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Describing Death Acceptance Among Thai Buddhists With Cancer

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Abstract

Introduction: Death acceptance (DA) is perceived in culturally specific ways. The purposes of this study were to describe DA among Thai Buddhists with cancer and to compare DA differences in demographic data. Methodology: This research was a secondary data analysis. The participants were 363 Thai Buddhists with cancer, recruited using multistage sampling method. Data were collected using the Buddhist Death Acceptance Scale, reliability coefficient. .82. Data were analyzed using T-Tests and Two-Way ANOVA. Results: The participants had high levels of DA. Age and stage of cancer had main effects on DA. Discussion: This study highlighted the significant demographic differences with regard to DA levels among Thai Buddhists with cancer. Interventions include determining the patient's DA level, or offering patients and their families advance care plans. Nurses can then explore DA with patients, particularly those with life-limiting illnesses to ease their patients' lives and foster a good death.

Keywords

advanced stage cancer, Buddhist, cancer patient, death acceptance

Introduction

Each culture/religion has its own traditions, beliefs, and practices surrounding death, which have been handed down for centuries. Cultures vary not only about how they conceptualize death, but also about how they envision death acceptance (DA) and what happens when a person dies (Gire, 2014). DA reflects how the patient is psychologically prepared for the final exit (Long & Thanasilp, 2021; Zimmermann, 2012).

The instruments that have been previously used to assess and measure DA include the Life Attitude Profile–Revised (Reker, 1992 as cited in Krapo et al., 2018), the Death Attitude Profile-Revised (Wong et al., 1994 as cited in Krapo et al., 2018), and the Attitude toward Death (Brandtstädter et al., 1997 as cited in Pinquart et al., 2006). DA in these prior studies was measured as a part of an attitude related to life or death. A newer holistic perspective of DA emerged from Buddhist philosophy and suggested that, for Thai people with cancer, DA is more than attitude, more than a cognitive process; it encompasses behavior, and embodied expression of the concept (Akkayagorn, 2018; Thanasilp et al., 2020). In the current study, DA refers to an action, force, and/or process that includes the thoughts, verbalizations, and actions of people. These can be measured by the Buddhist Death Acceptance Scale (BDAS), a measurement tool with acceptable psychometric properties, which developed from the holistic Buddhist approach (Thanasilp et al., 2020).

In Thai traditional culture, almost all members of society have been educated about basic Buddhist teachings for many centuries. The vast majority of Thai people are Buddhist and Buddhism is embedded and foundational in all aspects of Thai society and daily life. From early infancy and childhood, parents bring their young ones with them to the temple to listen to the Buddha's teachings and participate in religious activities. Thai people learn about the Buddha's teachings from monks and family. In addition, Buddhist teachings permeate the Thai education system and are applied to other

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aspects of daily life. For example, in Thailand most holidays are of Buddhist origin. One of the most important Buddhist tenets is that everyone must die and so it is not surprising that passing away from age is generally acceptable for Thais (Kuppako, 2018). Clearly, DA is significantly influenced by cultures and religions and yet even within cultures and religions, demographic differences like age, gender, marital status, duration of illness, and stage of cancer, can all make a difference in the level of DA.

Death, in Thai culture, is understood as a fact that occurs to everybody, a natural condition which is consistent with the Buddhist principles of suffering, or *dukkha* in Thai and Pali languages, impermanence, or *anicca*, and the egoless non-self, or *anatta* (Buddhaghosacariya, 2019). A death with a peaceful and pure mind is considered a good death. A good death is very important because from the Buddhist perspective, it can lead to a higher quality of life during dying, a better rebirth or reincarnation, and even to enlightenment (Buddhaghosacariya, 2019). Therefore, Thai Buddhism encourages people to think of their death as a natural process and be aware that they must die someday; to understand it is impossible for them to go beyond death; nevertheless, Buddhism supports people working to do only good, physically, verbally and mentally for the sake of leaving this world peacefully and happily (Kuppako, 2018). This is of critical importance, not only to Thai patients and their families but also to their health care providers as they work to aid their patients in living their lives fully as they move toward a good death.

Background

Previous studies found that DA levels differed in various cultures and in persons with specific demographic variables. For example, a study by Pinquart et al. (2006) assessed DA among 337 adult cancer patients who were starting to receive chemotherapy, and 180 healthy controls. The results in cancer patients found that DA was at the mean of the scale and so characterized, according to the scale scoring, as "moderately low" ($M = 2.98$, $SD = 1.12$). In addition, the results indicated those who were male, described themselves as highly religious, and who had a good cancer prognosis, had higher levels of DA than their counterparts.

Similarly, Philipp et al. (2019) explored DA among 307 German cancer patients recruited from gynecology outpatients, general surgery inpatients, and oncological inpatients. The results found that German cancer patients tended to have moderate levels of DA ($M = 4.33$, $SD = 1.30$). Moreover, those who had higher DA scores were most likely the older, male, widowers, and those with stage IV cancer. Cancer is often staged from I to IV, with stage I meaning the cancer is small and localized, stages II and III mean the cancer is larger and has grown into nearby tissues or lymph nodes, and stage IV cancer means the cancer has spread to other parts of the body. In addition, for the German patients, their DA levels decreased each month from their diagnosis, evidenced by a significant and negative correlation between the duration of illness and their DA scores.

Interestingly, different results were found in a study of Thais. Krapo et al. (2018) assessed DA among 242 adult Thai advanced cancer patients (20-59 years) who received palliative treatments from outpatient cancer clinics in tertiary hospitals in Bangkok, Thailand. The study found that Thai advanced cancer patients had high levels of DA ($M = 6.24$, $SD = 0.72$). In addition, death anxiety, and unfinished tasks were negatively related to DA while Buddhist beliefs about death, self-efficacy, and family relationship were factors that had positive relationships with DA. On the other hand, duration of illness and stage of disease were not significantly related to DA in these Thai cancer patients. However, for this study Krapo et al. (2018) used a non-religious specific measurement, the Death Attitude Profile-Revised, to assess DA among this population.

The above evidence supports the notion that DA is bounded by cultural and individual factors. However, the research of DA would not be relevant to the culture being studied if its religion is not considered. This is fundamental to the study of DA in Thailand where 85% to 95% of the population is Buddhist (Office of International Religious Freedom, 2021) and because Buddhism is at the root of almost every aspect of Thai society. Although there are aspects of animism embedded in Thai culture, such as the belief that nature is sacred, the Thai tend to classify all of their belief systems under Buddhism (Carter, 2021). Nevertheless, little is known about DA among Thai Buddhists with cancer from a Buddhist perspective.

Better understanding how cancer patients accept their deaths would facilitate nursing practice. It was reported that DA can improve the quality of death and patient dignity, both of high concern to nursing practice (McLeod-Sordjan, 2014). More importantly, once DA is understood from the lens of the patients' practicing religion, nurses would be able to discuss it, and to develop religion-congruent interventions for patients. It is likely such interventions would be well-accepted and could be integrated as a part of the daily religious practices of receptive patients and their families. As one of the first steps to set the foundations for both further descriptive and intervention studies on this concept, this study was conducted to describe DA levels among Thai persons with cancer from a Buddhist perspective, and to examine the interplay among demographic differences, including age, gender, stage of cancer, and duration of illness in relation to DA.

Methodology

Design and Procedure

This paper was part of a larger research study entitled "The comparison of death acceptance between Thai and

Vietnamese persons with cancer." One component of that study involved the development of the BDAS. The current study is a secondary analysis of the data collected during scale development for the BDAS (Thanasilp et al., 2020). The research questions addressed by this paper were as follows: 1) what was the level of DA among Thai persons with cancer, and 2) what were the associations between selected variables (age, gender, stage of cancer, and duration of illness) with DA in this population.

Sample Selection and Size

The sample for the main study was comprised of 530 Thai Buddhists with cancer recruited from six hospitals in four regions of Thailand (North, Northeast, South, and Central). Using multistage sampling methods, data were collected from April 2018 to January 2019. In Thailand, there are national standardized treatment protocols for patients so geographical differences were not assessed. However, some differences may exist depending on the treatment settings. Therefore, to analyze the cluster effect, data were grouped into three categories depending on the treatment setting: (a) general hospital, (b) special hospital, and (c) community hospice. Analysis of findings showed that there were no significant differences in DA regarding setting ($F = 2.512$, $p > .05$). Eligibility criteria for study inclusion were comprised of the following: self-described Buddhist with cancer, 18 or older, who knew the diagnosis of their disease, were able to communicate (speak, read, and write) in Thai, and who did not have any mental illnesses or developmental disabilities.

The sample size for the current study was determined by the power of test analysis using the G* Power Version 3.1.9.2 program (Faul et al., 2009), which was determined using the power of the test at 95%. It was determined that by using this effect size (0.20; Polit & Beck, 2017), statistical significance at the .05 level could be achieved with at least 319 participants. Therefore, the sample size for this study was comprised of 363 participants, with more participants added than the minimal 319 to ensure a robust analysis. The subset of 363 participants for this study were selected from the larger sample using simple randomization method.

Instruments

1. Personal Information Questionnaire was conducted by researchers and the instrument was comprised of information about gender, age, marital status, education level, occupation, type of cancer, stage of cancer, underlying disease, and duration of illness.
2. The BDAS was developed by (Thanasilp et al., 2020). It is a self-reported questionnaire that consists of 13 items covering two dimensions: 1 ("acceptance of the natural process of death") (nine items), and 2 ("preparing for death") (four items). The questionnaire has a 4-choice rating scale format, scoring each item from 1 to 4 (*strongly untrue* = 1, *untrue* = 2, *true* = 3, and *strongly true*). Mean score was calculated for the scale. The scale score, ranging from 1 to 4, was scaled to interpret a low level of DA (1.00–2.00), moderate level (>2.0–3.00), and high level (>3.0–4.00). Content validity was reviewed by five Thai experts, all Buddhists. Among them, two were nurse educators in palliative cancer care, one was registered nurse in palliative care, one an educator who specialized in measurement development/evaluation, and one was a monk who coaches cancer patients about death preparation. The overall BDAS had item-content validity index (I-CVI) scores that ranged from .80 to 1.00 and the scale-content validity index (S-CVI) was .93. The scale was piloted for preliminary item testing with 30 participants checking for readability, difficulty, and relevancy and all were met. The internal consistency coefficient of the BDAS was .82. The BDAS was determined to have acceptable psychometric properties to measure DA in Thai Buddhists who are diagnosed with cancer using exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) methods (Thanasilp et al., 2020).

Ethical Considerations and Data Collection

The original BDAS development study was approved by the Ethical Review Committee of each hospital (Approval No. 231-2018RC-OUT561; No. 40/2561; No. 004/2018; No. 19/2561; No. 0312.6/622.1; and No. 002/2017). Data were collected by research assistants after permission was obtained from the director of each hospital. The research assistants were all registered nurses with master's degrees in nursing who were trained by the researchers; all well understood the research process. Written informed consent was obtained from the participants before data collection was conducted. If the participants did not want to answer the questionnaires or did not have sufficient time to participate in this study, they were reassured they had the right to withdraw from the study at any time. In addition, if participants, while answering questionnaires, became tired or fatigued, they were encouraged to rest periodically and reminded that if they felt very tired, they could withdraw or take a rest, though none did. Participants' names or other labels were not collected at the time of data collection preserving patient confidentiality. Data for the current study were analyzed as a subset, after finishing the data collection process in the original study. Data are stored in locked files which will be destroyed after publication.

Data Analysis

Descriptive statistics, including frequencies, percentages, means and standard deviations were computed for

participants' demographics. Comparing DA of Thai Buddhists with cancer, based on age, gender, stage of cancer, and duration of illness used independent participant *t*-test. Exploring interaction effects between age and duration of illness, and between stage of cancer and gender on DA used two-way analysis of variance (ANOVA).

The preliminary assumption in the use of inferential statistics is the test of normality based on Skewness (*Sk*) and Kurtosis (*Ku*) statistics; these should be equal to zero. But it is generally concluded that a *Sk* statistic between -1 and +1 and a *Ku* statistic between -3 and +3 (Mishra et al., 2019) are acceptable for the assumption to be valid. According to the test of normality in this study, the data analysis showed *Sk* = -.83 and *Ku* = 0.22, falling within the acceptable assumption range. In addition, Levene's Test for Equality of Variances, a test used to show homogeneity of participant variance (homoscedasticity), another assumption for valid inference, resulted in insignificant differences between participants. Therefore, analysis could be performed using inferential statistics.

Results

Personal Characteristics

The mean age of the participants ($N = 363$) was 53.73 years ($SD = 11.58$, range = 18-85 years). Most of the participants were in the "adult" group or less than 60 years old (71.35%). The majority of the participants were female (63.09%) and married (75.48%). Nearly half of the participants had completed primary school (47.93%). The largest number of the participants identified their occupation as "farmer" (24.79%). The most common diagnosis was breast cancer (28.10%). A few less than a half of the participants were in stage IV of the disease (42.15%). More than half of the participants had no underlying disease (62.81%), and also more than half had a duration of illness of 6 months or more (60.06%; Table 1).

Table 1. Participant Characteristics (n = 363).

Participant characteristics	*N*	%
Age (min = 18 years, max = 85 years, *M* = 53.73, *SD* = 11.58)		
<60	259	71.35
≥60	104	28.65
Gender		
Male	134	36.91
Female	229	63.09
Marital Status		
Married	274	75.48
Single	43	11.85
Separated/ Divorced /Widowed	46	12.67
Education Level		
No education	20	5.51
Primary school	174	47.93
Secondary school	36	9.92
High school	46	12.67
Vocational school	32	8.82
Bachelor degree	48	13.22
Higher than a bachelor degree	7	1.93
Occupation		
No occupation	81	22.31
Agriculture	90	24.79
Employee	80	22.04
Merchant	43	11.85
Government officer	25	6.89
House keeper	12	3.31
State enterprise officer	8	2.20
Business owner	8	2.20
Pensioner	7	1.93
Other	9	2.48
Type of cancer (Systems)		
Breast	102	28.10
Gastrointestinal/Liver	89	24.52
Lung	50	13.77
Uro/Reproductive	43	11.85
Lymphoma/Acute Myeloid Leukemia	39	10.74
Ear-Nose-Throat/Neuro	43	11.85
Other	2	0.55
Stage of cancer		
Stage I	51	14.05
Stage II	68	18.73
Stage III	91	25.07
Stage IV	153	42.15
Underlying disease		
No	228	62.81
Yes	135	37.19
Duration of illness		
Less than 6 months	145	39.94
≥ 6 months	218	60.06

DA of Thai Buddhist Cancer Patients and Specific Dimensions of BDAS

The results showed that the participants' overall DA was at a high level ($M = 3.34$, $SD = 0.43$) according to the BDAS. When considering its dimensions, the results showed that acceptance of the "natural process of death" dimension was the highest scoring dimension ($M = 3.37$, $SD = 0.52$), followed by "preparing for death" ($M = 3.27$, $SD = 0.61$). In view of each item, the highest mean score ($M = 3.69$, $SD = 0.57$) item was "I accept the results of the treatment because I think nothing can be certain in this life," followed by "I am not afraid of death because death is a natural matter for all people" ($M = 3.53$, $SD = 0.82$). The lowest mean scores were items "I think that my family can overcome their grief after I die" and "I request not to use any aggressive treatments to prolong my life" ($M = 2.96$, $SD = 1.02$ and $M = 2.96$, $SD = 1.03$, respectively) (Table 2).

Table 2. Mean, SD, and Level of DA Among Thai Buddhist With Cancer Divided by Item, Dimension, and Total (n = 363).

Item	*M*	*SD*	Level
Acceptance of the natural process of death	**3.37**	**0.52**	**High**
• I accept the results of the treatment because I think nothing can be certain in this life	3.69	0.57	High
• I am not afraid of death because death is a natural matter for all people	3.53	0.82	High
• I believe that releasing everything will help me die peacefully	3.51	0.71	High
• Death is unavoidable, so I am willing to use my time left to help others	3.44	0.77	High
• Seeing the death of others makes me accept my death	3.40	0.84	High
• I can live with pain without suffering	3.33	0.83	High
• I accept the symptoms and can live with them without suffering	3.27	0.86	High
• I can talk with others about my death	3.21	1.01	High
• I think that my family can overcome their grief after I die	2.96	1.02	Moderate
Preparing for death	**3.27**	**0.61**	**High**
• Talking about my concerns before I die makes me Comfortable	3.48	0.84	High
• Conversations and making plans about managing my property is useful for my family and others	3.37	0.89	High
• The planning of my funeral decreases the burden on my family and others	3.27	0.94	High
• I request not to use any aggressive treatments to prolong my life	2.96	1.03	Moderate
Total	**3.34**	**0.43**	**High**

Note. DA = Death acceptance.

Comparing DA of Cancer Patients Among Demographic Differences

The findings exploring demographic factors in DA showed that the participants with differences in age and stage of cancer had significantly different levels of DA (t = -2.085 and 2.245, respectively; $p < .05$). That is, older adult participants (≥60 years) had higher DA levels than adult participants (<60 years). And participants with non-advanced cancer (stage I and II) tended to accept death at higher levels than those with more advanced cancer (stage III and IV). In contrast, there were no significant differences in levels of DA regarding gender and duration of illness ($p > .05$) (Table 3).

The results showed no interaction effect between age and duration of illness on DA ($F = 3.127$; $p > .05$). Similarly, the stage of cancer and gender had no interaction effect on DA ($F = 0.953$; $p > .05$).

Discussion

This study was conducted to describe DA among Thai persons with cancer from a Buddhist perspective, and to examine the interplay among demographic differences, including age, gender, stage of cancer, and duration of illness in relation to DA following the research questions. This research revealed that Thai Buddhists with cancer had DA at a high level (M= 3.34, SD = 0.43). Moreover, when considering the BDAS's two dimensions, "acceptance of the natural process of death" had the highest mean score, followed by "preparing for death." This might be explained because in the Thai context, people learn about basic Buddhist principles in primary school and these principles may guide them to an intellectually understanding about death—that is we all must die (Kuppako, 2018). Focusing on Buddhist principles about "the three characteristics of existence," which are suffering or *dukkha*, impermanence or *anicca*, and non-self or *anatta*, may also help Thai people be aware of their inescapable eventual death and be more aware of the importance of death preparedness (Buddhaghosacariya, 2019). For example, Buddhist patients often mention those three characters by saying these or similar words when talking with family or health care providers before deciding their code status wishes, that is, whether they accept natural death with no resuscitation. It could be the Buddhist foundational beliefs of the Thai people provide a framework for the processing of death and thus, allow for relatively high levels of DA. The result of the present study was consistent with the previous research of (Krapo et al., 2018) who found that Thai patients with advanced cancer had high levels of DA while studies in other populations found lower acceptance level (Philipp et al., 2019; Pinquart et al., 2006).

When considering specific items of the BDAS scale, "I accept the results of the treatment because I think nothing can be certain in this life" had the highest mean score, followed by "I am not afraid of death because death is a natural matter for all people." This echoes the Buddhist perspective that everything is impermanent, even the self or soul. People with cancer who accept their death are more likely to prepare for it.

The two lowest scoring items were "I think that my family can overcome their grief after I die," and "I request not to use any aggressive treatments to prolong my life." In the process of DA, the family and patient may be at different stages. The former item may invite exploration of this potential discrepancy. The other item which had low rates of endorsement was "I request not to use any aggressive treatments to

Table 3. DA of Thai Buddhist With Cancer Divided by Age, Gender, Stage of Cancer, and Duration of Illness (n = 363).

Variable	*N* (%)	DA			*t*
		M	*SD*	Level	
Age					
<60	259 (71.35)	3.30	0.45	High	–2.085*
≥60	104 (28.65)	3.39	0.38	High	
Gender					
Male	134 (36.91)	3.37	0.37	High	1.548
Female	229 (63.09)	3.30	0.46	High	
Stage of cancer					
Non-advanced cancer (stages I and II)	119 (32.78)	3.39	0.39	High	2.245*
Advanced cancer (stages III and IV)	244 (67.22)	3.29	0.45	High	
Duration of illness					
Less than 6 months	145 (39.94)	3.35	0.40	High	1.012
≥6 months	218 (60.06)	3.30	0.45	High	

Note. DA = Death acceptance.
*$p < .05$.

prolong my life." This item may indicate that cancer patients wanted to continue with treatment as long as they could because of a fear of death, beliefs that they should continue life as long as possible, or because they want to follow physician recommendations for treatment. Any of these reasons could affect their willingness to say "enough" at some point and make a request to their physicians to stop aggressive treatments. In any case, further study is needed to understand responses to this item.

Comparing the DA of Thai Buddhist cancer patients across age, gender, stage of cancer, and duration of illness, revealed that cancer patients with differences in age and stage of cancer had different levels of DA at the significance level of .05.

Age

Thai Buddhist cancer patients in the older adult group (≥60 years) had higher levels of DA than the adult group (18–59 years). Older people often prepare themselves for leaving this world (Wysokiński et al., 2019). The older people are, the more they have to deal with the death of their friends and relatives, and, consequently, the more often they reflect on passing away and death's inevitability (Wysokiński et al., 2019). Moreover, the practice of the Buddhist religion through religious activities could have made them feel more peaceful and willing to accept that death is universal (Khaw et al., 2020). This finding, the older group having higher levels of DA in the Thai group with cancer, is similar to the findings of Philipp et al. (2019) in his study of a German group with cancer. In addition, the current study found that there was no interaction effect between age and duration of illness on DA. In summary, age had only a main effect on DA as described above, meaning that the duration of illness did not change the direction or strength, that is, did not have a moderating effect, on the relationship between age and DA.

Stage of Cancer

In this study, the Thai Buddhist cancer patients in non-advanced cancer (stages I and II) had DA at higher level than those in advanced cancer (stages III and IV). Even though death occurs in normal life, most people fear death and denial of death is a normal biological function reflecting the human instinct for self-preservation (Upasen, & Thanasilp, 2020). In this study, more than half of the participants had advanced cancer (65.82%). The expectancy of death can be deeply disturbing to patients with advanced cancer, who may struggle with balancing the possibilities of life with the finality of dying (Neel et al., 2015). This finding is similar to the study of Philipp et al. (2019).

In this study, there were no significant differences on levels of DA in Thai Buddhist cancer patients with regard to gender and duration of illness. So, in this sample, everyone, both male and female, and those recently diagnosed (<6 months) as well as those who have been aware of their diagnoses 6 months or longer, had the same levels of DA. These results differed from the study of Philipp et al. (2019) that found males accepted death at higher levels than females and also found that the duration of the patient's illness had a negative relationship with DA. Perhaps because in Thai culture death is considered to be an uncontrollable and natural part of life and these notions permeate the culture, no differences are noted between Thai men and women or between groups of patients depending on the length of their illnesses (Upasen & Thanasilp, 2020). The differences noted between Thai patients and those from Germany are quite interesting. However, it would be hasty to conclude that the differences

are uniform between Thai and Western, or at least German, culture. Further studies are recommended to explore more about roles of such variables in determining DA. Seemingly, the combination of both qualitative and quantitative approaches could offer enriched understandings about this issue.

In addition, there was no interaction effect between stage of cancer and gender on DA. Based on the main effect of stage of cancer on DA, whether the patient was male or female did not change the direction or strength of the relation between stage of cancer and DA.

Clinical Implications

Findings of this study provide additional evidence about the complexity and individuality of death and DA among cancer patients. Expert palliative care health professionals and nurses working with these patients respect their unique beliefs and practices toward death. Although this research pointed out that Thai individuals with cancer tend to accept their deaths at high levels, nurses are committed to support patients to the end of their journey, wherever they score on DA. There is evidence suggesting that DA may change over the time. Therefore, continuing support and interventions such as advance care plan (ACP) introduction, or conducting an assessment of DA, to ascertain the patient and family's wishes are relevant to patients' preferences and how they perceive meaning. Religion congruent interventions may be more helpful and easily accepted by receptive patients/families. Obviously, supporting patients in accepting their inevitable death is not meant to encourage them giving up and eschewing treatment early. It is about helping patients approach their deaths peacefully. In working with these patients, nurses should pay special attention to patients aged less than 60 years old, and patients in advanced stage of cancer. Counseling to explore patients' feelings and perceptions about DA might be a potential nursing intervention when considering therapy prior to any ACP communication.

Conclusions and Recommendations

DA of people may vary in cross-cultural and cross-religious settings. The current study found that Thai Buddhists with cancer had overall DA at a high level. Moreover, participants' age and stage of cancer affected their DA. Older adult cancer patients (≥60 years) had DA levels higher than adult or younger patients. In addition, participants whose cancer was in the non-advanced stage perceived DA at higher levels than those with advanced stage cancer. Patients with high DA scores may be able to benefit from ACP communication and from discussing these ACPs with their families and the overall care team.

Further studies are recommended to explore more about roles of other individual and social factors in determining DA among cancer patients. Importantly, this study provides only cross-sectional descriptions of patients' DA. Longitudinal research to evaluate the concept along the disease trajectory is an area that needs more attention from researchers. The development and testing of interventions based on Buddhist perspectives and approaches are also recommended.

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