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ROLE OF BUDDHIST SPIRITUAL PRACTICE IN THE LIVES AND HEALTH OF BUDDHIST NUNS LIVING WITH A CHRONIC ILLNESS IN SRI LANKA

Sunny Wijesinghe

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Sunny Wijesinghe
Candidate

Nursing
Department

This dissertation is approved, and it is acceptable in quality
and form for publication:

Approved by the Dissertation Committee:

Mark Parshall, PhD, RN, Chairperson

Jennifer Averill, PhD, RN

Piyadasa Kodituwakku, PhD

Judy Liesveld, PhD, RN

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By

Sunny Wijesinghe

B.A., Linguistics and German, Hamilton College, New York, 1979
BSN, Johns Hopkins University, Maryland, 2000
M.S., Human Nutrition and International Agricultural Development,
University of California at Davis, 1984
MPH, International Health and Anthropology, Tulane University, Louisiana, 1995

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

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Dedication

- To the prolific storytellers of Sri Lanka who granted me the opportunity to vicariously experience the sights, sounds, and smells of their journey through life

- To Gereon Hunger, the wind beneath my wings to soar above rough seas

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Ph.D., Nursing, The University of New Mexico, 2013

ABSTRACT

This study focused on the role of Buddhist spiritual practice in the lives and health of Sri Lankan Buddhist nuns with a chronic illness. The concept of spirituality has emerged recurrently in research as a means to cope with chronic illness. The question as to whether Buddhism, as observed in traditionally Buddhist countries, influences coping in chronic illness, has received little attention.

Buddhism covers several sects and even within the same sect practices vary depending on each socio-cultural environment. Any attempt to study Buddhism's role in chronic illness requires isolating not only a sect, but also a country in which it is practiced. A focus on Sri Lankan Buddhism is important because it is generally believed that the oldest form of Theravada Buddhism remains preserved in Sri Lanka. The choice of the Buddhist nun serves the pragmatic purpose of allowing a female researcher access to conduct interviews in privacy.

In order to ground the findings in the data, this descriptive ethnography followed the iterative, and recursive linguistic approach of Spradley (1979, 1980). The 45 primary participants, Sri Lankan Buddhist nuns with a chronic illness were selected through a snow-ball sampling strategy. Twenty secondary informants were identified to shed light on the topic from health-care, lay-Buddhist, and Buddhist-scholar perspective. Participant observation and semistructured interviews were used to explore cultural domains, to clarify each domain with taxonomies, and finally to uncover cultural themes.

The repeating cultural theme was identified as *responsibility*, which took four forms: responsibility to the Buddha, to others (social circle), to self-liberate oneself through meditation, and to find security in old age. Nuns shaped their Buddhist spiritual practices to suit their sense of these responsibilities. The role of spiritual practice in their health was mediated by the strength of their resolve to fulfill their responsibility and resources, against a backdrop of the Buddhist phenomenon of impermanence. Their coping styles ranged from health-seeking to resigned acceptance. Incorporating the viewpoints of primary and secondary informants indicated these behaviors resembled constructs of the theory of Salutogenesis (Antonovsky 1979). Implications for nursing research, education, practice, and policy are discussed.

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Chapter 1

Introduction

Background

Overview. This dissertation examines the role of Buddhist spiritual practice in the lives and health of Sri-Lankan Buddhist nuns with a chronic illness. Chronic illness has gained in prevalence worldwide, and adapting to a lifelong chronic condition has become a reality for many. How people adjust to and live with a chronic illness is a concern not only to the afflicted and their social circle, but also to the health-care providers. The influence of spirituality and religious practice in the lives of the ailing has received increasing attention in chronic illness literature. Although many spiritual practices have been captured in such research, the portrayal of Buddhist spiritual practice in these studies is incomplete and mostly has involved Western adaptations of Buddhist practice, such as mindfulness meditation that differ from what is observed in traditionally Buddhist countries, especially those in which Theravada Buddhism predominates. Questions about whether or how Buddhism, as practiced in these socio-cultural environments, facilitates coping with chronic illness have received relatively little attention.

This dissertation contributes to filling that lacuna in spirituality literature by focusing an ethnographic lens on the Theravada spiritual practice in Sri Lanka and how it relates to chronic illness. The study narrows its scope to explore the lives and health of a specific group of practicing Buddhists that, thus far, has received little attention in the sphere of health: Sri-Lankan Buddhist nuns with a chronic illness. Shedding light on the Sri Lankan Buddhist nun with a chronic illness is significant because of the unique position she occupies as a Buddhist stewardess and an implicit caretaker in a socio-cultural milieu of a country in which

traditional Theravada Buddhism is the predominant religion. By exploring the role that Theravada Buddhist spiritual practice plays in the lives and health of chronically ill women who have dared to take an uncommon path in life, this ethnography serves two purposes: first as a method to shed light on issues important to these women and second as a product that leads to a way of knowing relevant to spiritual practice in chronic illness.

  Chronic illness. Chronic illness has grown to epidemic proportions throughout the world. In 2005 one in two Americans (133 million) lived, at least, with one chronic condition (RWJF, 2004). Seven of 10 deaths in the United States each year are blamed on chronic diseases (Kung, Hoyert, Xu & Murphy, 2008).The burden of chronic illness is not a problem only in developed countries. Worldwide statistics show that chronic illness exceeds communicable diseases and traumatic injuries as causes of death and disability. (Lopez, Mathers, Ezzati et al., 2006).

  Cardiovascular disease and cancer account for more than 50% of all deaths each year (Kung et al., 2008). Other prevalent chronic conditions include arthritis, diabetes, chronic pulmonary disease, epilepsy, mental disorders, and HIV/AIDS (when effective treatment is available) (CDC, 2006; Devol & Bedroussian, 2007; Dorwick, Dixon-Woods, Holman & Weinman, 2005). Due to the evolving nature of understanding, diagnosing, and experiencing symptoms, a commonly used definition of chronic illness up to 2008 was "a condition that lasts over three months" (National Center for Health Statistics, 2008). Currently, however, the Centers for Disease Control and Prevention stops short of formally defining chronic illness and refers instead to common characteristics associated with chronic conditions such as long duration, often unknown etiology, multiple risk factors, noncontiguous origin, and the tendency to lead to weakness or disability (CDC-INFO, personal communication, Feb 28,

2012). The World Health Organization (WHO), on the other hand, places more emphasis on defining individual chronic conditions rather than providing a universal definition for chronic illness, but the WHO refers to long duration and slow progress as characteristics of chronic illness (WHO, 2011).

The trajectory of a chronic illness is unpredictable, and even those afflicted with the same condition may not experience the same symptoms or course. Yet, those living with different chronic illnesses often may be united by similar experiences of having to live with a lifelong illness (Dorwick et al., 2005). Common characteristics of living with a chronic illness include loss of independence (Phillips, Moneyham, Thomas, Gunther, & Vyavaharkar, 2011; Pollin, 1994), loss of self-image (Charmaz, 1990, 1995; Morales & Castillo, 2007), powerlessness (Aujoulat, Luminet & Deccache, 2007; Miller, 1983), uncertainty (Honkasalo, 2008; Mishel, 1990), invisibility (Stone, 2005), anxiety (Soo, Burney, & Basten, 2009), alienation (Erdner, Magnusson, Nystrom, & Lutzen, 2005), disability and stigma (Goffman,1963;Harris, 2009), and being neither cured nor completely sick or disabled (Jaye & Fitzgerald, 2011; Murphy, Scheer, Murphy, & Mack, 1988).

Living with chronic illness. Chronic illness is not amenable to cure. Some conditions may be characterized by mild or no symptoms at times and, thus, may not always require major adjustments to daily routines. But, for those faced with a severe condition, chronic illness can be a devastating lifelong prospect. A coping mechanism that helps with enduring difficult life conditions due to illness could be extremely useful. Ample literature on coping theories can be found that explains how people live through stressful situations such as illness and disaster. Two aspects, discussed frequently in the literature in a positive light with regard to coping, are access to a supportive social network and a meaning-making process

(Jackson, Enderby, O'Toole, Thomas, Ashley, Rosenfeld, et al., 2009; McCabe & O'Conner, 2012; Narayanasamy, 2002; Skaggs & Barron, 2006). A recurrent theme that goes along with the concept of meaning-making in the literature is spirituality or religion.

Spirituality, religion, and religiosity. Literature is replete with evidence of a positive connection between spirituality/religion and coping with chronic illness. Some of the chronic conditions mentioned in this context are rheumatoid arthritis (Bartlett, Piedmont, Bilderback, Matsumoto, & Bathon, 2003), diabetes (Kilbourne, Cummings, & Levine, 2009), cardiovascular illness (Griffin, Lee, Salman, Seo, Marin, Starling, et al., 2007), fibromyalgia and chronic pain (Moreira-Almeida & Koenig, 2008), AIDS (Tuck & Thinganjana, 2007), and cancer (Whitford, Oliver, & Peterson, 2008). Despite the positive link, a frequently mentioned limitation in the majority of these studies is the inability to clearly define spirituality. McSheery and Cash (2004) conducted an exhaustive survey of people's definitions of spirituality and placed their findings on a taxonomic continuum with the descriptor theistic on the extreme left and mystical on the extreme right. They said the definition of spirituality varied according to the affiliation with a religion, language, culture, political philosophy, social ideology, phenomenology, existentialism, and implicit quality of life. They concluded that individuals fashioned their own definition, and they cautioned that attempts to establish a theoretically universal definition would be misguided.

Attributes of spirituality are measured with more than 30 psychometric tools that measure domains such as quality of life, attitudes, religiousness, and spirituality (Chiu, Emblen, Van Hofwegen, Swatzky, & Meyerhoff, 2004). A handful of conceptual frameworks (Coyle, 2002; Gall et al., 2005) also have described how spirituality/religion may (or may not) be an asset in coping with chronic illness. Although an attempt has been made to include

other faith communities, a preponderance of these studies have focused on religions within the Judeo-Christian tradition. Despite many differences, all of the Abrahamic faiths are monotheistic and revolve around a belief in a supernatural Supreme Being who is the source of revealed truth.

Buddhist faith, by contrast, originated with a human being, not a deity and aims to condition the human mind. To the extent that the Buddhist belief has been studied, the context often differs from Buddhism as practiced today in predominantly Buddhist countries. The majority of these studies claim Buddhist psychology as their base, and their findings point to a positive correlation between the practice of one particular form of Buddhist-inspired technique called "mindfulness meditation" or "vipassana" (interchangeably used in the literature) and coping with chronic illness (Astin et al., 2003; Kabat-Zinn, et al., 1987, 1998; Reibel et al., 2001; Randolph, 1999; Singh et al., 1998; Teasdale, 2000; Weissbecker, 2000). Another customized version of mindfulness that has received great deal of attention in clinical research and psychological literature is mindfulness based stress reduction (MBSR), which is a composite of practices including, a body scan (awareness of bodily sensations), breathing meditation, walking meditation, and Hatha yoga (Kabat-Zinn, 1990, 1994). The mindfulness concept also is adopted in behavior therapy as in mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002), dialectical behavior therapy (Lineham, 1993), and relapse prevention (Marlatt & Gordon, 1985). Popularity of mindfulness/vipassana meditation has grown tremendously in the past decade or two, and meditation courses, therapy, and retreats are offered in universities, meditation and training centers, hospitals, clinics and even on the Internet.

The above research and interventions that bring solace to the chronically ill are commendable, but the question remains unanswered whether Buddhism, as practiced in traditional Buddhist countries today, also can be a solace in chronic illness. The research that aims to address the above question needs to consider three important points: first, mindfulness in Buddhism cannot be abstracted from its interrelated concepts; second meditation is only one part of practicing Buddhism; and third, Buddhism as practiced today, even within same sect (e.g., Theravada Buddhism) can be unique to the socio-cultural environment in which it is practiced. For example, Sri-Lanka, Thailand, Burma, Laos and Cambodia are Theravada Buddhist countries, but despite the common core principles in Buddhism believed in those countries, local customs of Buddhist worship/practice could be significantly different.

The essentials of Buddhism. "The teaching of the Buddha is qualified as *ehi-passika*, inviting you to 'come and see,' but not to come and believe" (Rahula, 1978, p. 9). The essence of Buddha's teaching lies in the four noble truths: (a) *dukkha* – suffering, imperfection, or insubstantiality; (b) *samudaya* – the arising or origin of *dukkha*; (c) *nirodha* – the cessation of *dukkha,* and (d) *magga* – path leading to the cessation of *dukkha*. The most significant philosophical aspect of the first noble truth *dukkha* is "conditional states", the combination of ever-changing physical and mental energies divided into five aggregates: Matter, sensations, perceptions, mental formations (of which there are 52 mental activities that can cause karmic effects, both good and bad), and consciousness or the reaction one has, which is, in turn, associated with six faculties of eye, ear, nose, tongue, body and mind. The origin of *dukkha* is the thirst for senses (*kama tanha*), thirst for existence (*bhava tanha*) and thirst for nonexistence (*vibhava* tanha). The destruction or abandoning of craving for the five

aggregates is the key to cessation of *dukkha*. Finally, the Eightfold Path the Buddha elucidated is the way to live to eliminate *dukkha.* This consists of right understanding, right thought, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration. Thus, one can see that meditation, which has mainly to do with right mindfulness and concentration, is only one part of living the Buddhist way.

    The concept of mindfulness in Buddhism. The core attribute of mindfulness is the type of awareness that is described as nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise (Gunaratana, 1990). Another term used interchangeably with mindfulness meditation in the current popular usage is "vipassana meditation". Vipassana meditation is the method for purifying the mind of the mental factors that cause distress and pain. The suffix "-*passsana*" means seeing or perceiving; "*vi-*" means through. According to Buddhism, this is an immediate insight experienced without reasoning or thinking (Nyanasatta, 2000).

    The concept of mindfulness used in the quantitative studies mentioned earlier is distilled from the inter-related Buddhist concepts of impermanence (*annica*), insubstantiality or suffering (*dukkha*), and non-self (*anatta*) to suit the psychometric instrumentation. Thus, researchers (Christopher, Charoensuk, Gilbert, Neary, & Pearce, 2009) admit that comparing mindfulness as understood in the West and in the East (Thailand, in this case) is akin to comparing apples and oranges.

    In the literature that discusses Buddhist-like features, it is difficult to identify a clear relationship between any particular school of Buddhism and its influence on chronic illness. It would be of interest to clarify the association between Buddhism and coping in chronic illness by exploring what aspects of which practice of Buddhism may aid in which manner to

cope in chronic illness. Making a clear distinction between Western and Eastern Buddhist practices also can be a complicated task, first because Eastern Buddhism is not a monolithic entity, and second Western Buddhism is not without elements of Eastern Buddhism. Since its advent nearly 2,500 years ago, Buddhism has undergone several changes and led to different spiritual practices under the umbrella term of Buddhism, with different schools and traditions based on the interpretation of certain aspects of the scriptures. These traditions can be categorized as Mahayana, Hinayana (or Theravada), and Tantrayana (also known as Vajrayana). Buddhist psychology-based (or related) spiritual practices in the West may include any or many aspects from these sects intermingled or even mixed in with other faiths.

The majority of those who profess to be Buddhists in the Eastern countries such as in China, Japan, Laos, Myanmar, Sri Lanka Thailand, and Taiwan belong to one of the previously named sects such as Mahayana, Theravada, or Tantrayana. To further complicate the matter, Buddhists within the same sect also may vary their practices depending on the social cultural environment. However, a salient aspect of Buddhism that all Asian Buddhists share is an established practice of Buddhist rituals and ceremony as an adjunct to their reflective activities such as meditation. A paucity of published research examines how Buddhist practice, in its entirety, with its ritual, and ceremony (along with meditation) influences coping in chronic illness.

Since Eastern Buddhism covers a vast area, any attempt to study Eastern Buddhism's role in chronic illness would be facilitated by isolating not only a sect or tradition, but also a country in which it is practiced. A focus on Sri Lankan Buddhism is important because it is generally believed that Sri Lanka preserves the oldest classic form of Theravada Buddhism to

a far greater extent than other countries, even those in which Theravada is the predominant tradition (Donath, 1971; Habito, 2005; Snelling,1999).

Historical records attest to the fact that Sri Lankan Buddhist monks and nuns have served as the liaison between the written scriptures of Theravada Buddhism and the Buddhist adherents in Sri Lanka and in other Asian countries. Buddhist monks and nuns (arguably to a lesser degree) study, interpret, and propagate the knowledge given in Buddhist scriptures. The majority of Buddhist monks and nuns dedicate their lives to this task and thus are seen as preservers or stewards of classic Theravada Buddhism.

Little or no research exists about the influence that Buddhist spiritual practice has in the lives and health of Sri Lankan Buddhist religious monks or nuns. The connection between spiritual practice and health in this context would be of particular interest because of their focus on preserving traditions and rituals.

Sri Lankan Buddhist Nun

My focus on the Sri Lankan Buddhist nun is significant because the role involves elements of being both, a religious stewardess and an implicit caretaker (who attends to needs of the extended family) among women in the Sri Lankan cultural context. The Sri Lankan Buddhist nun's religious authority is substantial in the sense that she is more highly respected and bestowed with more deciding power than Buddhist nuns in other Asian countries of Theravada Buddhism, such as Laos, Myanmar, and Thailand (Kabilsingh, 1998; Sein,1998; Weerakoon, 1998).

In modern Sri Lanka, Buddhist nuns dedicate their lives to follow a religious path and are female guides of the Buddha's word. They not only are devout female adherents to Buddhism but have chosen a path that deviates from the conventional roles assumed by

women in this largely patriarchal culture. Thus, studying the role her Buddhist spiritual practice plays on her life and health sheds light not only on a female Buddhist guide in Sri Lanka with a chronic illness but also how Buddhism influences the life and health of a Buddhist woman who has pursued an uncommon path in a conservative Asian culture.

Specific Aims

The specific aim of this study was to develop a detailed ethnographic description of the interplay between chronic illness and Theravada Buddhist belief and practice in the lives of Sri Lankan Buddhist nuns.

Although research has shown that Buddhist spiritual practices may aid in coping with chronic illness positively (Astin et al., 2003; Kabat-Zinn et al., 1987, 1998 ; Reibel et al., 2001; Randolph, 1999; Singh et al.,1998; Teasdale, 2000;Weissbecker, 2000), these studies have concentrated on spiritual practices interpreted in the West as Buddhist or Buddhist–like, most notably meditation. Because Western and Eastern interpretations of Buddhist practices may differ significantly (M. Christopher, V. Christopher, & Charoensuk, 2009) research that addresses the role of Buddhist spiritual practice in chronic illness needs to be very specific as to the sect of Buddhism as well as to the cultural context in which it is practiced.

Studying the lives of Sri Lankan Buddhist clergy who undergo a chronic illness may shed light on how Buddhist spiritual practice in this Asian Theravada Buddhist country affects chronic illness. The purpose of this study was to describe the role Theravada Buddhist spiritual practice plays in chronic illness by focusing on Sri Lankan Buddhist nuns. For several reasons the study narrows its focus to comprise only Buddhist nuns (as opposed to Buddhist monks). First, the Buddhist nun plays a dual role as a religious guide as well as a Sri Lankan woman who has chosen an unconventional path. Second, the choice of the

Buddhist nun serves the pragmatic purpose of allowing a female researcher access to conduct interviews in privacy.

The study design involved a problem-focused descriptive ethnography that aimed to describe the thoughts and activities that constitute Theravada Buddhist spiritual practice to Sri Lankan Buddhist nuns, how chronic illness affects their activities, and what factors help or hinder them from carrying out the activities important to these Buddhist nuns with chronic illness. Study data will be analyzed using domain analysis (supported by taxonomic analysis where necessary) as described in Spradley (1979, 1980). The analysis will be supplemented with one or more visual templates of matrix analysis (Miles & Huberman, 1994) to enhance the development of evidence and to draw meaning.

Anticipated Strengths and Limitations in Studying One's Own Culture

An ethnographic researcher originating from the culture being studied must recognize that she cannot entirely suspend her own knowledge of the social world to achieve objectivity (Pellatt, 2003). I was born in Sri Lanka and spent my formative years there. I foresee my familiarity with the Buddhist socio-culture of Sri Lanka acting as an advantage as well as a hindrance. For example, in face-to-face interviews with Sri Lankans, my cultural experience will guide me against taking responses at face value because a native recognizes her kith and kin exaggerating, understating or being indirect to save face. Based on my experience conducting a pilot study with diabetic nuns Buddhist nuns in Sri Lanka (Wijesinghe & Mendelson, 2012), my identity as a Sri Lanka-born American, who is fluent in the local language and knowledgeable about Buddhism as practiced in Sri Lanka, will raise interest and curiosity that in return will give me access to many places closed to regular Buddhists, such as an invitation to stay at a temple.

Significance of the Study to the Field of Nursing

Nursing scholarship revolves around the factors of person, health, environment, and nursing care. In addition, nursing has a strong focus on the understanding and relief of human suffering and how people cope with chronic and acute illness. Studying how the spiritual practice of Theravada Buddhist nuns influences living with a chronic illness is significant to nursing because of Buddhist conceptions of the nature of suffering and emancipation from it. The focus on Eastern philosophy in this study will expose the Western nurse to an alternative to the prevailing materialist conception of most Western science. The philosophical basis of Buddhism is to attain freedom from suffering by understanding what suffering is, its causes, how to eliminate suffering, and to advance on the Eight-fold Path elucidated by the Buddha. Unlike the traditional Western idea of person, Buddhism places greater emphasis on the mental aspects of existence. The fundamental reality of human existence is the ever-changing consequence of thoughts feelings and perceptions comprised by conscious experience. In Buddhism everything is explained in terms of causality or conditionality. Human life exists within a relationship of interdependence with everything else. According to Theravada Buddhism, only a minute portion of human ailments commonly associated with suffering is of a physical nature. Eastern philosophy is a rich source of insight into human suffering and its relief, concerns that are central to the practice and science of nursing (Rodgers & Yen, 2002). Paying attention to other possible ways of knowing can potentially enrich nursing practice and research (Anderson & McFarlane, 2011; Carper, 1987; Chinn & Kramer, 2011; Clements & Averill, 2006; Davidson, Ray, & Turkel, 2011; Nightingale, 1860 / 2010; Rodgers & Yen; Watson, 2012).

It is understood the healthcare of a chronically ill Sri Lankan Buddhist nun may not be an everyday concern of the Western nurse. However, a glimpse at the mental and socio-cultural context of women whose belief and practices related to pain and suffering may not correspond to a pharmacological problem may help nurses and other health-care providers to provide culturally sensitive care for patients in ways that will be meaningful within their reality. As such, this ethnographic qualitative research will give insight into social and cultural processes of these women's experience, which in turn can inform development of culturally attuned theory and practice in nursing and health care. In this sense, this dissertation will contribute to the pool of knowledge in the science, and art of nursing. In addition, this research will broaden a canvas of understanding by enriching the knowledge base of the spiritual practice and culture of Buddhist nuns with chronic illness, quality of life as well as the implications of these on their stakeholders.

Research Questions

1. What activities and thoughts constitute "spiritual practice" of these Buddhist nuns?

2. How does chronic illness affect these women's daily life?

3. How does Theravada Buddhist spiritual practice affect their experience of chronic illness?

4. How does chronic illness impact their spiritual practice?

5. What other factors help or hinder their living with chronic illness?

Definitions

Within the context of this proposed study the following definitions of terms will be employed:

Spirituality. Spirituality in the context of this study entails being affiliated with Buddhism and undertaking what is customary for Buddhist practice within the given socio-culture. The spiritual behavior may or may not include participating in rituals and ceremonies adopted and accepted as part of a general Buddhist environment within that culture.

Chronic illness. Chronic illness is "the presence of a protracted disease process which is not amenable to cure, is responsible for impairment or disability and has a sustained influence on the functioning and life style of the individual." (Alexander, Fawcett & Runciman, 2000, p. 946).

Coping. Constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. (Lazarus & 1984, p. 141).

Sri Lankan Buddhist nun. A Sri Lankan Buddhist nun is a world-renunciant (one who has resigned from worldly activities such as being attached to a family and property, earning income) who may be ordained or not ordained. Ordained nuns are referred to as *bhikkhunis*, and observe 311 monastic rules. The nonordained nuns are called *dasa-sil-matas*, and they observe 10 Buddhist precepts. Nuns may live in nunneries as in group of two to 10 along with one or two live-in female aides, or in some rare cases a nun may live by herself in a house or room. All ordained and nonordained nuns are dependent on the community for their livelihood although in a rare case an erudite ordained nun serving as a Buddhist instructor in an institute of higher education may draw a salary (Bartholomeusz, 1996). At the present time ordained and nonordained Buddhist nuns coexist and exercise their freedom to choose a religious path in life.

Chapter 2

Review of Literature

The components of Chapter 2: (a) living with chronic illness; (b) chronic illness and spirituality; (c) brief history of Buddhism; (d) early Buddhist medicine and attending to the ill; (e) the notions of suffering and healing in Buddhism; (f) Buddhist spiritual practice in contemporary Sri Lanka; (g) brief history of Sri Lankan Buddhist nun; (h) research on Buddhism-based spiritual activities and chronic illness; (i) background to methods used in the study; and (j) rigor and trustworthiness.

Living with Chronic Illness

The trajectory of chronic illness is extremely unpredictable; its onset can be sudden or gradual; it can progress with no symptoms or mild symptoms or lead to severe incapacity (Pollin, 1994). It also is evident that chronic illness occurs not just in the elderly. In the United States 60% of those with chronic illness are aged 18 to 64 (RWJF, 2004).

A key attribute of chronic illness is its incurability. How people adapt to living with chronic illness has been the topic of many studies. The author of the well-known book *On Death and Dying*, Kübler -Ross (1969) developed a model to delineate the emotional adjustment to grief in five stages: denial, anger, bargaining, depression, and acceptance. Continuing her work with terminally ill HIV/AIDS patients, Kübler-Ross (1987) argued that denial was expected of the grieving for a short period, but if they failed to attain the stage of acceptance, the grief was pathological. This view, however, has since been questioned by others who believed that labeling would make it a self-fulfilling prophecy, especially in the case of the chronically ill who had fragile and shifting sense of identities (Kelly, 1992; Mendelson, 2006). Introducing the shifting perspectives model of chronic illness, Paterson

(2001) sought to open the dialog between health-care professionals and patients in an environment of accepting patients' limitations and losses and supporting their perspective, which was shaped by their socio-cultural and psychological situations.

Corbin and Straus (1998) worked for more than 30 years grounding their findings in the data of people with chronic disabling conditions. They produced a model with the premise that even if the course of the disease cannot be modified, the illness course can be shaped and managed, and thus, the patients as well as the health providers had a role in it. The model identified three dimensions of person's life course: body, biographical time, and concepts of self. This "biographical work" as they called it, aimed to restore the link between these three dimensions and were elucidated in four stages: (a) incorporating illness trajectory into biography; (b) arriving at some degree of understanding and acceptance of biographical consequences of failed performance; (c) reconstructing a new feeling of wholeness around the limitations; and (d) giving new directions to the biography. This trajectory followed the phases of pre-trajectory, trajectory onset, stable, unstable, acute, crisis, comeback, downward, and dying (Boeije & Duijntee et al., 2002; Burton, 2000; Corbin, 1998; Corbin, 2003). Arthur Frank (1998), in a similar vein, stated that when peoples' lives were disrupted by chronic illness, they struggled to maintain their identity by forming narratives of restitution, chaos, and quest, which enabled them to gain a sense of what was happening to them.

Coping theorists concentrated on elements that aided and/or hindered those in stressful and disconsolate situations. Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p.

141). Although it is beyond the scope of this study to survey theories of stress and coping, it can be said that research on coping converges on several types of adaptation: (a) coping associated with regulation of distress and the management of problems that cause the distress; (b) coping linked to appraised characteristics of the stressful context and its controllability; (c) coping influenced by personality dispositions such as neuroticism, extraversion, or optimism (Kilburn, & Whitlock, 2011); and (d) coping aided by social resources. Literature is replete with research on the role of social support as a resource in coping in a stressful situation (Jackson et al., 2009; Klauer, Knoll, & Schwarzer, 2007; McCabe & O'Conner, 2012; Rodin & Salovey, 1989; Sarason, Sarason, & Pierce, 1990; Schwarzer & Leppin, 1989; Veiel & Baumann, 1992). Research also shows that whenever patient efforts focus on "meaning", it involves drawing on values, beliefs, and goals to give a personal response to a stressful situation. Examples of chronic conditions that have been researched to show such a link between coping and value identity include rheumatoid arthritis (Bartlett et al., 2003); depression in diabetes (Kilbourne, Cummings, & Levine, 2009) ; fibromyalgia and chronic pain (Moreira-Almeida & Koenig, 2008); AIDS (Tuck & Thinganjana, 2007); and cancer (Whitford, Oliver, & Peterson, 2008).

Chronic Illness and Spirituality and/or Religion

Religion or spirituality has been associated with meaning-focused coping (Baldacchio & Draper, 2001). Ample evidence in the literature points to spirituality's positive impact on mental and physical health (Johnstone, Glass, & Olivier 2007; McIntosh, Poulin, Silver, & Holman, 2011; Koenig, 1995; Landis, 1996; Fehring, Miller, & Shaw, 1997; Burton, 1998; Mathews et al., 1998). The potential link has sparked great interest for over two decades in understanding the role of spirituality or religion (or both) in health (George, Larson, Koenig,

& Mccullough, 2000; Johnstone, Glass, & Oliver (2007). The Journal of Rehabilitation and The American Psychologist published special editions on the topic in 2001 and 2003, respectively, and The Journal for the Scientific Study of Religion has existed since 1961. Since then new journals focusing on spirituality in various fields have proliferated. However, a number of studies that discuss the link between spirituality and chronic illness point to difficulties in tracing the boundaries of the concept of spirituality (Dale & Hunt, 2008; Narayanasamay, 2004; Reed, 1992; Swatzsky, Ratner, & Chiu, 2005). Opinions on what constitutes spirituality or religion and how the two are related vary widely (Delgado, 2005; McBrien, 2006; Newlin, Knaft, & Melkus, 2002; Tanyi, 2001). Some argue that spirituality is a search for the sacred and that religion refers to the social and institutional context in which the sacred search takes place (Pargament, Desai, & McConell, 2006). A concept that lacks a clear definition often leads each person to define it according to the meaning it gives within life (Gibson, 1991). An exhaustive survey of people's definitions of spirituality conducted by McSherry and Cash (2004) indicated that attempts to establish a theoretically universal definition of spirituality would be misguided.

How spirituality may help the chronically ill

Theoretical frameworks. Although my dissertation research does not follow any specific theoretical model of spirituality, an acknowledgment of several frameworks is given below: Nursing theories of Rogers (1990),Watson (2012), Leininger (2000), Reed (1991), Newman (1996), Roy (1976), and Parse (1998) refer to spirituality in various ways. Nurse researchers who study spirituality have mostly used models of Rogers, Parse, and Newman (Chiu et al., 2004). No single nursing model stands out as an all-encompassing guide for cross-cultural spiritual-care practice.

Coyle (2002) reviewed published literature to conduct a concept analysis to identify essential attributes of spirituality and to develop a framework that might facilitate understanding the link between spirituality and health. Another conceptual framework from the domain of psychology that attempts to encompass a wider religious/spiritual population is that of Gall, Charbonneau, Clarke, Grant et al., (2005). This framework uses the transactional model of stress and coping (Lazarus & Folkman, 1984) as its basis to integrate empirical literature on spirituality, coping, and health, and illuminates key spiritual constructs that may have a role in coping.

As an overview, with or without the guidance of a conceptual model, one can discern that, at least, three factors point to tying spirituality to positive coping in stressful situations such as living with a chronic illness. For example, spirituality provides a source of support and empowerment, directs the afflicted to a process of meaning-making, and emboldens the chronically ill to transform goals and priorities (Pargament, Desai, & McConnell, 2006). Although some studies show a general tendency for the chronically ill to grow closer toward the "divine", the contrary also is possible: In extreme trauma and grief, those who were previously religious can distance themselves from God with feelings of abandonment and being punished by God (Pargament et al., 2006).

Two fundamental limitations are apparent in the research mentioned so far. First, the majority of studies revolve around lay persons with chronic illness, and a paucity of information is available about chronically ill individuals, such as clergy of any faith, who have dedicated their lives to spirituality. Second, the overwhelming majority of this research has been in the context of religions that worship a supernatural deity (e.g., any of the Abrahamic faiths) or deities (e.g., Hinduism). It would be of interest to shed light on a

spiritually /religion that conditions the human mind to act as the therapeutic base. Buddhism

promises that. The Buddha was born human, lived as a man, and his life came to an end. He

was an extraordinary man (*acchariya manussa*), but he emphasized during his life that he

was only human and was no deity. Buddhism may have elements of religion and philosophy,

but it is not a faith devoted to a supernatural being that saves man. "The confidence placed by

a follower of the Buddha is like that of a sick person in a noted physician or a student in a

teacher" (Narada ,1982, p.8).

A Brief History of Buddhism

There is wide disagreement about the chronology of the events surrounding the

Buddha's life. The dates mentioned in this report are gleaned from a review article of a

symposium on the topic by Cousins (1996) and thus may provide only an approximation.

Since the enlightenment of the Buddha (around 548 BCE) and the completion of his 45-year

career of teaching the Four Noble Truths (to be described in detail later), Buddhism has gone

through several schools and traditions and has reached vast areas in Asia and beyond, and as

far as the West. Buddhist practices have strongly been influenced by the socio-cultural

aspects of the countries in which Buddhism has dwelled (Khema, 1998). A remarkable

characteristic of Buddhism has been its ability to adapt over centuries to various cultural and

historical situations without compromising its core insights. Buddhism continues to be of

interest to great many throughout the world (Donath, 1971; Habito, 2005; Rahula, 1978;

Snelling, 1999).

Theravada origins. Siddhartha Gautama, who later became known as the Buddha,

was born around 583 BCE in Northern India (today's Nepal) to a royal family and was raised

in luxury, shielded from human suffering because his father had heard a prophecy from a

holy man that someday the prince would leave all opulence in life to become a great spiritual leader. At the age of 29, however, the prince was exposed to the stark realities of old age, disease, and death during several sightings along the road and decided to renounce the world and become an ascetic. In search of truth to escape human suffering, Siddhartha followed in vain the philosophies of several well-known teachers of his era, and then for a period of time subjected himself to extreme ascetic tests of physical endurance, such as starvation and holding breath. He soon realized that he would not be led to liberation by renouncing extreme pleasure, as in his princely days, and accepting self-mortification. He settled, instead, on disciplining the mind through meditation. Through great mental prowess, the Buddha realized the Four Noble Truths: "suffering" or "insubstantiality" (*dukkha*); the origin of suffering (*samudaya*); the cessation of suffering (*nirodha*); and the way leading to the cessation of suffering (*magga*). He then elucidated the Eightfold Path to follow. These Four Noble Truths culminating in the Eightfold Path constitute the essence of the Buddha's teachings (Rahula, 1978).

After the death of the great teacher, 500 enlightened disciples (*arahath bhikkhus*) gathered to hold the first Buddhist council to recite the entire body of the Buddha's teaching. The teachings consisted of three major treatises known as *Tripitikaya* (three baskets): (a) the recitations of monastic code (*vinaya pitakaya*); (b) the recitations of *dhamma* or the word of the Buddha (*sutta pitakaya*); (c) the recitations of the higher teachings or the philosophical commentaries (*abidhamma pitakaya*). Only the first two were recited during the first Buddhist council, and the *abidhamma pitakaya* was recited later during the third Buddhist council. The entire Buddhist teachings, however, were not committed to writing until much later in around 35 BCE at the fourth Buddhist council in Sri Lanka. There, the teachings were

recorded in the Pali language on palm leaves and became the Theravada Canon (Habito, 2005; Rahula, 1978; Snelling, 1999).

Divisions and additions. The first schism among the disciples of the Buddha (*sangha*) was already apparent 100 years after the death of the great teacher at the second Buddhist council where congregants assembled to discuss the controversial points of the Buddhist monastic code (*vinaya*). At the time, the two principal schools of Buddhism were *Mahasanghika* and *Sathaviravadins* "way of the elders" (or in Pali, Theravada). The Mahasanghika school differed from the traditionalist in that the former was reluctant to accept *vinaya* and *sutta* as the final authority on the Buddha's teachings. These disagreements of the Mahasanghika sect later led to inclusions of the ideas of the transcendent nature of a Buddha, the "bodhisattva ideal", and the doctrine of s*hunyata*, or "emptiness." Around the first century BCE, the name Mahayana, or "great vehicle" was established to distinguish this divergent school from Theravada. Theravada is known as "Hinayana" or the "lesser vehicle". These names point to the distinction between Theravada's emphasis on individual enlightenment and the Mahayana ideal of the enlightenment of all beings. Moreover, at the time of the introduction of abidhamma pitakaya (higher teachings or the philosophical commentaries) many more disagreements resulted in the development of 18 schools, each with its interpretations of issues and spreading over India and Southeast Asia. The only surviving original Theravadan school today is in Sri Lanka (Donath, 1971; Habito, 2005; Snelling, 1999).

The variations between many schools and traditions can best be classified into three *yanas* (vehicles), namely Hianayana (or Theravada), Mahayana, and Tantrayana (or Vajrayana). Among the many variations within Tantrayana are the most known Zen and

Tibetan Buddhism which also have developed distinctive forms. (Donath, 1971;Habito,

2005; Snelling,1999).

Figure 1. **Sri Lanka and other Asian Theravada Buddhism countries**

Source: http://www.buddhanet.net/e-learning/history/thera_map.htm (Copyright: Public

domain)

   Early Buddhist medicine and attending to the ill. Long before the advent of the

term chronic illness, Buddhist medicine was based on the traditional Indian Ayurvedic

system that incorporated body and mind in its remedies. According to the Buddhist humoral

theory body health depended on the equilibrium of three entities: air/wind inside the body,

bile, and phlegm (Yamey & Greenwood, 2004). Early Buddhism was concerned with

physical health as an important condition for seeking spiritual health (Kitagawa, 1989).

Direct utterances from the Buddha in the scriptures with regard to illness and caring for the

sick included "He who attends on the sick attends on me." The Buddha has said that a good

nurse knew not only how best to attend to a patient's medicinal nutritional and physical care,

but also could stimulate the patient's mind with noble ideas. In one Pali canon, the Buddha is

reported to have mentioned that illness is an inevitable part of life, and when ill, all available

resources, even magical incantations, should be used to restore the patient's health (De Silva, 1994).

The Notions of Suffering and Healing in Buddhism

The psychology of Buddhism is based on the answers to questions such as, What are the causes of suffering? What is the way out of it? The therapeutic process that Buddhism advocates is more of a way of life than a form of treatment. Buddhist scholars (De Silva, 1984) bring ample evidence to the existence of an array of behavior modification techniques (other than meditation) in early Buddhist stories. These techniques include modeling and learning behavior, fear reduction by reciprocal inhibition, stimulus control, aversion therapy, rewarding and control of intrusive thoughts. Buddhist canons written in the ancient language of Pali teach that the Four Noble Truths of the universe are *suffering*, *cause of suffering*, *cessation of suffering*, and *the Eight-fold Path to annihilate suffering*. Buddhist philosophy explains that all phenomena in the universe are impermanent (*anicca*), bound to be unsatisfactory (*dukkha*), and devoid of a self (*anatta*).The idea of a self is an imaginary belief without corresponding reality, and it produces thoughts such as "me" and "mine" that in turn cause most of the trouble that exists in the world (Rahula, 1978; Varela, Thompson, & Rosch, 1993).

In *abhidamma pitakaya*, the higher teachings of the Buddha, there are no references to persons or objects as I, we, he, she, man, woman, tree, lake, etc. These are considered relative concepts, and these elements are analyzed and defined in terms of five aggregates (*khandas*) or instruments of clinging to the world: mind and matter (*nama-rupa*), sensations (*vedana*), perceptions (*sanna*), mental formations (*sankara*), and consciousness (*vinnana*) (Palpathwala, 2006). Those who are ignorant of these tools cling to existence, which is a

transient phenomenon that is subject to change and is laden with suffering (Palpathwala, 2006). The *dukkha* or suffering will continue with birth (*jati*), decay and old age (*jara*), and death (*marana*).

The Eightfold Noble Path taught by the Buddha describes a moral and responsible way of life and contemplative activities such as meditation that will lead to the ultimate insight. Following the noble path will transform ignorance into wisdom, which opens the door to the total liberation or emancipation called Nirvana. Nirvana is the state attained by the Buddha in his Enlightenment (Rahula, 1978; Varela, Thompson, & Rosch, 1993). However, one who is ignorant of the Four Noble Truths will undergo many births, which will bring about suffering.

Buddhism refers to two forms of illness: physical and mental ailments. All living beings, including the enlightened disciples (*arhants*) of the Buddha, were/are subject to physical illness from time to time. The majority of human illness, however, according to Buddhism, is caused by mental turmoil. Mental anxiety is rooted in three elements: *lobha* (greed, desire, craving, or attachment**);** *dosa* (anger, hatred, or ill-will); and *moha* (delusion or ignorance). Physical ailments may be cured, but mental ailments will prevail until the roots of passion animosity and ignorance are eliminated (De Silva, 2005). Buddhist logic follows that an unpleasant situation, regardless of its origin, becomes a cause of anxiety because of the person's lack of self-knowledge. In addition, a Buddhist conceptualization of therapy is not restricted to patients with behavioral disorders but is also for healthy people.

Thus, it follows that a man who grieves the loss of his mobility due to a protracted illness is in turmoil not because of his physical condition but because of the mental condition he creates for himself because he is not able to accept reality. He has yet to grasp the

concepts that all phenomena in the universe are impermanent and are bound to bring

unhappiness (Pitiduwe Mahathera, personnel communication, July 19, 2010). Many

Buddhists who suffer from illness such as cancer lament more for the people they leave

behind (Suranga Amarakoon, personal communication, July 22, 2010). Buddhist counselors

help such patients to understand the concept of non-self (*anatta*) by delineating how the

imaginary notion of "myself" produces feelings of possession such as "*my* property, and "*my*

children" and makes parting with them a tragedy. The Buddhist teaching that the notion of a

permanent self is a delusion paves the way to understanding that one finds his "true self"

when he loses his ego-filled permanent self (Palapathwala, 2006). Healing of oneself is a

relational and interdependent process (Shumm & Stoltzfus, 2007). The Mahayana Buddhist

concept of "*Bodisattva* quest" describes the spiritual value of healing others as the extension

of one's existence (Shumm & Stoltzfus, 2007).

Another salient aspect of Buddhist therapy is its nonspecification of the grieving

process. Buddhist thought does not identify with a task-oriented model of a grieving process

as in the West where a discrepancy between an actual and desired state is something to be

corrected (Wada & Jeeseon, 2009). In Western thought, the human experience of suffering,

which is part of life, is reduced to a condition to be managed (Palapathwala, 2006). In

Buddhist therapy, the illness and patient are placed in their existential context (Obeysekere,

1989) in which suffering (*dukkha*) is universal.

Buddhist Spiritual Practice in Contemporary Sri Lanka

In Sri Lanka, (as in other Buddhist countries) Buddhism has assimilated into the

culture in a manner that is conducive to meeting the socio-cultural needs of the people by

complementing the "great tradition" of canonical Buddhism by the "small tradition" of

popular Buddhism with rituals and ceremonies (Kariyawasam, 1995). A brief description of

the repertoire of rituals and ceremonies in the Sri Lankan Buddhist socio-culture is given

below:

Personal worship. The most common type of offerings is flowers and lighted lamps,

(usually of coconut oil). Flowers and light are said to symbolize the Buddha's attainment of

enlightenment (blossoming) and the dispelling of the darkness of ignorance. Buddhists pick

the flowers of different colors and arrange them in a dish or small basket and bathe them in

filtered water before offering.

Another aspect of the homage is offering food and drink in front of a Buddha statue

corresponding to the time of the meal of the devotee. An example: milk-rice for breakfast and

rice and curry before noon accompanied by a hot or cold beverage. Burning incense sticks or

sweet-smelling camphor often are added to enhance the quality of the worship.

Image 1: **Buddha-puja**

Temples with shrines (*dagabas*) attract more devotees because the repository of *dagaba*

contains worshipful objects such as body relics of the Buddha, and articles used by the

Buddha. A separate shrine room (*vihara* or *buduge*), usually with walls painted with stories

from the Buddha life (*jataka kata*), houses the Buddha statue and often other statues such as

Buddha's disciples.
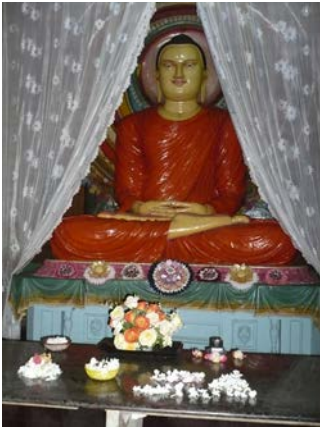
Image 2: *Buduge* (Buddha house)

Image 3: Painted walls of the Buddha house

Communal worship. In communal worship of the Buddha (usually on the full-moon day), the devotees stand in a row or a circle near the worship area and pass from hand to hand the items to be offered (flowers, food, incense, etc.) until these offerings reach the shrine room, *dagaba*, or the *bodhi-tree.* In some temples, a sonorous bell (*gantara*) is rung throughout the entire ritual process. A monk or a nun occupies the head of the line. Some larger temples have separate *devalaya* where various deities are offered above mentioned

Image 4: Communal worship on full-moon day

Image 5: Sonorous *gantara* (bell)

items and garlands. In such deity offerings, a hired professional for pleading to deities

(*kapurala*) is seen making the offerings on behalf of the worshipper.

  Bodhi-puja. Considered as a symbol of the Buddha himself, the worship of the

bodhi-tree (Ficus *religiosa*) is considered as a ritual of great merit. It was the tree under

which the Buddha attained enlightenment in Buddagaya, India. The Indian *Theri* Sangamitta

(a *bhikkhuni* who had attained the *arahath* stage, thus the honorific name "*theri*") brought a

sapling of the original bodhi-tree to Sri Lanka in the third century B.C. and planted it in

Anuradhapura in the North Central province. The veneration of the bodhi-tree has become

such a widespread ritual in Sri Lanka that no temple exists on the island without a bodhi-tree.

The tree on sacred grounds of Anuradhapura in the North Central province is considered to

be the oldest historical tree in the world for having survived for more than 2,200 years

(Kariyawasam, 1995).

Image 6: **Circumambulating the *bodhi*-tree**   *Image 7:* **Written pleas to deities**

    Another important reason for its popularity is the belief that the bodhi-tree is

associated with deities dedicated to the continuation of Buddhism. Thus, the logic follows

that pious worshippers are heard in times of their need. The ritual consists of offerings such as coconut oil lamps, other sort of lights, offering of flowers, milk-rice, fruits, medicinal oils, coins (tied in small bundles called *panduru*), and burning of incense. Banners (some with messages in the nature of pleas written on them) often are tied to the branches in the hope that wishes will be fulfilled. Another essential aspect of the ritual is circumambulating the tree several times with a small pot of water to bathe the tree. Appropriate stanzas (*gathas*) are recited to the tree, and the conclusion of the ritual merits are transferred to the deities, who protect the Buddha foundation (*sasana*).

The origin of these rites can be traced to utterances of the Buddha himself, while others have roots in folk religions (Kariyawasam, 1995). For example, although Buddhism does not recognize an all-powerful God who created the world, various sorts of supernatural beings such as *devas, brahmas, gandharvas,* and *yakshas*, are mentioned in the Pali Canon. Since Buddhism originated in India, it is believed that the deity worship of early Indian Buddhism (influenced by Hindu mythology and other ancient practices in India at the time) expanded to other areas, such as Sri Lanka. In the Buddha era, it was widely believed that *devas* (deities or benevolent supernatural beings) could help one achieve mundane benefits, and as a consequence *deva* worship was prevalent. The Buddha did not promote praying to *devas*; rather he taught to share one's merits with them to gain their help. In Buddhist belief, *devas* are not agents of salvation (e.g., they cannot help one attain nirvana), but they can be helpful to achieve mundane aims (Bhikkhu Bodhi, personal communication, Feb 29, 2012; Kariyawasam, 1995). Another point of view about the proliferation of deity worship is the power of politics. Malalgoda (1976) points out that using Buddhism to legitimize political power has been in existence in Sri Lanka from as early as the second century during Hindu

invasions to the independence movement in the 1940s. Winslow (1984) adds that in addition to Buddhism serving political ends, political developments have affected Sri Lankan Buddhism. Pointing to the territorial specificity of the pantheon of deities in Sri Lanka, Winslow (1984) argues that the deity worship may very well have an effect upon the nature of local-level territorial integration of the nation.

Kathina pinkama. Another significant ritual is *kathina* or *vas* to denote the rainy season retreat for ordained monks (*bhikkhus*) and nuns *(bhikkhunis)*. Lay Buddhists believe supporting the clergy during the rainy season is one of the highest sources of merit, and the Buddhists express their devotion with special enthusiasm. The retreat continues for approximately four months and corresponds to the north Indian Rainy season (from full-moon of July to the full-moon of October), as instituted by the Buddha himself. The monks and nuns avoid all travel and stay in their temples during this time. The *kathina* ceremony is conducted on different days during the last month before the full moon of October.

Image 8: **Drummers of procession**   *Image 9:* **Attendees of *vas* retreat**

The main event of the ceremony is offering a special robe known as the *kathina-civara* to the head clergy of the temple; the robe is brought to the temple with great fanfare, such as drumming, decorated floats, and devout worshippers in a procession that goes around the

village in the early morning. A *pirit* chanting (protective or purifying chants) ceremony is

conducted throughout the previous night, and Buddhists zealously anticipate the procession

to touch the special robe, which they believe brings great salutary effects (Kariyawasam,

1995).

On the front of meditation or reflective activities (*bhavanas*), the most common types

of meditations are compassion meditation (*metta bhavana*), meditation on the revulsion of

the body (*pilikul bhavana*), and contemplation of virtues of the Buddha (*buduguna bhavana*).

As for mindfulness meditation mentioned in the introduction, a complete treatise known as

sattipattana sutta is devoted to the study of this practice. The term familiar to many

Westerners *vipassana* literally means "insight knowledge" and, according to the *sattipattana*

sutta, this is gained through gradual passing through the four-fold foundation of mindfulness

(*passana*) known as mindfulness of bodily processes (*kayanupassana*), mindfulness of

sensations (*vedanupassana*), mindfulness of thoughts (consciousness; *chittanupassana*), and

mindfulness of mind objects (*dammanupassana*). Each of these contemplation types is

further divided into detailed objectives and thus produces a complex exercise that is ideally

suited for ascetics who have renounced the world. Sri Lankan lay Buddhists practice only a

small part of its first foundation, the previously mentioned *pilikul bhavana* or the

contemplation of various forms of repugnance of the body. This practice is expected to lead

to accepting the unsatisfactory nature of body (*dukkha*) and the lack of control or non-

selfness (*anatta*) of the body (Obeysekere, 1989).

In the context of the role of lay Buddhist spirituality in chronic illness, the following

scenario can be imagined: The rites and ceremonies help the patient to renew her hope for

improving conditions, but it always happens against the backdrop of the three fundamental

phenomena of existence, which are impermanence, dissatisfaction, and non-self. If all minor forms of healing rites fail, the patient surrenders to the ultimate nature of life. Referring to socio-cultural adaptations of classic Theravada Buddhism from a religion devoid of divinity to include easily consumable elements of folk religions (e.g., pleading to supernatural powers when in need), Obeysekere (1989) writes to the effect that to the Buddhist masses, the Buddha functions as the "super deity" while all other supernatural beings worshipped are "smaller deities" (p. 129).

A major gap in the literature on Buddhist spiritual practice, health, and illness is its lack of focus on contemporary Buddhist clergy. What constitutes their Buddhist spiritual practice? Do they subscribe to the great canonical tradition of Buddhism or does popular Buddhism serve their needs better? How different or similar is the path they follow from that of the great disciples of the Buddha? What role does Buddhist therapeutics play in their chronic illness? The role of Buddhist spiritual practice in the experience of chronic illness of Buddhist clergy is a topic that has yet to be studied in Sri Lanka.

A Brief History of the Role of the Sri Lankan Buddhist Nun

The three refuges of Buddhism are named as the Buddha, *Dhamma* (Buddha's word) and the *Sangha*, the community of ordained Buddhist monks (*bhikkhus*) and nuns (*bhikkhunis*). The Sangha is responsible for maintaining, translating, advancing, and spreading the teachings of the Buddha (Rahula, 1978). The establishment of the bhikkhuni order in Sri Lanka took place in 307 B.C by the arrival of the Buddhist bhikkhuni Sangamitta, the daughter of the emperor of Ashoka of India (Goonethilake, 2010), who was credited for dispatching many Buddhist missions to other nations.

According to historical reports, the bhikkhuni order in Sri Lanka attracted many women who gained a prestigious reputation as religious teachers and followers of the Buddha. In addition to the religious activities they carried out within the island nation, they were reported to have functioned as the missionaries of Theravada Buddhism to China in the sixth century, which then spread to other Southeast Asian countries, such as Korea, Japan, Taiwan and Vietnam (Andrews, 2011; Bartholomeusz, 1994; Goonatilake, 2010).

The Sri Lankan order of Buddhist clergy, however, collapsed in the 11th century during the South Indian (*Chola*) invasions into Sri Lanka. The Cholas destroyed monasteries and killed many monks and nuns although some survivors fled to Burma. When the Cholas were defeated in the late 11th century, the order of monks (*bhikkhus*) was re-established by the intervention of Theravada Burmese monks (possibly the Sri Lankan monks who had escaped to Burma), but the bhikkhuni order became defunct (Goonatilake, 2010). According to the Buddhist monastic rules 10 bhikkhunis and two bhikkhus of the Theravada tradition are necessary to ordain a nun (Bartholomeusz, 1994; Goonethilake, 2010; Bhikkhu Bodhi, 2010). These numbers (10 nuns and two monks) may vary depending on whether Buddhism and *bhikkhuni sangha* are well established in a country (Bhikkhu Bodhi, personal communication, Feb. 29, 2012). No satisfactory explanation can be found to explain why the bhikkhuni order was not re-established with the help of Burmese nuns. Currently, no order of ordained Theravada nuns exists in any Buddhist country, and therefore, orthodox monks argue, it no longer is possible to ordain a nun in the Theravada tradition.

The re-emergence of the Buddhist nun in the form of a "lay nun," to borrow a term from Bartholomeusz's (1994, p.10) comprehensive study of Buddhist nuns in Sri Lanka, was a response to the political and nationalistic fervor of the late 19th and early 20th century

Sri-Lanka to revive Buddhism. Christian missionary activities were rife during the British colonization of the country. The fear of disestablishment of Buddhism and the Buddhist national identity were very much alive in the minds of Western-educated Sri Lankan elites who acted to merge the boundary between the laity and ordained clergy to ground a form of religious protest to counter foreign influences (Bartholomeusz, 1994; De Silva, 1977; Gombrich & Obeysekere, 1988; Perera, 1988).

These nonordained "lay nuns" or *dasa-sil-matas* observe 10 Buddhist precepts as opposed to ordained bhikkhunis, who keep 311 rules of the female Buddhist monastic code in addition to the above 10 precepts. Despite the strict monastic regulations of ordaining Buddhist nuns, since 1988, Buddhist world renunciants (those who have resigned from the worldly activities such as being attached to a family and property, creating income) have taken alternative paths to achieve ordained status in the West, either in association with the Mahayana tradition or in Sri Lanka under the tutelage of Sri Lankan Buddhist monks who possess a more liberal and accommodating attitude toward women's roles as Buddhist clergy. (Bhikkhu Bodhi, 2010; Bartholomeusz, 1994; Wijayasundara, 1999).

Thus in Sri Lanka today, the translation of the term "Buddhist nun" yields two categories of religious women associated with the Theravada Buddhism, namely dasa-sil-matas or bhikkhunis. For the purpose of this study, the activities of the contemporary Sri Lankan Buddhist nun, ordained or not, do not differ significantly save for few exceptions (i.e., bhikkhunis refraining from cutting plants that grow, such as onions or flowering plants that produce seeds, and practicing a form of ritual confession every month).They coexist, but do not mix, and Buddhist nuns, in general, participate in furthering their knowledge of the Buddha's word, function to preserve and spread the Buddha's word, perform meditational

and devotional activities, and attend to social services that pertain to the lives of the laity in their communities. The arguments for and against the ordination of Sri Lankan Buddhist nuns, however, generate heated debate in contemporary Sri Lanka.

The question of ordination for Buddhist nuns. The current status of the Buddhist nun in Sri Lanka is entangled in issues of gender and power, which are largely ignored or buried by Sri Lankan politicians and orthodox Buddhist monks. "The ambiguous status of Buddhist nuns is currently located in a politics of representation that continues to both include them as members of a renunciant Buddhist community and distance them from it" (Salgado, 2004, p. 951). The majority of Buddhists in Sri Lanka are unaware of the depth of the conflict, while lay nuns and educated, ordained Buddhist nuns have strong viewpoints of the topic.

The current "lay- nun" or dasa-sil-mata conforms neither to the cultural role model of wife and mother nor to that of the fully ordained renunciant, although she tends to almost the same functions as an ordained nun in Sri Lankan society. She has left her family, property, social circle, and other conveniences in life. She has shaved her head (unthinkable to most Sri Lankan women who value long flowing hair), and she leads a celibate life. Her saffron robe symbolizes her as a religious ideal. It has been argued that the Sri Lankan government and the orthodox monks are responsible for seeing that ordination is a difficult goal for nuns (Mrozik, 2010). Buddhist clergy (monks and nuns) are totally dependent on the community for their sustenance. Some monks may fear that affording Buddhist nuns the same ordained status as monks would lead to competition for support and privileges. The government tends to favor the interests of orthodox monks who are most respected by the population and have a strong political voice. According to Mrozik (2011), the government is funding monastic

schools (*pirivenas*) for monks, and dasa-sil-matas whereas bhikkhunis have no government-funded monastic schools because they are considered "invalidly ordained" by orthodox monks and the government.

The majority of dasa-sil nuns I have met maintain that it is not necessary to be ordained to attain the ultimate goal of the Buddhist, nirvana. They consider their renouncing the world and entering the Buddhist religious order as tantamount to ordination. These women also see some of the 311 monastic rules as impractical under their humble living conditions (e.g., not destroying any living thing; even a part of a plant would be violated if, for example, one were to cut, an onion or break open a coconut (DeGraff, 1994, Kusuma, 2003). Dasa sil nuns also disagree with the ordained nuns' contention that the government should support them in any manner except for funding mass entities such as training schools, which they argue, ordained nuns also could attend. Ordained nuns argue that dasa-sil nuns are at a disadvantage because they do not have the same religious education as the monks, and as such their services to the community are inferior to that of monks. This, they argue, leads Buddhists to prefer supporting monks rather than nuns as a means to attain merit for a better future (or birth the next time around). The dasa-sil nuns counter this argument by saying that any individual nun can learn the Buddha's word, follow the path illuminated by him, and be an example to the community, which helps build a devoted community around her.

As for the Buddhist public, the majority are unaware of this ongoing conflict over ordination. Many with whom I talked were unsure of even the term "ordination" (*upasampada*), and explained that what mattered to them was that the nun was devout, knew the Buddha's word, and delivered a good sermon at social functions. Their words confirmed

one dasa-sil nun's statement: "in a devout Buddhist country like Sri Lanka, every nun would be taken care of if she proves to be worthy" (Kesbewa dasa-sil mata, personal communication, July 17, 2010). I have come across several Buddhist nuns (both bhikkhunis and dasa-sil matas) in destitute conditions, (one very ill). Therefore, it remains to be seen whether ordination plays a role in the correlation between Buddhist spiritual practice and chronic illness.

Notwithstanding the debate on merits of ordination, Buddhist women have reclaimed their right to dedicate their lives to follow a religious path and to be the female guides of the Buddha's word, a role that since the Buddha era had liberated women from household drudgery and demands of tyrannical husbands and in-laws.

Research on Buddhism-based Spiritual Activities and Chronic Illness

It follows from the discussion thus far that Buddhist spiritual practice varies widely throughout the world. The immigrants who brought Asian forms of Buddhism to the West continue their practices, and new Western forms thrive in their environs. However, the studies conducted to explore the potential benefits of Buddhism based spiritual practices in the West revolve predominantly around mindfulness meditation. In a large array of research literature the terms, "mindfulness meditation", "mindfulness based stress reduction (MBSR)" and "*vipassana* meditation" appear repeatedly. Many organizations, university courses, self-help books, journal articles, and electronic websites promote mindfulness meditation to help reduce negative thinking and habits and to increase positive experiences. Often the terms mindfulness and *vipassana* are interchangeably used and associated with Buddhism although the practitioners may not necessarily identify themselves as Buddhists. Mindfulness as

understood in the West differs from that in the East. However, to begin with the similarities, the definition of mindfulness is the same in the East as in the West.

Mindfulness is the nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise (Chah, 2002; Kabat-Zinn, 1990, 1994; Linehan,1993; Marlatt & Kristeller, 1999). The manner in which thoughts are nonjudgmentally examined may differ slightly according to the application of mindfulness in the West. The most well-known and most-often cited, intervention is the mindfulness based stress reduction (MBSR) introduced by Kabat-Zinn (1990). In MBSR, mindfulness is practiced through a set of exercises (body scan, sitting/breathing meditation, walking meditation, and imagery such as mountain meditation, and Hatha yoga).

Mindfulness based cognitive therapy (MBCT) (Segal, Williams, &Teasdale, 2002) is influenced largely by mindfulness based stress reduction (MBSR), and its practice facilitates clients to gain a detached view of their thoughts. For example, according to Segal et al., the client is trained to observe his emotions as falling leaves with each leaf carrying a label of his emotions. The objective is to practice recognizing the emotion briefly, not getting involved in it, labeling it, letting it pass and observing the transient nature of it and being able to realize, "I am not my thoughts" (pp. 244-258).

In dialectical behavior therapy, mindfulness is practiced within a slightly different context of acceptance and change (Linehan, 1993). Clients are trained to learn three kinds of "what" skills – observe, describe, and participate – and "how" skills – non-judgmentally, one-mindfully, and effectively – under the supervision of the therapist (McKay, Wood, & Brantley, 2007, pp. 66-101).

Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999) includes exercises that are consistent with mindfulness. Clients would learn to separate the essence of their negative thoughts that have a permanent base in their existence. According to Hayes et al., a successful training session would help a client realize something similar to "I am having the thought that I am a bad person" rather than "I am a bad person" (pp. 148-177). Other interventions such as relapse prevention (Marlatt & Gordon, 1985) include mindfulness meditation as a part of their package of therapies to prevent a relapse of substance abuse.

Research literature is replete with studies using mindfulness meditation in the West. Even though many such studies are believed to have methodological flaws (Baer, 2003), evidence seems to point in the direction of a correlation between mindfulness practice and improved health outcomes. Although it is beyond the scope of this paper to go into details of such research, it is worth mentioning at least some of the domains of this research:

Anxiety: MBSR intervention improved scores in physical and mental health (Reibel et al., 2001).

Cancer: Overall 65% reduction in total mood disturbance and 31% reduction in stress symptoms (Carlson, Ursuliak, Goodey et al., 2001).

Chronic pain: Patients who failed to respond to other interventions ameliorated mood disturbances and total pain rating, and a four-year study showed patients maintaining their improved status (Kabat-Zinn et al., 1987; Randolph, 1999).

Fibromyalgia: Following eight-week intervention outcome measures showed significant reductions in pain, fatigue, sleeplessness, and improved function, mood

and scores on the sense of coherence scale (Astin et al., 2003; Baetz & Bowen, 2008; Singh et al., 1998; Weissbecker, 2000).

Psoriasis: Thirty seven patients who listened to MBSR tapes (without participating in a regular course) during their light therapy sessions showed a four-times higher rate of clearing of skin lesions than the control group (Kabat-Zinn et al, 1998).

Recurrent depression: The addition of MBCT, which integrates aspects of MBSR, halved the risk of relapse in patients with history of three or more past episodes (Teasdale, 2000).

It was pointed out earlier that mindfulness had the same definition in the West as in the East. Similarities, however, seem to end there. In Eastern Buddhist thought mindfulness is a way of living in which meditation is only one important part (Chah, 2002). In current popular understanding and practice, mindfulness and vipassana often are equated and used interchangeably. But the main issue is that the concept of mindfulness as currently used in the Western context is void of the essential central Buddhist element of *anatta* (nonself or no soul). In traditional Eastern Buddhism, the notion of nonself is related to the idea of impermanence (*anicca*) and suffering (*dukkha*). *Anatta* or nonself offers the basis for the nature of true self, which enables one to understand human life and its stages—birth, youth, maturity, old age, and death—in perspective so that these stages become the foundation for a meaningful spirituality (Palapathwala, 2006). In contrast, Palapathwala (2006) argues that in contemporary Western society, the idea of self is equated with identity in a broad social context of consumerism, mass culture, politics, and gender.

Background to the Methods Used in this Dissertation

  Overview of methods. In the first and second chapters I aimed to clear a path toward the phenomenon that I would like to study in this dissertation, namely the role of Buddhist spiritual practice in the lives and health of Sri Lankan Buddhist nuns living with a chronic illness. In the third chapter I discuss how I intend to explore that phenomenon to a level that will enable me to describe it to my reader. This search, if I may borrow a phrase or two from Atkins Atkinson (2005), should be faithful to the phenomenon under investigation by incorporating the forms and media through which cultural beliefs are enacted, encoded and transmitted. My search for a method led me to the qualitative research area of ethnography, a domain that encompasses variety of forms and specific methods. My decision to select ethnography was most influenced by the need to strike a balance between creating a product that promoted "a way of knowing" for the discipline of nursing, and also provided potentially usable information to audiences beyond nursing. At the forefront of this latter group stood the Sri Lankan Buddhist nuns and other stakeholders (not excluding health-care workers) who in some manner influenced the welfare of these nuns and in return were influenced by these nuns.

  Having pre-identified a specific question to investigate, I called my work a problem-focused (or particularistic) descriptive ethnographic study. In the attempt to ground my findings in the representations of socio-cultural life of Sri Lankan Buddhist nuns, I was most influenced by the recursive and iterative ethnographic research style of Spradley (1979, 1980), which seemed uniquely suited for this study because it enacted a rigorous systematic analysis of the language being used. Spradley's method encompassed participant observation, asking descriptive, constructive, and contrasting questions, and made domain, taxonomic,

and component analyses to discover cultural themes. However, I chose to adapt only the first two aspects of the Spradley data reduction method (1979, 1980), namely, domain and taxonomic analysis, for my study because they can provide sufficient leads for me to identify cultural themes and they allowed me more flexibility for interpretation. To present my interpretations clearly to an inquiring audience, I chose to supplement my analysis with a visual template. A visual matrix facilitates evaluation and dissemination of findings (Averill, 2002; Miles & Huberman, 1994). Adding a second method also contributes to enhance the rigor and trustworthiness (Lincoln & Guba, 1985; Farmer, Robinson, Elliot, & Eyles, 2006) of this study through method triangulation. I also selected other triangulation forms (data sources, data collection, analysis methods, and interpretation), prolonged association, and member checks to further address the rigor of this study. On the same theme, I made a concerted effort to adhere to the norms of reflexivity recommended for an ethnographer studying the culture in which she spent her formative years.

Qualitative Research

As I discussed earlier, the definitions of chronic illness, Buddhist spiritual practice and explanations of how people coped with chronic illness fell into a nebulous territory. As such, finding an explanation through quantitative instrumentation would not have suited this study because it would have accounted for neither an objective nor a fair reality for these nuns' lives.

Approaching fieldwork without predetermined categories of analysis allows for openness and for detailed inquiry to understand the world as seen by the respondents either through their own words or in written form, or through direct observation by the researcher. Qualitative inquiry leads to exploration and discovery by means of an inductive logic and

methodology to facilitate studying a topic in depth from the perspectives of participants. Though qualitative inquiry covers a range of approaches, three common threads – naturalistic inquiry, holistic outlook, and inductive analysis – bind all these forms. The degree to which all three characteristics appear may depend on the research purpose, situation and questions, and on the theoretical orientation of the researcher. One caveat, however, is that regardless of the genre of qualitative inquiry, the researcher is the instrument in qualitative research, and it requires her to carefully reflect on, and deal with potential sources of bias and error in her work (Creswell, 2003; Patton, 2002).

Advantages, Innovations, and Limitations of Spradley's Ethnographic Research Cycle

Of all the qualitative methods available, I chose Spradley's ethnographic research cycle (1979, 1980) for my study for a number of reasons. First, it provides a systematic and rigorous approach to classify data, which as I argue below, will be beneficial to this study. Although grounded theory (GT) is known to bring a systematic approach in qualitative research, Spradley's method (1979, 1980) leads the researcher to ground her findings in the data to reach cultural themes without the rigidity required in GT to generate a theory. Spradley's ethnographic method, though rule-based at the beginning can be adapted by the researcher to allow more flexibility required for interpretation. Ethnography has its philosophical roots in ethnological anthropology (Hammersley & Atkinson, 2007) and thus Spradley's method aims to capture the emic aspect of the culture by allowing participants to describe their own reality in their own terms.

Second, belonging to the genre of cognitive ethnography of the 1960s, Spradley moved away from the Malinowskiesque (1922) requirement to spend extended periods in a foreign culture as a participant observer "to grasp the native's point of view, his relation to

life, to realize his vision of his world" (p, 25). Instead, Spradley regarded ethnography as a systematic process to define structures in which people have organized their point of view. One's point of view can be captured in a shorter time, though still with intense involvement. This makes it a more pragmatic approach when time constraints exist for field work. Although other ethnographic methods may allow analysis in a short duration of time, Spradley's (1979, 1980) method has other unique aspects useful to my study. For example, he argued that discovering an insider's view by an outsider calls for a "conscious attitude of almost complete ignorance" by the researcher to avoid describing one's social life in terms and concepts known to the researcher. This concept is vital to my research because I have ventured to study the culture into which I was born and in which I spent my formative years. A systematic approach would discipline me from taking things for granted and jumping to conclusions.

Third, linguistics is of utmost importance to this study. Spradley (1979, 1980) gives intense attention to the semantics and syntax of the verbal message, and to hidden connotations of the language because he defines the essential core of ethnography as understanding the meanings people give their actions and events. His specific methodology to acquire this knowledge of people includes techniques such as taxonomies of words and semantic analysis. Spradley's early work was criticized as following an ethnoscience approach that concentrated on attributes of concept rather than on connotation (Brink & Wood, 1988; Field & Morse, 1991). However, Spradley's work in 1979-1980 added ample contextual information from the informants' perspectives. For example, he identifies several language principles (more of which will be discussed in ethnographic record section), such as "language identification principle" to clearly notice the language that should go into each

entry, "verbatim principle" to maintain a verbatim record to avoid interpreting an informant's phrase solely as understood by the researcher, and "concrete principle", not to generalize, but to extend the events using specific details. All of these language aspects are important to my study because the primary participants, the Buddhist nuns fall into a specific group whose parlance is strewn with phrases from ancient Indian languages such as Pali and Sanskrit, which are different from Sinhala, the local dialect of the majority of Sri Lankans. Moreover, after a woman has entered a religious path, she uses a new set of verbs to denote her actions. For example, the verb "to sleep" to a lay person is "*nidagannawa*," but to a nun or monk it is "*sethapenawa*," connoting respect for the actions of the new person she has become. Moreover, nuns pack their speaking with metaphors that have meanings that are not to be taken at their face value.

Fourth, contrary to critical theorists' (Habermas, 1984, 1987) arguments that Spradley's method assumes noninvolvement of the researcher, she who follows Spradley is not restrained from going beyond rule-based linguistics to create rich descriptions and to interpret findings. For example, taxonomies are not automatically generated by data; rather the researcher has a role in building taxonomies. A close reading of Spradley's work (1970, 1979, 1980, 1988) demonstrates that his methods, despite rule-based aspect, nonetheless produce "thick descriptions" of human behavior (Geertz,1973), a hallmark of ethnographic analysis. Spradley's insistence on combining interviews with observations as many times as necessary to narrow on a situation fills the findings with details necessary for an understanding that is lacking in many qualitative methods that rely solely on the words from a single interview. Moreover, Spradley's writings in many ways coincide with those of critical ethnographers who believe there is no single correct interpretation. For example,

Agar (2006) sees ethnography as iterative and recursive and proceeding through abductive logic aimed at understanding the context and meaning from the point of view of the participants, not of the ethnographer. Spradley held similar views of the purpose of an overall approach of ethnography. Agar (2006) argues that ethnography is abductive instead of deductive or inductive in its basic mode of logical reasoning. Abduction is necessary to produce hypotheses that may account for the observed data. The ethnographer has to look at repeated themes interactively within data before advancing to any hypothetical explanations. This raw material the ethnographer finds, Agar calls "rich points", or "surprises" which the ethnographer pursues iteratively.

Agar (2006) points out that the iterative abductive ethnographer is not dependent on an interview guide. He writes, "Do a couple of interviews, then obsess about them, then change the interview guide, then do a couple more, and on it goes." This is similar to what Spradley (1979, 1980) recommends for the ethnographer. An ethnographer comes into the field without a theory, aims to ground her findings in the data, and then tries to collect answers to her initial questions through participant observation and casual conversation. The ethnographer does move from initial descriptive questions through constructive questions to ask contrast questions as they develop in the field through the words of the participants. Along with the advice not to describe the context and meaning of the rich points from the ethnographer's point of view, Agar (2006) reminds the reader that even this new and different context and meaning may not be static because there are "infinitely expandable answers to the questions." Although Spradley (1979, 1980) does not refer to a concept of "multiple reality" as Agar does, Spradley does say that no ethnography is complete because

each describes a social situation at a certain point in time. Like Agar (2006), Spradley (1979, 1980) believed one site can bring many ethnographies.

The argument of structuration theorists' that relationship between culture and the individual is recursive and that individuals are not necessarily a manifestation of their culture (Giddens, 1990) has not been sufficiently addressed in Spradley's (1979, 1980) method. Hence it is up to the researcher to interpret the conceptualizations of individuals in her research as a recursive expression of individuals and culture. Finally, another salient aspect of Spradley's ethnography is the question of relevance of knowledge to the service of humankind. Spradley argued that the time has come for ethnographers to move beyond generating knowledge for the sake of knowledge, a notion that agrees with the philosophy of my research. In this sense, Spradley's work strikes a chord with more recent critical ethnographers such as Madison (2005), who discusses at length the ethical responsibility of the ethnographer to move from "what is" to "what could be" (p. 5). Distinguishing between subjectivity and positionality, Madison says ethnographers should move their focus from subjectivity relative to the participants to subjectivity relative to the audience to shift toward an enlightened and involved citizenship. In my research, I aspire to do this but with the understanding that little knowledge of complex issues can generate only activism rather than true meaningful change.

Problem-focused descriptive ethnography. It is said that ethnography is both a product and a method (Muecke, 1994). As a product, it is a work done by anthropologists or similarly trained researchers who create knowledge and possibly a way of knowing for its own sake. As a method, ethnography may be used by researchers or others who want to investigate a specific problem or a topic in a particular social, cultural, or organizational

context, whether or not it is feasible to spend extended periods of time to immerse in the cultural milieu. This type of ethnography is identified by various names by various authors, but seemingly converging on the same themes: shorter time involved in field work and the limited breadth of scope. For example Hymes (1978) used the term "topic-oriented ethnography" to indicate narrowing the focus to one or more aspects of life known to exist in a community and distinguished it from comprehensive ethnography and hypothesis-oriented ethnography. Knoblauch (2005) contrasted comprehensive ethnography conducted in a culture immersed in a protracted time period with a more time-limited (focused) ethnography. Mendelson (2006) characterized a focused ethnography as a genre within ethnography.

I called my study a problem-focused descriptive ethnography, giving the same significance that Spradley(1980) accorded to "doing a micro-ethnography" (p. 30). He stressed that the techniques of data collection and analysis were identical, whether one did a macro or micro ethnography. Exploring a single social situation with a more narrowly defined sample, (e.g., Buddhist nuns living with a chronic illness) was amenable to shorter, though still intensive, periods of immersion as opposed to more protracted immersion of a more comprehensive, broader based ethnography (e.g., health and illness in Buddhist Sri Lanka).

Theoretical basis of Spradley's (1979, 1980) approach. Spradley (1979, 1980) views culture as acquired knowledge and maintains that ethnography is the study of explicit as well as tacit aspects of the acquired knowledge. Ethnographic fieldwork attempts to distinguish between what people do, what people know, and the things people make and use. Spradley likens the concept of culture – acquired knowledge – to the theory of symbolic

interactionism, and refers to the three premises of Blumer (1962) on which that theory rests: (a) " human beings act toward things on the basis of the meanings they ascribe to those things" (b) "meaning of such things is derived from, or arise out of the social interaction that one has with one's fellows" (c) "meanings are handled in, and modified through, an interpretive process used by the person dealing with the things he encounters" (Blumer,1969, p.2). Spradley points out that making inferences is important to learning a culture and that we do so by observing what people do (cultural behavior) and things people make and do (cultural artifacts). Because language is the primary means of passing culture from generation to generation, a culture is encoded in linguistic form, and as such, speech messages also play an essential role in aiding to make inferences. Thus, both participant observation and interviews are significant to understanding a culture. Spradley (1980) defines ethnographic analysis as "a search for the parts of a culture, the relationships among the parts and their relationship with the whole" (P.116). Pursuing this search is a recursive and iterative process. From the stage of identifying the social situation (in this case, Buddhist nuns living with a chronic illness), the researcher proceeds in the following manner. She becomes a participant observer (in this case, in the lives of the nuns), takes field notes and makes ethnographic records, and then makes descriptive observations and asks descriptive questions. Descriptive observations and questions lead to identifying large units of cultural knowledge, which are called domains (described in detail in the data analysis section), which in turn, point to where the next focus should be in observations and how to structure the next interview questions. New field data gathered then leads to a taxonomic analysis of each cultural domain recognized in the previous step (details in the data analysis section). The taxonomic analysis helps narrow the focus further and points to selective observations and

specific questions to understand the contrast between similar items in the taxonomy. Next, the more refined data permit the formulation of themes. Thus, ethnographic data analysis begins with the stage of data gathering and continues until the final draft of the ethnography has been written. This process is shown in Figure 2.
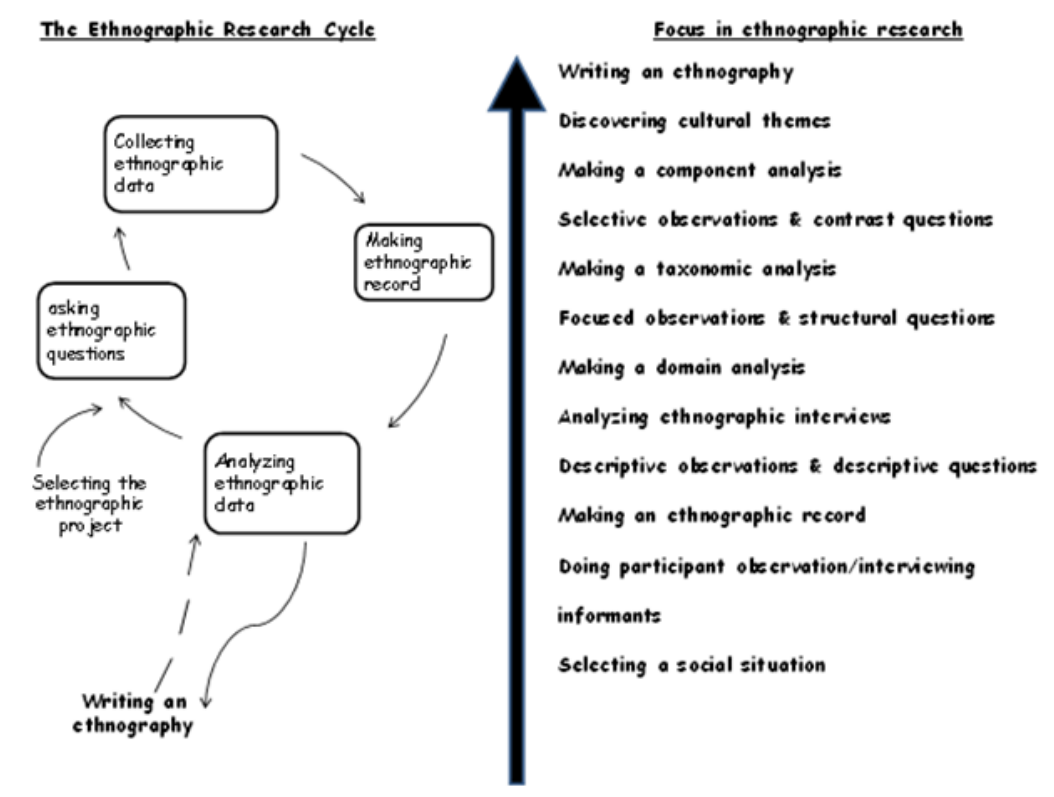
Adapted from Spradley (1980, p.29).

Figure 2. **Ethnographic research cycle and focus in ethnographic research**

Matrix analysis. Matrix analysis is a logical process of cross-classifying different dimensions of potential categories or domains of reduced data to detect relationships among these categories on a visual template. Matrices allow various ways of arranging data on the display, which can generate new insights about how data can be organized to look for

patterns that might not have been obvious in the initial inductive analysis. The flexibility, logic, and visual effect of matrix analysis are great assets not only in interpretation and pragmatic evaluation of data, but in the dissemination of results to an audience (academic or otherwise) by systematically layering evidence in a language easily comprehensible (Averill, 2002; Patton, 2002; Miles & Hubermann, 1994). Matrices can be descriptive or explanatory, can show outcome or process, and can be ordered partially, fully, two ways, three ways or multiple ways to represent single or multiple-case data (Miles & Huberman, 1994). An added advantage of using matrix analysis in this study is that it serves as a second method in triangulating with the method of Spradley (1989,1980), which will improve the rigor of the data analysis by strengthening the integrity of the inferences given from two vantage points (Farmer, Robinson, Elliot, & Eyles, 2006; Lincoln & Guba, 1985).

Use of reflexivity in qualitative research. The concept of reflexivity as used in qualitative research emphasizes an effort by the researcher to be self-aware of how she is located in a particular social, political, cultural, linguistic, and ideological context (Alvesson 2002; Patton, 2002). In general, reflexivity is supposed to improve the rigor of data collection and interpretation by way of accounting for the researcher's subjectivity and prior experience. Qualitative research based on an interpretivist paradigm maintains that reality can be seen as multiple and fluid, and as such knowledge is negotiated between the observer and participants, and researcher subjectivity is used actively and creatively through the research process. The researcher can articulate how the phenomenon in question is seen multiple ways by clearly delineating the research process, rich substance, and evidence of immersion and self-reflection (Cohen & Crabtree, 2008). Staying on the middle ground, Hammersley & Atkinson (2007) state

> The concept of reflexivity acknowledges that the orientation of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them. What this represents is a rejection of the idea that social research is, or can be carried out in some autonomous realm that is insulated from the wider society and from the biography of the researcher, in such a way that its findings can be unaffected by social processes and personal characteristics (p. 15).

Hammersley and Atkinson (2007) argue that reflexivity is inherent in all aspects of ethnographic research, from decisions about research design to participant observation and choices of questions and informants to the writing of the ethnography.

Against the backdrop of such knowledge, I would like to approach the two aspects that would be of greater importance to me in this study: first my professional training in public health and nursing, and second, my choosing to study the culture into which I was born and in which I spent my formative years. Both aspects revolve around previous knowledge leading to pre-assumptions. Pre-assumptions harbored by the researcher lead her not only to a lack of heightened curiosity to probe issues deeper but also to premature and inappropriate interpretations (Alvesson & Sköldberg, 2000).The nurse researcher, Arber (2006) points out that for inexperienced qualitative researchers their training in health-care fields can become an unconscious source of control over an interview. Nurses are trained to interview patients "paraphrasing sentences", "summarizing statements", which could appear as indicating closure and thus preventing interviewees from engaging in their natural train of thought. Arber (2006) recommends reflecting on the multiple identities the researcher brings to the research scene and bracketing her own experience. Addressing the second concern, as mentioned in the introduction, my familiarity with the culture can be an advantage as well as a hindrance. First and foremost is whether I can successfully develop "a conscious attitude of almost complete ignorance" (Spradley, 1979, 1980) about the culture into which I was born.

Thus, it will be imperative for me to critically reflect on my own assumptions and values that could color the study.

Researcher perspective on recognized sources of assumptions and the plan to handle them. I recognize several factors that might interfere with my attempts to maintain objectivity. First, I was born in a Buddhist country and spent my formative years in a practicing Buddhist family. Second, from an early age, I was conscious of the ambiguous position of women in that country, which had produced the first female prime minister to the world. During my undergraduate and graduate education in the United States, Germany, and France, I was exposed to feminist thought, and my many years of public health work in Africa, a continent on which women were disadvantaged in many aspects of life, I developed a feminist outlook toward the world.

Entering this dissertation with baggage, it will be necessary for me to refer to these facts repeatedly throughout this dissertation to guard myself against hastening to conclusions and settling into preset explanations. I will develop the habit of making daily entries in a reflexive journal, which is described below.

Reflective journals. Lincoln and Guba (1985) state that regular entries in a private journal could be cathartic: These entries could include methodological decisions, researcher's reasons for them, logistics of the study, and researcher's reflections on how research events react with her values and interest. Ortlipp (2008) writes reflective journals make it visible that research is not always a neat and linear process. Patton (2002) provides a visual template (as given in Figure 3) to help orient the researcher to the questions she should address in the reflective journal with regard to herself, participants, and the audience to whom the research will be presented.

Reflexive questions: Triangulated Inquiry

Those studied (participants)

How do they know what they know? What shapes and has shaped their world view? How do they perceive me? Why? How do I know? How do I perceive them?

Reflective Screens:
Culture, age, gender, class, social status, education, family, political praxis, language, values

Those receiving the study (audience)

How do they make sense of what I give them? What perspectives do they bring to the finding I offer? How do they perceive me? How do I perceive them?

Myself: (as qualitative inquirer)
What do I know? How do I know what I know? What shapes and has shaped my perspective? With what voice do I share my perspective? What do I do with what I have found?

Figure 3. **Reflexive questions: Triangulated inquiry**

Source: (Patton, 2002, p. 66, Copyright 2012 @ SAGE Publications Inc.)

Data Collection Methods

  Participant observation. The primary technique of data collection in the ethnographical method is participant observation, and it allows the researcher to be immersed in the culture (Fetterman, 2010; Savage, 2000). Participant observation allows the holistic and emic perspective, which helps to understand people's normalness without reducing their particularity (Geertz, 1973). The participant observer is different from being a simple observer or a regular participant in that the investigator maintains a dual purpose: She will participate and watch herself and others at the same time. She will seek to become explicitly aware of things a regular participant will block out to avoid overload (Spradley, 1980, p. 55). The participant observer will experience being both an outsider and insider at the same time; she also must approach her social life with a wide-angle lens to capture the broader spectrum of information (Spradley, 1980). In addition to participating and observing, she must engage in introspection about how she did things and how she felt about them.

  The types of participant observation vary with the degree in which the investigator wishes to participate. She could be a passive participant by not interacting to a great extent or to maintain a balance between being an insider and outsider and then participate moderately. When she chooses to become an active participant, she will do what other people will do not just to gain acceptance but to learn the cultural rules for behavior. Spradley (1980) adds that although active participation is not always feasible, even a limited use of it will contribute to a greater understanding of the culture. The final category – complete participation – refers to the highest involvement as when the investigator herself is an ordinary participant. A caveat, however, according to Spradley, is that the more you know about a situation as an ordinary participant, the more difficult it is to study it as an investigator.

The skills Bernard (1988) identifies as helpful for a participant observer include the ability to learn the people's language well (enough to use insider phrases), to be aware of details usually taken for granted, the ability to build memory to remember things than happen in the field and develop a method to jot them down, and the ability to maintain the naiveté to learn new things. Participant observation is advantageous in that it can give access to situations that otherwise may not be seen by an outsider. However, in the meantime investigator's presence, depending on her visibility at the scene, may alter the group dynamics or behavior of the individual.

Interviews. Interviewing generally involves obtaining responses to researcher's questions from participants and can take a variety of forms, including face-to-face individual or group interviews, via telephone or computer, and even adapted to be on paper. Interviews can be structured, semistructured, unstructured or informal, and each can suit different purposes. Fontana and Frey (1994) and Spradley (1979) consider these last two types as more beneficial in ethnographic situations. Regardless of the interview type, some factors that become barriers to communication include cultural and language differences (Meetoo, 2004, Squires, 2008), sensitive personal issues (Beale, Cole, Hillege, McMaster, et al., 2004) and topics associated with stigma (Harris & Roberts, 2003).

Spradley (1979) calls an interview "a speech event that has cultural rules for beginning, ending, taking turns, asking questions, pausing, and even how close to stand to other people" (p.55). He maintains that a skilled interviewer gathers most of her data through participant observation and many casual, friendly conversations. Introducing new elements to the conversation is a gradual process that does not give it a sense of an interrogation.

Rigor and Trustworthiness in Qualitative Research

The concept of trustworthiness connotes credibility and authenticity that qualitative research data interpretations can be trusted (Lincoln & Guba, 1985; Roberts, Priest & Traynor, 2006). It can be argued that traditional criteria for rigor, the concepts of reliability and validity, are not relevant in qualitative paradigm (Lewis, 2009; Roberts, Priest & Traynor, 2006). However, determining criteria to assure rigor in qualitative research has been subject to contention. Lincoln & Guba (1985) suggest credibility, transferability, dependability, and confirmability to ensure the rigor and trustworthiness of qualitative research. Some of the techniques they and other qualitative researchers (Farmer, Robinson, Elliot, & Eyles, 2006; Lietz, Langer & Furman, 2006; Mays and Pope, 2000; Morrow, 2005), suggest to ensure rigor include triangulation, prolonged association, respondent validation, clear detailing of methods of data collection and analysis, attention to negative cases and fair dealing. Morse, Barret, Mayan, Olson, and Spiers (2002) contend that these methods focus on the "tangible outcome of research (which can be cited at the end of a study) rather than demonstrating how verification strategies were used to shape and direct research during its development" (p.8) and thus are more useful to evaluate rigor rather than to ensure it. Morse et al., (2002) argue that the reliability and validity of an evolving study are determined by the creativity, sensitivity, flexibility, and skill researcher employs in verification strategies. Morse et al., (2002) recommend four verification strategies: methodological coherence (e.g. "question matches the components of method "(p. 12); theoretical sampling; collecting and analyzing concurrently; and thinking theoretically (e.g. "ideas emerging from data are reconfirmed in new data" (p.13).

Another school of thought understates the importance of applying strict criteria for judging the quality of qualitative research. Rolfe (2006) argues that qualitative research includes varied approaches based on different foundational assumptions (Lincoln & Guba, 2000; Schwandt, 2000), and as such establishing a uniform set of standards to evaluate qualitative approaches is impossible. Rolfe (2006) and Sandelowski and Barroso (2002) recommend re-conceptualizing a research report as a literary technology to be mediated between researcher and reader. A researcher's appraisal of the quality of her work carries no more authority than that of the reader of the research. Readers seek to make texts meaningful through a subjective reading rather than through applying rigid standards and criteria. These authors emphasize reflexivity of the researcher during every step of the research process.

Returning to the concepts of credibility, transferability, dependability and confirmability in qualitative research, the following paragraph describes how the research achieves the rigor through above four states.

Credibility

Credibility of a research study is its ability to accurately meet the intended purpose (Pitney, 2004). Lincoln and Guba (1985) identify four ways to increase the credibility of a study: prolonged engagement, persistent observation, triangulation, and member checking.

Prolonged engagement. Cohen and Crabtree (2006) describe prolonged engagement as spending sufficient time in the field observing various aspects of a setting, being in touch with a range of people, and developing rapport with the members of a culture to understand the social setting. Such prolonged association will allow the researcher to orient herself, understand and appreciate the context, build trust, and blend into the social situation so that the respondents are more inclined to feel comfortable disclosing information.

Persistent observation. Lincoln and Guba (1985) view the purpose of persistent observation "to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail. If prolonged engagement provides scope, persistent observation provides depth" (p. 304).

Triangulation. Several types of triangulation – triangulation of methods, data sources, analyst, and theory – are mentioned in the literature. Triangulation increases credibility and quality by countering the concern that a study's findings are simply a product of a single method, a single source or a single investigator's musings (Patton, 2002). Although triangulation originally was viewed as a means to combine rationalistic and naturalistic paradigms, triangulation has gained acceptance in naturalistic studies alone (Tobin & Begley, 2004). Miles and Huberman (1994) view triangulation not so much as a tactic but as a way of life. "Seeing and hearing multiple instances of it from different sources by using different methods and squaring the findings with others it needs to be squared with. Analytic induction, once again" (p. 267). The salient point is that uncovering the information from more than one vantage point under different circumstances assists the confirmation of the validity of the findings. In cases where data from different sources may not converge fully for completion and expansion, differences can enrich the phenomena of interest (Curtin & Fossey, 2007; Farmer, Robinson, Elliot, & Eyles, 2006).

Member checking. Member checking may be done formally and informally during the normal course of observation and conversation. It generally is considered helpful to establish validity of the study because it provides an opportunity to understand and assess what the participant intended to report, correct errors in the original account, check the adequacy of data, make necessary additions, and confirm the findings (Creswell, 2003;

Lincoln & Guba 1985). Lincoln and Guba go further to state that member checking is the strongest available technique of the credibility of a research study. However, drawbacks of this argument are: Participants may find it difficult to comprehend abstract synthesis and may change their mind about issues on the second run. If and when respondents disagree with researcher's interpretations, a question might arise as to whose interpretation should stand because the participant and the researcher have different roles and thus may have conflicting ways of viewing the interpretations. Moreover, there might not be an objective truth or reality in the interpretation of phenomenon under study to which the results can be compared. (Angen, 2000; Morse, 1994; Sandelowski, 1993).

Transferability

Transferability denotes the degree to which the results of qualitative research can be consistent with another setting (Pitney, 2004). Lincoln and Guba (1985) call it "fittingness" (p. 124) to describe the similarity between the two contexts. A necessary precondition for evaluating the fittingness of the context is a "thick description" of the phenomena under study.

Dependability

The concept of dependability emphasizes the consistency of the research findings. The researcher is responsible for maintaining a transparent description of the research steps taken from the start of a research project to the development and reporting of findings. In other words the researcher is responsible for accounting for changes that took place in research context during the entire study. To achieve this end, the researcher must keep a clear audit trail, which includes research design and data collection decisions and the steps taken to

manage, analyze, and report data (Creswell & Plano-Clark, 2007; Lincoln & Guba, 1985; Morse et al., 2002; Shenton, 2004)

Confirmability

Confirmability refers to the degree of neutrality or objectivity to which the findings of a study are framed by the participants' response and not by researcher bias, motivation, or interest (Lincoln & Guba, 1985). The queries in this regard include whether general methods and procedures have been explained explicitly, if the sequence be followed, if conclusions are linked to condensed data, if the researcher been explicit about personal assumptions, if rival hypotheses been considered, and if data are retained and available for reanalysis by others (Miles & Huberman, 1994). Techniques for establishing confirmability include maintaining an audit trail, respecting the concept of reflexivity, and triangulation (Lincoln & Guba, 1985). How I assured rigor and trustworthiness in this study is described in Chapter 4.

Chapter 3

Methods

Specific Aim

The specific aim of this study was to develop a detailed ethnographic description of the interplay between chronic illness and the Theravada Buddhist belief and practice in the lives of Sri Lankan Buddhist nuns. The following research questions were used to begin this ethnographic exploration:

1. What activities and thoughts constitute "spiritual practice" of these Buddhist nuns?

2. How does chronic illness affect these women's daily life?

3. How does Theravada Buddhist spiritual practice affect their experience of chronic illness?

4. How does chronic illness impact their spiritual practice?

5. What other factors help or hinder their living with chronic illness?

Design

The design of this study was a problem-focused descriptive ethnography that closely followed the iterative and recursive linguistic approach of Spradley (1979, 1980). In this approach, data collection and data analysis are concurrent. The process uses several rounds of participant observation and interviews as necessary to reach the goal of discovering cultural themes. Each participant observation session is to be followed by asking descriptive, constructive, and contrasting questions either through casual conversations and/or semistructured in-depth interviews. After each clarification, the focus narrows to facilitate

forming cultural domains. The final step is to discover how cultural domains intertwine to reveal cultural themes.

Sample and Setting

Sample. Primary participants were ordained or lay Buddhist nuns (*Bhikkhunis* or *Dasa-sil-matas*) who had a chronic illness condition as described in the inclusion criteria. These nuns were selected through a snowball sampling strategy.

Secondary informants were persons from Sri Lanka who were not Buddhist nuns, but who were knowledgeable about Theravada Buddhist belief and practice or about living with a chronic condition in Sri Lanka. They were called secondary informants because they were not a part of the formal sample. Sri Lankans who fell into the secondary informant category were live-in-aides and several Buddhist men and women with a chronic condition. Other secondary informants included health-care providers (e.g., nurses, a physical therapist, medical doctors) and Buddhist scholars (e.g., a professor in Buddhist studies/Buddhist counselor, a Buddhist monk). Prior to beginning fieldwork I set a general limit on sample size not to exceed 50 primary participants and 20 secondary informants.

The decision on the sample size and sampling strategy was based on the following theoretical and practical reasons: Unlike in quantitative research, there are no hard fixed rules or formulas for estimating sample size in qualitative research. Qualitative inquiry focuses on depth of relatively small samples selected purposely (Patton, 2002). Factors that play a role in deciding the size of the sample include the scope, topic, quality of data sought, and design (Morse, 2000; Patton, 2002). Information-richness of the cases selected and the observational and analytical skills of the researcher play more significant a role in the validity, meaningfulness, and insights generated from data in qualitative research than the number of

participants in the sample. Several purposeful strategies that could serve to enrich data and enhance the confidence in conclusions include deliberately searching for maximum variation (e.g., confirming and disconfirming cases, extreme or deviant cases, and typical cases (Miles & Huberman, 1994; Patton, 2002), and using "shadowed data" that is, "information that participants give us about the types, characteristics, and dimensions of concepts, perceptions, behaviors, and opinions of others" (Morse, 2001, p. 291). A purposeful sample gathered through snowball sampling strategy facilitates theoretical saturation (Morse, 2000), or in other words, reaching the point where information becomes repetitive and no new themes emerge. As a reference point, Morse (2000) and Sandelowski (1995) recommend 30 – 60 participants for a sample in ethnography.

From a practical point of view, the pilot study with diabetic Buddhist nuns (Wijesinghe & Mendelson, 2012) in Sri Lanka demonstrated that it would be sound to base the sample for the current study on the above mentioned theoretical concepts. For example, gathering a purposeful sample through a snowball sampling strategy using nuns and their community members seemed to be an efficient way to contact other Buddhist nuns as they knew nuns' whereabouts and health conditions. Theoretical saturation was important because Sri Lankan Buddhist nuns were not a homogeneous group, and their answers varied according to demographic, attitudinal, or philosophical factors. It also was evident that seeking and including extreme cases would be valuable because in the pilot study several Buddhist nuns in unexpected situations (i.e., begging on the road, living in brother's home) provided eye-opening information.

Setting. Sri Lanka is a predominantly Buddhist country with 76% of its population identifying itself as Buddhists (Department of Census and Statistics in Sri Lanka, 2001). Sri

Lanka has nine provinces. According to the census report, Buddhists inhabit all provinces

except in the northern and eastern parts of the country where Hinduism and Islam,

respectively, are more prevalent (Figures 4 and 5). However, since the defeat of the

separatists rebels in 2009, more Buddhists have returned to the eastern province.
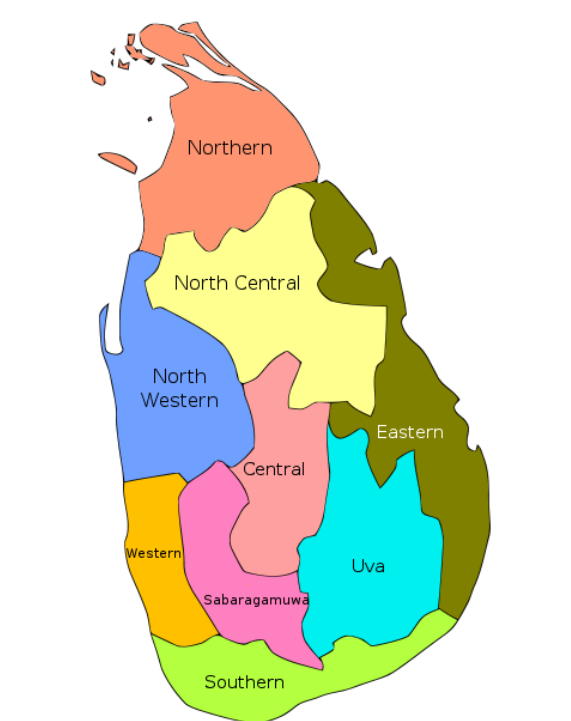
Figure 4. **Provinces of Sri Lanka**
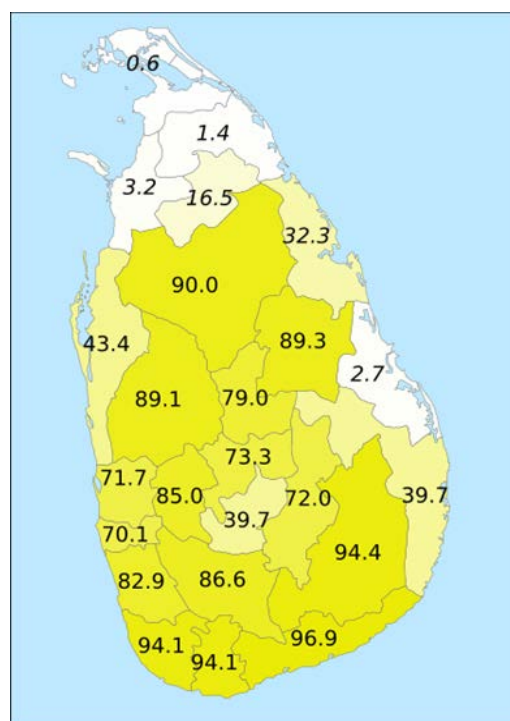
Figure 5. **The percentage distribution of Buddhism**
(Copyright: Google public domain)

No reliable statistics can be found about the number of Buddhist nuns in Sri Lanka;

no registry exists for ordained nuns, but some nonordained nuns are registered with either a

national or a local organization. All statistics of Buddhist nuns thus are tentative. An

approximate count came from Susanne Mrozik (2011), who at the time was studying the

topic of ordination of Buddhist nuns in Sri Lanka. According to her sources approximately

1,000 fully ordained nuns (*bhikkhunis*) and about 1,000 nuns in training to become ordained

nuns (*samaneris*) could be counted. As for nonordained nuns (*dasa-sil-matas*), the estimate

was about 3500.

Recruitment of Participants

A concerted effort was made to recruit Buddhist nuns from the eight provinces where

Buddhism was practiced. To facilitate this task, I requested assistance from three institutions

to assist in contacting Buddhist nuns: the Sri Lanka International Buddhist Academy (in

Kandy, the capital of the Central province); the Sakyadhita Training and Meditation Centre

(in Panadura, Western province); and the Sangamitta Association branch of the Vihara Maha

Devi temple (in Anuradhapura, capital of North Central province). I had made acquaintance

with Buddhist nuns for the pilot study, and these contacts were another source for

recruitment. Furthermore, colleagues and acquaintances in Sri Lanka who were familiar with

my research interest helped identify potentially eligible Buddhist nuns in other locales.

Criteria for primary participants. The primary participants were lay or ordained Sri

Lankan Buddhist nuns at least 18 years of age with a chronic illness as defined in Chapter 1.

Chronic health conditions consistent with the inclusion criteria included osteoarthritis or

rheumatic arthritis, Type 1 or 2 diabetes mellitus, asthma or other chronic pulmonary

diseases, cancer, heart failure or other chronic cardiovascular disease, chronic autoimmune or

connective tissue disease, chronic kidney or liver disease, or long-term neurological

disability such as multiple sclerosis or consequences of stroke or trauma. Potential

participants were expected to comprehend spoken Sinhala or English adequately to provide

informed consent and to participate in interviews.

Exclusion criterion for the primary participants was the presence of a disability that impaired capacity for informed consent or participation in interviews.

Criteria for secondary participants. Inclusion criteria for secondary participants were: at least 18 years of age and able to comprehend spoken Sinhala or English and participate in interviews.

Consenting procedures. The study was approved by the Human Research Review Committee (HRRC) of the University of New Mexico Health Sciences Center (HRRC #12-343). The approved recruitment letter and consents were translated by an accredited English / Sinhala translator and were approved by HRRC. Upon approval, I contacted the nuns (suggested by the three institutes and through previous network of contacts) by regular mail to inquire whether they were living with a chronic illness, and if so, would they be willing to participate in a study. The letter included a simple description of the study, inclusion criteria, and a copy of the consent approved by the HRRC (in Sinhala) along with a stamped pre-addressed post card to acknowledge receipt and indicate interest. Potentially eligible nuns who expressed willingness to participate were contacted again on the phone or by mail to set a tentative date for an initial interview. On the confirmed day of the interview, I visited each participant equipped with a copy of the consent and items necessary for an audio-taped interview. I also took a small bag of food items consisting of dry skimmed milk power, lentils, packet of tea or coffee, and fresh fruits such as a papaya or bananas. The cost of such collection did not exceed $5 and was consistent with the Sri Lankan custom of entering a residence with a token of friendship to avoid being considered impolite by appearing "*his athin*" (empty-handed). In a case of visiting a religious, it was especially pertinent for two reasons; first, all Sri Lankans know that Buddhist monks and nuns depended totally on the

community for sustenance, and second, giving to the religious community was considered *pin karagannawa* (a way to accrue merit) for a better birth next time around. Thus, a bag of food items was expected by the Buddhist nuns and would not be considered coercive. The same general principles applied to secondary informants.

Data Collection Methods

Among the data collection methods in ethnography, participant observation and interviewing are more frequently mentioned, but ethnographers benefit greatly from collecting texts and artifacts that are used by the members of the society being studied (Sandelowski, 1995; Silverman, 2001). These methods were described in detail in Chapter 2 under "background to study methods". This study used all of these methods to gather data.

Interviews with primary and secondary participants were conducted throughout the study. Initial interviews were expected to last 60-90 minutes with the possibility of a shorter follow-up interview. However, the length and number of interviews were negotiated individually according to participant preference to avoid fatigue or burden. Participants were asked if they were willing for the interviews to be taped for later transcription. Among the secondary participants, four medical providers were sent a written questionnaire and all nurses and the physical therapist were interviewed by telephone.

In addition to interviews with primary and secondary informants, participant observation was an integral part of the study. I stayed in the temples of four nuns who had invited me previously. Living with Buddhist nuns for a period of time was not considered unusual for a woman in Sri Lanka because many women seek solace or time for contemplation in nunneries, and they are accepted according to space availability. While engaging in participant observation, I also had an opportunity to gain insight and

understanding from casual conversations with community devotees and participation in day-to-day activities as allowed.

Participant observation afforded naturally occurring opportunities for triangulating data sources. Buddhist discourse, especially in the religious community, was replete with legends, stories, and metaphors. Graham (1993) and Stephens (2011) describe narratology in terms of personal or group narratives, family stories, literary nonfiction, and life stories that reveal cultural and social patterns through the lens of individual experiences. As I participated in activities and events as they occurred, I kept regular entries in a reflective journal to assist as I documented events, experiences, reactions, and insights as they occurred (or as soon as possible afterwards) to be incorporated as appropriate into data analysis and interpretation.

Interviews with primary participants. Although much data was collected through casual conversation while observing as a participant, I kept a semistructured interview guide to keep me on track (English interview guide in Appendix A). In semistructured interviews, I began the conversation with a grand tour question such as "Please tell me what it is like to deal with (name of condition) in living as a Buddhist nun" Then I steered the conversation opportunely, adding probes and mini-tour questions as necessary to obtain information on demographics, daily activities, priority activities, social involvement and relations, satisfaction with life, health status, changes due to chronic illness, environmental barriers and facilitators, financial status and attitude toward illness.

Spradley (1979, 1980) recommends data collection and analysis take place concurrently, and as such, more than one session of participant observation and interview might be necessary to understand the social situation. The three main types of questions that

Spradley recommends are descriptive, structured, and contrasting. An example of a descriptive question from the Buddhist nuns' environs was "Could you please describe how you spend the day from the time you wake up until you rest at night?" Structural questions enabled the investigator to obtain information about how informants have "organized their knowledge" (Spradley, 1979, p.60). For example, "You said you were meditating, what kinds of meditation do you do?" Structural questions often were repeated and built upon (Spradley, 1979, p. 60), so that if the informant identified three types of meditation the investigator asked "Can you think of any other meditational type activity that you would do?" Contrast questions were asked to find out what the participant meant by terms used in her native language, for example, "What are the differences between *metta*, *karuna* and *mudita*?" (a rough English translation would be "compassion", "kindness", and "empathy with someone's joy and/or gain").

Moreover I employed additional elements suggested by Spradley (1979, p. 67), such as expressing interest, expressing cultural ignorance, repeating, restating informant's terms, incorporating informant's terms, creating hypothetical situations, and interspersing friendly, casual questions. Interview transcripts alerted me to the areas where additional constructive questions, and/or contrast questions could be posed in subsequent interviews.

Interviews with secondary participants. Interviews with the secondary participants were more casual and only one interview with each was used to gather information. The interview guide (Appendix A) was adapted as appropriate to the situations of secular women and men who had a chronic condition. Interviews with secondary informants, such as Buddhist scholar/counselor and Buddhist monk were more open- ended and focused on their perspectives on Buddhist spiritual practice, or chronic illness, whichever was appropriate.

Other secondary data sources. Silverman (2001) points out that collecting and analyzing text and other artifacts associated with a socio-cultural group can foster understanding. Documents may include pictures, articles, documentaries, educational material, books or any reports. The researcher can examine these materials, juxtaposed with other data collected, and focus on how and for whom these materials were created, and their use. Information gained through mass media and in other public forums may be incorporated as appropriate into data analysis and interpretation. I paid close attention to the daily newspapers published in Sinhala and English and listened to the radio and television broadcasts as opportunity arose to maintain the wide-angle view Spradley (1980) recommended.

Data Analysis

In qualitative research, data analysis begins with data collection and continues iteratively and recursively (Spradley, 1979, 1980). The researcher continues to ask analytical questions, reflect about data, observe, and take field notes throughout the research process. (Creswell, 2003; Richards &Morse, 2007). Data analysis had the following steps in this study.

Making ethnographic records. Spradley (1979) states "making an ethnographic record acts as a bridge between discovery and description, linking them into a single, complex process" (p. 70). Making this bridge requires careful consideration of the translation process. The language context of communication and field notes in the company of Buddhist nuns varied according to the person on the scene. For example, when I was with a nun, regardless of our age difference (or similarity), I was called "*duwa*" meaning "daughter" and I called her "*meniyani*" meaning "mother". When a nun addressed a nun with more seniority

she used *loku swamin vahansa* or "senior nun". When a nun was in the hospital she was called "*leda*", which meant a patient. Following the verbatim principle, Spradley (1979) it is important to pay attention to what is said, and how it is said. For example, a phrase such as "*sanasaren etherawenanwa*" uttered by a nun literally meant "crossing the cycle of continuous birth", which a nun might liken to crossing a river. If a researcher simply translated it "to attain nirvana" (although that is an implication) that potentially deprived the reader of important contextual meanings with which the phrase was laden. In accordance with Spradley (1979, p.68)'s "concrete principle" to give a vivid explanation, I refrained from generalizing events and gave as much specific detail as possible.

Adopting the approach recommended by Spradley (1979), I kept five types of notes after each session of fieldwork.

The condensed account. I used a small notebook that fit into my skirt pocket to keep track of phrases, single words, and sentences that allowed me the flexibility to observe what I saw and heard around me, and to listen to the informant without distraction. This technique aided me immensely in participant observation. I made a habit of making condensed notes even while an interview was being taped.

The expanded account. This was a detailed account of what was summarized in the condensed notes. Interview transcripts made up a major part of the expanded record. I transcribed interviews on the same day as the interview, or as soon as possible afterwards. Based on notes in the condensed account or review of the audio tapes, I annotated transcripts as appropriate, to indicate potentially important nonverbal cues (e.g., posture, facial expressions, changes of tones of voice or vocal emphasis pauses, etc.) to assure they were preserved along with the words. I translated and transcribed each interview from Sinhala to

English on the same day or the day after to ensure the accuracy of translation. When in doubt I sought the advice of the bilingual linguist who had assisted me previously in the pilot study (Wijesinghe & Mendelson, 2012).

Analysis and interpretation journal. This journal was a link between the ethnographic record after the interview, participant observation, and the final written ethnography (Spradley, 1979). Spradley calls it a place to "think on paper" or brainstorm (p. 76). I recorded analysis of cultural meanings, interpretations and insights in this journal. The function of this journal was similar to memoing (Miles & Huberman, 1994). Memos (unlike expanded reports) do not report just data, but are conceptual in intent. "They tie together different pieces of data into a recognizable cluster, often to show that those data are instances of a general concept" (Miles & Huberman, 1994, p. 72). Memos were dated and linked to both key concepts discussed and to location in the transcript or the expanded notes. They also were indexed for easy access.

Reflective journal. According to Spradley (1979), a reflective journal permits the researcher to record experiences, ideas, introspections such as fears, mistakes, confusions, problems, and breakthroughs. It, too, was integrated into the overall data acquired through fieldwork. Using the reflective journal as a means of maintaining reflexivity was described in greater detail in Chapter 2 (background to study methods).

Reducing the data. The major components of the data analysis process were selecting cultural domains, collecting the taxonomies that go under each cultural domain, and searching cultural themes.

Domain analysis. Spradley (1979, 1980) defined a cultural domain as a category of cultural meaning that includes smaller categories. They are composed of three basic elements

that include a "cover term", "included terms" and "semantic relationship" (Spadley,1980, p. 89). An example relevant to Buddhist nuns based on secondary analysis of data from the pilot study (Wijesinghe & Mendelson , 2012) is depicted in *Figure* 6.
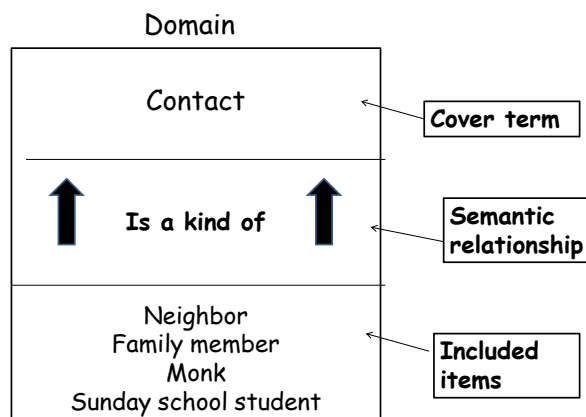
Figure 6. **Basic elements of a cultural domain.**

Spradley (1979, 1980) makes multiple linguistic uses to describe cultural domains For example, "analytic domains" (Spradley, 1980, p. 91) are created by the researcher to represent situations in which cultural meanings are tacit or implicit and must be inferred (e.g., from behaviors and artifacts) as in Figure 7.
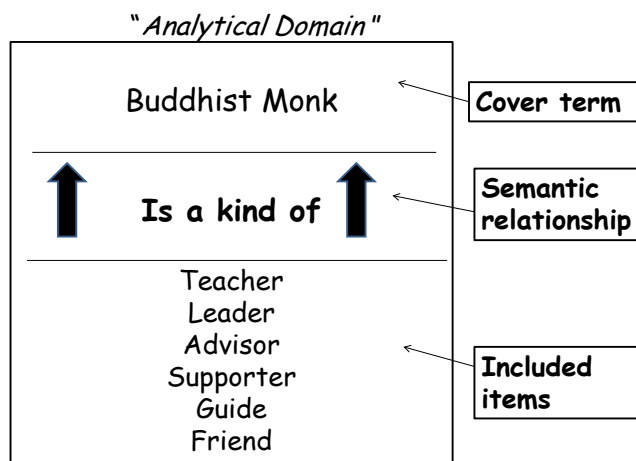
Figure 7. **Example of an analytical domain**

The following is a non-exhaustive list of universal relations based on nine dimensions – space, object, act, activity, event, time, actor, goal, feelings – that Spradley (1980, p. 102) identifies as being useful for analysis (See Table 1):

Table 1. *Examples of potential universal relations for domain analysis*

Relationship	Form	Example
Strict inclusion	X is a kind of Y	Neighbor (is a kind of) contact Buddhist nuns have.
Spatial	X is a part of Y	Flowers are (a part of) daily offerings to the Buddha statue.
Cause-effect	X is a result of Y	Diabetes is (a result of) sins committed by me in a previous birth
Rationale	X is a reason for doing Y	Our feeding all animals (is a reason for which) people abandon pets here.
Location-for-action	X is a place for doing Y	Little shed outside (is a place for) reading and reflecting
Function	X is used for Y	The bell outdoor (is used for) alerting us to someone's visit
Means-end	X is a way to do Y	Meditation (is a way to) calm angry thoughts
Sequence	X is a step in Y	Giving blessings before eating is a step in accepting alms.
Attribution	X is an attribution of Y	Compassion is an attribute of the Buddha that we imitate.

The number of cultural domains that can be formulated is vast. However, Spradley (1979, 1980) recommends that the researcher narrow her ethnographic focus using several types of criteria, one of which is organizing domains that encompass specified study aims or research questions. Spradley (1980) defines an organizing domain as "a large domain that seems to organize most of the cultural meaning of a particular scene. Somehow, it pulls together the

relationships among many other domains" (p.106). Citing from many ethnographers'
experience, Spradley recommends using domains based on sequence relationship (e.g., X is a
stage/step in Y), which are said to frequently help organize a cultural scene. An example of
such a large domain used in this study was "Changes in the life of Buddhist nuns." Details
will be discussed in the theme analysis section.

Taxonomic analysis. Taxonomic analysis serves to understand relationships among
the units found under each cultural domain. A taxonomy is a set of categories organized on
the basis of a single semantic relation, but it differs from a domain in that taxonomy shows
the relationship among all the included terms in a domain (Spradley, 1980). An example of a
non-exhaustive taxonomy based on secondary analysis of data from Wijesinghe and
Mendelson (2012) is depicted in Figure 8.
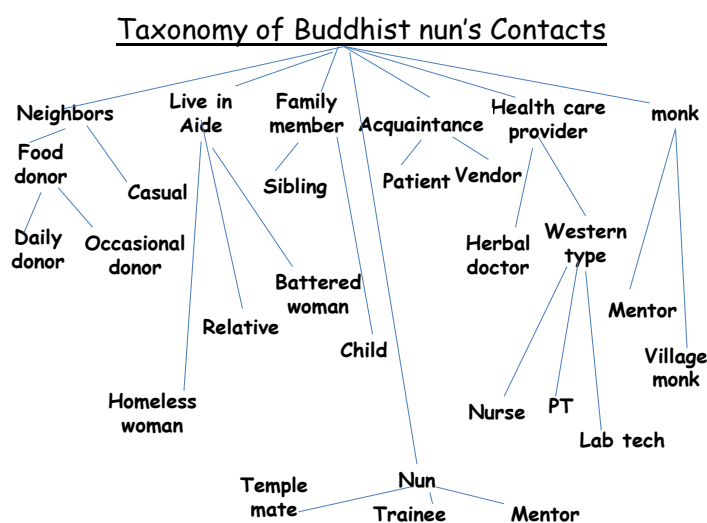
Figure 8. **Taxonomy of Buddhist nun's contacts**

Uncovering cultural themes. Spradley (1980) identifies a cultural theme as "any
principle recurrent in a number of domains, tacit or explicit, and serving as a relationship
among subsystems of cultural meaning" (p. 141). Of the several strategies Spradley suggests

for making a theme analysis, my choice was "identifying organizing domains" for intensive analysis (p. 149) and immersion in the culture. An example of an organizing domain is a semantic relationship such as X is a stage of Y. A concrete example from the current study was "tell me about the changes in your life". Responses encompassed one or more domains (e.g., underlying semantic relationships) such as changes by becoming a nun, changes progressing as a nun, changes due to sickness, changes they want, kind(s) of persons involved, difficulties and consolation of being a nun, feelings about being diagnosed with illness, ways of dealing with the disease, elements of current treatment plans, reasons for adherence or non-adherence, and desirable changes expected in life etc.

Matrix Analysis

Matrix analysis (Miles & Huberman, 1994) is used to cross-classify domains or themes to identify patterns (Patton, 2002). In this study, matrix analysis was proposed for comparing the domain analysis results and cultural themes. By way of example, the following matrix (Table 2) displays the cultural themes of the pilot study (Wijesinghe & Mendelson, 2012) against the source (participant or researcher; there were no secondary participants) in a manner that displays how (in this case from whom) exemplars of several themes were derived. It also is possible to use a matrix to compare emergent themes from the domain and taxonomic analysis with elements of existing theory or framework. Thus, triangulation of two methods will add to the methodological rigor (Lincoln & Guba, 1985).

Table 2. *Example matrix display of cultural themes against source (participants)*

Respondents & researcher's reflections	Theme Devotion	Theme Responsibility	Theme Detachment
Primary participants	"offerings are made daily, no matter what"	" like the Buddha we will not look for our comfort when we do good for others"	"good and bad go in a circle in this life, disease is part of living and we accept that"
Researcher reflections			

(Adapted from Averill, 2002; Wijesinghe & Mendelson, 2012)

Data Management

Having good control over data during different points in time is integrally related to data analysis; these steps include keeping track of them, using them with ease, making them available to others such as research committee members, and maintaining them (Miles & Huberman, 1994; Levine, 1985). I maintained a meticulous physical filing system following the general principles of Levine (1985) for a storage and retrieval system. These general principles included formatting, cross referral, indexing, abstracting and pagination. I adapted four of these principles in the following manner:

Formatting. A filing system was developed to include each participant, each event, each activity, and relevant topics. Entries in the fieldwork notebook and reflective journal were indexed by date, alias of participant, and type of interaction, event, or observation. Field notes were transcribed to electronic files.

Pagination. I developed a coding system that can locate data by participant, event, and topic by reference to source document (e.g., transcript, field notes, or reflective journal), page, and line numbers.

Indexing. Indexing permitted identifying codes definable and retrievable. It included defining clear categories, maintaining a code book, pairing codes with appropriate places, and people and showing the maintenance in a book of code rules.

Abstracting. Abstracting allowed me to condense field notes and other relevant documentary material, such as specific related events, newspaper articles, into summaries and to link it to the file system.

I also used a digital tape recorder that allowed backup to computer files.

Data Storage

Secure storage of data was of utmost importance when traveling and living in areas where safety cannot be taken for granted. I kept a daily routine of storing all files as they were produced (all digital audio files, translated interview transcripts, and field notes described) on an encrypted external hard disk.

Protection of Human Subjects

The University of New Mexico Health Sciences Center Human Research Review Committee's approval was sought in this dissertation research because it involved human subjects. The approval was granted before beginning the study.

Procedures for Minimizing Risk

The risks of this study were considered to be minimal. In any research, there is a potential risk of inconvenience to the participants. There were also potential risks of loss of privacy. This research involved interviewing Buddhist nuns who generally led a secluded life

in a temple. Although my interview guide did not include culturally sensitive issues, speaking to a researcher who is not there just to request blessings might create an awkward situation for some nuns. To avoid this situation, I took sufficient time to explain in full detail what the study involved and the reason for contacting the nuns, and I answered the questions they posed. I assured the participants that I would protect their confidentiality and I kept that promise. I informed them that as participants, they were free to not answer any questions or to withdraw from the study at any time. Their identities were coded, and the code key was kept by me and was not revealed to anyone. Participants' names and contact information and all identifiers will be destroyed at the conclusion of the study.

Chapter 4

Results

The specific aim of this study was to describe the role of Buddhist spiritual practice in the lives and health of Sri Lankan Buddhist nuns living with a chronic condition. The following research questions were proposed to explore the topic: 1) What activities and thoughts constitute "spiritual practice" of these Buddhist nuns? ; 2) How does chronic illness affect these women's daily life? ; 3) How does Theravada Buddhist spiritual practice affect their experience of chronic illness? ; 4) How does chronic illness impact their spiritual practice? and 5) What other factors help or hinder their living with chronic illness?

This chapter will describe how the domain and taxonomic analysis and cultural themes (adopted from Spradley, 1979, 1980) were employed to examine the areas pertaining to the research questions. The chapter is organized in the following sections: (a) overview of fieldwork; (b) sample and setting; (c) cultural domains; (d) findings addressing specific aim and research questions; (e) methodological rigor

Overview of Fieldwork

The Spradley method (1979, 1980) allowed me to immerse myself for two months into the socio-cultural and Buddhist milieu of Sri Lanka. Although I had formed a network of contacts on my previous trips to Sri Lanka, I had not had the opportunity to integrate into the culture as a participant observer in Buddhist rituals and ceremonies, in nuns' domiciles, temples, and communities, and for secondary informants, in a variety of Sri Lankan public and private venues (e.g., hospitals, private residences). Data collection took place during two visits of four to six weeks' each in the latter half of the 2012. I also kept a close watch on the mass media through radio, television, and newspapers in Sinhala and English.

After obtaining informed consent, I spent approximately 97 hours in face-to-face interviews with 45 Buddhist nuns (primary participants). Five were visited more than once, either at their request or for clarifications of a previous interview.

In addition, I enrolled 20 secondary informants: seven Buddhists with chronic conditions (five female); four medical doctors, four nurses, two live-in aides, a physical therapist, a Buddhist monk, and a Buddhist counselor. All health-care providers worked in crowded clinical settings, and most of them in the secondary group requested to be interviewed by phone or to respond to written questions. All other secondary informants were interviewed face to face in homes or offices. Most interviews with secondary informants took 40 minutes or less. Interviews with the Buddhist monk, counselor, and with some of the patients tended to last longer because, in general, they wished to say more.

Sample and Setting

Geographic distribution. The 45 Buddhist nuns were recruited from eight provinces (of nine) in Sri Lanka where Buddhism was the predominant religion. Approximately three-quarters of the sample were from the Western, Central, or North Central province (Figure 9). From one to four were recruited from the other five predominantly Buddhist provinces (Figure 9). A concerted effort was made to include Buddhist nuns from diverse living arrangements. These included small to large temples (*aramayas*), training centers for bhikkhunis and dasa-sil-matas (ordained and nonordained nuns), meditation centers, private domiciles or rooms, and even a temporary homeless shelter. The 20 secondary informants were recruited from three provinces in Sri Lanka.
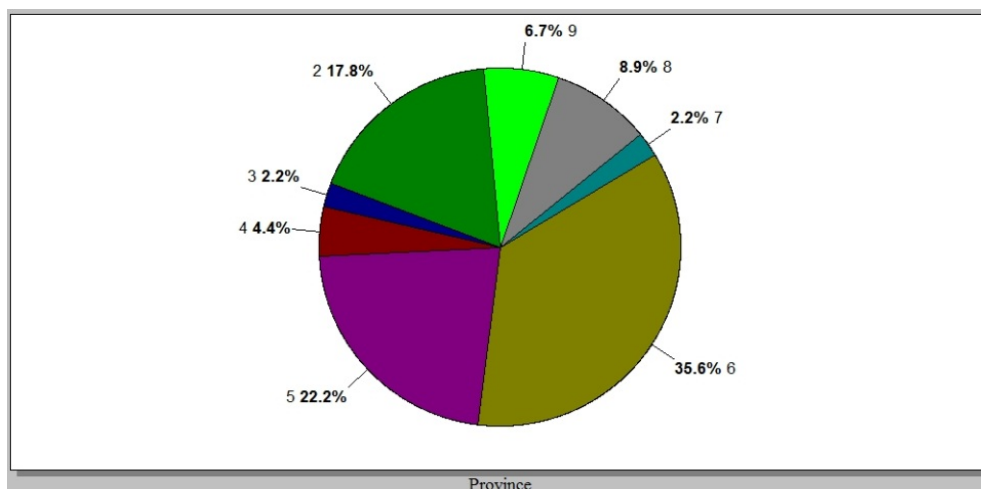
1. Northern
2. North Central
3. North Western
4. Eastern
5. Central
6. Western
7. Sabaragamuawa
8. Uva
9. Southern

Figure 9. **Recruitment statistics of the Buddhist nuns from the Provinces in Sri Lanka**

Characteristics of primary participants.

Age. The current age of nuns ranged from 29-89 (mean= 58years). Twenty eight had entered the religious order before the age 30, and 10 of them were younger than 18 when they entered their religious vocation. Except for the four women who had become nuns at a mature age (per Sri Lankan cultural standards) before entering marriage (>35 years of age), all other late beginners had been married, and 12 had children.

Reason for becoming nuns. More than half (n=24) said they became nuns primarily because they came from families with a strong devotion to Buddhist spiritual practice. Seven

nuns because they felt they had completed their responsibilities by having raised children and

attended to husbands and in-laws.(Table 3).

Table 3. *Reasons for entering religious order*

Reasons for entering religious order	Frequency	Percent
Parents or close relatives were devoted Buddhists	24	53.3%
Finished responsibilities for families	7	15.6%
Personal tragedy	4	8.9%
Habit passing from birth to birth to be part of the religious order (*sansara purudda*)	4	8.9%
Realization of futility of life through meditation	3	6.7%
Marital problems	1	2.2%
Other family problems as a young person	1	2.2%
Father wanted her to be a nun	1	2.2%
Total	45	100.0%

Domicile. The majority of the nuns (73%) lived in *aramayas* or temples, most

commonly with three or four other nuns (range, one to15). All except one temple had at least

one live-in female aide. In meditation or bhikkhuni training centers participants lived within

a larger community of nuns (range, 10 to 50). Eight nuns lived in their own houses or in

temporary quarters such as a room in house owned by someone else or in temporary shelter

after moving from aramaya to aramaya in search of an acceptable home.

Table 4. *The type of domicile from which (head)-nuns were interviewed*

Domicile	Frequency	Percent
Aramaya/temple	33	73.3%
Meditation or *bhikkhuni* training center	4	8.9%
Own residence	3	6.7%
Somebody else's house	4	8.9%
Homeless shelter	1	2.2%
Total	45	100 %

Buddhist Education. The sample was predominantly dasa-sil-matas (n=37): Only

eight were bhikkhunis who followed a structured monastic education and became ordained.

The dasa-sil-matas had gained their Buddhist knowledge various ways: 15 of the dasa-sil-

matas had attended a monastic school or university, at least, for several courses. Ten had

been exposed to Buddhist studies in Sunday schools or regular schools and some of them had

built on this knowledge by reading Buddhist books on their own and/ or listening to *dhamma*

explanations/sermons by monks. Mentoring nuns in the aramayas was the source of

knowledge for seven of dasa-sil-matas. One had learned Buddhism at a meditation center,

and two gave nonspecific answers such as "knowledge came to me while meditating" or "you learn it when you open your heart to the Buddha."

    Major diagnosis, comorbidities and type of treatment. Twenty two (49%) of the Buddhist nuns said their principal chronic condition was diabetes. As Table 5 illustrates, other conditions mentioned were arrhythmia, asthma, catarrh (persistent "head cold" associated with chronic sinusitis), persistent gastritis, heart valve problems, high blood pressure, migraine headaches, osteoarthritis, rheumatoid arthritis, and stomach tumor.

Table 5. *Chronic conditions*

Primary chronic condition	Frequency	Percent
Arrhythmia	2	4.4%
Asthma	2	4.4%
Chronic catarrh	2	4.4%
Diabetes	22	48.9%
Chronic gastritis	3	6.7%
Heart valve problem	1	2.2%
High blood pressure	3	6.7%
Migraine headaches	3	6.7%
Osteoarthritis	3	6.7%
Osteoporosis	1	2.2%
Rheumatoid arthritis	2	4.4%
Stomach tumor	1	2.2%
Total	45	100%

Many participants reported more than one of the conditions in Table 5. However, the "primary condition" was determined by the question, "What diagnosis did the doctor give you for the major symptoms you have to live with." Other reported comorbidities: frequent fever, weakness as a consequence of measles, breast cancer in remission, falls due to nerve weakness, asthma, osteoporosis, swollen knees, recurrent bladder infections, diverticulosis, eye problems, ear problems, problems with memory and a dislocated hip.

The type of treatment (Table 6) ranged from Western to traditional (Ayurveda). Several participants mentioned avoiding potential causes or triggers, attempting lifestyle changes, and not seeking treatment unless a problem became serious. Although the majority of nuns did not strictly adhere to any type of treatment (to be discussed later) 71% had begun their treatment with Western medicine while 18% made use of Western and traditional treatments sometime during the course of their illness.

Table 6. *Type of treatment sought*

Type of treatment	Frequency	Percent
Western medicine	32	71.1%
Both Western and Ayurveda medicine	8	17.8%
Avoid causes/dietary control	3	6.7%
Seek help only very serious	2	4.4%
Total	45	100%

Characteristics of secondary informants.

Characteristics of the secondary informants are in Table 7.

Table 7. *Characteristics of the secondary Informants*

Informant	Gender	Age	Years in occupation or with illness
Buddhist monk	M	50	30
Buddhist with diabetes	F	43	8
Buddhist with rheumatoid arthritis, family tragedy	F	62	10
Buddhist with osteoarthritis after personal tragedy	F	64	18
Buddhist with osteoarthritis	F	62	18
Buddhist diabetic	F	61	15
Buddhist diabetic	M	56	30
Buddhist diabetic	M	62	32
Buddhist counselor	M	48	12
Medical doctor	M	44	10
Medical doctor	M	48	15
Medical doctor	M	44	12
Medical doctor	M	68	15
Physical therapist	M	70	25
Nurse: medical surgical	F	62	20
Nurse: medical surgical	F	36	8
Nurse: medical surgical	F	35	9

Table 7 Continued

Informant	Gender	Age	Years in occupation or with illness
Nurse: cancer unit	F	68	17
Live-in aide	F	43	1
Live-in aide	F	28	1

Cultural Domains

Spradley (1979, 1980) described cultural domains as categories of cultural meaning that include other smaller categories. I identified three cultural domains: 1) Expression of Buddhist spiritual practice; 2) Activities of Buddhist nuns; and 3) Changes in lives of Buddhist nuns. There were several reasons for my selection of these three cultural domains. First, my immersion in the Sri Lankan socio-culture during field work gave me the impression that all that was considered spiritual in Buddhism might not be easy to practice exactly the way it was prescribed. This direction of thinking coincided with the first two research questions of the study. Thus, the first two cultural domains, expression of Buddhist spiritual practice and activities of Buddhist nuns, fell naturally into place and also served a pragmatic purpose of answering the questions. The third cultural domain, changes in lives of Buddhist nuns, came to life from recurrent discussions of changes in life by many nuns that also encompassed issues that the remaining research questions sought to answer. However, in contrast to the first two domains, changes in lives of Buddhist nuns was more of "an organizing cultural domain" (Spradley, 1979, 1980). According to Spradley an organizing cultural domain "is a large domain that seems to organize most of the cultural meaning of a particular scene. Somehow it pulls together the relationships among many other domains"

(Spradley, 1980, p.106). Spradley also maintained that identifying organizing cultural domains facilitates uncovering cultural themes.

Expression of Buddhist spiritual practice.

Dana, sila, and bhavana. Nuns unanimously agreed that good Buddhists, lay or clergy, practiced *dana* (almsgiving, or offering), *sila* (moral practice), and *bhavana* (mental development through meditation). They said these were requisites for advancing towards all Buddhists' ultimate goal, nirvana. One nun simplified it this way: "The more we give, the more we lose our miserliness. The more we observe moral rules, the more we lose our anger; the more we meditate, the more we lose illusion." –Nuwarella

Dana (giving). Many nuns offered lengthy, and in some cases, colorful stories from the Buddha's many previous births as *Bodhisatta* (a being to be a Buddha at a future time) to explain the types of alms offerings and the various results that stemmed from the volition of the giver. In general, giving was important in the Buddhist spiritual practice for three main reasons. First, a person who gives loses attachment to the object given, and the frequent act of giving weakens the mental factor of *tanha* (craving) that causes unhappiness. Second, almsgiving when practiced with a wholesome intention, will lead to future births favorable to encountering and practicing *dhamma* (Buddhist doctrine) as opposed to being reborn as animal. Third, acts of generosity help develop virtue (*sila)*, which is a prerequisite to progress in concentration (*samadhi*) in order to attain wisdom (*panna).* These three stages are achieved through the Noble Eight-fold Path elucidated by the Buddha to eliminate ignorance. Nuns' explanations also indicated that the salutary results of alms offering were meted out according to a strict system of merits that would have ramifications in the lives and health of Buddhist nuns:

There is a difference between offering something to a poor person and offering to a holy person. What is given to the poor is given with sympathy, but when offering to someone holy such as Buddha or an "*arahant*" (one who has attained the fourth and the final stage of enlightenment), it confers the giver limitless "*kusala*" (karmically wholesome or beneficial effects). But, the Buddha has encouraged giving to the poor and the helpless. When a wholesome act is committed, the doer will have salutatory effects during this birth (*melowa sepa*), after this birth (*paralowa sepa*), and merits toward attaining nirvana (*nivan sepa*). – Uda

If we do not offer *dane* to others, we cannot attain nirvana. Even the Buddha did this. For example, when a hungry person was in front of him, he would offer something to eat before a sermon. How would he preach to a hungry person? –Kiniga

Image 10: **An alms donation to Buddhist monks**

Thus, the first factor of the merit system is the donor's volition or motive. The common denominator for giving is getting rid of greed. The second factor is the purity of the recipient. The worthiest recipients of the gifts are the noble ones such as the Buddha and his disciples who have achieved higher level of enlightenment. Giving to monks or nuns who strive for these states, and even to lay meditators who are devout, would yield bountiful results. It also was said that results of generosity were measured by the deserving quality of the recipient rather than by the size and value of the gift. Some contradictory, yet valuable (for this study) information related to the quantity of the offering came from yet another Buddha story (about Visakha, the Buddha's chief female lay devotee). Visakha, in a former life time of a different Buddha (Kassapa Buddha as opposed to the most recent Gautama Buddha), had given a

generous gift of five kinds of dairy products to a group of 20,000 monks and had continued

to urge the monks to consume more milk, curd, and ghee even when they felt fully satisfied.

According to this legend related with great relish by several nuns, the royal woman inherited

such a large number of cattle to go along with her marriage that the cows never stopped

producing dairy products for her. Nuns also indicated that alms-offering to a monk who may

possess weaker moral standards still could bring merit to the giver when offered "mentally in

the name of the *Sangha* " (the Buddha's community of saintly monks and nuns). Even when

the receiver was unwholesome and not spiritually advanced, the giver's wholesome motive

was what mattered.

> I think we have no right to criticize monks. Those who act that way will have their
> consequences. Yes, people say this and that about monks, but it is no use talking
> about these things. Monks do a religious protective service. –Mala

The Buddha, according to the nuns, had placed great value in giving and honoring one's

parents, and dependents, be they family or employees. Discussions on the third factor, the

objects to be given, showed that gifts could be material or immaterial. On the material side,

the items fit for charity included robes, food, domiciles, medicine, unguents, lamps, vehicles

etc. On the spiritual side, *dhammadana* (dissemination of the knowledge of the doctrine) was

considered to exceed all other forms of giving. Three nuns referred to the concept of

"perfection of giving", which implied disregard for the qualities of the recipient and donating

the dearest and most difficult of gifts. The nuns were enthusiastic storytellers of how the

bodhisatta (the Buddha to be at a future time) had removed his eyes from the sockets to give

to a person who cherished Buddha's attractive eyes, and how Buddha on a previous birth had

given away his two wailing children, Jaliya and krishnagina to a beggar.

Sila (practice of virtue*). Sila* denoted the maintenance of morality or virtue in life. The code of moral conduct to follow in Buddhist spiritual practice varied from laymen to the clergy. Lay persons are obligated routinely to observe five precepts or rules of conduct (*pancha sila),* abstaining from killing any living being, stealing, sexual misconduct, lying, and using intoxicants, and then elevate the practice to eight precepts (*attha sila*) on the *poya* or full-moon days (a national holiday in Sri Lanka to facilitate *sila* practice) and in some cases new moon days. On these holy days, lay Buddhists also are encouraged to abstain from eating after mid-day, participating in merriment such as dancing, singing, music, using garlands, scents, cosmetics and adornments, and sleeping on luxurious beds.

***Image 11*: Alms offering to those observing (*sila*) 10 precepts on full-moon day**

The 10 rules (*dasa-sila)* are binding at all times on all novices, monks, and nuns: the same five rules as lay persons, plus the rules lay persons must observe on full-moon days by abstaining from merriment and abstaining from donning garlands, cosmetics, etc. (considered as separate rules), plus abstaining from accepting gold or silver (or money).

Ordained nuns (*bhikkhunis*) and monks (*bhikkhus*) were to abide by many more monastic rules above and beyond these precepts (217 for bhikkhus and 311 for bhikkhunis). The rules were categorized according to the penalty for breaching them, which ranged from confession in the presence of another monk or nun to permanent expulsion from the religious order. Although it is beyond the scope of this study to delve into all the rules, several that pertained to health arose from the categories of *pacittiya* and *sekhiya*. *Pacittiya* rules governed food: not eating after noon time, eating only the food that was formally given, not storing food received today for tomorrow, not prompting or taking advantage of an extremely generous donor, not cooking food for oneself, and not cooking or storing food in the living quarters. *Sekhiya* included rules of etiquette dictating that a Buddhist nun's comportment in public exemplify discipline (e.g., she should walk with her eyes lowered and talk with a lowered voice and without laughing. She may not swing her body or arms when walking or put her hand on her hip).

There were only eight bhikkhunis in the sample, and some said they worked around some of these rules in the current society, especially those pertaining to cooking and touching money. One bhikkhuni said:

> For us as for not picking flowers, seeds that sprout.. [pause].. the reason is.. [pause].. during days of the Buddha when the monks walked on young grass, worms and other such little creatures died. And that came as a blame for the Buddha. That is why there is a "*vas* time", four months of "*vas* time" (rainy season retreat of four months duration). That is the time the monks are not supposed to *pindapatha* (beg for food from house to house). That is why bhikkhus are supposed to be in one place during the "*vas* time". For example we are not supposed to cut trees, but if there is no hut to live in, we can ask someone else to make it for us. Like that cutting onions. Onions grow, so we are not supposed to cut them and also flowers with seeds. The disciplinary rule is that we can pick flowers that do not bear seeds. If we pick other flowers to offer to Buddha, that is fine.. [pause]..The essential things.. [pause]..I can ask someone else to do for me. It is not a difficulty. It is a freedom.. [pause].. I had to go learn Pali and Sanskrit, I was not in a position to pay for 2 people, so I had to

touch money. Even now I have to use money. Even in an *Aramaya*, concerning money, we have had barriers because we cannot trust everybody with money. There are times when you can do something for 200 rupees, (about two U.S. $) it ends up becoming over 400 rupees because it has gone through the person that you trusted. – Kuda

Morality when observing the four monastic requisites (Siupasa). The term

"*Siupasa*" came up recurrently in nuns' conversations, and it applied strictly to those in the

Buddhist religious order. In interviews, the word almost always followed the Sinhala phrase

"*ginibola gilinawa wage*" (similar to swallowing red-hot metal balls). Nuns clarified that

siupasa meant being guided by the right mental attitude with regard to using the four

requisites: robes, alms or food, dwelling, and medicine.

> These four we have to do correctly. We cannot earn money to acquire these. They are given to us. If we consume these, we should respect that by performing *dana, sila, bavana*. Otherwise we will be committing a sin. It is not who gives us these who would accrue defilements. It would be us, who eat the food that they bring. It is said that what is offered is not "alms-rice", but *ginibola* (red-hot metal balls). Did you know that? We are taught to consider the food we eat from others as *ginibola*. – Mata

Image 12: **Buddhist monk on *pindapatha* (outing for alms-food with a begging bowl)**

Another nun pointed out that following these rules was not self-evident when donning a

yellow robe:

> Just because we have a yellow robe, the mind is not automatically tamed. From that
> moment we enter this path we have to keep asking. Why have I come? What am I
> doing? I have to live without owing to others. I have to ask these questions because I
> partake of *siupasa*. I have to be mindful. – Mala

Nuns continued that the Buddha had asked all who had entered the religious path to reflect

wisely when using the robe, only to protect from cold, heat, insects, wind, the sun, and to

cover nudity. The alms food was meant only for endurance and continuance of the body, to

prevent discomfort of hunger, and to assist the holy life instead of wishing it to bring

physical beauty. The dwelling place was also only to protect from cold, heat, animals, wind,

the sun, and warding off other perils of climate during retreat. Finally, the medicinal requisite

was only for protection from illness and for the benefit of good health.

  Bhavana (mental development or meditation). All nuns said the ultimate purpose of

Buddhist meditation was to free oneself from illusion and to eliminate ignorance and craving.

Discussions alluded to two kinds of meditation: tranquility (*samatha-bhavana*), and

development of insight (*vipassana-bhavana*).

  Tranquility meditation led the person to a state of one-pointedness of the mind

(*samadhi*). Nuns added that to attain this level of concentration, the meditator should begin

with a firm footing on the ground of morality (*sila* or virtue). Nuns used the term,

kammatthana (working grounds/subjects of meditation) to characterize the methods to reach

deep concentration with an ultimate goal of developing insight (*vipassana*). The state of

vipassana permitted the meditator to intuitively realize *annica* (impermanence), *dukkha*

(dissatisfaction or suffering), and *anatta* (non-self, impersonality), the three characteristics of existence.

> When I conduct meditation sessions with devotees, first I give several, "*kammatthana*" (working ground or subject of meditation).Then in the evening, I talk to each person individually and ask which particular subject stimulated his or her mind most. I give subjects like recollections of "*asubha sati*" (loathsome subjects of the body), "*tilakkhanasati*" (three characteristics of existence), "*marananusati*" (reflection of death), "*Buddhanussati* " (reflections of the Buddha), and "*metta*" (loving kindness). –Uda

Every aspect of the meditative process (contemplating the body, feelings, mind or consciousness, and mental objects or ideas) was practiced in conjunction with mindfulness in breathing (*anapanasati*), described in the Buddha discourse, *maha satipattana sutta*, as necessary to insight awareness. Two nuns simplified the process of concentration leading to insight awareness in the following way:

> You start with loving kindness meditation until the mind calms down and then concentrate on in and out breathing ..[pause].. you are mentally looking at the naval that moves with each breath in and out. It is normal for the mind to wander but you bring it back and look at the breath. Being aware of your body is called *kayanupassana*. Do it half an hour, and when you calm down, then … there comes pain, from shoulder, knees, back..[pause].. from all over the body. This is what we call *vedanupassana* (mindfulness of feelings). When that happens we bring the concentration on to the place where it hurts. We say, "pain, pain, pain" until it goes away..[pause].. You don't open eyes..[pause].. continue and then let us say..[pause].. you hear a dog barking..[pause].. you do not analyze it, but say, "noise, noise." – Mata

> When you keep meditating, when the body hurts, many thoughts come with the pain such as not liking the pain, but you just look at a feeling as passing by..[pause].. when passing all these steps, there is a great consolation..[pause].. This is the third stage of consciousness *chittanupassana*. You think it is a permanent stage, but it is not. Constantly passing..[pause].. Next stage is taking all together and realizing that the body is a just a result of *karma*. This body could have been organized as a human or at a lower level as an animal or even lower as a *yaksha* [spirits from Hindu mythology with a negative connotation in the Sri Lankan context]. It happens, but we cannot make it happen. All parts eventually become part of earth. Only the part called *vayu* (air) is dispersed out. This last stage *dhammupassana* continues and when developed one can get rid of our false notion that there is a mortal soul. –Goraka

Pirit chants. The *paritta* (Pali) or *pirit* (Sinhala, which means protection) chants are selected discourses by the Buddha. These recitals, according to the participants, helped protect from evil, induced the mental attitude that would help bring happiness, and helped those sick to recover. Pirit recitals were in demand during rites of passage such as at birth and death, illness, housewarming, and even in difficult pregnancies. The complete book of pirit chants, a copy of which the nuns said was in every Sri Lankan home, was a collection of 23 discourses delivered, almost all, by the Buddha. Other significant Buddhist observances nuns described in detail (e.g., *Bodhi-puja* and *vas* or rainy season retreat) were described in Chapter 2 under rituals in contemporary Sri Lanka.

Material and spiritual homage (amisa-puja and patipatti-puja-puja). Nuns' explanations of *amisa-puja* and *patipatti-puja* helped illuminate many events that often passed fleetingly in a participant observer's eyes. For the purpose of this paper, these terms helped to organize the spiritual activities described so far loosely, under one umbrella concept. *Amisa-puja* and *patipatti-puja* denoted two types of homage paid in Buddhist spiritual practice. *Amisa-puja* was material homage, which was manifested either as a daily personal ritual or as communal events, especially on *poya* (full-moon days) in temples and on pilgrimages. *Patipatti-puja* expressed homage through "practice" – taking the Buddha as an example and follow what he practiced – which meant mental development through meditation. The distinction between these terms, arguably, corresponds to a distinction between ritual and ceremony (*amisa-puja*) versus meditation (*patipatti-puja*) often mentioned in Western characterizations of Buddhist spiritual practice.

Amisa-puja could bring worldly happiness, for attaining qualifications for beneficial human or heavenly rebirths. Merits from this form, however, kept the individual circulating through rebirths in the worldly and heavenly realms. In contrast, the practice of mental development through *patipatti-puja* helped Buddhists gain release from spinning in the circles of rebirth.

Nuns agreed that Buddha's advice was to lean toward *patipatti-puja* to attain a *magga phala* (fruits of the path, *sotapanna*, *sakurdagami*, *anagami*, and *arahat* the four tiers of enlightenment), but they understood the importance of practicing both. According to the nuns, the emotional aspect of homage too should be developed to advance toward the final goal. The consensus was that Buddhists could not progress to meditation without faith (*sadha*) in the Buddha. If a Buddha-statue was placed on the altar, it would facilitate even a child's understanding of homage to a blessed person and thus grow devotion.

Nuns employed colorful metaphors to stress the relationship between the two homages: "The relationship between *amisa-puja* and *patipatti-puja* is similar to what the bark means to the tree. *Amisa-puja* is the bark, and the core of the tree is protected only when the bark is healthy." *Amisa-puja* was important to bring the mind, which usually was directed toward defilements, to salutary acts. According to one of the nuns, *amisa-puja* was akin to preparing to go out by washing the face, combing hair, getting dressed, but not actually going (i. e.,. more a state of continued preparation). *Patipatti-puja*, this particular nun said, was when the person actually did go out. Another nun compared *patipatti-puja* to taking the medicine a doctor had prescribed. *Amisa-puja* was analogous to looking at the bottle of medicine and praising the doctor with gifts instead of taking the medicine. Only by taking the medicine would the person be healed.

The elements of the domain, Expression of Buddhist Spiritual Practice are summarized taxonomically in Figure 10.

Taxonomy : Expression of Buddhist Spiritual Practice

Dana · Sila · Bhavana · Amisa-puja · Observances

Material given to
Monks
Nuns
Sila -observers
Poor
General others
Organizations

D. Of Perfection
Organs etc.

Dhamma dana
Knowledge

5 precepts
8 precepts
10 precepts
217 rules
monastic(M)
313 rules
monastic (N)

Siu-pasa
Robe, food,
Abode,
medicine

Patipatti-puja · pirit

Offerings of
external homage

Bodhi puja

Katina-vas

Samatha-40 subjects of meditation
Vipassana- 4 foundations of mindfulness

Figure 10. **Taxonomy: Expression of Buddhist Spiritual Practice**

Activities of Buddhist Nuns

To facilitate comprehension of nuns' activities, a brief explanation of the most important contacts of nuns is provided.

Fellow nuns and live-in aides. The majority of nuns lived at least with two to three nuns. In training centers, the number was much higher, up to 50. Although nuns had contact with other nuns out of their temples, there was a tendency to limit those contacts to most necessary transactions. In some aramayas, the nun lived alone with a female aide. The live-in-aides were usually middle-aged women, but some younger women who aspired to be nuns someday were also found in aramayas. They were different from the novices (called as *samanera*, in the case of ordained nuns) in that the live-in-aides were attired in regular but

lighter colored clothes. The majority of the women encountered in this position appeared to

be going through a period of transition due to personal or family issues. It also was not

unusual to meet lay women, such as a nun's own mother or sister, helping out in temples.

Conversations with several nuns gave me the impression that they may have a lower

opionion of women in general. For example, three nuns mentioned that when women got

together, they talked about things that were not conducive to mainintaining *sila*. However,

others were more accommodating:

> It is not difficult not to associate with others. One is not all good or all bad. So we
> cannot leave one because one has a weakness. They have good qualities too. So, it is
> important to associate others with understanding. There is no need to drop someone
> completely. It does not fit our behavior. –Mala

Several aramayas had very old nuns (in some cases in their 90s) who had served as

head nuns of these temples and now in their feeble condition were taken care of by the

younger nuns. Nuns showed great respect for their elderly nuns. In at least three aramayas,

nuns were siblings. Despite their chronological age, the first to enter the path had seniority,

and she was paid homage by other sisters by bending their knees and lowering their heads at

her feet. Typically, nuns renounce ties to family and friends, but it was not unusual for family

to visit the temple. Several nuns explained that they had not yet reached the *arahath* stage

(fourth and final tier of holiness), so family bonds were not entirely erased, but for them,

everyone was, in effect, a family member.

Community members. The community members who provided nuns with their

provisions proved to be among the most important links in the communication network of the

nuns. Nuns ate only twice a day: an early tea and a breakfast shortly afterwards and then

lunch at 11.30 a.m. They ate no solid food or thick beverages such as milk after the noon

meal. Many nuns received almost all of their meals cooked and brought to the aramaya. Many aramayas had a list of names and days of this meal-donation plan. When the devotees were unable to provide the prepared food on the scheduled day, they would bring in unprepared food the previous night or on rare cases gave money to buy it. Some nuns had more devotees than others. In some cases, lay devotees on pilgrimages, especially in sacred cities, gave alms, including food to many nuns, monks, and lay Buddhists observing sila. Often this was done to fulfill a vow made at a bodhi-puja or simply to accrue merits. These distant devotees served an important function for those nuns with little support.

Health providers. Conversations showed that some nuns knew their health providers, mostly physicians, by name, and their descriptions of them were often couched in terms of respect and regard. Nuns were of the opinion that men and women of the religious order were always respected by health-care personnel, but two nuns had observed how nurses could be "very cruel to other patients." One nun had even given a sermon to nurses to emphasize the need to care for the sick with kindness. She had quoted from a Buddha story where Buddha himself had tended to a sick monk who had pus-filled sores all over his body. Nuns with diabetes had frequent contact with lab technicians because the nuns had to get their blood tested every month in a lab. Only one nun in the sample owned a glucometer. (A monthly fasting blood glucose test cost 350.00 rupees (approximately $2.80). HbA1c was not tested in these labs). Some lab technicians even served the function of warning nuns about their high sugar or cholesterol levels, and emphasized not missing medical appointments. Despite the good relationship nuns had with health-care providers, seeking their help was not on the nuns' priority list.

Buddhist monks. Monks came up in nuns' conversations occasionally. Nuns never criticized monks, but these conversations did not leave the researcher with the impression that most nuns' contacts with them were mutually beneficial. Only a few nuns knew a Buddhist monk closely and mentioned that they were supported by him or by a monk-run temple. Two bhikkhunis insinuated that there was tension between ordained nuns and several Sri Lankan monks who held powerful positions.

The contacts of nuns are depicted in Figure 11.
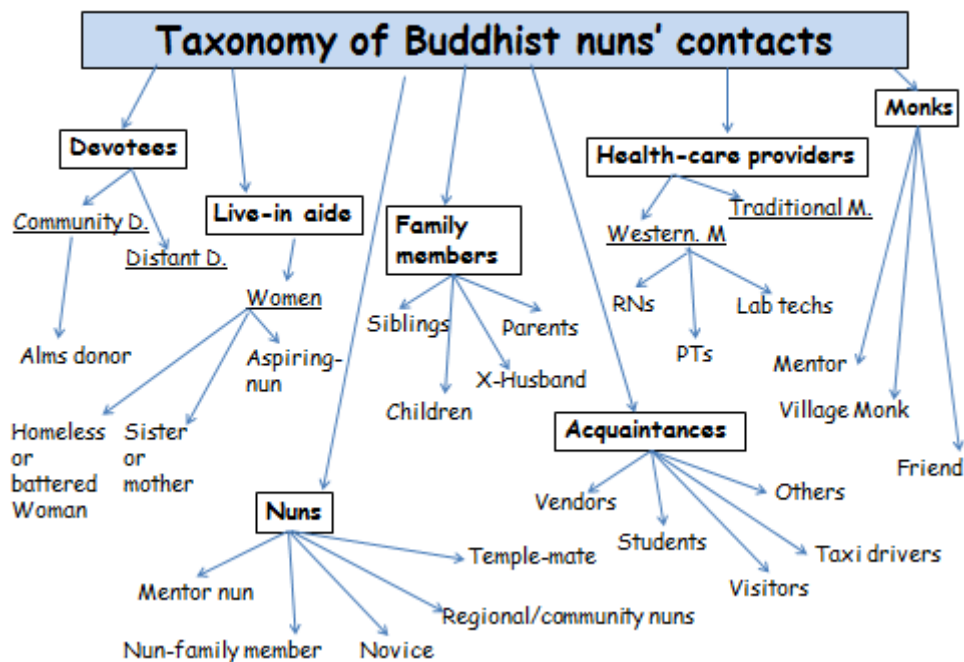
Figure 11. **Taxonomy of Buddhist nuns' contacts**

Activities. A taxonomy guide (Figure 12) was used to reach a systematic account of activities of bhikkhunis, and dasa-sil-matas. Formal and informal questions and participant observations facilitated describing daily, monthly, yearly and non-routine activities of the nuns.
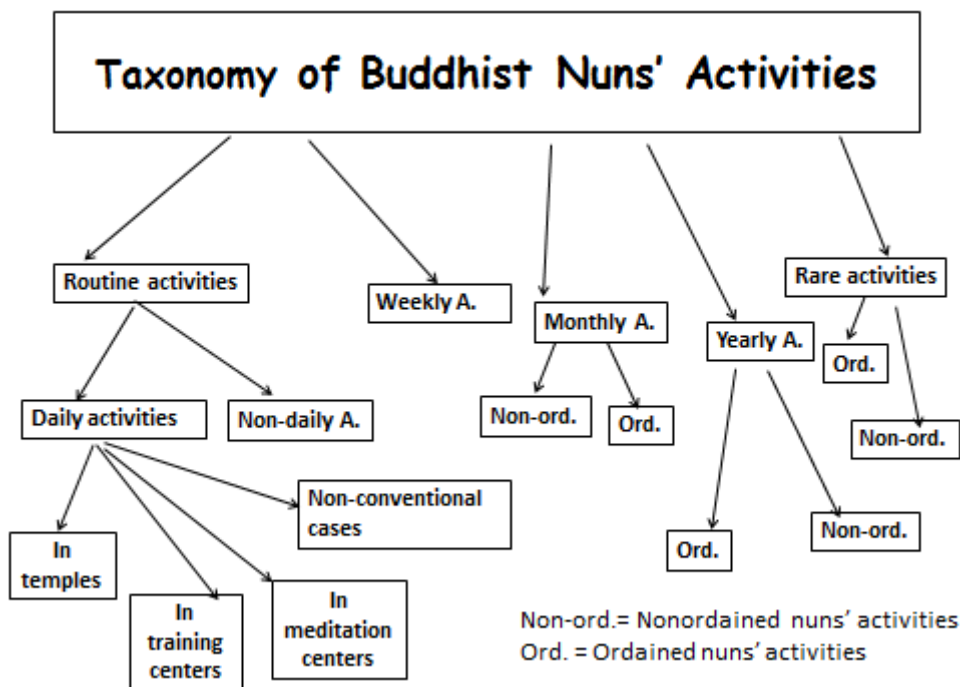
Figure 12. **Taxonomy guide for Buddhist nuns' activities**

Despite the study sample comprising of nuns from nearly all provinces, and with a variety of living arrangements, activities performed by bhikkhunis and dasa-sil-matas were not as varied as anticipated. All aramayas had at least a small setup of a *buduge* (house for Buddha worship) with an altar to place offerings of flowers, a saucer of food, a glass of tea or water, a rack for oil lamps, and a vessel for incense sticks. Morning and evening worship was the norm, but the frequency and duration, and quantity of offerings varied according to visitors' requests for pujas and to availability of resources. Several nuns in smaller aramayas

(one to four nuns) preferred not to have visitors requesting pujas throughout the day and thus had a timetable visible on the wall to limit outside visits to the allotted time. These temples, however, were few and far between. Most nuns were very happy to have visitors, discuss their activities, preach and bless them, and treat the visitors with tea and snacks. More organized activities were seen at training centers (separate centers for dasa-sil-matas and Bhikkhunis) and meditation centers (open to the public). At the largest *dasa-sil-mata* center visited (with 10 trainees), the head nun summarized the activities of a regular day:

> We all get up at 4:30 a.m. and if we know there are no alms offering on that day, then we cook together in the kitchen, attend to chores like sweeping inside and outside the temple. Then we all go, separately, to the Bodhi-tree and worship the Buddha. Then at 6:30 we give Buddha-puja before taking our breakfast. Those devotees who bring our alms for lunch come early. If there are no devotees with lunch alms offering on that day then we clean around flower beds and weed, break cobwebs, if it is necessary, clean latrines. If no lunch alms are anticipated, then we have to do the cooking. After cooking those who want to bathe do so. At 11:00 a.m., it is the time to offer Buddha-puja. We take the first portion from the cooked food before we eat for that. Then at 11:30 we take our lunch. Then until 5:00 we do not have any scheduled activities. We attend to things necessary like sweeping under the bodhi-tree area, keeping filtered water in the buduge (house for the Buddha statue). At 1:00 that child [pointing to a child] who wants to be a nun meets with me. Until she comes, I read a book. After that from 2 to 4, I teach other nuns as they come to me. From 4 to 6 it is 'don't call me for anything time' for me. I ask them to take phone messages, write down if necessary, and I ask the nuns not to tell others that I am meditating; I don't need any publicity. Instead, I ask them to tell people 'head nun is occupied.' At 5 p.m. other nuns prepare for Buddha-puja. After that we take our evening beverage (*gilanpasa)* at 6 p.m. Then at 7 we do the puja to the Buddha and we all worship together. Around 8, we all listen to dhamma sermon on the radio. Next we all go worship the elderly nun (bend knees and lower the head to show respect to an elder). Then after that we all go to our individual rooms and read books or those who study do their homework. At 10:30 we go to sleep.

Nondaily activities of most nuns consisted of going to invited alms offerings in devotees' homes or in other aramayas, as well as attending pirit recitals in the community or in local hospitals. Some nuns were invited to sermons in the community or in schools. Many nuns took an active part in participating or helping out in religious activities in other temples.

Without failure, we do bodhi-puja, sermons, on full-moon days meditation activities for those who observe sila, we go to all night pirit recitals, participate in preaching or meditation activities in schools and community during Wesak, and Poson festivals. If there is any religious activity in the community we are there too. When houses are built, when people get married, we give religious blessings. –Kuda

Both bhikkhunis and dasa-sil-matas performed these activities. Two bhikkhunis who taught Buddhist studies in high school had less time for involvement with the community. On Sundays some nuns conducted Sunday schools in their communities as long as the aramaya was not located close to a temple run by monks who had Sunday schools. Monks disapproved of nuns performing those activities when monks were available.

I do all meditations. I do not do merit-making ceremonies here. There are 11 temples around here. So the monks are not completely happy if we were to do the same type of ceremonies. So, when my devotees do activities in other temples, I give them a hand. –Handa

A more structured schedule was seen at one meditation center that housed 50 young dasa-sil-mata trainees. It was sponsored by a well-known Buddhist monk who ran several centers on the island. The day started early in the morning as in any other temple, but the activities varied depending on the day of the week. For example, on Mondays and Tuesdays, these nuns took a vow of noble silence, whereas Wednesdays were dedicated entirely to meditation. On Thursdays, the trainees were supposed to read books to improve their knowledge. Fridays were dedicated to tending to chores in the center. On Saturdays and Sundays, the center had special programs that included laypeople that flocked to the centers run by this monk. The program included meditation and a nightly sermon by the founder monk, mostly on tape. There were two other activities unique to these centers: first, every 15th day the dasa-sil-matas gathered together to openly discuss the problems of communal living of the past weeks and to resolve them. The trainees felt strongly that this activity

helped them realize their deficiencies and improve their behavior. It also allowed them to become a *kalyana mitta* (a noble friend who guides and is concerned with one's progress on the path of dhamma) to each other to direct them to the right path. The center changed the domicile of nuns among the six temples for females every four months to prevent nuns from developing an attachment to a particular region, temple, group, or room. Unlike all other nuns interviewed, the nuns in these centers neither left the temple to receive alms in devotees' homes nor to chant pirit and give dhamma talks outside. They associated only with the nuns or laypeople who attended the six temples. Even the family members of the nuns had to join a program in the temple during the weekends to visit the nuns.

Monthly activities unique to bhikkhunis—uposatha (Pali) (poya karanawa-Sinhala). Observance of ritual confession or *uposatha* was performed only by ordained clergy such as bhikkhus and bhikkhunis on the new-moon and full-moon days. During the ritual, the 313 rules of monastic code of the Buddhist nuns (also known as *Patimokkha*) were recited. If the ordained nun had infringed on any of the rules of the seven sections of the monastic code, she would confess and undergo penance. One bhikkhuni who was following doctor's advice to take a milk beverage at night with medicine said:

> Every month I have to admit certain slips in disciplinary rules. I had to take medicine with a Nestle malted milk at night. According to our monastic rules, this is "*vikala bojana*" (eating at un-prescribed times), so I have to admit having done that. – Mahia

Yearly activities of Buddhist nuns. A significant yearly event for nuns was the commemoration of the arrival of the Indian nun, Sangamitta *theri* (honorific prefix for a woman at the arahath stage) who brought the sapling of the bodhi-tree to Sri Lanka in the third century B.C. This was the beginning of the Bhikkhuni foundation in Sri Lanka. The

event was commemorated in December throughout the country, but the most festivities took place in the holy city of Anuradhpura in the North Central province.

Other organized yearly activities included all-night pirit recitals in bigger cities by nuns. Although all-night pirit chanting was customary for monks rather than for nuns, Sangamitta dasa-sil-mata committee chapters in different cities made an attempt to gather nuns from many nearby small aramayas for this event. Many nuns strove to give large yearly alms offerings to monks. Those nuns who did not have a large congregation to permit mustering resources for such an undertaking contributed what they could to help other nuns who could.

Kathina (rainy season retreat). Another important yearly event for ordained nuns was kathina. Many bhikkhunis who lived in small aramayas in areas surrounded by temples run by monks contributed generously (through participation and material resources) to the celebrations held by monks. Only one small bhikkhuni center with six trainees had its own celebrations.

Rare activities. A few nuns engaged in *pindapatha* (on foot begging for alms-food). They explained that during the Buddha time all bhikkhus and bhikkunis went from house to house with a bowl in hand to beg for their meal. The Buddha had enforced this practice to cultivate contentedness or renunciation. Although the practice was still carried out by bhikkhunis, two dasa-sil-matas described having done this during their training, and one wished to do so in the future to be less dependent on others. Other rare activities were nuns' pilgrimages to places sacred to Buddhists in India, Thailand, and Myanmar. Nuns with many supporters or even with just a few wealthy devotees had an opportunity to participate in overseas pilgrimages.

Activities of non-affiliated nuns. Four nuns enrolled in the study were quite different from the others in their living situations and activities. I call them non-affiliated nuns because they were not attached to an aramaya or center. Two of them were "mendicant nuns," and the other two lived in their "own" house on a semi-permanent basis. All had entered the religious life in their late 50s because they believed they had completed their responsibilities as wives and mothers and that time was ripe for them to "*para lowata weda karaganna*" (work toward life after death). However, the distinction should be made here that the sample included several other nuns who had entered the religious life late for similar reasons, and a few of them even lived in private residences but were not mendicants. Those nuns lived under scarce resources conditions, but they had small but permanent aramayas or small houses with a bodhi-tree and a place for Buddha worship. They had at least a weak link to the community or to a bigger aramaya that housed active nuns. By contrast, the two iterant nuns frequented sacred cities, sought opportunities to bless a pilgrim, (e.g., quick chant of pirit to a pregnant woman and tie a pirit-blessed cord around her wrist). In return, they received alms food or a small sum of money. The nun who lived in her aunt's house had lost her aramaya to another nun because of a land issue. Her activities consisted of devotional activities at her aunt's place. The fourth nun lived in her own house and often went out to bless community members or patients in a nearby cancer hospital. She received alms food and material needs for her services.

All Buddhist nuns were ashamed of mendicant or iterant nuns. Other nuns in the proximity of sacred cities ensured that people did not mistake them for a mendicant just because they lived close to a sacred city. One nun who lived in a sacred city and had a large

congregation was especially vocal about the situation with mendicant nuns because of how

the presence of mendicant nuns reflected on Buddhist nuns in general. She said:

> This can never be eliminated completely. Just imagine a woman 50 years old..[pause]..She comes to the holy city of A.. and goes to a nun sitting under a tree and asks her to make her also a nun and gives her some money. So, her head is shaved, but she has no training in monastic code whatsoever, and she too becomes a nun of the same sort. So they have to survive somehow, so they beg. This affects the way our society thinks of our Buddhist nuns. At A., we have changed the situation, at least, a little. They are not too many here. They creep in here from somewhere on holy full-moon days like, Wesak, or Poson, fix a shed some place and stay. To these old women, we have said, 'If you have needs come to us. Don't be like this. One said, 'oh my lady, what do we do for hunger?' So I also gave her 100 rupees (about $1 U.S.). Even if we establish a foundation to help put them up, it is not easy to manage them. Our advice for them is not to be like this, but go to an aramaya and ask to stay there, so that they might be kept there. They do not like it either. They want to worship at the holy *dagabas* (shrines), stay around there. If somebody gives something take it, and just hang around the area. There are also others who take what they can and send them to their homes. When good wealthy devotees come around, they give things and these nuns take these things and send to their families. –Vihara

The choice of homage shown in nuns' activities. It was remarkably clear that

despite their previous explanations of the need to balance amisa-puja and patipatti-puja to

prepare for their ultimate goal, nirvana, only a handful of nuns made meditation (patipatti-

puja) the exclusive, or even primary, focus of their spiritual practice. Conversations indicated

that most nuns tended to it whenever they could find time, such as while walking on the road,

while traveling on the bus, early in the morning before getting out of bed, or just before

falling asleep. Some nuns used the argument that it was not necessary to have the eyes closed

and sit in one place because amisa-puja, such as offering flowers, could serve as meditation

when they reflected on "how beautiful flowers wither away representing the impermanent

nature" of life. Some nuns said they did not have formal training in meditation. Except for

three or four nuns who had a deep understanding of meditation, great majority mentioned the

type of meditation they practiced as "loving kindness," commemorating Buddha qualities,

and *pilikul bhavana* (reflection on the repugnant nature of the body).Thus, most nuns engaged more regularly in amisa-puja (ritual and ceremony) than in meditation.

Changes in Buddhist Nuns' Lives

In describing changes in nuns' lives participants reflected on events from their past, recent events and also changes they wished to see in future. Nuns took great pleasure relating the milestones of the path leading to her current status as a nun. Spiritual changes and adjustments to illness were the major components of the present condition. Higher spiritual achievements and material needs were among the anticipated or planned for future changes.
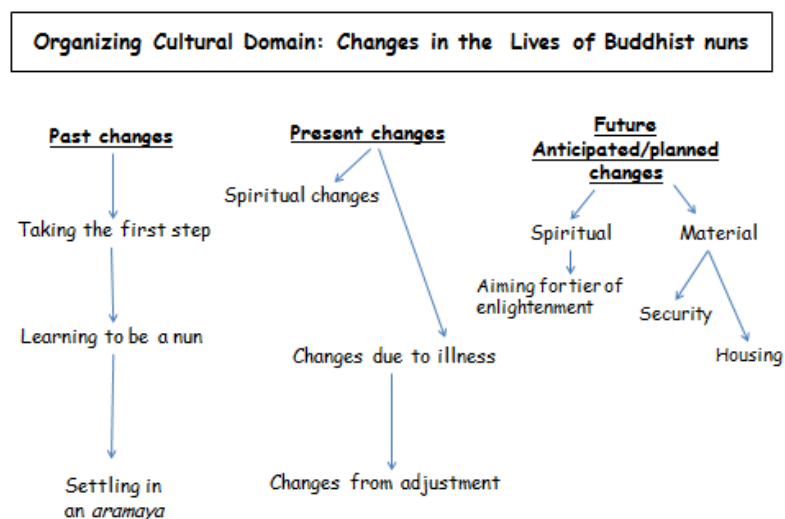
Figure 13. **Organizing cultural domain: changes in the lives' of Buddhist nuns**

Past changes.

Taking the first step. The great majority of nuns agreed that their current status as nuns accounted for the happiest time in their lives. Several also had pleasant memories of their childhood. Some women, especially those who had entered the religious order at a

young age, described, often with great emotion, how serving as a nun was the most

significant event in their lives.

> The happiest day in my life was when I finally entered this path as a Buddhist nun. I had the enthusiasm and energy to convince my parents to allow me to leave them to become a nun. It was with great difficulty I could get permission to come to this path. They were not happy about this at first. It was the most unforgettable event in my life. –Mala

Some parents were opposed at first, but had since reconciled themselves to their daughter's

choice to become a nun.

> My father hit me when I kept saying I wanted to become a nun, but now he comes here and sheds tears of happiness. –Mahiya

One nun ran away from home as a young woman to escape an arranged marriage. Others

entered religious life because a parent wanted them to.

> My father wanted me to be a nun when I was just 14 years old. I was the eldest in the family. We came from a rural area. I did not really want to be a nun. I even thought of running away from the temple several times, but I am glad I somehow stayed. – Sanmahiya

One had planned on becoming a teacher. Her father had encouraged her to follow her dream

and had often sat by her reading the newspaper while she studied long hours into the night.

When her father suddenly died of a heart attack, she was inconsolable. A nun in a nearby

temple convinced her that solace was possible only through renouncing the world. But

preparing for this change was difficult.

> I used to be very fashion-conscious. I used to wear lipstick and nail polish. I had nice hair and I used to do many things to it. I wore miniskirts. I actually came to the temple like that. My older sister had laughed that I would be expelled from the aramaya. The second nun in the aramaya was a bit rough. She said to the head nun, 'You are not trying to bring this fashion bug into the religious order, are you?' I was patient. –Vihara

Other personal tragedies such as a parent abandoning the family, a sudden death, and infidelity or substance abuse of a husband had made some of the women enter the life of the religious. Several entered religious life relatively late. Among these were well-to-do childless women who embarked on the religious path after age 50. One was not even Buddhist until that time. Another latecomer of a more humble background wished to become a nun from a very young age but could not bring herself to disobey her parents when they had said, "Daughter, if you leave us now, who will give us a drop of water at the time we are dying?" She had cared for them until their death and entered the Buddhist order in her 50s.

Not all women who entered this path were disillusioned with life. Many were in accord with the following sentiment of one nun:

> It is not that I was disillusioned by some particular event in life. It is the realization of the futility of life that brought me to become a nun to end these rounds of births. – Baka

Some ended with this qualification: "It must have been a *sansara purudda* (the disposition to become a religious person that had followed her through the rounds of births)." For another woman, becoming a nun was only a natural continuation of her zealotry after having been "*pissu*" (mentally unstable) for some years:

> As a kid I was always thinking of the Buddha, and I used to put a small statue of Buddha in a box and walk around spending all day in temples and sleeping in paddy fields. –Elaka

Learning to be a nun. Having entering the path, the nuns had to learn the monastic way of life. Progress toward this end was not smooth for all nuns. The age of entry into the order appeared to be a factor in the facility of their preparation.

Age of entering the religious order. The chronological age of entry mattered less than the station of life the woman had occupied just before entering the religious order. Whether

she had entered a marriage and borne children seemed to have a significant impact in her

monastic training and her spiritual practice. Baka, currently in her 40s but who entered at age

20, observed:

> Those who entered this path late have gone through many years of lay life. They are different. They have to start from ABC. They have to learn to talk, walk, daily chores of a nun.

> Goraka, the head nun of a small bhikkhuni training center, itemized areas where

latecomers fell behind: mentoring, being set in one's ways, and missed years of training.

> When someone enters nun-hood young, she will be under the mentorship of an older religious person who would lead the junior to have a good education. So when they reach adulthood, they have many skills in doing merit-making events, dhamma sermons, meditation offerings, and community development. Some go to advance education in universities later on.

Mentorship helped build security in the austere life they had chosen as young girls:

> Even when we entered religious path as children we had no fear. We had adult nuns for protection, not lonely, wherever we went to study they were there, for any need, they gave us a hand. So even if we felt sad or wanted to do a merit-making event, they were there.

Length of time spent as adult lay women was a disadvantage

> Those who enter nun-hood late do not get a primary education to be in the religious order. There are *sekhiyya* (monastic discipline rules) that apply especially to ordained nuns, like how to clean or sweep, cook, brush teeth, wear clothes respecting adults, how to do spiritual tasks, how to behave with people. They learn a lot from an early age. But the person who enters the path late as an adult, already knows her ways because she used to work in her own home. So teaching such a person like teaching a child..[pause].. There is just no time, and also it is not done

Even voice training was important for preparing for community service

> There is a difference between someone who enters nun-hood when 20 years old and an older person. For example, learning to preach and chant..[pause]..Young novices are asked to chant loud, learn pronunciation, sit under a bodhi-tree or near the shrine and learn to read aloud in a rhythmic way that is pleasing to the ear. This training is important. Many devotees are attracted to this pleasant chanting when we give bodhi-puja. We cannot chant from the voice we speak. It has to be a pleasant voice that

narrates Buddha qualities, that cites the compassion meditation, during Bodhi-puja so that it can calm people's minds. There are exceptions. If someone has devotion from the beginning and has practiced sila and bhavana, she may develop skills in preaching.

Entering monastic school as an adult was not easy:

An adult can go learn in *pirivena* (religious school), but the young monks/nuns who enter *pirivena* have an advanced knowledge because when they enter they had already learned a lot. So when an adult enters *pirivena,* this discrepancy is seen at once. They may take some course at a higher level of education, but it is rare that an adult will go from the beginning. There is no age limit to enter *pirivena*, but it is not done.

Although there was no age limit to learning, most nuns abided by a self-imposed age limit to continuing their education in a school or institute.

I went to a *pirivena* for two years. I am not at an age to keep on studying. Now I read books to gain knowledge. Also, when I teach Sunday school classes, even the things I had forgotten come back to me. –Mala

In general, the number of years of education at an advanced level seemed to matter less for being a nun than her ability to explain, motivate, create interest, and transmit a message in Buddhism. This applied not only to how the nun determined her priorities in Buddhist practice but how she created a great following in her community and beyond. There were examples of nuns, both erudite and those with a basic Buddhist education, who were in great demand in the community. Those with a limited Buddhist education had enthusiastically built up on their base by reading and listening to dhamma discussions.

Stability in domicile. Finding a suitable aramaya to settle in after the basic monastic training appeared to be a trigger for tension to many nuns. Several nuns had changed domiciles more than five or six times and were still in search of a place to fit in. Nuns did not emphasize that age of entry played a role in this, but several participants indicated during interviews that nuns who had left their families at an older age (after marriage and raising a

family) had more difficulty adjusting to a highly regimented living situation than those who had entered the religious life at an earlier age.

Another apparent advantage of growing up in a steady mentorship was inheriting the aramaya and becoming the head nun when the old head nun passed away or became incapacitated. Some nuns also had received land or already built aramayas as presents from devotees or monks and in one case from a government minister. The nuns who inherited an aramaya had various stories of how that came about, but all such stories had at their base the mentorship of a well-respected monk or a nun. In contrast, some nuns who came from families of means lived in temples constructed by a wealthy parent or relative. Other nuns had inherited family land where they had spent their childhood. Building a temple on inherited land made life easier for these nuns. The community devotees were known to them, and in some cases, they were extended family members.

Regrets. Only two nuns admitted any regrets over becoming nuns. Ampa, a nun from a hardship area explained that she had become a nun because her husband had died in the civil war and she had no children. But she believed nuns were treated as belonging to a lower class compared to monks. "In all honesty, I could have done a better service to Buddhism as a layperson because it gives one more freedom," She said. However, she quickly added:

> On the other hand, one has unending responsibilities and strings attached to a family life. They keep one occupied and give no time to devote to things that I am doing now.

Another nun living in her own residence after living in several aramayas said she had made the decision to become a nun in haste before knowing the living conditions of nuns. She had been a devout Buddhist, attending to religious festivities and helping out in temples:

I observed the eight precepts every full-moon day and learned to meditate in a training center. But, I was having problems with my daughter-in-law. In order to avoid the situation, I took the advice of a friend. My friend convinced me that becoming a nun would be a natural next step for me after all I was doing in the temple. She also recommended a temple where they recruited older women. It was very difficult there. Then I went to two three other aramayas to learn the monastic code of the nuns but found it very hard to live with fellow nuns. I think there are problems when women live together. I do not think monks have similar problems. – Katuwa

Present changes. The nuns talked at length about their spiritual progress as well as

their adjustments due to illness. Most nuns talked about their religious life with great joy.

When we compare our lives to those of others and our siblings, we can see that our lives are lighter, we can advance internally, we do not have issues of the lay people. – Baka

One young nun mentored by a well-known monk in a meditation center found her wisdom

continuously enhanced by her teacher, whom she called a "*kalyana mitta*" (a noble friend

who guides and is concerned with one's progress on the path of dhamma).

Many nuns felt internally secure in a devout life:

Ever since I have come along this path, dhamma has become the most important thing for me in this life. Even when nobody wants me, dhamma will not abandon me. If you live in any place, no matter what happens around you, you will be protected. – Minna

I do not have any worries. The Buddha has preached that one should live in a suitable place. Also, our behavior toward people is also important. We have not had any problem since we have been here. – Mala

Learning to sever attachments was an ongoing process but one that brought them internal

peace:

It was once asked of the Buddha why his disciples looked so pleasant when they ate only one meal a day and sheltered outdoors under trees. The Buddha replied that 'my disciples do not worry about the past and the future. They live in the present.' I do not have the problems that the other lay people have at this age. –Vihara

Several nuns pointed out that those who entered nun-hood later in life, after having families, had a difficult time breaking attachments to their children.

Changes due to illness. All nuns emphasized the importance of good health to strive toward their ultimate goal, nirvana. However, the majority of nuns showed little interest in talking at length about how their chronic illness affected their spiritual practice or other activities. Many nuns had the tendency to digress in to spiritual stories from the Buddha life and Buddhist stanzas. On the whole, it was more the case that their spiritual practice had more impact on their illness than the illness had on their beliefs and practice. For example, when participants spoke of their limitations due to illness, they emphasized that the illness meant little to them or that they lived "above illness." Four nuns were exceptions who were eager to talk about their illness. They indicated that the most important thing for them was to get over their illness.

Changes due to diabetes. Because the most common condition of the participants was diabetes, the changes these nuns experienced will be discussed first: The main change nuns had in their lives due to diabetes was forfeiting the freedom to accept anything edible that helped "prevent discomfort of hunger" as the moral attitude toward food dictated in the monastic code. Because the nuns were dependent on the community for their food, "anything edible" corresponded to the typical Sri Lankan diet, which consisted mostly of foods high in carbohydrates and saturated fat. Therefore, changes were necessary in both quality and quantity.

Negotiation. Type 2 diabetes has reached epidemic proportions in Sri Lanka, and all nuns had received instructions from health providers at least once. Many nuns could recite by rote the list of appropriate foods for managing diabetes and preventing or delaying the onset

of complications. Many Sri Lankan Buddhists had the tendency to give the best quality and

best tasting food to the monks and nuns because this generosity is thought to lead to the

greatest merit. Unfortunately, such offerings were high in carbohydrates and fats. Buddhist

monastic code dictated that clergy should accept without complaint whatever is offered by a

generous donor. It took a self-assertive and diabetes-savvy nun to communicate effectively to

alter the situation in a manner that remained humble and appreciative (for example, by

requesting just the raw material for the food to be cooked at the aramaya):

> When we accept an offering, we accept only the ingredients, and those devotees get together with the live-in aide here to prepare it because if they prepare the food in their own homes using different flavorings, it will be a problem for us, not for just a diabetic person but even for a healthy person. These flavorings are disease makers. When making food, it is not the side of taste you have to look at but the nutritious aspect of it. –Uda

Some devotees, especially in low-income areas, offered what they could afford to the nuns.

Many nuns were reluctant to ask for different foods from the donors, partly because they

were familiar with the local economic conditions, and partly because they had learned from

Buddhist history that even the Buddha had accepted anything that was placed in his begging

bowl by a donor. They gave the example of how the Buddha did not refuse cow dung placed

in his begging bowl by a mean-spirited man. Instead, he had taken it back to the temple and

asked Ananda, his disciple, to use it for fortifying the clay floor of the temple.

A nun who lived close to a sacred city said:

> Well, some may know I have diabetes because I am old, but we cannot tell devotees this and that. They give according to their possibility. We cannot disturb anybody. There are a lot of nuns all over here. There are temples all over. So whatever they give cooked food or raw material, we accept them. –Anura

Moderation in cooking with oil. Many nuns had heard that high content of oil was detrimental to managing their diabetes. This was a challenge because for many Sri Lankan women oil was used to make the food tastier:

> My cholesterol had reached over 390. The doctor yelled asking if I was waiting for a heart attack to take place. They took my EKG immediately. Now it is lowered, 180 or so. It was like that before, like everybody else I enjoyed eating tasty food. I could cook very well too, so I used oil to make things tasty. But now, I say, 'if I can dedicate my life this way to become a nun, why can't I change my diet?' Now I drink skim milk, vegetable gruel three times a week, now it is much better. –Vihara

> We cook sometimes with a bit of oil, but we try not to overdo it. I think we have diabetes, when we overdo thing. –Raga

Moderation in intake and taste. Many nuns had learned to pick and choose from their donated food and to substitute from donated raw material. For example, if the alms offering consisted of white rice and a curry, the nuns would cook brown rice for the diabetic nun in the aramaya.

> It is because of desire for taste that we take all kinds of food devotees offer us. If we dominate the craving for the taste, we can take plain rice thinking it is ice cream. This is how we take it to our minds. The Buddha has not said that you should consume everything you get. You can cover the bowl with your hand when the devotee serves to say 'this is enough.' For example, if you take a spoonful of ice cream, you may not have a problem, but if you fill the bowl with ice cream this could be a problem. According to your age, you can manage these things. –Talwa

Adding physical activity. Medical advice to add exercise to nuns' daily activity was especially challenging for nuns. Before globalization and rapid modernization in Sri Lanka, people had lived in an agrarian society in which exercise corresponded to physical labor required in everyday life. Attitudes from this era may have lingered because physical activity without a specific purpose (e.g., just walking as opposed to walking to buy groceries or to school) was less acceptable. An added barrier to exercise for Buddhist nuns was the

monastic code of conduct that restricted vigorous movements. At least one nun had taken

steps to adapt to the situation:

> Vigorous exercise, the type others do, does not fit our virtuous practice. It is better to combine it with something that is useful to us. For example, when we sweep, we clean and sweat at the same time. We go back and forth and meditate and that way doing two things that are good for mind and the body. I do chores to sweat. It is not that I need these chores, but as an exercise. I do these because I think it helps me manage diabetes. I sweep, break cobwebs, climb up stairs, and get down, teach kids. I feel that does good in the body. We get enough food to satisfy us, but we do not use it up. So is it a wonder that we get sick? – Mala

Only one of the nuns with Type 2 diabetes was on insulin. Although there was a tendency for

them to switch between Western and traditional (Ayurveda) treatments, many diabetic nuns

were on metformin or were managing diabetes through diet. Some tried herbal supplements

to reduce blood sugar levels on hearsay knowledge rather than receiving treatment from an

Ayurveda practitioner.

Other medical conditions requiring change.

Taking meals after noon time. Many nuns who had to violate the monastic rule of

taking a meal after lunch had difficulty with this change:

> In additions to cough, headache caused by sinus problems, I have chronic gastritis. I have to break a precept *vikala bojana* by taking a glass of milk in the evening. – Uppala

> I take medication at night. So, I have to take something little at night so that my stomach will not have the burning sensation in the morning. It is a lifeless feeling. – Mora

Taking animal protein. Although the Buddha had not enforced a rule of

vegetarianism (allowing for medical advice for illness conditions), all Sri Lankan Buddhist

nuns were self-imposed vegetarians. One nun who was advised by the physician to include

some animal protein in her diet due to weakness had found it repugnant to include sprats in her diet.

Cutting previously scheduled activities. Several nuns were required to be less active on their feet due to their illness or weakness stemming from the illness. A nun who had several conditions, such as diabetes, breast cancer in remission and a nerve problem that caused her to fall when getting up from a seated position said:

> Before illness I spent my time efficiently, but when I got ill I had to distance myself from many merit-making events. I do less work. I help sweep inside and outside, if not I read a book. When devotees bring offerings, I participate in conversation with them. It is difficult to stay in one position to meditate often, but I do so because it has become a habit. Yes, I do things like preach, but with help. –Mora

More serious conditions. Some common characteristics apparent in the narratives of nuns, especially in serious cases, were their lack of specificity to illness details, nuns' difficulties with adherence to strict medical regimens, and their willingness to switch to alternative remedies or experiment on their own. Nuns, in general, appeared to have an attitude that could be summarized as acknowledging that they have had to make changes due to illness and that it had limited some things they used to do, but there is no point showing this to others or giving in to illness. This is the nature of life, and one deals with it as best as one can.

One nun started her story by saying that she had had diabetes for 13 years, and the doctor had also warned her about elevated blood pressure and cholesterol levels. She mentioned her limitations but immediately added being "above illness."

> My health status goes up and down. It is not always possible to continuously meditate because of my health situation. I have to often go out to clinic appointments, check-ups, etc. I do not think of sickness very often. I try to guard what goes into my mouth. I do not have an inclination to eat everything I see. Often I control what I eat. Like that I am never under the power of sickness, I continue my service to *sasana*

(Buddhist foundation) as much as possible. Whatever happens, happens, according to my previous karmic energy.

When I was diagnosed with diabetes, I was just 19 years old. I was already a nun then. First I felt weakness, dizziness and got medicine from here and there, but it did not work. So, a lady known to us took me to a Colombo hospital and at that time they checked my blood and urine and said 'How old is this nun, she has diabetes.' And since that time I have diabetes. I started using insulin just four years ago, but before that I was just on pills. I took the pills for a week, and diabetes abated, and for the next five years I took no medication. And gradually I had to get back to two different kinds of pills and then the problem came as far as my kidneys, and even hospitals refused to accept me. They even said that I had few months to live, and then I was sent to the medical college hospital and there, after asking many personal questions, they checked my kidneys. I was told that my kidneys were very bad, but I went to another place and they said that the kidneys have recuperated. –Swara

Two other nuns with rheumatoid arthritis had gone through treatment in the hospital and had

learned about the requirement for exercise to regain the strength of their joints. They,

however, were not fond of traveling to the capital city to be surrounded by crowds and noise.

Their solution was to learn what they could in a speedy manner and to improvise the

exercises on their own. Uda who had both diabetes and rheumatoid arthritis, explained:

All these [showing her hands in a fist] were stiff like rocks. I had many exercises to do at the hospital. There are 33 exercises. I was unable to turn any of these fingers. In order to learn those exercises, one needs to go to hospital for months. An electric current had to be passed through the knees because I had 'water.' For that also have to go two days a week. I need these exercises, but I do not like very much to go to Colombo. So I said, 'Teach me all these exercises in a short time. I have to be responsible for my health, teach me all.' Nerves were all gone, daughter, unable to lift even 10 grams, not able to move the robe. So, I was told, 'Count and lift 100 *madatiya* seeds [small red seeds of the size of peas -*Adenanthera pavonina*] 10 times' like that. I was told everything I had to do. I learned everything very well. In a short time, I could bring my whole body to function like before. This is supposed to be one of the diseases, which makes your body unsightly. All these [pointing to her legs after moving the robe] turn and become bent inward, like rocks, all these fingers unable to bend. I did all these exercises. When we go there, I often preach the word of Buddha. Everybody during rheumatic times talking about ending the life. Why? Because one is not honest to oneself. Exercises learned there, they do not do at home. So, the exercise-helper-daughter there [female physical therapist] said 'Venerable mother, you are the only one who, after these years, has recuperated.' I was not able bring my arms back. In the hospital there are exercises for this with large pegs, nails, and boards. So for me, there are no nails or boards here, but I took a piece of wood

with similar weight to do that and continued doing these exercises again and again and fixed the problem.

Uda lived in a colder climate, which the doctor had advised against. She told the doctor:

> Although it is warmer there, it is possible I will die soon because of the mental confusion that environment will bring. Here, at least, we have only to worry about the cold. But, there are ways to reduce this cold. We can wear long sleeved-clothes, use a thick, heavy blanket, put a pair of slippers, use hot water, close the doors and windows to the chamber in the morning, in the morning put both hands in hot water. Then I really feel this warmth moving to all parts of my body to reduce the cold. I don't know if I sense this way because I meditate and am mindful of sensations. If the knees are cold, and then we rub an ointment called, "*suhapali*" on knees.

Goraka, who had rheumatic arthritis, admitted that her health was not optimal though nothing was visible to others. "Pain is sometimes like an animal biting my joints.", she said. She attributed her illness to having worked hard as a young nun and not getting proper nutrition. "We made the shrine, with our own labor.", she said and continued:

> Now when I get up in the morning, it is difficult to bend. I do not take anything special for it. According to the situation, I handle it. If the pain increases I take a Panadol [paracetamol], avoid taking 'cold things' like king coconut [orange husked-Cocos *nucifera*] ice cream, don't use cold water. If I get wet in the rain, I immediately heat water and bathe. If the pain continues, use some Ayurveda oil, and rub until my legs feel warm from it. I wear a pair of socks and in the morning, it is already better.

Another nun with a host of ailments such as high blood pressure, diabetes, and elevated cholesterol also suffered from a heart condition, which she described as, "three heart valves are too narrow." She said with a bright smile that getting these illnesses "was a good thing" so she would "realize the impermanent nature of this life." She continued:

> I need to take close to 20 pills for my problems. Since I cannot go to Colombo often to go to the hospital, I get Ayurveda medicine at [place name] now. It is difficult to work now because I tire out. I do not do a lot of work in the morning. Most of my functions are in the *vihara*. Sometimes when I cannot sleep, I wake up even at 2 a.m. I would still go to the *vihara*. The doctor says I should rest, but in this life, during the time I can still be on my feet, I should take the maximum advantage. –Handa

Spiritual means of handling symptoms. In addition to the prescribed, traditional, or improvised medical remedies, some nuns had confidence in a spiritual means of handling their symptoms. These included entreating "*sattha kriya*" (advantageous action; e.g., commemorating events from the Buddha life or some positive action one previously had performed), applying their skills in meditation, or reiterating the phrase *anicca vata sankara* (all formations are impermanent) that they had heard throughout their lives and accepting its reality through their own lives.

      Sattha kriya. Uda, the nun suffering from rheumatoid arthritis and diabetes, based her *satttha kriya* on the power of commemorating the excellence of the Buddha

> At night, I always commemorate *budu guna* (Buddha qualities). Although I like to drink cold water, I would use boiled water, a bit cooled…facing the East, reflecting on nine supreme qualities of the Buddha I consume a large amount of water but slowly in the following manner: I imagine that the Buddha qualities become a medicine for me. I am taking this medicine, a kind of supreme energy, and let this energy enter my body, my blood, go through big veins, and then move through smaller veins, go toward my skin. May all the deficiencies caused by my illness be dispelled, may that bad "*vayu*" (wind element) leave my body, and may I gain energy and wisdom. Meditating this way, I take this water for one hour or so and don't take anything else into the body.
>
>   And then, I begin my work, I worship all the Buddhas born [before the most recent Gautama Buddha] and the Buddha to be born next. I worship in my mind all the aramayas Buddha lived in, I worship the palace of the tooth relic of the Buddha, and wish that with this power, not only me but all sentient beings be blessed and cured of illness. Early in the morning, a great amount of positive thoughts cleanse my blood. I bring the Buddha to my heart, and the Buddha's shining rays go through my large veins, small veins, into my blood. I wish I will be healthy and be without woe and I can achieve my goal toward nirvana and I will be able to explain about nirvana to so many others today, and I will have energy, fortitude and wisdom.

      Meditational skills. Meditation mitigated symptoms of nuns who had advanced their skills in this area:

> I have not made my sickness a problem for my meditation and other activities. As I explained when talking about meditation, you don't just sit and close your eyes. There are steps to follow. When you have trained meditation properly, whenever you

feel the pain, you look at it as it is not my pain, there is no such thing as pain.
–Goraka

Kadawa, a nun in her 70s, said:

> Being healthy is important to achieve nirvana. I have diabetes and high blood
> pressure. I am taking medication. What to do? Above and beyond sickness I reflect on
> the supreme qualities of the Buddha. Even when I am lying and resting I reflect on
> *vipassana* (insight meditation), then I feel the disease is a bit reduced. Otherwise to
> live with diabetes, so long, 35 years, wouldn't work. Right? It is a serious illness.
> Every time I can, even when I change from one position to another, I reflect on my
> movements. Like that I improve my meditation.
>   Sometimes I feel dizzy, but whatever I have, I don't concentrate on that.
> When you have dizziness, you reflect on that very thing, 'dizziness, dizziness,
> dizziness' Then I get up, wash my face, make myself a beverage, and continue with
> what I have to do. When dizziness is bad, I take a tablet for blood pressure. It is like
> that. What to do until we cross this "sansara" (round of rebirth); this is, what we have
> *dukkha* , dissatisfaction, physical *dukkha* and mental *dukkha*. Health is important to
> achieving nirvana, so I do whatever I can do.
>   I go to chant pirit. There is no such thing called 'I can't.' Just a few days ago,
> I was even out until 10 p.m. returning from a dhamma sermon. Like that I go to give
> pirit chantings, do everything, don't stop saying 'I am sick.' Yesterday when I
> finished a bodhi-puja it was 7:30, or 8:00 p.m. Like that..[pause]..my plan of work
> from the beginning, I carry out. I was supposed to go to the clinic today, but because
> of an alms offering I did not go.

Other nuns too regarded meditation as bringing health, but it was difficult to discern in which
way the nuns benefitted from the practice:

> Meditation controls our mind. It helps cultivate good thoughts, grows compassion,
> removes angry thoughts, and in that sense it affects your health. It helps one follow
> the path the Buddha has shown. –Raga

Anicca vata sankara (All formations are impermanent). All nuns, regardless of their
level of Buddhist knowledge or health status, at some point during the interview, interjected
the notion of accepting the impermanent nature of life. They often referred to it in terms of
the body disintegrating "into its original constituents." They all accepted that *karma* had an
important role to play in what disease they contracted and how they fared with it or how their
life ended.

I often reflect upon it that even the Buddha was sick during his last days. It is like that karma runs after you. –Mora

They brought many stories to point out that many disciples of *arahat* stage (highest tier of holiness) not only had physical ailments but one of the Buddha's two main disciples (Mugalan) had to finally accept the destiny of being murdered by a band of robbers as a karmic punishment. The story went that venerable Mugalan *thera* previously had escaped twice from the robbers (once fleeing through the keyhole of the room using his *jhana* or specific meditational absorption states suspending all sense activity), but he knew he finally had to accept his fate. Nuns often ended with words to the effect of: Even the Buddha could not avoid his final illness, so what can we say about us? They explained that happiness and sorrow alternated in a cycle, that the human body manifested such circles in various diseases and that eventually one succumbed to it.

Changes in the future. Observations, casual conversation and interviews indicated that Buddhist nuns' expectations or wishes fell into spiritual as well as material realms. All nuns, at some point of their conversations, had mentioned their ultimate goal as nirvana, but several statements provided clues about how they evaluated where they stood in relation to their goal. The majority of nuns said they were 100% happy (one even said 500% with a bright smile and even added that she was the happiest nun in Sri Lanka), but they elaborated that they could be even happier if they could reach *sotapanna* (the first tier of enlightenment) during this lifetime. One nun explained it this way:

> The most important thing for me is to attain the stage of *sotapanna* during this lifetime. I still have a bit of difficulty abandoning the notion of I, myself. If I can crack it a bit, I can attain *sotapanna* stage. – Kanda

Another nun combined this concern with the practice of meditation more than she was doing currently:

> We used to meditate day and night in a place in R…. There, we only did meditation. In places like these, we have difficulty going on the path we need to go. One cannot go on meditating if it has to be broken again and again. It is difficult to advance that way. You have to be dedicated to it. – Mona

The importance of meditation was reiterated by other nuns:

> I am 100% happy now, but I can be even happier. I have not gone to a meditation center and meditated. This is one reason why I got that building by the devotees [pointing to a small isolated room recently built and freshly painted] so that I can go to a meditation center, learn and practice meditation. I have to gradually free myself and fulfill the purpose that I came to this path for. I have to meditate. I am thinking of sending all these young nuns to do the same. –Vihara

More free time for reflective activities was a wish for other nuns too:

> I live very happy. I can be even happier if I can live in a less popular place, live by *pindapatha* (begging for alms with a bowl). I am hoping that in a year or two I will be able to realize this. I have little time to listen to dhamma sermons or meditate. Because I have the title *samadana vinisyaka* [analogous to the justice of the peace), and people come to get certificates. –Mala

Other nuns were planning for several births ahead:

> My only wish is to be able to enter nun-hood as a child every birth that I pass on this journey. –Banda

Some nuns were even more specific:

> I live in great happiness. I wish that if I were to be born again, I would enter the religious order at 7 years of age. –Mora

Yet another woman who had become a nun in her 50s wished that in her next birth she would be born male and become a monk at the age of 7. She explained that a man could meditate in forests or under a tree without having the safety concerns of a woman.

Some of the nuns felt more confident about their state of spiritual achievement. For example, one young nun at a meditation center assured me that not only the nuns but also

myself could achieve *sotapanna* during this lifetime, and she encouraged me to continue

meditation.

Several nuns distinguished between achievements that could bring lasting joy in the

future and other temporary fulfillments:

> I do not have any specific plans because we have already entered the path leading to the *arahath* stage (fourth tier of enlightenment). So the more progress we make on that path, the happier we will be. Apart from that, some external things could also make us momentarily happy. For example, I am teaching young children to meditate and learn Pali. If they reach a position where they will do well, it will bring me great happiness. If our pupils go the wrong way, hurt themselves and others, it will be a cause of great unhappiness for all of us. We already have the main reason for our 100% happiness, but these external things can give us momentary happiness or unhappiness. –Uppala

The wish to meet the needs of the aramaya emerged repeatedly in the interviews. In some

cases it was only an option, but in others a significant requirement:

> We wish to advance our path with patipatti-puja. We know we cannot attain nirvana in this birth, so we move on that path gradually, toward nirvana. Of course, there are other things we can do such as improving our dwellings, temple, etc., but it can happen that when we finish one thing, something else will come up, so we cannot say that such things bring us happiness. –Baka

Some nuns compromised:

> This aramaya has been here since 1986, and the bodhi-tree has roots going into the house and therefore the aramaya has to be rebuilt somewhere else. But we do not worry about this. If we can, we will do it, if not those after us will do it. –Mahiya

The need for recruiting and training additional nuns seemed to weigh heavily on the minds of

several nuns. Most head nuns preferred to recruit nuns at young ages. One nun explained that

when a nun was recruited into a temple, she became like a child in that temple and all her

needs in health and sickness had to be borne by the temple. Although for a temple with a

strong supportive congregation this might not be a great concern, for nuns who lived in

difficult and remote areas financial support would be required. A large portion of the

expenses included making small "*kutis*" (small cabins) for individual nuns. Several interviews ended with nuns emphasizing this financial need.

For nuns who lived in somebody else's house, rented a small place close to a scared city, or occupied a temporary shelter, housing was a troubling issue. Most of these nuns had experienced unpleasant living situations with their own family members or fellow nuns in previous aramayas. One described how her temple was forcefully taken by another nun who had become a nun to solve her personal problems. Although no attempt was taken to verify any of these stories, it was evident that several nuns feared being homeless and abandoned in their feeble age. Two nuns even asked if I could help find them an aramaya.

Descriptions of the changes in the nuns' lives seemed to offer a pattern that varied according to factors such age and purpose of entry into the religious order, nuns' mentors or supporters, and their training as nuns, which made nuns chose ritual and ceremony or meditation (amisa-puja or patipatti-puja). It was, however, necessary to consider all three cultural domains together and try to comprehend the larger picture to uncover a cultural theme that would explain how nuns' spiritual activities influenced their coping.

Review of the Cultural Domains

The domain, "expression of Buddhist spiritual practice" encompassed what spirituality means to Sri Lankan Buddhists in general and to Buddhist nuns in particular. The terms, Amisa-puja and patipatti-puja together cover most of the spiritual activities included in the "activities of Buddhist nuns" domain. Nuns described ritual and ceremony as well as meditation as essential activities for attaining nirvana. Although they emphasized the importance of balance between ritual and ceremony, and meditation, most nuns engaged in the former to a greater extent than in meditation. The third domain, "Changes in nuns' lives"

was an organizing cultural domain because it encompassed several subdomains (e.g., changes when entering the religious path, changes in level of spiritual attainment, changes when living with a chronic illness, changes anticipated in the future). These changes were, in turn, relevant to nuns' choice of spiritual activities and their overall expression of Buddhist spirituality (i.e., the first two domains). To understand how all three domains fit together and influenced health required uncovering a cultural theme.

Spradley (1979, 1980) recommended several strategies for uncovering cultural themes. They included: total immersion in culture, identifying organizing domains, making a cultural inventory of all domains, and searching for elements in common across all domains (e.g., sex and age distinctions). I relied mainly on the first two strategies: cultural immersion and identifying organizing domains.

Overview of the Cultural Theme, *Responsibility*

The organizing cultural domain, changes in the lives of Buddhist Nuns together with immersion in the general socio-cultural milieu of Sri Lanka with the intention of being "consciously ignorant of the culture" (Spradley, 1979, 1980) allowed me to recognize the repeating cultural theme of *responsibility* as the key to understanding how health was situated within the spiritual practice of Sri Lankan Buddhist nuns living with a chronic illness. I identified four salient forms of *responsibility*: (a) responsibility to the Buddha; (b) responsibility to others (the social circle); (c) responsibility to self- liberation through meditation; and (d) responsibility to find security in old age (Figure 14).
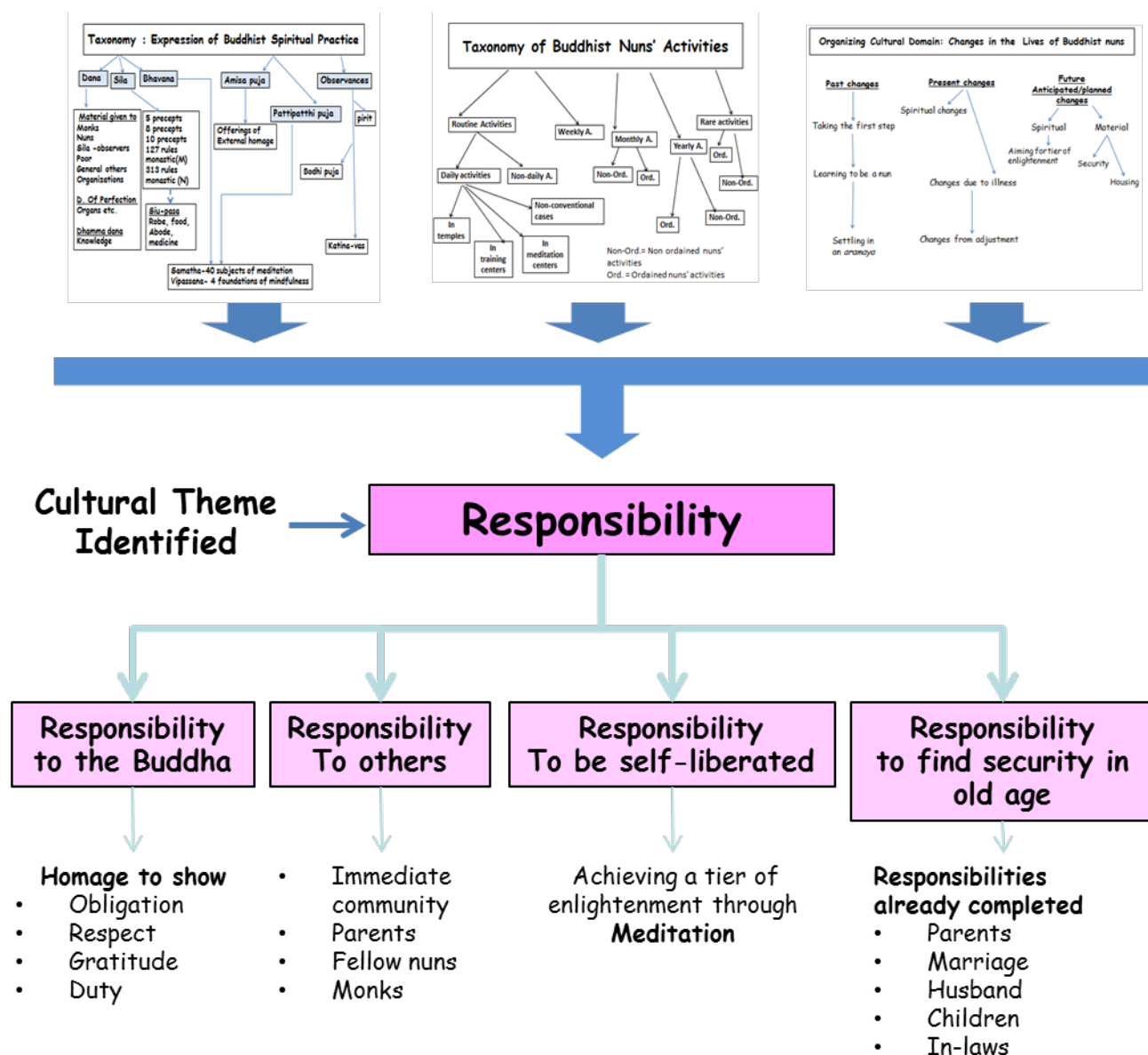
Figure 14. **Graphic presentation of cultural theme,** *responsibility*

Buddhist nuns manifested more than one responsibility simultaneously.

Responsibility to the Buddha was of paramount importance to all Buddhists, and it often took

the form of gratitude and respect for what the great leader had taught. Gratitude was shown

by offerings (material homage) and respect (*garukaranna*). Forms of respect included taking

off shoes or hat in front of a Buddha statue or getting up from a seated position on a bus

while traveling past a Buddha statue. Nuns also expressed words to the effect that even people who drank alcohol did so only after worshiping (as opposed to worshipping inebriated) at the Buddha statue in the temple. However, it was the relative importance that nuns gave to the other three forms of responsibility (Figure 14) that triggered them to action in different directions (e.g., giving precedence to social service over their self- liberation). These priorities appeared to vary according to several circumstances in their lives such as the age of entry into the religious order, acquired knowledge in Buddhism, and the nature of social resources available to them. Buddhist nuns shaped their spiritual practices to suit their prioritized responsibilities. In particular, nuns who gave priority to social service (responsibility to others) could not dedicate time solely to meditation (responsibility to self-liberation) because their devotees' needs came first. Those needs, for the most, part consisted of requests for material homage such as bodhi-puja, sermons, and pirit chants. The extent to which a nun was successful in community social service was reflected to nun in the form of reciprocal service by the community. Therefore, any medical remedies or spiritual devices she may have used to stay above illness were complemented by support from the community. By contrast, nuns who gave priority to their responsibility to self-liberation through mental development (meditation) allowed little time for social service. This also meant that reciprocal support from community could not be taken for granted. These nuns had to be equipped with alternative sources of support.

Prioritizing responsibilities and shaping their spiritual practices accordingly contributed greatly to having access to various resources and maintaining health. However other background factors provided by Buddhism itself, such as the Buddhist beliefs about impermanence, and inner security (or confidence), played a role in how nuns coped with

health problems. The cultural theme of responsibility and its subthemes are described in more detail in the following sections.

Responsibility to the Buddha. Nuns used many Sinhala terms with regard to homage to the Buddha that loosely translated into responsibility or duty: *yuthu kama* (obligation); *vaga kiima* (responsibility); *kalaguna selakima* (gratitude) *wath piliweth kranna yuthu kama* (obligation to do ritual/material worship); *watha wath karanna onee* (have to do homage); and *hemadama garukaranna eka yuthu kamak* (showing respect every day was an obligation). All nuns, regardless of their current age (or the age at which they entered religious order), education level, and living conditions, expressed their ultimate gratitude toward the Buddha for having shown the path that led to nirvana. Homage to Buddha was performed by all nuns without fail several times a day. This was seen in the descriptions of their daily activities. Honoring the Buddha also was extended to showing gratitude to the tree that gave shade and protection while the Buddha was achieving the highest level of freedom. An essential part of tree worship (bodhi-puja) was not forgetting the deities associated with the Bodhi-tree that Buddhists believed blessed and helped people devoted to maintaining the Buddha *sasana*. Many nuns, including those who had only a small congregation, performed bodhi-pujas for their community devotees as well as for themselves. Some bigger temples also included *devalayas* (house for deity worship) to allow Buddhists to transfer merits to additional deities (believed to be even more powerful than those associated with the sacred tree). Nuns believed that powerful deities could help humans in need. Worshipping sacred areas associated with the Buddha's life events in distant lands such as India, Thailand and Burma also brought great merits. All nuns, according to their ability, conducted these activities. Therefore, Buddha worship fulfilled not only a responsibility,

duty, or obligation to the great teacher but also brought inner security and confidence that

devout Buddhists' pleas for help in need were heard by deities.

Responsibility to others. The responsibility to the others was a salient feature in the

nuns' lives. The term, society, applied here to all varieties of social contacts mentioned in the

taxonomy (Figure 11) in general, but the most visible, and significant component of these

social ties was the nuns' immediate community (the social circle). There was a strong

reciprocal relationship between the nuns and their community, which played an important

role in their livelihood, health (physical and mental), and ascertaining a strong sense of

purpose. This responsibility was a two-way street. As one nun put it: "The society has to

realize that Buddhist nuns are needed. When they feel 'We need this individual,' that is when

they care for us."

Earning this trust made it essential for the nuns to shape their spiritual practice to tend

to the needs of the community. It also inclined the nuns to prioritize material homage (amisa-

puja) over meditative activities **(**patipatti-puja). One nun defended this choice in the

following manner:

> Those monks who spend time in the forest [to meditate)]stay away from many *tanha*
> (cravings). They do not do social service. It is easier to attain nirvana when you are a
> forest monk. But, if one knows the way, it is not necessary to go isolate in a forest,
> can attain nirvana being in the society. You cannot meditate all day. You need to take
> care of the society as well. –Handa

Nuns knew what was at stake by spending time in meditating in isolation, and they coined

their terms well to express the compromise they had made:

> If we meditate hiding in a forest, we do not know if we have tamed our senses. It is
> like learning to fight in a camp, getting a certificate. We will only know if we can
> fight if we put on a uniform and go to the battleground. It is also like learning to swim
> in a classroom. For us in order to understand if we can live in this troublesome

society and still tame our senses and spread compassion, we have to be in the society. –Goraka

Meditation alone was also not the most effective way to use time according to some nuns:

We must take the maximum advantage of our lives. It is not enough to be in a forest hidden and keep meditating. –Banda

To make the best use of time, nuns rose early and did not rest during the day.

We get up early in the morning in order to make the best of our time. If we take naps in the afternoon, from one side it is unhealthy, and from the other, we waste our time. Sleep means rest for the body, but too much rest is also not good. –Mala

Performing material homage in society was multifaceted and first and foremost, it required the nuns to be available when the community sought them. Those nuns who could capture an audience with a story from the Buddha's life with a strong moral lesson, those who mesmerized the community with a pleasant chanting voice, and those who could answer the community's questions had a large following and a great rapport with the community:

We don't have all the possibilities of Buddhist monks, but nuns have help from their devotees..[pause]..A nun can convert a village in a sense. It depends on people sometimes. People who want to gain merits do so, and others don't. A nun can attract villagers toward doing these merits and make it a joy to them. For example, some devotees here say that bodhi-pujas we do here are nicer than in temples run by monks. In a Buddhist society like Sri Lanka, no virtuous nun will be in need. –Mora

Most of the nuns saw the spiritual enhancement of their community as the most important mission of their lives and gave their own health a lesser priority.

Nuns tended to training young minds. For example, one nun described her skill in teaching young children.

On full-moon days, I am very satisfied because I preach dhamma in seven temples, 45 minutes of talk, and 45 minutes of meditation at one stretch. It goes from early in the morning till 6:30 in the evening. I have only 20 minutes for my lunch, and on these days I do not even worry about the timing of my insulin injection. If I can contribute to bringing someone to observe the five precepts, a person who usually does not to do so now, and if I can bring someone to give [to others] who usually does not share

things, how much I have gained! When I process the events of the day at the end of it, and even when I put my hand to my forehead and feel it hot with fever, and my back aches, I can forget all that when I think of what I have accomplished that day. –Swara

According to her, even the village monk was surprised at how young children stayed put like statues for hours listening to her when the monk lost their attention in 20 minutes.

Spreading the words of the Buddha. Nuns had explained that *dhamma dana* (sharing the knowledge of Buddha's word with others) was one of the highest forms of giving. This was of paramount importance to some nuns who served the community.

> Medical tests have shown that my blood vessels have thinned. Doctors of western medicine and traditional medicine have asked me not to tire out with talking too much, but I speak tons, my mind is clam, what I am doing, I am doing with a pure mind. I am doing something in this era where there is no living Buddha, this dhamma realized by him, he went through six years of extreme suffering…Oh what suffering do we have compared to what he had gone through to understand this dhamma. When I open the door in the morning, my wish is that, at least, one person, even if the person comes crossing the oceans, has come to me to listen to the pure words the Buddha had preached after realizing them through great suffering. This is the only service we can do in return for the great treasure he has given us. Because of that I have to preach his words to at least one person every day. I have said that it does not matter if I am taking my last breath, if a person comes to me, please do not turn that person away, I will die no matter what, but, if I will die uttering the words of the Buddha, I am not in debt to the Buddha. –Uda

These nuns had a sense of urgency to give the Buddha's message during the (short) time available to them. Their aim was to ensure that it was a wiser person who left the aramaya than who entered. This responsibility to society prevented many nuns from accepting a sick role:

> When we have a disease, we do not like to show it to others because there is no point in making that person sad. My aim is to give knowledge in all my interactions. –Uda

Attending to needs of the community. Community devotees sought nuns for various types of blessings

We go to pirit chanting, dhamma talks in homes, schools, conduct Sunday schools many children [pause]..In this life I value the service I do. The thing I do for this village [pause].. not only this village but many others all around here. If I had stayed at home it would have been just for home. Here there is no limit to what we can do. We can serve any place in Sri Lanka. Even the Buddha served for 45 years. –Mahiya

Some nuns concentrated on just their community:

I aim toward the ultimate goal nirvana instead of running all over trying to get everybody together. Many nuns go to India to visit Sangamitta society, but I have not worried about going to India although it is where it all started. To me this temple is my India. I am very busy here. I have 350 kids in the Sunday school and I do things to improve the immediate neighborhood instead of having a larger focus. – Raga

Bringing peace to the community. In some cases nuns acted as counselors:

I spend my time for the benefit of others. If I hear that my neighbor's woman worries about her husband being an alcoholic, I try to help by giving blessed foods (foods previously offered to the Buddha), water blessed by the pirit chanting, or perform a Bodhi-puja. Many times it helps to change these things. –Minna

Stories of loyalty to others from the past. The nuns had many stories of past activities

toward society that had made a difference in the lives of both parties:

Up to now, I have prevented a person from committing suicide placing his head on the railway track. A mother who has abandoned children has now come back to live happily. Women who have left their husbands have come back to resolve their differences. Some people still visit me and tell me that although I am a young person, they respect my advice and they wish me the best *kusala* (merits). It gives me immense happiness. I have brought them consolation through the words of dhamma. –Swara

Some nuns had trained others to extend meritorious activities to society. For example, a

young boy who had frequented this nun's aramaya on full-moon days to listen to dhamma

preaching had grown up to become a correctional officer in a penitentiary. He had initiated a

program for prisoners to learn and practice meditation. The nun visiting the prison had been

deeply moved by the discipline the prisoners had shown in their meditation practice. She

spoke proudly of having "produced a son who would change prisoners."

Material help. Although nuns depended on the community for their livelihood, they offered others as much material assistance as they could manage. One nun who had come from a family with some wealth had requested her father to build a little aramaya in a poor, remote village where she could practice giving to the poor as much as possible. She lived in a humble abode with two sisters who also were nuns, and they shared everything they had with the community:

> I have told them, come and ring the bell. I like it. I chose this indigent area because what I get, I use only very little, let us say, a toothpaste tube, a very little, spare everything, don't ask anybody for anything, if given righteously, only that, that too use frugally, even a box of matches. I have told people, children, allow me to gain religious merit, when you need something come here and ring that bell. I prepare white clothes for women and allow them a chance to observe "*sila*" on full-moon days. –Uda

Many nuns who had access to material resources either through their families or through other generous social contacts used those resources to benefit their communities:

> When I first came here in 1968, there was a village here. There were just eight houses, a small school that went up to the fifth grade. The schoolmaster, and his wife, and I got together..[pause].. I hired two teachers, working very hard and we brought progress here..[pause].. We held Sunday schools..[pause].. slowly, slowly we built this big school here, and gradually added an orphanage, held committees, and built up the place. The devotees in the community helped..[pause].. my brother's family, siblings, even now come to clear the garden when we give alms. –Kadawa

Another nun who had friends in Canada and in the United States had established a scholarship foundation for poor village children in her community. Other similar stories included improving the temples of the monks by establishing a women's association that had facilitated, in the nun's own words, "breaking the rich-poor barrier" to contribute to a cause. The same nun had steadily improved the status of Sunday schools over 30 years to spread the dhamma to the society.

Other activities that nuns mentioned with great joy included saving the lives of newborns when no midwives were available, adopting homeless girls and educating them, providing a home for unwanted and battered women, organizing work groups to clear roads, and establishing committees to improve temples and religious activities.

Moreover most nuns had done their utmost best to take care of their parents when they were ill or dying. Several of them had brought their parents to their aramayas or had gone to be with them in their parents' homes to tend to them.

Uda, whose father had taught her Buddhism, had such respect for her parents that she had built their statues in her aramaya. She wished to see all old-age homes in Sri Lanka closed because she found no excuse for children to abandon their parents in their old age:

> I have a rule here that those who do not care for their parents need not pass the gate to enter this temple. Parents are our first teachers. We serve all over the country because of our two parents. So, I tell people not to think of just a nuclear family. We never kept our parents in public hospitals. We three daughters did not want to leave the place of mother when she was sick. We chanted pirit and stayed there until they both passed away. We wanted to keep their minds like flowers. We had no debts this way.

Other services to others by nuns included taking care of their elderly nuns as if they were their own mothers. Nuns were seen taking the tray of Buddha-puja offering to frail nuns, some of whom had dementia, which allowed them to touch the offering and share the merits. Nuns seemed elated when they could relate a story of attending to every need of their mentors on their death beds.

At least three nuns visited Buddhist monks with frequency, especially when the monks were ill. One young nun who had great respect for the monks of her childhood village continued homage to all monks near her current aramaya. Starting with the statement, "When you let go, you get more," she explained how she made *wade,* and *patties* (local snacks) to

temples all around the area. She also contributed to all merit-making events in temples whenever she could and found her devotees would "run after her" to contribute. Moreover, when she saw a monk on the bus, she offered to buy his ticket.

Role of community in nuns' health. Not only did nuns see to the welfare of their communities, but there was a reciprocal relationship whereby nuns' social contacts played an integral role in coping with their illness and enhanced the quality of these nuns' life. Many social contacts made at least some contribution toward the nuns' health, but it was the immediate community that shouldered most of this responsibility. Stark evidence of this came during an interview with an elderly nun who was describing her "mind over matter' reaction to illness when a live-in- aide seated behind the partially closed door invisible to the researcher, blurted out: "Oh yes, that is so, then I run to the neighbors and we all lift her up and put her in a three-wheeler and take her to the hospital!"

Even the nuns who still kept close relations with their biological parents agreed that the community made a difference in their lives:

> My devotees have become mothers and fathers. I do not make a difference in my blessings whether someone helps me or not, whoever can afford to get me an insulin syringe, I draw merits from the bottom of my heart. My mother and father and relatives are far away. They actually care for me even today. At least three times a week, they inquire whether I have medication, I have taken my medication, how I am faring, etc., but my neighbors nearby, they are my loyal crowd, and for them I worship Buddha three times a day, chant hymns and pirit, and salutary effects of these are directed to them with all my heart. I do not do a job. I do not have an income. I have no other way to earn money.. So my life actually depends on the *siupasa* [four requisites; robe, alms-food, abode, medicine] devotees give me. For that I bless them from my heart. –Swara

Nuns could not hide their health problems from the community.

> I have very close devotees. I once had an operation. I went to the hospital without telling my devotees. When the devotees found out that I was in the hospital they came there with a car. They made the driver go very slowly not to let me suffer in any way.

In between, some devotees had washed and cleaned my room before I came back. And then, before the sun rose people were coming from all different sides bringing me soups and vegetable gruel. Some were afraid that I would draw water from the well to bathe, so they had improvised a bathroom with a large vessel of water and there were about 15 women there to help me bathe. So, I consider that I have all luxuries. We are very close to our devotees. –Mahiya

Many other nuns agreed that their community members sacrificed their time to tend to their needs. Some devotees' care extended beyond their neighborhood aramaya:

We have not had any problem since we have been here. They ask me often, 'Venerable mother, if there is a very sick nun, let us know, we would like to get her the medication.' Also if there is major problem like, having a bypass surgery, one needs to pay a large sum of money. – Mala

Nuns' conversations indicated that community members helped not only in emergency or curative situations but also in preventive health. This was especially apparent in cases of nuns with diabetes. Although some diabetic nuns had to pick and choose from the meals provided by community members because they were not fully appropriate for a diabetic, when devotees were knowledgeable about diabetes and put that knowledge into practice, the donations included food items with a low glycemic index. Moreover, the community contributed to enhancing the knowledge base of the nuns in several ways. Community members alerted the nuns when a diabetes education program was in progress on TV or radio. (Nuns who had a radio or television generally listened only to programs related to Buddhism.) Community members often saved newspaper or magazine articles on diabetes to pass on to the nuns. There also was a hearsay type of education because the nuns knew their community well and often conversed with diagnosed diabetics and their families.

My sugar went down and doctor told me it was not necessary to take pills now, I discontinue them and control what I eat. After that you know, some people in the neighborhood say 'It is good for diabetes to take *koskola neti* [stems of the jackfruit leaves, botanical: Artocarpus *heterophyllus*] certain leaves, certain green leaves, red rice, *pittu* made of *kurakkan piti* ..[pause].. So I was doing that..[pause]..People talk a

lot about diabetes. A lot of people, I would say 75% have it. There are also people whose sugar has reduced drastically. – Mala

Devotees close to the nuns also ensured that nuns kept their medical appointments. Medical visits, in some cases, took place after great persuasion by devotees. At least two nuns had their diabetes diagnosed because of their devotees' watchfulness and concern. One said:

> I was drinking water, but I was not hungry. I was just thirsty. So one lady said, 'Venerable mother, my daughter also had this problem.' She asked me to give her a sample of my urine so she would take it to the doctor. So this lady took my urine to the doctor. – Mawa

In addition to that, community devotees tried to ensure that an elderly nun would not tire out. Kadawa, the 70-year-old nun, described her neighbors' care for her:

> If I happen to stand at the bus stop to go someplace, if someone happens to see that, in a few minutes they send a pre-paid three-wheel taxi for me. They do not let me stand here. I have a very kind congregation. After I arrived here, 33 new children were born. They are now grown up and they got together and did a very big *pinkama* [a merit-making event] to commemorate my service to the society. They explained how I had helped them develop good qualities in life. I was very moved..[pause].. When no one is here to help, the young children in the orphanage come to help me.

However, some nuns had less community engagement and support. One elderly nun living with another nun in a remote area mentioned that they received alms only occasionally. These nuns had very basic knowledge in Buddhism gained from Sunday school. Thus, they were not sought by the community for preaching or chanting although they were asked to perform a Bodhi-puja occasionally by a devotee. On occasion, they would join with other nuns from a larger temple when a large group of nuns was needed to attend a pirit ceremony in a large city such as the capital. Some nuns with similar backgrounds indicated they had difficulties paying even their electric bills.

Role of fellow nuns and live-in aides' role in nuns' health. The fellow nuns in the temple and women aides also played a significant role in nuns' health. Nuns who continued

with their duties despite the inconvenience of illness symptoms often depended on other temple-mates' support: "If I am tired to do things alone, I will take other nuns too.", Kuda said.

In some cases, the ill nuns delegated many responsibilities to fellow nuns and participated in only the most necessary events. Their fellow nuns and aides knew the details of the ailing nun's condition intimately and could help at any hour of the day. A frail nun who was prone to falls said.

> There is always somebody with me even in the house so that even when I fall someone can catch me. Even when I am seated, there are two to three nuns seated around me to catch me in case I fall. My body is not very strong now. I spend many hours in one place..[pause]..This nun [pointing a younger nun sitting close by] helps me, takes me to check my sugar, she even pays for my expenses. –Mora

Live in aides were essential to the aramaya. They assisted the nuns with not only doing the chores in and out of aramaya but also with keeping a keen eye on the health of the nun. One such live-in aide had alerted her nun to consult the doctor, which led to her diabetes diagnosis:

> My live-in devotee kept saying, 'Why do you sleep like this? It is not normal. You were not like this before. Why don't you go to the doctor and ask about this?' – Viveka

Role of family in nuns' health. When nuns resorted to their families for care in sickness, it mostly occurred in following situations: (a) the nun had several adult children who would send her financial resources for care in a nearby hospital and the live-in aide would be by her side to help; (b) the nun would stay with her children during her illness; and (c) the nun would visit a sibling, who would care for her. Almost all these nuns with stronger family life had entered the religious order late in life. It should be pointed out here that the other nuns (who had a strong community connection) also had a mother or a sister who

would visit them in their temples and stay for some time, but these nuns did not depend on family support during periods of ill health.

Responsibility to be self-liberated. The nuns who spent most of their time in meditation to achieve insight awareness (*vipassana*) focused on the Buddhist teaching that each individual was solely responsible for her own liberation. The Buddha had likened the human being to an island. The goal was to experience first-hand the reality of life's impermanence, dissatisfaction, and non-self (*anicca, dukkha, anatta)* as direct personal knowledge as opposed to theoretical knowledge. The first tier of enlightenment, *sotapanna*, gave a glimpse of this. A nun gave the metaphor of lighting a match in a dark room and having flash of an idea that there were four walls, but these walls were not clear. She continued that the meditator progressed to a candle, then to a lamp, seeing a little better each time (corresponding to eliminating *keles* [defilements] along the way) and then finally reaching a bright, electric light that left no doubt of the shape, size, and color of the room. This was the fourth and final tier of holiness. Only two of the participants dedicated themselves to strict meditation practice. Both had entered religious life in their late 30s, one having been a store owner, and the other a seamstress. Both began religious life linked to well-established meditation centers of Buddhist monks. As Sri Lankan Buddhist monks possessed unquestioned authority and privileges compared to Buddhist nuns, the livelihoods of these two nuns were supported with limited family ties and little need for engagement in social service. Several other nuns attempted to allocate more time to meditation, but community demands made them postpone strict practice of meditation until a future time.

Responsibility to find security in old age. Another form of responsibility was seen among the nuns who had few resources and sought sufficient stability in their living

situations to assure they would not be abandoned in old age and fragility. These nuns had

entered the religious life late and lived under conditions of scarce resources, but some had

small but permanent aramayas or small houses with a bodhi-tree and a place for Buddha

worship. Their community links usually were weak, but there were exceptions. For example,

one woman had wished to enter the religious order very young but could not leave her

parents to die alone and had to forego her need to become a nun as a young woman. This nun

had several loyal devotees. It was mentioned previously that nearly all of the nuns gave less

attention to their health conditions than they did to their responsibilities. In contrast, some of

the nuns who fell into this category were eager to talk about their illness. They described

various kinds of instability in their social relationships. Some had quarrels with families and

had weakened their ties. Another had gone through a lawsuit for the land on which her

temple was located. She believed she suffered from her conditions (uncontrolled diabetes and

restricted mobility due to an orthopedic condition) because the former landowner had cast a

spell on her. At the time of interview, she was planning to consult a sorcerer to expel this

cast. Several nuns required multiple medications: They emphasized the difficulty securing

their medication due to financial instability. Two of these were itinerant nuns who lived in

unconventional conditions. Survival techniques of such nuns included frequenting sacred

areas waiting for pilgrims who might stop for a quick blessing for which these nuns would

receive alms food or money. Distant devotees were the mainstay of these mendicant nuns. As

revealed in interviews with other nuns, itinerant nuns' means of survival often fell outside the

boundaries of monastic code (e.g., theft from fellow nuns in a shelter). Although these were

activities that might have led to punishment or expulsion from the religious order, they went

unpunished because these nuns did not belong to any temple or center.

The following section will be dedicated to words of the secondary informants on the topic of living with a chronic condition in Sri Lanka.

Evidence from Secondary Informants

Secondary informants shed light on living with a chronic illness in the Buddhist culture of Sri Lanka from a different perspective than that of Buddhist nuns. Characteristics of the secondary informants were summarized above in Table 7. All secondary participants were practicing Buddhists. One layman participated in both Christian and Buddhist worship as a child, but self-identified as a Buddhist.

Nearly all health-care providers said the access to health care in Sri Lanka was good because consultation in public hospitals was free of charge.

> In Sri Lanka the health care system is good, has a high standard. [It is] free of charge. [People] can go to nearby hospital. People have fewer symptoms due to early detection, and early treatment. – MD -3

Free and easy access also meant long wait lines for most patients, which prevented patients from fully benefitting from the free system.

> Clinics are crowded and physical therapy patients often do not get the full treatment. Some people bring private PTs home. Often, people turn to Ayurveda traditional medicine. –PT

MD-2 mentioned that "financial stability and family support" were helpful in finding alternative private facilities. However, Buddhist monks and nuns rarely had to wait in long lines or seek private alternatives because patients generally insisted the monks and nuns be served ahead of themselves.

Diabetes was in epidemic proportions throughout Sri Lanka. All diabetics received insulin free of charge in public hospitals, but they had to purchase syringes. (One syringe with a needle cost 15 rupees or 12 cents in U.S currency). Patients also bought oral

medications in pharmacies (Metformin, one pill costs 1rupee, less than a penny in U.S. currency; Dianil and Glimipride, each pill less than 10 cents in U.S, currency). Patients also paid for laboratory tests done outside of the hospital (The test for fasting blood glucose was 350 rupees = $2.80). Few patients had their own glucometer.

Interviews with the seven laypeople with chronic conditions revealed that many people turned to Ayurveda medicine. They indicated that many Sri Lankans believed herbal medicines were better for the body (i.e., this was not merely a response to crowded conditions in the public health-care system). However, the Ayurveda approach often required long-term treatments that patients often did not adhere to. Instead, patients would stop and restart such treatment as it suited them. When conditions turned serious, they turned to the hospital. Two lay women had diabetes for more than eight years had little interest in learning to use their glucometer because they depended either on their husband or son-in-law to test their blood. One woman who woke up earlier than her husband did said she never knew her fasting blood glucose level because by the time her husband had woken up, she had already taken her morning tea.

"Consoling" a patient using Buddhist psychology or advice suited to other faiths, was not an unusual activity in a consultation if the provider found time for it. However, MD-1 said, "Our health-care delivery system does not allow patients to have very much time with health-care providers to be able to console them." Nevertheless, he said he tried to find time for that.

> Getting diabetes is like getting gray hair. It is the nature of life to have these changes. I console my patients according to their background. I encourage them to follow whatever they believe in. Here in Sri Lanka anyway, people are not depressed when they have a disease like diabetes. I wish the clinics were not so crowded and patients had more chances. –MD-1

Three salient messages relevant to living with chronic illness in Buddhist culture of Sri

Lanka emerged from the interviews with 20 secondary informants.

1. Confidence grounded in Buddhist faith

2. Acceptance and attributing illness to *karma.*

3. The importance of strong family and social support.

Confidence from the Buddhist faith. A Buddhist scholar and counselor likened the

nature of faith to a "confidence" one develops from an early age.

> When you have no other help, you need that confidence. To give an example, my mother, when I am abroad, and when she hears about some disaster, a war, bomb blast..[pause].. My mother knows that nothing can happen to her son, but every time she goes to the temple she gives a bodhi-puja and asks the blessing to go to her son. If in Sri Lanka all the temples and *devalayas* [places of deity worship] close for one week, I think people will go crazy. You go to any place, Sri Maha Bodhi, kataragama, kelaniya, there are a lot of people. What are they doing? They know their husbands may not help, parents may not help, but they know temple or *devalaya* will help, mentally. If you can see their faces when they go into the temple, their faces show how stressed they are, but when they come out, it is different, as if the unseen power has helped, or their belief that it has helped.

He explained that although vows and wishes people make under the Bodhi-tree may not

come true, they continue with the practice.

> It is like they know in their unconscious mind it may not happen, but on the surface they do not want to be rid of that help, confidence. Village people, even town people, go to astrologers, but astrologers are not always right, but they keep going. Why? They need that support. Even bodhi-puja, *devala*, temple they have to go there. They have to keep that hope and confidence alive.

Prem, who walked on a prosthetic leg because of an amputation due to diabetes exemplified

the confidence that came with Buddhist faith and practice. He spoke with me on his way to

his daily Buddha worship in a nearby *vihara*. He had been diagnosed with diabetes 15 years

ago. He emphasized that nobody in Sri Lanka lived for more than three years after a leg

amputation, but he had been richly blessed by the deities.

> I worship the Buddha and ask for nothing. That way I get nothing because the Buddha
> is someone who left everything to go become the Buddha. No book says that the
> Buddha gives things. What I do is worship the Buddha, have devotion and direct
> those merits to the deities. I give these merits to all deities. It is said there are 33,000
> deities. It is here in our country there are these deities called kataragama, Visnu,
> Huniyan, etc. This is not what we were taught, but what we believe coming from
> generation to generation. We give deities these merits and say, we are lost on the road
> although we do know the *dhamma*. 'Please give us wisdom to find the right path,' we
> say. At least last few years, I think I have had very good results from that.

Prem was a prolific storyteller who made the listener vicariously experience sights, sounds,

and smells of his journey through life. He said he had failed miserably in school,

apprenticeships, and relationships but always with the help of an unseen power obtained the

necessities of life. His life was spared in a flood and from being gored by a cow on a

rampage. Some deity or other ensured that he never stayed in line on his prosthetic leg in a

hospital or in places of alms food and that bus conductors never took money for his bus

ticket. All he did in return was worship the Buddha and transfer the merit to the deities.

Ami, in her 60s, beamed with happiness. She had recovered from a mental illness as a

young woman and 26 years ago was diagnosed with diabetes. She also had a leg problem that

had made it difficult to get in and out of a car or to sit on the floor for worship. Her devoutly

Buddhist mother had influenced her from an early age to "solve problems happily through

dhamma."

> I do loving kindness meditation, commemorate the Buddha qualities, do in and out
> breathing (*ana pana sathi*). We have been instructed in all those types….. I know that
> even when I go on the road, if I go alone, I chant *ethipiso bagava* . When I repeat it
> that way, it becomes a *Buddhanusathi* meditation. I think because of my faith in the
> Buddha, I got better. I worship the Buddha only in the evening. When I go to observe
> *sila*, it is on masa poya (new moon), not the full-moon, then you don't find 80-90
> people and one can meditate very well. I have blessings. Even when I consult my

horoscope..[pause].. you know we believe in these things..[pause].. it says that I do triple Gem [Buddha, Dhamma, Sangha] worship well, and from deities I have blessings

The role of impermanence and course of karma. Belief in *karma* was widespread. Health-care providers mentioned both positive and negative aspects of a patient's belief in *karma*.

Patients accept illness as due to karma. They often do not try to fight the disease. Mental suffering is not grave as it is not considered as a crisis. –MD - 4

People often do not complete the exercises they are asked to do. Old people often say, 'What exercises, doctor, this is *karma*. I will die soon anyway.' –PT

All health providers pointed out that patients and their families were allowed to carry out most ritual activities in the hospital. The rituals practiced included bodhi-puja using banners with the name of the patient and pirit recitals conducted by monks and nuns. Visits by clergy of other religions were accepted as long as they were congruent with patients' beliefs.

There also was tolerance toward accommodating patients' wishes for traditional remedies. However, one nurse believed that sometimes patients were vulnerable to having traditional beliefs exploited. "Until the last minute, patient has hope and sometimes falls for charlatans as the last resort.", the nurse said.

According to the Buddhist counselor and the Buddhist monk, *karma* was linked to finding solace in Buddhist belief and practice.

Anybody who practices pure Buddhism can get solace in illness. Buddhism can give good guidance. The most important thing is to understand oneself. You are responsible for your actions. That is the basic thing. We cannot apply Buddhist philosophy commonly to people unless they are followers of dhamma, but if we talk to people individually, we might be able apply some principles. Things can turn around when taken case by case. People often concentrate on 'my problem, my problem.' You need to talk many hours with them. We should use their own stories. If

they think logically, they can come to karma, *satipattnana* [discourse on mindfulness]. We need to talk with them patiently.

The scholar also mentioned a Buddhist discourse called *Jagattha sutta* in which one went to deity for help, and if that did not work, one went to another and to another, but ultimately came to the Buddha because all these deities were gods of fear. But, according to this scholar, the reality in Buddhism was impermanence. You eventually faced the reality that your life would end.

Family and social support. The importance of family and social support was exemplified by one woman who had a severe case of rheumatic arthritis that incapacitated her for days at a time. She said her husband had died of a heart attack when their son was just 9. Despite her difficulties, Mada was happy. She had realized the nature of life, but had a reason that kept her occupied, and she also had support in her life:

> My son is the priority. He is now 19 years old. My husband passed away. I have nothing to occupy my mind now than my son. I spend all my money on him. I cannot get up sometimes for a couple of days, but I never keep my son hungry. I will even get the food from a store and feed him..[pause]..never will keep him hungry. In such a situation, I call my friends or two sisters..[pause]. My sister has money and they come and help. They help me even with the money. One sister helps my son financially with his studies. My father is a retired school principal and he also helps. Last week I had fever. I could not move my hands, and my sister gave all the food. My friends help too. Even my son cleans, works in the garden, washes my clothes. Sometimes when I cook at night he cleans all the pots before he goes to bed.

The woman also said that after her husband's death, "I think I was able to console myself because of my religion." She considered a Buddhist monk that she knew as her *kalyana mitta* who always put her on the path of the Buddha's word.

> It is from the Buddhism itself that he helps me. He makes me realize that life is like this. I have no husband, have financial problems, I am sick. I can talk to the monk individually. I have a lot of problems, but I am never unhappy. I try to help others. I do a lot for the temples close by. I mortgaged all my jewelry. Now I have only two bangles. By doing that I helped the temple. –Mada

The importance of social relations also was highlighted by the nurses who worked closely with hospital patients. Although the three medical-surgical nurses were not very communicative, they agreed that what brought patients the most consolation was their social contacts. Some described how patients looked through windows to check if visitors were in sight. When visitors were late or if no one came, at least, for one visit, they were very upset. Some patients came from faraway places, especially in the case of the cancer hospital. Families usually were there until the very end of a patient's life, but nurses said that those who had no permanent family, such as people who worked as servants for others to eke out a living, usually got visitors at first, but the visits abated after a while. In such cases the hospital performed the last rites for them.

Other Issues

The two women who had served as live-in aides to Buddhist nuns had aspired to be nuns themselves but had abandoned the idea for different reasons. The first had been impressed by the nun with whom she lived, but she had found it difficult to learn to meditate because deep concentration gave her hallucinations. The second woman was deeply disappointed with the nun, whom she found to be a hypocrite. Both women admitted that nuns had been very skillful in meditation techniques. Both women also agreed that these nuns, although they did not admit to their devotees, believed in help from deities such as Kataragama deity (well known to Sri Lankan Buddhists for his powers). These women also narrated stores of other Buddhist nuns (not from this sample) and monks who performed services such as palm reading, reading horoscopes and faith healing, activities the monastic code had prohibited.

A final note of interest from the discussion of the Buddhist scholar and the Buddhist monk was their opinion of Buddhist monks' condition in Sri Lanka. Although many nuns had referred to monks as " having time to meditate isolated in forests," "having people to do all their chores for them," " having more knowledge because of more education," etc., a slightly different image of the Sri Lankan Buddhist monk emerged from the description of the above two Buddhist scholars. The Buddhist counselor revealed that many monks were not aware of *suttas* (discourses of Buddha) and many did not practice meditation. According to the monk (who was interviewed at a different time and location), "It is like having a job," referring to tending to social services similar to those done by the nuns, with even more frequency because a monks' presence had more value, thus more merit, in the eyes of Sri Lankan Buddhists. The counselor even sympathized with the monks who were violating monastic rules. "They themselves are victims," the counselor said, because in a modernized Buddhist society they are expected to demonstrate ancient virtues of the Buddha era, and this population of monks has little time to practice them. Both, the Buddhist counselor and the devout lay woman who practiced meditation, believed that Buddhist nuns joined the Buddhist foundation to solve their personal problems. When I countered their argument with living examples of virtuous nuns, the woman answered that she had not met them, and the counselor thought they were few and far between.

Comparisons

Themes from the secondary informants supported the interpretations I had made from the primary data. The cultural theme identified from the domain analysis was *responsibility*, and the conversation with the five lay women and men also alluded to responsibility; they discussed their responsibility to families, to children and to careers, which gave them

meaning in life. The importance of a support system was evident in the second group as well and again how it helped in chronic illness depended on the strength of these links. Medical providers' information showed how the Sri Lankan health-care delivery system also served as a source of support to those with a chronic condition. A similar inner security from Buddha worship (bolstered by deity help) was present in the second group as well. It gave them the confidence that blessings and support were available, as exemplified by the popular Sinhala-Buddhist farewell, "*Budu saranai devi pihitai*" (May the Buddha's blessings and deities' help be with you).The understanding of impermanence appeared in conversations again, but varied on a continuum with the deep understanding of *anicca* through Buddhism on the extreme left by the meditator and a general acceptance of illness due to *karma* along the continuum. At the extreme right of the continuum of understanding the concept of impermanence, its appearance was more as a resigned acceptance of conditions, almost giving an excuse similar to the cliché, 'c'est la vie' .

Summarized Answers to the Research Questions

1) What activities and thoughts constitute "spiritual practice" of these Buddhist nuns? Analysis of the domain, "expression of Buddhist spiritual practice," provided a detailed answer to this question. In summary, it can be said that all Sri Lankan Buddhist nuns regarded alms giving, a moral life as (as defined by 10 precepts and the monastic code), and mental development through meditation as significant observations of Buddhist spirituality. Homages to the Buddha, performing homage to the bodhi-tree, pirit chants, and observing rainy season retreats, also were important features of Buddhist spiritual practice. The terms amisa-puja (material/external homage) and patipatti-puja (homage through

principle; e.g., meditation) roughly covered the Buddhist spiritual practice described by the primary participants. For the purpose of this paper, these two terms can be paraphrased as ritual and ceremony, and meditation.

2) How does chronic illness affect these women's daily life? The chronic condition reported by the majority of nuns was Type 2 diabetes. Because these were not extremely serious cases (managed with metformin and/or dietary control), it can be said that nuns' daily activities were affected more by the comorbidities of diabetes (rheumatoid arthritis, osteoarthritis, asthma). It also can be said it was the general weakness stemming from these conditions that affected their daily activity by limiting chores in and out of temple, accepting fewer pirit recitals, outside alms offers, sermons etc.

3) How does Theravada Buddhist spiritual practice affect their experience of chronic illness? Theravada Buddhism provided the nuns with a backdrop; the Buddhist phenomenon, *anicca* or impermanence. Buddhism also gave them a sense of inner security or confidence, which they could enhance by the satisfaction they were fulfilling an identified priority mission. They chose the Buddhist spiritual practices that served their identified priorities. Their mission subjected them to experience their chronic illness slightly differently because of the resources that accompanied each choice. These priorities were shaped from certain life circumstances, such as age of entry, knowledge of Buddhism, and the resources they came with. Some nuns chose a social service, and some sought self-liberation through meditation. Some combined them. All had a responsibility to Buddha. Some nuns used spiritual acts such as *Sattha kriya* meditational skills to find

solace in symptoms, and the social resources available to them also made a considerable contribution to their quality of life.

4) How does chronic illness impact their spiritual practice? Their illness made them violate certain minor monastic rules. For example, some diabetic nuns had to negotiate with donors for suitable food, and some medications nuns used required taking a small amount of food with the pills thus compelling them to eat after 12. Some nuns limited their going out to sermons, or pirit recitals, which went against their urgent need to do all they could in their short lifetime.

5) What other factors help or hinder living with chronic illness? The Buddhist phenomenon of impermanence appeared to color Sri Lankan Buddhists' (nuns as well as lay people's) outlook on life. Although this was the backdrop against which most Buddhists functioned, they deferentially reacted to it in life. This difference, probably, can be imagined along a continuum, making coping a positive, or an indifferent experience.

***Image 13*: The banner stating: Alas, all formations are impermanent! May the ….name of the dead…transcend to a meritorious birth and proceed to nirvana!**

Anicca vata sankara (all formations are impermanent) was a phrase that every nun started hearing in childhood; on every full-moon day mass media saturated sound waves with different forms of this message (example: in sermons, stanzas, and songs by beloved singers). Funeral banners and flyers at every death reminded Sri Lankans that their life could end anytime, and it was understood without explanation that *karma* would decide the course. Chronic illness was just one manifestation of this impermanence in life. This impermanence gave a sense of urgency to those who had a task to complete. Some nuns had a strong sense of mission (example: spreading the word of the Buddha and/or self-emancipation through meditation), and they were reluctant to waste their short time by giving into to sickness and strived to stay above sickness because being healthy was important to carrying out their responsibilities. And there were also nuns without such a strong responsibility. Those nuns mostly were the women who had entered the nun-hood late in life and had already fulfilled their responsibilities in life by caring for parents, husbands, and children. For them, what mattered was adapting to illness according to their possibilities.

Another factor that may have helped keep a positive attitude toward coping was the confidence or inner security they received through Buddhism. That came from the worship of the Buddha, bodhi-tree, and deity help that ensured, that "things will somehow fall into place." Another factor that contributed to nuns coping with chronic illness was the resources, mostly social resources, available to them. Free healthcare and easy access to it also contributed to their welfare. Other resources, arguably associated with social resources that helped living with chronic illness, were financial stability and permanent housing.

Factors that hindered living with chronic illness were closely related to the reasons Buddhist nuns chose their priorities and how they fared with those choices. Entering the

religious order at an advanced age and having had a history of being mother and wife seemed to have an unfavorable outcome in their progress in Buddhist spiritual practice, and that had a domino effect on one's mental health. This may have a link to the general notion of nuns being inferior to monks and the lack of enthusiasm shown by Sri Lankans to change this situation.

Assuring Methodological Rigor in this Study

Several schools of thought on rigor and trustworthiness in qualitative research were presented in Chapter 2 under background to study methods. The following discussion focuses on how I maintained credibility, transferability, dependability, and confirmability in this study.

Credibility. Credibility of this research study was attempted through prolonged association, persistent observation, triangulation, and member checking in the following manner:

Prolonged association. As described previously, I was born and raised in the Sri Lankan culture in a practicing Buddhist family. As a child, I was required to attend Buddhist Sunday school for 10 years, learn Buddhist culture, commit certain chants and scripts into memory, and pass several state exams on various subject matter on Theravada Buddhism. I also conducted a preliminary study on diabetic Buddhist nuns in 2009. Thus, I was able to orient myself and build trust in the socio-culture of Buddhist nuns.

Persistent observation. As mentioned in the sections of participant observation and attention to mass media, I was fully engaged in learning issues pertinent to the lives of Buddhist nuns and chronic illness in the Sri Lankan culture.

Triangulation. My study included triangulation of data sources, data collection, and analysis procedures.

Triangulation of data sources. I gathered data from the Buddhist nuns during the semistructured in-depth interviews and in casual conversations while paying close attention to nonverbal cues. I cross-checked this data with the live-in aides of the nuns, neighbors who frequented the temples, and other sources of contacts of the nuns that I encountered during my stay in the vicinity. Because I re-interviewed at least three nuns from the previous pilot study, I was able to cross-check some of their information. Moreover, as I mentioned elsewhere the Spradley (1979, 1980) method used in this study required me to conduct more than one interview with participants, which enabled me to detect discrepancies in some areas. Another good source of data was the mass media to which I paid close attention during my study.

Triangulation of data collection methods. In addition to the in-depth interviews, my fieldwork consisted of a large component of participant observation through living in several temples with the Buddhist nuns and attending events and activities inside and outside of the temple. As mentioned under participant observation, I used narratives, chants, and focus groups wherever possible with Buddhist devotees and nuns. Temple attendance on full-moon days and public transport were two good places to converse with groups of people on many Buddhist issues. I also collected documents through mass media, and Buddhist publications, and talked with other Sri Lankan Buddhists and Buddhist scholars. I also made use of audio-visual aids (camera, tapes, and sketches) when appropriate and permissible on these occasions.

Triangulation of data analysis procedures. I made use of several data analysis methods described in Spradley (1979, 1980): domain analysis and taxonomic analysis, and theme analysis, and I made an attempt to use matrix analysis (as described in Miles & Huberman, 1994) as a complementary method to cross-check my interpretations obtained through Spradley's method. This decision was based on my experience with the pilot study (Wijesinghe & Mendelson, 2012), which produced results amenable to categorizing data easily into matrices for a clear display. However, results of this study called for an alternative form of presentation because categories were not mutually exclusive and had fluid boundaries, and there was an important interplay of the variables. However, a simple matrix is presented at the end of the chapter along with a graphic presentation to help better understand the results.

Member checking. My personal experience with the attempt to conduct member checking with Buddhist nuns during the pilot study led to confusion because the nuns, in general, responded, "We told you what we know. Do good things with your work. Tell other people about Buddhism." In the current study, member checking was an option for the nuns, but only an erudite ordained, English-speaking nun was interested in this kind of discussion. Among secondary participants, the Buddhist scholar and the lay Buddhists also were interested in discussing my interpretations and were in accord with the interpretations, with the remarkable exception that they compared the results as they applied to Buddhist monks rather than to nuns. An eye-opening comment, "I do not really know any devout nuns," was the reason for choosing monks as opposed to nuns.

Transferability. In my study, I described the context in sufficient details and made my assumptions known to the reader so that he or she will determine if my findings can be

applied in another setting. If the findings of my study would prove to serve another Theravada Buddhist setting, I would consider it as a service, but transferability is not a primary concern for this study at this juncture.

Dependability. To assure dependability, I kept a clear audit trail, which included research-design and data-collection decisions and the steps taken to manage, analyze, and report data.

Confirmability. I have already described in different parts of this paper how I maintained an audit trial, kept a reflexive journal, and followed several sources of triangulation. These techniques aided me to establish confirmability in this study.

Matrix Analysis

Matrix analysis originally was proposed for this study because it was anticipated that matrices would allow flexibility, logic, and visual effect to interpret and disseminate findings to an audience in a language easily comprehensible. However, findings of this study proved less amenable to categorizing neatly into a matrix for the following reasons.

1. The categories such as meditating nun, socially engaged nun, nun participating in little of both, and nuns participating in neither were not strictly mutually exclusive, and the fluid boundaries made it inaccurate to put these women into boxes.

2. The cultural theme *responsibility* had four subthemes (*responsibility* to the Buddha, *responsibility* to others, *responsibility* to be self-liberated, and *responsibility* to find security in old age). These categories were not mutually exclusive and included situations where they overlapped.

3. The sense of purpose or mission also had a subjective, nebulous boundary that could be better displayed on a continuum than on a matrix.

4. Most importantly, the topic of this study as to how Buddhist spiritual practices influenced coping with chronic illness required showing many variables such as sense of purpose, resources available to nuns, and the backdrop of impermanence, which proved difficult to portray in a two-dimensional matrix.

To illustrate some of these difficulties, a simple matrix frame is presented here and the completed matrix is given in Appendix: I. A pictorial representation of the summarized findings is also presented (Figure 15) to elucidate how Buddhist spiritual practice may influence coping in Sri Lankan Buddhist nuns with a chronic illness.

Table 8: *Buddhist spiritual practice by nuns in the Sri Lankan social cultural context*

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self- liberated	Responsibility to find security in old age	Researcher comments
Practices almost exclusively meditation					
Engages almost exclusively in social services					
Practices some meditation and engages in social services					
Practices little or no meditation and engages in limited social activities					
Little or no practice of meditation or social engagement					

All formations are impermanent, Karma will decide the course

Social, Material & Environmental Resources

Sense of Purpose (Responsibility)

Health seeking ← Coping → Resigned acceptance

Social, Material & Environmental Resources

All formations are impermanent, Karma will decide the course
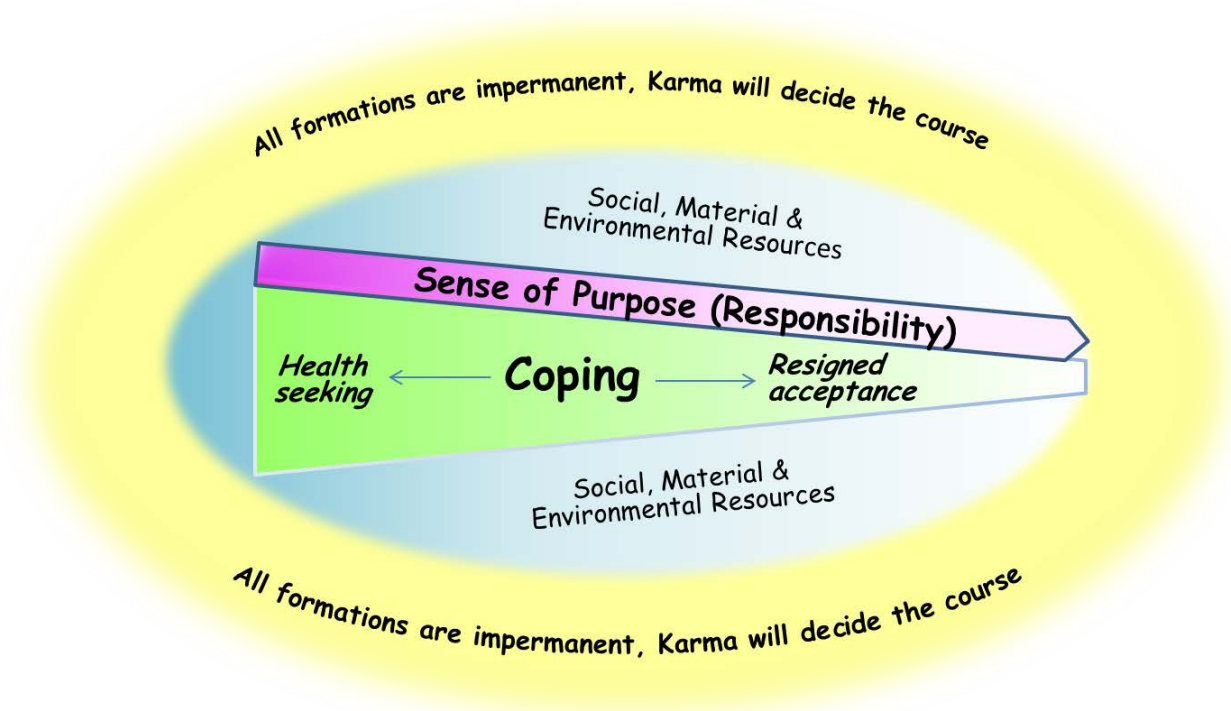
Study Findings

Figure 15. Pictorial presentation of study findings

Chapter 5

Discussion

The specific aim of this study was to develop a detailed ethnographic description of the interplay between chronic illness and Theravada Buddhist belief in the lives of Sri Lankan Buddhist nuns. The topic was explored through domain and taxonomic analysis (Spradley, 1979, 1980). Three domains were identified (a) expression of Buddhist spiritual practice; (b) activities of Buddhist nuns; (c) changes in the lives of Buddhist nuns. *Responsibility* was identified as the repeating cultural theme. Responsibilities ranged from responsibility to the Buddha, responsibilities to others, responsibility to be self-liberated through meditation, and the responsibility to find security in old age. A woman's reason for becoming a nun, her age of entry, and her resources influenced how nuns prioritized these responsibilities.

All Buddhist nuns showed responsibility to the Buddha through material homage, but beyond that, each nun shaped her spiritual practice according to the priorities of her responsibilities as she saw them. For example, nuns with a strong sense of mission to bring society to the path of the Buddha chose material homage that was most in demand by the community and gave a lesser priority to meditation. However, a few nuns prioritized meditation above all else. In between were the nuns who attempted little of both: occasional service to society and practicing basic forms of meditation. At the other extreme, a small number of the nuns subsisted primarily by begging for alms and material needs, thus renouncing any responsibilities to others or even to self if they could not be sustained in that fashion.

Although all nuns recognized the importance of being healthy to attain their goal, nirvana, Buddhist spiritual practices and beliefs about impermanence and karma influenced their coping with chronic illness. Coping took place differentially against the backdrop of impermanence. Those who had a strong sense of mission or purpose and adequate resources available to them felt an urgency to fulfill their responsibilities in this short life. They were reluctant to give in to illness and thus were inclined toward health-seeking behavior. In contrast, women who entered the path later in life often had a sense of having already completed their responsibilities to others (e.g., to their parents, husband, and children) and did not feel as strong a sense of social responsibility. They were quick to attribute illness to karma; their attitude toward chronic illness was characterized more by resigned acceptance and adaptation than by health-seeking.

In the preceding chapter, findings from interviews with primary participants were explained in detail in relation to research questions. Those results were compared with, and largely supported by interviews with secondary informants. This chapter will discuss how the findings compare with published literature, limitations and strengths of the study, and its implication for nursing research, education, practice, and policy.

The components of the Chapter 5 are: (a) discussion of findings; (b) comparison to published literature; (c) implications of these findings; (d) limitations of this study; and (e) strengths of this study.

Discussion of Findings

Buddhism as practiced in predominantly Asian countries differed according to sect, country, and the socio-cultural environment. I chose to study Sri Lankan Buddhist nuns because it was of interest to understand how Theravada Buddhism as practiced in Sri Lanka

influenced the health of women who had chosen an unconventional path in life. In addition, Buddhist nuns represented a group of women who had dedicated their life to Buddhism and provided an approachable group for a female researcher. Sri Lankan Buddhist nuns indeed were approachable and willing to participate, but the assumption that Sri Lankan Buddhist nuns dedicated their lives to Buddhism was only partially supported by the findings. Nuns were happy to discuss why they became nuns and how they fared, but the degree of dedication to Buddhism varied. A few women were nuns only nominally. It also was disconcerting to learn that often, Buddhist nuns were recognized only by their local communities, despite performing substantial services to Sri Lankan society. From information I received from secondary and even some primary participants, a common view was that women became nuns to solve their personal problems. Although people were generally deferential (e.g., nuns did not have to wait in line to see a health-care provider), even the ordained nuns and the more erudite nonordained nuns were not universally recognized as legitimate authorities on Buddhism in Sri Lanka. This ambivalence toward the legitimacy and authority of Buddhist nuns in Sri Lanka is an important aspect of the socio-cultural context, but its root causes are beyond the scope of this dissertation. Nevertheless, I provided a brief explanation in Chapter 2.

The status of ordination, according to the findings, appeared to influence neither the nuns' choice of spiritual practice nor their coping with illness. For example, all the dedicated mediators in the sample were dasa-sil-matas, while bhikkhunis were more articulate in explaining to me how meditation led to insight. Many dasa-sil-matas and bhikkhunis were skilled at giving a mesmerizing Buddhist talk, and many from both groups had close-knit community relations. As all nuns saw health as important to their goal, nirvana, many

bhikkhunis and dasa-sil-matas were making adjustments to their illness with medical remedies as well as with spiritual means. There were both bhikkhunis and dasa-sil-matas even in the small group of mendicant nuns who participated (and several others I met while travelling who did not participate). I was not able to identify meaningful criteria to categorize nuns neatly into matrices by their ordination status. As discussed in Chapter 2, few Sri Lankan Buddhists (including me until I began this research) even knew the meaning of the term *upasampada* (ordained) as it applied to Buddhist nuns, and even fewer devotees could tell me if their community nun was a bhikkhuni or dasa-sil-mata. All that mattered to the community was that she was a "*silwath meeniyo*" (devout mother, using an honorific term for mother in this context).

The question of how Theravada Buddhism influenced the health and experience of chronic illness of women who chose an unconventional path in life was partially answered, but as is common in qualitative research, led to further questions, not all of which could be adequately answered in the present investigation. As indicated in Chapter 1, research on Buddhist spiritual practice in relation to positively coping with chronic illness has focused mainly on Westernized Buddhist practice, especially meditation that, in some cases (e.g., mindfulness meditation), may be divorced from other Buddhist beliefs and practices. Therefore, I was broadly interested in whether Theravada Buddhist practice in the Sri Lankan socio-cultural milieu (with a large component of ritual in addition to meditation) impacted coping with chronic illness. In general, I found it does, but how and how much it does depends on several factors. What came to light was that it was not the act of ritual or meditation per se that mattered in coping, rather it was the context in which meditation or ritual was carried out, and that context must be specified.

All nuns functioned against the backdrop of impermanence, but they reacted differentially to their illness. Nuns who had a strong sense of responsibility, be it to liberate themselves (through meditation) or to bring others to the Buddha's path (material homage, or through a mix of both amisa-puja and patipatti-puja), were driven to do their best to reach their goal. These nuns had a more positive outlook on life. Giving into illness was not an option for them. This positive, health-seeking behavior was not, however, universal. The degree of health seeking behavior gradually abated along a continuum from active engagement to stay above illness to passive acceptance of illness. In addition to the notion of impermanence and the role of karma, Buddhism gave nuns an inner security that had several sources other than dhamma (e.g., personal attributes, social network, and deity worship) that may have contributed to this confidence.

As mentioned in Chapter 2, Buddhism of Indian origin carried with it influences of Hinduism and other folk religions that have influenced Buddhist practices in Sri Lanka. For example, accounts of nuns who performed bodhi-pujas for devotees and for their own benefit wishing for salutary results, alluded to beliefs (e.g., in deities) that Buddha's philosophy of know thyself had not promoted. A secondary informant said, "We give deities merits and say, 'we are lost on the road although we do know the dhamma. Please give us wisdom to find the right path.'"

Obeysekare (1989) suggested that Sinhala Buddhists believe in many "smaller deities" and one "super deity" (p.129). The big deity that they approach as a last resort is the Buddha. Hope and confidence is kept alive by deity worship until they have come to the reality and accept the karmic destiny and adapt to it. Results of this study are congruent with that point of view in that even meditators and scholars did not question the popular belief that

it was important to transfer merits of Buddha worship and bodhi-tree worship to deities so that the pleas of these devout people will be heard by the deities. There was a repertoire and a hierarchy of deities, and all Buddhists, even those who did not invoke these deities, knew about the power (to fulfill wishes of those who pray) attributed to these deities. But all Buddhists understood that there was a limit to the extent even the most powerful deity would succeed in changing the course of karma, for eventually, everybody had to accept the reality that all formations were impermanent and karma would take its course.

Comparison to Published Literature

It was pointed out earlier that all nuns were not alike. Their depth of understanding of Buddhism, the strength of their sense of responsibility, and the richness of resources available to them varied along a continuum, and their coping behavior ranged from health seeking to resigned acceptance. The health-seeking, positive behaviors in Chapter 4 bear certain similarities to the work of positive psychologists such as Seligman and Csikszenmihalyi (2000). The findings, however, show an even stronger a resemblance to earlier sociological theory of salutogenesis (Antonovsky, 1979), which focuses on exploring the origins of health rather than on reasons for illness. Antonovsky's aim was to understand how some people managed stress and maintained health even in difficult circumstances. He explained that the way people related to their life had an influence on their health. To elucidate this phenomenon, he proposed a framework that emphasized two major constructs: sense of coherence and generalized resistance resources. Sense of coherence (SOC) includes the degree to which stressful events are viewed by an individual as comprehensible, manageable, and meaningful (e.g., as opposed to being viewed as vague, existential threats). Generalized resistance resources include ego identity, knowledge and intellectual ability,

material support, and preventive behaviors (Antonovsky, 1985). In brief, a strong sense of

coherence enables one to manage stress-causing events (illness or disaster) by identifying

generalized resistance resources and mobilizing them toward effective coping (Antonovsky,

1985).

Antonovsky (1985) described a sense of coherence as a product of one's experiences,

whereas generalized resistance resources are things (material or nonmaterial) one possesses

or has access to that together may influence how one copes with stress. The factors of sense

of coherence can be applied to the situation of the Buddhist nuns in the following manner.

Comprehensibility and predictability involve the ability to make sense of events in one's life

and to reasonably predict what will happen in the future. For nuns, predictability was the

knowledge of the impermanent nature of life, which they had grown up hearing in the phrase

anicca vata sankara. Life was bound to pass and terminate according to karma. Stability was

gained (at least theoretically) from learning about the instability of life. In that context, their

chronic illness made sense to them. Manageability is the belief that one has the skills or

ability, the support, or the resources necessary to take care of things and that things are

manageable and within one's control. In the nuns' cases, resources were multifaceted;

devotees provided nutrition, and in some cases, knowledge about health conditions. Nuns had

access to a health-care delivery system that provided free care, and usually they did not have

to wait in line for services. In many cases, if funds were necessary for care beyond what the

public health system provided, devotees provided them. Community members provided

transportation and in some cases housing. Nuns who mostly meditated were supported by the

monks or other wealthy donors. Those who had no congregation often had some family

support (e.g., from grown-up children). Things were manageable according to the resources they received.

Meaningfulness is the belief that there is good reason or purpose to care about what happens. According to Antonovsky, a perceived meaningfulness was the most critical aspect of the sense of coherence for coping with a stressful situation. Having optimal health was meaningful to nuns who believed they had a mission to complete. Those who were leaning toward social service and material homage saw the importance of their work. Those who practiced homage by following the Buddha through meditation realized the meaning it provided for them to attain an advanced state of enlightenment. Those who became nuns later in life due to personal reasons may have believed that they already had completed their mission to families and thus may not have seen the meaningfulness at the same level as other nuns.

Implications of the Findings

Implications for nursing research. Findings of this study have stronger implications for nursing research, than for nursing education, practice or policy. First, findings of this study inspire asking an old question in a new context. Antonovsky asked, "What makes us healthy?" Antonovsky's (1985) sense of coherence (SOC) framework is the basis for a questionnaire; the SOC scale has been used in more than 30 languages and countries and has shown satisfactory reliability, validity, and cross-cultural relevance (Becker, Glascoff, & Felts, 2010). However, most research involves using the scale to explore how people stay well rather than by questioning if there could be variables that give meaning in people's lives other than what is covered in Antonovsky's original ideas of sense of coherence and generalized resistance resources. Time may be ripe for new information.

I envision an ethnographic design suitable for exploring the answers to a question such as, "What would give a chronically ill person meaning in life that would want her to continue, and what means she would (ideally) envision achieving these means?" Such research should begin on a small scale, such as through conversations or journaling perhaps five or six ill persons. Many people may not want to converse or write. In such cases, active observations can be used by a nurse or caretaker. The same methods can be used to study persons without chronic conditions. Such research often has nebulous boundaries and thus is less likely to attract funds from donors. I venture to say that nurses can be pioneers of such small-scale research motivated by the sheer satisfaction of knowledge. I believe small studies can contribute to valuable knowledge (e.g., Jean Piaget's study of cognitive development on his own children) and lead to (speaking from my personal experience) meaningful interventions to help target groups.

In addition to the idea of a sense of purpose, the findings of this study pointed to the significance of participants' acceptance of impermanence and the cause of karma. Although people of all religions know they will die, the constant reminder of *annica wata sankara* in Buddhism has a particularly strong influence on a Buddhist's outlook on life. Ethnography can, again, be used to explore whether different cultures accept the end of life in different ways and how that knowledge can or cannot contribute to enhancing the lives of the chronically ill. For example, Charmaz (1993) describes "transcendence" as a level of acceptance by chronically ill patients. It would be of interest to compare and contrast the health seeking and resigned acceptance found in this study with the narratives of Charmaz's patients. Some of this research may prove to be a case of ethnography being a product for the

sake of knowledge rather than for a method to achieve an end. However, even then it will contribute to the pool of knowledge in chronic illness and spirituality.

Implications for nursing education. Nursing students can benefit greatly from being exposed to research in other disciplines, especially psychology, sociology and anthropology (Earle, & Denny, 2005; Pinikahana, 2003). Current health-care conditions call for expeditious training of nurses to meet the demand in clinical and outreach work and, thus it may not be seen as pragmatic or cost effective to expose students to such interdisciplinary studies. However, a good grasp of the bigger picture of health, in addition to clinical skills, can be beneficial to all nurses, not just to nurse researchers. It would enhance the quality of nursing education if nursing curricula included a component of sharing research as a requirement for graduation. For example, each nursing student will learn about a new concept relevant to health care from the perspective of another discipline, discuss how that applies to her work, and share with others in a seminar.

This study showed that what is done locally can have global applications, and as such it would be helpful to widen the focus of nursing education to include transcultural nursing in a different culture. Students can be given academic credit for participation in a volunteer program such as Doctors Without Borders. Many such programs are available, and even the U.S. Peace Corps strives to create shorter programs than its two-year commitment (i.e., Peace Corps Response) for skilled professionals. It is not feasible for all students to travel overseas. Therefore, working in a different culture within the United States is another option. The idea is to develop understanding that students can learn from even the most humble and destitute communities. For example, there are cases of positive deviance (Marsh, Shroeder, Dearden, & Sternin, 2004) where a few individuals follow uncommon beneficial practices that lead to

better outcomes than their neighbors who share similar risks. Examples from my experience

prior to this study include the existence of few well-nourished children in a malnourished

community, a man who strives for order in a community of squalor, and a post-traumatic

growth of a young woman in a neglected household. Such cases propel one to seek the

lessons to be learned and apply them to various situations to help others. A suggestion for

nursing students who work in the area of health disparities would be to seek not only problem

cases but cases of triumph against all odds. Nursing students can be encouraged to explore

so-called "disadvantaged communities" to seek whether there is an individual, a family, or a

community that thrives despite its race, ethnicity, disability, or poverty, and bring it to light

with the intention of empowering others.

Implications for nursing practice. It is premature to suggest any specific new areas

to concentrate on in nursing practice. However, nurses as the first contact with patients would

do well to be culturally competent when working with the chronically ill (or any other) to

realize that patients would not have the same attitude toward pain, treatment, death, etc. This

study had intended to expose nurses to other ways of knowing in health, and with the

findings it brought the message that the concepts of karma and impermanence may not be

just metaphorical when working with a Buddhist patient. In the current health-care

environment, it is difficult to expect nurses to spend considerable time with patients.

Nevertheless, an open-minded attitude to observe and listen to patients and caretakers,

especially those of diverse backgrounds, can facilitate gaining new knowledge and enhance

transcultural nursing care in U.S. health-care settings.

Implications for health-care policy. Implications of these findings for health-care

policy can be seen from the perspectives of how it applied to the Sri Lankan context as well

as globally. Taking the Sri Lankan context first, although this study focused on chronic

illness and coping, it is important also to focus on the concept of health. Health is not just the

absence of disease but rather is "a state of complete physical, mental, and social well-being"

of an individual (WHO, 1948). Several nuns encountered in this research might have enjoyed

better mental health if they had options for security in old age other than joining the religious

order. That they had, or believed they had, few choices may have had roots in gender politics

and power in Buddhism and in the wider Sri Lankan culture. The ambivalent status of

women in Theravada Buddhism is thoroughly discussed in the literature (Carbonnel, 2009;

Andrews, 1990). However, the status of women in Sri Lanka, within which the Buddhist

nuns should be seen, is more complex. Discussions of primary participants often indicated

that they themselves had a lower opinion of women in the religious order (e.g., statements of

nuns to the effect of staying away from other Buddhist nuns because when they get together

they talk about issues not conducive to maintaining *sila*). Nuns often held monks on a higher

pedestal and never criticized them directly, despite several media reports of monks violating

monastic code with serious issues (e.g., an arrest for drunk driving). The nuns mustered their

scarce resources to give large alms offerings to monks (as is customary for lay Buddhists),

but monks, endowed with more power and resources, reciprocated rarely, only in cases where

they sponsored meditators or a nun from the same village. Nuns often invited monks to

preside at religious events run by nuns, which they explained with words to the effect of,

"When we have a monk it is not like having just a nun." This state of affairs took place in a

country in which women can reach the highest level of power in politics (e.g., the first female

prime minister in the world), education, and income (e.g., equal pay for equal work), which

even the United States has yet to achieve. I believe that any change to help Buddhist nuns in

destitute conditions must come from Sri Lankan citizens themselves, especially bearing in mind that my feminist outlook on life could hasten me to empty activism rather than to achieving meaningful change for the Sri Lankan Buddhist nuns.

Turning to chronic illness and focusing on the epidemic of diabetes in Sri Lanka, it is commendable that the ministry of health continues to provide medication, consultation, and diabetic education free of charge. Nevertheless, repetition of similar messages through education programs via television, radio, newspapers, and expositions with little or no attempt to produce innovative programs or research to question if these messages propel Sri Lankans to change their health behaviors bring little yield. Recent media reports indicated that Sri Lankan Buddhists will be discouraged from offering alms food of high fat and cholesterol to monks due to the high rate of chronic conditions among them, but no mention of nuns who are just as susceptible to chronic conditions was made in the article (Fazulhaq, 2012). This research, and the pilot study of this researcher (Wijesinghe & Mendelson, 2012) showed evidence that a knowledgeable community when encouraged to put that knowledge to practice could learn to offer alms food that was not detrimental to diabetic nuns. Thus, the logic follows that reinforcing the good behavior of the community and investing in interventions that made people practice correct diabetes information could benefit the health of the clergy as well as lay people.

Physical activity needs to be a large component of diabetes behavior modification in Sri Lanka. Physical activity, such as walking, that is acceptable to both clergy and lay people, should be reintroduced in a proper cultural context. Recent investments in constructing jogging/walking paths in urban areas, commendable though they may be in principle, could have brought more yield had there been more government-sponsored research to understand

what would motivate modern Sri Lankans to accept walking as a purposeful activity. The

researcher has already taken preliminary steps toward banking on two cultural aspects

observed in rural Sri Lankan communities: (a) Sri Lankans have an affinity to participating in

village committees useful to them (e.g., committee to help each other in a funeral by hanging

banners, informing the public, providing food to the family of the dead, etc.); (b) enjoying

evening tele-dramas (similar to afternoon soap operas in the U.S.). The idea behind this small

project is to create a health committee that creates enjoyable activities, such as competitions

in household activities that they used to do before modernization. (i.e., fastest team to pound

rice to create flour, fastest team to walk a distance while carrying pounded floor in a basket,

draw water from a well, etc. If enough interest can be created for these activities, another step

would be to introduce several village role models to walking, and observe issues involved

that could feed into a plot of a small tele-drama. A television producer has already been

contacted in this regard, and the current search continues for a Sri Lankan sponsor and a local

diabetes educator who could assist in making walking fashionable in Sri Lanka by showing

popular television characters participating in these activities. The religious community also

can be involved by creating scenes of walking pilgrimages.

These findings of this study emphasize the great importance of social connections in

coping in chronic illness. Information emerged from interviews, as well from direct

observations by the researcher that led to a strong recommendation that the training

curriculum for nurses (by the ministry of health) change. Sri Lankan nurses need to have a

wider focus than on speed performing as many doctors' orders as possible. As revealed in

interviews, and as often heard in the community, patients and caretakers were hesitant to

approach nurses with questions or for other needs because they *hariyata baninawa* (yell at

you a lot). Current working conditions trigger an abrasiveness in nurses that is not seen often when they are off duty and such behavior is counterproductive to the gains Sri Lanka has made through a free and fair health-care delivery system.

As for policy implications for the West, it is too early to offer specific details. A starting point may be to advocate for governmental or nongovernmental agencies to fund innovative research focused on understanding relationships among health, happiness, and spiritual beliefs and practices, not just on prevention and treatment of illness.

Limitations of This Study

There are a number of important limitations to this study. As in most qualitative studies, the sample was not representative in a statistical sense. As in any exploratory study, the conclusions are tentative. The sample was sufficiently diverse to identify a range of spiritual practices along a continuum, from highly involved with meditation through varying degrees of social and community engagement, to nuns with a more precarious, itinerant life. But very few participants were at either extreme of that continuum. Therefore, the characterization of those extremes was based on relatively sparse first person-data and therefore may be somewhat less confirmable than the characterization of the more socially engaged nuns.

Remaining true to the words of the people is a necessity in ethnographic research, but that entails also taking participants at their word. In the present study, that meant relying on participants' self-reported descriptions of their diagnoses, symptoms, treatments, and health status. No attempts were made to verify reports using medical prescription records, checking vital signs, or conducting physical examinations. Another limitation was that only a handful of chronic conditions stated by the participants were very serious cases. The majority of the

participants reported their diagnosis as Type 2 diabetes, and only one participant used insulin. A question remains as to whether more serious disabling chronic conditions could have led to other findings and conclusions.

I also believe that this study would have produced a more authentic Spradleyseque (1979, 1980) ethnography, had it not been bound by the restrictions enforced on dissertation research. I approached my fieldwork with a set of predetermined research questions. During my fieldwork I had the overwhelming sense that I should be looking for the questions for the answers I saw all around me rather than the other way around. Moreover, to answer these preformulated research questions, I had to manipulate cultural domains in a manner not entirely true to Spradley's method. In addition, immersion in a culture meant dissolving boundaries as to with whom one conversed and for what reason. I had spontaneous conversations with people in offices, on buses, in markets, and paddy fields regardless of their religion or health status, which made me realize that the sense of purpose or meaningfulness people saw in life went beyond artificial boundaries of demographics and could have been described better using many concepts (e.g., resilience, resourcefulness, locus of control, learned helplessness, etc.) addressed in positive psychology. However, I was unable to use this rich information in this study because I had to restrict *knowledge* to a product arising from a defined sample.

Strengths of This Study

The greatest strength of the study was its ethnographic methodology based on the interactive and recursive ethno-scientific linguistic method of Spradley (1979, 1980), even acknowledging the limitations alluded to above. This allowed the nuns and secondary informants to tell their own stories in their own words. The approach forces the researcher to

tend to relentlessly specific details of observations and clarifications of spoken words. In the present study, this led to detailed description of Buddhist spirituality as practiced by Sri Lankan Buddhist nuns, in temples, centers, homes, and on the road and how it is related to nuns' experiences of chronic illness. If practiced rigorously, the method also prevents the researcher from taking a familiar culture for granted. The fact that globalization has led Sri Lanka to rapid modernization also helped me to distinguish between contemporary Sri Lankan socio-culture and that of my childhood. Similarly, my extensive familiarity with Western Buddhist thought facilitated comparisons with Eastern Buddhist spirituality while constantly referring to the reflective triangle of presenter, participants, and audience. In addition, this study assured a high level of rigor and trustworthiness through prolonged engagement, persistent observation, triangulation (of data sources, data collecting, and of theory), and member checking.

In conclusion, the findings of this study suggest that the focus on meditation in Western research on the effects of Buddhist spirituality on health is narrow and misses the variety of Eastern Buddhist practice, in particular the importance of social engagement with peers and devotees. The findings have potential significance beyond the lives and health of Buddhist nuns and lay Buddhists and point to broader questions on a path toward positive psychology.

Appendices

Appendix: A

Guide for semistructured, in-depth interviews: Topics and probes

General demographic information: Participant's description of herself.

- How long you have been a nun?

- Please tell me how you decided to choose this path?

- May I ask you how old you are now?

Time use: How participant sees her activities

- Tell me about a normal day in your life? (Probes: an unusual day, good day, bad day.)

Priority activities: What participant finds as important.

- Tell me about the most important activities for you? (Probes: things she is happy

  doing now or looking forward to doing, disappointed about not having done, or not

  doing. Probe also how it came about that she could or could not do these.)

- Can you tell me a bit about your meditation?

Social involvement and relations: Who participant considers her social contacts are.

- Tell me about the people in your life (Probes: other people in the residence, former

  family members or friends, other religious personnel or outside contacts.)

Feelings about life: How participant see the quality of her life.

- Tell me what makes you happy in your life? (Probes: what makes life not happy, how

  satisfied she is now, whether her life could be any happier, and how it could come

  about.)

Health status: How participant sees the development, and current status of her chronic illness

- Tell me the story of your illness? (Probes: onset, treatment, what has helped, what has

  not, ongoing treatment, if any)

Changes due to chronic illness: How she sees chronic illness has affected her life.

- You have told me a lot about what you like to do and what things are important to you. Now please tell me how your illness has changed any of these in your life? (Probes: activity changes, adjustments, self-confidence, self- image, faith in religion.)

Environmental barriers and facilitators: What participant sees as help or hindrance.

- Can you think of something (or someone) that makes your life with this illness difficult for you? (Probes: household environmental conditions, noisy neighbor, relationship with health- care provider, any other.)

- And now tell me about things or people who can help you make life with this illness easier for you? (Probes: material, tool, transportation, attitudes of people, health-care personnel)

Financial issues: How participant meets costs of her illness

- Tell me how you deal with the costs incurred due to this illness. (Probe: ability to pay, any assistance available.)

Attitude toward illness: How participant comes to terms with her illness

- Do you think this illness has affected the quality of your life? (Probe: explanation of why she is ill, guilt feelings, destiny, etc.)

Appendix B

Matrix of Buddhist Spiritual Practice

Table 8: Matrix of Buddhist spiritual practice by nuns in the Sri Lankan social cultural context

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self-liberated	Responsibility to find security in old age	Researcher comments
Practices almost exclusively meditation	Buddha puja three times a day. Community members do not come for Bodhi pujas at this temple	She travels between two meditation centers. One center has several young trainees that she instructs once or twice a week. She seldom goes out to preach or chant	"We have to consider this. If we are not fully prepared with our meditational level, we cannot help other people. It is like one person who is not on steady ground trying to pull a person out of deep mud. The result will be both go down in the mud. So, we want to make sure that we do this in an appropriate manner. Before we reduce the suffering of others we have to realize this ourselves first." - **Talwa**	Feels very secure because she is supported by a few very loyal, well-to do devotees and also several monks.	*Dasa sil mata*, Talwa lives in 2 meditation centers. I met her at the center where she instructs several young recruits in meditation. The center had several very simple *kutis* (simple cabanas for living & meditation). The center was extremely quiet and the sandy ground was well- swept to leave a pattern of soft waves. There were a shrine and a Buddha house on the premises. The wealthy man who had offered this land to Talwa lived close-by, and he was introduced me as " This is my

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self-liberated	Responsibility to find security in old age	Researcher comments
					kalyana mitta" (friend who brings me to the path of the Buddha) Talwa's responsibility to others is minimal. However, she sent me a time & date for my interview because she saw this as important.
	Buddha puja three times a day. Community members do not come for Bodhi pujas at this temple.	She goes out once a month for a meditation teaching in a temple. She blesses briefly the people who bring her alms-food. She has no other social responsibilities.	"The Buddha said that *Prana* (wisdom) comes from conditioning the mind. How do you condition the mind? Through *ana pana sati* (in & out breathing). Through this we can understand, realize what we call this 'self'. What we experience through senses, we actually experience through our mind. We can train animals, for example a bull or an elephant to carry a burden. Then why can't we train our mind? We can only see *Dhamma* through a conditioned mind. We cannot stop sickness. Even the Buddha and his *arahant* (holiest level) disciples had pain. Pain is there, but a conditioned mind will not strongly attach to it (*upadana*)." -**Umatala**	She says she is not afraid to live and she is also not afraid to die. She says she needs very little in life, and what she gets she often gives away.	*Dasa sil mata,* Umatala lives in a small meditation *asapuwa* (small temple intended just for meditation), which is attached to a bigger meditation center for monks. Umatala and the other nun who live with her meditate all day long except for the times they take meals and worship the Buddha

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self-liberated	Responsibility to find security in old age	Researcher comments
Engages almost exclusively in social services	Buddha puja three times a day and bodhi pujas as many times as community requests	"On full moon days I am very satisfied because I preach *dhamma* in 7 temples, 45 minutes of talk, and 45 minutes of meditation at one stretch. It goes from early in the morning till 6.30 in the evening. I have only 20 minutes for my lunch and on these days I do not even worry about the timing of my insulin injection. If I can contribute to bringing someone to observe the 5 precepts, a person who usually does not to do that, and if I can bring someone to give [alms] who usually does not share things, how much I have gained! When I process the events of the day at the end of it, and even when I put my hand to my forehead and feel it hot with fever, and my back aches, I can forget all that when I think of what I have accomplished that day" -**Swara**	Meditates if she finds time for it. The type of meditations are limited to "loving kindness meditation" and "reflection of the Buddha qualities" (the type of meditation lay people say that they practice)	Feels very secure in her position as a community nun.	*Dasa sil mata*, Swara has a knack for giving a powerful message through a story from the Buddha's life. She is young & energetic despite her advanced diabetes status which she manages with insulin. She has a close family, but she feels her family is the immediate community.
	Buddha puja three times a day and Bodhi pujas as many times as community requests. However, she maintains a timetable to	"We have a time table. We have to do social service. We have to attend to their needs because we live from them. Even right now, we are going to a function for them. We have to attend to their funerals all other functions. If they provide us s*iu-pasa* (four	Mostly I do *Budu guna bavana* (Buddha qualities) we say *ethipiso bagahva* in Sinhala, imagine the living Buddha, we commemorate *nava guna* qualities of the Buddha. We also do "compassion meditation", *pilikul meditation*	She feels very secure in the company of her community.	*Bhikkhuni* Mahiya has a close-knit community and she is very engaged in the community activities. She tries to balance social service and

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self-liberated	Responsibility to find security in old age	Researcher comments
	indicate when the community devotees should visit the temple for these pujas.	requisites) we also have to attend to their needs."-**Mahiya**	(repugnant nature of the body), *Maranasati* meditation (impermanent nature of life)." -**Mahiya**		meditation as much as possible.
Practices some meditation and engages in social services	Buddha puja three times a day and Bodhi puja as many times as community requests.	"We do *bodhi puja* only as necessary. We very rarely go out to chant *pirit*, if invited we do. If we are invited to an alms offering we chant *pirit* to bless the people."	"We used to do *amisa puja* frequently because we saw that others did. But now we see that even during the Buddha days at his death bed there were many deities [*Sakra*] worshipping the Buddha and he said: 'You are not respecting me by doing this,' and then addressed the relevant concern of others about a monk named Dharmarama , who, knowing very well that the Buddha was on his death bed, did not come to pay his respect, but instead he was meditating in seclusion. Then the Buddha requested the monk to come and asked if it was true. The monk said, 'Yes, Sir, I would like to attain the highest level of holiness within your life time.' And the Buddha praised his action and said, 'if someone wants to respect me, this is the way to do it.' "There are many people here who understand this and come to follow this path. With the help of our *Kalyana mitra* [a close friend who brings one to	She feels very secure with her small group of community devotees who are mostly interested in meditation.	*Dasa-sil-mata* Mahaula came from a well-to do family and her *aramaya* was built for her by her father. She has devotees with advanced education who are mostly interested in meditation rather than pujas.

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self-liberated	Responsibility to find security in old age	Researcher comments
			the *dhamma* way] we understand that we have to give some of this up and attend to meditation." - **Mahula**		
	Buddha puja three times a day and bodhi puja as many times as community requests	**"We should try to plan some meditative activities according to time we have. If we keep just meditating, this place we live in will be covered by the jungle. It is not like monks who have people to attend such things. We need to do our chores. Otherwise we will not have a place to step into. If this place is covered with weeds and over-grown with trees and bushes, our neighbors will not have a good impression of us. It is important for us to keep our environment pleasing to look at for the devotees." - Baka**	**Plans some time for meditation, and balances with social service.**	**She feels very secure with her community, which is comprised of poor farmers.**	*Dasa-sil-mata, Baka* **lives very happily with her limited resources and feels she is doing a service to the community**
	Buddha puja three times a day and bodhi puja as many times as community requests. Some bodhi pujas are done by the disciples.	**"Our devotees do not allow us to be in need of anything. Even yesterday, I was taken to the doctor" [for getting medications]. "We have people coming and going from this training center all the time. But, it is not a problem. We have made a allocated time for our**	**"It is not always keeping eyes shut. Meditation can be done by taming our senses. We manage to tame senses when we hear and see things. It is a type of meditation. If we can continue without awakening our mind defiling wholesome qualities, then it is meditation" -Goraka.**	**Feels very secure in her community**	*Bhikkhuni,* **Goraka is the head nun of a small** *bhikkhuni* **training center. She has a great rapport with her community.**

Profile	Responsibility to the Buddha	Responsibility to others	Responsibility to be self-liberated	Responsibility to find security in old age	Researcher comments
		meditation. There are some devotees who come at this time to meditate with us.” - Goraka			
Practices little or no meditation and engages in very limited social activities	Buddha puja three times a day and bodhi puja occasionally if someone comes requesting that.	Participates in minimum social services. Usually joins other nuns from a larger temple to chant *pirit* when a large group of nuns is needed for this activity in a bigger city such as the Capital	“Meditation…. I do not do a lot. Even when I think of Buddha, *dhamma, sangha,* it calms my mind, that is what is needed, nothing else. It is the same thing others get from hours of meditation. So, we do according to the time we have. When we lie down to sleep, until sleep comes we meditate, Sleep comes easily, when mind is calm. **Dimbula**	Lives in a region of scarce resources and there are only a few Buddhist devotees to give alms-food. She even has difficulty paying her electric bill	*Dasa sil mata,* Dimbula depends mostly on the help of her grown up children. She also receives support (e.g. alms, robes etc.) from bigger *aramayas* when she participates in their activities. Her knowledge in meditation is mimimal.
Practices little or no meditation or social activities	Buddha puja three times a day mostly at pilgrim sites	Awaits pilgrims at sacred areas, blesses persons such as pregnant women, chants few stanzas of *pirit*, ties a *pirit*- blessed cord around pilgrims wrist	States practices ‘loving kindness meditation’ akin to what lay people say that they practice, but otherwise has little knowledge about meditation.	“Now we live with great difficulty, now we are older, We do not have facilities, we come here and community gives *dane*, we receive that, that is how we live, we do not get *dane* like, in temples, if we have an illness, there is no body to do something” - **Kata**	Kata became a nun in her late 50s. She has medical issues such as arthritis and osteoporosis. She makes a point to explain in detail her difficulty securing funds to buy medication.

Appendix C

Consent Documents

THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

Human Research Review Committee
MSC 08 4560 BMSB Room B71
1 University of New Mexico–Albuquerque, NM 87131-0001
(505) 272-1129 Facsimile (505) 272-0803
http://hsc.unm.edu/som/research/hrrc/

31-Jul-2012

Parshall, Mark B,
College of Nursing

SUBJECT: HRRC Approval of New Research Protocol
HRRC#: 12-343
Study Title: Role of Buddhist spiritual practice in the lives and health of Buddhist nuns living with chronic illness in Sri Lanka
Type of Review: Expedited Review
Approval Date: 30-Jul-2012
Expiration Date: 29-Jul-2013

Dear Dr. Parshall:

The Human Research Review Committee (HRRC) has reviewed and **approved*** the above-mentioned research protocol including the following:

1. Application submitted 7/20/2012;
2. Attachments 1,7, 13 submitted 7/3/2012;
3. Protocol v7/20/2012;
4. Recruitment Letter submitted 7/20/2012;
5. UNMHSC Consent (Primary) v7/20/2012;
6. UNMHSC Consent (Secondary) v7/20/2012;
7. Assessment (Interview Guide) submitted 7/3/2012.

Consent decision:
Requires a signed consent form
HIPAA Authorization Addendum not applicable

If a consent is required, we have attached a date stamped consent that must be used for consenting participants during the above noted approval period.

If HIPAA authorization is required, the HIPAA authorization version noted above should be signed in conjunction with the consent form.

This study is approved to enroll only the number of subjects listed in the application, protocol and consentform(s). If the PI wants to enroll additional subjects, it is the responsibility of the PI to submit an Amendment/Change to the HRRC before the approved number of enrolled subjects is exceeded. If increased enrollment is requested, the application, protocol and/or consent form(s) must also be amended to include the new target.

Sincerely,

Mark Holdsworth, PharmD
Executive Chair
Human Research Review Committee

* Under the provisions of this institution's Federal Wide Assurance (FWA00003255), the HRRC has determined that this proposal provides adequate safeguards for protecting the rights and welfare of the subjects involved in the study and is in compliance with HHS Regulations (45 CFR 46), FDA Regulations (21 CFR 50, 56).

University of New Mexico Health Sciences Center

Informed Consent Letter

Role of Buddhist Spiritual Practice in the Lives and Health of Buddhist Nuns Living with a Chronic Illness in Sri Lanka

Sunny Wijesinghe MS, MPH, RN is a doctoral (PhD) candidate at the University of New Mexico, College of Nursing in the United States. She is conducting a study to evaluate the influence of Buddhist spiritual practice in the lives of Buddhist nuns with a chronic illness. A chronic illness is a health condition that is not curable and with which one has to live. Some examples of chronic illness in Sri Lanka include diabetes, arthritis, heart problems, respiratory problems or cancer. This study is being conducted under the guidance of Mark Parshall, PhD, RN who is Ms. Wijesinghe's faculty advisor and PhD dissertation chair. We anticipate that as many as 50 nuns may participate in the study.

Participation in the study is entirely voluntary, and you may choose not to participate. Participation will include an interview with Ms. Wijesinghe that will last around 60-90 minutes total. The interview will be conducted in Sinhala. Questions will inquire about your daily activities as a Buddhist nun, and how your experiences with your chronic illness affect your daily activities, relationships, and your religious practice. Examples of questions include:
- Can you please tell me about a normal day in your life?
- What are the most important activities for you?
- Can you please tell me a bit about your meditation?
- Do you think this illness has affected the quality of your life?
-

Interviews will be audio-taped and notes will be taken during interviews. You may request not to have the interview audio-recorded, if you prefer, and your wishes will be honored.

There are no known risks in this study, but some individuals may experience discomfort when answering questions. You are free to decline to answer any question(s). Every effort will be made to protect your identity and to maintain the confidentiality of any information you provide.

Your name will not be used in any notes, audio-tape or transcript of your interview. Audio tapes of interviews will be transcribed by Ms. Wijesinghe who will guard your identity under a code name. Interview recordings and transcripts will be maintained as electronic files in a secure encrypted computer drive or server. The audio recordings will be destroyed at the conclusion of the study. Findings may be published or presented at academic conferences. However, no information that could identify any participant will be presented or published.

You may ask any questions about the study at any time, and your questions will be answered. You may decline to participate or withdraw from the study at any time. If you withdraw, information already obtained from the interview may be used unless you request that it not be used.

There are no direct benefits of participating in this study. Your participation in this study may help to increase understanding of factors that affect the quality of life of Sri Lankan Buddhist nuns who live with a chronic illness. There is no payment for participating, but the researcher will provide a traditional food offering.

| HRPO #: | 12-343 | Page 1 of 2 | Version: | 7/20/2012 |
| APPROVED: | 7/30/2012 | OFFICIAL USE ONLY | EXPIRES: | 7/29/2013 |

UNM | *Human Research Protections Office*

The University of New Mexico Institutional Review Board (HRRC/MCIRB)

If you have any questions, comments or concerns you would like to share, please feel free to contact Ms. Wijesinghe or Dr. Parshall at:

Sunny Wijesinghe, MS, MPH, RN
82 Mattegoda, Polgasowita
0112845385
e-mail: Swijesinghe@salud.unm.edu

Phone: +94-112845385

Mark Parshall, PhD, RN
College of Nursing MSC 09 5350
1 University of New Mexico
Albuquerque, NM 87131-0001 USA
e-mail: mparshall@salud.unm.edu
Phone: +1 (505)-272-4540

If you have any questions or concerns about your rights as a research participant, you may contact: Human Research Protections office, University of New Mexico Health Sciences Center, MSC: 08-4560, 1 University of New Mexico, Albuquerque, NM 87131-0001 USA, Tel: +1 (505) 272-1129, E-mail: HRPO@salud.unm.edu

Consent to Participate
My signature below indicates that I have read this consent form (or it has been read to me). I have had an opportunity to ask questions, and all questions have been answered to my satisfaction. By signing this Consent Form, I am agreeing to participate in this study and give my permission for the information I provide to be used as described above.

_____

Name (print)   Signature   Date

I have explained the study to the participant and answered all questions. I believe the participant understands the information in this consent and is freely consenting to participate

_____

Name of Researcher (print)   Signature of Researcher   Date

University of New Mexico Health Sciences Center

Informed Consent Letter for secondary participants

Role of Buddhist Spiritual Practice in the Lives and Health of Buddhist Nuns Living with a Chronic Illness in Sri Lanka

Sunny Wijesinghe MS, MPH, RN is a doctoral (PhD) candidate at the University of New Mexico, College of Nursing in the United States. She is conducting a study to evaluate the influence of Buddhist spiritual practice in the lives of Buddhist nuns with a chronic illness. A chronic illness is a health condition that is not curable and with which one has to live with. Some examples of chronic illness in Sri Lanka include diabetes, arthritis, heart problems, respiratory problems or cancer. This study is being conducted under the guidance of Mark Parshall, PhD, RN who is Ms. Wijesinghe's faculty advisor and PhD dissertation chair.

Primary participants of this study are Sri Lankan Buddhist nuns with one or more chronic conditions. This study also includes a group of secondary informants from Sri Lanka who might be able to shed light on the topic of chronic illness and/or Buddhist spiritual practice in Sri Lanka from potentially a different perspective. Examples of secondary informants include Buddhist scholars, health providers who work with Buddhist clergy, a live-in aide in a monastery, a neighbor to a nun living with a chronic illness, or a Sri Lankan woman with a chronic illness). You are invited to participate in this study as a secondary informant. It is anticipated that up to 20 secondary informants will participate in this study.

Participation in the study is entirely voluntary, and you may choose not to participate. Participation will include an interview with Ms. Wijesinghe that will not exceed one hour. You can choose to answer the questions either in Sinhala or English. These are not pre-set questions, but they will revolve around your experience, observations, and comments on living with a chronic illness, influence of Buddhist spiritual practice in people's life in Sri Lanka, living close to a person with a chronic illness, or providing health care for a Sri Lankan Buddhist with a chronic condition. Interviews will be audio-taped and notes will be taken. If you do not wish to have the interview recorded, your wishes will be honored.

There are no known risks in this study, but some individuals may experience discomfort when answering questions. You are free to decline to answer any question(s). Every effort will be made to protect your identity and to maintain the confidentiality of any information you provide.

Your name will not be on the audio-recording or transcripts of interviews or in study notes. The recorded interviews will be transcribed by Ms. Wijesinghe who will guard your identity under a code name. Interview recordings and transcripts will be maintained as electronic files in a secure encrypted disk or server. The audio recordings will be destroyed at the conclusion of the study. Findings may be published or presented at conferences. However, no information that could identify any participant will be presented or published.

You may ask any questions about the study at any time, and your questions will be answered. You may decline to participate or withdraw from the study at any time. If you withdraw, information already obtained from the interview may be used unless you request that it not be used.

There are no direct benefits of participating in this study. Your participation in this study may help to increase understanding of factors that affect the quality of life of Sri Lankan Buddhist nuns who live with a chronic illness. There is no payment for participating, but the researcher will provide the customary refreshments during the interview.

If you have any questions, comments or concerns you would like to share, please feel free to contact Ms. Wijesinghe or Dr. Parshall at:

Sunny Wijesinghe, MS, MPH, RN	Mark Parshall, PhD, RN
82 Mattegoda, Polgasowita	College of Nursing MSC 09 5350
0112845385	1 University of New Mexico
e-mail: Swijesinghe@salud.unm.edu	Albuquerque, NM 87131-0001 USA
	e-mail: mparshall@salud.unm.edu
Phone: +94-112845385	Phone: +1 (505)-272-4540

If you have any questions or concerns about your rights as a research participant, you may contact: Human Research Protections office, University of New Mexico Health Sciences Center, MSC: 08-4560, 1 University of New Mexico, Albuquerque, NM 87131-0001 USA, Tel: +1 (505) 272-1129, E-mail: HRPO@salud.unm.edu

Consent to Participate

My signature below indicates that I have read this consent form (or it has been read to me). I have had an opportunity to ask questions, and all questions have been answered to my satisfaction. By signing this Consent Form, I am agreeing to participate in this study and give my permission for the information I provide to be used as described above.

_____

Name (print)   Signature   Date

I have explained the study to the participant and answered all questions. I believe the participant understands the information in this consent and is freely consenting to participate

_____

Name of Researcher (print)   Signature of Researcher   Date

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APPROVED:	7/30/2012	OFFICIAL USE ONLY	EXPIRES:	7/29/2013

UNM | *Human Research Protections Office*

The University of New Mexico Institutional Review Board (HRRC/MCIRB)

THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

Human Research Review Committee
MSC 08 4560 BMSB Room B71
1 University of New Mexico-Albuquerque, NM 87131-0001
(505) 272-1129 Facsimile (505) 272-0803
http://hsc.unm.edu/som/research/hrrc/

11-Sep-2012

Parshall, Mark B,
College of Nursing

SUBJECT: HRRC Approval of Research - Amendment
Project Title: Role of Buddhist spiritual practice in the lives and health of Buddhist nuns living with chronic illness in Sri Lanka
HRRC#: 12-343
Type of Review: Expedited Review
Approval Date: 10-Sep-2012
Expiration Date: 29-Jul-2013

Dear Dr. Parshall:

The Human Research Review Committee (HRRC) has **approved*** the above mentioned research protocol action based on review of the following:

1) Recruitment letter (Sinhala translation) v 08/10/2012;
2) Primary Consent (Sinhala translation) v 08/10/2012;
3) Secondary Consent (Sinhala translation) v 08/10/2012.

Consent Decision:
Requires a signed consent form
HIPAA Authorization Addendum not applicable

VA Studies Only:

If a consent is required, we have attached a date stamped consent that must be used for consenting participants during the above noted approval period.

If HIPAA Authorization is required, the HIPAA Authorization version noted above should be signed in conjunction with the consent form.

This study is approved to enroll only the number of subjects listed in the application, current protocol and consent form(s). If the PI wants to enroll additional subjects, it is the responsibility of the PI to submit an Amendment Request to the HRRC before the approved number of enrolled subjects is exceeded. If increased enrollment is requested the application, protocol and/or consent form(s) must also be amended to include the new target.

When consent is required, it is the responsibility of the Principal Investigator (PI) to ensure that ethical and legal informed consent has been obtained from all research participants.

Sincerely,

Mark Holdsworth, PharmD
Executive Chair
Human Research Review Committee

*Under the provisions of this institution's Federal Wide Assurance (FWA00003255), the HRRC has determined that this proposal provides adequate safeguards for protecting the rights and welfare of the subjects involved in the study and is in compliance with HHS Regulations (45 CFR 46), FDA Regulations (21 CFR 50, 56).

Recruitment Letter

[HRPO_12-343_(Parshall)_recruitment_letter_(Sinhala_Aug.10.2012).pdf]

82, මත්තේගොඩ, පොල්ගස්ඕවිට

ශ්‍රී ලංකාව

දුරකථනය: +94-0112845385

2012 ජුනි මස 25 දින

භික්ෂුණීන් වහන්සේගේ ලිපිනය

ගරු භික්ෂුණීන් වහන්ස /දසසිල් මාතාවෙනි,

මගේ නම සැනී විජේසිංහ වන අතර, මා දැනට ඇමරිකා එක්සත් ජනපදයේ ඇල්බුක්වර්කිහි නව මෙක්සිකෝ විශ්ව විදාහලයේ ආචාර්ය උපාධිය හදාරන ශ්‍රී ලාංකික හෝ සිසුවියක් වෙමි. ඔබගේ ලිපිනය මා වෙත ලබා දුන්නේ .... (ඇගේ ලිපිනය ලබා දුන් බෞද්ධ සංගමයේ නම යොදන්න) විසිනි. ශ්‍රී ලාංකික බෞද්ධ භික්ෂුණීන් වහන්සේලා සමඟ මා සිදු කරන පර්යේෂණ අධ්‍යයනයක් පිළිබඳව .... (කලාපයේ නම) හි සිවිල් වන බෞද්ධ භික්ෂුණීයක වන ඔබව දැනුවත් කිරීමට සහ මෙම පර්යේෂණයට සහභාගි වීමට ඔබ කැමැත්තත් දක්වන්නේද යන්න විමසීම සඳහා මෙම ලිපිය ලියමි.

මාගේ පර්යේෂණ අධ්‍යයනයට නිදන්ගත රෝගවලින් පෙළෙන බෞද්ධ භික්ෂුණීන් වහන්සේලාගේ ජීවිතයට සහ සෞඛ්‍යයට බෞද්ධ ආධ්‍යාත්මික ක්‍රියාකාරකම් බලපාන ආකාරය අධ්‍යයනය කිරීම ඇතුළත් වේ. නිදන්ගත රෝගයක් යනු සුව කළ නොහැකි සහ වඩාන්නත් වැළඳී ඇති අයෙකුට එම රෝගය සමඟ ජීවත් වීමට සිදු වන තත්ත්වයකි. නිදන්ගත රෝගවලට නිදසුන් ලෙස දියවැඩියාව, ආතරයිටිස්, හදවත් රෝග, ජීවිසන ආධාර හෝ පිළිකා දැක්විය හැකිය. ඔබට වැඩුනි රෝග තත්ත්වයක් හෝ පිට සමාන රෝග තත්ත්වයක් ඇති බව ඔබ සිතන්නේ නම්, සහ ඔබ ඒ සම්බන්ධයෙන් පර්යේෂිතාව සමඟ කථා කර කිරීමට කැමති නම්, පහතින් විස්තර කර ඇති ආකාරයට මා සමඟ සම්බන්ධ වී ඒ බව මා වෙත දැනුම් දිය හැකිය.

මා අපේක්ෂා කරනුයේ වයස අවුරුදු 18ට වැඩි සහ කථා කරන සිංහල හෝ ඉංග්‍රීසි අවබෝධ කර ගත හැකි බෞද්ධ භික්ෂුණීන් වහන්සේලාය. මෙම අධ්‍යයනයට සහභාගි වීමට කැමති එම බෞද්ධ භික්ෂුණීන් වහන්සේලා මාගේ සම්මුඛ පරීක්ෂණයට මා භාජනය කරමි. සම්මුඛ පරීක්ෂණය සඳහා විනාඩි 60-90 අතර කාලයක්ගත වන අතර භික්ෂුණීයක වහන්සේ මාගේ සම්මුඛ පරීක්ෂණයට මා ....

සම්මුඛ පරීක්ෂණයට සහභාගි වන්නන්ට කිසිදු මුදලක් හෝ වෙනත් දුවැමය ගෙවීමක් සිදු නොකරන බව කරුණාවෙන් සලකන්න. මෙම අධ්‍යයනය නිදන්ගත රෝග සම්බන්ධයෙන් නුවද සම්මුඛ පරීක්ෂණයද විසින් නිසියම් කිසිවිත සෛද පහසුකමක් භාවිතා කිරීම සඳහා භවිත කිසිදු ඖෂධයක් හෝ වෛද්‍ය නිර්දේශයක් ලබා නොහැකි. සම්මුඛ පරීක්ෂණයට පසුව ඔබට ඔබගේ තත්ත්වය ගැන ප්‍රශ්න ඇසිය හැකිය, එසේ නමුත් මෙම අධ්‍යයනයේ අරමුණ වෛද්‍ය සේවා සැලසීම නොවේ.

අධ්‍යයනය පිළිබඳ විස්තර දැක්වෙන අනුමැතිය ලබා දීමේ ලිපියක් මෙම ලිපි කවරය තුළ තිබේ. එම ලේඛනය ඔබින් සහභාගි වීමෙන් ඇති විය හැකි අවදානම් තත්ත්වයන් සහ එම අවදානම් අවම කිරීම සඳහා ගන හැකි පියවර ඇතුළත් වේ. මෙම සම්මුඛ පරීක්ෂණයට සහභාගි වීමෙන් ඔබට ක්ෂණික හා සෘජු ප්‍රතිලාභ අත් නොවන නමුත්, නිදන්ගත රෝගයක් සහිත ශ්‍රී ලාංකිය බෞද්ධ භික්ෂුණීන්ගේ තත්ත්වය පිළිබඳව වන අවබෝධය පුළුල් කර ගැනීමට ඔබේ සහභාගීත්වය ඉවහල් වන අතර, එය විශාල ජනතාවකගේ අවධානයට යොමු වීම වැනි සමස්ත ශ්‍රී ලාංකිය බෞද්ධ භික්ෂුණීන් වහන්සේලා සඳහා වඩා ප්‍රතිලාභ සැලසීමට හේතු වනු ඇත.

මෙම ලිපිය ටියෑපි සඳහා වෙලාව කැප කිරීම සම්බන්ධයෙන් මා ඔබුහිවන්ත වන අතර ඔබට නිදන්ගත රෝගයක් තිබේද සහ මෙම අධ්‍යයනයට සහභාගි වීමට ඔබ කැමතිද යන්න මා වෙත දැනුම් දීමට කටයුතු කරන්නේ නම් කෘතඥ වෙමි. ඉද්දර ඇලදූ, ලිපිය ලියන ලද ඇලෑල්වතත් මෙම ලිපිය සමඟ එවා තිබේ. ඔබ මෙම අධ්‍යයනයට සහභාගි වීමට කැමති නම් හෝ මෙම අධ්‍යයනය සම්බන්ධයෙන් වැඩිදුර කරුණු දැනගැනීමට කැමති නම් හෝ ඒ බව මා වෙත දැනුම් දීමට මෙම තැපැල්පත හෝ වා කරන මෙහි කාරුණිකව ඉල්ලා සිටිමි. ඔබ ලිබින ලිපි ගනුදෙනුවකට වඩා දුරකථන සංවාදයකට වැඩියෙන් කැමැත්තත් දක්වන්නේ නම්, කරුණාකර මා වෙත ඔබගේ දුරකථන අංකය ලබා දෙන්න.

මිට විශ්වාසී,

සැනී විජේසිංහ

I certify that the foregoing is a true translation done by me.

R. M. S. PREMARATNE (NAATI Accredited)
Sworn Translator
Ministry of Power & Energy
72, Ananda Coomaraswamy Mawatha
Colombo 7, SRI LANKA.
(+94714405457)

Secondary Letter

[HRPO_12-343_(Parshall)_secondary_consent_(Sinhala_Aug.10.2012).pdf]

නිව් මෙක්සිකෝ සෞඛ්‍ය විද්‍යා මධ්‍යස්ථානය

ද්විතීයික සහභාගී වන්නන් සඳහා වන දැනුවත් කළ අනුමැතිය ලබා දීමේ ලිපිය

ශ්‍රී ලංකාව තුළ නිදන්ගත රෝගයක් සමඟ ජීවත් වන බෞද්ධ භික්ෂුණීන් වහන්සේලාගේ ජීවිතය සහ සෞඛ්‍යය තුළ
බෞද්ධ ආධ්‍යාත්මික කටයුතුවල කාර්යභාරය

සනි විසේසිංහ MS, MPH, RN එන්සන් ජනපදයේ කොලේජ් ඔෆ් නර්සිං හි නිව් මෙක්සිකෝ විශ්ව විද්‍යාලයේ
ආචාර්ය උපාධි අපේක්ෂිකාවකි. ඇය නිදන්ගත රෝගවලින් පෙළෙන බෞද්ධ භික්ෂුණීන් වහන්සේලාගේ
ජීවිතවලට බෞද්ධ ආධ්‍යාත්මික පරිචයණි ඇති බලපෑම් සම්බන්ධයෙන් අධ්‍යයනයක තරන වේ. නිදන්ගත
රෝගයක් යනු සුව කළ නොහැකි සහ එවැන්නන් වැඩි ඇති අයකුට එම රෝගය සමඟ ජීවත් විමට සිදු වන
තත්ත්වයකි. නිදන්ගත රෝගවලට නිදසුන් ලෙස දියවැඩියාව, ආතරයිටිස්, හදවත් රෝග, ශ්වසන ආබාධ හෝ
පිළිකා දැක්විය හැකිය. මෙම අධ්‍යයනය විසේසිංහ මහත්මියගේ පිය උපදේශක සහ ආචාර්ය උපාධි නිබන්ධනයේ
සභාපතිනිය වන ආචාර්ය මාර්ක් පාර්ෂල්ගේ RN උපදේශනය යටතේ සිදු කරනු ලැබේ.

මෙම අධ්‍යයනයේ ප්‍රාථමික සහභාගී වන්නන් වනුයේ නිදන්ගත රෝග එකක් හෝ කිහිපයක් සහිත ශ්‍රී ලාංකීය
බෞද්ධ භික්ෂුණීන් වහන්සේලාය. බොහෝ විට වෙනත් පැතිකඩාත් තුළින් ශ්‍රී ලංකාවේ නිදන්ගත රෝග සහ/හෝ
බෞද්ධ ආධ්‍යාත්මික ක්‍රියා පිළිවෙත සම්බන්ධයෙන් දැනුමක් ලබා දිය හැකි ද්විතීයික තොරතුරු ලබා දෙන්නන්
කණ්ඩායමක්ද මෙම අධ්‍යයනයට ඇතුළත් වේ. ද්විතීයික තොරතුරු සපයන්නන් සඳහා නිදසුන් ලෙස බෞද්ධ
උගතුන්, බෞද්ධ පුන්සවරුන් සමඟ කටයුතු කරන සෞඛ්‍ය සැපයුම්කරුවන්, නිදන්ගත රෝගයකින් පෙළෙන
භික්ෂුණීන්ගේ අසල්වැසියකු, හෝ නිදන්ගත රෝගයකින් පෙළෙන ශ්‍රී ලාංකීය කාන්තාවන් දැක්විය හැකිය.
මෙම අධ්‍යයනයට ද්විතීයික තොරතුරු ලබා දෙන්නෙකු ලෙස සහභාගි වන ලෙස අපි ඔබගෙන් ඉල්ලා සිටිමු.
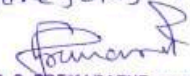ද්විතීයික තොරතුරු ලබා දෙන්නන් 20 දෙනෙකු පමණ මෙම අධ්‍යයනයට සහභාගි වනු ඇතැයි අපේක්ෂා කරමු.

මෙම අධ්‍යයනයට සහභාගී විම සම්පූර්ණයෙන්ම ස්වේච්ඡාවෙන් සිදු වන අතර, මෙම අධ්‍යයනයට සහභාගි නොවීම
හෝරා ගැනීමට ඔබට හැකිය. විසේසිංහ මහත්මිය විසින් පවත්වනු ලබන මෙම සම්මුඛ පරීක්ෂණයට පැයකට වඩා
වැඩි කාලයක් ගත නොවනු ඇත. සිංහල භාෂාවෙන් හෝ ඉංග්‍රීසි භාෂාවෙන් පිළිතුරු දීම ඔබට තෝරා ගත හැකිය.
මෙවා කළින් සාකච්ඡා කර තිබෙන ප්‍රශ්න නොවේ. එසේ වුවද ඒවා නිදන්ගත රෝගයක් සමඟ ජීවත් විම හා අදාළ
ඔබේ අත්දැකීම්, නිරීක්ෂණ හා අදහස්. ශ්‍රී ලංකාවේ ජන ජීවිතයට බෞද්ධ ආධ්‍යාත්මික කටයුතුවල බලපෑම්.
නිදන්ගත රෝගයක් සහිත තැනැත්තෙකු සම්පයේ ජීවත් විම, හෝ නිදන්ගත රෝගයක් සහිත ශ්‍රී ලාංකීය බෞද්ධ
භික්ෂුණියකට උපස්ථාන කිරීම වැනි කරුණු සමඟ සම්බන්ධ වනු ඇත. සම්මුඛ පරීක්ෂණය පටිගත කරනු ලබන
අතර සම්මුඛ පරීක්ෂණය අතරතුර කරුණු සටහන් කර ගනු ලැබේ. ඔබ සම්මුඛ පරීක්ෂණ පටිගත කරනු ලැබීමට
අකමැති නම්, ඔබගේ කැමැත්තට අපි ගරු කරමු.

මේ අධ්‍යයනය හා අදාළව කිසියු අවදානම් තත්ත්වයක් නොමැත. එසේ වුවද සමහර අයට ප්‍රශ්නවලට පිළිතුරු
දීමේදී යම් අපහසුතාවයක් දැනීමට ඉඩ තිබේ. කිසියම් ප්‍රශ්නයකට/ප්‍රශ්නවලට පිළිතුරු දීම ප්‍රතික්ෂේප කිරීමට ඔබට
පුළුවන. ඔබගේ අනන්‍යතාව ආරක්ෂා කිරීම සඳහා සහ ඔබ සපයනු ලබන කිසියම් තොරතුරක රහස්‍යභාවය
ආරක්ෂා කිරීම සඳහා සෑම ප්‍රශ්නයක්ම දරනු ලැබේ.

ඔබේ නම ශ්‍රව්‍ය පටිගත කිරීමේදී හෝ ඔබේ සම්මුඛ පරීක්ෂණයෙහි හඬ ලේඛනගත කිරීමේදී භාවිතා නොවේ.
පටිගත කළ සම්මුඛ පරීක්ෂණ ලේඛනගත කිරීම සිදු කරනු ලබන්නේ විසේසිංහ මහත්මිය විසින් වන අතර තේන
නාමක් යටතේ ඇය විසින් ඔබගේ අනන්‍යතාව සුරක්ෂිත කරනු ඇත. රහස් ආරක්ෂිත ඩුම යැදු ඩිස්ක් හෝ සර්වර්
තුළ සම්මුඛ පරීක්ෂණවල ශ්‍රව්‍ය පටිගත කිරිම සහ හඬ පටවේ ලේඛනගත කිරීම ආරක්ෂාකාරීව තබා ගැනේ.
අධ්‍යයනය අවසානයේදී හඬ පටි විනාශ කර දමනු ලැබේ. අධ්‍යාපනික සම්මන්ත්‍රණවලදී මෙම අධ්‍යයනයේ සොයා
ගැනීම් පළ කිරීම හෝ ඉදිරිපත් කිරීම සිදු කෙරේ. කෙසේවෙතත්, සහභාගි වන තැනැත්තෙකුගේ අනන්‍යතාව
හඳුනාගත හැකි කිසියු තොරතුරක් ඉදිරිපත් කිරීම හෝ පළ කිරීම සිදු නොවේ.

අධ්‍යයනය අතරතුර ඔබට ඔනෑම ප්‍රශ්නයක් ඇසිය අතර, එම ප්‍රශ්න සඳහා පිළිතුරු ලබා දේ. ඔබට ඔනෑම
අවස්ථාවක අධ්‍යයනයට සහභාගි විම ප්‍රතික්ෂේප කිරීම හෝ ඉන් ඉවත් විම කළ හැකිය. ඔබ ඉවත් වුවහොත්, ඔබ

I certify that the foregoing is a true translation done by me.

R. M. S. PREMARATNE (NAATI Accredited)
Sworn Translator
Ministry of Power & Energy
72, Ananda Coomaraswamy Mawatha
Colombo 7, SRI LANKA.
(+94714405457)

Secondary Letter

[HRPO_12-343_(Parshall)_secondary_consent_(Sinhala_Aug.10.2012).pdf]

භාවිතා නොකරන ලෙස ඉල්ලීමින් සිදු කළහොත් හැර, ඒ වන විටත් ලබා ගන්නා ලද තොරතුරු භාවිතා කෙරෙනු ඇත.

මෙම සම්මුඛ පරීක්ෂණයට සහභාගි වීමෙන් ඔබට සෑදු ප්‍රතිලාභ අත් නොවේ. නිදන්ගත රෝගයක් සමඟ ජීවත් වන ශ්‍රී ලාංකීය බෞද්ධ භික්ෂුණීන්ගේ ජීවිත තත්ත්වයට බලපාන සාධක විටහා ගැනීමට මෙම අධ්‍යයනයට ඔබගේ සහභාගීත්වය ඉවහල් වේ. සහභාගී වීම සඳහා මුදල් ගෙවීමක් සිදු කරනු ලබන්නේ නැත, එසේ වුවත් පර්යේෂණකරු විසින් පර්යේෂණය අතරතුර සාම්ප්‍රදායික ආහාර පාන පුද කරනු ඇත.

ඔබට කිසියම් ගැටළුවක් ඇත්නම්, හෝ කිසියම් අදහසක් හුවමාරු කර ගැනීමට කැමති නම්, පහත ආකාරයට විජේසිංහ මහත්මිය හෝ ආචාර්ය පාර්ෂල් හා සම්බන්ධ වන්න.

සනී විජේසිංහ, MS, MPH, RN
82, මත්තේගොඩ, පොල්ගස්ඕවිට
0112845385
ඊමේල්: Swijesinghe@salud.unm.edu
දුරකථනය: +94-112845385

Mark Parshall, PhD, RN
College of Nursing MSC 09 5350
1 University of New Mexico
Albuquerque, NM 87131-0001 USA
ඊමේල්: mparshall@salud.unm.edu
දුරකථනය: +1 (505)-272-4540

පර්යේෂණයට සහභාගි වන්නෙකු ලෙස ඔබට කිසියම් ප්‍රශ්නයක් හෝ ගැටළුවක් ඇත්නම්, ඔබට පහත ලිපිනයෙන් ඒ සම්බන්ධව විමසිය හැකිය:
Human Research Protections office, University of New Mexico Health Sciences Center, MSC: 08-4560, 1 University of New Mexico, Albuquerque, NM 87131-0001 USA, Tel: +1 (505) 272-1129, E-mail: HRPO@salud.unm.edu

සහභාගී වීම සඳහා එකඟතාව පළ කිරීම

පහත දැක්වෙන මාගේ අත්සනෙන් ප්‍රකාශ වන්නේ මා මෙම එකඟතා පත්‍රය කියවූ (නැතහොත් එය මා වෙත කියවා දෙන ලද) බවය. මට ප්‍රශ්න ඇසීම සඳහා අවස්ථාව හිමි වූ අතර, සියලු ප්‍රශ්නවලට සතුටුදායක ලෙස පිළිතුරු මට ලැබුණි. මෙම එකඟතා ප්‍රකාශය අත්සන් කිරීමෙන්, මා මෙම අධ්‍යයනයට සහභාගි වීමට කැමැත්ත ලබා දෙන අතර, මා විසින් සපයන තොරතුරු ඉහතින් විස්තර කරන ලද ආකාරයට භාවිතා කිරීම සඳහා ලබා දීමට මාගේ අනුමැතිය ලබා දේ.

_____   _____   _____
නම (මුද්‍රණය කරන්න)   අත්සන   දිනය

මා විසින් මෙම අධ්‍යයනය සම්බන්ධයෙන් සහභාගි වන තැනැත්තා වෙත පැහැදිලි කළ අතර අසන ලද ප්‍රශ්නවලට පිළිතුරු ලබා දුන්නෙමි. මෙම එකඟතා ප්‍රකාශයේ දැක්වෙන තොරතුරු සහභාගි වන්නාහට අවබෝධ වී තිබෙන බවත් සහභාගි වීමට කැමැත්ත පළ කිරීම නිදහසේ සිදු කළ හැකි බවත් මම විශ්වාස කරමි.

_____   _____   _____
පර්යේෂකයාගේ නම (මුද්‍රණය කරන්න)   අත්සන   දිනය

I certify that the foregoing is a true translation
done by me

R. M. S. PREMARATNE (NAATI Accredited)
Sworn Translator
Ministry of Power & Energy
72, Ananda Coomaraswamy Mawatha
Colombo 7, SRI LANKA.
(+94714405457)

Primary Letter

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නිව් මෙක්සිකෝ සෞඛ්‍ය විද්‍යා මධ්‍යස්ථානය

දැනුවත් කළ අනුමැතිය ලබා දීමේ ලිපිය

ශ්‍රී ලංකාව තුළ නිදන්ගත රෝගයක් සමඟ ජීවත් වන බෞද්ධ භික්ෂූණීන් වහන්සේලාගේ ජීවිතය සහ සෞඛ්‍යය තුළ බෞද්ධ ආධ්‍යාත්මික කටයුතුවල කාර්යභාරය

සනී විජේසිංහ MS, MPH, RN එක්සත් ජනපදයේ කොලේජ් ඔෆ් නර්සිංහ නිව් මෙක්සිකෝ විශ්ව විද්‍යාලයේ ආචාර්ය උපාධි අපේක්ෂිකාවනි. ඇය නිදන්ගත රෝගවලින් පෙළෙන බෞද්ධ භික්ෂුණීන් වහන්සේලාගේ ජීවිතවලට බෞද්ධ ආධ්‍යාත්මික පරිවයනි ඇති බලපෑම් සම්බන්ධයෙන් අධ්‍යයනයක නිරත වේ. නිදන්ගත රෝගයක් යනු සුව කළ නොහැකි සහ එ්වැන්නන් වැළදී ඇති අයෙකුට එම රෝගය සමඟ ජීවත් වීමට සිදු වන තත්ත්වයකි. නිදන්ගත රෝගවලට නිදසුන් ලෙස දියවැඩියාව, ආතරයිටිස්, හදවත් රෝග, ජ්‍යවසන ආබාධ හෝ පිළිකා දැක්විය හැකිය. මෙම අධ්‍යයනය විජේසිංහ මහත්මියගේ පීය උපදේශක සහ ආචාර්ය උපාධි නිබන්ධනයේ සභාපතිනිය වන ආචාර්ය මාර්ක් පාර්ෂල්ගේ RN උපදේශනය යටතේ සිදු කරනු ලැබේ. මෙම අධ්‍යයනයට බෞද්ධ භික්ෂුණීන් වහන්සේලා 50ක් සමණ සහභාගී වේතැයි අපි බලාපොරොත්තු වෙමු.

මෙම අධ්‍යයනයට සහභාගී වීම සම්පූර්ණයෙන්ම ස්වේච්ඡාවෙන් සිදු වන අතර, මෙම අධ්‍යයනයට සහභාගී නොවීම තෝරා ගැනීමට ඔබට හැකිය. විජේසිංහ මහත්මිය විසින් පවත්වනු ලබන මෙම සම්මුඛ පරීක්ෂණයට සම්පූර්ණ වශයෙන් විනාඩි 60- 90 අතර කාලයක් ගත වනු ඇත. සම්මුඛ පරීක්ෂණය පැවැත්වෙන්නේ සිංහල භාෂාවෙනි. සම්මුඛ පරීක්ෂණයේ ප්‍රශ්නවලට, නිදන්ගත රෝගය බෞද්ධ භික්ෂුණීයක ලෙස ඔබේ එදිනෙදා වැඩ කටයුතුවලට බලපාන ආකාරය සහ ඔබේ නිදන්ගත රෝගය ඔබේ එදිනෙදා කටයුතුවලට, සම්බන්ධතාවලට, හෝ ආගමික කටයුතුවලට බලපාන ආකාරය පිළිබඳ ඔබේ අත්දැකීම් ආදිය ඇතුළත් වේ. එ්වැනි ප්‍රශ්නවලට නිදසුන් පහත දැක්වා තිබේ:
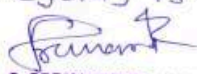
- ඔබේ ජීවිතයේ සාමාන්‍ය දිනයක් ගැන කරුණාකර මට කිව හැකිද?

- ඔබට වඩාත්ම වැදගත් කාර්යයන් මොනවාද?

- ඔබ ලබා ගන්නා ඖෂධ සම්බන්ධයෙන් මට තොරතුරු ස්වල්පයක් ප්‍රකාශ කළ හැකිද?

- අසනීප තත්ත්වය ඔබේ ජීවන තත්ත්වට බලපා ඇති බවට ඔබ සිතන්නේද?

සම්මුඛ පරීක්ෂණය පටිගත කරනු ලබන අතර සම්මුඛ පරීක්ෂණය අතරතුර කරුණු සටහන් කර ගනු ලැබේ. ඔබ කැමති නම්, සම්මුඛ පරීක්ෂණ පටිගත නොකරන ලෙස ඉල්ලා සිටීමට හැකි අතර, ඔබගේ කැමැත්තට අපි ගරු කරමු.

මේ අධ්‍යයනය හා අදාළව කිසිදු අවදානම් තත්ත්වයක් නොමැත. එසේ වුවද සමහර අයට ප්‍රශ්නවලට පිළිතුරු දීමේදී යම් අපහසුතාවයක් දැනීමට ඉඩ තිබේ. කිසියම් ප්‍රශ්නයකට/ප්‍රශ්නවලට පිළිතුරු දීම ප්‍රතික්ෂේප කිරීමට ඔබට පුළුවන. ඔබගේ අනන්‍යතාව ආරක්ෂා කිරීම සඳහා සහ ඔබ සපයනු ලබන කිසියම් තොරතුරක රහස්‍යභාවය ආරක්ෂා කිරීම සඳහා සෑම ප්‍රයත්නයක්ම දරනු ලැබේ.

ඔබේ නම සටහන්වලදී, ශ්‍රව්‍ය පටිගත කිරීමේදී හෝ ඔබේ සම්මුඛ පරීක්ෂණයේ හඩ ලේඛනගත කිරීමේදී භාවිතා නොවේ. සම්මුඛ පරීක්ෂණවල හඩ පටි ලේඛනගත කිරීම සිදු කරනු ලබන්නේ විජේසිංහ මහත්මිය විසින් වන අතර සේත නමක් යටතේ ඇය විසින් ඔබගේ අනන්‍යතාව සුරක්ෂිත කරනු ඇත. රහස් ආරක්ෂිත කුම යෙදූ පරිගණක ඩාඩ්කවල හෝ සර්වර් තුළ සම්මුඛ පරීක්ෂණවල ශ්‍රව්‍ය පටිගත කිරීම සහ හඩ පටවල් ලේඛනගත කිරීම ආරක්ෂාකාරිව තබා ගැනේ. අධ්‍යයනය අවසානයේදී හඩ පටි විනාශ කර දමනු ලැබේ. අධ්‍යාපනික සම්මන්ත්‍රණවලදී මෙම අධ්‍යයනයේ සොයා ගැනීම් පළ කිරීම හෝ ඉදිරිපත් කිරීම සිදු නොකෙරේ. කෙසේවෙතත්, සහභාගී වන තැනැත්තෙකුගේ අනන්‍යතාව හඳුනාගත හැකි කිසිදු තොරතුරක් ඉදිරිපත් කිරීම හෝ පළ කිරීම සිදු නොවේ.

I certify that the foregoing is a true translation done by me.

[signature]

R. M. S. PREMARATNE (NAATI Accredited)
Sworn Translator
Ministry of Power & Energy
72, Ananda Coomaraswamy Mawatha
Colombo 7, SRI LANKA.
(+94714405457)

Primary Letter

[HRPO_12-343_(Parshall)_primary_consent_(Sinhala_Aug.10.2012).pdf]

අධ්‍යයනය අතරතුර ඔබට ඕනෑම ප්‍රශ්නයක් ඇසිය හැකි අතර, එම ප්‍රශ්න සඳහා පිළිතුරු ලබා දේ. ඔබට ඕනෑම අවස්ථාවක අධ්‍යයනයට සහභාගී වීම ප්‍රතික්ෂේප කිරීම හෝ ඉන් ඉවත් වීම කළ හැකිය. ඔබ ඉවත් වුවහොත්, ඔබ භාවිතා නොකරන ලෙස ඉල්ලීමක් සිදු කළහොත් හැර, ඒ වන විටක් ලබා ගන්නා ලද තොරතුරු භාවිතා නොකෙරෙනු ඇත.

මෙම සම්මුඛ පරීක්ෂණයට සහභාගී වීමෙන් ඔබට සෘජු ප්‍රතිලාභ අත් නොවේ. නිදන්ගත රෝගයක් සමහ සිටින් වන ශ්‍රී ලාංකීය බෞද්ධ ගිහිභික්ෂුන්ගේ ජීවිත තත්ත්වයට බලපාන සාධක වටහා ගැනීමට මෙම අධ්‍යයනයට ඔබගේ සහභාගීත්වය ඉවහල් වේ. සහභාගී වීම සඳහා මුදල් ගෙවීමක් සිදු කරනු ලබන්නේ නැත. ඔබේ පුද්ගලික පර්යේෂකරු විසින් සම්පුදායික දත්තයක් පුරා සිදු කරනු ඇත.

ඔබට කිසියම් ගැටළුවක් ඇත්නම්, හෝ කිසියම් අදහසක් හුවමාරු කර ගැනීමට කැමති නම්, පහත ආකාරයට විජේසිංහ මහත්මිය හෝ ආචාර්ය පාර්ෂල් හා සම්බන්ධ වින්න.

සනී විජේසිංහ, MS, MPH, RN
82, බත්තරමුල්ල, පොල්ගස්ඔවිට
0112845385
ඊමේල්: Swijesinghe@salud.unm.edu
දුරකථනය: +94-112845385

Mark Parshall, PhD, RN
College of Nursing MSC 09 5350
1 University of New Mexico
Albuquerque, NM 87131-0001 USA
ඊමේල්: mparshall@salud.unm.edu
දුරකථනය: +1 (505)-272-4540

පර්යේෂණයට සහභාගී වන්නෙකු ලෙස ඔබට කිසියම් ප්‍රශ්නයක් හෝ ගැටළුවක් ඇත්නම්, ඔබට පහත ලිපිනයෙන් ඒ සම්බන්ධව විමසිය හැකිය:

Human Research Protections office, University of New Mexico Health Sciences Center, MSC: 08-4560, 1 University of New Mexico, Albuquerque, NM 87131-0001 USA, Tel: +1 (505) 272-1129, E-mail: HRPO@salud.unm.edu

සහභාගී වීම සඳහා එකඟතාව පළ කිරීම

පහත දැක්වෙන මාගේ අත්සනෙන් ප්‍රකාශ වන්නේ මා මෙම එකඟතා පත්‍රය කියවූ (නැතහොත් එය මා වෙත කියවා දෙන ලද) බවය. මට ප්‍රශ්න ඇසීම සඳහා අවස්ථාව ලැබී ඇති අතර, සියලු ප්‍රශ්නවලට සෑහීමට පත්වන ලෙස පිළිතුරු ලැබුණි. මෙම එකඟතා ප්‍රකාශය අත්සන් කිරීමෙන්, මා මෙම අධ්‍යයනයට සහභාගී වීමට කැමැත්ත ලබා දෙන අතර, මා විසින් සපයන තොරතුරු ඉහතින් විස්තර කරන ලද ආකාරයට භාවිතා කිරීම සඳහා ලබා දීමට මාගේ අනුමැතිය ලබා දේ.

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නම (මුද්‍රණය කරන්න)   අත්සන   දිනය

මා විසින් මෙම අධ්‍යයනය සම්බන්ධයෙන් සහභාගී වන තැනැත්තා වෙත පැහැදිලි කළ අතර අසන ලද ප්‍රශ්නවලට පිළිතුරු ලබා දුන්නෙමි. මෙම එකඟතා ප්‍රකාශයේ දැක්වෙන තොරතුරු සහභාගී වන්නාට අවබෝධ වී තිබෙන බවටත් සහභාගී වීමට කැමැත්ත පළ කිරීම නිදහසේ සිදු කළ හැකි බවටත් මම විශ්වාස කරමි.

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පර්යේෂකයාගේ නම (මුද්‍රණය කරන්න)   අත්සන   දිනය

I certify that the foregoing is a true translation done by me.

To Whom It May Concern:

I, the undersigned R.M.S. Premaratne do hereby declare that I am a full time English/Sinhala Translator working attached to the Ministry of Power & Energy, Sri Lanka since year 2000.

I am a BA graduate in Economics from the University of Peradeniya (Sri Lanka) and I completed two year Diploma course in Translation at the Sri Lanka Institute of Development Administration, before I joined the Translators' Service in the government of Sri Lanka. In the meantime, I have been accredited as a English/Sinhala Translator by the National Accreditation Authority for Translators & Interpreters (NAATI), Australia.

Further, I have taken oaths as a Sworn Translator before the Magistrate in the District Court of Colombo so I am legally eligible to undertake to translate any type of document.

Thank you.

R. M. S. PREMARATNE (NAATI Accredited)
Sworn Translator
Ministry of Power & Energy
72, Ananda Coomaraswamy Mawatha
Colombo 7, SRI LANKA.
(+54714405457)

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