepathy, tunnel phenomena, an out of body experience, and acquisition of knowledge of life after death. According to Simpson, the sense of seeing oneself from a distance is a common finding in near death experiences (Simpson 2001:522-523). For further information on sensory motor perception during mystical experience, the reader is referred to section 2.6.2.4 on mystical experience associated with health stressors and death.

4.4.2.1.3 Interaction with family

Interaction with family members included interactions with both the dead and the living. Experiences with dead family members were not described as encounters with ghosts; the family members were described as being real and truly present. Daggett finds such encounters, which she calls "after-death-communication" (ADC) to be common and meaningful responses to bereavement (Daggett 2005:191). Family members included grandparents, parents, siblings, and children, engaged in generally tender interactions. Participant 37 described nocturnal visits from her dead brother. Participant 53 said she saw her dead brother rocking her newborn. Participant 56, grieving his dead father, described a visit from his father which reassured him and helped him set his life straight. Participant 59's dead father was perceived as being instrumental in her resuscitation from cardiac arrest. Participant 62 said she received messages of love and support from her dead son.

Some aspects of the interactions were troubling. Participant 37 described her deceased brother as sometimes being drunk when he visited (as he was sometimes in life). Some

of the dead relatives were described as frustratingly eluding physical contact, as in the experiences of participant 56 and 59.

Not all family members described in the experiences were dead. Participant 49 said she saw her father looking younger, but bruised – in fact, he had just had a heart attack. Participant 59 stated she heard her angry son say, during her cardiac arrest, “You can’t die on me bitch” (P59 59).

These interactions with family members were intense and meaningful to the participants. Such experiences are not prominently represented in the literature, but represent an important theme in mystical experience in the context of health care. Data display 4.4.2.3 shows statements of *family interaction* associated with participants’ mystical experiences.

Data display 4.4.2.1.3
Occurrence: Interaction with (dead and living) family

P33 42 I found myself floating when I was a little girl (*with scarlet fever*). And **looking down on my parents**.

P37 9-13, 28 I have been having for the last year, it’s getting more. I haven’t had any while I’ve been here. I’ve been seeing and talking to people. In fact, I’m asleep but I’m not asleep and **it’s mostly dead people and my brother died two years ago**, he had cancer. **He comes and visits me ... I see my mom. I see my dad.**

P49 6-11 ... one morning I woke up very agitated from a dream that I had and I could not go back to sleep. It was very haunting, the images. I had a dream that my dad had had a heart attack and in the dream **we were in the backyard of my home that I grew up in which is also where my dad lives now**. There was a swing set in the backyard like it used to be when I was little. Of course it’s not there any longer. And he was thin again. He went on a diet because he had had a heart attack before. This was his second one. He’d had had a heart attack before. He’d went on a diet and lost a lot of weight, but he had gained the weight back and started smoking again. And in the dream though, he was thin. The whole left part of his body in my dream was black and blue like someone had beat him. He was bruised on the left side in my dream. I can’t really remember much else about the dream other than these couple of images and that **I knew he’d had a heart attack**.

P53 2-6 He (*the baby*) was premature and I had to feed him about every three hours which would take about an hour to feed him. So really it was like two hours, every two hours. But anyway, his bassinet was right behind my bed and I thought well maybe I didn’t hear the alarm to do his feeding cause when I woke up I looked over, he wasn’t there and I didn’t hear anything. He wasn’t in there. And I stayed with my sister cause I was young and my first baby. I was seventeen. And I went upstairs to look to see if my sister had had him and was feeding him upstairs. Or maybe even taking him back to bed to sleep you know cause maybe he was colicky or

something and then I looked and I just was like hysterical and I looked behind the bed thought he might have fell behind the bed and then I **looked up and it was my (dead) brother holding the baby ... and he was just looking at him and smiling, and then he just walked over and put him back in the basinet.** And then I woke up for the next feeding.

P53 7-9 And the same brother came back another time. I went down with the same baby that I named, his namesake. He was about 5 months old then. I went down there to my Mom's to stay with the younger children 'cause my brother was in prison and was going before parole board. **And the same brother came to warn me about that brother. He came.** My mom said, "You can go upstairs and get in my bed". It was earlier and they had to make the trip to Moundsville (*site of the state penitentiary*). So I did. And my baby was already sleeping and I was just looking at him and watching him sleep and I **felt a presence and I got real scared. And that was my brother. He was always slinging keys and shuffling his feet and he started laughing, and I guess 'cause he startled me. And then he warned me about a situation that really did happen.**

P53 16 I talk to my (*deceased*) dad and I have three siblings that committed suicide and I talk to 'em.

P56 23-25, 31-44 I got up in this dream and I walked out on my front porch. **There stood my (deceased) dad.** He talked to me. He said what you are crying about. He said the old man's alright. I said, Daddy, I was worried about you. He said you don't have to worry about me. He said this place is just like everybody said it was. He said the sky is blue, and the grass is green. He said it's the most peaceful I ever felt in my life. He said I'm just missing two things. He said I'm missing your mom and I'm missing you. He said you've got to go on. I'm with you all the time. He said just promise me one thing, you'll take care of your mother. I said I'll take care of her until she dies, Dad. He looked at me and he said I've got to go. He said your grandma's got breakfast ready. And I grabbed him by the arm and when I grabbed him by the arm, I said, no I lost you once I ain't going to lose you again. He said well I'm with you all the time and you'll never lose me. He said your grandma's got breakfast ready.

P58 9, 12 My sister died 11 years ago and my grandmother died October 17th in 82 ... **I've never seen them, but especially in times of stress, you know, I've felt them with me.**

P59 18-19, 22, 24 My father actually brought me half way (*when being resuscitated*) **back but my grandmother brought me the rest of the way ...** I was told I couldn't leave yet ... **And I saw my father-in-law.** I couldn't touch him. If I had touched him I would have had to have stayed, so **he wouldn't let me touch him and there were people around him.** I don't know if they were protecting him from me or me from him but they wouldn't let me touch him because I'd of had to have stayed.

P59 46-47, 49, 59 As a matter of fact, they (*my family*) knew about it before I did ... because the nurse came back and said my father was coming back. And it wasn't my father, it was my uncle. But they thought it was my father and my mother told the nurses ... you don't understand, her daddy's dead. **But my daddy was with me and he was coming home from work and I was little again and he had me by the hand and said you go on in the house now darling.**

I: *So the nurse almost was part of that whole thing.*

P: Yeah. She came back here and she said her father's on his way. He wants to see her one more time. And then **I heard my son**. I had made him a promise that I'd have one more baby before I left him and **I could hear him, "You promised me, you can't go"**. But he's one of the ones that brought me back the first time. He caught me before I hit the floor. We had had a disagreement earlier and I punished him and I had gotten real upset and he was trying to make me fight to live. **He said, "You can't die on me bitch."**

P62 13-15 I went back to what they call the New Age section (*of the bookstore*), I guess, and I tried to do what the book had said (*the John Edwards book she heard about on television*), just stand there and follow impulses. So I did, and I had a stack of about four books, and I remember thinking this is going to be awful expensive. I don't know if I really ought to spend this much money. **And I had this voice (her dead son's) come in my head that said, "Use my money, Mom."** I had J's (*her dead son*) wallet in my purse, and he had money in there that was. I was still carrying his wallet. And, of course, I ignored it. And I'm still standing there debating, and **it got more insistent and said, "Use my money, Mom"**. So it just all of a sudden felt right. That's what I'd do. So I bought the books, and I started down the hill from the mall. And I very rarely ever ride with the radio on in the car because I find it to be a distraction. **But I had this voice come in my head again that said, "Turn the radio on."** Of course I ignored. And it became more insistent and said, **"Turn the radio on."** So I reached up and I pushed the button on the radio and **the first words that came out of the speaker were "When I left home that day, I never got to kiss my mother goodbye or tell her how much I love her" [crying]**.

P62 22 I was in the shower one day and **I heard J (dead son) say to me, "You've got to be taught, Mom"**.

P62 24 And one day, this man (*in the psychic chat room*) instant messaged me, that I had no idea who it was. And he said **I have a message for you from your son**, and he delivered the message and it was quite profound.

P63 43 45-46 And I'll bet you **my daddy is one of them playing a violin** cause he was a concert violinist, (*laughs*) and I'll bet **my mother is playing the piano** cause she was a piano teacher. But across from the pavement, on the other side. **He brings forth your loved ones who have deceased as more like a welcoming committee ... my mother was right there in full front.**

Although no specific literature is listed on the occurrence of interaction with (dead and living) family, the contents of data display 4.4.2.1.3 takes on special meaning when read in conjunction with the life world of the participant as evidenced by the contents of data display 4.4.1.1.

4.4.2.1.4 *Emotional intensity*

As may be seen in the description of interactions with family, emotional responses are important in the participants' descriptions of mystical experience. These emotions were both positive and negative, and were accompanied, at times by autonomic factors, such as chills and tears.

The word *peace* was used by participants 33, 37, 43, 48 and 49, but happiness and serenity was expressed even more often in a variety of ways. Fear was accompanied by a sense of safety or protection by participants 43 and 44. Participant 63 made a statement which reflects the emotional response of several others: "It probably sounds unusual for me to say this, but I am so glad that that happened to me. I am so glad that I had that massive heart attack. And I am so glad." (P63 92).

Still, not all emotions were positive. Participant 37 described the distress when her dead brother visited her and he was drunk. Participant 40 sensed himself moving between heaven and hell repeatedly during emergency surgery. He described pain, and discussed the experience with extreme intensity. Participants 43, 44 and 48 described fear associated with their experiences. And participant 59 movingly described the sense of loss she continues to at returning to life after resuscitation.

Teariness was demonstrated by some of the participants and also chills or erector pili enervation. Although piloerection (erector pili enervation) is associated with fear, anger and cold (Como 2002:621), for the participants interviewed, it seemed to represent a more general sense of emotional arousal. Laski identifies a number of autonomic responses associated with mystical experience: cardiac sensations, respiratory changes, and "tinglings and flashes and stabs and shocks" (Laski 1961:77-82).

4.4.2.1.4.1 *Negative emotions*

The expression of negative emotional content occurred in several interviews. The intensity varied from mild to intense. Data display 4.4.2.1.4.1 shows this range of *negative emotions*.

Data display: 4.4.2.1.4.1
Occurrence: Emotional intensity:
Negative

P: **It's just very sad.** My brother had a real bad car wreck ... mentally, but what made it worse all the time was if he'd go on the beer, get to drinking and once in a great while, most of the time it's really wonderful when he visits me, **once in a great while maybe he'll be drinking and it's real sad. It was always sad to me.**

P40 17-20 ... *his aorta blew and he died and he went into the darkness. He said "the pain when you're dead is a thousand times worse than when you're living." And he told me about how **he was in the first stage of hell when he died.***

P43 10 It **scared** me to death, you know, it would scare anybody.

P44 NURSE 10, 23-24 And so he (*the dying patient*) would open his eyes, I mean from the beginning there was **the creepiness**. This feeling that we couldn't really; it was just **a bad feeling**. And we felt something that we had never experienced, but we couldn't say anything ... And we would try and calm him and he was jerking and a lot of movement and **we had this heaviness on us and we felt, I felt and then we later talked about it that I felt that I was in the midst of evil**. I mean it was a true experience of fear, I wanted to leave. It was like a spirit, I know that sounds weird, but it was like this spirit that was present; it was there ... And **there was no warmth no peace and it was torture, and it was torture for us and we felt he was going through this torture.**

P44 NURSE 29 And finally just she (*daughter*) no longer stepped out of the room and he took his final breath of life. And when that was happening though, he had this most intense scream that lasted, and I was all the while, I was feeling for a pulse. And it was just a scream that began wailing and then just come down to a slow whining, just a whine. And I was not getting a pulse at all and I just felt drained I guess is the only word. **I mean I'd been there. We'd probably been there about three hours over this time. We could not utter a word and we talked about this later. I couldn't say anything and she couldn't say anything.** We knew we had experienced in our mind and I not come to this conclusion. I had come to my own conclusion and she had too, but as believers we felt, **I felt, I had just witnessed Satan's presence**. I mean that was my feeling you know I mean whatever it was, **it was a powerful evilness** that was there. And **I was so emotionally distraught**. All I could do was, you know, I went out and I felt, you know I went to get the family.

P48 13-14 I seen the doctors working on me at the foot of my bed. I was still **scared** a little bit.

P49 23 So that's pretty much it. I mean so now I take them very seriously so now I'm **always paranoid** so if I ever have bad dreams I always have to call everybody to make sure everybody's ok but **it worries me**, and that's the only time I've every had something serious happen that I've thought of, but that was.

P59 38 It **aches**. **There's an empty hole**. And that's the only thing that fills it is knowing that I'm going back. (*Voice breaks.*)

4.4.2.1.4.2 Positive emotions

Positive emotions were explicitly identified by participants. The term *peace* was used repeatedly, and reference was made to protection, contentment, and lack of fear. Data display 4.4.2.1.4.2 shows statements illustrating *positive emotions*.

Data display: 4.4.2.1.4.2
Occurrence: Emotional intensity:
Positive

P33 35 But I was just at such **peace**.

P37 12-14 ... it's mostly dead people and my brother died two years ago, he had cancer. He comes and visits me. **Oh, it's great ... Oh, it's wonderful. Oh, I love it when he comes to see me.**

P37 41 It's just pleasant, it's peaceful. I **love** it.

P40 14 "I had no pain once I saw the light. **I felt good, so happy. Life was just perfect.**"

P43 22-24 I was scared at first when I fell, for lack of a better word, got back in my body, and I was scared at first, but then **it was like this overwhelming peace. Like, you know, it's o.k. you're gonna be fine.** And nothing was wrong with me.

P44 NURSE 53 I felt a **protection**. I felt **cocooned** is the only word, and I always keep thinking that because I almost felt as if though there was this around me and I felt it's o.k. just go ahead and do what you need to do and this isn't about you and that's just what I think. It wasn't about me.

P48 39 I wish I could explain it better how he (*Jesus*) looked and **the peace, oh ...**

P56 6-9 I think he (*his father*) knew the night before that he was going to die. He talked to his brother for hours on the phone like he didn't want to let him go. **He come up and he give me a kiss on the check. He said "I'm sorry." I said for what? He said "well I never got to take you to play ball with you as much as I wanted to or I never got to take you fishing as much as I wanted to". He said "it's not because I didn't want to, he said I had to work. You know, I was young." I said "well I couldn't have made a better dad if I could have made my own."**

P59 9-11, 26-28 But **it's the most peaceful place**. You can't describe it in words here. And there's just a feeling of **complete and total contentment and beauty. It was the most beautiful place you could ever imagine.** There's no bright light. It's not a bright light like they say, it's just **beauty and peace and serenity and no worries.** You're not sick. You're not encumbered.

P59 90 It's a beautiful experience.

P63 92 It probably sounds unusual for me to say this, but **I am so glad that that happened to me. I am so glad that I had that massive heart attack. And I am so glad.**

With regard to supportive literature, much of what is contained in data display 4.4.2.1.4.2 is also reflected by Eadie (1992:25-61) (section 2.6.2.4). In addition, with regard to emotionality relating to mystical experience, Merkur (1999:123) indicates that, with regards to mystical experience and “unitive experience”, [b]oth euphoria and desolation are reactions by the ego to its ego ideals.” Merkur (1999:137) continues by stating that “[m]ystical moments typically consist of positive super-ego materials.”

4.4.2.1.4.3 *Autonomic response: tears*

The richness of emotional expression in the interviews was accompanied by teariness at times. Both positive and negative emotional expression elicited tears. Data display 4.4.2.1.4.3 shows the occasion of *tears* or crying in the interviews.

Data display: 4.4.2.1.4.3
Occurrence: Emotional intensity:
Autonomic response: Tears

P33 21-22 ... they wouldn't let me come in the light, [laugh] where it was so pretty in the light, they made me go back. (*with almost a gentle sob*)

P48 Intro She was *teary* intermittently.

P56 29-30, 45-46 He said what are you crying about. He said the old man's all right ... He took a step off that step, when his foot hit that step I stood straight up in the bed, in my bed cause you know I was crying in my dream. **My insides ached me so bad when I woke up, like I just cried my eyes out, tears. The first thing I look and there wasn't no tears on the pillow or nothing.**

P59 (Interview notes) *Teary at times*

P62 17 The first words that came out of the (*radio*) speaker were “when I left home that day, I never got to kiss my mother goodbye or tell her how much I love her” [*crying*].

P63 8,10 If I **cry** you'll have to forgive me ... It's very emotional.

4.4.2.1.4.4 *Autonomic response: sympathetic enervation*

In addition to tears, other aspects of sympathetic enervation were identified. The sensation of chills in the absence of temperature change is considered to be the result of sympathetic enervation. The term “chills” may also include the presence of erector pili

stimulation (gooseflesh), also a sympathetic nervous system response. Data display 4.4.2.1.4.4 shows the occurrence of *sympathetic enervation*.

Data display: 4.4.2.1.4.4
Occurrence: Emotional intensity:
Autonomic response: Sympathetic enervation

P37 37 I: *Oh, that gives me **the chills** ...*

P: Uh, huh. It does **me too**.

P41 21 I had **chills** down my back.

P44 NURSE 13 But as I sat on the edge of the bed and when I sat down on the edge of the bed, it was cold. I even remember standing up and thought did I sit on something put my hand down on the bed and it didn't feel cold but when I sat down on it I immediately just got **chilled**.

P44 NURSE 21 But the room temperature we thought changed. It seemed as though, and I got up even at one point, and I went to the window and I thought the window is open because there was like a **chill** that just sort of came into that room and I went over and kind of looked at the window, you know it was an old house but it wasn't open, but on the windows, and it was cold, a cool day but nothing freezing nothing like that but around that window was just ice. And I thought this is really strange

P58 33 But you could really tell when he (*the ghost*) was really mad. You could walk into certain spaces in the house and it just became very, very **cold**.

4.4.2.1.5 *Dynamic tension*

Imbedded in many of the experiences described by participants was a sense of dynamic tension. The experiences weren't static; there was a push and pull between the participant's desires and how the experience progressed. This tension is reflected in the emotional aspects of the experience.

In several cases, the dynamic tension lay in the participants' desire to remain in the light, or a heavenly state, despite being returned to the here and now. This is vividly described by participants 33, 59 and 63. Similarly, participants 56, 59, and 63 described the inability to touch or hold on to dead family members. Participant 56 also described the poignant sadness of his dead father missing his son and his wife.

The tension manifested in a variety of other ways. For participant 40, the tension occurred as he experienced moving between heaven and hell three times in

succession. For participant 48 there was a sense of tension in seeing Jesus; her understanding of the Bible was that this was not possible. Participant 61's father had expressed frustration to her that he could see angels and hear singing, but that his wife was unable to do so. Similarly, participant 63 still expresses deep despair that she cannot share her vision and belief with her son, who rejects her faith. Participant 62 described a sense of moral conflict in the use of her newly acquired psychic skills.

Participant 44, a nurse visiting a home health patient, described intense internal conflict as she prepared to give care to a dying patient. She took a nursing aide with her for support, but throughout the experience felt a continual urge to leave the home, in which the atmosphere was strange and unsettling: the family members were partying and the patient was screaming in agony, perceived by the nurse to be encountering hell.

Mystical experiences are not always smooth and pleasant. Patients and nurses sharing in these phenomena may face troubling and unsettling experiences. Data display 4.4.2.5 shows evidence of *dynamic tension* associated with mystical experience.

Data display 4.4.2.1.5
Occurrence: Dynamic tension

P33 16-22 I had a heart attack at home and I was lying on my sofa in a lot, in a lot, of pain, and I thought well I'm just dying. That's what I thought. And so, then I went through this dark tunnel and at the end of it was this wonderful light and I didn't, and **they wouldn't let me in that light.** *Here there were lots of little pauses, and soft chuckles and laughter, not as though it was humorous, but rather like it was an experience she savored.* There were people, people, family there, but **they wouldn't let me come in the light, [laugh] where it was so pretty in the light; they made me go back.** *(almost a gentle sob)*

P33 35-36 But I was just at such peace ... and I say today, and my children say, they call my children all call me Me-me, that's my grandmother name, and my grandchildren, and they'll say, **Me-me, you can't leave**".

P4017-21 *(He said) His aorta blew and he died. He went into the darkness. "The pain when you're dead is a thousand times worse than when you're living."* **He was in the first stage of hell when he died. That happened three times [moving between heaven and hell]** and when he came back the third time after being dead, *the , the angel disappeared.*

P44 NURSE 2 But anyway, when we got there, well the thing was, for some odd reason, and I would never have done this, but there was a feeling just from the very beginning and I thought, you know, **I don't want go by myself ...** so I called one of the nursing assistants that I could take in the home.

P44 NURSE 28 And so I was just thinking oh gosh **I want to go.**

But at that point in time, I felt that I couldn't leave this family 'cause nothing, nobody was there and I knew this was imminent.

P44 NURSE 36 So I pulled in (to visit the home site) and I got out of my car one day and of course I was alone I was out doing a visit that way and as I started over the bridge, I couldn't go. **It was this strangeness it was like don't go there, don't go there. Don't go there and I didn't. I left. I wanted out of there and I didn't go. So I don't know. I thought in fact me and this nursing aide, I said I'd like to go there, but I'm afraid to go by myself. And she's like well I ain't going with you.**

P48 18, 21 But I know it was Jesus there ... But I know, people tells me the Bible says nobody can see Jesus.

P56 34 He said I'm just missing two things. **He said I'm missing your mom and I'm missing you.**

P56 42-43 And I grabbed him by the arm and when I grabbed him by the arm, I said, no I lost you once I ain't going to lose you again. **He said well I'm with you all the time and you'll never lose me.**

P59 12-14 ... you don't want to come back. I was very angry for a year, and I'm still a little angry **but I'm going in soon so ...** I'm happy about that.

P59 22 Yes. And I saw my father in law. I couldn't touch him. **If I had touched him I would have had to have stayed, so he wouldn't let me touch him** and there were people around him.

P59 30-33 And you know what you have to do when you're sent back. **You don't always get it done, I didn't get it done. I'm trying, but I almost didn't make it this time,** so, but I turned a corner yesterday, so I'll be here for a while longer.

P59 94-95 You're not allowed. **You're not allowed to completely express everything or even completely remember everything ...** You remember a lot, but there are certain things that you remember, you're right there on the fringe, but **you can't get past the fringe.**

P61 6-9 And he, uh, **but during this whole time and once he kind of** went into this vegetative state, he could remember at some point in time, and I guess my mom was at his bedside, he could remember seeing angels and singing hymns. And **he could not understand why my mom could not hear them.** But he could remember seeing them

P62 28-29 *(Explaining why she no longer does psychic readings on a regular basis)* Moral issues. Moral questions ... Trying to rationalise to myself. **Is this what I'm supposed to do? Is this right? I mean if we're here to learn stuff and make choices, is it right for somebody to intervene?** So at this point, I don't do it on a regular basis. It's when I'm specifically instructed to. And I'm more comfortable with it that way.

P63 46-49 ... my mother was right there in full front. **I wanted so much to just go over and hug her one more time, but I had to keep in mind he has work for me to do and I have to understand why this time I can't. And uh, it was a real struggle.**

P63 54 I wanted so much, I love material and sewing, **I wanted**

so much just to feel it (the clothing of the heavenly beings). I never seen anything like that. We don't have anything like that here, **but my situation was hands off.**

P63 82 I am desperate for people to know what I know. I've even said to N before, I can't help but wish that some people out there that I love so much but don't understand what I'm telling them could have this experience and then be sent back so they would know. So I would know that there are more people who know what I know ... **I just get so desperate.**

P63 23-24 I was not interested in coming back here at all, although I love them dearly. He still explained to me that I have work for you to do.

4.4.2.1.6 *Conviction of reality*

Participants were well aware that the experiences they described were unusual and inconsistent with the usual understanding of reality. But they were convinced that the experiences were real. Hardy identifies “a feeling of transcendental reality” as a significant aspect of such experiences (Hardy 1979:131). Some participants, such as participants 37, 49, 56, qualified their statements by explaining the experiences as occurring in dreams, but they still asserted their reality. Others, such as participants 48, 53, and 59 emphasised they were not crazy or hallucinating. Participant 48 continued to assert the reality of her experience in the face of her conviction that the Bible says one cannot see God.

Veridicality is an important concept in the literature on mystical experience (Stace 1961:31-34, Ellwood 1980:xi, Corduan 1991:125, Forgie 1994:7, Pike 1994 116-153). The participants in this study would seem to be on the side of saying that their experiences, whatever the context, were absolutely real, and that if they saw heaven, or hell, or angels, or God Himself, then that was indeed what they saw. Data display 4.4.2.1.6 shows statements reflecting the *conviction of reality* expressed by the study participants.

Data display: 4.4.2.1.6
Occurrence: Conviction of reality

P37 11, 21 I'm asleep but I'm not asleep ... It's like a dream and it's **more real than it is a dream.**

P37 25 And I see him (her deceased brother) **as plain as I can see him.**

P44 NURSE 53 Yeah, and I was sort of being shown look here and see this and **this is real**. It was almost, I have almost taken it as a vision, I don't guess it was a vision, but I know it renewed it and it was a strengthening of my own faith and that I know, and it also changed me, and I don't know what really took place there. I know what I think and every now and then I think this is just some weird phenomenon, but **in my heart and my own mind, I believe it was not**.

P46 NURSE16-17 I believe in ghosts, so **I think he is (real)**. I think it's the spirit of someone who died in this facility who either didn't want to leave or isn't happy or something.

P46 NURSE 7-9 My most famous experience of him (*the ghost*) was I was working with A. I locked the door (*of the bathroom*) and finished what I was doing and unlocked the door and it wouldn't open, and it wouldn't open. And I thought o.k. maybe it was just stuck. So I did it two or three times, wouldn't do nothing. Banged on the door and A said, well, turn it. I said I can't get out. She said turn the knob. I said I can't get out. I turned the knob and the door opened right up. And I would have thought well maybe that's a different problem with the door knob, but nobody else and it was a fairly new one, fairly new door period, **nobody else had any problems with it after that, just that one time**.

P48 21 But I know, people tells me the Bible says nobody can see Jesus. **I know in my heart that I seen him**.

P48 30-31 You know, before I was saved, people would say things like that and I used to think that stuff, that medicine stuff they give me. **But now I know it's not**.

P49 18-21 At about 9 o'clock, my sister called and my dad had had a heart attack that morning ... when I first got off the phone, I thought he was dead; actually he was in the hospital. But because of the dream and everything **I just took it so much more seriously**.

P56 20-28, 48 I went to bed one night, and I said Lord I've got to know if he's all right (*his deceased father*). I went to bed and I had a dream. And in this dream, I was laying down in my bed at the house. I could see myself laying in that bed in this dream. Just as real as I'm touching his leg right there. (*Touches friend's leg*.) I got up in this dream and I walked out on my front porch. There stood my dad. He talked to me. **Lady, in my heart and soul I honestly believe that that happened. I mean I know if you think I'm crazy, I don't care. I also believe that because it was as real as I'm grabbing that fan right there ... I honestly believe in my heart and soul that that actually happened**.

P53 10 People think I'm crazy ... I don't think I'm crazy, cause **I know I seen it**.

P63 7 Well ... I first realised that **this was a true experience** when I asked my son at the hospital later when I was more coherent, who picked me up and held me. He said "no one". I insisted I said a doctor or a nurse or someone picked me up and held me.

P63 81-82 Heaven is there, it's real ... this, this is real. I don't know how else to say it. (*softly*)

P59 84-85 But I wasn't hallucinating. I know exactly where I was, what it looks like, how it smells, how it feels. I can feel it, I can taste it, I can smell it.

With regard to the participants' conviction of reality of the experience (occurrence) the reader's attention is again focused on the fact that this is the essential point of articulation with the research methodology namely phenomenology; more specifically that reality is what appears real to the individual.

4.4.2.1.7 Cognition

As participants described their experiences, the emotions involved, the tension, and the reality, it became clear that there was a significant element of cognition involved. The participants were awake (in some sense, see section 4.4.1.2) and aware as they processed these unusual phenomena. There was an element of *knowing* which several participants explicitly identified. Sometimes a particular understanding was addressed; participant 48 stated she knew that her infant daughter would survive; participant 56 said he realised that his father was safe and happy in heaven. However, for other participants the knowledge was broader. For example, participant 59 said "I know it" in relation to "miracle experiences" (P59 5). And, participant 63 stated emphatically "I know that I know that I know", at the end of the interview (P63 95). Data display 4.4.2.1.7 shows statements relating to the *cognitive* aspects of the experiences described by participants.

Data display 4.4.2.1.7
Occurrence: Cognition

P 46 NURSE 12,14 They have seen the results of Alexander (*the ghost*) and why they call him Alexander I don't know whether there was a patient that died around the time that this started because he's been called Alexander for 30 years. Ours (*paranormal experiences*) have predominantly been TVs coming on, lights coming on. And **you know** when that happens it's just a matter of time before somebody dies and that's usually what happens. But it's not every time.

P48 18 But I **know** it was Jesus there.

P48 24-25 ... It was (*profound*). And it's like I told R, I said, she's gonna make it (*her infant daughter*). You know I don't remember crying. Because I **seen Jesus; he was there, he was there**. She's gonna make it.

P49 11 (*In my dream*) I **knew** he'd had a heart attack.

P59 5 I know it (“miracle experiences”) (with great emphasis).

P59 29-30 You know and you remember everything you see, the past, the present, and the future. And **you know what you have to do when you’re sent back.**

P62 12 Well it was mostly in a **search** for life after death, just so I’d know that my son still existed somewhere.

P62 21-22 A lot of the stuff in the books that I read, it was like going, of course, it just made perfect sense. **It’s like I’d always known it, but now I could explain why I was acting certain ways to certain things all my life.** So I was in the shower one day and I guess I was still grasping that I would just love to be able to do this communication thing myself. I was in the shower one day and I heard J say to me, “you’ve got to be taught, Mom”. And I said, yeah, right. And just as plain as day, I could hear him say, “God, Mom. You are so stubborn.”

P62 25 One of the organisers of one of the rooms instant messaged me and said would you like to become a reader. And I said, **I don’t know how to do that. And she said, yes, you do.**

P63 84 I knew that I knew God was walking with me all the way (as a teenager, on the way to her first job in a threatening situation)
...

P63 95 “I know that I know that I know!” [emphatically]

The element of cognition displayed in data display 4.4.2.1.7 also relates to the conviction of reality as portrayed by the evidence in data display 4.4.2.1.6. Conviction and cognition evidence the essence of the lived experience of the mystical occurrence. With regard to cognition and mystical experience, it is also noteworthy that Jones (1993:78) indicates that “there is a very real possibility that mystical thought is rational”.

4.4.2.2 Maturation

After the experience occurs, it does not remain static in understanding. It goes through a process of *maturation*. The following aspects of *maturation* are not completely separate, and should be seen as components of an interrelated process rather than sequential steps.

First the mystical experience is *processed*. This involves reviewing the experience, interpreting it and seeking meaning, owning it and naming it. The participant *lives with the experience*, seeking further implications, and realising the enduring effects. The experience is *shared* as a story, reported as perhaps not completely effable, but expressed as such in the desire to communicate. This sharing, in turn, provokes an

effect and a response by others. Data displays addressing *maturation* are shown in the table below.

Data display 4.4.2.2: Overview of maturation		
Sub-Categories	Count	Data display
Processing		4.4.2.2.1 (Series)
Review and affirmation	9/18	4.4.2.2.1.1
Interpretation, meaning	4/18	4.4.2.2.1.2
Ownership	5/18	4.4.2.2.1.3
Naming	4/18	4.4.2.2.1.4
Living with the experience		4.4. 2.2.2 (Series)
Seeking further implications, fulfilling purpose	7/18	4.4.2.2.2.1
Enduring effect	6/18	4.4.2.2.2.2
Sharing the story		4.4.2.2.3 (Series)
Reports mystical experience/ (effability)	5/18	4.4.2.2.3.1
Effect on others, responses	15/18	4.4.2.2.3.2

4.4.2.2.1 Processing

Processing incorporates *review and affirmation*, *interpretation* and development of meaning, gaining a sense of *ownership*, and *naming*.

4.4.2.2.1.1 Review and affirmation

The processing of a mystical experience involves internal review. Individuals go over the experience mentally, examining it and seeking assurance that it was real. Participants asked themselves if the experience were a dream, or an instance of mental aberration. They attempted to reconcile conflicting explanations of the experience, as did participant 37 when she said, “I’m asleep, but I’m not asleep” (P37 11) and when participant 44, a nurse said, “It was almost, I have almost taken it as a vision, I don’t guess it was a vision, but I know it renewed me and it was a strengthening of my own faith and what I know, and it also changed me, and I don’t know what really took place there. I know what I think and every now and then I think this is just some weird phenomenon, but in my heart and my own mind, I believe it was not” (P44 53). However, difficult it may be, the experience was in some way reconciled and affirmed.

Data display 4.4.2.2.1.1 illustrates *review and affirmation* as part of processing in the maturation of mystical experience.

Data display 4.4.2.2.1.1
Maturation: Processing: Review and affirmation (validation)

P33 15 (*regarding childhood experience*) Yeah, **I knew what was going on, but I didn't really know**, I thought I was having a dream or something, you know.

P33 47-48 No **I wasn't confused. No, I wasn't confused.** I was an adult. (Pause) But I can just remember this peaceful, beautiful peaceful feeling, you know, just comes all over you and you are totally at peace with it. (*almost dreamily*)

P37 11 I'm asleep but I'm not asleep.

P43 38, 43 Yeah, I think there were times though, a couple of times when I was younger, I questioned whether or not it really did happen like that or not ... I think for a little while I worried that maybe it did do something to me that couldn't be seen, mentally.

I: You talking about mentally or physically.

P: Mentally

P44 NURSE 53 : It was almost, **I have almost taken it as a vision**, I don't guess it was a vision, but I know it renewed it and it was a strengthening of my own faith and that I know, and it also changed me, and I don't know what really took place there. I know what I think and **every now and then I think this is just some weird phenomenon, but in my heart and my own mind, I believe it was not.** I think it was an experience that actually can take place and some people don't pay attention to it, I guess you would say, but I think any kind of experience like that. But see here's the thing, *stumbles* if I didn't have my own faith, I think I'd have just been in the midst of all of it. It would have just been uh, all right.

P48 31 I used to think that stuff, that medicine stuff they give me (*caused the experience*). But now I know it's not.

P49 36-37 Well I told the girls at work that morning so **there's verification** so they knew before my dad had the heart attack that I'd had the dream.

P62 61-62 It was because (*writing*) it allowed me to, what's the word I'm looking for, all that reading and research that I was doing searching for answers. What's the word I'm looking for? **It allowed me to make it official. Or to put an o.k. stamp on it. That's it's within the realm of everyday life** now because it was for an English paper ... Instead of the "woo woo" stuff.

P62 92-97 My sister-in-law, this one being one of them, is very strictly religious and she was the last one that I discussed any of this with. But her sisters, people around me now know about my "woo woo" stuff and slowly but surely, they would ask me questions about it, and now they carry rocks (*crystals*) ... And **there's this one little thing that I did that more than anything I ever said convinced them. If we were going to the mall, or somewhere its expected to be crowded I will ask in advance for a parking place close to the specific entrance and they know now that it will be there.** [laugh] ... The first couple of times it was coincidence, and now we go up the hill to the mall and one of them will turn to me and say did you ask. I'll say yeah. Ok. **That was the first test that I did to validate stuff for myself ...** Yeah, to ask for a parking place. Because it

was so easily validated and I could repeat it over and over ... Simple. Simple. I didn't ask for money you know, just **something simple that I could validate.**

P 62 31 No what I mean was, in the (*psychic*) reading rooms, it was like, I can't explain how I did it. I don't know. **And I don't think I did it, it's just that I was allowed to do it.**

The process of review and affirmation in a sense also relates to the participants conviction of reality and cognition. The difference is that whereas cognition and conviction involve a blend of the past (the moment of the occurrence of the mystical experience) and the present (the recall) of the experience, review and affirmation are in the present, like reflection on any life experience that had happened in the past.

4.4.2.2.1.2 Interpretation and exploring meaning

Having reviewed and affirmed the experience, individuals seek further interpretation and they explore the meaning of the experience. As a descriptive phenomenological study, the current research does not seek to interpret the meaning mystical experience has for participants. This would be the field of hermeneutic phenomenology. The content of this section merely *mirrors* the meaning the mystical experience had for individual participants.

Participant 36 could only say that his experience was “spiritual”; in explaining it he identified the influence of Native American spirituality associated with the location of his experience at a Native American burial ground. Participant 37 evaluated her experience of talking to the dead as occurring across a broad range of possible good and bad experiences. Participant 41, a nurse who said he saw an angel entering a dying patient's room, was still in the process of exploring the meaning of the experience. (This may have been his motivation for offering an interview.) He asked the researcher, “My wife thinks it was an angel. Was that mystical?” Participant 62 explicitly described her search after her son's fatal accident and subsequent experiences. She integrated this search with wide reading and writing into her activities, seeking both meaning and affirmation of her experiences. Data display 4.4.2.2.1.2 shows statements relating to *interpretation and exploring meaning* associated with the processing that occurs during the maturation of mystical experience.

Data display 4.4.2.2.1.2
Maturation: Processing: Interpretation, exploring meaning

P36 6 *He couldn't explain what happened, except that it was a "spiritual feeling". He used this term several times.*

P37 38 **Now there's experiences out there, good ones and I suppose there's bad ones.** Because you know we know the devil's real. I don't give him credit. I get behind and I say get out of here, leave me alone. I don't need you. And I can start singing. I can't sing. I can start singing about the blood of the old rugged cross or washed in the blood and you know he can't stand that word blood ... Oh, he'll leave you every time. He'll leave me alone.

P41 NURSE 22-23 **"My wife thinks it was an angel. Was that mystical?"**

P62 9 Well on Christmas Eve, 2001, my 19 year old son was killed in a motorcycle accident. And that was my traumatic stressor because you start looking for reasons why and you start looking for ways to cope. **So you go on a search. Hopefully you'll find something that will help you deal. And I think I did.**

P62 56-58, 61-62 I was working on my bachelors when J's accident happened. And I had to go back. I had to finish a composition English class in January. And I didn't know if I could do it. I didn't know if I could put aside my grief long enough to focus on being in class. But I decided to do it anyway, and I wound up in a Composition English class up here at the high school and at least half of the class were high school seniors taking their first college course and then the other half of us were adult learners trying to finish up something ... And she had the open-mindedness to allow me to use that class as therapy ... so the name of my paper was Possibilities ... And I wrote that story that I just told you as my English paper ... because **it allowed me to, what's the word I'm looking for all that reading and research that I was doing searching for answers. What's the word I'm looking for? It allowed me to make it official. Or to put an o.k. stamp on it. Instead of the "woo woo" stuff ... That's it's within the realm of everyday life now** because it was for an English paper.

4.4.2.2.1.3 Ownership

A sense of ownership develops in participants who have reviewed, affirmed, and explored the meaning of their mystical experiences. This sense of ownership means that they can control their experiences within a personal boundary and keep them private, or share, as *they see fit*. Although it is not reflected in the interview recordings, before participants told their stories, the researcher noted a pause in which it seemed that the participant was considering his or her experience and deciding whether to share it. The researcher sensed that many of the experiences were indeed very private and closely held. Participants 33 and 48 said they did not consider telling a nurse their experiences even though they occurred in hospital settings. Participant 43 said she didn't even tell anyone, including her mother, about a childhood experience of being struck by lightning, until recently. Data display 4.4.2.2.1.3 shows expressions of

ownership occurring as an aspect of processing in the maturation of mystical experience.

Data display 4.4.2.2.1.3
Maturation: Processing: Ownership

P33 37 No. I didn't tell anybody about it, not 'til some y ... sometime later.

P33 45 I don't think you would tell them (a nurse). I think you'd just have it. I don't think you'd ask a nurse what do about it or anything like that.

P41 NURSE 5 I don't tell everyone; they'll think I'm crazy.

P43 27, 30-32 Un huh. I never told anyone (*quietly, reflectively*). You know, I've told a few people over the years, but it's not like it's been a common knowledge kind of thing. But what's funny is I'm the kind of person I tell my mother everything. I always have even when I was a teenager, I didn't tell her about this until a couple of weeks ago about that ... I said I'm serious.

P43 37 But you know, like you say things like that, **it's so personal**.

P48 29 I felt like **that's my own personal ...** (*why she didn't tell the doctors or nurses*).

P62 44-45 And I wasn't too sure that all my buttons were fastened down too tight. So I wasn't too sure I wanted to share this information with other people. And then as time progressed, I become more and more comfortable with the whole thing and it became perfectly o.k. if you think I'm crackers. [*laugh*] I'm very comfortable with this. (*Assertively*).

4.4.2.2.1.4 Naming

Concurrent with ownership comes naming. Not all participants gave their experiences a specific name, but participant 37 called her conversations with her dead brother "visiting night", participant 56 referred to his meeting with his dead father as "the dream" using the definite article in a specific manner, and participant 59 made reference to "miracle experiences" when the researcher asked her about mystical experience. Participant 62, a nurse, named her experience "Possibilities" in a paper she wrote for an English class. But, she also referred to her experience as "woo woo", suggesting a certain self consciousness or self deprecation. Participants' *names* for mystical experience are shown in data display 4.4.2.2.1.4.

Data display 4.4.2.2.1.4
Maturation: Processing: Naming

P37 20 Uh, I call it "visiting night".

P56 53-54 P: I was awful to live with, wasn't I when that happened?
Wife: Not after "**the dream**".

P: No, that's what I'm saying. After "**the dream**", the next morning I got up and I went to work, and I've been fine ever since.

P59 2 (*reference to*) "miracle experiences".

P62 56-58, 61-62 I was working on my bachelors when J's accident happened. And I had to go back. I had to finish a composition English class in January. And I didn't know if I could do it. I didn't know if I could put aside my grief long enough to focus on being in class. But I decided to do it anyway, and I wound up in a Composition English class up here at the high school and at least half of the class was high school seniors taking their first college course and then the other half of us were adult learners trying to finish up something ... And she had the open-mindedness to allow me to use that class as therapy ... so the name of my paper was **Possibilities** ... And I wrote that story that I just told you as my English paper ... because it allowed me to, what's the word I'm looking for all that reading and research that I was doing searching for answers. What's the word I'm looking for? It allowed me to make it official. Or to put an OK stamp on it. Instead of the "**woo woo**" **stuff** ... That's it's within the realm of everyday life now because it was for an English paper.

4.4.2.2.2 *Living with the experience*

An experience which has been processed must be lived with. Living with the experience involves *seeking further implications*, and *attempting to fulfill the purpose or mission* given to the participant. The effect on the participant is long term and *enduring*.

4.4.2.2.2.1 *Seeking further implications, fulfilling purpose and mission*

Participants must live with the implications of the mystical experience as they understand it. This may take the form of exploring implications to themselves or the form of fulfilling the mission or purpose they believe God has given them or which they feel they have been otherwise given. Participant 43 had to live with the concern that her experiences after being hit by lightning were really signs of mental illness. Perhaps for this reason, she was reluctant to tell her family. Participant 44, a nurse also considered the possibility that her mind was "playing tricks" on her, and was reluctant to tell others of her experience. Participant 49, on the other hand, was overwhelmed by her precognition of her father's heart attack, and was preoccupied with the possibility that other family members might be in danger. Participant 59 lived with a sense of regret that she had been "sent back".

The sense of fulfilling a purpose or mission was expressed an important aspect of living with the experience. Participant 61 described her father as having a life mission to care

for her after his mystical experience. Participant 63 described desperate, repeated attempts to bring her son to an understanding of Christian faith, believing this to have been the mission set on her by God. Data display 4.4.2.2.1 illustrates *seeking further implications* and *fulfilling purpose and mission* as aspects of living with the experience in the maturation of mystical experience.

Data display 4.4.2.2.1
Maturation: Living with the experience:
Seeking further implications, fulfilling purpose and mission

P43 41,43 I worry that maybe something was really was wrong with me you know ... I think for a little while I worried that maybe it did do something to me that couldn't be seen, but ... (*something*) mentally.

P44 NURSE 48 Because I'll give you one thing, **if that had occurred early on I'd have never done it again.** It would have scared the life out of me to the point that, and also if I hadn't experienced some nice deaths.

P44 NURSE 52 Yeah, maybe. And maybe being a nurse, the only ones I wanted to tell and to be honest with you, **the few that I have talked to about it, I wanted them to say to me, yeah, I've done this, too, but nobody ever did.** They're like you're nuts. I would say no and **had I not have had somebody there with me, I may have thought that my mind was playing tricks on me but it wasn't you know.**

P49 44-45 ...now I'm scared not to take something seriously. My husband's got tumors on his liver and sometimes. It's almost **like I make myself have these flashes of negative.** I'm like oh my God, he's going to be in the hospital when I get home. Something's wrong. **Sometimes I think I make myself worry because of it now.** So then I'll rush home and he's there. I'll check him to make sure he's breathing sometimes because I'm always concerned that he's ... **It's almost in a way kind of a bad thing now that I have them because now I'm over paranoid sometimes.** You know how just thoughts will cross through your mind. You know what would happen if he would be in an accident. Oh my God what if he was in an accident. **So then you start freaking out.**

P59 30-38 And you know what you have to do when you're sent back. **You don't always get it done, I didn't get it done.** I'm trying, but I almost **didn't make it this time, so, but I turned a corner yesterday,** so I'll be here for a while longer.

Brief episode of respiratory distress and shortness of breath

I: So this was an important time for you here too?

P: Very, because I wanted to go. I even asked for help.

I: Yeah. What kind of help did you ask for?

P: Let me go.

I: Yeah. It sounds like that must be pretty hard to know that beautiful place is there and then to still be here.

P: It aches. There's an empty hole. And that's the only thing that fills it is knowing that I'm going back [voice breaks].

P61 44-46 *You now it sounds to me almost in a way now, see if this makes any sense to you, he has what you might see as a spiritual experience, but sounds to me like what was his real spiritual experience in his life was having his daughter.*

P: Right ... That was his driving force.

P62 27-29, 31 *(She no longer does psychic readings on a regular basis, and explains why.)P: Moral issues. Moral questions. Trying to rationalise to myself. Is this what I'm supposed to do? Is this right? I mean if we're here to learn stuff and make choices, is it right for somebody to intervene?* So at this point, I don't do it on a regular basis. It's when I'm specifically instructed to. And I'm more comfortable with it that way. *I: So you have little more control over it.?*

P: I have no control over it whatsoever ... No what I mean was, in the reading rooms, it was like, I can't explain how I did it. I don't know. And I don't think I did it, **it's just that I was allowed to do it.**

P63 56-58 See, we are spirit. Our spirit has its own heart. **These are the things that I know now, and I want so much for those young people out there to know but how to do you get it across to them ... it is so sad to have to sit here and witness it happen (rejection of Christian truth and values) when I have the answer.**

P63 82-83 I am desperate for people to know what I know. I've even said to N before, I can't help but wish that some people out there that I love so much but don't understand what I'm telling them could have this experience and then be sent back so they would know. So I would know that there are more people who know what I know ... I just get so desperate. **I'm writing my testimony ... I've reached a point where there's so much to say and so much to describe that it just overwhelms me, and I stop at that point and start over.**

4.4.2.2.2 Enduringness

A reference to the table in section 4.3.1 shows the recollection of mystical experience to span as many as 70 years. This significance and endurance is an essential aspect of mystical experience. Participants 33 and 39 said they will never forget their experiences; participants 62 and 63 said they still feel the ongoing effects of their experiences. Regardless of the age of occurrence, the phenomena are still vivid and important to the participants. Data display 4.4.2.2.2 shows enduringness as an aspect of living with the experience in the process of maturation of mystical experience.

Data display 4.4.2.2.2
Maturation: Living with the experience:
Enduringness

P33 33-34 That happened, that happened to me **30 years ago** when I had that heart attack ... Oh yeah, **you won't forget it.**

P39 18 I've told that story many, many times, and **I'll never forget it. Never.**

P44 NURSE 1 My experience took place as a nurse probably about 15 years, well it would be actually more than that, maybe **16 years, 17 years ago**, something like that.

P49 23 So that's pretty much it. I mean so **now I take them very seriously** so now I'm always paranoid so if I ever have bad dreams I always have to call everybody to make sure everybody's ok.

P62 92 I: *It sounds to me like your experience is very profound.*

P: *It was and continues to be on a daily basis.*

P63 83 P *Always, I feel his (Jesus's) presence always.*

4.4.2.2.3 *Sharing the story*

That which is embraced, owned and lived with can be shared. Sharing is carried out verbally, by those sufficiently articulate and able to explain their experiences. The ability to “report mystical experience”, stated as a defining characteristic in the nursing diagnosis *Readiness for Enhanced Spiritual Well-being* (Wilkinson 2005: 513) requires that the experience be, in some degree *effable*, or capable of being communicated. This sharing with others prompts an *effect on others and a response* which is incorporated into the overall maturation process of mystical experience. The two following sections have a great deal in common and although they could be combined, they are addressed separately in the data analysis for clarification. Section 4.4.2.2.3.1 emphasises the theme of effability, the *ability* to articulate and share the mystical experience. Section 4.4.2.2.3.1 emphasises the *interactive* quality of the sharing, including the effect on others and their responses.

4.4.2.2.3.1 *Reports mystical experience (effability)*

For participants to report their mystical experiences, a certain level of descriptive capability or effability, was required. James (1929:371) notes *ineffability* as a key feature of mystical experience, but section 2.6 discusses many firsthand descriptions of mysticism in the literature. For the participants in this study, allusion was frequently made to the *difficulty* of describing mystical experience, followed by an attempt to do so. (It must be noted, however, that potential participants who were truly unable to describe their experiences would probably have declined to be interviewed.)

Participant 36 was the most inarticulate in describing his “spiritual feeling”. He gave no details at all, and in fact had somewhat unclear speech. Still, it was clear that he did have a specific experience in mind. Others, such as participants 48, 59, and 63 recognised their limitations, but expressed themselves dramatically, as evidenced by the vivid sensory and motor images described earlier. Data display 4.4.2.2.3.1 treats

reports mystical experience and effability together as fundamental to sharing the story in the process of maturation.

Data display 4.4.2.2.3.1
Maturation: Sharing the story:
Reports mystical experience (effability)

P36 6 *He **couldn't explain** what happened, except that it was a "spiritual feeling"*

P48 39 *I wish I could explain it better how he (*Jesus*) looked and the peace, oh.*

P49 5 *... how do I explain this? When I think stuff sometimes it happens. I don't know if it's like ESP or whether it's *deja vu* or what it is.*

P59 94-95 *You're not allowed. **You're not allowed to completely express everything** or even completely remember everything ... You remember a lot, but there are certain things that you remember, you're right there on the fringe, but you can't get past the fringe.*

P63 81-82 *Heaven is there, it's real ... this, this is real. **I don't know how else to say it.** (*softly*)*

P63 25 *When I came home and I'll get to describing heaven, **there's no words really to describe it, but I'll try.***

P63 83 *I've reached a point where **there's so much to say and so much to describe that it just overwhelms me** and I stop at that point and start over.*

4.4.2.2.3.2 Effect on others and responses to sharing

When mystical experience is shared with others, it provokes a variety of responses, all of which become part of the experience and essential to it. Participant 33 said she told no one at first, but participant 37 told "anybody that would listen" (P37 39). Participant 37 was surprised that a nurse would be interested in her nocturnal visits from her dead brother, and mused over this. Many participants said they had told family members and friends. For example, when struck by lightning in childhood, participant 43 told a friend about her experience; her friend laughed it off, but her mother, told many years later, accepted it. Participants 39 and 62 shared their experiences at church as part of their Christian testimony. Participant 40 told others and wanted to give his testimony in church, but was not encouraged to do so by his pastor. (The researcher found participant 40's story to be intense and his delivery almost frightening. It may have been perceived similarly by his pastor). Participant 48 had a vivid experience of angels and Jesus, but never shared it with a pastor because she felt it to be inconsistent with the Bible to see God.

Rejection by others or refusal for others to believe the experiences was not uncommon. Participant 53 said, “People think I’m crazy” (P 53 10); participant 59 said she was told by her doctor that she was “homicidal” because she advised letting dying patients die. Participant 63’s physician was perceived as rejecting her dramatic and emotional explanation of experience of heaven and subsequent recovery from cardiac arrest, by saying, “sometimes you just do well” (P 63 71). Data display 4.4.2.2.3.2 illustrates some of the variations in *effect on others* and *responses to sharing* that occur in association with sharing the story in the process of maturation.

Data display 4.4.2.2.3.2
Maturation: Sharing the story:
Effect on others, responses to sharing

P33 37-39 No. I didn’t tell anybody about it, not ‘til some y ... sometime later. **And I told them about going through that tunnel and it was strange.**

I: You didn’t tell a nurse or a doctor ...

P: No, no I didn’t tell them.

I: Or a preacher or anything like that? ...

P: No, I didn’t tell the preacher I don’t think. **I don’t remember telling the preacher, but I know I’m not afraid of death**, because it’s just so [pause] I was just this wonderful peace came over me and if I went, I went, if I didn’t o.k. I really kind of wanted to go, I think. (chuckle) ...

P33 45 *I: You didn’t need to tell anyone at all?*

P: **I don’t think you would tell them.** I think you’d just have it. I don’t think you’d ask a nurse what do about it or anything like that.

P37 39-40 *I: Who did you tell?*

P: **Anybody that would listen.**

I: Did you ever tell any nurses or any doctors?

P: No I don’t think so. No.

I: I was just kind of curious because I’m a nurse, you know.

P: **You’re probably the only one I ever told.**

P37 48 This seems peculiar that somebody like yourself would come and ask me something like this ...

P37 55-56 It feels good to talk about it. But it sounds amazing that you’d be here asking me. *[laughing]* I got a girlfriend that I talk to all the time about all this stuff.

P39 18 I’ve told that story many, many times and I’ll never forget it. Never.

P39 31 Oh yeah. Yeah. In fact the last time I told that was at my, we lived, my husband passed away last year, so I keep saying we, but he was still alive and Jane, we’re on their property, they have two houses. We have the small newer house and they have the old farmhouse, and she had a group up from a college of, it was a choir and she wanted us to come over so we could meet them. And they were a lot of foreign students, they could speak English, you know, but it was a religious college. **And she said, “Mom, why don’t you tell them your story?” And I did and I didn’t realise how tense they had gotten** *[laugh]* and you should have heard ‘em when I said at the end I said well, that’s my story. They just kind of whoa. *[laugh]*

P40 2 ... it would take a long time to talk about it.

P 40 30-35 *I asked him who he told. He said at first he “kept it all in”. He said he kept it in for six months. He kept it in for ever so long. He finally told one son about six months later. He said he didn’t tell anybody because if he started to think about it, he said “I’d break down.” He tried to tell his pastor, but he could never finish. His pastor always had something coming up. He wanted to testify in church, but he hasn’t done it yet, because he didn’t want to take so much time that other people wouldn’t have a chance. He never told a doctor. He never told a nurse. “They never had the time”.*

P43 27 Un huh. I never told anyone (quietly, reflectively). **You know, I’ve told a few people over the years, but it’s not like it’s been a common knowledge kind of thing.**

P43 15-16, 30-32 P: What’s funny, **I just told my mother about this a couple weeks ago** (*even though the experience happened 29 years ago*).! *Didn’t tell her then?* P: Didn’t tell her then. Didn’t tell her then... You know, I’ve told a few people over the years, but it’s not like it’s been a common knowledge kind of thing. But what’s funny is I’m the kind of person I tell my mother everything. I always have even when I was a teenager, but I didn’t tell her about this until a couple of weeks ago about that. And I don’t even remember what it was that made me think ... about that to tell her. I really don’t know, I don’t remember what it was we were talking about or whatever, but it’s like you know. But I said I’m serious. **She said, well I believe you.** [laugh] **She said, I don’t think you’d make up a story about that.**

P43 19-21 ‘Cause **I remember saying to my best friend that I could see it all happening**, She’s like what do you mean you could see it all happening. Well I said I was watching myself. What are you talking about? I said I was up there. I was floating. You know, we were 10, and **she was like something must have happened to you, A, because you were here. You weren’t up there, you were here. You must have done something to your brain or something.** [laugh]

P44 NURSE 52 Yeah, maybe. And maybe being a nurse, the only ones I wanted to tell, and to be honest with you, the few that I have talked to about it, **I wanted them to say to me, yeah, I’ve done this, too, but nobody ever did. They’re like you’re nuts.** I would say no and had I not have had somebody there with me, I may have thought that my mind was playing tricks on me but it wasn’t you know.

P48 26-28, 32 *I told [j]ust R (husband) and a little while later ... A little while later, I told my mom. I still ain’t never, like we go to church, I didn’t ... I made a scrap book (for my daughter) ...*

P49 16-17, 36-37 **And the girl that was working with me asked me what was wrong. She said you just don’t seem like your normal self. I said I just don’t feel right. I said I’m tired; I was up most of the night. I had a dream that my dad had a heart attack and it’s really is bothering me.** I said there’s something about it that’s just really bothering me. And that was all that was said about it ... Well **I told the girls at work that morning** so there’s verification so they knew before my dad had the heart attack that I’d had the dream. I told them (*my parents*) afterwards.

P49 39 No, I don’t believe so. (*Didn’t tell hospital staff about dream that her father had had a heart attack.*)

P53 10 **People think I’m crazy ... I don’t think I’m crazy, cause I know I seen it.**

P 56 50-52 (who he told) **Anybody that I seen that’s been you know, sick or my good friends, well I told D about it. I told him and just people you know.** Yeah. I have (*told the pastor*). No (*never told a nurse*).

P58 45 No researchers or anything (*were told about the experiences*). **But you know, family members.**

P59 67- 70 (*She told her pastor and the doctors and nurses*) Yeah, **my doctor thought I was nuts. And he said I wasn't suicidal but I was homicidal. [laugh.]**

P59 83-84 **My sister thinks it was an almost near death experience and that I was hallucinating.** But I wasn't hallucinating.

P61 17 (*My father told me about his experience*) **when I was young.**

P62 38, 40, 42-45 [*At first I told*] **the ladies I talked to on the internet. I have a close friend from the hospital. She knows ...** You've got to understand that, that period in my life, I wasn't too sure whether I was sane or not. I just lost my baby ... And I wasn't too sure that all my buttons were fastened down too tight. So I wasn't too sure I wanted to share this information with other people ... And then as time progressed, I become more and more comfortable with the whole thing and it became perfectly ok if you think I'm crackers. [*laugh*] I'm very comfortable with this. (*Assertively*)

P63 70-71 (*daughter, N, joins in interview*) **She did tell the doctor at one point at an office visit about some of it and he said "and sometimes you just do well".**

P: Oh yes.

N: and she gave God the credit.

P: Oh yes, yes. **I was giving him my testimony and he obviously does not know God as we do, and he said "well sometimes you just do well."** And I thought yeah sure. Tell that to N. [*laugh*]

P63 74 Oh, **the pastor did more than one sermon on it** (*her experience*). [*laugh*]

4.4.2.3 Integration

The process of a mystical experience ends with its integration into the participant's life world. If receptive, participants were asked if the experience had changed their spiritual perspectives, and their interactions with others, or their attitudes. The recognition with which the participants responded to the researcher's questions, and the ease and facility with which the participants described their experiences, convinced the researcher that the experiences were familiar aspects of the participants' life worlds. Data display 4.6 gives an overview of the categories that comprise this section.

Data display 4.4.2.3: Overview: Integration

Integration	Count	Data display
Spiritual perspective	11/18	4.4.4.1
Behaviour and interactions	12/18	4.4.4.2
Attitude	7/18	4.4.4.3

4.4.2.3.1 *Spiritual perspective*

For some, the experience was asserted to have little effect on personal spirituality, other than to strengthen it. Participants 39, 43 and 40 described an enhanced spiritual conviction. But for many, the effect was even more profound. As mentioned before, several participants derived a sense of purpose from the experience which was received as a continuing spiritual mandate. Participant 40 said, “God had mercy on me, has a purpose for me” (P40 7). Note that purpose is stated in the present tense. This participant said he became baptised and read the Bible, especially Revelations, numerous times. Participant 48 said she lost any fear of death, and in addition found an assurance that even if her infant died, she would be with God. Participant 63, in addition to embarking on a concentrated mission to save her son’s soul, reported gaining an understanding of spiritual and religious reality. It would be difficult to convey the intensity with which she said, “But, Alison, the masses and masses of spirits that are there. We are spirit. We simply live in this flesh and blood house while we’re here. We’re *truly* spirit” (P63 15).

Several participants integrated the experiences into a spiritual perspective which was not a traditional Christian one. Several of these participants could be said to fall into the category of “spiritual but not religious” described by Fuller (2001:5). Participant 49 discussed her belief in the possibility of ghosts and her understanding of people as energy. She said, “I think that the ghost is the spiritual part of your body, and I think that spiritual part of your body is almost like an essence that people can sense or not sense” (P 49 48). And participants 58 and 59 spoke movingly about their belief that the dead were always with us, as well as the love they engendered. In addition, although participant 49 did not make a specific statement, her entire interview suggested an increasing movement toward acceptance of psychic phenomena and holistic healing techniques. Data display 4.4.2.3.1 shows how participants’ *spiritual perspective* reflects integration of mystical experience.

Data display 4.4.2.3.1 Integration: *Spiritual perspective*

P39 32 No, (*the experience*) just **reinforced** it (*her spirituality*).

P40 7 “God had mercy on me, has a purpose for me”.

P40 25 “... ready to go at any time now”.

P40 36 37 After the experience, he read the Bible through all the way for the first time. Then he read it about two thirds the way through. But he's read Revelations 16 times. He said we're in the time of Revelations right now. After the experience, **he couldn't wait to be baptised.**

P41 NURSE 24-25 I asked him if the experience had changed him. He said "no". He said, "It was spooky".

P43 35 Uh, I think maybe because of that, you know how some people have doubts that there is a God or whatever, I think because of that, **I've never had any doubts ...** and I think now when times are bad and times are rough, it probably **helps me keep my faith** more since that happened.

P44 NURSE 53 Yeah, and I was sort of being shown look here and see this and this is real. It was almost, I have almost taken it as a vision, I don't guess it was a vision, but I know **it renewed it and it was a strengthening of my own faith** and that I know, and it also changed me ...

P48 45 I'm not afraid. Like going to have surgery and could die. I know now it's ok. He's right there and **I know if I don't make it here, I'll be with him.** [laugh]

P48 33-35 Oh, I believe that, you know. We can't say just because, say, our baby died, that it was God's fault. You know. That right there told me that if she had have died, she would probably have been holding his hand ... **You know I had that assurance,** and it don't matter if people believe me you know.

P49 48-49 I think it made me believe a little bit more **that there's something more that exists other than just being here.** There must be some type of, you know, like ghosts. I've never seen a ghost, but I've had experiences that make me believe, and I think that the ghost is the spiritual part of your body, and I think that spiritual part of your body is almost like an essence that people can sense or not sense and I think I do believe in that a lot more now having that experience than I did before ... Yeah, it's almost **like you can leave energy places and you can send energy** if need be or something so miserable that if I feel so much pain and agony that I'm gonna exude that that someone else might be perceptive to it. Not everybody is perceptive.

P58 51-53 Yeah it does (*change feelings about spirituality*). You know, I feel like they feel that they could talk to me at least or give me some sign that they're there. And **I do feel very comforted** when I, especially from my sister because she wasn't just my sister, she was my best friend and she died when she was 28, so you know that was a hard thing. And she was a second mother to my children so.

P59 64-66 They tell you, you can't hear, you can hear and **the love goes with you, all the love goes with you ... All the love you've had in your life. It all goes with you. It never leaves.**

P63 15 But Alison, the masses and masses of spirits that are there. **We are spirit. We simply live in this flesh and blood house while we're here. We're truly spirit.**

P 63 21, 24 (*He*) explained to me, I can't bring you in now because I still have work for you to do. And in doing this work you must remember to correct three flaws that you've grown up with in your character ... **he still explained to me that I have work for you to do.** (*Spiritual purpose*).

4.4.2.3.2 *Behaviour and interactions with others*

Participant 43 thought her experience made her a more outgoing person. Participant 56 was able to overcome the grief he felt over his father's death and return to normal functioning, a change verified by his wife.

Some participants described behaviours which may have seemed remarkable or unusual to those around them. Participant 53 said she "laughed all day" after her front teeth were extracted, thinking of her dead sister's amusement. And participant 37, who described visiting with her dead brother at night, was noted by her daughter to be talking loudly in her sleep.

The sense of mission or purpose which was expressed by some participants was understood variously by those around them. Participant 61 understood her father's whole purpose in life, after his illness and angelic vision, to be to provide for her care. But participant 63, who felt a mandate to save her son, said her son rejected her belief.

Some participants shared their experiences, as described above, only to have them rejected, or to be labeled "crazy". But they *persisted* in sharing their stories, with various reactions, especially by family members. Participant 39 was invited by her daughter to share her testimony with others, about an angel who saved her from a car crash. Participant 40, who told an intense and frightening story about moving between heaven and hell, shared his experience with his daughter, who reportedly was profoundly moved. In contrast, when participant 33 shared her experience with her grandchildren, and her longing for the peace she lost, she said her grandchildren pled with her not to leave them.

It should be noted that for two participants (P39 and P63), both women, the pastors of their church were so receptive that the participants were invited to share their testimonies, or their experiences were incorporated into a sermon. This recalls the leadership opportunity for women that mystical experience gives women in the contemporary Pentecostal Church tradition (Cox 1995:133).

Data display 4.4.2.3.2 shows how *behaviour and interactions with others* reflect the integration of mystical experience into participants' life worlds.

Data display 4.4.2.3.2
Integration: Behaviour and interactions with others

P33 35-36 But I was just at such peace ... and I say today, and my children say, they call my children all call me Me-me, that's my grandmother name, and my **grandchildren, and they'll say, Me-me, you can't leave**".

P37 29-30 **I've been waking up other people up talking ...** My kids were in and my one told me, she said the next morning 'Mom I didn't sleep all night, or, Grandma, Grandma, I didn't sleep all night. Said you was talking up a storm over there I wake myself up doing it.

P39 31 And she (daughter) said, "**Mom, why don't you tell them your story?**"

P40 28 I have to tell you about my oldest daughter. She was not a Christian. **But when I told her about it, a tear appeared on both sides of her face, rolling down her cheeks.** She didn't even wipe them away. And two weeks after he told her, two weeks to a month, she was in church herself.

P40 43 *His wife said she hadn't heard much like his experience until she saw a TV show.*

P41 NURSE 22 **My wife** thinks it was an angel.

P43 15-18 What's funny, I just told my **mother** about this a couple weeks ago ... And she just looked at me and she said, "You're kidding aren't you?". And I said, no, **Mom** I'm not ... She said, well it had to be like angels watching over you or something. And I said, well it must have been.

P43 34 Oh, I think it changed how I **interacted with other folks**, because I have always been real outgoing, mouth of the south as my daddy used to call me.

P49 23 So that's pretty much it. I mean so now I take them very seriously so now I'm always paranoid so if I ever have bad dreams I always have to call **everybody** to make sure everybody's OK.

P49 37 I told them (**parents**) afterwards. They think that's a little weird. My dad especially.

P53 15-17 It (*the experience*) changed that I'm never without my loved ones, and the way I feel and I talk to them. I talk to my dad and I have three siblings that committed suicide and **I talk to 'em ... funny things happen. Like when I lost this tooth and when I had to go get the root pulled out. It was my sister's birthday. She passed on. And I just laughed all day 'cause I was thinking that she was saying look at her down there, crying about her two front teeth.**

P: No, that's what I'm saying. **After the dream, the next morning I got up and I went to work, and I've been fine ever since.**

P59 83-84 My sister thinks it was an almost near death experience and that I was hallucinating. But I wasn't hallucinating.

P61 22-23 **He lived his life basically to take care of me. That was his main goal in life was always just to care for me.** And once I left, when I was first married and I left home, that was it. And he died within about a year after me leaving home. So he died when he was 51.

P61 7-8, 51 ... he could remember seeing angels and singing hymns. And **he could not understand why my mom could not hear them ... (My mom) never talked about it** (*my father's experience of angels*) and of course my parents divorced when I was 5 or 6, and I raised by my dad, so I'm not really sure.

P63 26-30 But when I came home, N had me in her home, and I wasn't there very long, until my son B called and asked her to come get him, that he was ill. B has an alcohol problem and is still having problems with it. From there between her family and me for the last over two years, **we've tried to help him. I have tried to open every door I could to explain to him that the route to his recovery is faith in God's healing power**, but B is an evolutionist. He could not accept what I was trying to tell him. He does not understand how the Bible and why the Bible was written. He just hasn't gotten it yet.

P63 74 Oh, **the pastor did more than one sermon on it** (*her experience*).
[laugh]

4.4.2.3.3 Attitude

With only a few exceptions, participants expressed positive changes in their attitudes. These changes included a loss of the fear of death, acceptance of others and increased self-confidence. Participants 33, 40, 48 specifically identified the loss of the fear of death as a result of their experiences. Participants 59 and 62 expressed a greater acceptance or tolerance of others. Participants 49, 59 and 62 also noted self-acceptance and self-confidence.

But participant 49 identified an increased sense of worry about others, and participant 61, when talking of her father's behaviour after chronic illness and an angelic vision, said that although he found a purpose in life in caring for her, he had little other appreciation for life.

It is as though having a glimpse of the transcendent, many of the participants were able to incorporate more accepting attitudes into their life world, tempered, in some cases, by an awareness of their responsibilities, and what they had glimpsed and failed to achieve. Data display 4.4.2.3.3 shows how mystical experiences have been integrated into participants' attitudes.

P33 24-30 Well, it was wonderful and I wasn't one bit afraid. I just felt such ease and I was ... that's why **I'm not scared of dying. I'm not afraid to die** because it was just a wonderful peace, you know ... It was quite an experience. Today you know, my heart's really bad, **and I know my time is short, but you know I really don't mind. I'm just going to get out of this body and go someplace else.**

P40 25 (*I'm*) **ready to go** at any time now.

P48 35 You know **I had that assurance**, and it doesn't matter if people believe.

P48 45 I'm not afraid (*of the upcoming surgery*). Like going to have surgery and could die. **I know now it's o.k.** He's right there and I know if I don't make it here, I'll be with him. [*laugh*]

P49 43 It kind of does (*change how I feel about myself*). **It almost makes you feel like you're special.** A lot of people talk about having *deja vu* or having some type of a precognitive type of experience so you don't feel special like you're freakish, but I guess you just kind of feel like, **I almost makes me feel like I care so much about my family so much that I am perceptive to them.**

P49 44-45 But now I'm scared not to take something seriously ... It's almost in a way kind of a bad thing now that I have them because now **I'm over paranoid sometimes.**

P49 54 I almost feel like I have, you know **I'm very proud of myself** that I told somebody and they know that it happened before I found out that he had a heart attack.

P59 75-81 It made me take nothing for granted ... You can't take anything for granted and people that are mean to you, you pray for them ... You don't get mad back or try to get even, you feel sorry for them and you pray for them. And you learn that on the other side ... Because they can't help it, they don't know any better, but you do and so you've learned ... **It changes everything. Your whole outlook on life changes you.**

P61 20-22 He (*her father*) was never able to work after that (*his chronic illness*). And to me considering everything he'd been through and even though he lived through everything he'd been through. To me looking at it from an adult point of view now, **he had no appreciation for life.** He lived his life basically to take care of me (*his young daughter*). That was his main goal in life was always just to care for me.

P62 49 [*I'm*] **less judgmental, more willing to accept** events, people, things, that things happen for a reason. We may not realise what they are at the moment, we may not ever. It may be years before we can look back and say, oh, that's what that was about ... For every negative, there is a positive.

P62 90 But it's really, really, really nice to come to the point where **I don't care what you think. [belly laugh] I'm comfortable where I am.** If you want to giggle at my rocks, go ahead.

In summary, with regard to the research question: "*What is the meaning of the lived experience of mystical phenomena to participants experiencing it in the context of*

health stressors and/or hospitalisation?”, that is, with regard to the occurrence, maturation and integration of mystical experience in the life of the experiencer, Van Dussen’s (1999:4) indicators of a *mature mystic* is insightful. It is not the researcher’s intention to declare the participants “mature mystics” however, traces of the following are evident from the preceding discussion, though scattered among participants with no single participant reflecting all these indications. It is also noteworthy that Van Dussen’s views mysticism from a religious point of view whilst the researcher’s presentation is meant as both non-secular and secular. Some participants:

- Reflect an unfolding continuous relationship with God (or the All or some divinity)
- Shows wisdom
- Are humble
- Have explored beyond their personal identity to the Universal Identity
- Love goodness and recognizes this virtue in others (Van Dussen 1999:4)

4.4.3 Nursing process and mystical experience in the context of health care

A look at the *Concept Map of Mystical Experience* (Figure 4.1) shows the nursing process to be present throughout the entire course of the process of mystical experience, if the nurse is aware of his or her role. This requires a widening of the nurse’s perspective throughout the nursing process. Mystical experience must always be held as a possibility. The discussion of the nursing role answers the research question: *What nursing assessments and interventions support patients reporting mystical experiences?* The circled area shown below in the *Concept Map of Mystical Experience* (Figure 4.4) relates to nursing process. (Nursing diagnosis and a connecting arrow are hidden as an artifact of the software).

Certain considerations spring to light directly from the research process. First of all, if mystical experience be considered a process rather than a discrete occurrence, the nurse may be unaware that a patient has had such an experience, or unaware of where the patient is in the process of maturation and integration of the experience. Certainly, in the early stages of processing, the patient may not feel that he “owns the experience”, nor may he have the vocabulary or the facility to share it.

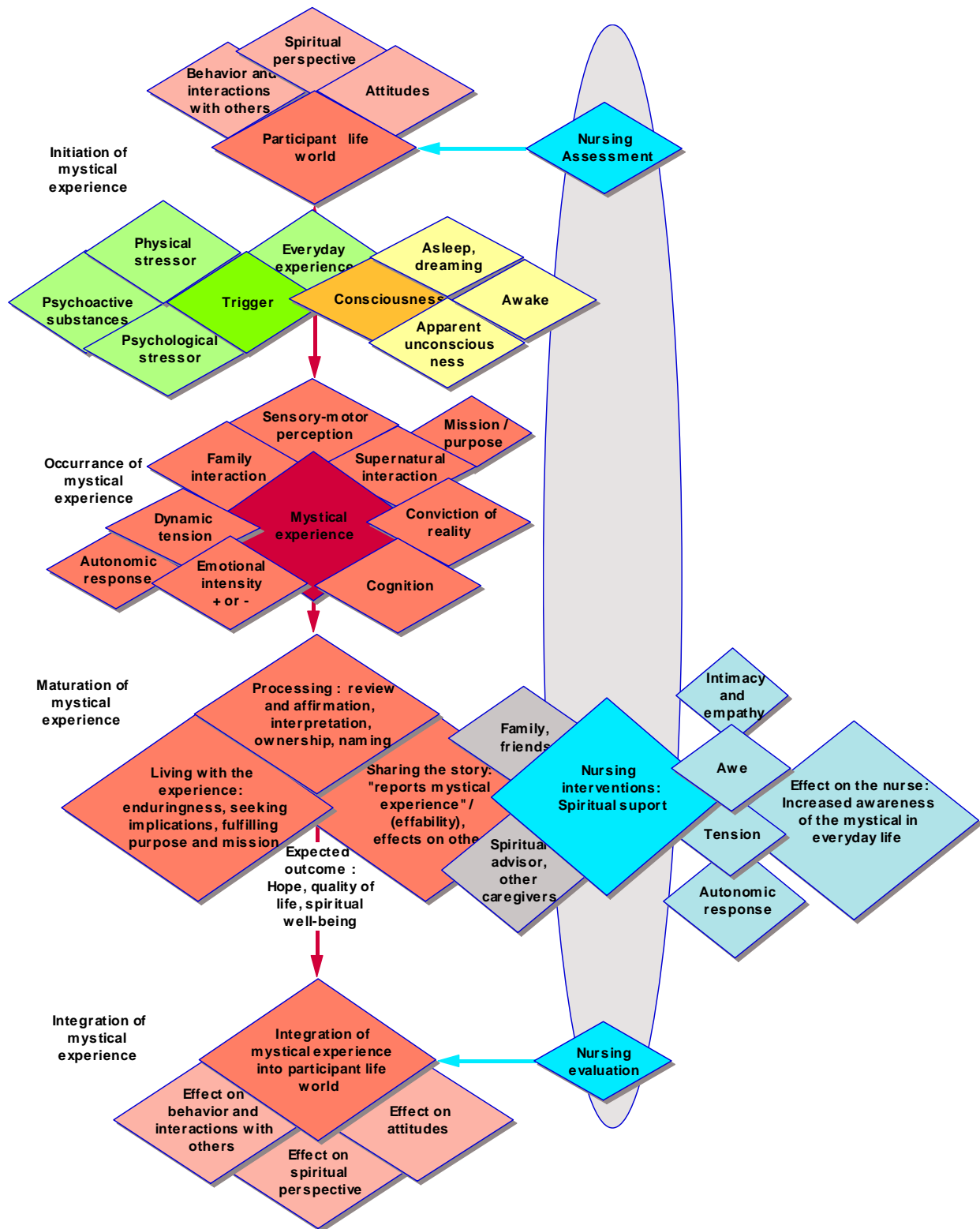


Figure 4.4
Concept Map of Mystical Experience:
What nursing assessments and interventions support patients
reporting mystical experiences?

The nurse who is busy and who has a (realistic) concern with the patient's pressing needs may not be able to afford the patient the time or privacy required to give justice to the expression of a significant spiritual event. Certainly, even in the research process, the patients' physical needs often interfered with the flow of the interviews, and interruptions and privacy concerns were equally challenging. In addition, patients who are frail, weak, or short of breath, may find it difficult to muster the energy to communicate at length.

One nursing concern could not be answered in the interview process: what about the patient who may have had a mystical experience, but is unable to remember it? Discussions with colleagues suggest that this occurs, but it is unclear if there would be any value in reminding a patient of an experience which he fails to remember. The psychological and cognitive mechanisms at work are unclear.

The focus of the research was on the assessment and intervention aspects of the nursing process, but the phase of goal setting and evaluation are also addressed. The nursing actions discussed below spring from the interventions suggested by participants and the actions that the researcher herself found most useful. Participant suggestions are derived from interviews, but the researcher's suggestions for nursing process represent data compiled over the course of the research and are not linked to specific interviews.

4.4.3.1 Participant suggestions

Although several participants were unable to identify any role for the nurse regarding mystical experience, most saw some value in nursing support. Participant suggestions focused on assessment and intervention, probably because most participants were not aware of the scope of the nursing process. Many suggestions were made which identified specific nursing interventions of acceptance, listening, and support. Data display 4.4.3.1 gives an overview of participant suggestions regarding the role of the nurse.

Data display 4.4.3.1		
Overview: The nursing process and mystical experiences: Participant suggestions		
Sub-categories	Count	Data display
Nursing role not identified	2/18	4.4.3.2.1.1
Assessment and intervention		(Series)
Assessment	1/18	4.4.3.2.1.2
Acceptance	3/18	4.4.3.2.1.3
Reassurance	3/18	4.4.3.2.1.4
Listening and support	8/18	4.4.3.2.1.5
Living a spiritual life and prayer	3/18	4.4.3.2.1.6

4.4.3.1.1 No nursing role identified

Not all participants were able to identify the nurse's role with regards to patients' mystical experiences. As indicated in data display 4.4.3.1.1, at least two participants had some doubts as to the effectiveness of the role of the nurse in this regard.

Data display 4.4.3.1.1
No nursing role suggested
<p>P33 45 I don't think you would tell them (a nurse). I think you'd just have it. I don't think you'd ask a nurse what do about it or anything like that.</p> <p>P44 NURSE 47 You know for one thing I think that nurses need to know is that this kind of thing can occur, and I've shared that with some. And you know that it's still ok but that might occur and I think also at that time there's not a lot you can do.</p>

4.4.3.1.2 Nursing assessment

With regards to nursing assessment, Participant 58, who was not a nurse, suggested that the nurse include mystical experience in the admission assessment. She thought that would provide a natural lead-in for further discussion. Participant 58's recommendation is shown in data display 4.4.3.1.2.

Data display 4.4.3.1.2
Nursing assessment
<p>P58 61, 63-63 I might on an admission or something ask them if they want to talk to anybody about spirituality ... You know because that's a neutral kind of in the admission thing and then could talk if they got a "yes". Because if you came up to someone just, you know, like the nurse come up and talk to them and started talking to nonbelievers or people that are resistant about life after death, they might get very cantankerous.</p>

4.4.3.1.3 Acceptance

Acceptance was identified as a need by participants 43, 49 and 62. Participant 62 stated it most assertively: “Don’t be so damned narrow-minded ... Don’t discount it just because it’s outside your realm of what you understand” (P62 53). The researcher senses that she was expressing the defensiveness and frustration that other participants may also have felt at times. Data display 4.4.3.1.3 shows recommendations that the nurse demonstrate *acceptance*.

Data display 4.4.3.1.3

Acceptance

P43 39-41,43 I think that if I would have had a nurse listen to me **and not debunk it**, that it probably would have helped me feel better about it and I worry that maybe something was really was wrong with me you know...I think for a little while I worried that maybe it did do something to me that couldn’t be seen, but ...

P43 48, 50 (*Nurse could say*): Yeah, it’s ok ... It’s ok, you’re not crazy ... Oh yeah. **I’d have been real upset if an adult would have told me that (*belittled the experience*).**

P49 51-53 So, **I think they should be receptive to it a little bit**, or somewhat. **Don’t belittle** somebody because they feel that they’ve had some strong feeling or they feel that they’ve went through something or feel like they have seen the light at the end of the tunnel or whatever it is. Don’t belittle that or pretend like it doesn’t exist. **Be a little bit more receptive** and talk to the person about because they might just need to ... I think if hadn’t told somebody that I had that dream, I may not be willing to talk to you now.

P62 53-55 **Don’t be so damned narrow-minded ... Don’t discount it just because it’s outside your realm of what you understand.** You know, that’s so narrow-minded. That’s the root of so many problems that we have in the world today. If you believe in God, creator, whatever name you want to call it, I firmly believe there is only One. All the rest is window dressing that humans have put on it, and if you can get past your tunnel vision and look outside the box and accept possibilities.

P62 67-69 It’s the bottom line and to answer your question, that’s what I think the nurse ought to do. **Allow that person in their own way to vent, verbalise, encourage them to write it down and just sit and listen. Ask appropriate questions, just don’t discount them ...** Because that’s the one thing that most people in a time of grief, they don’t know what to say. But that’s, personally speaking, that’s not the most important thing. It’s not knowing what to say, it’s knowing what not to say ... **Sometimes it’s more important not to say anything, just to be accepting.**

4.4.3.1.4 Reassurance

It was important for participants to know or be told that they were not “crazy” or mentally ill. Participant 43 stated this need directly. Other participants also indicated that they had been told that they were hallucinating (P59 83-84) or crazy (P53 10). Even participant 44, a nurse herself, wondered if her mind were not playing “tricks on her” (P44 52). Participant recommendations that the nurse *reassure* patients are shown in data display 4.4.3.1.4.

Data display 4.4.3.1.4 Reassurance

P43 39-41,43 I think that if I would have had a nurse **listen to me** and not debunk it, that it probably would have helped me feel better about it and I worry that maybe something was really was wrong with me you know...I think for a little while I worried that maybe it did do something to me that couldn't be seen, but ...

P43 48, 50 (Nurse could say): Yeah, it's ok ... **It's ok, you're not crazy** ... Oh yeah. I'd have been real upset if an adult would have told me that (*belittled the experience*).

P48 36-37 Maybe you could **say tell them it's common maybe** ... Or it's happened. You may have had a spiritual experience.

4.4.3.1.5 Listening and support

Listening and support were noted as important and welcome nursing interventions. While all participants did not emphasise it, some suggested that they would have appreciated some interpretation of the experience as part of that support. For example participant 48 said, “Maybe you could say tell them it's common maybe ... Or it's happened. You may have had a spiritual experience.” (P48 36-37).

Participant 49, who said she was a former nurse, had a suggestion which may reflect her own psychological issues. She indicated that the nurse should make particular efforts to support dying patients and to not prolong the dying process. Although only in her 50s, she made several allusions to her own death during the interview. While her suggestions are of value, they can not be said to have general application to patients with mystical experience.

Data display 4.4.3.1.5 shows participant recommendations relating to *listening and support*.

Data display 4.4.3.1.5
Listening and support

P43 39-41,43 I think that if I would have had a nurse listen to me and not debunk it, that it probably would have helped me feel better about it and I worry that maybe something was really was wrong with me you know ... I think for a little while I worried that maybe it did do something to me that couldn't be seen, but ...

P43 48-49 (*Tell the person*) Yeah, it's ok. It's o.k. You're not crazy. I think **it would be very upsetting to be saying important to you and have somebody just blow it off (by not listening)**

P44 NURSE 47 But I think **your presence** you know you still have the responsibility, and they still have to **be there** and that was my sense, I still needed to have been there ... And I also think that it might give a, it may even be that people may need to have some sort of even a buddy system when you're experiencing (*death*).

P48 36-37 Maybe you could say tell them it's **common maybe** ... Or it's happened. **You may have had a spiritual experience.**

P49 51-53 So, I think they should be receptive to it a little bit, or somewhat. Don't belittle somebody because they feel that they've had some strong feeling or they feel that they've went through something or feel like they have seen the light at the end of the tunnel or whatever it is. Don't belittle that or pretend like it doesn't exist. Be a little bit more receptive and **talk to the person** about because they might just need to ... I think if hadn't told somebody that I had that dream, I may not be willing to talk to you now.

P53 18-19 Well **I'd tell them to be thankful and not to be scared.** And I would tell 'em this just proves that they love you enough to travel all the way back to you.

P56 55 Oh, (*the nurse should*) **just listen** to them

P59 40 In the death process, when you touch to someone or shake someone or you speak to them and call them back, you're prolonging the death process. They're going. It's better for you to **tell them it's o.k. to go now. It relaxes their mind and relieves them of any worries or tensions that, you know, you can hold their hand and stuff but don't try to keep them here.** Don't keep fighting. It's ok to go now.

P62 67-69 It's the bottom line and to answer your question, that's what I think the nurse ought to do. **Allow that person in their own way to vent, verbalise, encourage them to write it down and just sit and listen. Ask appropriate questions, just don't discount them** ... Because that's the one thing that most people in a time of grief, they don't know what to say. But that's, personally speaking, that's not the most important thing. It's not knowing what to say, it's knowing what not to say ... Sometimes it's more important not to say anything, just to **be accepting.**

4.4.3.1.6 *Living a spiritual life and prayer*

In addition to identifying nursing actions, participants also addressed the nurse's own psychological or spiritual status. Participant 40 said the nurse should, "Just be a Christian" (P40 38). Participant 62, a patient who was also a psychiatric nurse, noted the value of using nursing intuition. Participant 63 noted the importance of unconditional love, and prayer, placing this in a specifically Christian context. Data display 4.4.3.1.6 shows participant suggestions that the nurse *live a spiritual life* and/or engage in *prayer*.

Data display 4.4.3.1.6 Living a spiritual life and prayer

P40 38 He says *just being a Christian*.

P62 81 It has happened before and I have to go with what I'm feeling right that moment and hope somebody's helping me. (*Intuition*)

P63 78 It's unconditional love. Your job, **your position requires unconditional love**.

P63 78-79 My speech therapist, L P, bless her heart, is a devout Christian. As busy as she was with patients, **she took the time to come and pray with me at least once a day ...** So you see I had not only a doctor who was a devout Christian, but my speech therapist. And those people are my friends today, I mean we just made friends. When I left there, when I learned to walk again, I couldn't walk at all, and J W , bless his heart, taught me to walk again, and a, through therapy, of course. You know all about that. And he's a good Christian man. **But I had Christians around me taking care of me.**

I: Ok. And they prayed with you.

P: Yes.

I: So that would be something that the nurse could do.

P: Absolutely.

4.4.3.2 *Nurse researcher recommendations for nursing process*

One of the researcher's key interests in the initiation of the study was the recognition of the NANDA International nursing diagnosis *Readiness for enhanced spiritual well-being*, which has as a *defining characteristic* "Reports mystical experiences" (Wilkinson 2005:513). The following discussion is a response to that nursing diagnosis and the Nursing Outcome Classifications (NOC) and Nursing Intervention Classifications (NIC) associated with it. This section should thus also be read in conjunction with chapter 5 on recommendations based on the findings of the study.

The nursing role must incorporate the entire nursing process: assessment, diagnosis, planning, intervention, and evaluation. The character of this research was such that the participants' actual mystical experiences were all in the past, so the researcher conclusions are drawn from her nursing role at the time of the interviews. Since the interviews were a one-time-only event, there was limited opportunity for evaluation.

In selecting participants for interviews, the assumption was that they would exhibit the characteristics of the nursing diagnosis *Readiness for enhanced spiritual well-being*. The definition for this diagnosis is "Ability to experience and integrate meaning and purpose in life through a person's connectedness with self, others, art, music, literature, nature, or a power greater than oneself" (Wilkinson 2005:513).

However, concurrent with this, some participants had psychological and physiological characteristics which suggested additional nursing diagnoses such as *Ineffective airway clearance*, *Activity intolerance*, *Fatigue*, *Acute pain*, and *Chronic confusion*. The presence of multiple diagnoses suggests that the nurse must prioritise nursing care to address the patient's most pressing needs first, remaining cognisant of the importance of spiritual care at the same time. In addition, the nurse must realise that other spiritual nursing diagnoses may be relevant, such as the NANDA International diagnosis, *Spiritual distress*. O'Brien has developed a number of additional spiritual nursing diagnoses which may also be considered: *Spiritual anxiety*, *Spiritual anger*, and *Spiritual despair* (O'Brien 1999:69). Some of the mystical experiences described by participants incorporated fear, anxiety and frustration, even when the overall experience was perceived as positive. Clearly, the nurse has a challenge to assess the patient in depth, attending to complex physical, psychological and spiritual needs.

Planning for patient outcomes is derived from accurate nursing assessment and diagnosis. NOC outcomes for the nursing diagnosis *Readiness for enhanced spiritual well-being* include "*Hope ... Quality of life ... and Spiritual well-being*" (Wilkinson 2005:514). Because of the nature of the interviews, it was impossible to address whether these outcomes were achieved as a result of nursing intervention. This is an aspect of evaluation which could not be addressed. However, these are reasonable goals, and are consistent with the changes in behaviour, attitude, and interaction with others that participants described as aspects of *integration* of mystical experience into their life worlds.

NIC interventions for the nursing diagnosis *Readiness for enhanced spiritual well-being* include “*Hope instillation ... Spiritual growth facilitation ... and Spiritual support*” (Wilkinson 2005:51). NOC interventions are stated in a way to suggest that the nurse can, through nursing intervention, actually facilitate spiritual growth.

The researcher found listening to be the primary intervention in supporting patients expressing mystical experiences. Her sense was *not* that *she herself* was facilitating the patient’s growth spiritually, but rather that she was encouraging the patients to acknowledge the growth that *they themselves* had achieved, and was offering support to their spiritual journeys. When the researcher considers the enormity of the experiences described by the participants, and the strength and courage with which they integrated these experiences into their own life worlds, she hesitates to suggest that the nurse may do more than listen, support and genuinely *care* for the patient, as described below.

The researcher also found that it was essential to attend to the patient holistically, addressing a wide array of physical and psychological needs. The patient’s physical and psychological needs took priority over the expression of spiritual experience. Unless a patient’s spiritual needs are overwhelming, this prioritisation seems appropriate.

Despite the suggestion made by participant 58, the researcher does not recommend including questions about mystical experience in routine admission assessments, unless the nurse has the time and expertise to discuss the topic with ease and respect. The mechanical question and answer format of some admission assessment procedures might tend to trivialise these important spiritual experiences. In the Appalachian population studied, an abrupt approach to personal concerns may be unwelcome (Purnell & Paulanka 2005:48). If the nurse has the time and expertise to perform an in depth spiritual assessment, then it would be appropriate. Of course, if it is a matter of significant concern to the patient, the nurse must be prepared at any time to discuss an unusual spiritual experience and to offer support. It is quite true that the nurse must use his or her intuition in this matter, as suggested by participant 62, who is an experienced psychiatric nurse.

The researcher was prepared to make pastoral care referrals if this seemed necessary. However, no such referrals were made, and in general, participants seemed to be dealing with their experiences capably. The researcher was surprised that relatively few of the participants had shared their experiences with a pastor or spiritual guide. This was partly explained when participant 40 explained that his pastor didn't seem to have the time to hear his story (P40 30-35) and when participant 48 explained that her vision of Jesus was incompatible with her understanding of the Bible (P48 21). Size-Cazabon notes the importance of bringing in "qualified care-givers" hospital chaplains – to deal with spiritual concerns in health care (Size-Cazabon 1996:1). However, the pastoral support available in hospitals in the study area is comprised of area clergy, who may be no more receptive or skilled than the pastors of participants 40 and 48. The researcher suggests that the nurse make pastoral referrals only if this is clearly welcomed by the patient, and the pastoral resources are likely to be supportive.

The following aspects of nursing process are recommended as appropriate and useful for nurses caring for patients sharing mystical experiences. Though "recommendations" strictly speaking belong in chapter 5, they are presented at this point to complete the "picture" of the nursing process and the integration of this process with mystical experience as process.

4.4.3.2.1 Nurse researcher recommendations for assessment and nursing diagnosis

- Assess spiritual experiences sensitively, with reference to the setting, the patient's culture, religious orientation and understanding.
- Provide adequate time and privacy for spiritual assessment.
- Use language that the patient understands. The phrase "unusual spiritual experience" may be better understood than "mystical experience".
- Be open to a variety of spiritual nursing diagnoses. Not all spiritual experiences are comfortable.
- Prioritise. Remember that other needs may supersede the need to communicate the experience.

4.4.3.2.2 Nurse researcher recommendations for planning/evaluation

- Plan outcomes *with* the patient, with attention to *hope, quality of life* and *spiritual well-being*.

- Evaluate the patient's sense of *hope, quality of life* and *spiritual well-being*.

4.4.3.2.3 Nurse researcher recommendations for intervention

- Express acceptance and willingness to listen.
- Tailor interventions to the patient's physical and emotional status.
- Provide adequate time and privacy so that the patient can share freely with minimal interruption.
- Keep an open mind.
- Use familiar terminology and language.
- Be willing to be silent.
- Validate the experience as spiritual and real to the patient.
- Respect the awesome significance of the patient's sharing the experience
- Recognise intuition as a useful tool for the nurse.
- Make pastoral referrals only after validating acceptability with the patient.

4.4.4 Subjective experience of the nurse

In the *Concept Map of Mystical Experience* (Figure 4.1), nursing process is mapped in relation to mystical experience in the context of health care, and is structured to include the subjective response of the nurse. In this section, the researcher's responses to the participants' expressions of mystical experience are discussed. These data address the question: *What is the subjective experience of the nurse sharing a patient's expression of mystical experience?* The circled area in the *Concept Map of Mystical Experience* shown below (Figure 4.5) relates to the researcher's subjective response.

The primary data sources for understanding the nurse's subject response are the researcher's research notes and her reflective journal. Some reference is made to experiences of the participants who were nurses themselves. The researcher's experiences are also considered in light of the conversations she had with nurses and others who were not actually research participants.

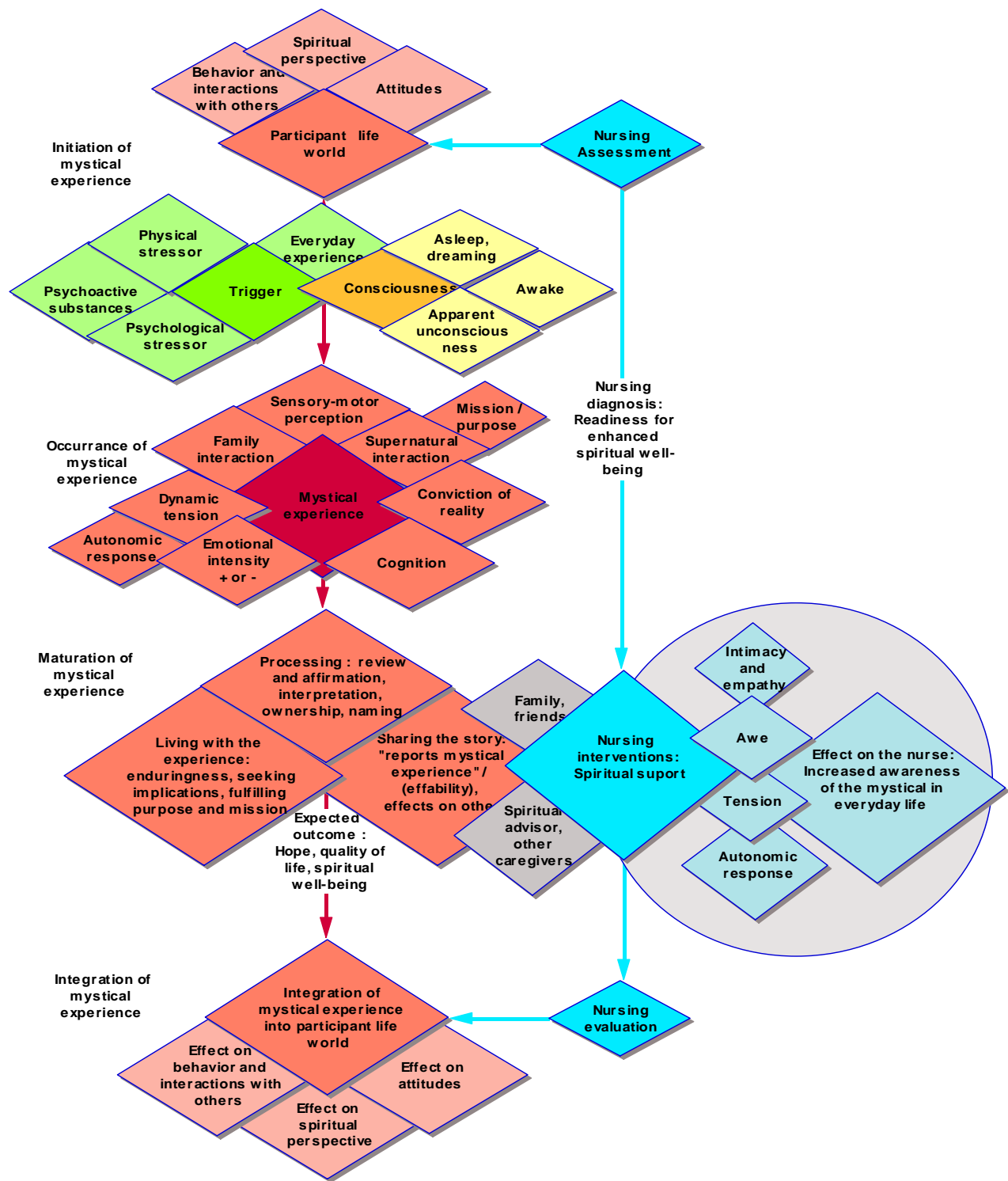


Figure 4.5

Concept Map of Mystical Experience:

What is the subjective experience of the nurse sharing a patient's expression of mystical experience?

A review of the researcher's interview notes shows an awareness of *tension, intimacy and empathy* and *awe*. Occurring in relation to these reactions, several *autonomic responses* were identified: more commonly erector pili enervation (gooseflesh) and sometimes a visceral clenching and the pricking of tears in her eyes. The experience of autonomic enervation was so fleeting what the researcher did not make a note of it in initial interviews, but she came to recognise it as a harbinger of an especially intense or moving interview.

Support for the nurse is addressed, with the reasoning for this arising from not only the researcher's experiences, but also her interactions with others.

Finally, an enhanced sense of the mystical is discussed. As the research progressed, and the researcher came increasingly to see mystical experience as process, she revisited the *Torus Model of Mystical Experience* (Figure 1.3). She grew to appreciate mystical experience as an intrinsic aspect of everyday life, consistent with the model, but having a further developed meaning. This enhanced sense of the mystical in everyday life is not tied to a particular interview, or journal entry, or intellectual exercise, but has grown out of the research process as a whole.

Data displays derived from the research process are provided below in association with discussion of some of the subjective responses. The reconsideration of the *Torus Model of Mystical Experience* (Figure 1.3) and the enhanced sense of the mystical are derived from an overall reflection on the research process rather than an analysis of specific data chunks and are thus not illustrated with data displays.

4.4.4.1 Tension

A certain amount of tension may accompany the initiation of any research project. Still, the intensity of the interviews and the unfamiliarity of the topic combined to make some of the interactions tense and uncomfortable for the researcher. The tension stemmed from differences in belief and challenges to the nursing role.

The researcher wished to show acceptance and respect to the participants, even when they expressed beliefs different from her own. The researcher felt it inappropriate to counter beliefs which were fundamental to the participants' spiritual or religious

systems. Ethical mandates require that the researcher respect even beliefs that are uncongenial.

Another aspect of the interview process that took some getting used to was the challenge to the nursing role. The hospital settings were full of interruptions – intravenous pump alarms, the blaring television, and of course, the patient’s own needs, which as a researcher, and not a nurse, the researcher could not respond to directly. The researcher was also challenged by the attitudes of the staff themselves, which ranged from interest and support to disdain.

When talking to other nurses about their experiences, the researcher identified a certain aloneness. Despite the intensity and the intimacy experienced when carrying out the interviews, she experienced this aloneness. Participant 44, a nurse, identified the need for nurses to have support when dealing with experiences such as her own – being at the bedside of a dying man she thought was facing hell. But her suggestion might be expanded as support for any nurse caring for patients expressing mystical experiences and nurses experiencing mystical phenomena as they give care. The researcher herself felt a need to share her feelings and would have welcomed an opportunity to explore the tension and frustration she found with some of the experiences. She recalls the value of “debriefing” exercises which are carried out subsequent to crises in some health care settings. Data display 4.4.4.1, based primarily on interview notes, gives evidence of *tension* as the subjective experience of the nurse.

Data display 4.4.4.1
Subjective experience of the nurse:
Tension

P33 53 *It's interesting to me. She ended the conversation here. She was in charge of the interaction! I was afraid I had tired her, or had said something that she took wrong.*

P40 1 *Before he started, he asked me my denomination. I felt a bit tense, but told him I was Protestant. This seemed to satisfy him. I perceived his tone and body language as somewhat aggressive. He leaned into my body space as he sat on the side of his bed. Instead of saying he didn't want to participate, he made his own terms of participation clear. His wife and sister sitting at the end of the bed were silent until the end.*

P40 40-41, 44 *He said he wants me to come back. He wants me to talk to him again. (I almost felt like this was a control issue). Wife and LPN were in and out and the IV kept beeping. And his IV kept beeping and the nurse was starting the IV, so I thought it was time to go. (The interruptions were frustrating and affected my concentration.)*

P40 *This was a **very intense** interview and I feel the tension every time I review it. Was it that he was shuttling between Heaven and Hell so vividly, or was it the “in your face” quality of his communication? I know I was a little worried that he wanted me to come through with some personal commitment about faith. I was uncomfortable with him on this. Was it because he was male?*

P40 35a *I felt **embarrassed** for doctor and pastor who hadn’t (or wouldn’t) heard the story.*

P44 *Conclusion: I was **uncomfortable** during the interview, not just with the intensity, but also with the theological implications, of the patient facing a frightening hell. I tried to affirm the participant’s experience without challenging her beliefs.*

P48 2 I: ***The room is just not set up for me.** Ok. I’ll go tell them that’s beeping, ‘cause I don’t want that to bother you.*

P58 *(Conclusion) I’m still **not fully comfortable accepting descriptions of people interacting with ghosts.** This participant was easy to talk to, but I felt that something just didn’t add up. She was well educated, but apparently disabled and spent a lot of time on crafts. (A hospital administrator interrupted us to ask if the participant wanted to reserve a table for the hospital craft fair.)*

P61 57 *Here I am sharing a little of my experiences to establish more rapport and to acknowledge her nursing role. Also, maybe **it helped move away from the intensity we were experiencing.***

P62 *I felt a certain **tension in that I didn’t share her perspective** in regards to therapeutic touch and crystals, but I felt myself wanting to believe, and in fact, find myself more accepting.*

P63 *We talked twice on the phone before the interview. Once **she corrected me for referring to “God”, “No,” she said, “The Lord”** ... Earlier, the daughter had said that hearing her mother’s experience would be a “blessing” to me. The daughter spoke little during the interview, but was present the whole time. The interview had an element of the social, but I believe that it was carefully scripted as a testimony. The participant and her family are members of a local group that might even be called a subculture — very conservative Christians, who socialise and network together, even though they do not belong to the same churches. I am a friend with several of these families, even though **I am pretty sure it is evident that I do not agree with them on every point of faith.***

P63 *I did try to support her in her desperation. I pointed out that **different people learn in different ways, and that her son might yet find spiritual growth.** I shared just a little about my own children, only enough to indicate that I realised the quality of her concern*

4.4.4.2 Intimacy and empathy

In this research, participants were sharing life-changing spiritual experiences. This type of interaction is deeply personal and engenders a profound sense of intimacy. Sometimes the descriptions were so intense, and the expression so vivid, that the

researcher almost felt she was living the experience herself. The noises of the hospital or other setting fell away, and the researcher was rapt in the participant's experience. This intimacy and empathy exceeded that degree of interaction which accompanies most nursing care.

Participant 37 identified this aspect of the interaction, by saying, "This seems peculiar that somebody like yourself would come and ask me something like this ... It feels good to talk about it. But it sounds amazing that you'd be here asking me [*laughing*]. I got a girlfriend that I talk to all the time about all this stuff" (P37 48, 55-56).

Some of the interactions were very compelling emotionally to the researcher. Participant 53 appeared to come from a marginal background, with many losses and few personal resources. Yet her confidence in the love of her dead siblings was unutterably moving. Participant 56 shared a wonderful experience, when he related how his deceased father came to him, and described heaven: "The sky is blue and the grass is green" (P56 23-25). This phrase is poetry in its simplicity and its joy.

Although almost all of the interviews had an element of intimacy and empathy, sometimes the intimacy was less welcome, almost overwhelming. For example, participant 40 demanded to know the researcher's "denomination" and would not speak to her until the researcher said she was Protestant. He also demanded that she visit him again, after the research was complete. (This required delicate negotiation to prevent the researcher making a promise she could not fulfill.) As he spoke about his experience of heart surgery, and moving back and forth between heaven and hell, participant 40 was dramatic and intense, leaning into the researcher's personal space. This was an aggressive, almost assaultive sort of intimacy. (And while the researcher empathised with the patient, she could not help but wonder how this man had lived his life that he believed hell was reaching for him so dramatically.) Data display 4.4.4.2 shows data derived primarily from the interview notes which reflect *intimacy and empathy* as aspects of the nurse's subjective experience.

Data display 4.4.4.2
Subjective experience of the nurse:
Intimacy and empathy

P37 48 55-56 This seems peculiar that **somebody like yourself would come and ask me something like this** ... It feels good to talk about it. But it sounds amazing that you'd be here asking me. [*laughing*] I got a girlfriend

that I talk to all the time about all this stuff.

P40 *This was a very intense interview and I feel the tension every time I review it. Was it that he was shuttling between Heaven and Hell so vividly, or was it the “in your face” quality of his communication? I know I was a little worried that he wanted me to come through with some personal commitment about faith. I was uncomfortable with him on this. Was it because he was male?*

P43 (throughout) *Curiously, even though there were lots of interruptions, TV and the noise of the toddler and his mother other family members and, it didn't much bother me; we were really deeply involved with the conversation.*

P49 *Introduction: Although the experience wasn't dramatic, it was very important to her and I found it valuable to hear how a family member might be involved in this way.*

P53 introduction *Looking back, I feel very moved by this interaction. This woman was so marginal. Her health was poor and she seemed to come from a very dysfunctional family. Yet she kept the gift of their love close to her.*

P56 conclusion *This whole interview seems so culturally linked to the area. A popular song some years ago was John Denver's "Almost heaven, West Virginia". It was also a slogan used in tourism. The description of the sky and the grass reflect the West Virginia/heaven link. This is one of the interviews I liked best. We were interrupted a lot, and there was no room for me to sit, so I leaned against the IV stand, but I felt like I was truly hearing the participant. He expressed himself simply, but with passion. He didn't try to argue religion; he just shared his profound experience. An immensely satisfying interview.*

P62 *But when she spoke of her son's death, her grief was palpable, even at this later time. It was so strong; it filled the space between us.*

P62 101 *I told her I had to give her a hug when I left, unusual for me.*

P59 1 *She wanted to know when I came (to the area), she has been here 33 years. I said, "almost a native" She said, "took me a year". A sense of intimacy was established early on.*

P59 *I was touched by her sharing details of her son's murder.*

P61 *It was a short, intense and sad interview.*

4.4.4.3 Awe

More than anything else, the researcher felt a sense of awe, a sense that she was receiving a spiritual gift, as the participants shared their stories. O'Brien (1999) uses the phrase "standing on holy ground" when discussing the spiritual dimension of nursing care (O'Brien 1999:7). Something of this sense was felt by the researcher. She felt surprise that so many participants had stories to tell her. She felt humbled as she realised that some of the most unprepossessing participants had had profound spiritual

experiences and were willing to share them with her. She was in awe at the loss and grief which participants had experienced and overcome, aided by their mystical experiences. And she came to respect the wisdom of some of the participants. It was not that she had thought that patients and those around her were not spiritual beings, but it was a glorious shock to discover just how spiritual they were and how much they had to offer. Data display 4.4.4.3 gives examples from the interviews and interview notes that illustrate awe as an aspect of the nurse's subjective experience.

Data display 4.4.4.3
Subjective experience of the nurse:
Awe

P33 23 *I was **stunned** as she told me all this. I felt like I could do nothing but listen.*

P33 *All of interview 33 Although I was anxious, **I felt like I had received something important**, and I thought that perhaps I had given her something important too, if only the opportunity for her to share her knowledge and experience with others.*

P59 *The LPN who suggested I could talk with this patient did not say that she had had a mystical experience, but rather that this patient would be sure to talk to me. **I did make a connection with this participant, and ended up with respect for the intensity of her experience and her wisdom.***

P59 91 I: *I've never had an experience exactly like that, you know, but when I hear people say things like that, **I feel changed myself.***

4.4.4.4 Autonomic response

Little in the literature discusses the autonomic response of the nurse to different aspects of nursing care. Yet the researcher found the sense of chills or "gooseflesh" to be a rather common occurrence during the research process. After a while, she learned to recognise this sensation as an accompaniment to the most intense interviews. Such recognition of personal responses may be what is implied by intuition, as it surely sensitised the researcher to the interactions.

And very occasionally, the researcher felt close to tears, most notably when participant 62 described her adolescent son's death. Even in recollection, the recollection of the pricking of tears and the internal wrenching is vivid. Participant 63 told the researcher that she might cry as she told her story; the researcher's awareness of her own

responses lead her to tell the participant that that was fine, and that the researcher herself could understand how it might be so. Data display 4.4.4.4 illustrates the subjective experience of the nurse as incorporating *autonomic responses*. Data are derived from interviews and interview notes.

Data display 4.4.4.4
Subjective experience of the nurse:
Autonomic response

P39 26 I: *That was so interesting. That's a wonderful thing. I got the chills when you told me about the car jerking.*

P41 26 *Myself, I had chills several times as he was telling me!*

P48 Introduction: *Chills throughout the interview.*

P62 *I felt tears prick my eyes when she discussed her son's death. I felt my insides almost twist up.*

4.4.4.5 Increased awareness of the mystical in everyday life

A significant aspect of the researcher's subjective response to the research process and the experiences participants shared with her was an increased awareness of the mystical in everyday life. In this section an attempt is made to present this increased awareness as a finding derived from the data. The researcher originally developed the *Torus Model of Mystical Experience* (Figure 1.3) in the process of bracketing, or rather to bring to consciousness, her understanding of mystical experience during the research process. This proved challenging, as the act of listening to others' mystical experiences could not help but stimulate the researcher to reflect on her own experiences. However, she was partially successful, as may be indicated in the way in which the *Concept Map of Mystical Experience*, derived from the actual data, differs in focus from the original *Torus Model of Mystical Experience* (Figure 1.3).

In the *Torus Model of Mystical Experience* (Figure 1.3), the conscious self was seen as the ground from which the mystical experience was triggered and occurred. The experience itself is only indicated by a thin curved line, although it reflects experience moving outward from the self (extrovertive experience) and experience moving inward (introvertive experience).

The *Concept Map of Mystical Experience* (Figure 4.1) is primarily an explication of the thin curved line found in the *Torus Model of Mystical Experience* (Figure 1.3). It explains the *process* and *meaning* of the mystical experience itself. The process is seen to derive from the life world which includes a measure of consciousness and a variety of triggers, as in the *Torus Model of Mystical Experience* (Figure 1.3), including everyday experience. The experiences described in this study would best be characterised as extrovertive experiences, full of imagery and opening the participants to new experiences. However, as the experiences are integrated into the life world, it is possible to see them returning back to the participant, as in the *Torus Model of Mystical Experience* (Figure 1.3).

However, the researcher no longer considers the *Torus Model of Mystical Experience* (Figure 1.3) completely adequate as a model for mystical experience in the context of health care. She proposes that the *Concept Model of Mystical Experience* (Figure 4.1) may articulate with the *Torus Model of Mystical Experience* (Figure 1.3), more comprehensively describing human connectedness, *including the researcher's own connectedness*. The researcher no longer attempts to associate a particular trigger with mystical experience; rather *all* experiences, including stresses and alterations in health, are believed to have the potential to engender complex and many layered mystical phenomena.

Despite (or perhaps because of) the ups and downs of the research process, (including the attempt to bracket), and the tension encountered in some of the interviews, the researcher has come to a state where she embraces the concept of the *mysticism of everyday experience*, explicated by Carse (1994:xi) and others (Larkin 2004:1, Rahner 1966:50-51). In fact, she feels that to call any experience *ordinary* may be a misnomer. She feels a profound connection to the participants in the study, and to the world around her. Walt Whitman's poem *Miracles* expresses something of this sense: "Why! Who makes much of a miracle? As to me, I know nothing else but miracles" (Whitman 1900 <http://209.10.134.179/142/226.html> accessed 22/8/2006).

An outsider, critically evaluating the experiences of the study participants, might deny that they were mystical – unusual perhaps, but not mystical, especially in the sense of the great classical mystics such as St Teresa of Avila and St John of the Cross. But the researcher, recognising the range of mystical phenomena identified by James

(1929:373-388), and seeing the mystical in all experience, affirms the participants' experiences as rich and valuable, transformative, and in some degree, genuinely mystical.

The researcher was at first reluctant to accept participants' descriptions of ghost encounters and paranormal phenomena as genuinely mystical or even spiritual experiences. But Fuller (2001) states that, "Finding *even one instance of the supernatural* is the only way they [the unchurched] can honestly affirm any reason whatsoever to entertain religious hypotheses about the nature or meaning of life ... (M)any are indeed able to piece together an outlook predicated on the specifically spiritual understanding (1) that the visible world is part of a more spiritual universe from which it draws its chief significance and (2) that *union* or harmonious relation with this 'more' is our true end" (italics added) (2001:69) Fuller's statement suggests that seeing ghosts or dead relatives or experiencing paranormal phenomena are individual interpretations of significant spiritual experiences which might be communicated in a different fashion, (perhaps using mystical terminology) by individuals with a more religious orientation.

The connections with family and supernatural the participants themselves identified, the images they described, the insights they derived, may seem at times undoctrinal, jejune, even pedestrian, but they all hint at a deeper understanding of our world. The great mystics experienced the Void, the All, Unity, and saw God; the participants in the study saw God and Jesus, ghosts, dead parents, and experienced paranormal phenomena. In all cases, they were recognising something beyond their usual, understanding, something greater than themselves.

So it is for the researcher. She is increasingly aware of connections embedded in every experience, a sense of non-separation, a sense of being part of a greater whole. At times, the very shapes of leaves on trees, outlined against the sky, the flow of water over a creek bed, seem to have a significance she can scarcely articulate. The movements of a wrist, a passing phrase, seem precious and meaningful. The expressions of people around her echo the profundities of the great mystics and philosophers in subtle and esoteric ways. What a privilege life is! What a privilege to be a nurse and to work with others in this extraordinary world!

The researcher's experience may derive partly from the research process itself – not only the interactions with participants, but also the process of analysing and writing her findings. Armstrong (2004), an English religious writer and former Roman Catholic nun (although no longer a believer), describes growing into mystical experience with the process of intense study and writing. Armstrong (2004:165) examines her own development during this time and finds transcendence to be part of life. She says, "What I now realise from my study of the different religious traditions is that a disciplined attempt to go beyond the ego brings about a state of ecstasy. Indeed, it *is* in itself *ekstasis* ... We are most creative and sense other possibilities that transcend our ordinary experience when we leave ourselves behind" (italics original) (2004:279). She further notes the significance of compassion and empathy (2004:295) as contributing to ecstasy. She makes a statement that has significance for nursing: "Our task is to see that sacred dimension in everything around us - including our fellow men and women" (Armstrong 2004:302).

This has much in common with Humanistic Nursing Theory. Kleiman says Humanistic Nursing Theory involves "affirmation of being and becoming of both patient and nurse through the choices they make and the intersubjective relationships they engage in. This dynamic is expressed as the nurse's concern with the struggle toward self-actualising potential or "more-being" (Kleiman 2001 in Parker 2001:152).

The researcher's increased awareness of mystical in everyday life supports Watson's prediction of the direction in which the nursing profession is moving. In discussing the future of nursing knowledge, Watson says, "Process, transcendence, transformation, emergence, patterns of relationships, relativity of time and space, non-physical phenomena, fluid, energy fields all have implications for a new room of nursing science as we now see new knowledge for new reasons" (Watson 1990:23).

4.5 SUMMARY

Mystical experience has been presented as a process represented by the *Concept Map of Mystical Experience* (Figure 4.1). Research questions were discussed in relation to the concept model resulting from the data derived from the interviews, other conversations and the researcher's reflective journal. Mystical experience represents an important aspect of human spirituality which is of concern to the nurse as caregiver *and*

spiritual being. Understanding mystical experience in the context of health care has implications for nursing practice and the development of nursing knowledge.

Chapter 5

Discussion and conclusions

5.1 INTRODUCTION

Mystical experience is not uncommon in the context of health care. In this study, mystical experience in the context of health care was acknowledged relatively frequently by participants, *once the research question was asked*.

Eighteen participants who reported mystical experience in the context of health care were interviewed. Not all participants described their experiences as occurring during hospitalization or a specific alteration in health, but all reported the presence of psychological or physical stressors at the time of their experiences. Among hospitalised patients, 12 out of the 48 patients directly queried (25%) reported having had a mystical experience in the context of health care. (This does not include the patient visitor, but does include the patient experiencing shortness of breath who was not interviewed.) In his research on ecstasy, Greeley (1974:139-140) finds that between 14 and 29 percent of his respondents give affirmative answers to a broad range of questions about ecstasy experiences. Hood (1994:157) finds a similar frequency of mystical experience in his own and others' research – about one third of populations surveyed in Europe and America say they have had mystical experiences.

Female participants outnumbered male participants in expressing mystical experiences, both in the hospital and the community. Fourteen women participated in interviews; four men did so. Hay (1982:118) and Hood (1994:158) find women more likely to report religious experiences. No clear pattern of age for the experiences was found. Participants ranged in age from 29 to 82. In all cases, the experiences they described had happened some time in the past, between two and 70 years ago.

Despite the variation in participant demographics, and the variety of the mystical experiences described, mystical experiences occurring in the context of health care were shared with the researcher as spiritual and meaningful. The experiences emerged as a process, a complex of events and essential characteristics for both the participants and the nurse researcher.

The immersion/crystallisation approach to data analysis was used to develop understanding of mystical experiences occurring in the context of health care, to analyse the nursing process in relation to mystical experiences, and to understand the impact on the nurse of the participant's sharing of the mystical experience. The immersion/crystallisation approach yielded the *Concept Model of Mystical Experience* (Figure 4.1), which graphically illustrates the research findings.

In this model, the *process* of mystical experience begins in the individual's life world, occurs in consciousness, matures in consciousness, and results in changes in the life world. Stages include *Initiation*, *Occurrence*, *Maturation*, and *Integration*. The model also illustrates the nursing role, with emphasis on nursing interventions, and includes the effect on the nurse.

In the following sections research findings are first addressed according to each research question. After this, implications for nursing practice are presented. Next, the limitations of the study are presented. Finally, recommendations are made for further research.

5.2 WHAT FACTORS ACCOMPANY OR PRECIPITATE MYSTICAL EXPERIENCES?

The process of mystical experience begins with *initiation*, which includes both triggers and consciousness. Numerous authors (Duff 1993; Hollenbeck 1996; James 1929; Laski 1961; Medwick 1999) have identified physical and psychological factors as triggers to mystical experience. In this study, triggers include a variety of physical and psychological stressors. Everyday experience is conceived as an equally important aspect of initiation. This finding is supported by Carse's (1994:xi) discussion of mystical experience arising from everyday experience.

Infectious disease, surgery, and other health crises were among the physical stressors identified. Among psychological stressors, fear, grief and loss were prominent. However, the participants did not discuss triggers in terms of cause and effect. They were more likely to simply identify a temporal relationship – “This happened *when* ...”, and not “This happened *because* ...” Inasmuch as specific stress, illnesses, or procedures were not identified as consistent triggers for mystical experience in the

context of health care, it behooves the nurse to consider that *all* experience may serve to initiate mystical experience, and that this may occur in the hospital or community setting.

Forman (1990, 1998) and Deikman (2000) discuss mystical experience in relation to consciousness. Consciousness to some degree was noted to be a factor in the initiation of mystical experience, although not in the sense of a trigger. Participants in the study described going under anesthesia, using marijuana, experiencing cardiac arrest – circumstances in which the nurse might well suspect altered consciousness or even unconsciousness. However, it seems likely that the alteration of consciousness was not such as to prevent cognition entirely. This raises some interesting concerns about the ability of unconscious persons to have spiritual experiences. In Chapter 3, Audrey Santo, a comatose young woman, was discussed as someone “who willingly takes on the suffering of others to help in the redemption of humanity” (Felix 2001:4). While this interpretation of mysticism is different from the focus of the current research, it still suggests that an unconscious person may have a spiritual nature and spiritual experience. Might not all comatose persons have a potential for mystical experience? Might not demented persons and the mentally handicapped also have such potential? It is a sobering thought to consider that the incontinent, unresponsive patient in the bed might be experiencing connectedness with great spiritual realities. Surely this is motivation to treat all patients with great respect.

5.3 WHAT IS THE MEANING OF THE LIVED EXPERIENCE OF MYSTICAL PHENOMENA TO PARTICIPANTS EXPERIENCING IT IN THE CONTEXT OF HEALTH STRESSORS AND/OR HOSPITALISATION?

The process of mystical experiences occurs for patients, community members and nurses – nurses giving care, and nurses outside the caregiver role. There was considerable variety in the types of experiences described and the ways they were initiated, but essential commonalities in *occurrence*, *maturation*, and *integration* emerged from the data. These commonalities form the essential meaning of the mystical experience.

Most commonly, *occurrence* involved interaction with the *supernatural* and vivid *sensory motor perceptions*. Interaction with *dead and living family members* and *emotional*

intensity were also prominent. Accompanying these were *dynamic tension*, a *conviction of reality*, and elements of *cognition*.

It is not surprising that interactions with God, Jesus and angels should be a prominent aspect of mystical experience in a population with a strong religious orientation. Interaction with ghosts and paranormal beliefs may reflect local folk beliefs. Experiences with the *supernatural*, both traditional and nontraditional, are valid to the process of mystical experience

Interaction with family as a component of mystical experience is not unexpected, but is not prominent in the literature. Appalachians are very family oriented (Purnell & Paulanka 2005:47), and it is possible that cultural factors are reflected in this finding.

It is of note that experiences with the supernatural and with family members were interactive and incorporated *vivid sensory motor perception*. There was not the sense of passivity which is described by James (1929:372). It was more like Underhill's description of mystical experience as "experience in its most intense form" (Underhill 1955:82).

The experiences were *emotionally intense*, with both positive and negative emotions being expressed. Accompanying the emotional aspect of the experiences was a sense of *dynamic tension*, in which the participant was subject to conflict as part of the experience – such as whether or not he or she could stay in a heavenly place, or touch a deceased loved one who was just out of reach.

Elements of *cognition* and a *conviction of reality* were also intrinsic to the mystical experiences reported by the participants. Several scholars identify the noetic or cognitive aspects of mystical experience (Greeley 1974:56-72; Hollenback 1996:40; James 1929:371; Laski 1961:117; Wulff in Cardeña, Lynn & Krippner 2000:400). Many also discuss the understanding of the reality of mystical experience (Hollenback 1996:40; James 1902:58-60; Stace 1961:79; Underhill 1955:79).

Several authors emphasise the transience of mystical experience (Greeley 1974:16; James 1929:372; Laski 1961:45; Wulff in Cardeña et al 2000:400]), but in this study, mystical experience is seen as a developing process which extends beyond the initial

occurrence of the experience. Mystical experience goes through a *maturation* that is not limited to a certain amount of time, and the experience is ultimately incorporated into the individual's life world. This is not a strictly linear process, but is many-layered and complex.

Maturation incorporates processing, *living with the experience* and *sharing the story*. *Processing* involves reviewing the experience, interpreting it and seeking meaning, owning it and naming it. The individual *lives with the experience*, seeking further implications, and realising the enduring effects. The experience is *shared as a story*, perhaps not completely effable, but expressed as such in the desire to communicate. This sharing, in turn, provokes an effect and a response by others.

The process of mystical experience culminates in *integration* into the participant's life world – spiritual perspective, attitudes, and interactions with others. It becomes an inseparable part of who the person is.

5.4 WHAT NURSING ASSESSMENTS AND INTERVENTIONS SUPPORT PATIENTS REPORTING MYSTICAL EXPERIENCES?

The research was undertaken with the understanding that holistic nursing care must address patient spirituality. However, none of the participants reported ever sharing their experiences with a nurse, and only one specifically stated that she had told her physician. Preferred recipients of confidence were family and friends. Several of the participants had shared or tried to share their experiences with a pastor. Others, including some who described a strong church affiliation, had not done so.

However, when the appropriate question was asked (*Have you ever had a mystical experience or unusual spiritual experience at a time of physical or mental stress or when you were receiving health care?*) patients were willing and even eager to communicate with the nurse.

The NANDA International nursing diagnosis, *Readiness for spiritual well-being*, has as a defining characteristic, "reports mystical experience" (Wilkinson 2005:513). This nursing diagnosis is assumed to apply to the participants in this study based on the inclusion

criteria for the interviews. However, other nursing diagnoses, such as *spiritual distress* must also be considered.

Assessment for spiritual needs and mystical experience must reflect a holistic approach to the patient, with physical and psychological needs sometimes assuming primacy. In addition, it should be noted, that, based on the researcher's experience, attention should also be given to the environment to assure that it is private and conducive to sharing intense and personal spiritual experiences.

The desired NOC patient outcomes for the nursing diagnosis *Readiness for spiritual well-being* include "*Hope ... Quality of life ... and Spiritual well-being*" (Wilkinson 2005:514). These outcomes comprise aspects of the *integration* phase of mystical experience and were identified in many of the interviews. They are realistic outcomes which the nurse must consider in the planning and evaluation phases of the nursing process. Behaviour and attitude changes, mostly positive, and changes in spiritual perspective were found to be integrated into participants' life worlds. Still, the nurse must be open to the possibility, that mystical experience may be troubling for some. Evaluation of patient outcomes should address this possibility.

Nursing interventions which supported patients reporting mystical experiences received considerable attention during the analysis of the interviews. NIC interventions for the nursing diagnosis *Readiness for spiritual well-being* include "*Hope instillation ... Spiritual growth facilitation ... and spiritual support*" (Wilkinson 2005:51). In this research, the nurse's role was identified more strongly in the area of *spiritual support* than of *Spiritual growth facilitation or Hope installation*. This is partly explained by the fact that the participants had had their mystical experiences some time in the past and had integrated them in their life worlds to the point that they were willing to share them with a stranger doing research. They had, in effect, facilitated their own spiritual growth with the aid of family, friends, and in some instances, pastoral support.

However, interventions that provide spiritual support might well serve to instill hope and facilitate spiritual growth for patients reporting mystical experience to the nurse at the time of occurrence, or patients sharing troubling or problematic mystical experiences.

Listening and *support* are identified as valuable spiritual interventions in this research. These interventions are consistent with the nursing literature. Baumann and Englert (2003: 53) make a strong case for the nurse to be a good listener to oncology patients with spiritual concerns. Forbes and Rosdahl (2003:218) discuss dying patients' visions of bright lights, spiritual beings, and loved ones and note the need for the nurse to support the patient and the family when these phenomena occur. Wimbush and Hardie (2001:49) also discuss the support needs of patients reporting NDE.

Nursing actions that support the patient include the use of understandable terminology and the provision of privacy and an atmosphere conducive to listening. Most importantly, the nurse must be open and accepting, willing to listen *and* hear what the patient has to say. Participants emphasised the need for the nurse to be open and accepting. Nurses who feel inadequate to offer spiritual support should recognise the power and efficacy of listening. It might seem that a pastoral referral would be indicated for patients who express spiritual concerns, but this is not necessarily so. Several of the participants related experiences which they were unable to share with a pastoral caregiver, but which they could share with the researcher. The nurse should attempt to listen to the patient's concerns first, and then validate acceptability of pastoral care with the patient before making pastoral referrals.

5.5 WHAT IS THE SUBJECTIVE EXPERIENCE OF THE NURSE SHARING A PATIENT'S EXPRESSION OF MYSTICAL EXPERIENCE?

The researcher examined her responses to interviews with participants sharing their mystical experiences. Her reactions ranged from tension and frustration, to a feeling of intimacy and empathy and a sense of awe. Occurring in relation to these reactions, autonomic responses were identified, especially erector pili enervation (gooseflesh). Such autonomic reactions served as an intuitive alert to the likelihood that a participant had an especially intense experience to share.

Nurse theorists recognise the potential for growth and change involved in nursing interactions such as the researcher experienced in the interviews. For Watson, the caring relationship is described as a contact between nurse and patient, having "the potential to transcend time and space and the physical, concrete world as we generally view it in the nurse-patient relationship" (Watson 1999a:47). This shared interaction

between patient and nurse is seen as creating a phenomenal field and a “spiritual union”. In this relational context that caring is seen as an art, and the patient is supported in “self-healing and discovery of inner power and control” (Watson 1999a:66-68).

In their *Humanistic Nursing Theory*, Paterson and Zderad describe “peak experiences related to health and suffering in which the participants in the nursing situation are and become in accordance with their human potential” (Paterson & Zderad 1976:7 quoted by Kleiman in Parker 2001:154).

The researcher did indeed, experience personal growth and change as the research progressed. As she came increasingly to see mystical experience as process, she revisited the *Torus Model of Mystical Experience* (Figure 1.3). She came to appreciate mystical experience as an intrinsic aspect of everyday life, not only for the participants, but also for herself. It can not completely be represented by a thin line, as in the *Torus Model of Mystical Experience* (Figure 1.3), but may be considered reflect the crystalline structure of the *Concept Map of Mystical Experience* (Figure 4.1). The participants’ experiences came to represent to the researcher yet another manifestation of the rich complexity and reality of mystical experience in everyday life, a concept recognised in nursing (O'Brien 1999:115) and other scholarly literature on mystical experience; Carse 1994:xi; Larkin 2004:1; Rahner 1966:50-51).

5.6 IMPLICATIONS AND RECOMMENDATIONS FOR PROFESSIONAL NURSING PRACTICE

This section must be read in conjunction with section 4.4.3.2: “Nurse researcher recommendations for nursing process”. In addition, there has been a recrudescence of interest in mysticism in the nursing and medical communities. In medicine this is represented by the recent research by Griffiths et al (2006) into the potential of the entheogen psilocybin to initiate mystical experiences. In nursing it may be found in the intense controversy engendered by Dossey’s (2000) work exploring the mystical dimensions of Florence Nightingale’s life and writings. A forum for this controversy is found in a series of articles in *The Journal of Christian Nursing*. Canadian nurse historian Grypna expresses reservations about labeling Florence Nightingale a Christian mystic, or considering her a nursing role model, based on her unconventional beliefs

(Grypna 2006:10-12). Dossey responds with a defense of Nightingale's mysticism (Dossey 2006:27-31).

The nursing profession is conflicted about its obligation to address the spirituality of patients, based on differing personal competencies, differing worldviews and differing understandings of spirituality and religion (Pesut 2006:134). Mysticism, as an aspect of spirituality, may be expected to be equally problematical.

However, nurses must recognize that physical and psychological stressors may be associated with mystical experience, and that the patient having these experiences may benefit from nursing support. The nurse must also realise that the act of giving *care* may result in extraordinary experiences for himself or herself.

The researcher does not advise assessing for mystical experience as part of a routine nursing assessment, but does believe that when the nurse identifies potential spiritual concerns, a structured spiritual assessment should address the possibility of mystical experiences. The spiritual assessment should incorporate language understood by the patient, and the term "unusual spiritual experiences" may be helpful.

Nurses should be encouraged to make spiritual nursing diagnoses when appropriate. However, it is possible that the terminology used in the NANDA International spiritual nursing diagnoses is unfamiliar to some nurses, or inconsistent with their beliefs. Nursing education programs should present the full range of spiritual nursing diagnoses, as well as the NIC interventions and NOC outcomes. Support and listening should be presented as interventions which are effective and appropriate and do not require specialized expertise. Referral to pastoral caregivers should be seen as a secondary intervention, based on assessment, listening and support.

In addition to addressing the mystical experiences of the patient, educators and administrators might consider having mechanisms in place to support nurses dealing with patients expressing such experiences. This could be incorporated into post-conferences in the education setting or staff meetings in the hospital. In former years, the *psychiatric liaison nurse* role was developed to support patients and staff having challenging personal and professional experiences. The *psychiatric liaison nurse* is not

commonly found on the staff of hospitals today, but support of this type may be offered by nursing clinical specialists.

5.7 RECOMMENDATIONS FOR FURTHER STUDY

The researcher is encouraged by the recent dialogue about mysticism. The research presented here should be seen as a starting point toward understanding the phenomenon within the discipline of nursing. Further research is needed with broader populations and possibly an expanded understanding of mystical experience. For example, “spiritual emergencies” and near death experiences might be addressed as variations of mystical experience.

This research should be placed in the context of other research into mystical experience as human experience. Nurses should collaborate with other disciplines, including psychology of religion, pastoral care, and neurobiology in this regard. Such collaboration should be qualitative and quantitative, using scales such as Hood’s (1994) M-scale.

In addition, there would be value in researching the mysticism of nursing care, especially if nursing care be considered an aspect of everyday experience. The spiritual aspects of giving care have received only limited focus in the literature, but may represent an underrecognised component of professional satisfaction.

5.8 LIMITATIONS

Significant limitations of this study include the small number of participants and their homogeneity. Results cannot be generalised to non-Appalachian or non-Christian cultures, especially those cultures in which mystical experiences are culturally mediated as shamanism.

In addition, aspects of participant selection and the interview process limit the applicability of the findings. Only articulate participants who remembered their experiences were interviewed; very ill persons were not interviewed; and all participants were interviewed some time after the occurrence of the mystical experience. The interview format may also have been somewhat restrictive. Mystical experience was

addressed in a relatively narrow way, with the emphasis on stress and the health care focus possibly limiting responses. This is inconsistent with an understanding of mysticism as potentially initiated in everyday experience, but reflects the reality that the nurse must tailor her assessment to the setting and the patient's circumstances.

The researcher's personal response to the interview process does, of course, reflect her own intense interest in spirituality and mysticism. It would be unrealistic to assume that all nurses would react in the same way, nor that they would develop the same sense of the mystical in everyday life. But, the researcher's sense of tension, and recognition of the need for support must be considered as potentially relevant to all nurses. Rather than limitations, her personal responses suggest a range of possible nursing reactions.

5.9 SUMMARY AND CONCLUSIONS

In this phenomenological qualitative study, the researcher interviewed 18 patients and community members in a rural Appalachian community about their mystical experiences in the context of health care. A loosely structured interview format addressed the factors that initiate mystical experience and the essential qualities of mystical experience. In addition, the researcher examined the nursing process, focusing on assessments and actions which supported the participants in sharing their experiences. The researcher also considered her response to being the recipient of these shared experiences.

Data were analysed using the immersion/crystallisation method and concept mapping. Mystical experience was conceptualised as a *process* incorporating *initiation, occurrence, maturation, and integration* of mystical experience. Essential qualities occurring in mystical experience include *sensory-motor perception, interaction with the supernatural, interaction with dead and living family members, a conviction of reality, cognition, dynamic tension and emotional intensity*. Nursing actions which supported the participant included *listening* and *support*. The researcher's response to the participants' sharing of their experiences included *tension, intimacy and empathy, sense of awe* and *autonomic responses*. In addition, the researcher developed an *appreciation of the mystical in everyday experience*.

Limitations to the research include the small number of participants and the homogeneity of the sample. Future research should include participants from other

cultures and religious backgrounds and collaboration with other disciplines, using both qualitative and quantitative methodologies.

Holistic nursing care requires that nurses understand “the bio-psycho-social-spiritual dimensions of the person ... [and] integrate spirituality and reflection in their own lives” (American Holistic Nurses Association 2005:3). It is important for nurses to understand mystical experience as an integral aspect of human functioning and a fundamental concern for professional nursing.

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Interview Record/Personal Reflections

Date		ID number		Date transcribed	
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Location of interview-circle one					
Alpha Hospital					
Beta Hospital					
Other (specify)					

Age		Sex		Last 4 digits of pt. number	
Admitting diagnosis-----					
Length of stay-----					
Willing to participate in interview?-----		Yes		No (reason?)	
Permission slip signed? -----		Yes		No	
Permission to record? -----		Yes		No	
ID recorded on audio? -----		Yes		No	

Interview Guide —The Mystical experience -----					
<i>Ask initial questions to elicit description of mystical experience. Ask subsequent questions only if content is not spontaneously elicited.</i>					
Initial questions (Underline questions that initiate response)					
<ul style="list-style-type: none"> • Have you ever had a mystical or spiritual experience associated with a change in health? • Have you ever had an experience in which you felt that you were very close to a powerful spiritual force that seemed to lift you out of yourself? • Have you ever had an experience which you felt it was impossible to describe? • Have you ever had an experience of being unified or connected with all things? • Have you ever had an experience where you felt the loss of yourself into something greater? • Have you ever had an experience of sudden knowledge or understanding about the universe or God? • Have you ever had an experience of mysticism or transcendent ecstasy? 					
Would you tell me about this experience? (Only if not spontaneously elicited.)					
What was the time and setting? (Only if not spontaneously elicited.)					
Who was present ? (Only if not spontaneously elicited.)					
What were the circumstances ? (Only if not spontaneously elicited.)					
<ul style="list-style-type: none"> • Physical stress • Mental stress • Other triggers (specify) 					
Whom did you tell? (Only if not spontaneously elicited.)					
<ul style="list-style-type: none"> • Health caregiver (specify) • Family member • Significant other • Clergy/ spiritual advisor • Other 					
Do you have any reflections on the meaning of the experience in your life? (Only if not spontaneously elicited.)					
<ul style="list-style-type: none"> • How has the experience changed how you see yourself? • How has the experience has changed how you interact with others? • How has the experience changed your understanding of spirituality? 					
What thoughts do you have about how nurses could help people having experiences like yours? (Only if not spontaneously elicited.)					

Interview Notes----- <i>Record the following data after the interview</i>
Patient description Affect, physical status
Interview setting Patient room, private or semi private, persons present, environmental factors, including noise and equipment
Communication patterns Ease of expression, nonverbal behaviors, interruptions
Additional notes
Personal reflections-----

Information/Permission Sheet

Research Project

An Exploration into Mystical Experience

in the Context of Health Care

What is the purpose of this project?

The purpose of this project is to learn about certain psychological and spiritual experiences people may have when they experience stress or changes in their health. The researcher, Alison Witte APRN, BC, is a West Virginia Registered Nurse enrolled in a doctoral program at the University of South Africa (UNISA).

What is involved for participation?

You are asked to voluntarily take part in an interview lasting approximately one hour. This will be done at your convenience and can be ended if you wish, at any time, for any reason. The researcher will ask questions about mystical experiences or similar experiences you may have had. If you agree, the interview will be audio recorded.

How are confidentiality and privacy ensured?

The researcher will only use your name to identify you on the hospital census list. She will not look at your patient record, even if you give her permission. She will record only the following information from the census list:

- Last 4 digits of your hospital ID number
- Your age and sex
- Your length of stay
- Your admitting diagnosis

If your name is mentioned during the interview, when the recording is transcribed, your name will be deleted. Field notes maintained by the researcher will not include your name, although they will contain an identifying number. The researcher will maintain the signed permission slip, the audio recording, the typed transcript, and field notes in a secure location. When the research report is written up, and if it is published, your name will not appear anywhere, although quotations may be used. Any information that would identify you will be deleted. The researcher will not share your name, or any information identifying you, in any way.

Are there any risks? No specific risks are identified with participation in this study. However, it is possible you may experience some fatigue associated with taking part in the interview. You may also experience some stress associated with talking about an intense personal experience. If you or the researcher determines any risks, the interview can be stopped at any time.

Permission to participate

I understand that participation in this project is voluntary. I understand that I am free to withdraw my consent to participate in this study at any time and that such refusal to participate will not affect my future care. Refusal to participate or withdrawal will involve no penalty to me. I have been given the opportunity to ask questions about the research, and I have received answers concerning areas I did not understand. Upon signing this form, I will receive a copy.

I willingly agree to consent in this research.

x _____

Signature of participant or participant's legal representative

Date

x _____

Signature of investigator

Date

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Curriculum Vitae

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jwitte@rtol.net

Educational Preparation

- Current - D Litt et Phil - candidate
Health Studies
University of South Africa
Pretoria, South Africa
- 1981 – MS University of Maryland School of Nursing
Baltimore, Maryland 21201
Role Preparation: Administration of Nursing Service
Clinical Area: Psychiatric Liaison Nursing
- 1975 – BSN University of Maryland School of Nursing
Baltimore, Maryland 21201

Certification and Licensure

Certified Clinical Specialist in Gerontological Nursing (ANCC Board-Certified)
Registered Professional Nurse - West Virginia #26002

Professional Experience

- 1986 to present - Assistant Professor*
Clinical teaching and supervision of nursing students in the Glenville State College/West Virginia University Joint Nursing Program. Focus is on holistic care of children and adults in hospital, nursing home, rehabilitation and community settings. Additional courses taught include: Nutrition, Physical Fitness and Wellness, Drugs and Human Behavior, Organization & Administration of School Health, and Physiology Lab.
(West Virginia University School of Nursing Morgantown, WV 26506 /
Glenville State College, Glenville, WV 26351)
- 2003 to 2004 - Clinical Nurse II*
Unit management and direct delivery of nursing care at a state inpatient facility for psychiatric, neuropsychiatric, and forensic patients.
(William R. Sharpe Jr. Hospital, Weston, WV 26342)
- 2000 to 2005 - Coordinator, Presidential Scholars Program*
Designing, implementing and teaching in an Honors Program for outstanding students at Glenville State College.
(Glenville State College, Glenville, WV 26351)

- 1993 - *Lactation Counselor*
Peer support for pregnant and lactating women, offering education and counseling, through the Gilmer County WIC program.
(Mid-Ohio Valley Health Department, Parkersburg, WV 26505)
- 1981 to 1986 - *Assistant Professor*
Classroom teaching and clinical supervision of nursing students in community health, community mental health, and psychiatric nursing.
(West Virginia Wesleyan College, Buckhannon, WV 26201)
- 1985 to 1986 - *Home Health Nurse*
Delivery of skilled nursing care to elderly homebound Gilmer County clients on a contract basis.
(Summit Home Health, Inc., Glenville, WV 26351)
- 1975 to 1981 - *Clinical Nurse II, Clinical Nurse III, Acting Head Nurse, Shift Coordinator, Instructor*
Positions of increasing responsibility in the Children's Medical and Surgical Center and The Wilmer Eye Institute at Johns Hopkins Hospital.
(Johns Hopkins Medical Institutions, Baltimore, MD 21205)

Public Service

Board of Directors, Little Kanawha Area Rural Health Education Partnership

Board of Directors, Northern WV Rural Health Education Center

State College Representative, WV State Advisory Panel for Rural Health Educational Partnerships

Professional Memberships

Sigma Theta Tau - International (Honor Society for Nursing)
West Virginia Nurses Association
American Nurses Association
American Holistic Nurses Association
North American Nursing Diagnosis Association - International
International Network for Doctoral Education in Nursing
West Virginia Rural Health Association (founding member)
National Rural Health Association

Letters to hospitals requesting permission to conduct research

Rt. 1 Box 161
Cox's Mills, WV 26342

June 1, 2005

Ms Susan Barnes RN, M Ed
Director of Nursing
Minnie Hamilton Health Care Center
Grantsville, WV 26147

Dear Susan

As you know, as a doctoral student in nursing, I am hoping to conduct research on mysticism in the context of health care. My goal is to conduct semi-structured interviews with hospitalised patients, to see if they have ever had a mystical experience, and if so, what it was like. From these interviews, I plan to develop a phenomenological description of mystical experience from the patient perspective, and to develop recommendations for the nursing role.

I am requesting permission to conduct this research at Minnie Hamilton Health Care Center. I believe that developing knowledge about patients' mystical experience is both timely and relevant. Spirituality has been identified as an important influence on both health outcomes and patient satisfaction in the Joint Commission Journal on Quality and Safety (Clark, Drain & Malone, 2003). JCAHO standards mandate that spiritual assessment be incorporated into patient care (JCAHO website). Mystical experience itself is listed as a "defining characteristic" for the NANDA Nursing Diagnosis "Readiness for Enhanced Spiritual Well-Being" (NANDA International 2005).

I have enclosed several packets which include the patient permission form, interview guidelines, and my Curriculum Vitae. I would like copies to be made available to the Medical Director, the Chief Executive Officer and others who express interest. As you review the information in the packet, questions about HIPAA, privacy, and confidentiality should be answered.

If you agree to allow me to pursue research at Minnie Hamilton Health Care Center, I need confirmation in writing, so that I can include it with my research results. Thank you very much for your consideration and your help.

Sincerely

Alison Witte, APRN, BC, MS
Rt. 1 Box 161
Cox's Mills, WV 26342

June 1, 2005

Mr. Tim Harclerode RN, BSN
Chief Nursing Officer
Stonewall Jackson Memorial Hospital
Weston, WV 26452

Dear Tim

As you know, as a doctoral student in nursing, I am hoping to conduct research on mysticism in the context of health care. My goal is to conduct semi-structured interviews with hospitalised patients, to see if they have ever had a mystical experience, and if so, what it was like. From these interviews, I plan to develop a phenomenological description of mystical experience from the patient perspective, and to develop recommendations for the nursing role.

I am requesting permission to conduct this research at Stonewall Jackson Memorial Hospital. I believe that developing knowledge about patients' mystical experience is both timely and relevant. Spirituality has been identified as an important influence on both health outcomes and patient satisfaction in the Joint Commission Journal on Quality and Safety (Clark, Drain, & Malone 2003). JCAHO standards mandate that spiritual assessment be incorporated into patient care (JCAHO website). Mystical experience itself is listed as a "defining characteristic" for the NANDA Nursing Diagnosis "Readiness for Enhanced Spiritual Well-Being" (NANDA International 2005).

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If you agree to allow me to pursue research at Stonewall General Memorial Hospital, I need confirmation in writing, so that I can include it with my research results. Thank you very much for your consideration and your help.

Sincerely

Alison Witte, APRN, BC, MS

Letters confirming permission for research

Rt. 1 Box 161
Cox's Mills, WV 26342

June 1, 2005

Mr. Tim Harclerode RN, BSN
Chief Nursing Officer
Stonewall Jackson Memorial Hospital
Weston, WV 26452

Dear Tim:

As you know, as a doctoral student in nursing, I am hoping to conduct research on mysticism in the context of health care. My goal is to conduct semi-structured interviews with hospitalized patients, to see if they have ever had a mystical experience, and if so, what it was like. From these interviews, I plan to develop a phenomenological description of mystical experience from the patient perspective, and to develop recommendations for the nursing role.

I am requesting permission to conduct this research at Stonewall Jackson Memorial Hospital. I believe that developing knowledge about patients' mystical experience is both timely and relevant. Spirituality has been identified as an important influence on both health outcomes and patient satisfaction in the Joint Commission Journal on Quality and Safety (Clark, Drain, & Malone, 2003). JCAHO standards mandate that spiritual assessment be incorporated into patient care (JCAHO website). Mystical experience itself is listed as a "defining characteristic" for the NANDA Nursing Diagnosis "Readiness for Enhanced Spiritual Well-Being" (NANDA-International 2005).

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If you agree to allow me to pursue research at Stonewall General Memorial Hospital, I need confirmation in writing, so that I can include it with my research results. Thank you very much for your consideration and your help.

Sincerely,

Alison Witte APRN, BC, MS

Alison Witte, APRN, BC, MS

*Permission granted to conduct interviews
@ SJMH.*

*N Harclerode RN, CNO
9-9-05*



September 27, 2005

To Whom It May Concern:

This letter is to verify that Alison Witte, APRN, BC, MS, has been given permission to conduct research on Mysticism in the context of healthcare at Stonewall Jackson Memorial Hospital.

Sincerely,

A handwritten signature in dark ink, appearing to read "Tim Harclerode".

Tim Harclerode, RN
Chief Nursing Officer

TH/kar

230 Hospital Plaza, Weston, West Virginia 26452-8558
Telephone (304) 269-8000

Rt. 1 Box 161
Cox's Mills, WV 26342

June 1, 2005

Ms. Susan Barnes RN, MEd
Director of Nursing
Minnie Hamilton Health Care Center
Grantsville, WV 26147

Dear Susan:

As you know, as a doctoral student in nursing, I am hoping to conduct research on mysticism in the context of health care. My goal is to conduct semi-structured interviews with hospitalized patients, to see if they have ever had a mystical experience, and if so, what it was like. From these interviews, I plan to develop a phenomenological description of mystical experience from the patient perspective, and to develop recommendations for the nursing role.

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I have enclosed several packets which include the patient permission form, interview guidelines, and my Curriculum Vitae. I would like copies to be made available to the Medical Director, the Chief Executive Officer and others who express interest. As you review the information in the packet, questions about HIPAA, privacy, and confidentiality should be answered.

If you agree to allow me to pursue research at Minnie Hamilton Health Care Center, I need confirmation in writing, so that I can include it with my research results. Thank you very much for your consideration and your help.

Sincerely,

Alison Witte APRN, BC, MS
Alison Witte, APRN, BC, MS

*Approved with appropriate HIPAA documentation
May 8/25/05*



Minnie Hamilton Health Care Center

July 1, 2005

Dear Mrs Witte:

I have been in discussion with Barbara Lay, our CEO, concerning Minnie Hamilton's involvement in your post graduate research in "Exploration of "Mystical Experience in Context of Health Care". She was very supportive of this endeavor and felt that the subject was intriguing and will anxiously be awaiting your results.

We will need for you to sign a confidentiality form, and to remind you that patient participation is on a voluntary basis. We look forward to working with you and if I can be of any assistance do not hesitate to contact me at 354-9244 ext 363.

Respectfully,

Susan A. Barnes, BSN, M.Ed.
Director of Nursing
Minnie Hamilton Health Care Center

HIPAA competency training



Nursing
A joint offering with West Virginia University

October 13, 2005

To Whom it May Concern:

Alison Witte has completed the Medcom Trainex program, HIPAA: A guide for Healthcare Workers.

If you have any questions and need any additional information, please let me know.

Sincerely,

Theresa D. Cowan, MSN APRN BC
Coordinator / Assistant Professor

E-mails for participant recruiting

From: "Alison Witte" <Alison.Witte@glennville.edu>
To : faculty@gscinfo.glennville.edu, staff@gscinfo.glennville.edu
CC :
Date : Thu, 25 Aug 2005 16:08:44 -0400
Subject : **request for help with research**

Dear Friends and Colleagues,

As part of my doctoral research I am interviewing people who have had mystical and related spiritual experiences associated with health care or occurring at a time of physical or mental stress. If you have had any experiences like this, and are willing to talk with me, I would like to interview you. The interview would take less than an hour. I would arrange to do so at your convenience.

You can contact me at my college e-mail address, or call me at extension 7313. You are welcome to call me at home: 462-7920.

Please feel free to give my name and contact information to anyone else who you think would like to be interviewed.

Thank you for your help!!

Sincerely,

Alison Witte

Alison Witte APRN, BC, MS

From: "Kathy Butler" <Kathy.Butler@glennville.edu> | [javascript:headerDisplay\(1\);](#)
To : alison.witte@gscinfo.glennville.edu
CC : larry.baker@gscinfo.glennville.edu
Date : Thu, 25 Aug 2005 11:20:58 -0400
Subject : **FWD: Re: FWD: question about research**

Alison, With Larry's blessing, let's proceed.

KB

Dr. Kathy Butler
Vice President for Academic Affairs
Glennville State
Glennville, WV 26351
(304) 462-4100

----- Original Message -----

From: "Larry Baker" <Larry.Baker@glennville.edu>
Reply-To: <Larry.Baker@glennville.edu>
Date: Thu, 25 Aug 2005 08:05:54 -0400

Kathy,
Alison,

Glenville State e-mail cannot be used for personal gain or political agenda items as outlined in policy. On the other hand it is to be used for educational purposes and research to better the students, faculty, staff and administration at Glenville State. I feel this request by Alison is education based and will benefit Glenville State as we need more professors with terminal degrees and performing research. I feel this request is in line with serving Glenville State.

Please proceed Alison and I wish you the best. If my staff can be of assistance please let me know. :-)

Larry R. Baker
Associate Vice President - Technology
Glenville State

----- Original Message -----

From: "Kathy Butler" <Kathy.Butler@glenville.edu>
Reply-To: <Kathy.Butler@glenville.edu>
Date: Wed, 24 Aug 2005 17:33:35 -0400

>Please advise, Larry. This is for her dissertation.

>

>KB

>

>Dr. Kathy Butler

>Vice President for Academic Affairs

>Glenville State

>Glenville, WV 26351

>(304) 462-4100

> >

>

>----- Original Message -----

>From: "Alison Witte" <Alison.Witte@glenville.edu>

>Reply-To: <Alison.Witte@glenville.edu>

>Date: Wed, 24 Aug 2005 14:00:29 -0400

>

>Dear Kathy,

>

>Do you think it would be all right for me to e-mail faculty and staff (not students) to see if any of them have had experiences like I am researching (mysticism in the context of health care), and if they would be willing to be interviewed?

>

>I didn't want to use the college e-mail unless I checked with someone first.

>

>Thanks, >

>Alison