

SPIRITUALITY & HEALTH - CONCEPTS & CONTROVERSIES

Dr. Avudaiappan S *

Introduction

A long historical tradition connects religion, medicine, and health care. Religious groups built the first hospitals in Western civilization during the fourth century for care of the sick unable to afford private medical care. For the next thousand years until the Reformation and to a lesser extent until the French Revolution, it was the religious establishments that built hospitals, provided medical training, and licensed physicians to practice medicine. By the end of the 17th century, however, the scientific profession of medicine had nearly completely separated away from its religious beginnings.⁽¹⁾ Early Psychiatrists like Charcot and Freud linked religion to neurosis.⁽²⁾ According to Moreira-Almeida et al, some scholar seven predicted that religiosity would tend to decrease and disappear by late 20th century.⁽³⁾

But the latter half of the twentieth century has witnessed a manifold increase in the scientific enquiry into spirituality and health. According to Weaver et al, the rate of articles addressing spirituality rose steadily from an average of 56 per 100,000 during 1965–1969 to 463 per 100,000 between 1996 and 2000. Articles addressing both religion and spirituality occurred at an average rate of 64 per 100,000 in 1965–1969, and increased to an average rate of 362 per 100,000 between 1996 and 2000.⁽⁴⁾ Even the World Health Organization has incorporated spirituality in their definition of “palliative care”.⁽⁵⁾ Recent research reports strongly suggest that to many patients, religion and spirituality are resources that help them to cope with the stresses in life, including those of their illness.⁽²⁾ It has been suggested that spiritual enquiry should be made as a part of medical curriculum and interns training.⁽⁶⁾⁽⁷⁾

But the integration of spirituality into medical care is not without detractors.⁽⁸⁾ Objections have been made in terms of significant methodological flaws or misrepresented claims in published

research.⁽⁹⁾ Ethical and practical considerations are still being debated.⁽¹⁰⁾⁽¹¹⁾

In this article, a review of progress made in spirituality research so far and the problems being encountered, is presented. The controversies surrounding integrating spirituality and medical care are also reviewed. Finally, attempt has been made to suggest future areas of research in this topic.

Defining spirituality

The definition of spirituality is a continuing controversy.⁽¹²⁾ The Oxford English dictionary defines spirituality as “the quality or condition of being spiritual” and “attachment to or regard for things of the spirit as opposed to material or worldly interests.”⁽¹³⁾ In 1912, James Leuba identified 48 different ways to define religion.⁽¹⁴⁾ Early in the 20th century religiosity and spirituality were considered one and the same. The latter half of the 20th century has witnessed a rise of secularism and a growing disillusionment with the religious institutions of the western society. The effect of these changes during the 1960s and 1970s was that spirituality began to acquire a more distinct meaning and more favorable connotations separate from religion.⁽¹⁵⁾

For most social scientists “spirituality” appears to be the favored term to describe individual experience and is identified with such things as personal transcendence, supra-conscious sensitivity and meaningfulness.⁽¹⁵⁾ Religion is defined as an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality).⁽¹⁶⁾

Broad as well as narrow definitions of spirituality exist in the literature. An example of a broad definition was put forward by Myers et al., who defined spirituality as “personal and private

* Dr. Avudaiappan S, Assistant Professor of Psychiatry

Mahatma Gandhi Medical College and Research Institute, Puducherry 607402, India

beliefs that transcend the material aspects of life and give a deep sense of wholeness, connectedness, and openness to the infinite". According to this conception, spirituality includes (a) belief in a power beyond oneself, (b) behavior in relation to the infinite such as prayer, (c) meaning and purpose of life, (d) hope and optimism, (e) love and compassion, (f) moral and ethical guidelines (g)transcendental experience. Another broad definition has been given by Lewis who conceived spirituality as the life affirmed in a relationship with God, self, community, and environment which leads to the nurturance and celebration of wholeness. Within this context, spiritual needs include meaning, purpose and hope, transcendence circumstances, integrity and worthiness, religious participation, loving and serving others, cultivating thankfulness, forgiving and being forgiven, and preparation for death and dying.⁽¹⁷⁾

As cited by Hill et al,⁽¹⁵⁾ Spilka⁽¹⁸⁾ has concluded in his 1993 review that the current understanding of spirituality fall into one of three categories: 1) a God oriented spirituality where thought and practices are premised in theologies either broadly or narrowly conceived; 2) a world oriented spirituality stressing one's relationship with nature or ecology and 3) a humanistic (or people oriented) spirituality stressing human achievement or potential. Thus, according to Spilka, spirituality should be viewed as a multidimensional concept. This view is shared by a number of researchers who have proposed various multidimensional frameworks.⁽¹⁹⁾⁽²⁰⁾⁽²¹⁾ Similarly Worthington et al also identified four types of spirituality, with the first one more related to religion: religious spirituality (closeness and connection to the sacred defined by religion), humanistic spirituality (closeness and connection to mankind), nature spirituality (closeness and connection to nature), and cosmos spirituality (closeness and connection to the whole of creation).⁽²²⁾ An integration of the literature shows that several elements are commonly employed in the definition of spirituality. These include meaning and purpose of life, meaning of and reactions to limits of life such as death and dying, search for the sacred or infinite, including religiosity, hope and hopelessness, forgiveness, and restoration of health. Lau pointed out that three key elements of spirituality had been identified in the literature.

The first element is horizontal as well as vertical relationships in human existence. While horizontal relationships are related to oneself, others, and nature, vertical relationship involves a transcendental relationship with a higher being. The second element is beliefs and values which are integral to answers to spiritual questions such as life and death. The third element is the meaning of life.⁽¹⁷⁾ Analyzing each element individually and all elements collectively within a multidimensional framework would be a fruitful way forward to approach the study of spirituality.⁽²³⁾

Instruments to measure spirituality

Shek identifies two broad strategies to assess the construct of spirituality: quantitative approach and qualitative approach. In the quantitative approach, either single items or scales are used to assess spirituality. For example, researchers have used single items to assess a respondent's ranking of the importance of things in life, such as wealth, family, health, friends, social status, and peace of mind. Also, researchers use a few items to assess religiosity and religious involvement. Obviously, both single-item measure and multiple-item measures are problematic because their reliability and validity have not been examined. To overcome such problems, psychological scales have been developed to measure the construct of spirituality. Some examples include the Spiritual Well-Being Scale, Purpose in Life Questionnaire, Templer's Death Anxiety Scale, Enright Forgiveness Inventory, and Herth Hope Index.⁽¹⁷⁾

Qualitative methods (such as open-ended questions, drawing, verbal commentary techniques, and case studies) are also employed to examine spirituality, particularly in the clinical settings. The common features of qualitative research include naturalistic inquiry, inductive analysis, holistic perspective, qualitative data, personal contact and insight, dynamic system, unique case orientation, empathetic neutrality, and design flexibility. For example, children have been invited to draw pictures about their attitudes towards death and dying. While qualitative study can capture the perspectives of the informants and is a more naturalistic form of research, it is often criticized as biased and polluted by ideological preoccupations.⁽¹⁷⁾

Monod et al, in a systematic review of instruments to assess spirituality, identified a two-step process in development of instruments to assess spirituality.⁽²⁴⁾ The first step would be the definition of the conceptual aspect of spirituality that the instrument intends to assess. The second step would be the definition of items that operationalize the spirituality concept in question. They also proposed a classification of instruments that follows this line of reasoning in instrument development.⁽²⁴⁾

1. Conceptual Classification

This classification is based on the underlying concept of spirituality that the instrument mainly intends to capture from the point of view of the authors who developed the instrument. Four common categories of measures are described: general spirituality, spiritual well-being, spiritual support or coping, and spiritual needs.⁽²⁴⁾

2. Functional Classification

This classification is based on the examination of all items within the instrument. Three categories of items are proposed, according to the expression of

spirituality they intend to capture:

a. Measures of cognitive expressions of spirituality:

These items intend to measure attitudes and beliefs toward spirituality (e.g., “Do you believe meditation has value?”). These measures have been shown to be relatively stable within individuals over time.

b. Measures of behavioral expressions (public or private practices) of spirituality (e.g., “How often do you go to church?”). These measures are also supposed to be stable over time.

c. Measures of affective expressions of spirituality: These items intend to capture feelings associated with spirituality (e.g., “Do you feel peaceful?”). These measures illustrate the patient’s spiritual state, which is not necessarily stable over time. Spiritual states might change over time along a hypothesized spectrum of wellness ranging from spiritual well-being to spiritual distress. A spiritual state might be worse because of external stressors such as illness or bereavement, or improved by

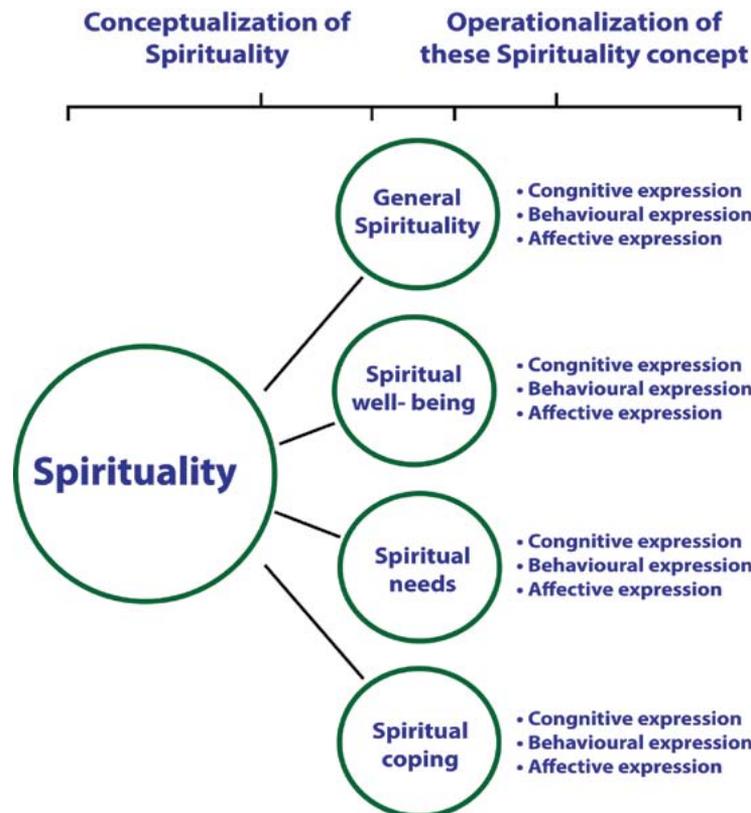


Figure 1 Process generally used to develop instrument to assess spirituality.

spiritual intervention.⁽²⁴⁾

Health Benefits of Spirituality

Many of those faced with illness turn to faith traditions and spiritual beliefs for aid and comfort. This is seen among hospitalized patients, 94% of which believe spiritual health to be as important as physical health.⁽²⁵⁾ Thus spirituality and religion are major target areas for holistic health care of patients. Koenig et al, have reviewed 1200 scientific articles demonstrating an association between various physical and mental health benefits and spirituality, in 2001.⁽¹⁶⁾ Since then, there had been a growing body of research in this aspect. However, most studies have not made a distinction between religiosity and spirituality and often use these terms interchangeably and with varying definitions.⁽⁸⁾ Measurement of spiritual variables are also ambiguous, with many studies utilizing crude, single-item indices of global religious involvement (e.g., How often do you attend church or religious services?), which do not assess for specific aspects or positive and negative dimensions of spirituality. Consequently, findings have been inconsistent, and functional relationships between spirituality and health, including directions and mechanisms of effect, remain largely unclear.⁽²⁶⁾

A majority of the nearly 350 studies of physical health and 850 studies of mental health that have used religious and spiritual variables have found that religious involvement and spirituality are associated with better health outcomes.⁽²⁷⁾ During the past 3 decades, at least 18 prospective studies have shown that religiously involved persons live longer.⁽²⁷⁾ Studies have found that religious/spiritual involvement is associated with lesser risk of cardiovascular disease,⁽²⁷⁾ rheumatoid arthritis,⁽²⁸⁾ lower blood pressure, with health-promoting behaviors such as more exercise, proper nutrition, more seat belt use, smoking cessation, and greater use of preventive services.⁽²⁷⁾ In addition, religious involvement predicts greater functioning among disabled persons.⁽²⁷⁾ Finally, religious involvement is associated with fewer hospitalizations and shorter hospital stays.⁽²⁷⁾

Spirituality/religiosity plays a major role in end of life care by giving strength and hope to terminally

ill patients.⁽²⁹⁾ In patients with HIV, higher levels of spirituality/religion have been associated with better immune function, survival, health-related quality of life, life satisfaction, treatment success, medication adherence, and overall well-being.⁽³⁰⁾ Spirituality is also a powerful coping mechanism providing older adults with the ability to adapt to changing individual needs.⁽³¹⁾

Spirituality is recognized as an important aspect of mental health.⁽²⁾ Role of spiritual well-being in mental health has been examined in relationship to depression, anxiety, schizophrenia. But most investigators use religiosity and spirituality as interchangeable terms, making it difficult to separately estimate the effect of spirituality on mental health. One study found that placing high importance on spiritual values is associated with higher lifetime depression, mania, and social phobia.⁽³²⁾

Smith and colleagues conducted a meta-analysis of 147 studies that involved nearly 100,000 subjects. The average inverse correlation between religious involvement and depression was 20.1, which increased to 0.15 in stressed populations. Religion has been found to enhance remission in patients with medical and psychiatric disease who have established depression. The vast majority of these studies have focused on Christianity; there is a lack of research on other religious groups.⁽³³⁾ Studies on anxiety and religion have yielded mixed and often contradictory results that may be attributed to a lack of standardized measures, poor sampling procedures, and failure to control for threats to validity, limited assessment of anxiety, experimenter bias, and poor operationalization of religious constructs.⁽³⁴⁾ Research on schizophrenia & spirituality is still infantile; Mohr et al found that for some patients, religion instilled hope, purpose, and meaning in their lives, whereas for others, it induced spiritual despair. Most reported that religion lessened psychotic and general symptoms, increased social integration, reduced the risk of suicide attempts, reduced substance use, and fostered adherence to psychiatric treatment.⁽³⁵⁾

In individuals with substance abuse, spirituality has been shown to be a significant and independent predictor of recovery and/or improvement in

indices of treatment outcome. Levels of spirituality increase between treatment entry and subsequent recovery, and levels of spirituality may be greater in individuals whose recovery is successful compared to those who have relapsed. Length of sobriety has also been positively associated with spirituality, while commitment to a higher power may lessen the severity of relapse episodes.

Criticisms to inclusion of spirituality into mainstream medicine

There have been number of criticisms to above findings.^(8,9,37) These can be viewed in two aspects – methodological and ethical objections. Methodologically, first objection would be that most of the studies done in spirituality are simple observational studies that link a spiritual variable to physical or mental health. But, as pointed out by Sloan et al, these results are to be controlled for confounders such as age, sex, education, ethnicity, socioeconomic status and health status. Failure to do so, as is the case in many studies, may point to seemingly important findings where none exist.⁽⁸⁾The second methodological objection would be the operationalization of the concept of spirituality. Though various authors have tried to clarify the concept,⁽³⁸⁾ still there is a great deal of overlap between the definitions of religiosity and spirituality, which makes any meaningful extrapolation of data concerning health benefits difficult. Also most studies take into account only “outward” religious or spiritual activities such as going to church, mass prayers etc., but fail to consider “inward” Spiritual practices like praying at home, reading scriptures etc., which are also very common among religiously inclined. Finally there is a great deal of inconsistency within published data. Effects which have been shown in some studies have not be replicated in other samples.⁽⁸⁾ Most of these studies also have poor inter-cultural comparability. Spirituality being a culturally varying concept, this needs to be addressed.

Ethically, the first objection would be that, most physicians are ill-trained and ill-suited to discuss spiritual issues with the patients and are prone to misguiding patients.⁽³⁹⁾ Also, the physician-patient relationship is asymmetric: physicians expect patients to comply with their recommendations,

and patients generally accede to this authority. Recommending religion to patients in this context may be coercive.⁽³⁷⁾ Linking religious activities and better health outcomes can be harmful to patients, who must confront age-old folk wisdom that illness is due to their moral failure.⁽⁸⁾ If, as advocated by proponents of spirituality, we distinguish discreet patient groups for whom religion and spirituality are important from those for whom they are not, physicians run the risk of discriminating by encouraging only the former group to engage in religious activity.⁽³⁷⁾

Conclusion

To conclude, even though there is a great deal of evidence suggesting a link between spirituality and health, the lack of conclusive evidence in the form of randomized controlled trials make it difficult to assess the true clinical benefit of spirituality. But as it is asked, how can we measure faith, which is a radical opposite of the method of scientific enquiry with scientific tools. Also, the ethical objections pointed out by experts should be taken into account. Till these concerns are addressed, it would be premature to formally include spirituality in the current clinical model.

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