

Religion, Spirituality and Health: A Social Scientific Approach

Giancarlo Lucchetti
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Spirituality, Religiousness and Health

From Research to Clinical Practice

 Springer

Religion, Spirituality and Health: A Social Scientific Approach

Volume 4

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The relationship between religious/spiritual belief or behaviour and health behaviour has been explored over several decades and across various disciplines. Religious variables have consistently been found to have a direct relationship to physical and mental health. At the same time - research has also indicated potential societal tensions that can exist between religion and health – we have seen this in relation to family planning, HIV/AIDS, and reproduction. This book series aims to uncover the impact of religion on individual health behaviours and outcomes but also the influence of religion on health practices at the community level. This book series uncovers the impact of religion on individual health behaviors and outcomes, as well as the influence of religion on health practices at the community level. It consists of volumes that are based on multi-methodological approaches, provide quantitative and qualitative forms of analysis, and advance the understanding of the intersection between religion and health beyond the correlation of religious belief and health outcomes. Building on earlier research, the series explores the direct relationship between religious variables and physical and mental health, as well as the potential societal tensions that have been shown to exist between religion and health – for example in relation to family planning, HIV/AIDS, and reproduction. Spoken values are often shared within religious communities; however, religious influence can at times be extended outside of the community in instances of service provisions such as hospital ownership, various research active think tanks, political action, and the development of community mores.

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Giancarlo Lucchetti: *To my parents, José Carlos Lucchetti (in memoriam) and Margarete C. C. Lucchetti, for being examples of honesty and perseverance and for supporting my journey into my medical career. To my lovely wife, Alessandra L. G. Lucchetti, my partner in the good and not-so-good moments of my life, this book is also your achievement, and it would not happen without your guidance. To my friends Mario Peres and Rodolfo Damiano for believing in this project from the beginning, I learnt a lot with you.*

Mario F. P. Peres: *To the opportunity of living with a great family, having great education, working with great people, having great examples in life, having enlightened by great masters, and learning with my mistakes and for whoever made all this possible.*

Rodolfo F. Damiano: *To my parents, Henrique Damiano and Magali C. F. Damiano, who supported me through this adventure in medicine. To Dr. Lisabeth L. DiLalla and Dr. Giancarlo Lucchetti, both who trusted in my capacity and became a role model to me (and probably to all their students). To all my friends, professors, and colleagues who did not hesitate in showing my fragilities and helped me to become a better person.*

Foreword

Many studies have shown that spiritual and religious beliefs impact mental and physical health outcomes. Spirituality and religiosity (S/R) are usually positively associated with quality of life and well-being and negatively associated with depression, anxiety, suicidality, and drug use. Likewise, S/R is related to a variety of health parameters including blood pressure, levels of body inflammation, susceptibility to coronary artery disease, and overall survival.

There are currently thousands of S/R studies published in peer-reviewed indexed journals in all psychological, social, public health, and medical fields, and several high-profile research groups from all over the world are now investigating these relationships. The studies are increasing in sample size, quality of methodology (increasing numbers of prospective studies in randomized clinical trials), and overall scientific credibility, and the results have been quite promising.

In addition, there are a growing number of clinical applications in medicine and healthcare. Hospitals are insisting that staff take a spiritual history on patients, physicians are being more and more attentive to these issues, and patients are being referred to chaplains to address their spiritual and religious needs. All these advances support a more integrative and patient-centered approach to healthcare.

Several national and international organizations (“Joint Commission: Accreditation, Health Care, Certification,” “World Health Organization,” “American Psychiatric Association,” “American College of Physicians”) have already begun to include the addressing of S/R in medical training programs, including nine out of ten medical schools in the USA.

Nevertheless, there remain many challenges. The definition of spirituality does not have universal consensus, and the instruments to measure S/R are diverse and include many different dimensions. The mechanisms underlying the association between S/R and health are not yet completely understood. Many studies are cross-sectional in design (prohibiting statements about causal direction), most samples are from Christian traditions, and the worldwide incorporation of S/R in clinical practice and in medical education has yet to occur.

This is the context in which this book, *Spirituality, Religiousness and Health: From Research to Clinical Practice*, is making its appearance, trying to link solid evidence-

based research to clinical practice. This approach is interesting because it embraces different perspectives and so is relevant to both scientific researchers and healthcare practitioners. Many important topics are addressed in the 15 chapters of this book, divided into 2 parts: “Part I: Spirituality, Religiousness and Health Research” and “Part II: Clinical Implications of Spirituality, Religiousness and Health.”

In Part I, scientific evidence demonstrating a link between S/R and health will be summarized, including a description of a great number of studies that have examined mental, social, and physical health. In addition, definitions and measures to assess S/R will be reviewed, and the criticisms and challenges facing the field will be examined. In addition, spiritual interventions for mental health problems, studies on S/R and pain modulation, and the impact of S/R in the health of older adults will be reviewed.

Part II will examine the application of the research findings to clinical practice and healthcare. Topics such as spiritual care in secular societies, spirituality-integrated psychotherapy, the role of healthcare chaplaincy, spiritual care at the end of life, spirituality and creativity in clinical practice, and integrating spirituality into medical education will be discussed.

These chapters were written by 36 contributors from many institutions all over the world, scholars with research and clinical experience conducting research on S/R and health and integrating S/R into clinical practice. The contributors are from a wide number of different healthcare specialties, which increases the interdisciplinary nature of this volume.

The editors of this book (Drs. Giancarlo Lucchetti, Mario Peres, and Rodolfo Damiano) have for many years been conducting research on S/R and come from some of the top research centers in Brazil. This reflects the international scope that research on S/R has achieved worldwide, from North and South America to Europe, the Middle East, Africa, and Asia. This topic has now become an area of global discussion.

This book provides an important contribution to the field of spirituality, religion, and health. Readers will find here a brief but comprehensive update on the influence that S/R has on health and how it is integrally related to the health of populations and necessary in providing whole person healthcare. This volume will help point researchers to the highest-priority studies for future research and provide clues on how to integrate S/R into clinical practice in a sensitive and sensible manner.

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Preface

Dear Reader,

The field of “spirituality, religion, and health” has been constantly growing in the scientific community, and, along the last years, there are several excellent contributions to the area. Seminal articles and important books have been published in the last decades, showing the influence of spiritual and religious beliefs in individual’s mental, physical, and social health.

The idea of this book appears in this context. However, why do we need another scientific book concerning this topic? What is the difference between this and many others works available out there? Why did we decide to carry out a project such as this one? Trying to answer these questions, we are going to report our rationale for creating another book in this field.

We – the editors – have been working in this field of research for more than 15 years, publishing hundreds of scientific articles and working as reviewers and editors of indexed journals. Two years ago, we were invited by Springer to develop such work. At that date, we had decided that it was the perfect time to move forward and write a book that could become a reference for the field.

In our first meeting, we decided to understand what was needed in this field and how could we help other researchers and clinicians to deal with these issues. Some important books, such as the *Handbook of Religion and Health; Spirituality in Patient Care: Why, How, When, and What; Oxford Textbook of Spirituality in Healthcare;* and *The Psychology of Religion and Coping: Theory, Research, Practice*, were extensively reviewed in order to achieve what you are going to read in the next sections of this book.

Thus, our first goal was to make this book easy reading and shorter than the other available handbooks, even though maintaining its comprehensiveness. We believe this format could satisfy different readers, from the healthcare student/clinician to the top researcher.

Our second goal was to present an international approach, including authors from all around the world, from Brazil to the USA, from India to Germany. This approach will help the reader to understand the global context of the “Spirituality and Health” field worldwide, by the hands of many different authors.

Our third goal was to provide an interdisciplinary discussion, including several professions such as physicians, psychologists, physical therapists, nurses, and chaplains, among others. The inclusion of all these different professions will help the reader to understand many different facets of this field and how there are different clinical implications for healthcare.

Our fourth goal was to bridge the research – very important to understand the scientific evidence of the field with the clinical practice – important to guide future interventions and practice in healthcare. For this matter, we included a section dedicated to scientific studies and another more dedicated to implications to healthcare and medical education.

Our fifth goal was to invite important authors in order to bring those who are working seriously in this field. Several well-known researchers were invited and accepted to participate in this project, including Dr. Harold G. Koenig (the most important researcher in this field, who honored us with his foreword), and many others from all around the world. We are very grateful to all of them for trusting our project.

Our sixth goal was to include important researchers affiliated to universities from all around the world, showing that this field has been in the agenda of important settings, such as the Duke University, Harvard Medical School, Baylor College of Medicine, University of Southern Denmark, University of Witten/Herdecke, Coventry University, Rush University, and Washington University, among others.

All these aforementioned goals become more and more evident on each of our meeting sections, and the results are seen in this book. The name, *Spirituality, Religiousness and Health: From Research to Clinical Practice*, was created in order to include both spiritual and religious aspects, as well as both scientific research and clinical practice. This represents the idea of a more comprehensive approach that we tried to achieve in this project.

Both parts of the book will help the reader to “navigate in different seas.” The first one, a more “hard” content, includes the concept of spirituality and religion, how to measure these constructs in health research, criticisms to this field, the study of belief, the evidence concerning physical and mental health in adults and older persons, and the scientific evidence of spiritual interventions. In this part, the reader will be able to understand at which point we are right now in this field, what comes next, and how to understand the evidence. To achieve these objectives, each author provides a comprehensive list of references, including up-to-date studies.

The second part deals with a more practical approach, highlighting the clinical implications of addressing spirituality and religiousness. For that matter, we invited authors from different cultural, professional, and scientific backgrounds. Readers will be able to understand how these issues are addressed in secular societies, in psychiatric care, in chaplaincy, at the end of life, to foster well-being, and finally in the field of medical education. Our objectives here are to bring a more “hands-on” approach and help the reader to use these guidelines in practice.

It is important to note that all these chapters work as a continuum, and we recommend readers to read the entire book in sequence. However, anyone can read a single chapter and will also understand the context within. Finally, we believe this

project could help all types of healthcare and non-healthcare professionals and researchers to understand and also to enhance their knowledge in the field, presenting an update, evidence-based, and integral view of the field.

We wish you a very pleasant reading!

São Paulo, Brazil
January 6, 2018

Giancarlo Lucchetti
Mario Fernando Prieto Peres
Rodolfo Furlan Damiano

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We would also like to express our gratitude to the publisher, Springer, for accepting this book as part of the series “Philosophy and Religious Studies.”

Finally, we would like to acknowledge our students; you are the future of our scientific community; we hope this book could serve as another step toward a more humanistic, person-centered, and integrative medicine.

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Part I
Spirituality, Religiousness and Health
Research

Conceptualizing Spirituality and Religiousness



Rodolfo F. Damiano, Mario F. P. Peres, and Marina A. B. Sena

Abstract Research on spirituality, religion and health has been growing considerably when analyzing the last 20 years. Much of this research concerns to patients' opinions and desires on medical treatment, specifically concerning the inclusion of patients' spiritual/religious issues and how it can influence the health outcome. However, there is still a lack of consensus about the definition of spirituality, and this need might affect the analysis of how the term "spiritual" have been understood by patients and health care providers, and how spirituality might affect patients' mental and physical health. Nowadays, researchers debate about how is the best way to understand spirituality, and if is possible to standardize the conceptualization of this concept. Two important schools of thought debate what is the best way to understand spirituality scientifically. The first group supports the inclusive (comprehensive) conceptualization, and the second support the narrow (or religious) idea of spirituality. Trough this chapter we will discuss both conceptual frameworks and also reinforce our idea about religion, and how it can influence our understanding of spirituality, especially on the twenty-first century.

Keywords Spirituality · Religion · Conceptualization · Definition · Health

1 Defining Health and Its Components

According to the principles of the World Health Organization (WHO 1946), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Since this definition, which has been strikingly disruptive to that time, an increasing amount of articles have been published

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concerned with a non-included health phenomenon on WHO definition, religiosity/spirituality (R/S), and its impacts in physical, mental and social health (Damiano et al. 2016; Koenig 2012; Lucchetti and Lucchetti 2014).

This paradigm change on health research, which will be discussed throughout this book, allowed some health specialists to even propose the inclusion of spirituality on health definition (Larson 1996; Chuengsatiansup 2003; Chirico 2016), expanding the concept to a state of complete physical, mental, social, and spiritual well-being and not merely the absence of disease or infirmity. Furthermore, following this proposal, the World Health Organization Quality of Life Group (WHOQOL group), developed a sub-scale of the WHOQOL questionnaire, proposing spirituality as a core component of quality of life (WHOQOL-SRPB Group 2006).

Nevertheless, albeit this growing number of research concerned to investigate R/S and its impact on health, and the increased attention given by the World Health Organization to spirituality, religiousness, and personal beliefs, there are still criticisms toward the inclusion of R/S on health definition and even on medical research (Sloan et al. 1999). The lack of consensus of spirituality definition might play an important role on these divergences toward the R/S area, and a standard conceptualization of spirituality as well as a better understanding of potential differences between spirituality and other aspects of health (mental and social) are crucial to the development of R/S area on science (and consequently on clinical practice).

Therefore, the main goal of this chapter is to review the different definitions of spirituality according to the medical literature, trying to differentiate it to other components of health, such as mental and social aspects. To reach this goal, it is imperative to prior define religion and religiosity in order to build the conceptual framework of spirituality.

2 Conceptualizing Religion and Religiosity

Religion has been one of the most important aspects of either modern or ancient societies, whose etymology comes from the Latin word *religio*, derivation of *relinquere*, which means to leave, to abandon; *religare*, to connect again; or *relegere*, to pay attention to the details. (Azevedo 2010).

It is impossible to talk about religion without citing the important contribution of the sociologist Émile Durkheim (1858–1917). Studying the elementary aspects of religious life (1912), Durkheim defined religion as “an unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden—beliefs and practices which unite into one single moral community called a church, all those who adhere to them.”

Recently, other social scientists, based on Durkheim’s definition, developed further concepts of religion. According to Sherkat (2014), “Religions are social groups that produce and maintain explanations about the meaning and purpose of life, and many humans value explanations about such important matters. These explanations go beyond the natural world, invoking some supernatural leap of faith.” Others

authors, such as Max Weber (1922), prefer don't give any definition of religion and even question if giving any definition is possible.

In health research, important authors support the religion conceptualization given above. Michael B. King and Harold G. Koenig (2009) defines religion as “an organized system of beliefs, practices, rituals, and symbols designed a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and b) to foster an understanding of one's relationship and responsibility to others in living together in a community”.

But what these concepts share in common? First, all concepts claim to a social aspect of religion. In other words, all authors postulate that to do religion is mandatory to share the same personal beliefs and practices into a group, not being sufficient to feel your own supreme power, or have your practices individually. Second, a moral aspect given and shared by religious beliefs. And last but not least, a supernatural or transcendent belief (except by Durkheim).

Furthermore, Koenig et al. (1997), intending to increase our understanding about R/S area and also to facilitate our analysis of potential researches, developed an idea of religiosity, which Lucchetti et al. (2010), reviewing the first edition of the Handbook of Religion and Health (Koenig et al. 2012), postulated as “the degree which an individual believes, follows, and practices a religion”. The same author (Koenig and Büssing 2010) divided religiosity into three major dimensions: organizational religious activity (ORA) (the frequency that someone goes to the church, temple or religious meetings), non-organizational religious activity (NORA) (involves private religious activities such as prayer, meditation or bible study), and intrinsic religiosity (IR) (having religion behind every aspects of one's life).

Hence, religion, despite largely practiced, has different meanings and sub-areas, which are really important to understand prior studying spirituality. Thus, on next topic, we will discuss the many possible definitions of spirituality, trying to give to the reader the autonomy to understand and choose those that most fit to him.

3 Defining Spirituality

One of the most important criticisms of spirituality researches is the lack of a standard definition. Defining spirituality is so difficult that many authors have written papers only to discuss and propose its best definition (King and Koenig 2009; Hill and Pargament 2003; Tanyi 2002; Gall et al. 2011; Reinert and Koenig 2013). Previous research has suggested that lay people see spirituality way different than theologians (Cour and Götke 2012), which may influence researches and their interpretation to this phenomenon.

To understand researches that ask patients about the importance of spirituality to their lives (Hilbers et al. 2010), or if they want that the health care provider addresses their spiritual needs (MacLean et al. 2003), or also ask a physician if they think is important to address patients' spiritual needs (Lucchetti et al. 2016), it is crucial to understand and know if the researcher provided a standard definition of spirituality

to their sample, or also if the sample gave the researcher their own definition of spirituality. For example, people who understand spirituality as synonym of religion might see with much more rejection the idea of sharing one's spiritual beliefs and/or issues with his/her health care provider and vice versa.

Furthermore, when defining spirituality one has to understand its etymology. According to the Oxford Living Dictionary, the word "spirit" derives from Latin *spiritus*, which has several meanings, such as "breathe", "breathe of a god", "inspiration, breathe of life", "the vital principal in man and animals" or "supernatural immaterial creature" (Online Etymology Dictionary). These multiple definitions might be due to the Christian distinction between "soul" (immaterial) and "spirit" (seat of emotions), probably caused by Greek and Hebrew different ancient words. The word spirit branched into two other concepts: spiritual and spirituality, which originality meant "the quality of being spiritual" or "the fact or condition of being a spirit" (Online Etymology Dictionary). Therefore, historically, the word spirit (and spirituality) has always been intrinsically attached to religion beliefs (such as soul, God, immateriality).

Nevertheless, with the greatest improvement and diffusion of science and the development of new religion movements (churches, cults and sects), and also with the increasing of the percentage of population self defining "spiritual but not religious" (Sherkat 2014), some non-religious and also religious groups claimed that spirituality must be set apart of religion. According to them, many people, nowadays, find their spiritual meaning outside religion, outside the organizational and/or non-organizational aspects of religion. Therefore, currently, researchers who study the field of "spirituality/religiosity and health" works (mainly) with two distinct definitions: one more inclusive (comprehensive) and the other narrow (or religious) concept.

3.1 *Inclusive Definitions*

During the years of 2012–2013, the George Washington Institute for Spiritual Health and the Caritas Internationalis, organized two conferences that, among many objectives, sought to create a standard definition of spirituality, improving the definition written in 2009 (Puchalski et al. 2009). After both conferences, a comprehensive definition was created in order to solve many problems concerning the cultural issues regarding this concept. According to the organizers (led by Christina Puchalski), "Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices." (Puchalski et al. 2014).

This broad definition brings important contribution to the area. According to this definition, religion is not anymore an indissociable aspect of spirituality. Contrariwise, spirituality is seen as much broader, including meaning, purpose, and

the relationship with family, society, nature, etc. Based on this definition, a person who finds meaning raising their children, or an alpinist who finds purpose climbing a mountain have a potential of being strongly spiritual. Some pundits have done some criticisms to this definition, and we will present below their reasons to criticize it.

3.2 *Narrow Definitions*

When analyzing the last 15–20 years (Lucchetti and Lucchetti 2014), Harold Koenig appears as one of the most prominent authors on R/S and health area. Certainly, he is the most important researcher who criticizes those most comprehensive definitions given by some health researchers recently (as shown above). According to him, defining spirituality as a meaning and purpose in life, peacefulness, connectedness to others, gratitude, forgiveness, existential well-being, etc. (King and Koenig 2009; Tanyi 2002) can be criticized because, besides including everyone (not only transcendental people) as spiritual, these virtues are synonym of good mental health, and not something distinct of it (Koenig 2013).

Albeit this wide definition is important to clinical encounter, it might be an important issue for researches. Correlate a good mental health variable (spirituality) with other mental health variables (depression, anxiety, etc.) might be a tautological bias, and should be avoided (Koenig 2013). To solve this issue, Pargament (1999) proposed a definition which a more substantial belief: the sacred. According to him, spirituality might be defined as “a search for the sacred”.

Koenig (2012), based on Pargament’s concept of spirituality, gave his own definition: “*Spirituality is distinguished from all other things—humanism, values, morals, and mental health—by its connection to that which is sacred, the transcendent. The transcendent is that which is outside of the self, and yet also within the self—and in Western traditions is called God, Allah, HaShem, or a Higher Power, and in Eastern traditions may be called Brahman, manifestations of Brahman, Buddha, Dao, or ultimate truth/reality. Spirituality is intimately connected to the supernatural, the mystical, and to organized religion, although also extends beyond organized religion (and begins before it). Spirituality includes both a search for the transcendent and the discovery of the transcendent and so involves traveling along the path that leads from non-consideration to questioning to either staunch nonbelief or belief, and if belief, then ultimately to devotion and finally, surrender. Thus, our definition of spirituality is very similar to religion and there is clearly overlap.*”

Therefore, according to Koenig (2012, 1013), being spiritual is being devoutly and intrinsically religious. It is differentiated from religion because the last is organized and must be practiced in community. Spirituality, however, is an intrinsic trait, that only a set of presuppositions and beliefs in aspects beyond our world (transcendent, sacred) might enhance and develop (Smith 1998).

3.3 *Openness to Spirituality*

When analyzing health literature, not only the spirituality itself but the degree which the health practitioner/student is opened to patients' spirituality seems to have a great importance. This concept (openness to spirituality) is quite new in medical literature. It has been introduced by DiLalla et al. (2004), and can be defined as "the degree to which a health practitioner is open to and respect patients' spirituality". (Damiano et al. 2017) To give an example, in a recent study done by our research group, openness to spirituality appeared to moderate empathy in a sample of medical students. (Damiano et al. 2017) However, more studies should be done to indicate in what levels a higher openness to spirituality health practitioner might influence patients' health.

4 Future Directions

Undoubtedly, defining spirituality and religiosity is key for understanding their role in clinical practice and its impact in health outcomes. Although there is lack of consensus for a broader or strict spirituality definition, when dealing with routine clinical management we should overcome any of these issues and address spirituality with our patients. How? Seeing our patient (or ourselves) as unique, a singular individual, and customize spiritual need for each patient at each clinical encounter.

In research, further studies are necessary to clarify unknown aspects for a better understanding of the role of religion and spirituality in health. Epidemiological research has to be done addressing cross-cultural aspects regarding how including the divine, and sacred aspects of spirituality and how it can influence mental and general health outcomes. In addition, other psychological constructs possibly related to spirituality (such as meaning in life, transcendence, peace, support, optimism, pessimism, faith, etc.) should be further studied.

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Measuring Spirituality and Religiosity in Health Research



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Abstract This chapter describes the methodological challenges to measure multidimensional constructs such as spirituality/religiosity. It describes indicators of ‘spirituality’ with respect to core dimensions and related secondary indicators. The underlying layers of distinct aspects of spirituality refer to a person’s experience/faith, attitudes and behaviors. These indicators could all be measured as independent dimensions with standardized instruments. Among the rich number of available questionnaires, some examples to measure specific aspects of spirituality were shortly described. These were categorized according to their themes and topics, i.e., Spiritual attitudes, convictions and activities; Spiritual Wellbeing; Spiritual Struggles; Spiritual Coping; and Spiritual Needs. However, there is not one optimal instrument, but different instruments which might be suited, and all have their pros and cons.

1 Background

The interest in health care and health research in the topic of spirituality as an independent dimension of quality of life is continuously growing, and also the research questions start to change because also the fields of religiosity are changing, becoming more diverse and pluralistic. To address the new topics in health research, one may rely on standardized questionnaires. Several of these new questions cannot be easily answered with the instruments designed for previous questions, and thus new instruments are constantly developed (Büssing 2017a). The number of instruments intended to measure specific aspects of spirituality is growing and it is difficult to value particularly the new ones.

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In fact, there are several attempts to measure multifaceted concepts such as spirituality and/or religiosity in health research. One of the core questions from a theological point of view is whether spirituality *can* be measured at all, while from the point of psychological research there is no doubt that one can, but *how* one should measure spirituality. While psychology measures a person's experiences and behaviors and their interaction, one could similarly measure a person's spiritual experiences and spiritual behaviors and their interaction. However, the problems arise from the fact that despite a rich number of different definitions (see chapter "[Conceptualizing Spirituality and Religiosity](#)"), there are no generally accepted and consented definitions what spirituality is, and whether or not spirituality and religiosity are different or overlapping or similar concepts. Therefore, all attempts to measure 'spirituality' are remain preliminary and 'incomplete'.

In fact, spirituality is a changing concept which may overlap with secular concepts such as humanism, existentialism, and probably also with specific esoteric views (Zwingmann et al. 2011). Each profession and religious group may have its own point of view, which all may be true in the respective context, and not shared by other professions or groups with other world views.

One may therefore consider to use instruments which are rather 'inclusive' (and thus less specific) than 'exclusive' (and thus not suited for varying denominations or a-religious persons). It is much easier to design an instrument measuring indicators of spirituality/religiosity of circumscribed religious groups because they may share the same religious beliefs and practices. But such an instrument might not be applicable to persons who do not share these beliefs and practices or refer to other concepts or world views. A solution for this problem might thus be to use instruments which address different aspects of spirituality, i.e., specific religious practices and attitudes but also secular aspects of spirituality which may be shared by different religious groups. Best would be an instrument which could address also the attitudes and practices of a-religious/non-spiritual persons, because to them different dimensions providing meaning and hope or giving orientation in their lives might be of relevance. This approach is relevant particularly in secular or diverse societies.

2 Conceptualizations

All attempts to measure the various aspects of spirituality are dependent on the underlying definitions. Spirituality is understood today as a comprehensive and more 'open' concept, while religiosity is often rejected as institutionally 'exclusive' and prescriptive. One could differentiate between spirituality in religion (which connotes a more open, individual and pluralistic faith) and spirituality as opposed to religion (which rejects organized religiosity).

Religion is an institutional and culturally determined approach which organizes the collective experiences of people (faith) into a closed system of beliefs and practices ('form') (Büssing 2012), while spirituality refers to the individual experiences of the Sacred which may go beyond the boundaries of a specific

religion. Religiosity can thus be the formal site of an open and diverse field of individual experiences, attitudes, convictions, feelings and behaviors, which all could be measured.

Inclusive definitions state that spirituality is “a search for the sacred” (Pargament 1997), whatever the sacred might be for a given person, or that it is an individual search for meaning and purpose in life (Tanyi 2002; Underwood and Teresi 2002).

A more complex definition of spirituality was presented by Engebretson (2004):

Spirituality is the experience of the sacred other, which is accompanied by feelings of wonder, joy, love, trust and hope. Spirituality enhances connectedness within the self, with others and with the world. Spirituality illuminates lived experience. Spirituality may be expressed in relationships, prayer, personal and communal rituals, values, service, action for justice, connection with the earth. Spirituality may be named in new and redefined ways or through the beliefs, rituals, symbols, values, stories of religious traditions.

Our group (Büssing and Ostermann 2004) used a similar approach and defined:

Spirituality refers to an attitude of search for meaning in life. The searching individual is aware of its divine origin (...), and feels a connection with others, nature and the Divine etc. Because of this awareness one strives towards the realization (either formal or informal) of the respective teachings, experiences or insight, which has a direct impact on conduct of life and ethical commitments.

Both definitions refer to a ‘core’ dimension of faith, and on resultant attitudes and behaviors.

To exemplify this, Franciscan Spirituality has as central point the intention (or ‘vocation’) to “Live the Gospel” because of an inner resonance with or experience of the Sacred (which also implies specific religious rituals and practices to connect with the Sacred) (Büssing et al. 2017). Its concrete (external) expression is the intention to develop a world-affirming spirituality, to live with respect in Creation and in solidarity with the marginalized, to make peace and meet each other fraternally, being of service to the world and everything that exists, but also to avoid “possessing” things. Here we have a central intention which shapes the attitudes and behaviors. These are not *per se* ‘spiritual’, but with the inspiring ‘core’ they indicate the underlying ‘spirituality’. With this specification it is clear that the religious intentions may influence not only spiritual attitudes and behaviors, their rituals and practices, but also a person’s social behavior.

Spirituality may thus be expressed through formal religious but also other forms of relational engagement, through an individual experience of the divine, and through a connection to others, the creation (environment) and the transcendent Sacred (Büssing 2012).

3 Indicators of Spirituality

Because societies become more and more diverse (i.e., culturally, ethnically, philosophically, politically), attempts to measure a multifaceted construct such as spirituality should be multidimensional not only with respect to the underlying world views and religious orientations, but also with respect to the ‘layers’ of spirituality. One may distinguish core dimensions and secondary effects which all could be measured independently. According to the aforementioned definitions of spirituality by Engebretson (2004) and Büssing and Ostermann (2004), different layers of spirituality could be exemplified, i.e., Faith/Experience, Attitudes and Behaviors (Table 1). Within these main layers one may differentiate several sub-topics. All these layers and sub-topics could be principally addressed independently.

The individual spiritual experience, a person’s encounter with the Sacred, is in most cases difficult to communicate and thus difficult to measure, too (albeit this experience might be addressed in qualitative approaches). Yet, when persons do not have own experiences with the Sacred, they may share the attitudes, convictions and rituals of their parents or a religious community they became familiar with (tradition). This will shape their *Faith* as the core dimension. A person’s faith in turns will have an impact on their *Attitudes*, their (cognitive) beliefs, their (emotional) hopes and also their trust in a transcendent source which may help in times of need. Both faith and associated attitudes influence a person’s *Behavior*, the related ethics, social and health behaviors, and the use of distinct rituals (i.e., prayer, meditation).

These different layers are interconnected, but the respective indicators might not be specific. Charity behaviors for example can be an ethical demand for religious persons, but could also be a matter of empathy and compassion found in a-religious persons too. Prayers could be performed unconditionally to be in contact with the Sacred (which assumes a dedicated religious persons), but also reactively tried to see whether God responds or not (in times of need they can be performed also by sceptic or insecure persons).

The secondary indicators of spirituality are much easier to be measured than the core dimensions (which often remain secret). Yet, these secondary indicators (which could be measured with standardized questionnaires which will be described later on) are only related and not identical with the ‘core’ (Fig. 1): i.e., gratitude and awe

Table 1 Schematic levels of representation of different aspects of spirituality. (Modified according to Büssing 2017b)

<i>Faith/Experience</i>		
tradition (as handed down)		spiritual experience
<i>Attitudes</i>		
Cognition:		Emotion:
Beliefs, afterlife convictions, ideals etc.		Unconditional trust, hope, etc.
<i>Behavior</i>		
Ethics:	Rituals:	Altruism:
Charity	Prayer, meditation, etc.	Charity

Fig. 1 Schematic representation of selected indicators of spirituality, with core dimensions (including the ‘secret’ domain) and related secondary effects (‘outcomes’) in terms of attitudes and behaviors which could be addressed with standardized questionnaires



are not spirituality – but may arise; inner peace is not spirituality – but may develop because of religious trust, altruism is not spirituality – but may be motivated by religious convictions; prayer or meditation are not spirituality – but may be their concrete expression in life. To illustrate this, altruism as a concrete compassionate activity is often regarded as a specific behavioral outcome of religious persons, and indeed it is correlated with several indicators of spirituality. Nevertheless, altruistic behavior can also be found in a-religious/a-theistic persons who are affected by the suffering of other people. Even in religious persons the underlying reasons might be different, i.e. an ethical imperative or a compassionate affection.

But what about persons who regard themselves as non-religious/non-spiritual (R–S–), what is their resource proving meaning, orientation and hope in their lives? In a sample of persons with multiple sclerosis from Germany, 54% regarded themselves as neither religious nor spiritual (R–S–), 16% as not religious but spiritual (R–S+), while 19% were religious but not spiritual (R+S–) and 12% both religious and spiritual (R+S+) (Wirth and Büssing 2016). Those with a R–S– attitude had significantly lower engagement in specific religious or spiritual (mind-body) practices, but also in existentialistic practices and gratitude/awe compared to R+S+/R+S–/R–S+ persons, but did not significantly differ with respect to prosocial-humanistic practices (Wirth and Büssing 2016). When for most of them faith is not a source of relevance, what do they rely on? With an open question all of these patients were therefore asked about their personal resource which gives meaning, orientation, hope and inspiration to their life. These responses were categorized as Faith/Religion (10%), Family, Partner, Children (22%), other sources of meaning (16%; i.e., nature, creativity, individual fulfilment, appreciation, happiness, animals,

and love), or no answer (53%) (Wirth and Büssing 2016). This means, there can be large groups of persons who do not exhibit conventional indicators of spirituality, and researchers may have difficulties to define what their important source giving “meaning, orientation and hope” is at all.

4 Quantification of the Numinous

In empirical research, standardized and validated questionnaires are widely used to assess the subjective attitudes, perceptions and behaviors of respondents. This subjective perspective reflects the life situation of a person with specific experiences, expectations and biographic background at a given time. One has to be aware of the inherent problems related to such an approach, i.e., standardized questionnaires may not detect the specific individuality (superficiality), the statements are often driven by social desirability (reliability), opinion and behavior often diverge (objectifiability), opinions and attitudes may change (validity).

Similar to the complex operationalizations of quality of life measures, which at least differentiate physical, emotional and social components of functioning and/or wellbeing, spirituality as an independent topic of quality of life research should be measured multidimensionally, too. There is not one, but there are several ‘spiritualities’ with different expressions, aspects and underlying level. Therefore, one has to deal with a large number of instruments to measure varying and specific aspects of spirituality (overview in Zwingmann et al. 2011; Büssing 2012, 2017b). However, several of these instruments might be too general and unspecific. Moreira-Almeida and Koenig (2006) critically commented that some of the widely-used instruments include items which are rather indicators of psychological wellbeing and mental health than spirituality, and thus misinterpretations and false positive correlations are inevitable. The multidimensional *WHOQOL-SRPB BREF* for example measures in its 8-facet version (Skevington et al. 2013) not only Faith, Connection with spiritual Being/Force and Spiritual Strength (which may represent a religious coping factor), but also Meaning of Life, Experience of Awe, Wholeness, Inner Peace/Harmony and Hope/Optimism (which are unspecifically associated with quality of life and are assumed to represent a factor of “spiritual quality of life”) (Krägeloh et al. 2015). However, perceptions of Inner Peace/Harmony and having Hope/Optimism are not necessarily measures of spirituality but indicators of psycho-emotional wellbeing – which may nevertheless have its cause in a person’s religious convictions/faith. The instrument’s Connectedness sub-scale was in fact only weakly related with the Hope sub-scale ($r = .28$) and moderately with its Inner Peace sub-scale ($r = .37$), but strongly with more strict indicators of spirituality such as Faith ($r = .82$) and Spiritual Strength ($r = .84$) (Krägeloh et al. 2015).

Further, one has to be aware which layers and dimensions of spirituality should be related with psychosomatic health or life satisfaction. In a sample of Catholic priests and non-ordained Catholic pastoral workers from Germany, which all are assumed to have a vital religious life, we analyzed associations between the

frequency of their religious engagement (i.e., Holy Eucharist, Prayer of Hours, Sacramental Confession, private prayers) and perception of the transcendent (as measured with the *Daily Spiritual Experience Scale*) on the one hand and depression, anxiety, somatization, stress perception and life satisfaction on the other hand (Büssing et al. 2016a). Here, their religious engagement was either not at all or only marginally related with indicators of psychosomatic health, while the perception of the transcendent as an experiential dimension was moderately associated with life satisfaction and inversely with stress perception and lower depression (Büssing et al. 2016a). Yet, the 6-item version of the *Daily Spiritual Experience Scale* includes an item on the perception of “inner peace”, and this item correlated best (moderately to strongly) with Catholic priests’ life satisfaction, depression and stress, while “feeling God’s presence” or “being touched by the beauty of creation” were related only marginally to weakly with these quality of life indicators (Büssing et al., unpublished data). This means, although the scale measures a relevant topic of spirituality and is sound from a theoretical point of view, it is nevertheless contaminated with a ‘wellbeing’ measure.

These examples may underline that even instruments with good psychometric quality indicators which are well-recognized and widely used may have intrinsic pitfalls. For health research and adequate interpretation of results it is thus essential to choose instruments which are (1) not contaminated with indicators of psychological health and wellbeing and (2) which address different layers and aspects of spirituality with independent sub-scales or different instruments (instead of condensed sum-scores). However, this does not argue against the use of such instruments which have their place in health research, but underlines that a profound knowledge of the pros and cons of the available instruments is essential.

5 Categorization of Questionnaires

There are several options to categorize the available questionnaires to measure specific aspects of spirituality. In the following some examples among a rich number of instruments are shortly described (without any attempts of completeness), and pragmatically categorized with respect to their themes and topics:

1. Spiritual attitudes, convictions and activities
2. Spiritual Wellbeing
3. Spiritual Struggles
4. Spiritual Coping
5. Spiritual Needs

Some of the instruments’ items refer to Theistic religious beliefs and name God. Here, persons from multiple-gods traditions could easily respond to these items, too. However, persons from religious traditions which lack circumscribed God concepts (i.e. Buddhism, Taoism) cannot respond positively to such God-items, but to all other items in case it is a multidimensional instrument. Only in few cases,

there are *a-theistic* variant versions of distinct questionnaires (i.e. Buddhist version of the RCOPE).

5.1 *Spiritual Attitudes, Convictions and Activities*

5.1.1 **DUKE Religion Index (DUREL)**

The generic 5-item instrument (Koenig et al. 1997; Koenig and Büssing 2010) assesses organized and non-organized religious activities with two single items (frequency of religious attendance, i.e., church/religious meetings, and private religious activities, i.e., praying, meditation, bible reading) and intrinsic religiosity with three items (Cronbach's alpha = .75) derived from Hoge's 10-Item *Intrinsic Religiosity Scale* (i.e., experience presence of good, religious beliefs are what lies behind whole approach in life, carry religion over into all other dealings in life).

The scale's benefit is its brevity which facilitates its implementation in large health service studies, while it is a less specific indicator of spirituality.

5.1.2 **Daily Spiritual Experience Scale (DSES)**

The generic scale was developed to assess a person's perception of the transcendent in daily life (Underwood and Teresi 2002; Underwood 2011), and thus the items measure experience rather than particular beliefs or behaviors. The 16-item version Cronbach's alpha = .94 addresses the relation to God (i.e., feel God's presence, guided by God, feel God's love, joy when connecting with God etc.), peace and harmony (i.e., feel inner peace and harmony; touched by beauty of creation; connecting to all life etc.) and selfless caring and accepting others,

The 6-item short version (Cronbach's alpha = .91) addresses:

- feeling God's presence
- feeling close to God
- finding strength in my faith (religion)
- feeling deep inner peace
- feeling God's love
- being touched by the beauty of creation

The benefit of this short scale (DSES-6) is its focus on the experiential aspect of spirituality, yet, it requires a belief in God and thus it is not applicable to a-religious persons. Further, including feelings of "inner peace" is sound from a theoretical point of view, but makes the short scale prone to positive associations with mental health indicators. The author of the instrument recommends to use the full 16 item version instead of the 6 item short version.

5.1.3 Gratitude/Awe Questionnaire (GrAw-7)

The scale is an extended version of the 3-item Gratitude/Awe subscale of the SpREUK-P and was developed to measure the emotional reactions towards an immediate and ‘captive’ experience (i.e., being moved and touched by certain moments and places/nature) and subsequent feelings of ‘undirected’ gratefulness (Büssing et al. 2018a). These perceptions of being ‘touched’ could be seen as a secular form of spirituality which does not require beliefs in God.

The generic 7 item GrAw-7 scale (Cronbach’s alpha = .82) addresses

- feeling of wondering awe
- pausing and staying ‘spellbound’ at the moment
- being quiet and devout in certain places
- stopping and being captivated by the beauty of nature
- stopping and then thinking of so many things for which one is grateful
- having learned to experience and value beauty
- feeling of great gratitude

The scale is not contaminated with specific religious topics or quality of life issues (and thus wellbeing was weakly only related). As an experiential aspect of spirituality, the GrAw-7 scales is strongly correlated with the perception of the sacred in life (DSES-6) in religious persons. Nevertheless, also non-religious persons may have these feelings and it thus suited also in secular societies.

5.1.4 Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ)

The generic 10 (alpha = .95) or 5-item instrument (Plante and Boccaccini 1997; Plante et al. 2002) measures the strength of a person’s religious faith. Specific items are:

- religious faith is important
- daily praying
- faith as a source of inspiration
- faith as providing meaning and purpose
- active in faith/church
- faith is an important part of who I am as a person
- relationship with God is extremely important
- enjoy being around with others who share my faith
- faith as a source of comfort
- faith impacts decisions

The scale uses as an ‘overall score’ and is not contaminated with wellbeing or character trait items which makes it a good candidate to focus on the strength (or centrality) of a person’s faith.

5.1.5 Centrality of Religiosity Scale (CRS)

The generic instrument measures the intensity of 5 theoretical defined dimensions and uses 15 (alpha = .92 to .96), 10 (alpha = .89 to .94) or 5 items to describe the relevance (centrality) of a person's religiosity in life (Huber 2008, Huber and Huber 2012). These five dimensions are:

- **Intellect:** think about religious issues, interested in learning more about religious topics, keep informed about religious questions through media
- **Ideology:** believe that God or something divine exists, belief in an after-life, how probable is it that a higher power really exists
- **Public practice:** take part in religious services, importance to take part in religious services, importance to be connected to a religious community
- **Private practice:** praying, importance of personal prayer, spontaneous praying when inspired by daily situations
- **Experience:** experience of situations in which God or something divine seems to intervene in life; feeling that God or something divine wants to communicate or to reveal something, experience situations in which God or something divine seems to be present

The instrument uses an 'overall score'. Its benefit is the theoretical foundation. Special items for different religious groups are available.

5.1.6 Aspects of Spirituality (ASP)

The generic instrument measures a variety of vital aspects of spirituality beyond conventional conceptual boundaries also in secular societies. It was shortened in multiple steps from 40 items (Büssing et al. 2007) to finally 20 items (Büssing et al. 2016b), and was applied so far in healthy adults but also in adolescents. It differentiates four factors:

- **Religious orientation** (alpha = .93/.91): praying, guided and sheltered, trust in and turn to God, spiritual orientation in life, distinct rituals, reading spiritual/religious books, etc.
- **Search for Insight/Wisdom** (alpha = .88/.82): insight and truth, develop wisdom, beauty/goodness, frankness/wideness of the spirit, broad awareness. etc.
- **Conscious interactions/Compassion** (alpha = .83/.73): conscious interactions with others, environment, compassion, generosity
- **Transcendence conviction** (alpha = .85/.75): existence of higher beings, rebirth of man/soul, soul origins in higher dimensions

The subscales are scored independently from each other and not as an 'over-all' score. A benefit of the instrument is its suitability for both, religious and also in non-religious persons.

5.1.7 Spiritual Practices (SpREUK-P)

The generic instrument measures the frequency and in a variant version the importance of a wide spectrum of religious, existential and philosophical forms of practice (Büssing et al. 2005a, 2012a). It uses either 24 items or in its shortened version 17 items (SpREUK-P SF17) and differentiates five factors:

- **Religious practices** (alpha = .84/.82): private praying, church/mosque/synagogue attendance, participate religious events, importance of religious symbols etc.
- **Existentialistic practices** (alpha = .83/.77): self-realization, spiritual development, meaning in life, turn to nature etc.
- **Prosocial-humanistic practices** (alpha = .76/.79): help others, consider their needs, do good, connectedness etc.
- **Gratitude/Awe** (alpha = .76/.77): feeling of gratitude, awe, experience beauty
- **Spiritual (Mind-Body) practices** (alpha = .80/.72): meditation, working on a mind-body discipline (i.e., yoga, qigong, mindfulness etc.), distinct rituals (from other religious/spiritual traditions), etc.

The multidimensional instrument is suited for religious but also for non-religious persons. The five dimensions are scored independently from each other and not as an ‘over-all’ score. Additional items for specific religious groups (i.e. Catholics and Muslims) are available.

5.1.8 Attitudes Toward God Scale-9 (ATGS-9)

The 9-item instrument measures feelings of anger towards God, but also to be comforted by God (Wood et al. 2010). Factor analyses identified two sub-constructs:

- **Positive Attitudes toward God** (alpha = .96): feel supported by God, feel loved by God, feel nurtured or cared for by God, trust God to protect and care for you, view God as all-powerful and all-knowing
- **Disappointment and Anger with God:** (alpha = .85) i.e., feel angry at God, view God as unkind, feel that God has let you down, feel abandoned by God

Because of the negative sub-scale the instrument could also be categorized in the “Spiritual Struggle” section, and because of the positive sub-scale also in the “Spiritual Wellbeing” section.

5.2 *Spiritual Wellbeing*

5.2.1 **Functional Assessment of Chronic Illness Therapy Spiritual (FACIT-Sp)**

The 12-item instrument ($\alpha = .87$) was developed to measure a person's spiritual well-being (Peterman et al. 2002; Bredle et al. 2011). It differentiates three core dimensions:

- **Meaning:** i.e., have reason for living, life has been productive, purpose in life, life lacks meaning and purpose
- **Peace:** i.e., feel peaceful, trouble feeling peaceful, feel comfort, harmony with myself
- **Faith:** i.e., find comfort/strength in faith, difficult times has strengthened spiritual beliefs, whatever happens with illness things will be ok

The Faith scale is contextual and refers to the experience of illness, while Meaning and Peace are generic scales (Canada et al. 2008). The instrument avoids traditional religious terminology and can thus be used also in non-religious persons. However, in the absence of a religious belief low Faith scores may not necessarily indicate low wellbeing but could reflect disinterest in this topic.

5.2.2 **Spiritual Well-Being Questionnaire (SWBQ)/Spiritual Health and Life-Orientation Measure (SHALOM)**

The generic 20-item instrument to measure a person's well-being (Gomez and Fisher 2003, 2005; Fisher 2010) differentiates four main dimensions:

- **Personal** ($\alpha = .89$), i.e., sense of identity, self-awareness, joy in life, inner peace, meaning in life
- **Transcendental** ($\alpha = .86$), i.e., relation with the Divine/God, worship of Creator, oneness/peace with God, prayer life
- **Environmental** ($\alpha = .76$), i.e., connect to nature, awe at a breath-taking view, oneness with nature, harmony with environment, sense of 'magic' in environment
- **Communal well-being** ($\alpha = .79$), i.e., love of others, forgiveness, trust between individuals, respect for others, kindness towards others

A conceptual benefit of the instrument is that it compares each person's ideals with their lived experiences, and is thus an indicator of spiritual harmony or dissonance.

5.3 *Spiritual Struggles*

5.3.1 **Religious and Spiritual Struggles Scale (RSS)**

The 26-item instrument was developed to assess “supernatural, interpersonal and intrapersonal struggles” (Exline et al. 2014). It differentiates six domains:

- **Divine** (alpha = .93): negative emotions associated with beliefs about God or a person’s relationship with God
- **Demonic** (alpha = .93): influence of evil spirits causing negative situations and events
- **Interpersonal** (alpha = .85): negative experiences with religious people or institutions; conflicts around religious issues
- **Moral** (alpha = .88): problems to follow moral principles; worries about perceived offenses by the self
- **Ultimate meaning** (alpha = .89): concern about not perceiving deep meaning in life
- **Doubt** (alpha = .90): perception of troubles associated with doubts or questions about beliefs

A benefit of this scale is its strict focus on the experience of spiritual/religious struggles rather than on strategies to cope with these. It can be used in persons who do believe in supernatural forces/spirits, but also in those who do not.

5.3.2 **Spiritual Dryness (SDS)**

The 6-item instrument) addresses whether or not religious individuals experience phases of ‘spiritual dryness’ as a form of spiritual crisis (Büssing et al. 2013). The items refer to statements in writings of mystics, i.e., experiences of spiritual dryness, darkness, loneliness or desolation. These phases of spiritual dryness are much more a process of loss or even ‘separation’ from God and are thus in contrast to St. John of the Cross’ “Dark Night of the Soul” which is a process to become closer to God in terms of an ‘attraction’.

The unidimensional Spiritual Dryness Scale (alpha = .87) assesses:

- feelings that God is distant (regardless of efforts to draw close to him)
- feelings that God has abandoned me completely
- experience times of ‘spiritual dryness’
- feeling that prayers go unanswered
- feelings to be ‘spiritually empty’
- feeling of not being able to give any more

Such feelings can be associated with an identity crisis and with symptoms of emotional exhaustion and psychological depression.

The instrument is extended by three additional items which are answered when these feelings and perceptions were already experienced. These address whether the interviewees have found ways to deal with these feelings, and then their reactions when these phases were overcome, i.e., being more engaged to help others and greater spiritual serenity and depth.

However, the instrument is not applicable to persons who do not believe in God as a source of hope, trust and orientation in life.

5.4 *Spiritual Coping*

5.4.1 **Religious Coping (RCOPE)**

The Brief RCOPE is a shortened version of the longer RCOPE and was developed to operationalize religious coping strategies to deal with religious struggles and life stressors (Pargament et al. 2000, 2011). It uses 14 items and two sub-scales:

- **Positive religious coping:** i.e., stronger connection with God, sought God’s love and care, sought help from God in letting go of anger, put plans into action together with God, focused on religion to stop worrying about problems, forgiveness of sins, etc.
- **Negative religious coping:** i.e., God had abandoned me, punished by God for lack of devotion, wondered why for God to punish me; questioned the power of God, questioned God’s love, devil made this happen, wondered whether church had abandoned me, etc.

Because of the negative sub-scale it could be also be categorized in the “Spiritual Struggle” section.

The Brief RCOPE is widely used and became an important instrument in health research. A disadvantage is the use of specific terms such as ‘God’, ‘sin’ or ‘devil’ which makes it less suitable for non-religious persons or adherents of non-theistic religions. To overcome the problem, Zwingmann et al. (2006) tested a 16-item version avoiding such phrases. Further, Phillips et al. (2009) developed the Buddhist BCOPE with 66 items across 14 subscales.

5.4.2 **Spiritual/Religious Attitudes in Dealing with Illness (SpREUK-15)**

The contextual instrument measures the impact of spirituality/religiosity on patients’ ways to cope with illness, specifically whether they have trust in a transcendent source of help, whether they are in search for such a source, and whether the experience of illness may change their attitudes and behaviors in terms of an ‘spiritual transformation’ (Büssing et al. 2005b; Büssing 2010). The items refer to motifs found in counseling interviews. The instrument is available as a 15-item

version (SpREUK-15) or a shortened 10-item version (SpREUK-10) and differentiates three dimensions:

- **Trust** (alpha = .90): trust in a higher power which carries through, trust in spiritual guidance in life, feel connected with higher source, etc.
- **Search** (alpha = .90/.84): searching for an access to spirituality/religiosity, renewed interest, finding access to a spiritual source can have a positive influence on illness, urged to spiritual/religious insight whether disease may improve or not, etc.
- **Reflection (Positive Interpretation of Disease)** (alpha = .82/.74): illness encourages to get to know myself better, reflect on what is essential in life, hint to change life, etc.

The instrument avoids specific religious terms and is suited also for non-religious persons. The three dimensions are scored independently from each other and not as an ‘overall-score’.

5.4.3 Reliance on God’s Help (RGH)

This contextual 5-item scale (alpha = .90 to .96) is intended as a short measure of a patient’s reliance on God’s help in difficult times (Büssing et al. 2015). It was originally derived from the AKU questionnaires which measures adaptive coping strategies referring to external or internal loci of health control. The following topics are covered by this unidimensional short-scale:

- Unconditional trust (“Whatever happens, I will trust in a higher power that carries me through”)
- Hopeful belief (“I have strong belief that God will help me”)
- Faith as a resource (“My faith is a strong hold, even in hard times”)
- Connection and effect/function (“I pray to become healthy again”)
- Behavioral correspondence (“I try to live in accordance with my religious convictions”)

The benefit of this scale is its brevity and the fact that it is not per se associated with indicators of well-being or quality of life. The underlying topics differ from Pargament’s concept of Religious Coping (Pargament 1997), which addresses the function of problem solving.

5.5 *Spiritual Needs*

5.5.1 **Spiritual Needs Questionnaire (SpNQ)**

The questionnaire was developed to address unmet existential and spiritual needs of patients with chronic diseases and of healthy adults and elderly (Büssing et al. 2010, 2012b). The instrument uses 28 diagnostic items; 19 items of these are allocated to differentiate four factors for SpNQ Version 1.2 (Cronbach's alpha = .93):

- **Religious needs** (alpha = .92): praying for and with others, participate at a religious ceremony, reading religious/spiritual books, turning to a higher presence, etc.
- **Inner Peace needs** (alpha = .82): wish to dwell at places of quietness and peace, plunge into the beauty of nature, finding inner peace, talking with other about fears and worries, etc.
- **Existential needs** (alpha = .82): reflect back on life, find meaning in illness and/or suffering, talk with someone about meaning in life/suffering, dissolve open aspects in life, talk about the possibility of a life after death, to forgive someone from a distinct period of your life, etc.
- **Giving/Generativity needs** (alpha = .74): active and autonomous intention to solace someone, to pass own life experiences to others, be assured that your life was meaningful and of value, etc.

The most recent and reduced version was validated with persons having various chronic diseases and palliative care patients, but also with healthy elderly and healthy mothers with sick newborns (Büssing et al. 2018b). Including healthy persons in the data pool of chronically diseased persons resulted in a slight decrease of the SpNQ's alpha coefficient (alpha = .89). This 20-item version (SpNQ-20) revealed 4 factors:

- **Religious needs** (alpha = .87): praying for and with others, participate at a religious ceremony, reading religious/spiritual books, turning to a higher presence
- **Existential needs** (alpha = .74): reflect back on life, find meaning in illness and/or suffering, talk with someone about meaning in life/suffering, dissolve open aspects in life, talk about the possibility of a life after death, forgive others and be forgiven
- **Inner Peace needs** (alpha = .73): wish to dwell at places of quietness and peace, plunge into the beauty of nature, finding inner peace, talk with someone about fears and worries
- **Giving/Generativity needs** (alpha = .71): be assured that your life was meaningful and of value, pass own life experiences to others, give solace to someone, give away something from yourself

A benefit is the standardized quantification of the strength of a person's unmet needs, whether the interviewees are religious or a-religious persons. The respective dimensions are scored independently from each other.

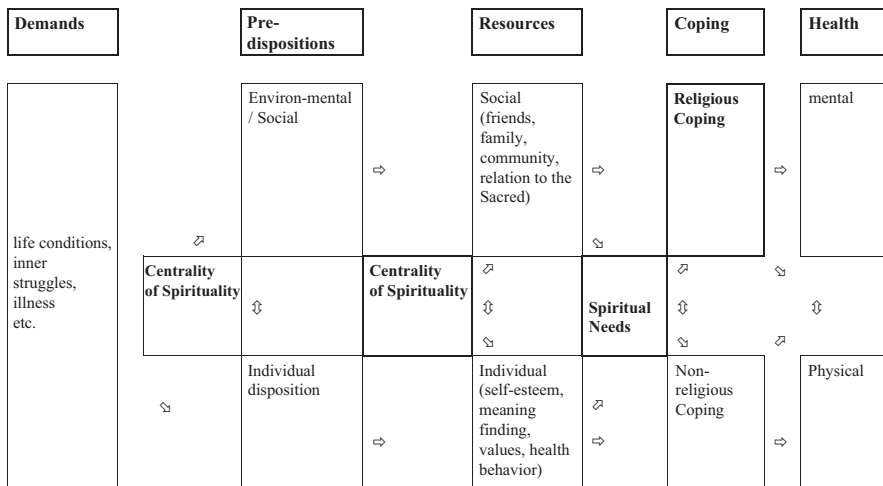
6 Selection of Instruments

To address the impact of a person’s spirituality/faith in their life concerns, one could either refer to modified Resource-Demand model (Table 2) as a theoretical concept or to aforementioned the model of spirituality level (Table 1).

Within the modified Resource-Demand model (Table 2) spirituality can be both, a source of resilience or adaptability which influences a person’s predispositions and resources, but also a reactive strategy to cope. To address the relevance of spirituality as a resource in times of need and life in general (‘centrality’), different questionnaires might be applicably (i.e., CRS, DUREL, ASP, RGH, SpREUK-P). Spiritual needs may arise when persons lack something which is important to them (Expectation) compared with their current situation (Perception), i.e. inner peace, forgiveness, meaning. The instruments described above measure at varying points along the hypothetical path between stressors and health as depicted in Table 2. Religious Coping could be addressed with the RCOPE but also with the SpREUK-15, spiritual needs might be addressed with the SpNQ. Spiritual wellbeing could be addressed either as a health outcome or a predisposition, and thus the FACIT-Sp or the SHALOM might be applicable.

With respect to the model of different layers of spirituality (i.e., Faith/Experience, Attitudes and Behaviors) (Table 1), the Experience level could be addressed with the DSES, GrAw-7 and SDS. Emotion-related attitudes could be assessed with the RGH scale, while cognition-related attitudes can be addressed with the RCOPE or SpREUK-15. On the Behavioral level, different forms of practices and rituals might be measured with the SpREUK-P. Other instruments may refer to different layers, i.e., CRS, DUREL, ASP, SpNQ, RSS).

Table 2 Spirituality in the context of a modified Resource-Demand model. (Modified according to Zwingmann et al. 2011)



For health research, one has to clearly define the intention of the assessment and to specify primary and secondary end points. Then one may select appropriate instruments which fit to these intentions. Further, when selecting instruments one has to find a balance between overachievement to please the researcher on the one hand (too many and too long instruments), and feasibility and reasonability on the other hand (using only a limited number of basic items, and thus several important aspects remain unaddressed). Of relevance is also to consider who will respond to the chosen questionnaires, i.e., healthy adults, adolescents, patients with a chronic disease, persons with cognitive deficits, etc., and also whether one assesses a religiously diverse population (including a-religious persons) or religiously more conform samples. Not all instruments are similarly suited for all persons: Some instruments are inappropriate for healthy persons because their items refer to an experience of illness, while other questionnaires might be too complicated for persons with cognitive deficits or too long for persons with attention deficits. For diverse populations, multidimensional instruments should cover also aspects of secular spirituality (i.e., measure the diversity of spiritual, existential and philosophical forms of practice and engagement), while in specific groups with similar beliefs it might be appropriate to apply more circumscribed instruments (i.e., to measure strength of religious belief). Further, one has to reflect on the modalities of the assessment, i.e., self-administered questionnaires, assistance to fill the questionnaires required, or assessment by external persons (via telephone).

In conclusion, there is not one optimal instrument to measure spirituality, but different instruments which might be suited, and all have their pros and cons. To check the instruments' quality criteria (reliability, validity, etc.) is a prerequisite in health research, and most of the established questionnaires (even in their shortened versions) have good psychometric quality indices. It is essential to reflect which instruments may ensure conceptually clear-cut operationalizations which fit to the aims of intended study. Because spirituality is a multidimensional construct, the different aspects and nuances should be measured with either multi-scale instruments or with divergent specific instruments to address the different layers and aspects of spirituality as independent dimensions (instead of condensed 'sum-scores'). Also short single-factor instruments have their importance when a specific dimension is intended to be measured. When 'contaminated' instruments are applied, because they are of relevance for the topic, then one should add a further instrument which measures a specific and circumscribed aspect of spirituality/religiosity to adjust the findings with the former one.

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Challenges and Criticisms in the Field of Spirituality, Religiousness, and Health



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Abstract Research in the field of spirituality is young. Empirical research started in the 60s, but conceptual issues have only been addressed recently. We sketch this history briefly. We also discuss some difficulties: Due to the implicit opposition to meta-physics that entered science through the process of enlightenment many see spirituality as an “un-scientific” topic. We argue that there is no such thing, but only methodology that can be called inadequate and hence unscientific. Mostly, the research field is beset with the problem that different authors use different definitions and concepts in their research on spirituality. We introduce some prominent ones, starting with a very vague definition that only requires some meaning-making for something to be spiritual up to a clearly theistic concept of God to be included. King and Koenig (BMC Health Serv Res 9:116. <https://doi.org/10.1186/1472-6963-9-116>, 2009) postulated four dimensions: faith, practice, importance for wellbeing and experience to be necessarily included in any definition of spirituality in research. We advocate a simple description of spirituality as “*implicit or explicit relatedness towards a reality beyond the needs of the individual ego, in cognition, emotion, motivation and action*” (Walach H, J Stud Spiritual 7:7–20, 2017). We point to the difficulty of previous research that has only included cognitive concepts, such as faith, or coping, into research, decoupling spirituality from its experiential component. We introduce our own attempt at capturing this using the novel questionnaire “*Exceptional Experiences Questionnaire*” (Kohls N, Walach H, Spiritual Health Int 7:125–150, 2006). We close with pointing to the problem of how to evaluate statements of inner experience or introspective epistemology.

Keywords Spirituality · Spiritual experience · Religiousness · Health · Exceptional human experiences · Introspection

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1 Introduction

Research in the field of spirituality, religiousness and health is a comparatively recent scientific enterprise. While the phenomenological study of spirituality and religion within psychology can be dated back to William James' famous Gifford Lectures at Edinburgh University in 1901/02 (James 1985), research in this field within the experimental-quantitative paradigm of psychology and medicine is rather new. In psychology, Allport and Ross began their research on religion and spirituality in 1967 with their classical study on the difference between extrinsic and intrinsic religious motivation and behavior (Allport and Ross 1967). They demonstrated that people with a more intrinsic form of religious motivation were happier and had less prejudices than those with an extrinsic religious motivation. Already this piece of research maps out the problems: being religious might not simply be the same as going to church, and believing in some higher entity or reality must not necessarily involve traditional forms of expression. So how to define and differentiate these various forms of religion and spirituality, and how to operationalise their potentially different, even opposite influence on variables of interest such as health is a pivotal question for establishing and enhancing this research field. Allport and Ross could show that there was a clear non-linear relationship of those constructs to prejudice. Perhaps the same is true for many other relationships like with measures of health?

In 1979 Hardy published his research from his Oxford project: he had collected numerous case reports of religious experiences from all walks of life and demonstrated that such experiences were frequent and important to those who encountered them. (Hardy 1979) But exactly how frequent? Did everybody have such extraordinary and at times even peculiar experiences? Or were they just rare occasions condensed through Hardy's method of soliciting reports through public channels?

Epidemiological research linking religious involvement with various parameters of health and overall mortality started at the end of the 60s. Levin's overview of 1987 reviewed as many as 250 studies linking religion – mostly religious attendance – and health and reported positive correlations (Levin and Schiller 1987), but Levin cautioned: most studies were correlative and cross-sectional in design, and the findings more a byproduct of a large epidemiologic fishing expedition rather than the execution of a systematically implemented research program (Levin and Vanderpool 1987; Schiller and Levin 1988).

In sociology, Moberg and Brusek (1978) called for an inclusion of spiritual well-being in quality of life research in 1978. They argued that the neglect of this construct is detrimental, because there might be an important relationship between spiritual and physical well-being. It had not been included so far due to the fact that the scientific community, being a pinnacle of enlightenment and supporting the separation of religion and public affairs was not very interested in the topic, and that, from a methodological point of view, measurement instruments and reliable operationalisations were lacking.

In medicine, cancer researchers started to discover the importance of spirituality at the end of the 90s, when they saw that cancer patients scoring high in spiritual

well-being and meaning were also physically better off, even if they were in pain and suffered from manifest cancer (Brady et al. 1999). The first scale to measure spiritual well-being in cancer patients, the spirituality module of the FACIT, was only introduced in 1999. The discussion of the topic in the medical field is still far from consensual with voices calling for an inclusion of spirituality in medical case taking (Anandarajah 2008; Anandarajah et al. 2010; Culliford 2009), and those calling for strict abstinence (Scheurich 2003).

Thus, systematic research in spirituality, religion, and health is a recent affair, and hence, we should not be surprised to meet with a lack of consistency, contradictory approaches and some confusion. We won't be able to clarify all confusion and solve all problems in this chapter, but we want to lay some ground for a more systematic approach by delineating problems and offering some potential roads out of the quagmire. Here is the roadmap:

We start out by analyzing the historical problem of researching spirituality and health. This has to do with the fact that the scientific enterprise with its implicit allegiance with the enlightenment movement subscribes to a materialistic ontology, at least implicitly and for the majority of actors on the scene (Kohls and Benedikter 2010). Hence the topic of spirituality is seen by many as "unscientific". Laying this problem open is the first step ahead. Then, we find, many researchers in this field bring in their own implicit personal pet-view of religion and spirituality: either coming from a theocentric perspective starting from the assumption that there is a personal god, or coming from a more Eastern inspired spirituality that there is some form of connectedness. This situation bedevils definitions and approaches. Furthermore, the bulk of research is conducted in the Anglo-American domain, and most researchers in the field seem to start from the assumption that religion and spirituality is something good for human beings and should be brought (back) to them. Hence, we will have to face the problem of implicit positive bias, both regarding publication of negative results that do not fit the bright picture, and regarding conceptualizations that assume always positive and healthy aspects and relationships. We end with the outlook that a more mature and less covert approach, more directly addressing the problems and rather open discourse will help both the impact and the breadth of perception by the research community at large.

2 Science, Religion, Spirituality: A Historical Perspective

As elaborated elsewhere (Walach and Reich 2005): Science, from the eighteenth century onwards, was a prime engine of the enlightenment movement. This demanded a separation of religion and state, individual freedom from ideological bondage, and in its final consequence a science free from any religious sentiments. As had been visible in some cataclysmic historical events, such as the banning of 219 theses, mostly from philosophy, in Paris in 1277 (Hissette 1977), or the burning of Giordano Bruno in 1600 (Yates 1982), or the inquisition against Galileo Galilei in 1616 and 1632 and the demand he should revoke his support for the Copernican

model (Fischer 2015; Shea and Artigas 2003): the relationship between science and religion, mostly the Catholic church and its inquisition, had never been easy. The impulse of enlightenment is always a threat to dogmatic teaching, whether it is religious, political, or scientific dogma.

The development of medicine as an academic profession led to an exclusion of ancient traditions of healing by herbalists, wise women and craftsmen-barbers in the fifteenth and sixteenth centuries. It was accompanied by severe struggles of power and definition of terms that, very often and unfortunately so, associated itself with the inquisition and employed blackmailing of those professionals as witches. This was a process that had its heydays in protestant regions and in the late seventeenth and early eighteenth centuries when scientific rationality was already part and parcel of the intellectuals' world-view (Decker 2005; Easlea 1980; Ginzburg 1988). Thus, the history of medicine is intimately linked to a rejection of non-official forms of (local) religion(s), occultism, esotericism and spirituality. This can still be observed in our modern days, where non-orthodox forms of medicine, such as alternative medicine, are brandished as "esoteric", "magic", or "irrational" by representatives of the mainstream orthodoxy (Gorski and Novella 2014; Pratkanis 1995), and the usage of alternative medicine is associated in users with a higher importance they attribute to spirituality and religion (Ellison et al. 2012).

The inherent conservatism of institutionalized religions and many of its representatives was noted by progressive minds, such as the French intellectuals that paved the way to the French revolution, like Rousseau, Diderot and others, up to our modern day politics. The debatedly most influential modern movement in this respect was the neo-positivist Viennese circle around Neurath, Schlick and later Carnap in Vienna at the beginning of the twentieth century (Smith 1994). With a decidedly social reform agenda that was meant to make a purist scientific world-view, built on the (abstract) principles of logics, relevant for the problems of the time, these philosophers and scientists set out to purify science from all antique costumes and old-fashioned fetters. They started with expelling religion and metaphysics from the realm of an empirical-positivist scientific investigation. They spelled out an explicit prohibition of metaphysics and banned all language from science that was not decidedly empirical or logical. The idea behind this was to ground science in strict observation and its purported objectivity, and use logic as an instrument to decide about the truth value of scientific statements. Although long proven inadequate by the debate within science studies (Laudan 1996; Suppe 1977) – as well as by Carnap himself – this neo-positivistic model of science and its anti-religious and anti-metaphysic stance is still a common topic of textbooks and undergraduate teaching, thus perpetuating the alleged incompatibility of science and religion as well as spirituality. In addition, some authors, like Draper, around the turn of the century, codified their own personal dislike of – Catholic – religion into a historically wrong but very influential conflictual relationship between science and religion. This led to the widely held, even if badly supported, view that science and religion are incompatible, and science has supplanted religion in explaining the world (Principe 2016).

Although also from Vienna and nourished by the same intellectual climate, Karl Raimund Popper developed a competitive model of science, criticizing his colleagues from the Viennese circle for overlooking severe problems (Popper 1976, 1984). But he shared their sentiment about religion and dogmatism. These two models of science, the positivist and the critical-rationalist model with its falsificationist rationale, are still very influential in modern day science. They are being taught and practiced, and with its teaching the implicit stance is being transported as well: the rejection of religious and spiritual topics as potentially valid scientific objectives. Very often they are labeled as “unscientific”, overlooking the fact that there is no such thing as a scientific or unscientific *topic*, i.e. a topic not worthy of systematic study, but that there are only scientific or unscientific *methods*, or methods that are not appropriate for a particular topic.

Thus, the development of modern science into our modern day collective enterprise has brought with it an implicit rejection of religion and spirituality, as a historical heritage. Had this process been the result of a long and open debate, it could be addressed directly. The problem is that this process was rather a subcutaneous and implicit development, working its ways in the inner sanctums of science: in the way how students are educated, how PhD-students and postdocs are being mentored and what topics are attracting attention and resources, or are being awarded publication space in high-impact outlets. The British philosopher Robin G. Collingwood coined the phrase “absolute presuppositions” for such presuppositions that inform and underlie all scientific activities without ever being discussed openly (Collingwood 1998, orig. 1940). Collingwood assumed that they are taken over from the generic culture and historical situation of a society. The prominent science theorist Thomas Samuel Kuhn later took over some of Collingwood’s ideas and incorporated them in his model of scientific revolutions that assumes stages of normal science that follow a particular paradigm until this is overthrown by a revolution (Kuhn 1962). In that sense, our current scientific paradigm excludes religion and spirituality as a topic worthy of scientific attention and merit. This is so, not because an open discourse has happened as a result of which this emerged as a scientific consensus, but rather because unconscious and undisputed absolute presuppositions in Collingwood’s sense are very strong within the scientific community.

Another way of putting this is to say that the implicit world model under which modern day science operates is a materialist model. Such a model stipulates that the most important elements in our world are material in nature extended in space, and that all complex appearances, such as macroscopic objects like trees, animals, people, cities, societies, galaxies etc. can be analysed as being constituted by smaller units. The smallest and final ones are tiny pieces of matter that were once called atoms, but are now known to be even smaller, such as quarks. This is, of course, the ancient atomistic world view first proposed by Demokritos and Leukippos in antiquity, propagated and popularized by Plinius and Epicure (Whyte 1961). Far from being scientific in the strict sense of the word – meaning methodologically well validated – this is a background philosophy that is *assumed* and expected to be true. Because of its strong historical ties with the scientific enterprise its proponents succeed in making the public and many other scientists believe that being scientific is

the same as being a materialist or, failing to be a materialist, keeping silent about not being one for fear of being dubbed “unscientific” by powerful peers. Rupert Sheldrake has elucidated this history and the implicit materialist bias in today’s scientific discourse and shown that this is in itself a very strong and unwarranted dogma. This is an interesting case of dialectics in history, whereby the enlightenment engine of science is turning its power against its own enlightenment trajectory, becoming dogmatic itself (Sheldrake 2013).

That this is not only some kitchen philosophy we are proposing here can be seen in a set of survey data where scientists, members of the National Academy of Science, i.e. the most prestigious scientists of the United States and possibly worldwide, have been surveyed regarding their belief in God and the existence of an immaterial soul (Larson and Witham 1998): 93% of all scientists surveyed do not believe in a God and 92% do not believe in a form of post-mortem survival of individual consciousness. Most are active disbelievers (72%) and a minority call themselves “agnostics” i.e. they do not have a final opinion. These data show: The enlightenment movement and its historical consequences have been very thorough in eliminating traces of transcendental belief and religious faith from the minds of those active in science themselves. Our age, as Charles Taylor has aptly put it, is secular (Taylor 2007). While in former times those not believing in religion, its doctrines and teachings were required to explain themselves and had to face consequences, nowadays the plight is being reversed. Those finding religion important or believing in realities other than material substances face a dominant secular culture that demands explanations, if its implicit world view is not honored by prominent proponents of its institutions of rationality, such as scientists, journalists, or intellectuals. Hence, topics such as “religion”, “religiousness”, or “spirituality” cannot be addressed *scientifically* in the same way as, say, “intelligence”, “depression”, or “health”. They need some contextualizing, bridging, explanation and justification first.

This is so despite the fact that these topics and experiences related to them are still germane to our modern societies, even in Europe. The so called “religion monitor”, a large panel survey instrument that samples the importance of spirituality and religion across a wide variety of countries and societies, using the concept of “centrality of religion” (Huber 2007), finds that religion and spirituality are still central to between 40% and 60% of people in Europe and nearly up to 100% in other countries like India or the US (Dragolov et al. 2016; Pickel 2013). We surveyed a representative sample of nearly 900 German psychotherapists and reported that roughly two thirds of these found spirituality or religion important, called themselves either spiritual, or religious, or both and had had at least one spiritual experience in their lives (Hofmann and Walach 2011). This is closely matched by a sample of 975 psychotherapists from the US, Canada and New-Zealand (Smith and Orlinsky 2004). Although psychotherapists undergo the same – secular – psychotherapy training that, at least in psychology, is inspired by positivistic and critical-rational ideas about science, they still find spirituality and religion important as topics both for themselves and their clients. This seems to be quite similar in countries with a strong religious culture such as the US and rather secular ones such as Europe.

It is frequently this discrepancy between the “official” scientific version and the experiential background of people that seems to drive the interest in the topic of spirituality and religion. And thus, despite the implicit ban on this topic from the scientific community as a whole, a pragmatically oriented research has started to grow over the last decades. This historical understanding is important, because it shows us, where the sensitivities lie, and why even good research will sometimes have difficulty being heard, seen, and taken seriously. It is useful to be aware of the fact that the background ideology of modern science is itself a quasi-religion, namely a more or less unreflected materialistic and empirically driven naturalism that presumes for itself the label “scientific worldview”, committing a conceptual error by doing so (Williams and Robinson 2016). The term “scientific” is an attribute that is reserved for methods, not for topics, for there is no such thing as an inherently unscientific topic. And a worldview can – in accordance with Kant and Carnap -, by itself, not be scientific, as it can never be tested by any empirical method but needs to be presupposed. Thus, a worldview that is purportedly scientific and assumes a materialistic ontology to be the true one is, at best, a hypothesis or a world model, or, in Collingwood’s term, an absolute presupposition, or a paradigm. But it is not “scientific” in the sense that it has been proven or demonstrated to be true. Yet this seems to be what an increasing number of scientists, especially high profile natural scientists, seem to believe (Pinker 2018). They have formed their own religious movement that calls itself “The Brights” with the political agenda to divest religions of their privileges and mainstream the so called “scientific worldview” of a materialistic naturalism through political activities (www.the-brights.net/).

It is against this background that any serious research of spirituality and religion has to make its stand and prove its viability.

2.1 Problems of Definition and Conceptualization

Any scientific research is only as good and as valid as the concepts used and the definitions employed. Defining the subject matter of spirituality, religiosity and religion is notoriously difficult, as has been observed many times (Emmons and Paloutzian 2003; Miller and Thoresen 2003). As long as we do not know what the subject matter is that we are studying, it is very difficult to make meaningful statements and claims. Definitions are naturally beset by conceptual problems. At one end of the spectrum, we have definitions that explicitly incorporate a higher entity, such as God, in their definition and thus implicitly propose a theistic world view, for instance:

The search for the sacred is central to definitions of religion and spirituality. This focus on the sacred helps to distinguish both spirituality and religion from other social and personal phenomena ... As used here, ‘sacred’ refers to a divine being, higher power, or ultimate reality, as perceived by the individual. (George et al. 2000, p. 104)

Other definitions also use “the sacred” as a defining and delimiting criterion and define spirituality as “feelings, thoughts, experiences, and behaviors that arise from a search for the sacred” (Hill et al. 2000, p. 66), whereby “sacred” refers to a divine being, ultimate reality or truth.

Those definitions that postulate some transcendent being, that the Western tradition used to call “God”, form one end, let’s call it the vertical dimension, of the conceptual spectrum. At the horizontal dimension are definitions that call anything that has to do with the larger meaning of life, sense of purpose, or incorporating meaning and the meaning-making of human beings, spirituality (Elkins et al. 1988). That broader definition we find not very useful as it is so broad as to encompass everything. Even the blindest materialist will engage in meaning making and thus, by the very definition, there would be no one who is not spiritual, which is clearly not a useful statement.

In between are definitions like the one by Swinton, who allows for some plasticity between spirituality and religion:

Spirituality is the quest for meaning, value and relationship with Self, other and, for some, with God. This quest provides an underlying dynamic for all human experience, but comes to the forefront in focused ways under particular circumstances. This quest for meaning, value and relationship may be located in God or religion, but in a secularised context such as the United Kingdom it may reveal itself in varied forms (Swinton et al. 2011, p. 644).

Other authors explicitly acknowledge the postmodern situation that religion has lost its attraction for many, especially young people, and yet there is this need for spirituality, expressing life’s deeper or higher dimension as sacredness, drawing on the anthropology of Max Scheler. (Jirásek 2013)

Two prominent researchers, Mike King and Harold Koenig, have proposed four defining elements of spirituality:

Faith: some belief in a reality beyond the material realm of what is visible and palpable
 Practice: some more or less natural and habitual practice that happens without difficulty and exertion, such as a daily practice of meditation or prayer or visiting a Sunday mass or other religious or spiritual service
 Awareness that this is important for one’s well-being
 Experience: Spiritual practice and faith are coming from one’s experience of such a higher transcendent reality. (King and Koenig 2009)

Our own favorite definition would be: Spirituality is an “implicit or explicit relatedness towards a reality beyond the needs of the individual ego, in cognition, emotion, motivation and action” (Walach 2017, p.10).

Reviewing these attempts at defining spirituality and religion we see two large tendencies: Religion and spirituality are two distinct modes of relatedness towards some larger whole in life and in the world. Spirituality seems to imply some relationship with an experientially accessible reality that can be understood to transcend the immediate needs and perspectives of an individual. Whether this reality is understood as a subject and a personal entity, such as implied by the term “God”, or rather a numinous reality would need to remain open, if spirituality is to be a subject matter for scientific discourse, as the definition of such a reality is beyond the scope of scientific investigation. It would be a topic for theology or religious studies. But

the experiential core of spirituality that seems to be germane to all proposed definitions is accessible and amenable to scientific study. Human experiences can be documented, their impact can be studied, their supposed meaning can be elicited, for instance by qualitative research, and their long-term relevance can be assessed, for instance by epidemiological research looking into its relationship with variables measuring health. Because we think that a naturalization of spirituality is useful, we have deliberately left out all references to a “sacred” or “numinous” reality. Humans might interpret the experiences and the reality that they infer from these experiences as “sacred”, but this is not a necessary part of the definition. What is necessary, it seems though, is that this reality is transcendent or going beyond the individual ego, while it is experientially accessible, at least in principle.

The defining elements “cognition”, “emotion”, “motivation”, and “action” are important. They are, in a way parallel to King’s and Koenig’s practice, awareness and experience. Experience we see as a deep mode of understanding, involving cognitions and emotions, and producing tendencies to act or motivations that finally crystallise in practices. We consider “Faith” as a cognitive structure that follows a more or less elaborate semantic-cognitive processing of the experience within the rules, images, concepts and language structures that a culture has to offer.

A big drawback of large parts of research within the current literature of religiousness and spirituality is, in our view, the fact that it has restricted itself to only parts of this defining core. It has either studied practice alone as a proxy for religiousness, for instance the relationship of church going and longevity or health. Or it has used cognitive structures of faith, such as statements or sentences of faith (e.g. “I believe in the reality of a higher being, or God”, or “I believe in the immortality of the soul”) and put those into relation with other variables of interest, such as coping with health problems. At times, it has used a mix of those. It would be the task of a future mature science of spirituality to use multifaceted instruments and try to tap into the reservoir of experience as much as possible to distinguish experiential forms from purely cognitive or dogmatic forms of religion. We have tried to achieve this by an approach that asks particularly for spiritual experiences at the expense of cognitive structures (Kohls et al. 2008; Kohls and Walach 2006, 2007; Kohls et al. 2009a, b). Our findings imply that positive spiritual experiences buffer stress to some degree, while spiritual practice particularly confers resilience and the potential to come to grips with negative experiences in life and thus contribute to mental health. Put succinctly: a lack of spiritual practice might be a risk factor for mental health, particularly if the integrity of the self is being violated by difficult circumstances such as illness, separation or lack of social coherence.

It is important to conceptually separate spirituality from religion. While religion often comprises spirituality the reverse is not necessarily true. There are increasingly people who call themselves spiritual, but not religious (Hyland et al. 2006), and the other way round (Büssing et al. 2005; Smith and Orlinsky 2004). If spirituality can be considered the experiential core of religion (Walach 2015, 2017), *religion* is the narrative, ritual, ethical and moral expression of spirituality in its cultural, social, historical and political environment. While spirituality is, debatedly, a human experience that can be considered a general core experience (Forman 1998, 1999),

religion is to some extent a historically and culturally contingent expression of this experience. While religion has produced lots of fights and wars, human experiences are uncontested. This is not to say that religion is bad, of lower value than spirituality or to be neglected. But it is important to conceptually and practically separate the two, as they operate on different domains (individual/society). Religious involvement, religious beliefs, religious practices, religious observance are all important and potentially beneficial or potentially harmful human endeavors. But there can be spiritual experiences without such religious expression and religious behaviors, beliefs and other practices without any spiritual experience or core. A lot of confusion could be avoided if researchers separated conceptually these two areas of interest. So, in studies demonstrating benefits of religious observance and beliefs, say, for mortality or health, we normally do not know: is the behavior itself the decisive factor, such as being a vegetarian and an antialcoholic, or is the belief system, the social bonding that comes with it, or the experiential core important, or a mix of all of them?

There is also an overlap between the two concepts: people who are both spiritual and religious. They very often have strong experiential backgrounds that they choose to express in religious terms. This we would call religiosity.

We hope this short discussion has made clear: It is important to at least be clear about the defining concepts one is about to employ and to explicate as much as possible of the implicit definitions one is about to use and transport in one's research. Another implicit bias of the field often goes unnoticed: The relationship of religion or spirituality and any variable of interest – for instance, health, longevity, resilience – is often presumed to be positive. Spirituality is often seen as a kind of potential resource, at times regarded as a “booster for health”. This might be true for most people and most of the time. But we would like to point out that especially deeply religious and spiritual people often also suffer from their spiritual involvement and because of it. Some of this has to do with the fact that their commitment produces friction with their environment. The prototypical example is the historical Jesus whose mission, from a mundane point of view, cannot be called a success. He ended as a criminal with the worst penalty the Roman empire had on offer. And in his wake there were many more examples, whether it was the deep depression St. John of the Cross suffered or, in more recent times, the dark doubts that Mother Theresa reportedly suffered from. The same is true for followers of other religions, especially, when their actions are motivated by strong inner spiritual experiences, such as politically active monks or priests from Buddhist, Christian, Hindu or other denominations. Sufi mystics of all ages were often in danger of being prosecuted. The point here is: what is seen as “success” from one point of view, for instance long life, health, happiness, wealth, is not necessarily seen as success from a spiritual point of view. So we caution against one dimensional assays and conceptualizations.

We have, in our instrument assessing exceptional human experiences, the “Exceptional Experiences Questionnaire” (EEQ), conceptualized spirituality as a double structure, having positive and deconstructing sides, and we have empirically validated such a structure (Kohls et al. 2008; Kohls and Walach 2006).

3 The Problem of Introspection and the Truth Value of Spiritual Experiences

Spiritual experiences are, by definition, individual inner experiences and therefore have a different epistemological status from, say, statements of sense experience. While for sense experiences of our world we can point to an external referent, for instance when we say “There is a green tree here in front of my house” that can potentially be verified by other competent observers, this is not necessarily true for statements of spiritual experiences. And this is part of the epistemological problem of spirituality. How do we know that Jeanne d’Arc, the virgin of Orleans, actually heard the archangel Michael and Saint Catherine speak to her to guide the French king to coronation, as she said, and that these voices were not just the expression of some narcissistic or delusional ideas of her? So how do we distinguish true from false? In science, one might claim, we have at least a somewhat reliable methodology that has developed over the last centuries to separate true from false claims, for instance through a painstaking reiterative process of experimentation, control, replications of observations through others, and mathematical and conceptual analysis. What would be the counterpart in the inner experiences of spirituality?

Here we must clearly state that this is a task for the future. The somewhat simplistic and spiritual-positivistic claim often heard that spirituality is similar to science in that one only has to follow the injunctions – sit down on your cushion and meditate in this and that kind of way. Then there will be experiences, already described by the tradition. Those need to be observed. And by carefully observing this inner world one can delineate a spiritual map. This approach has rightly been dubbed “spiritual positivism” and suffers from various problems (Ferrer 2000, 2002, 2014). The most important ones are that we can never step out of the frames of our language and concepts and hence would have to discuss those experiences with an expressly critical-reflective stance that is not normally the injunctive mode of formal religion. Nevertheless, this is a requirement for science. We have proposed that one would first need to translate the statements of inner experience from first-person singular statements into first-person plural statements, i.e. compare individual experiences with other, collective experiences, traditions, the experiences of other people and gradually arrive at a joint view (Walach and Runehov 2010). Others have proposed to refine introspective methods, for instance by eliciting, not the what, but the how of the experience (Bitbol and Petitmengin 2013; Petitmengin 2006, 2007; Petitmengin and Bitbol 2009). But we cannot expect to do the task science took a few hundred years to complete in a few years. Formulating the methodology of an introspective science is a methodological task for the future.

Religious traditions have known pragmatic criteria of truth that in the Christian tradition go by the name of “discernment of spirits”, criteria, by the way, that are used in modern concepts as well (Ferrer 2002). Here, not the content of an experience, but the functional consequences are the elements making it likely that it was a worthwhile experience. Does it contribute to more freedom, more happiness and more social commitment? Does it increase the capacity of a person to feel empathy

with others and be kind to them? Does it help to make someone an active member of a community, contributing to the well-being of others? Or is the experiential path one of contraction, growing egocentricity and growing narcissism? (Walach 2008) Such pragmatic criteria can be powerful in a very pragmatic sense and they might be a good hint as to where it is useful to look further, but they cannot replace a good epistemology. The history of science in the West has led to the situation that we have only developed an epistemology of external sense experience, of experiencing the outer world, while the East has devoted time and effort to an epistemology of the inner world (Akhilananda 1960; Rao 2005; Sedlmeier and Kunchapudi 2016). Indigenous cultures have developed still other modes of experiencing the world and conceptualizing their experience which are only gradually coming into the view of Western science (Ferrer 2013; Krippner and Sulla 2000; Rose 1956). Perhaps some fruitful dialogue might be useful? (Dockett and North-Schulte 2003; Hayes 2003; Wallace and Shapiro 2006).

4 Final Remarks: The Return of Metaphysics?

Doing research in the field of spirituality and religion is also challenging the mainstream world-view of a naturalistic-materialistic ontology. For, to some extent, such research presupposes that it is meaningful to study experiences that claim such a broader ontology that incorporates non-material reality as potentially important. Of course, one can implicitly bow to the mainstream dogma and only study the adaptive strategies that such experiences provide, the coping mechanisms, the meaning making, and in the end they might even turn out to be the most important elements in such an endeavor. But by the very fact of embarking on such an enterprise one makes an implicit statement that one believes an experience of a spiritual kind or nature to be relevant not only for individual interpretations of meaning but also for a larger understanding of the world. In a sense, the metaphysics expelled by Carnap and colleagues in the 30s is coming back to haunt science anew, it seems, albeit in the disguise of functionalization. The difference is: This time it will and has to come through the route of science and this is, following Franz Brentano's claims, thereby echoing Buddha, the route of experience (Albertazzi 2006; Brentano 1995; Smith 1994). While the philosophers of the Vienna circle, following in the steps of Franz Brentano in Vienna, were opposed to merely rational arguments around deeper principles of the world as expounded by the philosophy of their days, Brentano, who tried to install a modern introspective approach as a science of psychology, advised us to stick to experience and use methodology to purify it.

It is the research in spirituality that can and will take up this project again and in that it will become an experientially grounded and functionally justifiable metaphysics, and we should be aware that this is the project to be taken up again. This will entail studying the experiences that lie at the ground of spirituality and to describe defining elements and distinguishing phenomenologies. It will also entail intentionally creating spiritual experiences and describing them in the making. To

achieve this, we need well trained observers that have learned how to make use of their consciousness without being distracted. A culture of consciousness such as is created by the systematic practice of meditation and regular practice of mindfulness may be a prerequisite for this. Edmund Husserl, calling for a special state of consciousness which he called “epochè”, the Greek name for taking a distant view and separating one’s ideas and prejudices from the pure perception, was in the process of starting this, without telling us how to achieve it. Following this path we will necessarily have to find a way of honing our consciousness as an instrument. And the result might be an empirical foundation for a scientific type of metaphysics.

To sum up, our pivotal point is: we cannot work, operate and live without metaphysics. Our only choice is: to not choose it but to implicitly take over the underlying worldview of our culture, including its metaphysics which currently is a more or less explicit materialism; or to choose consciously and use our scientific method to study which type of metaphysics is actually a better one, fitting our experiences, fitting the facts, and liberating people. This, in our view, is the challenge of a good science of spirituality and religion.

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The Scientific Study of Belief and Pain Modulation: Conceptual Problems



Miguel Farias, Guy Kahane, and Nicholas Shackel

Abstract We examine conceptual and methodological problems that arise in the course of the scientific study of possible influences of religious belief on the experience of physical pain. We start by attempting to identify a notion of religious belief that might enter into interesting psychological generalizations involving both religious belief and pain. We argue that it may be useful to think of religious belief as a complex dispositional property that relates believers to a sufficiently thick belief system that encompasses both cognitive and non-cognitive elements. Such a conception of religious belief is more likely to correlate with psychological properties of believers that are both sufficiently shared and sufficiently unique to distinguish their psychology from believers in another religion or from non-believers. If the dispositional psychological property that constitutes religious belief does influence pain, then our analysis suggests that it doesn't do so directly but rather through one of its occurrent manifestations. We offer a taxonomy of the different ways in which occurrent states of belief or experience may interact with physical pain, and we try to identify those that are more interesting or promising. We then proceed to employ the conceptual framework we developed to some of the existing evidence about the neural and psychological correlates of religious belief and experience, and about the cognitive modulation of physical pain. Finally we turn to analyse two experiments that directly investigated the relation between religious belief and pain. We draw attention to the limitations of existing evidence and end by suggesting directions for future conceptual and empirical inquiry.

Keywords Pain modulation · Religious belief · Religious experience · Cognition and affect

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1 Introduction

Tradition and religious lore are full of stories about physical pain withstood and even vanquished with the power of religious belief alone. This is a view that continues to have a considerable hold on contemporary believers. One survey found that 58% of Americans have tried prayer to relieve their pain. Of these, about half reported that prayer has been extremely effective – as effective as prescription drugs.¹ One sufferer from chronic pain was quoted as saying, “[e]very day I wake up and go to bed doing my meditation. I wake up with my rosary in my hand and if my pain gets so severe, I put myself in another frame of mind in the back of my head.” Another claimed that when she prays, her pain “is still there, but you don’t notice it.”

These are striking claims. They attribute to religious belief the same causal effect on pain as powerful drugs. How can we approach such claims from a scientific standpoint? For scientific inquiry to proceed, we need to be able to frame specific and falsifiable hypotheses that involve causal generalizations about religious belief. A host of conceptual and methodological difficulties arise from the attempt to frame such hypotheses, which we discuss in the present chapter.

A scientific investigation of a question is not well-grounded if it does not employ an adequate conceptual framework. We need to make explicit the relation between the phenomena to be investigated and empirical phenomena accessible to scientific method, and to distinguish different types of possible causal relations between the phenomena. Crucially, we need to distinguish those questions of empirical fact that scientific inquiry can resolve from those issues of interpretation which, as a matter of principle, it cannot. In this chapter, we discuss some such conceptual issues that arise in the scientific investigation of the influence of religious belief on the modulation of pain. We will not attempt to give a definite answer to the question about the causal powers of religious belief over pain – research into this question is still in its infancy. What we try to do is to trace the path that scientific inquiry will need to take if it is to advance from the anecdotal evidence we just reported to valid scientific data and explanation.²

We will start the chapter with philosophical and methodological considerations, and gradually move on to examine concrete empirical questions and evidence. Section 2 thus starts with a discussion of the concept of religious belief. We cannot

¹Around 90% of those who tried prayer claimed it was effective. The survey was conducted by ABC News, USA Today and Stanford University Medical Center. See ABC News, May 12th, 2005.

²By definition, science is the investigation of natural entities and the natural relations between them (the laws of nature). Supernatural causation is, by definition, not bounded by natural laws. A true *supernatural* explanation of the outcome of an experiment would therefore invalidate inferences about *nature* based on that experiment. Consequently, scientists must assume that there is not a supernatural explanation of the phenomena they investigate. So we must assume that if religious belief does have a causal influence on physical pain, this influence doesn’t involve any supernatural powers. As we’ll see, this assumption is far from ruling out that the effect of belief on pain is distinctly and uniquely *religious*.

hope to review here the vast literature on this topic, let alone resolve the numerous controversies raised in it. Luckily, we do not need to. What we need for our purposes is a good enough account of the kind of *psychological properties* that religious believers are likely to share – psychological properties of the kind that may figure in interesting psychological generalizations. As we’ll see, the psychological properties that can plausibly underlie religious belief are not themselves plausible candidates for direct causal interaction with physical pain. If religious effect has an effect on pain, this effect must be mediated by a different category of mental state. What kind of mental state this might be, and how it might causally influence physical pain, is the topic of Sect. 3. With this conceptual framework at hand, we turn in Sect. 4 to examine some of the existing scientific evidence both about religious belief and about pain. We end with an analysis of two of the few scientific studies that directly investigated the relation between religious belief and pain.

2 Religious Belief as a Psychological Property

We want to investigate the relation between religious belief and pain. More specifically, we want to identify specific causal hypotheses relating the two, and possible mechanisms that might explain such connections. Given that pain is a mental state, the proximal cause of any modulatory effect on pain would presumably have to be some other mental state. So what we first need to do is to characterise an appropriate concept of religious belief that could play such a *psychological* role.

To see why an adequate psychological concept of religious belief is so crucial, just consider any of the studies that discovered some significant difference in reported pain between religious and non-religious groups (or between groups of differing degrees of religious commitment).³ Such findings are undeniably suggestive, but they do not get us very far. Any contrast between believers and non-believers might be due to any of the many factors that may distinguish the two groups. For consider just a couple of the obvious confounding factors. How can we distinguish effects which depend only on *conviction* of some kind (e.g. political), from effects which necessarily depend on a specifically religious *object* of conviction? How do we know that there is no factor that is causally responsible *both* for religious belief and for any discovered difference in experience between the groups?

We need to know rather more about what characterises a religious believer as such and to characterise their religious belief in a way that allows it to be causally involved in detected differences. So we need to think about what it is to be a religious believer, whether religious believers share relevant portions of the contents of their minds, how such contents may exert an influence over pain, and whether in doing so what occurs is distinct from what happens in the case of non-believers.

³For example, Koenig and his colleagues have found that patients with sickle cell disease who go to church once a week or more reported less pain than other groups. See Harrison et al. (2005).

2.1 *Religion and Religious Belief*

How precisely to identify and characterise a religion is a matter of substantial controversy. The scholarly work presently available – be it conceptual, descriptive, phenomenological or experimental – shows us a rich landscape which includes systems of belief, religious experience, religious ritual, structures of religious authority, and complex relations with a social context.

The complexity of religion has led the social sciences to approach the study of religion only after making various simplifying assumptions. Some views simply set aside the content of religious belief and focus on a claimed commonality of religious *experience* among believers. Others set experience aside and focus on shared belief in a narrow range of *special beliefs*, such as belief in a transcendent power. Yet others identify religious believers in behavioural terms, such as religious attendance, or on the basis of social factors. Such simplifications have their benefits. The question of whether different studies are addressing similar rather than heterogeneous phenomena can always be raised, and these simplifications provide a basis for an answer. At least in so far as the phenomena investigated are similar in the specified particular respects, the different studies are mutually relevant. But they also have their costs.

Reductionist attempts to find a simple unifying feature that would underlie the whole span of religious belief and practice, from the rainmaker shaman to the Jehovah's witness, can lead to a characterisation of religion as an amorphous mass of irrational ideas and peculiar behaviours. Such views may miss the internal coherence a religion may have, and may result in a distorted view of the capacity of religious belief, practice and experience to give form and meaning to the believer's life. Sympathetic simplifications may also distort. William James's focus on religious experience, to take up just one example, led to poor methodological discernment of the essential plurality of religious beliefs and experiences. The more recent emphasis on *non-religious* spirituality, popularly understood as the subjective experience of a transcendent force that binds all beings and things together and which is common to all religions, is an impoverished concept of *religious belief* as such and of *religious* experience. Even within a seemingly homogeneous religious tradition like Christianity, the past and present diversity of theological interpretations and religious practices cannot be taken as mere erudite disputes or cultural variation which bear no real significance for the lives of the religious individual. Religious beliefs and experiences do not exist in a vacuum: they both shape and are shaped by concrete individuals, have different shades of meaning at different times, and affect the course of events.

On the one hand, the social model is too broad. Social and institutional accounts of religion, whatever their merits, tell us little about shared psychological properties that might figure in causal explanations and generalisations. A believer's role in a social network, his participation in various religious practices, and his general behaviour are, at best, the distal causes of any relation between religious belief and pain. The proximal causes will invariably be located in his psychology. Furthermore,

even complete overt conformity to the dictates and practices of a given religion isn't sufficient for belief in that religion. To see this, think of a Jewish converso in medieval Spain who, while fully conforming to Christian practice in his public behaviour, nevertheless secretly clings to his faith inwardly. For our purposes, we clearly need to look for an exclusively psychological notion of religious belief.

On the other hand, although the experiential and special belief models meet the latter requirement, they are too narrow. They identify religious involvement in terms of a narrow range of particular mental states, but religious belief itself is not a simple matter of a small number of mental states. The influence of religious belief on pain, even if mediated on any particular occasion by particular mental states, may be more extensive than these models would allow.

To identify the psychological account of religious belief that we need, we can start with the near truism that being a religious believer is a matter of having certain kinds of *extensive* relations to a religion. A significant extent of those relations will be those *constituted* by having certain psychological properties, and hence those properties are especially significant for what it is to be a believer. Given the constitutive role and consequent special significance, it would be reasonable to identify those properties as the religious belief of a believer. So let us call these psychological properties that relate a believer to their religion their personal religious belief.

2.2 *Substantial Commonality of Religious Belief*

Granted that believers in the same religion are engaged with the same religious belief system, there remains the problem of what is to count as comprehensive engagement adequate to the substantial commonality of religious belief needed for our purposes. There are clearly some problems here. If a belief system is thin (or interpreted in a thin way), then it is less likely to be underpinned by distinctive psychological properties of an interesting sort. So it seems that purely cognitive systems are unlikely to play the causal role we need. On the other hand, the *thicker* and richer the system, the more we face the problem that there are many elements at play, and different believers might possess or relate only to a selection of these.

Even setting aside such non-cognitive attitudes, religious belief systems are so rich that it is unlikely that any believer believes the entirety of any particular religion's beliefs (in the sense of possessing mental states encoding it, as opposed, for example, to being disposed to defer to what religious authority informs them of the doctrine). However, believers do not acquire their religious belief at random, but in a highly organized manner. Whilst a creed on its own seems proportionally too thin to constitute a substantial commonality, the existence of a creed is a manifestation of the currents within religion which seek to foster commonality between believers. Being a believer often involves study of religious texts, substantial learning of religious doctrine and acquiring the unwritten lore by engaging with other believers in word and deed. Consequently, whilst it is true that both the written and unwritten lore of a religion are unevenly distributed between believers, and also that religions

vary with the respect to which they promulgate doctrinal conformity on the basis of authoritative interpretation, believers in the same religion are likely to share a substantial body of religious attitudes (attitudes including cognitions, conations and volitions). This would constitute a *thick* belief system, with psychological properties that shape the conscious states of a believer.

3 Belief, Consciousness and Pain

If religious belief is a belief system, in what way can it effect pain, a particular state of consciousness? We'll start with some general considerations about the relation between belief and consciousness. We will then look at religious belief, and at pain, more closely.

A belief system is best understood as a complex network of propositional contents and a range of associated propositional attitudes. For an agent to hold a certain belief system is for that person to have a complex dispositional property, a property that may often be latent, and that can be manifested in behaviour in a range of different ways. Since conscious mental states such as pain are occurrent states, we need a way of linking the two.

A religious believer remains one when asleep, when eating breakfast or driving a car. His belief may or may not colour his everyday life. But they will typically emerge to the surface of consciousness and behaviour in particular contexts – contexts when religious belief is relevant, needs to be directly brought to bear on ongoing events, whether in the surrounding world or in the person's inner life. Even then, it is not the entire belief system that is activated all at once. Usually it will be certain relevant aspects of it that will emerge to guide thought, feeling and action. Personal loss, philosophical reflection, or hopeful coincidence will each draw on a different facet of the person's faith.

3.1 *Propositional Belief*

The aspects of a personal belief system that will be activated at different points will involve constellations of different, interrelated mental elements, including cognitions, conations and volitions. Central among these will be propositional beliefs – including *evaluative* beliefs – and we'll focus on these for the moment. Later we'll explain how our analysis can be extended to other mental states.

When philosophers write about belief, they usually have in mind something far narrower than the concept of religious belief or of a belief system. What they write about is a basic type of mental state, the attitude of holding a certain proposition (however trivial) to be true. It is in this sense of belief that agents are said to believe that the sun has set, that the weather is bad, that the election was fixed, and so forth. A belief system such as a religion will contain *many* beliefs in this narrower sense.

We will not attempt a definition of this philosophical notion of belief. Suffice it to say that beliefs are attitudes towards *propositional contents*, that they guide intentional behaviour, that they are what is expressed in sincere indicative assertion and in private thought, and that agents normally have first-person authority about their beliefs – they normally know directly what it is they believe.

What is important for our purposes is to note that belief, in this narrower philosophical sense, is a demanding concept. Not every informational or representational state of an agent is a belief. The arrayed scene presented to me in perceptual experience isn't a belief, even if perception is ultimately the source of many of my empirical beliefs. Nor is the know how we use in riding bicycles and other forms of skilful behaviour a form of belief.

Perceptual experience and know how, although not state of belief, are nevertheless informational state of the person. In Dennett's (1987) terms, they are *personal-level* states. We need to distinguish these from *sub-personal states* – states ascribed not to the person but to various psychological or neural systems *within* him. Low-level representations of the visual scene in a person's cortex or representations of reward in his amygdala are not beliefs of the agent, not even unconscious beliefs (though such states may play a role in a causal explanation of the agent's beliefs).

We are interested in the way beliefs, drawn from a person's belief system, may have a causal effect on his or her conscious states. Beliefs are best understood as dispositional states, even if far simpler ones. But unlike an entire belief system, particular beliefs *can* become activated – become occurrent states of the agent – at particular points in time. One way in which a belief can become occurrent is by directly surfacing in an agent's consciousness – by becoming a conscious thought.

3.2 *Consciousness and Pain*

Turn now to consciousness. We are interested in state-consciousness – in particular conscious states, like pain. Philosophers have been mostly interested in *phenomenal consciousness*, that hard (or impossible) to describe way that it feels like to be in pain or to experience the redness of an apple. If there is a problem of consciousness, it's the problem of explaining how neural states can be identical to such 'raw feels' or qualia.

Pain is certainly poised for control of thought and action, and there's most certainly something it is like to feel pain. Unsurprisingly, philosophers have often taken pain to be the paradigmatic example of a conscious state. Unfortunately, pain is rather more complex than most philosophers of mind realise. It usually hurts to be in pain – that's one obvious way in which pain is "poised to control action." But people who've undergone frontal lobotomy don't seem to mind their pain. They seem to feel the *sensory* aspect of pain without feeling its *affective* side – without feeling it unpleasant. Scientists studying pain usually add a third, *cognitive* component – the immediate interpretation that an agent gives to the sensory and affective experience. Thus agents may expect the pain to last long or to end soon, associate it

with grave injury or take it to be harmless. Pain may be a paradigmatic state of consciousness, but it's also a rather complex mental state. Claims about the modulation of pain need to distinguish between these multiple dimensions.

3.3 *Ways in which Belief May Effect Consciousness*

There are a number of distinctions in the kinds of influence which belief (and hence religious belief) might have on pain:

1. *Modulation vs. endurance.* We must distinguish claims about the causal effects of religious belief on pain itself and claims about its effects on the way agents *respond* to pain. In particular, we need to distinguish the claim that religious belief *reduces* pain and the claim that it helps believers to better *endure* their pain. No doubt on some reading of the proposition that religious belief effects the perception of pain all that is meant is that it increases believers' endurance. We, however, are more interested in the rather ambitious causal effect: the claim that religious belief can directly modulate the intensity and unpleasantness of pain.
2. *Physical pain vs. overall unpleasantness.* Even if religious belief could, in certain contexts, lead to a reduction of the unpleasantness of the believer's experience, this might still not involve a direct reduction of his *physical* pain. For belief might affect rather the anxiety and distress that often accompany physical pain without actually changing it in any way. It may do so in a number of ways – by allowing the sufferer to give a benign or reassuring interpretation to the painful event.
3. *Direct vs. indirect modulation.* What we are asking, then, is whether belief can modulate the physical pain itself – reduce its intensity and unpleasantness. Such an effect, however, may only be an indirect one. It may not be the presence of the occurrent belief that would itself modulate the level of pain, but some further, non-cognitive mediating psychological state. For example, the activated belief may influence attention or affect in ways that would then have an effect on pain.
4. *Specific vs. non-specific effects.* A related distinction has to do with the source of the modulatory effect. Since beliefs are individuated by their contents, this is really a question about the role of the belief's content in the modulation of pain. In the context of our present inquiry, it would be most interesting if it would be the specifically *religious* content of an agent's beliefs that would have the relevant effect on pain rather than some content or property that religious belief may share with secular belief systems.

The above distinctions give us a taxonomy of possible ways in which states of belief may influence conscious states such as pain. Different combinations of the above would give different possible causal relations that empirical inquiry may identify and investigate (Fig. 1).

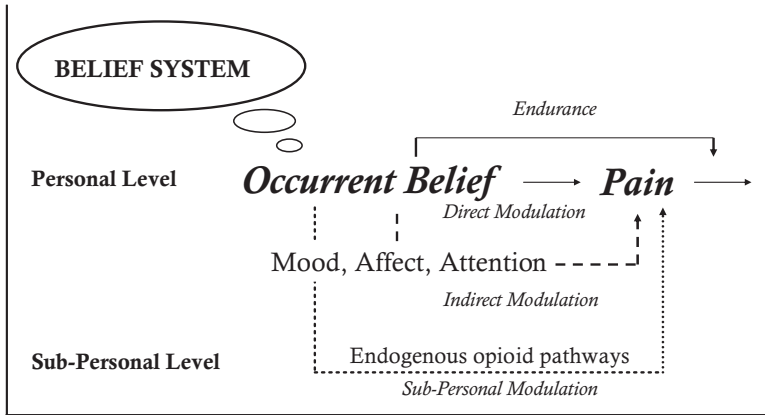


Fig. 1 Possible causal relations between occurrent belief and physical pain

Let’s pull together the different strands of the discussion. We are interested in the influence of religious belief on pain and we have suggested that this influence is mediated by occurrent mental states. We are thereby interested in possible causal relations between occurrent states of propositional belief and experiences of pain. We are not interested in causal relations between sub-personal states and pain. To identify a specific causal relation between belief and pain we must identify *which* beliefs are in question – that is, to identify beliefs in particular *propositions*, and we need to identify which of the different dimensions of pain has been influenced – sensory, affective, cognitive. So there is the possibility of different causal relations for different combinations of these, and to fully understand the influence of religious belief on pain will require knowledge of these relations.

We’ve so far focused on possible causal influence of belief on physical pain. This focus may seem unduly restrictive. For isn’t it rather *religious experience* that is the primary occurrent form of the manifestation of a religious belief system? In reply, let us draw us attention to two important points. First, talk of religious experience sometimes refers to a rather rare and exalted form of experience. Such extraordinary experiences, although of obvious scientific interest, couldn’t be definitive of religious belief itself. Many believers enjoy such experiences extremely rarely, if at all. Second, there are modes of distinctively religious affect and experience that are probably quite common and most probably central to possession of religious belief. However, the emphasis here should be on ‘distinctively religious’, and we’d like to suggest that the only thing that makes such experiences religious is their *intentional content*. And this means that we must identify such experiences in the same way we would identify a corresponding propositional belief. Indeed, certain propositional beliefs may have intrinsic connection to affect and motivation. So, as we’ve hinted earlier, our remarks about the relation between propositional belief and pain can be extended to cover other occurrent mental states that derive from an agent’s belief system.

4 From Religious Belief to Pain: Empirical Evidence

It's time to turn from rarefied conceptual analysis to some hard empirical data. In this section, we'll apply the considerations adduced so far to relevant empirical evidence, highlighting problems and pointing out important omissions. Religious experience is one central way in which a religious belief system manifests itself in occurrent mental states, and is thus a natural contact point with physical pain. How might such a cognitive-experiential state interact with pain? Setting aside religion, we'll survey some of the empirical data on the modulation of pain by various cognitive states. We then, finally, try to tie the different strands of the discussion together by analysing two experimental studies of the relation between religious belief and pain. By this point, it will be clear that much further empirical work is still needed.

4.1 *Religious Belief and Religious Experience*

Azari argues that religious experience is itself an essentially cognitive phenomenon, neurologically distinct from brute emotion and not necessarily marked by limbic activity in the brain. This result tends to undermine a sharp distinction between religious belief and religious experience. In particular, her study of religious experience is in sharp contrast to other studies, especially by Persinger and colleagues (see for example Persinger 2002), who have claimed to be able to trigger a mystical sensed presence when applying transcranial magnetic stimulation (TMS) to the temporal lobes, thus justifying the pre-cognitive character of religious experiences.

Another study, which unsuccessfully attempted to replicate Persinger's studies, has yielded results which partly support Azari's hypothesis. Although in this study the application of Persinger's TMS technique didn't result in a significant increase in reports of religious experiences, there were however some personality characteristics, such as suggestibility and the adoption of a New Age lifestyle orientation, which were correlated with a higher report of mystical experiences (Granqvist et al. 2005). In their conclusion the authors emphasise the multifactorial nature of religious experience, involving motivational, cognitive and also personality factors, which cannot be equated with easily defined neurophysiological states.

The few psychological experimental studies on religious experience support this multifactorial hypothesis, by showing that there is a combination of factors working together to produce a religious experience (for a review, see Hood et al. 1996). The cognitive component of possessing a religious belief system seems to be a *sine qua non* condition for the occurrence of a religious experience; otherwise a merely aesthetic interpretation of a state of physiological arousal is much more likely to be reported. The setting is another crucial variable, i.e. whether the experience happens in a religious environment or even in association with a particular religious image or text. A religious person would also be more motivated to have a religious experience, and would have 'learned' how to associate, or even direct, one's emotional

states in regard to a certain religious object (this is very characteristic of religious devotion to holy figures or objects). Finally, the variety of techniques available in the religious traditions to facilitate such experiences, also show us that people are affected in different ways by various types of religious stimulation, i.e. there are individual differences in the way religious experiences are triggered. For example, a person who easily gets into a deep state of contemplation by praying the rosary, may not be affected by a piece of sacred music which triggers a religious experience in another person. These results are in line with our earlier discussion of religious belief: being a complex dispositional property, it would be a conceptual mistake to identify it with any simple psychological state, let alone an *occurrent* state such an experience. Similarly, disputes between researchers about the character and neural correlates of religious experience may be due to failure to distinguish between *distinct* forms of religious experience and affect. As we noted several times, a religious belief system may manifest itself through different occurrent states in different contexts. We cannot compare the conflicting results of different studies of religious experience if we don't have a working criteria of identity for such experiences, which as we've seen requires a specification of the *intentional contents* being activated.

Notwithstanding the plurality of triggers for religious experience, what is central to our understanding of its occurrence is the overall importance of a previously held system of religious beliefs and the religious setting in which the experience takes place. If religious experiences do not happen in a cognitive vacuum, they are also not likely to occur unless there are cues (visual, acoustic) which make the person relate an experience to a religious framework. To make it more clear: religious people are not always thinking religiously. In fact, they tend to give more naturalistic than religious causal explanations to events in their lives (Lupfer et al. 1992). The experience of God's ubiquitous presence in our lives, in the way some Christian mystics tell us about, is not a common experience. Even someone like Theresa of Avila talked of how, in prayer, her mind tended to wander away from focusing on God (see Atran 2002).

4.2 *Cognitive and Affective Modulation of Pain*

Turn now to cognitive modulation of pain. It may seem that we've earlier characterised the phenomenon of direct modulation of pain by cognitive states in such a narrow sense to pretty much exclude everything. If belief and pain are personal level states, and if we focus only on the physical pain itself rather than on various forms of anxiety or distress that may accompany it, then how could a state of belief directly affect physical pain? Surely there are no *personal-level* connections that could do this job? This worry seems to us basically correct. However our taxonomy leaves space for a further kind of relation: that of sub-personal causation between two personal-level states (such causation would be of course mediated by a sub-personal mechanism of some sort). And in fact recent scientific inquiry has uncovered a

surprisingly diverse range of ways in which cognitive states appear to modulate physical pain (Oharaa et al. 2005; Petrovic and Ingvar 2002). We do not have space to give a detailed survey of these findings. We'll only briefly mention some of the most striking ones.

The most familiar, of course, is the placebo effect. Although some researchers have doubted its very existence as a general phenomenon (Hróbjartsson and Gøtzsche 2001), brain imaging studies have not only robustly established its existence, but also begun to identify the precise mechanisms of endogenous analgesia that the placebo effect exploits (Hoffman et al. 2005; Wager et al. 2004; Zubieta et al. 2005; Petrovic et al. 2005; Petrovic et al. 2002; Colloca and Benedetti 2005). So here we have an example of a higher cognitive state, the belief that the pain will get better, directly causing that very result, the decrease of the pain. So does, apparently, the belief that one has control over the pain (Salomons et al. 2004). But it is not only belief that may have this effect. The strength of the desire for the pain to stop may also play such a role, and emotions such as hope have been shown to lead to increased tolerance for pain (Breznitz 1999).

The placebo effect is the most familiar, but there are other ways in which cognitive states modulate pain. For example, the recruitment of attention to other tasks reduces felt pain (Bantick et al. 2002; Petrovic et al. 2000; Tracey et al. 2002), and exposure to images or stimuli that tend to induce positive affect reduce felt pain, whereas exposure to images laden with negative affect does the opposite (Meagher et al. 2001; Villemure and Bushnell 2002; Vogt 2005; De Wied and Verbaten 2001).

4.3 *Religious Belief and the Experience of Pain*

We are now finally in a position to consider the relation between religious belief and pain. We've initially set out from some anecdotal evidence that religious belief has *some* special bearing on the experience of pain. But from a scientific standpoint, all that this establishes is that there are religious believers who believe in such a connection. It is no more than a suggestive starting point for empirical inquiry.

The relevant work usually falls under the heading of research on religious belief and *coping*. Such research examines the beneficial role of religious belief in coping strategies with various conditions of adverse health, and naturally pain and suffering play prominent roles in these. A quick look at such research suggests that there are *many* methods of religious coping, some of which do indeed seem to be correlated with positive physical and mental health outcomes. These methods range from framing the painful or stressful event in terms that allow for its positive appraisal (as in the thought that 'this suffering might bring me closer to God'), to seeking religious support from clergy (Pargament et al. 2000). Most coping strategies involve active adaptation, both physical and mental, to stressful or painful situations. The individual does not become numb to the pain, but finds a way to live with it or even alleviate it by assigning a particular meaning to it, a meaning derived from his religious belief.

The diversity of coping strategies, even within members of a single religious tradition, should not be surprising. As we saw earlier, a given belief system can be brought to bear on present experience in a wide variety of ways. It does not have a single experiential or behavioural manifestation. Given this diversity, there may be a range of ways in which religious belief may interact with experiences of pain.

Even if we focus on particular strategies of religious coping, we are still at a great distance from identifying specific psychological mechanisms through which religious belief may modulate pain. The research in question focuses on large scale strategies of coping over time. This may give it greater ecological validity, but lesser methodological rigour. A range of personality and sociological factors may interact over time to affect patients' experiences of adversity. So most existing research on coping simply operates at the wrong level of magnification for our purposes.

Another problem is that it is very hard to distinguish, within this work, between strategies that allow for increased *tolerance* of suffering over time, and strategies that may directly shape the experience of pain (recall our earlier distinction). It is ever harder to distinguish methods of modulating physical pain from strategies for controlling overall distress or anxiety.

It would have been better if, within this large and growing body of work, there were more controlled attempts to identify ways in which religious belief may directly affect physical pain. We were only able to find a handful. Let us briefly describe three of these rare studies.

An early paper which used a task that involved putting the participants' hands in ice cold water reports that two out of four yogis in a deep state of religious meditation were able to keep their hands for 45–55 min in the water without experiencing any discomfort or registering any changes in their EEG records (Anand et al. 1961). This study, it must be admitted, is not much better than mere anecdotal evidence. No control group was used and the study seems mostly interested in attesting the unusual capacity of yogis to block any external stimulation by the use of a sophisticated physical-mental technique of concentration and religious experience (*samadhi*).

Setting aside the question of validity, let us make two methodological remarks. One is that although the study tested the yogis' capacity to *endure* pain over time, it seems natural to interpret the extraordinary endurance reported to be due to a genuine *reduction* in the level of experienced pain. The second is that this reduction, if this is indeed what it was, was clearly mediated by a distinctive *experiential state*. It is clearly an experiential state that is the result of prolonged and intense practice within the framework of a particular religious tradition. It is not entirely clear, though, whether this causal history is sufficient to make such a state of mind distinctively *religious*.

Moving forward in time to a more recent study, and from Eastern to Western religious traditions, Wachholtz and Pargament (2005) compared how various methods of spiritual meditation, practised 20 min daily for 2 weeks, led to different psychological and physical outcomes. There were three experimental groups in this study. One of them simply employed a technique of non-verbal relaxation. The other two groups had a short sentence which they repeated to themselves. While one

of these two groups engaged in what the authors call ‘secular meditation,’ i.e. meditation on a self-attribute (e.g. ‘*I am good*’), the other one instead focused on a God attribute, such as ‘*God is peace*’ (or good, joy or love). It was this latter group, the ‘spiritual meditation’ group, which showed the most significant results, namely a decrease in anxiety, more positive mood, and they were also able to withstand better the pain of holding their hands in ice cold water, by keeping it inside the water for almost twice as long as the other groups (about 1.5 min).⁴

It is not clear what psychological mechanism mediated this difference between the three groups, nor what role religious belief or experience played in it. There seems to be little doubt, however, that this difference involved greater tolerance, not direct modulation of pain.

The authors explain that it was not the subjective perception of pain that was altered but the capacity of enduring it. We may ask: what is there in the repetition of a God attribute that may make people cope better with pain than by simple relaxation or focusing on a positive self-attribute? Could it be the experience of feeling closer to God activated by the spiritual meditation task, as the authors suggest? If it is, it would be an interesting case in showing how an experience with a distinctly religious content may affect the modulation of pain. The existing evidence, however, falls far short of support for such a claim, as it does not rule the causal involvement of a range of possible factors that are generic – whether the placebo effect or the influence of attention or simple positive affect.

One other study was conducted by us (Wiech et al. 2008). We showed groups of Catholic religious believers and non-believers a religious or a secular image in alternating trials, while they experienced painful electrical stimulation and underwent functional magnetic resonance imaging (fMRI) (Fig. 2).

Religious participants reported a decrease in pain when meditating on the religious image. They also showed an activation of the right ventro-lateral prefrontal cortex (VLPFC) and we found a negative correlation between subjective pain intensity and activation of the right VLPFC—the lower the pain, the stronger the activation. The specific psychological role of religious belief in the cognitive modulation of pain was further substantiated by the phenomenological accounts. Religious participants reported thoughts of a religious content when presented with the religious image (e.g. “I felt calmed down and peaceful”; “I prayed”; “I thought of Mary’s suffering and of her courage”; “I felt being taken care of”; “I felt compassion and support”). On the other hand, both groups described their largely positive experience

⁴These findings, while significant, are of course far weaker than the dramatic ones reported by the Indian study (setting aside, again, the question of its validity). This highlights another difference between the two studies. The first examined a small and selected group of highly trained practitioners of a certain religious practice. The second examined a fairly ordinary sample of ordinary believers. So these studies nicely illustrate the ways in which claims about the causal efficacy of religious belief can relate to thicker or thinner shared psychological properties, as we’ve explained earlier in the chapter. Research is more likely to find radical forms of pain modulation in select groups of believers. On the other hand, it may be that the distinctive psychological properties shared by members of such select groups is the *cause* of such membership, rather than caused *by* it.

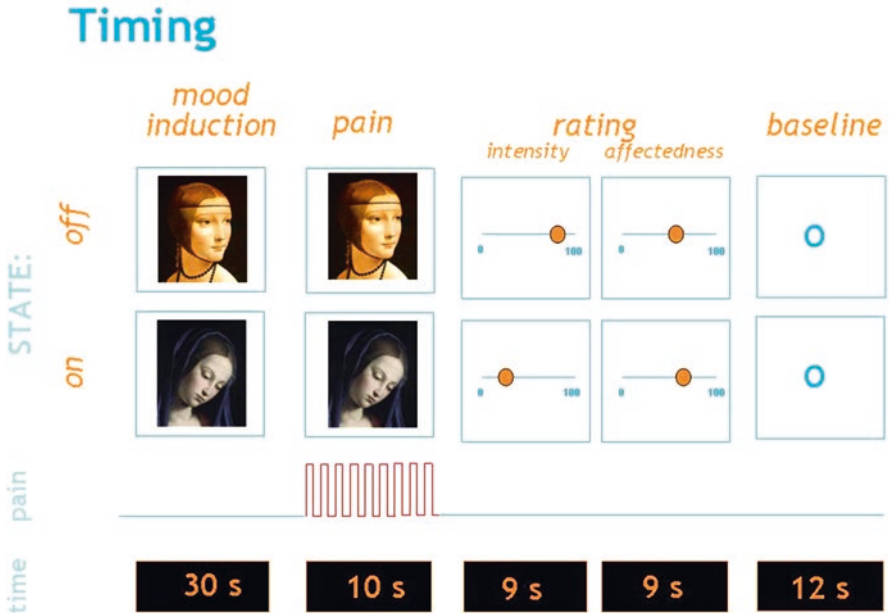


Fig. 2 Participants were instructed to focus on the image that was displayed 30 s before and during the application of the electrical stimulation. In each trial a series of 20 painful electric stimuli were applied to the back of the left hand. After the stimulation had stopped the participants rated the intensity of the electric stimuli and to what an extent they had been affected by the image. At the end of each block a circle appeared on the computer screen that signaled a baseline period of 12 s

of the non-religious image using only aesthetic terms (e.g., religious group: “I liked the picture and found it interesting”; “I liked the features of her face”; non-religious group: “She looked serene, chilled out”; “She looked attractive”).

What seems to have happened is that, for religious people, looking at the image of the Virgin Mary allowed them to reinterpret the emotional significance of pain – what has been described as reappraisal in the literature on emotion regulation. In other words, reappraisal occur when individuals change their emotional response by altering the *threat* value of the stimulus. In the case of our experiment, participants might have partly changed the threat value of the noxious stimuli by focusing on their religious beliefs. This is different from an attention or distraction strategy, where you focus away from the pain. However, we can only claim that the experience of pain was reduced or alleviated not directly, but via an indirect cognitive modulation.

Overall, what these studies suggest is that, in the most interesting cases, religious belief is not directly brought to bear on pain, but is brought to bear on present pain through the mediation of distinctive modes of experience, cognition or affect. This is in line with our analysis above, in which we distinguished the link from religious

belief to mediating occurrent mental states and the link between such occurrent states.

Finally, as we previously noted, much work on religious belief has shown that religious believers tend to interpret everyday events in broadly naturalistic terms. Religious causal explanations of events are given only in special contexts. Consequently, one would expect that religious belief is brought to bear on pain only in particular contexts that may ‘activate’ a subject’s religious belief system. This seems to be confirmed somewhat by the current evidence.⁵

5 Conclusion

Recent research on top-down modulation of pain has revealed a wealth of striking findings. But such research has focused on the modulatory powers of very narrow range of generic mental states – states such as expectation or positive affect. This approach to the subject may overlook the way that more distinctive mental states, states with richer and more specific content, may control pain. Anecdotal evidence, and general research on religious belief and coping, strongly suggests that religious belief may be such a state. The pitfall here is that religious belief is not even in the same conceptual category as expectation, affect or propositional belief. How then can we identify a distinctively religious mode of pain modulation?

In the early part of this chapter we have discussed some of the hazards that too coarse grained a criterion of religious believer would pose for investigating the influence of religious belief as such on the modulation of pain. Even if we wisely refrain from the attempt to give sharp necessary and sufficient conditions for religious belief, it is clear that it is a very complex psychological property that includes a range of distinctive dispositional and occurrent mental states. Empirical research that ignores this is not likely to genuinely advance our understanding of either religious belief or pain modulation.

There are a number of possibilities that need to be considered for states playing mediating causal roles. It would be most interesting if such states are identifiable by distinctive *intentional content* or *character*. In such cases it might be that a mediating state is of an apparently religious content or character, is of an apparently non-religious content or character or is not clearly either. All of these possibilities return us to the difficult conceptual and empirical task of defining what is distinctively religious. What does seem clear is that for such a state (cognitive or affective) to be distinctively religious, it needs to have a distinctively religious *intentional content*, though it may be that its effect of pain would not be direct but mediated by yet another, simpler mental state. For these reasons it seems likely that there will be

⁵Notice that in the Wachholtz and Pargament study, the comparison wasn’t between religious and non-religious subjects but between subjects of presumably roughly the same level of religious belief. The reported difference between the groups presumably had to do with the fact that in the ‘religious meditation’ group this belief was also *activated*.

significant controversies to be negotiated in interpreting the results of experiments. For example, in our own experiment, believers did engage with their religious beliefs while experiencing pain. But it is possible that a different kind of belief system thick enough (e.g. political) would also allow for a cognitive reappraisal of the perception of pain.

Much further empirical work will be needed to illuminate the links between a religious belief system and distinctive occurrent mental states, and between such occurrent states and pain. Further empirical *and* conceptual work is also needed to identify the sense in which such mediating occurrent states can be said to be distinctively religious in nature or content, as opposed to being *caused* by a religious belief system.

Given the complexity of conceptual and empirical issues we have identified, it is clear that investigating the influence of religious belief on the modulation of pain will require progressive development and refinement of methodology. Precisely what those developments will be is not clear at this stage of research. Presently it may suffice if we can distinguish the effects in our proffered taxonomy and rule out the explanation of the causal effect in terms of various generic mental states that have been independently identified. Subsequently we may try to get closer to determining whether it is something distinctively religious that is causally influential, and if so, what that is. In that case, methods to distinguish the content of religious belief responsible for the occurrent causally efficacious states, and methods to distinguish the content and character of those occurrent states, will have to be developed.

It is also likely that the development of those methods will require a continuing refinement of our understanding of religious belief. That refinement is not something that can successfully be left to a single discipline. On their own the scientists are liable to skew it in the direction of actual instantiations of religious belief, the philosophers to merge it into their general concern with intentionality, the theologians to focus on what it ought to be. Its refinement therefore requires a continuing collaboration of scientists, philosophers and theologians.

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Spirituality, Religiousness and Mental Health: Scientific Evidence



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Abstract This chapter reviews the main and most robust scientific evidence on the relationship between Religiousness/Spirituality (R/S) and mental health. We discuss the proposed mechanisms involved in this relationship, such as purpose and meaning in life, optimism, gratitude, social support, self-esteem, cognitive framework (involving, for example, a sense of coherence), healthier lifestyle, etc. In general, individuals who have higher levels of religious and spiritual involvement have lower rates of depression, suicidal behaviour, and alcohol and drug use and abuse. Although less consistent, there are studies indicating R/S as useful for coping with anxiety and psychotic symptoms.

Keywords Mental health · Religion · Spirituality · Anxiety · Schizophrenia · Psychosis · Depression · Suicide · Alcohol use and abuse · Substance use and abuse

1 Introduction

Demographic studies showed that in 2010 about 84% of the world's population reported affiliation with some religious group (Pew Research Center 2012). Despite this finding, until recently, the impact of religious and spiritual dimensions on people's mental health had not received adequate attention for more than 150 years (Koenig 2009). By the end of the nineteenth century, negative ideas about religion

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became prevalent in the psychiatry and psychology communities, lasting throughout most of the twentieth century (Moreira-Almeida et al. 2006). Examples of those are Jean Charcot and Sigmund Freud, who associated religion with hysteria and neurosis. This vision began to greatly separate religion from mental health care in the decades that followed (Koenig 2009). Hence, most patients still do not have their spiritual needs identified, and most clinicians do not include Religiosity/Spirituality (R/S) in clinical practice (Moreira-Almeida et al. 2014).

Only in the last four decades has rigorous scientific researches been regularly carried out and published in leading medical and psychological journals, generating a broad and strong body of evidence showing an association between religious involvement and mental health (Moreira-Almeida et al. 2006). Two systematic reviews of academic literature have identified more than 3000 empirical studies on R/S and health (Koenig et al. 2001, 2012). In general, individuals who have higher R/S have lower rates of depression, suicidal behaviour, and substance use/abuse than those with lower or no R/S. In addition, they usually experience better quality of life, optimism, well-being, better self-rated general health, and faster remission of depressive symptoms (Koenig 2009; Moreira-Almeida et al. 2006; Bonelli and Koenig 2013).

On the other hand, despite these positive aspects of R/S, and although less frequently, there is also evidence showing an association of R/S with negative mental health outcomes. These negative outcomes associated with R/S are often related to negative religious coping (Weber and Pargament 2014).

This chapter first discusses the main proposed mechanisms for the R/S and mental health association and then reviews the main findings of recent high-quality research on R/S and mental health, mainly in the areas of anxiety, psychotic disorders, depression, suicide, and substance use/abuse. In each section, we start with an overview of the available evidence and then describe some of the best or most representative studies on the subject.

2 Mechanisms

Although the R/S and health relationship has been well established based on thousands of studies, the mechanisms of this association have remained one of the most challenging issues for research and theory (Moreira-Almeida 2013).

The potential mechanisms most usually raised to explain (at least partially) the effects of R/S on health are: encouraging healthy behaviours (influencing eating habits, substance use, sexual behaviour, child rearing, etc); social support from the religious community; belief system (providing meaning to life and suffering); coping mechanisms; personality characteristics; and neuroendocrine and neuroimmunology pathways (cortisol, C-reactive protein, fibrinogen and cytokines).

For example, regarding depression, religious and spiritual involvement may prevent the onset of depression by fostering healthy coping behaviours to deal with precipitating psychosocial stressors. If depression sets in, R/S may provide meaning

and social support, facilitating faster adaptation to the underlying stressors and thereby accelerating the resolution of depression. However, if a person has strong religious beliefs but does not live up to religious values, this can create internal conflicts that can generate stress and disharmony, or lead to social exclusion from his/her religious group or family. Such internal/social conflicts may lead to guilt, hopelessness, social isolation and depression (Koenig et al. 2012).

Regarding suicide, the mechanisms might involve religious coping during stressful periods, providing meaning to life and suffering, social networks via the presence of a religious community, or specific living standards and values (Wu et al. 2015). All major religions in the world prohibit suicide, which makes this prohibition serve as a deterrent (Kleiman and Liu 2014). But the exact mechanisms are not clear. For example, a recent large longitudinal study showed that religious attendance was a strong protective factor against suicide deaths. However, although religious attendance had also been related to higher social support, lower depression and alcohol use (important suicide risk factors and possible pathways for R/S influence on it), the impact of R/S on suicide deaths was independent of these factors (VanderWeele et al. 2016).

Regarding substance use/abuse, there is evidence that self-help groups based on the 12-step programme, such as Alcoholics Anonymous (AA), that has a strong spiritual component, contribute to the process of recovery from alcohol dependence by increasing R/S and, mainly, by developing a new social network (Kelly et al. 2012). In addition, some studies found that “spiritual awakening” during the 12-step programme is a predictor of better recovery among patients with substance dependence (Kelly et al. 2011; Zemore 2007).

Some authors have proposed models based on these possible mechanisms. George et al. (2002) pointed to four potential psychosocial mechanisms: health practices, social support, psychosocial resources such as self-esteem and self-efficacy, and belief structures such as a sense of coherence. They conclude, after analysing the scientific evidence, that these four factors, although relevant, seem to be insufficient for fully explaining the mechanisms by which R/S impacts health outcomes.

Levin (2003) classified the potential salutogenic mechanisms of R/S into five types: biological, psychosocial, bioenergy-based, nonlocal, and supernatural. The biological pathway is about some religio-ethnic groups which preserve some genetic patterns that predispose their members to a disease or to a healthier life. The psychosocial pathway involves cognitive, emotional and behavioural after-effects of religious involvement, for example, social support, positive emotions, personality styles and positive thoughts. The bioenergy-based pathway is proposed in order to explain the therapeutic results of spiritual intentionality. The nonlocal pathway is derived from Larry Dossey’s theory, which says that there is some part of our mind or consciousness that is connected to all else (to all other moments and places and persons). Finally, the supernatural pathway would be interventions by God or a divine Being that is able to transcend the laws of nature.

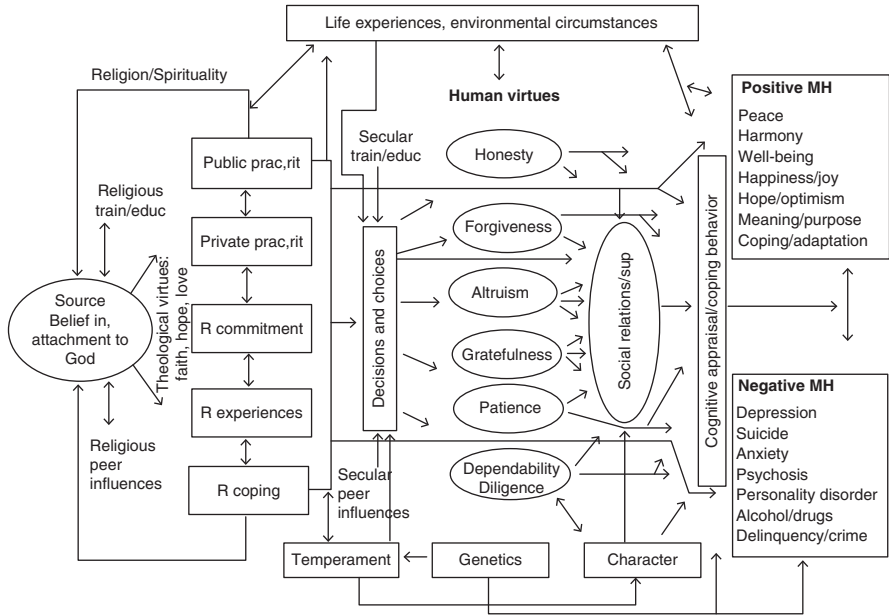


Fig. 1 Model to explain effects of R/S practices and beliefs on mental health. (Reproduced from Koenig et al. 2012)

Finally, Koenig et al. (2012) proposed a comprehensive model for the impact of several R/S dimensions on mental health through several interconnected bio-psycho-social pathways (Fig. 1).

2.1 Summary

Aspects such as greater purpose, optimism, generosity, gratefulness, social support, self-esteem, self-efficacy, cognitive framework (e.g., sense of coherence and meaning), healthier habits (e.g., related to smoking, drinking, sexual life), body sanctification, locus of control, positive and negative affects, stress moderation, treatment adherence, and coping seem to be major explanations for the relationship between R/S and mental health.

Indeed, evidence has shown that these proposed pathways are often related to R/S. However, when tested for mediation, these factors usually explain only partially or not at all the R/S and health relationship (VanderWeele et al. 2016; George et al. 2002; Corrêa et al. 2011). In summary, evidence about these possible mediators is still inconsistent, and they are probably not the whole story. There is no one mechanism that alone is able to fully explain how R/S affects health. This is one of the most challenging and promising research topics on R/S and health.

3 Anxiety

Anxiety is an unpleasant feeling of fear and apprehension, characterized by tension or discomfort derived from the anticipation of danger, from something unknown or strange. It is a natural and adaptive resource of the body in anticipation of a potentially threatening event. When it is intense, frequent, and/or generates great suffering, it can cause serious problems to mental and to general health. Generalized anxiety disorder, panic disorder and phobias are the most prevalent anxiety disorders (Araújo and Lotufo Neto 2013). Anxiety disorders are one of the most prevalent mental disorders, with an estimated global prevalence of 11.6% (Baxter et al. 2013).

3.1 *Relationship Between R/S and Anxiety*

Koenig et al. (2012) reviewed almost 300 studies (94% cross-sectional) investigating the relationship between R/S and anxiety. Almost half of them (147/ 49%) reported an inverse correlation. Thirty-three (11%) studies found greater anxiety related to higher R/S levels. Of the 19 longitudinal studies, 9 (47%) reported that R/S predicted lower anxiety levels over time; one study (5%) found an increase in anxiety (among women undergoing abortion for foetal anomaly), and seven reported no association between anxiety and R/S.

3.2 *Interventions Based on R/S for Anxiety*

A recent meta-analysis (Gonçalves et al. 2015a) aimed to evaluate the impact of R/S-based interventions on health, describing the study protocols and their quality, and found that R/S-based interventions showed significant effects on anxiety ($p < 0.0001$). A clinical trial with 62 Muslim patients with Generalized Anxiety Disorder found that patients who received religious-based intervention reported, after 3 months of treatment, significant reduction of the symptoms compared to the control group (Azhar et al. 1994). Another study tested the efficacy of Spiritually Integrated Treatment-SIT (a program involving Jewish spiritual strategies for coping with stress and worries) delivered via the internet to 125 Jews with subclinical anxiety. They found reductions in stress, worry, depression, and intolerance of uncertainty compared to the control group (who only had progressive muscle relaxation) and waitlisted control (Rosmarin et al. 2010).

Some kinds of complementary and integrative therapies (based on spiritual practices such as mindfulness and meditation) seem to decrease anxiety symptoms (Thrane 2013; Sankhe et al. 2017; Kiran et al. 2017). In a randomized controlled trial with 72 Brazilian internal medicine inpatients, those who received Spiritist Passes (SP) – a kind of laying on of hands – presented higher reductions in anxiety,

depression, and muscle tension and had lower heart rates than those who did not receive SP (Carneiro et al. 2017).

3.3 Summary

In spite of scientific evidence showing that R/S seems to be a protective factor for anxiety disorders, findings are still not conclusive. The most robust evidence is about R/S-based interventions to reduce anxiety symptoms (Gonçalves et al. 2015b). More studies are needed to explore this relationship.

4 Psychotic Disorder/Schizophrenia

Psychotic disorders are characterized by symptoms such as delusions and/or hallucinations, indicating impaired contact with reality. Psychotic disorders are usually very disabling and the prototypical example is schizophrenia.

The relationship between R/S and psychosis has been discussed for a long time; many studies (old and recent) show that religious delusions are common in psychotic patients (voices with demonic forces, messages from God or the devil) (Rose et al. 2017).

A critical question is whether this relationship is a causal one (R/S generating psychosis), or if people suffering from psychotic symptoms seek religious experiences to cope with these symptoms, or whether the contents of these religious delusions simply reflect patients' cultural backgrounds (cultural pathoplasty).

Another clinically relevant and widely debated topic refers to the differentiation between non-pathological religious experiences that resemble psychotic symptoms (e.g., hearing voices, trance and possession experiences, etc.) and psychotic disorders with religious contents. There is consistent evidence that "psychotic" or "anomalous" experiences are frequent in the general population and that most of them (90%) are not related to psychotic disorders. While about one-third of psychoses have religious content, most religious experiences are not psychotic (Koenig 2007; Menezes and Moreira-Almeida 2010).

In order to aid clinical reasoning, Moreira-Almeida and Cardeña (2011) proposed several criteria suggestive of non-pathological "psychotic" or "anomalous" experience: absence of suffering, functional or occupational impairment, compatibility with the patient's cultural background or with some religious tradition, acceptance of experience by others, absence of psychiatric comorbidities, control over the experience and personal growth over time. In summary, the emphasis should not be placed on anomalous experiences resembling positive psychotic symptoms (such as hallucinations) but on other psychotic symptoms such as disorganized behaviour, cognitive disorders and social withdrawal.

4.1 Relationship Between R/S and Psychotic Disorders

Koenig et al. (2012) identified 43 studies on the relationship between psychotic disorders and R/S. About 33% of these studies (14) showed an inverse relationship between psychotic symptoms and R/S, and 23% (10) found a positive relationship.

A study about the influence of R/S on substance misuse in patients with schizophrenia or schizo-affective disorder among 115 Dutch outpatients found that religious involvement may have played a protective role in preventing substance misuse in 14% of the total sample, especially for patients who had stopped substance misuse. Another study with 150 patients from Geneva's four psychiatric outpatient facilities, with diagnosis of schizophrenia or schizo-affective disorder pointed out that 43% of psychotic patients had already attempted suicide. Twenty-five per cent of them said that they recognized the protective role of religion with regard to suicide behaviour mostly through ethical condemnation and religious coping (Huguelet et al. 2007).

Almost 70% of 103 stabilized schizophrenic patients from Switzerland considered spirituality as very important or even essential in their everyday life. Of these patients, 57% had an opinion that their illnesses are directly influenced by their spiritual beliefs –31% positively and 36% negatively (Borras et al. 2007).

4.2 Summary

Religious delusions are common in psychotic disorders and psychotic patients very often turn to R/S as a coping strategy. Some non-pathological spiritual experiences may resemble psychotic disorders, and a careful and sensible clinical evaluation is needed, especially for a differential diagnosis (Huguelet et al. 2009).

Based on the evidence available, the importance of studying R/S in psychotic patients is clear (because of the importance of R/S for them, because of the protective factor that R/S have in their lives, and because of the content of their delusions), and it is necessary to learn more about R/S experiences in the general population that are not “psychotic” experiences (maybe spiritual experiences). There is still much about the relationship between religion and psychosis that remains unknown, pointing to the need for more studies to better inform clinical practice (Huguelet et al. 2016). Collecting spiritual history, considering interventions from spiritual groups for patients who have this inclination and/or supporting non-psychotic religious involvement are among the next promising steps (Clark et al. 2012; Huguelet et al. 2016).

5 Depression

Depression is a common mental disorder. Globally, more than 300 million people of all ages suffer from depression. Depression is one of the leading causes of disability worldwide and is a major contributor to the overall global burden of disease (GBD 2015 Disease Injury Incidence and Prevalence Collaborators 2016).

5.1 *Relationship Between R/S and Depression*

Koenig et al. (2001) identified 96 observational studies published up to the year 2000, of which 61 (64%) reported an inverse correlation between R/S and depressive symptoms. From 339 articles published between 2000 and 2010, 170 (63%) showed lower rates of depression and fewer depressive symptoms among those with higher R/S. Among the 45 longitudinal studies, 25 (47%) found that higher R/S involvement predicted lower rates of depression over time (Koenig et al. 2012).

A meta-analysis of 147 studies with a total of 98,975 individuals showed a significantly inverse relationship between religiosity and depression. Such outcomes were not moderated by gender, age, or ethnicity, but the association was stronger in those studies involving people who were experiencing recent stressful life situations. On the other hand, results were moderated by the type of religiosity measure used in the study; extrinsic religiosity and negative religious coping (e.g., blaming God for difficulties) were associated with higher levels of depressive symptoms (Smith et al. 2003).

A 1-year longitudinal study with 4791 US adolescents found that involvement in religious activities protected against the onset of depressive episodes (Van Voorhees et al. 2008). Adjusting for demographic characteristics and depressive mood at baseline, praying once a week and attending religious youth groups at least once a month correlated with fewer onsets of depressive episodes compared to those who never prayed (OR = 0.52; 95% CI 0.29–0.94) and who never attended (OR = 0.37; 95% CI 0.15–0.88).

A 10-year follow-up study of 114 US children found that those who reported at 10 years old that R/S was highly important to them had about a quarter of a risk of experiencing depression between 10 and 20 years later than those who did not consider R/S important. In the high-risk subgroup (having a depressed parent), those who reported high importance of R/S had a tenth of the risk of having depression between 10 and 20 years later compared with those who did not report R/S importance (Miller et al. 2012).

A 2-year study investigated 1992 depressed and 5740 non-depressed older US adults. Non-depressed baseline individuals who regularly attended religious services were more likely to remain non-depressed in the follow-up, while those depressed at baseline were less likely to remain depressed at follow-up when they

were more often engaged in private prayer compared to the ones who did not often engage (Ronneberg et al. 2016).

5.2 Interventions Based on R/S for Depression

A systematic review of randomized clinical trials evaluating R/S interventions showed that these interventions have decreased depressive symptoms (Gonçalves et al. 2015a). Other reviews also found that the inclusion of R/S elements in standard psychotherapies may be useful for patients with different types of psychological problems, including depression (Hook et al. 2010; Worthington et al. 2011). Another meta-analysis of randomized clinical trials found that faith-adapted cognitive-behavioural therapy (F-CBT) produced larger decreases in depression scores than control conditions (e.g., waiting list or treatment as usual) and even more than standard CBT (Anderson et al. 2015).

5.3 Summary

The good quality evidence currently available indicates that R/S involvement (especially intrinsic religiosity, attendance at religious services and positive religious coping) is usually associated with lower levels of depression, with a higher protective effect size among those individuals at higher risk, such as those in stressful situations. In addition, the use of religious resources may contribute to the recovery process of depressed patients. Evidence also suggests that religious interventions may also help reduce depressive symptoms.

6 Suicide

Suicide is a major cause of morbidity and mortality in the world. It is responsible for more than 800,000 deaths per year and ranks among the top three causes of death of people 15–44 years old (Wu et al. 2015). Causes of suicide include psychological factors, such as depression, anger and impulsivity; social factors such as family disorders, lack of social support and loneliness; behavioural factors such as alcohol and drug use and dependence; biological causes, including side effects of medications; medical conditions such as chronic and disabling diseases; genetic causes; and developmental causes, such as domestic violence and sexual, physical or emotional abuse (Koenig et al. 2012).

6.1 *Relationship Between R/S and Suicide*

A systematic review of 141 studies examined the relationship between R/S and suicidal ideation, suicide attempts and complete suicide. Of these studies, 106 (75%) found less suicidal ideation and behaviour among those who were more religious (Koenig et al. 2012). A meta-analysis of nine studies from 2000 to 2015 analysed 2369 completed suicides and 5252 controls (living or dead from natural causes). It found a global protective effect of R/S over complete suicides (OR = 0.38; 95% CI 0.21–0.71), with a stronger effect in Western cultures (Wu et al. 2015).

A 16-year follow-up study of a US nationally representative sample (n = 20,014) found that those who regularly attended religious services died three times less by suicide compared with those who did not attend (Kleiman and Liu 2014). In a Canadian nationally representative sample of 36,984 individuals, religious frequency was associated with fewer suicide attempts, even after adjusting for social support (OR = 0.38; 95% CI 0.17–0.89) (Rasic et al. 2009).

In a Brazilian case-control study (110 subjects who attempted suicide and 114 controls with no history of suicide attempts), religiousness was related to about a 50% decrease in the risk of suicide attempts, after controlling for other relevant risk factors (Caribé et al. 2012).

In a 14-year longitudinal study of 89,708 US women, after adjusting for demographic variables, lifestyle factors, medical history and depressive symptoms, weekly attendance at religious services was associated with seven times lower suicide rates compared to those who had never attended (VanderWeele et al. 2016).

6.2 *Summary*

R/S beliefs and practices have consistently been shown as important protective factors against suicidal attempts and deaths. However, there is a lack of controlled studies and clinical trials evaluating whether interventions based on R/S may contribute to reducing suicidal behaviour and controlling risk factors.

7 *Substance Use and Abuse*

Harmful alcohol use is related to more than 200 diseases, including liver cirrhosis and cancers. In 2012, about 3.3 million deaths or 5.9% of all deaths worldwide were attributed to alcohol. In that same year, 5.1% of the global burden of diseases were attributed to alcohol consumption (Global Status Report on Alcohol and Health 2014). It is estimated that in 2009, 149–271 million people used illicit drugs worldwide. Several adverse health outcomes, such as mental disorders, road accidents,

suicide and violence are related to cannabis, opioid, cocaine and amphetamines use (Degenhardt and Hall 2012).

7.1 Relationship Between R/S and Substance Use and Abuse

There is strong and consistent evidence that alcohol use and abuse is less frequent among those who have higher levels of religious involvement. A review of 278 quantitative studies examining the relationship between R/S and alcohol found that 240 (or 86%) reported less alcohol use/abuse among the more religious, the same proportion in prospective studies (86% of 49 studies) (Koenig et al. 2012).

Results are similar regarding illicit drug use/abuse. From 185 studies, 155 (84%) reported an inverse relationship between R/S and drug use/abuse. Of the 35 prospective cohort studies, 33 (94%) found baseline R/S predicting less future drug use/abuse. Over 70% of these studies were done with young individuals (adolescents, university students and young adults) (Koenig et al. 2012). These findings are important because there is evidence that experimental drug use in childhood and puberty is related to a higher risk of further development of dependence than when the use starts in adulthood (Nappo et al. 2010).

This protective effect of R/S has been reported by several national surveys in different countries. In a US national survey, the proportion of people who drink alcohol among those who attended church less than twice a month or did not attend was twice that of those who attended a church two to four times a month. The likelihood of alcohol use in the last year for those who said religion was not important in their lives was 50% higher than among those who reported that religion was important in their lives. Importantly, this association does not appear to have been mediated by social support and mental health status (Edlund et al. 2010).

Data from 11,169 women in the three waves of the National Alcohol Survey in the USA (2000, 2005 and 2010) were used for analyses of religiosity regarding lifetime alcohol use and harmful consumption of alcohol and drugs in the last 12 months. High religiosity was associated with lifetime alcohol abstinence and was found to be protective against harmful alcohol consumption and drug use (Drabble et al. 2016).

One of the largest surveys in Central America examined the relationship between religion and substance abuse in a randomized sample of 17,215 high school students between the ages of 12 and 20 in Panama, Costa Rica and Guatemala. Beliefs of adolescents in God were related to a lower likelihood of drunkenness (OR = 0.96, $p < 0.001$) (Kliewer and Murrelle 2007).

In a Brazilian national sample of 5040 people, those whose main leisure activity was to go to parties, bars and clubs were 73.3% more likely to have used drugs than those involved in cultural, sports or religious activities (Bastos et al. 2008). In a nationally representative sample of 12,595 Brazilian university students, about 40% regularly attended religious services. Compared with those who had regular attendance, students who did not regularly attend religious services were more likely to

use alcohol (OR = 2.52; 95% CI 2.08–3.06), tobacco (OR = 2.83; 95% CI 2.09–3.83), marijuana (OR = 2.09; 95% CI 1.39–3.14) and other drugs (OR = 1.42; 95% CI 1.12–1.79) (Gomes et al. 2013).

7.2 *Interventions Based on R/S for Substance Use and Abuse*

Despite observational evidence clearly showing R/S as a protective factor for alcohol and drug use/abuse, studies are still needed to investigate the impact of R/S interventions on the process of recovery from alcohol and other substance disorders.

In Brazil, a qualitative study conducted in 21 religious institutions in São Paulo evaluated 85 individuals who had been abstinent for at least 6 months and who had used non-medical religious resources to treat substance dependence. Frequent prayer, described as a form of direct contact with God, was one of the main strategies for preventing relapse and controlling cravings for the drug (Sanchez and Nappo 2008).

Mutual-help organizations, based on 12-steps, such as AA, have a spiritual orientation. The fundamental element of this approach is the premise that there is a “Higher Power” and the use of prayer and meditation is encouraged. Six of the 12-steps refer to God (Galanter 2007). The main recovery mechanism is identified as a “spiritual awakening” brought about through the completion of the 12-steps (Kelly et al. 2011).

Regarding research evidence of the 12-steps programme’s effectiveness, a Cochrane review evaluated eight trials involving 3417 people and found that AA may help patients to accept and maintain treatment (Ferri et al. 2006). A review showed that people who received professional treatment and participated in spirituality-based support programmes (such as AA) were more likely to remain sober than those who received only professional treatment (Koenig 2009). Another AA effectiveness study pointed out that among those attending AA (Kaskutas 2009), abstinence rates were twice as high as those of non-attendees.

7.3 *Summary*

There is strong evidence that R/S is an important preventive factor against alcohol and substance use/abuse. However, more studies are still needed to evaluate the impact of R/S-based interventions on the recovery process of these disorders. It seems R/S-based programmes, such as the 12-steps used in AA, can contribute in a complementary way to professional treatment.

8 The Dark Side of R/S

Although R/S is usually associated with better health outcomes, this is not always the case. Several studies have shown that negative religious coping (for example, passive deferral to God, reappraisals of God's powers, feeling abandoned or punished by God, etc.) that reflects a controversial relationship with God and spiritual struggles (feeling angry toward God, feeling unforgiven by God, or behaviours contrary to what their religion says) are associated with worse outcomes in mental health and well-being (Stauner et al. 2016; Exline and Rose 2013; Pargament 1997). A prospective study with more than 800 US undergraduate students found that spiritual struggle partially mediated the relationship between trauma and PTSD symptoms. Therefore, spiritual struggle may be an important factor to consider in the cognitive and emotional responses of trauma victims as a potential mechanism in the development and maintenance of PTSD symptoms (Wortmann et al. 2011).

Data from a nationwide online survey of US adults investigating links between spiritual struggles and depressed affect, anxiety, phobic anxiety and somatization suggest that there is a direct correlation between spiritual struggles and these distempers (Ellison et al. 2013).

Patients with obsessive compulsive disorder may have religious content obsessions or compulsive behaviour (praying repeatedly, going to confession or other religious rituals) to relieve their anxiety. This kind of OCD is more common among religious people than people who do not have religious involvement (Steketee et al. 1991; Greenberg and Witztum 1994).

Another "dark side" of religiousness is when mental health care is replaced by religion, when they are seen as mutually exclusive and not complementary. Some religious groups can advise their members not to look for specific mental health services (because only God can cure, or because psychiatric drugs are not from God, etc.) (Baltazar 2003; Alves et al. 2010).

8.1 Summary

Some symptoms of mental disorders can be influenced by religious beliefs; negative religious coping and religious struggles seem to increase the intensity of the symptoms. Some religious groups and practices discourage the pursuit of mental health services because of fanaticism and/or oppressive traditionalism.

9 Conclusion

In the last four decades, very consistent evidence has emerged showing an association between R/S and mental health. This can be understood as established knowledge. In general, individuals who have high R/S involvement have lower rates of depression, suicidal behaviour, and substance and alcohol use and abuse.

Despite some inconsistent results, studies reveal that R/S seems to be more protective than harmful in helping people cope with anxious symptoms. The relationship between R/S and psychotic disorders remains unclear. But there is consistent evidence that religious coping is frequent among psychotic patients and that it is needed to differentiate non-pathological religious and spiritual experiences from psychotic symptoms.

Among the areas that deserve more study are understanding the mechanisms of the R/S-mental health connection and how to translate the available knowledge to clinical practice. The evidence about possible mechanisms of the R/S and mental health relationship is still controversial and inconsistent. The main proposed pathways have been: greater purpose and meaning in life, optimism, generosity and gratitude, social support, self-esteem, cognitive framework (sense of coherence, meaning, resilience), healthier lifestyle habits, corporal sanctification, positive affect, coping with stress and adherence to treatment.

There is some evidence that R/S interventions or spirituality-adapted treatments can be effective in the treatment of mental health issues and mental disorders. However, more studies are needed to assess which are the “effective components” of these interventions, which patient profiles would benefit from it and how to ethically deliver them.

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Spirituality, Religiousness and Physical Health: Scientific Evidence



Marcelo Saad, Jorge Cecilio Daher Jr, and Roberta de Medeiros

Abstract Currently, one can find numerous longitudinal studies that examined the relationship between religiousness-spirituality (R-S) and health, with very good control for potential confounders. In most of these studies, the association is demonstrated, suggesting evidence of a protective effect of R-S factors on physical and mental health, quality of life, and longevity. The statistical correlation between R-S and health was found for several health-related outcomes, especially in cardiovascular diseases. Although causality can not be definitively established, the evidence that at least part of the association is causal seems quite strong. The R-S factor that seems most strongly associated with health is the frequency of attendance at religious services. The R-S dimension is associated with greater longevity in people in the most varied conditions. However, in some population subgroups, the benefit of this association seems to be greater. The mechanisms of action of R-S on health are not fully described, but they should include a combination of neuro-psycho-immune endocrinology pathways, encouragement of healthier behaviors, and social-congregational factors. In the other direction, under certain conditions, adverse health effects from R-S interpretations have been documented, with effects exactly opposed to those cited. Future studies should be designed in order to fill current gaps and to guide how this knowledge could shape medical practice.

Keywords Religion and medicine · Spirituality · Longevity · Psychoneuroimmunology · Psychophysiology · Integrative medicine · Metaphysical mind-body relation

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1 Introduction

The field of psychosomatic studies has opened a fundamental path to understand what are health, illness and healing, since mind and body relationships play important roles in such states. As psychosomatic research goes on, the breadth of mind-body interactions is progressively mapped. An old interpretation posed mind and body as two different entities, with few minor relationships, giving emphasis on biology. Nowadays the concept has evolved to consider mind and body as two components of the same entity, with many relationships of great importance, playing an important role in health and illness. In this conception, mind and body may have deeper connections, such as that ones supported by ancient practices, religious traditions, and contemplative approaches. To paraphrase Shakespeare (in Hamlet): we could say "... there are more things in mind and body than are dreamt of in our philosophy" (Saad and deMedeiros 2017).

Health is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." In this definition, adopted in 1948 by the World Health Organization after its foundation, the spiritual dimension was absent. However, in 1999, the 52nd. Assembly of this institution proposed an amendment to insert spiritual well-being into their concept of health (World Health Organization 1999). Although this amendment has not been implemented, its mere proposal already shows the importance of the subject. In other chapters of this book, the definitions of spirituality and religiousness are explored, as well as the interrelationship of these concepts. Although religiousness and spirituality are distinct constructs, the overlap between them is remarkable and consistent (Ammernan 2013). Therefore, the present text adopts the term religiousness-spirituality (R-S) to refer to the human dimension related to meaning, purpose and transcendence (Saad and deMedeiros 2012).

The earliest empirical studies on R-S and health began to appear during the 1950s and increased most substantially during the 1980s. Research continued to expand rapidly, with an increasing volume of studies, many of them with rigorous methodology. Currently, one can find numerous longitudinal studies examining the relationship between R-S and health, with very good control for potential confounders. In most of these studies, such associations are demonstrated, suggesting evidence of a protective effect of R-S factors on physical and mental health, quality of life and longevity (VanderWeele 2017; VanderWeele et al. 2017).

2 Religiousness/Spirituality and Physical Health

The significant correlation between R-S and health was found for several health-related outcomes, especially in cardiovascular illnesses such as heart disease (e.g., myocardial infarction) and circulatory dysfunction (e.g., arterial hypertension or

stroke). Literature cites also improved cholesterolemia, better outcomes in functional limitation, better global health self-assessment, and even reduced hospitalization need and length (Zimmer et al. 2016). Although causality cannot be definitively established, evidence that at least part of the association is causal seems quite strong.

A detailed monograph (Koenig 2012) cited 121 studies examining the relationships between R-S and longevity. Most of the reviewed studies were prospective, in which R-S is assessed as a predictor of mortality during follow-up, even controlling for other interfering factors. Considering the 63 methodologically more rigorous studies, 47 of them (75%) showed R-S is a significant predictor of greater longevity. The effects are particularly strong for the frequency of participation in religious services. Aspects related to R-S are related to lower blood pressure, better cardiovascular function, lower coronary artery disease, better immune function, better endocrine function, and subjective well-being (Koenig 2012). Additionally, several clinical and epidemiological studies suggest people with good R-S rates are healthier and require less access to health services (Williams and Sternthal 2007).

The duration of effects from R-S on physical health can be quite long-lasting. Researchers (Tobin and Slatcher 2016) examined the relationship between past R-S participation in previous 10 years (by attending R-S activities) and present religious coping (both the positive form as well as religious struggling) and salivary cortisol levels (which reflects the level of psychological stress). The study found R-S participation 10 years ago had a significant correlation with a healthier salivary cortisol profile in the present. In the opposite direction, the current presence of religious struggle was associated with an unhealthy profile of salivary cortisol. However, the positive health effects can be lost on people who leave the faith of their youth and carried over to no religious affiliation in adulthood. A survey (Fenelon and Danielsen 2016) found the disaffiliated people (who grew up religious but changed to no affiliation) had worse physical health and lower well-being than the consistently affiliates. Similar relationships were present when the disaffiliated people were compared to the consistently non-affiliated group (people raised without religious affiliation and thus remained) and with converted group (people raised without religious affiliation and who became religious). Differences in health and well-being were statistically significant and controlled for other variables.

A contemporary model for studying the impact of R-S on health is to quantify its influence at a cellular level by measuring the length of telomeres and the concentration of telomerase. Cellular biology describes these parameters function as a chromosomal clock, an indicator of cell health associated with longevity. Past studies have already shown whether stress affects these cellular health parameters, and whether stress management would have the opposite effect (Bersani et al. 2016). Recent studies that measured telomere length in leukocytes from a healthy adults sample have shown a significant relationship of these measures with religious involvement (attendance, prayer, religiousness), even controlling for potential covariates (Hill et al. 2016).

3 Religious Services Attendance

In addition to increasing scientific evidence of the association between R-S involvement and various health indicators, there is evidence of association between more frequent involvement in religious activity and reduction in mortality risk (Williams and Sternthal 2007). A growing body of scientific studies has demonstrated a positive, clear and consistent association between communal religious involvement and beneficial effects on physical health (Koenig 2015). In such literature, the measure that seems most strongly associated with health is attendance at religious services. More frequent participation in religious activity is associated with many biological markers that are indicative of good health in old age, leading to significant decrease in all-cause mortality and improvement in many other health outcomes (Hill et al. 2014).

Regular attendance to a religious service could contribute to health stability through various pathways, including behavior modeling, building a community and social role, or supporting a sense of self-esteem and purpose. Activities that encourage aid, such as volunteer work, are common among congregation members and have been shown to reduce mortality (Powell et al. 2003). Community forms of religious participation seem to affect health more powerfully than private practices. Religious social support can be deeper and broader than the support gained in a secular environment. Attendance at religious activities appears to be a stronger predictor of longevity and healthy outcomes than individual spiritual or religious practice or identity. Longitudinal studies published in recent decades have found significant associations between regular attendance at religious services and reduced risk of early mortality both in community populations and in some patient populations, such as those undergoing surgery (Larson et al. 2002).

Some researchers tried to quantify the impact of such relationship on the extension of life span. Koenig cited one systematic review and two meta-analyses that confirmed the relationship between R-S and longer life span (Koenig 2012). The survival of people with frequent participation in religious activities was increased, respectively, by 37%, 43% and 30% (mean of effect 37% considering these three papers). According to this author, an increase in survival of 37% is as clinically relevant as the effects of lowering cholesterol, regular medication use and adherence to exercise in survival after myocardial infarction. Other authors agree the practical significance of the association between regular religious participation and better overall health is comparable to commonly recommended practices, such as fruits and vegetables consumption, therapy with statin-type agents (Lucchetti et al. 2011; Hall 2006), or even comparable to belong to high socioeconomic level (Oman et al. 2002).

Research suggests religious participation may decrease the death odds within a 5- or 10-year follow-up, with a clear dose-response relationship (i.e., greater attendance associated with mortality reduction) (VanderWeele et al. 2017). Hummer reported those attending services more than weekly had a life expectancy of about 7 years longer than those who never attended (Hummer et al. 1999). In healthy individuals, there is a strong and consistent reduction on the mortality risk in reli-

gious attendants. This association is found in prospective studies, and is often graded. This reduction is approximately 30% after adjusting for the major confounding factors, dropping to 25% after further adjustment (Powell et al. 2003). On the other hand, infrequent religious participation (never, or less than weekly) was associated with significantly higher mortality rates due to circulatory, oncological, digestive and respiratory causes (Oman et al. 2002).

A recent study (Li et al. 2016) followed 74,534 women for 18 years, studying attendance at R-S meetings and services, and verifying the association between this factor and the all-cause mortality rate. The study found a progressively and linear association. Women who attended less than once a week had a 13% lower mortality rate than those who never attended. The reduction in mortality increased to 26% among those who attended once a week, and 33% to those who attended more than once a week (always compared to those who never attended). In another recent and relevant north American study (VanderWeele et al. 2017), 36,000 women were followed by 8 years. Regular frequency of religious groups was associated with a 36% decrease in overall mortality, even after controlling for sociodemographic and health variables. Other indicators of religiousness considered in this study had a much lower impact.

4 Greater Benefit in Population Subgroups

The R-S dimension is associated with greater longevity in people in the most varied conditions. However, in some population subgroups, there appears to be greater benefit in this association. Research still needs to move forward to better specify in what subgroups this association is most relevant to. A systematic review (Chida et al. 2009) found R-S activities (e.g., church attendance) were associated with reduced mortality in studies with healthy populations, but not in studies with sick populations. This finding is different from other studies, with patients with congestive heart failure, in whom R-S reduced the mortality risk by 20% (Park et al. 2016). Thus, one can infer both populations (healthy and sick) are prone to be benefited.

There may also be gender differences in the associations between religious participation and longevity. In many researches, the most important effects tend to be observed in women (La Cour et al. 2006; Strawbridge et al. 2001). Currently, there is no clear explanation for such gender difference. One author (Zhang 2008) postulated the greater effect prevalence occurs mainly in certain vulnerable groups in disadvantaged socioeconomic conditions, such as women (discriminated in some social contexts) and people with poor health.

In the quest for the subgroups of major beneficiaries of the positive relationship between R-S and longevity, one must consider the social context in which research is done. Most of research in which this positive association is statistically significant is done with data from North American populations. An author explored the same association in 59 countries and showed it is found in a relatively small number of places, especially in those where religiousness represents a social norm (i.e., it is

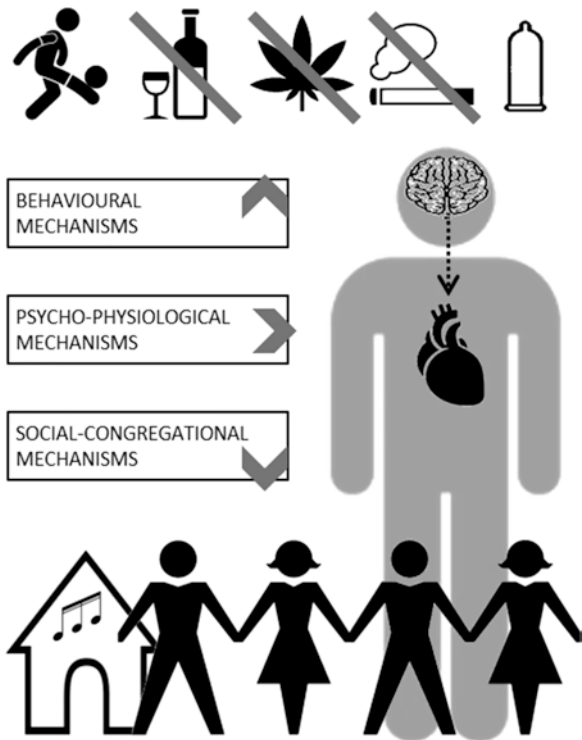
common and socially desirable) (Stavrova 2015). According to this author, even in the United States, the association of R-S with reduced mortality depends very much on the regional level of religiousness. This distribution may suggest the benefits of R-S to health and longevity would be more present in populations from more religious regions.

5 Mechanisms of Action

The mechanisms of action of R-S on health are not fully described. The effects must be due to a combination of complex and multifaceted factors (Moreira-Almeida 2013). More studies are needed to determine precisely which biological factors mediate the relationship between R-S and health. Among the variety of potential pathways, some mechanisms are mentioned below. Fig. 1 schematically illustrates the three major groups of mechanisms of action.

A. Psycho-Neuro-Immuno-Endocrine Pathways: Psychoneuroendocrinology and psychoneuroimmunology provide a framework for understanding the role of mind over organic functions (Vitetta et al. 2005). They describe how behavior interacts with the endocrine and immune systems, mediated by the nervous sys-

Fig. 1 Schematic illustration with the three major groups of mechanisms of action of R-S on health



tem. The brain regulates these functions through autonomic efferent pathways that innervate the immunoactive tissue, and also through neuroendocrine hormones, such as corticotrophin releasing hormone or substance P, which regulate the cytokine balance. These interactions are highly modulated by psychological factors.

For several diseases, the relevance of psychoneuroimmunological factors has already been demonstrated (Ziemssen and Kern 2007). Evidence strongly indicates mental state (the association of emotional states and behavioral dispositions) can directly and significantly influence the physiological function and, in turn, health outcomes (Vitetta et al. 2005). Sustained stress response has a relationship to many biological processes, with detrimental effects on diverse organs and systems, and consequent negative changes in overall survival. Social stressors and lifestyle choices can be a significant trigger for disease, which can affect longevity.

The stress response initiates these cycles of interconnection through the sympathetic-adreno-medullary system and the hypothalamic-pituitary-adrenal axis. A key hormone shared throughout the process is cortisol, an extensively studied stress-related hormone. The autonomic nervous system disorder due to stress leads to physical health impairment. Stress reduction through belief has the potential to modulate the physiological effects derived from these systems (Cohen et al. 2007). R-S experiences and practices modulate a variety of systems that can influence descending neural mechanisms. Regular practice of R-S activities can improve autonomic balance, resulting in decreased sympathetic activity and increased parasympathetic activity (Singh et al. 2016). By making life meaningful, the R-S dimension could help patient in coping with adversity. This framework reinforces life satisfaction, optimism, and self-esteem, all of which act to reduce the impact of stressful events. R-S is associated with virtues such as forgiveness, compassion, gratitude, wisdom, and altruism.

In stressful life events, the term R-S coping refers to the use of beliefs, attitudes or practices to give meaning to suffering, thus making it more bearable. The resultant mental drive seems to be important in engaging and facilitating some beneficial psycho-physiological mechanisms, evoking a relaxation response. Systems of meaning and feelings of strength help deal with stress and adversity (Williams and Sternthal 2007). R-S beliefs allow the individual to reduce stressful reactions by reinterpreting adverse events. This reframing process may provide greater psychological resilience in face of negative life events, and the individual may react to them with more hope and optimism.

B. Encouragement to healthy behaviors: Higher R-S scores could imbue a sense of self-regulation and self-control as they are significantly related to greater commitment to beneficial health behaviors such as exercise practice, balanced diet, alcohol and smoking avoidance, drug addiction, and risky sexual behavior (Koenig 2015). As reported before, R-S protects against cardiovascular disease, and this effect is largely mediated by the healthy lifestyle it encourages (Powell et al. 2003). Perhaps even 30% of the protection conferred by R-S can be explained by better health behaviors (especially physical activity) among regu-

lar participants to R-S activities (Musick et al. 2004). Evidence supporting the importance of a healthy lifestyle adoption for the relationship R-S and health is the finding that mortality rates among people who joined the Seventh-Day Adventist Church in childhood are lower than rates of members who joined it in adulthood (Heuch et al. 2005).

- C. **Social and Congregational Factors:** The R-S action on health can be enhanced through both a tangible social support (e.g., supply of financial resources and transport for treatment) and an intangible social support (e.g., a sense of trust derived from belonging to the group). Faith institutions are a meeting point for interaction, exchange and reinforcement. The health of individuals is often supported by engagement with their religious congregation, through the protection from social isolation, providing support in times of adversity. This communion also lead to strengthening of family and social relationships, giving the individual a sense of belonging and self-esteem. On the other hand, the act of giving social support to church members works as a stress-buffering on the provider (Krause 2006). To give help to others, more than receive help, could explain part of the stress reduction effect (LaCour et al. 2006). Moreover, the very R-S characteristics of the region in which a person lives could have effects on his/her mortality risk. A study (Jaffe et al. 2005) goes even further, suggesting an influence from the neighborhood R-S activity over health parameters of other residents in the same district.

6 Potential Negative Effects of R-S

For many people, R-S beliefs and practices are a source of comfort and wisdom to help them to make sense of what would otherwise seem insane. Such values often prescribe a way to address the basic issues of meaning, value, and relationship. R-S beliefs and practices can help people by providing a sense of control, understanding, confrontation, and interpretation of events or experiences. In the other direction, under certain conditions, harmful effects on health from some religious beliefs and behaviors have been documented, derived from specific doctrinaire interpretations (Williams and Sternthal 2007). Negative R-S coping can lead to internal conflicts related to medical issues, which may predict an increased mortality risk and worse clinical outcomes (Pargament et al. 2001), even after controlling for many other confounding variables. R-S suffering, like the sustained feeling of having been abandoned by God, tends to increase early death chance and medical treatment refusal for R-S reasons (Larson et al. 2002).

Spiritual struggles are longitudinally associated with poorer health, and negative congregational interactions are associated with lower welfare measures (VanderWeele 2017). Religious misconceptions can induce anxiety by promoting guilt and shame, stimulating adverse attitudes towards outsiders, and encouraging trust in faith healing as a substitute for medical care. A classification for potential

R-S struggles was formulated by Exline (Exline et al. 2014). In this classification, such conflicts may fall into one of these categories:

- A. Supernatural struggles:
 - A.1. Divine struggles: related to the concept of deity (anger or disappointment with God, feeling of abandonment or punishment by God).
 - A.2. Demonic struggles: feelings of oppression or persecution by evil forces, dark spiritual beings or malevolent spiritual entities.
- B. Interpersonal struggles: based on beliefs or previous negative experiences with other people or with religious institutions.
- C. Intrapersonal struggles:
 - C.1. Moral struggles: Internal conflict over beliefs about what is right or wrong.
 - C.2. Ultimate meaning struggles: Difficulty in finding meaning or purpose in specific events, or in life as a whole.
 - C.3. Doubt struggles: distressing questions about beliefs, teachings or experiences.

7 Clinical Implications From This Knowledge

Medical community must find the practical value or clinical relevance of the documented relationships between increased R-S activity and longevity. Since the patient R-S may have an impact on his/her physical and mental health, it should be more valued and explored on the clinical encounter. Notwithstanding, what could the health professional do differently, from the knowledge of such connections? “Religious participation” is not a therapy modality that could be prescribed. However, the health professional needs to be aware particular beliefs or behaviors influence their patients health and well-being, since people could choose to live differently if such information were present at the consultation. The patient R-S, as a strategy of positive coping with the disease, can favor the reestablishment of his/her health.

Many representative medical organizations have emphasized the need to address R-S issues in patient care practice as well as in the educational training of healthcare professionals. This group of organizations includes American Psychiatric Association, American Psychological Association, Accreditation Council for Graduate Medical Association, American Academy of Family Physicians, American College of Physicians and Association of American Medical Colleges, among many others (Chattopadhyay 2007).

Health institutions also can enhance their role on public health promotion by partnering with health programs developed in faith-based organizations. Such programs may focus on primary prevention, general health maintenance, specific approaches (such as cardiovascular health), or support for specific diseases (such as cancer). Health programs in faith-based organizations can significantly improve

health outcomes, including reduction in blood cholesterol, blood pressure, weight and symptoms of diseases, besides stimulating preventative care such as increased use of mammography and breast self-exam (DeHaven et al. 2004).

Faith-based health organizations are relevant to any public health consideration in the world, especially in a low-income population. While there may be some strangeness about the partnership between religious communities and health services, such association has the potential to be an important care provision source. There is increasing documentation pointing to its positive effect on treatment outcomes (Tomkins et al. 2015). Policy makers and religious groups strongly influence health care delivery and use, but generally they work independently. Exploring the interface between them can improve health care supply and use, especially for marginalized populations. To achieve it, health professionals, religious leaders and policy makers need to work together (Tomkins et al. 2015).

8 Future Directions

The sum of all previously mentioned data justifies further research aimed at examining specific aspects of the associations between R-S and physical health, as well as the potential relevance of such associations for clinical practice. There are still many gaps in current knowledge about the relationship between R-S and health. Future studies should address the needs described below.

Methodology More methodologically sound studies are needed, such as longitudinal studies with careful control for confounders. Many of the available studies are methodologically weak. More studies should be encouraged outside the United States and Europe. The concepts of religiousness and spirituality should also be better defined by expert researchers.

Causality Many data are from cross-sectional studies, limiting the researchers ability to make causal inference. Positive results are not universal and are context-dependent. In addition, some of the variables, such as many functionally disabling diseases, may themselves affect participation in religious service, reversing the causality of the relationship.

Health Outcomes Evidence for reducing mortality and for many clinical parameters is relatively strong, but effects over specific health outcomes may still require more careful examination. There are still flaws to support the hypothesis that R-S slows cancer progression or improves recovery from an acute disease. (VanderWeele 2017).

Mechanisms Among the various factors supposedly responsible for the associations between religious participation and health, the exact contribution of each one is difficult to be precisely quantified. More work will be needed using methods that evaluate mediation with time-varying exposures and mediators with time-varying

confounding to adequately quantify the relative contributions of these different mechanisms.

To advance in this direction, some study models are suggested for future research (Lucchese and Koenig 2013): (A) Prospective observational studies, especially those examining the interaction between R-S and better response to pharmaceutical, biological and surgical treatments; (B) Experimental studies to determine whether R-S involvement can influence physiological parameters in response to a laboratory-induced psychological or physical stressor; and (C) Randomized clinical trials evaluating the effects of a R-S intervention on clinical or surgical outcomes (e.g., effect of chaplain's visit before cardiac surgery over the postoperative recovery rate).

9 Closure

There is growing evidence on the correlation between R-S participation and physical health. In addition to reducing mortality, research data point to a better quality of life and symptom control (Petri et al. 2015), also showing a reduction in morbidity. The interface between R-S and health can be provocative and controversial; R-S is often seen as a private and subjective area that lies outside the therapeutic context. But patient beliefs can have a substantial impact on the construction of disease meaning, coping behavior, and treatment preferences (Saad and deMedeiros 2012). Thus, medical communities need to understand and accept that the patient's R-S is part of their own healing journey. A fully patient-centered care can only be achieved through considering the importance of patients R-S dimension and removing all obstacles to its integration to the healthcare plan.

10 Practical Points for Professionals and Educators

- Religiousness-spirituality (R-S): combined term related to the level of well-being linked to transcendent elements, such as meaning, purpose, connectivity.
- In most research on the benefits of R-S over health, quality of life and longevity, the association is statistically significant and clinically relevant.
- R-S affects positively physical health, and it is mainly related to better immune function, hormonal function, cardiovascular health, and longevity.
- The mechanisms of action for such associations are not fully described, and they are probably due to a combination of complex and multifaceted factors.
- The effects of R-S over longevity are particularly related to attendance to religious services, and they are more noted on women and on religious societies.
- Inadequate religious interpretation can produce R-S struggling, with worse physical and mental health parameters, and reduced longevity.

- However, to “prescribe” R-S activities for health purposes is not possible. The challenge is how to integrate all this knowledge into clinical practice.

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Religious and Spiritual Interventions in Health: Scientific Evidence



Juliane Piasseschi de Bernardin Gonçalves and Homero Vallada

Abstract Since the end of twentieth century, a crescent number of studies have reported the influence of religiosity and spirituality on health. In view of this evidence, strategies have been proposed for stimulating this dimension in individuals, especially patients coping with diseases. However, only a few studies manage to apply careful and sound methodological designs to assess the effect and mechanisms of religious/spiritual interventions (RSIs) involving randomized clinical trials. In these studies, RSIs presented similar or superior results when compared to other complementary approaches in alleviating suffering or promoting health. The most common reports in the literature associated with RSIs are: a reduction in anxiety and stress symptoms, a decrease in the intensity of addictive drug consumption, diminishing depressive symptoms and lowering levels of emotional exhaustion in health professionals. Nonetheless, the RSIs applied in these studies are quite heterogeneous, and therefore, in the future necessitating a standardization of procedures and training of facilitators or health professionals. In addition, emphasis has also been placed on the need of a rigorous methodological design for this type of intervention in order to obtain a more reliable and robust data. In conclusion, what has already been observed in clinical practice, is now in process to be confirmed in well-conducted clinical trials. The search and evaluation of the RSIs will also help to understand the underlying mechanisms of this type of intervention and to contribute to developing better strategies of complementary health treatment.

Keywords Spiritual and religious interventions · Spirituality · Religiosity · Clinical trial · Meta-analysis · Anxiety · Depression

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1 Introduction

Since the 1990s has been a growing interest in the religious and spiritual aspects of patients and their relationship to health and the disease process (Koenig et al. 2012). Particularly over the last decade, the number of publications on the subject has increased exponentially, with results showing a decrease in symptoms of physical and mental illnesses, improved quality of life and lower mortality (Chida et al. 2009; Koenig et al. 2012). Therefore, some studies have sought to promote clinical outcomes through interventions addressing this dimension.

The benefits of complementary health treatments such as yoga, Tai Chi Chuan, meditation and acupuncture have been documented in the literature. Following these examples, some researchers have proposed complementary health approaches centered on religiosity/spirituality (R/S), integrating themes such as praying and a reflexive discussion of moral and spiritual values. Subsequently, different presentation of this approach, generally called religious/spiritual interventions (RSIs), were tested in controlled clinical trials. Since those studies investigated different populations, in different settings, using specific methodologies for each study, the outcomes were also diverse, hampering comparisons between studies.

However, a systematic review and meta-analysis are two approaches to understand and answer whether RSIs from a variety of clinical trials present a general positive effect as a complementary health treatment. Very briefly, a systematic review study is a systematic method to collect secondary data (published studies), critically assess the quality of these studies and synthesize their important aspects. A meta-analysis investigation is a statistical analysis that combines the results of a number of previous published scientific studies (the studies selected previously by a systematic review investigation) in order to confirm a particular effect, i.e. the benefit of RSIs.

In addition, given the challenges inherent to conducting randomized clinical trials (Schulz et al. 2010), reports addressing RSIs are less frequent in the medical literature when compared with other forms of clinical trials. Despite this, there are already four systematic reviews and meta-analyses on RSIs at the moment. All five studies presented the RSIs as similar and/or superior to other complementary therapies in health (Smith et al. 2007; Oh and Kim 2012; Gonçalves et al. 2015, 2017; Kruizinga et al. 2016).

Nonetheless, in order to consider and reflect over the complexity of the area, the present chapter addresses the relevant information about RSIs as a complementary health therapy. Questions are presented throughout the text with the purpose to highlight the main themes. The chapter is based on our own published studies (Gonçalves et al. 2015, 2017) These two studies screened seven databases to include studies of RSIs, selecting initially more than 4000 articles, but eventually only 39 fulfilled the inclusion criteria. These selected 39 studies were investigations which presented detailed description (i.e. proposed protocols), and a sound methodology (i.e. the use of proper randomization, information about compliance, about drop-out etc).

2 What Are Religious/Spiritual Interventions (RSIs)? Why Should They Be Addressed in Health Care?

Three important points clinically justify these interventions. The first point is the large number of patients who seek the religious and spiritual dimension as complementary clinical treatment during the course of a disease, whether in religious institutions or privately. The second point concerns the need many patients have to address their R/S dimension with physicians and health professionals during treatments. The third point involves reports that health professionals feel satisfied and motivated when patients bringing the subject into clinical practice improve.

In fact, the scientific evidence that shows the impact of R/S on health is relevant. However, it is noteworthy that most of the evidence in the literature is derived from observational studies, and although this may suggest potential causal factors, randomized controlled trials remain the gold-standard for evaluating interventions in health (Schulz et al. 2010).

Consequently, some researchers have questioned whether the R/S can be stimulated in patients to positively influence their clinical outcomes. In the last few decades, different interventions have been proposed centering on health messages through the encouragement of the spiritual dimension and religious beliefs of individuals, referred to as RSIs. The underlying principle is to influence clinical outcomes by remodeling the person's thinking, offering social support, promoting resilience, understanding and acceptance of the disease and encouraging faith (Bormann et al. 2008; Hoguelet et al. 2011; Bowland et al. 2012).

Thus, RSIs seek clearer more robust answers regarding the actual clinical applicability of R/S concepts in health. It is also important to bear in mind that religiosity, when viewed in a punitive way as a "divine punishment", can increase levels of anxiety, depression and even mortality (Pargament et al. 2001). Although these data are scarcer in the literature, understanding how to stimulate positive clinical outcomes while preventing negative ones is a critical point. Clearly, given the complex and multifaceted nature of the subject, this question will not be elucidated by a few studies alone. However, investigations exploring these boundaries can present arguments, promote reflection and provide guidelines on the matter.

3 What Do RSIs Address? How Are These Interventions Delivered? Who Applies/Facilitates These Protocols?

Before evaluating the outcomes found in clinical trials, it is opportune to outline how the R/S theme has been incorporated into health interventions. Two main focuses emerge from the articles reviewed: spiritual and religious. The spiritual approaches encompass moral values, belief in a "higher power", stimulus for coping and transcendence, without necessarily a religious affiliation, and may include specific religious groups as well as atheist and agnostic individuals, without restrictions

or conditions imposed (Bormann et al. 2008; Kelly et al. 2011; McCauley et al. 2011; Breitbart et al. 2012; Elias et al. 2015).

On the other hand, the religious approach draws on specific beliefs and traditions for certain religious affiliations, e.g. Catholic, Jewish and Muslim (Duru et al. 2010; Rosmarin et al. 2010; Binaei et al. 2016). Both religious and spiritual aspects have been adapted for use in different approaches such as pastoral services, meditation and also psychotherapy, demonstrating a variety of ways of introducing the subject into clinical practice.

The most frequent type of RSI proposed in the literature is the psychotherapeutic approach. Some authors used known techniques, such as cognitive-behavioral or motivational methods in group discussions, involving 10–12 weekly sessions in an outpatient setting (Miller et al. 2008; Kelly et al. 2011; Breitbart et al. 2012). The protocols were facilitated by, either health professionals with prior knowledge of the R/S topic or by religious ministers trained by professionals to discuss health and disease.

Other studies involved spiritual meditation. This approach was based on religious and/or spiritual phrases or thoughts chosen by the participants to be used in the meditation technique (Bormann et al. 2006, 2008, 2009; Oman et al. 2006, 2008). The facilitators, who were the authors, brought the participants together before and/or during the study period and trained them for the procedure. The protocols were typically performed weekly.

There were interventions that encompassed audios, videos or books produced by the authors for individual use, followed by questionnaires or group discussions with participants (Moritz et al. 2006; Rosmarin et al. 2010; McCauley et al. 2011). The content was developed to help cope with the disease: videos included spiritual strategies focusing on compassion or religious beliefs, while books and audios were based on aspects of spirituality and transcendence.

Similarly, RSIs based on guided visualization consisted of a facilitator presenting a proposal of mental visualization of divine/spiritual beings to accompany participants on their journey of recovery (Elias et al. 2015; Guilherme et al. 2016). Mental imagery of lights enveloping the environment and love connecting individuals with their rehabilitation were also suggested.

Regarding protocols essentially focused on religious traditions, there were those produced in church environment and the chaplaincy (Djuric et al. 2009; Duru et al. 2010; Holt et al. 2012; Binaei et al. 2016). RSIs in church environment included readings of scriptures from sacred books in group discussions, group prayers and informative booklets on religious coping for the disease in question. The material was developed by the authors and sometimes discussed with religious ministers (priests, pastors, clergy) who acted as facilitators of the interventions. The authors, in turn, also trained religious ministers on health and disease issues.

RSIs involving chaplaincy were designed for hospitalized patients who received care pre- and post-operatively. The chaplains, facilitators of the interventions, used manuals consisting of rituals (prayers, anointing, among others) and offered religious/spiritual support. Discussions were adapted to patient needs: hospitalization,

postoperative complications, personal problems, as well as emotional and spiritual suffering.

4 Clinical Outcomes

The wide variety of RSIs protocols was used for different populations, investigating different clinical outcomes in each of these groups. For instance, some authors applied spiritual mediation to assess the impact on quality of life on patients with post-traumatic stress. Others used a psychotherapy based on spiritual belief to evaluate adherence and frequency of drinking in alcoholic patients. For instance, using Jewish religion traditions and concepts through audiovisual resources to improve anxiety in Jewish people was a suggested RSI. The clinical horizon of this complementary therapy has broadened, but a key question remains: given the particularities of the RSIs protocols and outcomes proposed by authors for different population, can the effectiveness of these techniques be compared with other complementary treatments in health? All the studies selected in the systematic review seemed to answer this question, therefore we gathered the similar outcomes to exemplify the proposals found in the literature.

4.1 *RSIs in Mental Health*

Most of the clinical trials involve mental health, especially depressive and anxiety symptoms, usually present in different primary diagnoses. Thus, meta-analyses evaluating the effectiveness of these interventions were feasible.

One of the meta-analysis studies compared conventional therapeutic with religious interventions in patients with general psychiatric symptoms. Based on the five final studies included in their review, the author concluded that the use of this type of treatment hinges on patient preference as opposed to its effectiveness (McCullough 1999). Another meta-analysis analyzed 31 articles in psychiatric diseases and showed a medium effect size for the RSIs when compared to conventional treatments (Smith et al. 2007). It is noteworthy, however, that neither of these two meta-analyses considered the risk of bias in the studies selected.

Oh and Kim assessed RSIs in psychiatric diseases, pain and functional states of individuals and also assessed the methodological quality of the studies. They found significant difference in RSIs for anxiety symptoms and depression compared to other complementary treatments (Oh and Kim 2012). The authors were able to separate both symptoms, due to the higher availability of published clinical trials in the period evaluated. However, the heterogeneity of the sample was high, perhaps owing to the divergence in the approaches.

In 2015, our research group also investigated RSIs in mental and physical health, focusing on randomized controlled clinical trials and considering important aspects

of the methodology of interventions without patient and facilitator blinding (Goncalves et al. 2015). We observed that RSIs were associated with a significant reduction in anxiety symptoms, but not in depressive symptoms relative to the control groups. The samples of both symptoms had low heterogeneity in meta-analyses.

Other studies addressed different outcomes that could not be grouped into meta-analysis. Regarding alcohol consumption, two studies were identified. Both studies structured the RSIs as psychotherapy group based on moral and spiritual values applied to drinking. One of the trials found statistical difference for decrease in frequency and intensity of drinking in the long term after treatment (Kelly et al. 2011), while another found the same result only in the fourth month after treatment, in a total follow-up of 12 months (Miller et al. 2008). This second study also showed higher levels of depression and anxiety in patients who participated in the RSIs compared to the standard treatment group.

With regard to patients with schizophrenia, the intervention found was based on a semi-structured interview of the psychiatrist with the patient which conducted spiritual and religious themes and thoughts into the session covering the disease symptoms. The results of the study showed that patients who received RSI did not differ for treatment adherence or social function but exhibited greater willingness to ask for help in treating the disease (Huguelet et al. 2011).

Regarding negative symptoms caused by stress, two studies evaluating posttraumatic stress revealed a significant reduction in stress in both men (Bormann et al. 2008), through spiritual meditation techniques, and women (Bowland et al. 2012), over spiritual physchotherapy approach, compared to the control groups. After protocols of religious and spiritual values designed through audiovisual resources, emotional stress was also reduced in a study involving individuals with this diagnosis (Moritz et al. 2006), but no changes in elderly individuals with chronic diseases were found (McCauley et al. 2011).

The burnout rate among health professionals is another topic raising concern. RSI based in a meditation technique showed a reduction in stress levels and emotional exhaustion in professionals, when compared to other conventional techniques (Oman et al. 2006), and more attention was paid to patient care after the intervention when the topic was discussed in therapy (Huguelet et al. 2011).

Also concerning health professionals, a study evaluated the impact of a spiritual care pedagogy in nursing education on their clinical practice (Burkhart and Schmidt 2012) and found that practioners who received training on patient spiritual care were able to better identify patient needs and promote more care for this dimension.

4.2 RSIs to Promote Quality of Life

In 2016, Kruizinga et al. performed a systematic review and meta-analysis on RSIs in quality of life among cancer patients (Kruizinga et al. 2016). The 12 final studies selected showed medium effect size of RSIs in outcomes assessed up to 2 weeks

after the intervention. However, no statistical significance was found 3 months after the interventions.

The different interventions and scales used in the selected studies in our review from 2015 did not allow a meta-analysis of RSIs on quality of life. Of the four articles on cancer that assessed quality of life, all used religious and spiritual values integrated in physiotherapy sessions, with the exception of one who used a guided visualization (Elias et al. 2015). Two reported statistically significant results of RSIs relative to the control groups (Breitbart et al. 2012; Jafari et al. 2013), while the other two showed no differences (Piderman et al. 2014; Elias et al. 2015).

Regarding other populations investigated, quality of life improved with spiritual meditation in patients with posttraumatic stress (Bormann et al. 2008) and guided visualization in patients with heart failure (Binaei et al. 2016), but no differences were evident for patients with headache who also performed spiritual meditation (Wachholtz and Pargament 2008). The protocols ranged from five to seven intervention sessions and none of the studies followed the subjects beyond 6 months after the interventions.

Quality of life outcomes can be promising, but further research with respect to the scales evaluated and protocols proposed are warranted to better understand the impact of RSIs on this outcome, which may be compromised in several diseases.

4.3 RSIs in Physical Health

With regard to physical health outcomes, such as biomarkers, a number of related studies were identified in the literature. Although the diversity of scales and measures for the same outcomes limited statistical analysis, the results found are described below.

Oh and Kim, in their meta-analysis, evaluated pain outcomes and showed a medium effect size for RSIs when compared to control groups. Although promising results, the heterogeneity of the articles selected was high (Oh and Kim 2012), perhaps due to the inclusion of clinical trials without randomization. In our review, no reduction in pain levels was observed in patients with chronic diseases who watched videos based on religious/spiritual values (McCauley et al. 2011). However, pain tolerance, when assessed in subjects with headache (Wachholtz and Pargament 2008) and in healthy adolescents (Wachholtz and Pargament 2005), both after spiritual meditation technique protocols, showed a significant increase in RSI compared to control groups.

Another aspect evaluated by the RSIs was weight loss. Three studies added R/S themes during physical activity protocols evaluating reduction in body mass index. There were no differences compared to control groups, however, the studies showed similar weight reduction in both groups (Duru et al. 2010; Krukowski et al. 2010). No differences were found regarding changes in eating habits (Djuric et al. 2009).

Blood pressure in sedentary individuals (Duru et al. 2010) was reduced after RSIs compared to a control group, whereas individuals with breast cancer showed

no difference in this outcome, only a reduction in heart rate (Guilherme et al. 2016). Also, with respect to biological outcomes, cortisol levels were evaluated in individuals with acquired immunodeficiency virus (HIV) and proved more reduced, the higher the score on faith's scales (Bormann et al. 2009).

4.4 RSIs Promoting Healthy Behaviors

Some RSI studies have been designed to stimulate and promote healthy attitudes and behaviors. Preventive actions against sexually transmitted diseases were more evident among individuals who underwent RSIs than controls (Margolin et al. 2006).

Adherence to cancer screening tests revealed a significant difference in healthy attitudes for those who had the RSI in one (Holt 2012) of the two studies evaluated. Another study investigated whether RSIs could increase organ donation intention compared to information protocols and found no significant difference (Arriola et al. 2010).

Public health proposals for the general population, especially for the prevention of sexually transmitted diseases, seem to benefit from the addition of the R/S dimension in their approach. Three of the five studies retrieved were designed in a church setting, which may indicate that the collaboration of religious ministers in health can be of great importance.

4.5 RSIs and Protocol Satisfaction

Participants' satisfaction with the intervention protocol offered is an important item to be considered when designing complementary health interventions. A significant difference of RSIs in relation to the other techniques adopted by control groups was reported by populations of health professionals (Oman et al. 2006), patients with generalized anxiety disorder (Rosmarin et al. 2010) and individuals with HIV (Bormann et al. 2008). Drugs users (Margolin et al. 2006) and breast cancer patients (Guilherme et al. 2016) reported no difference in satisfaction between the techniques used.

As outlined above, many patients seek religious and spiritual settings to help cope with their illnesses and for rehabilitation, and many would like to discuss this with their doctors. It is important, therefore, to evaluate the satisfaction of participants in these studies to assess whether the protocol used and approach to the dimension can meet the needs of the specific population.

The variety of the outcomes presented shows that depending on the populations, the benefits from RSIs approaches may be more or less. Also, it is possible that the types of intervention may have an important role on the results itself. The challenge to investigate the R/S on health is noteworthy, however, facing this challenge can help to reveal the real impact this dimension has. It would be interesting if future

studies could evaluate outcomes similar to those already investigated in the current literature, or to use similar protocols, in order to facilitate comparisons between the different studies in health.

5 Directions for Future Research

There is, therefore, a clear need for further studies to enhance the effects and elucidate the mechanisms of action of the R/S dimension in health interventions. Randomized and controlled clinical trials investigated in different reviews and meta-analyses have shown that RSIs may be equivalent, and sometimes superior to, other complementary health techniques.

From the scenario presented, we propose a flowchart (Fig. 1) that assesses the main points to be considered and defined when carrying out RSI studies.

In the first item, after choosing the population to be studied, it is important that the analyzed outcomes are clear and well-defined so that the specific measure chosen (biological markers, scales, among others) accurately portrays the results for the objectives outlined. We suggest the inclusion of different scales that measure spirituality, religiosity, daily spiritual practices, coping, among other previously validated measures, to identify which specific items may be responsible for the effects produced in this type of intervention. For instance, Kelly et al. found significant clinical improvement in drug users that initially had lower levels of spirituality, while those with previously higher levels did not obtain such marked results, suggesting the hypothesis of a “spiritual awakening” in these patients (Kelly et al. 2011). By contrast, Bormann et al. found in their study that patients with higher levels of faith before the intervention had significant reduction in cortisol levels (Bormann et al. 2009). Studies ascertaining this type of relationship can help clarify whether certain populations can benefit more from this type of complementary therapy.

Regarding the second item, the subjects and topics used in both RSI and control groups should be well structured to attain positive outcomes and avoid the negative religiosity mentioned previously. Notably, in order to avoid distortions in messages conveyed in the interventions, some authors consulted religious leaders to adapt the

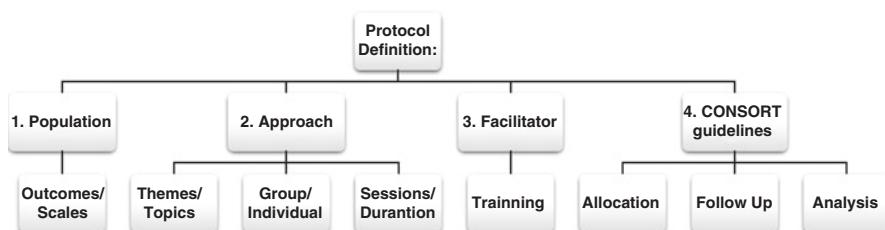


Fig. 1 Flowchart to future research

messages delivered, especially when these focused on specific religious beliefs, such as Catholic, Jewish and Muslim (Rosmarin et al. 2010; Holt 2012). We therefore reiterate the importance of describing the topics used for the discussions in published articles. In the case of protocols created by the authors, the topics covered in each session should be reported in the article to facilitate the reproducibility of the study by other research groups.

Regarding the third item, some studies found in the literature, besides evaluating the health professionals after receiving spiritual interventions, also evaluated the patients to determine indirectly whether there was any clinical change in participants (Huguelet et al. 2011; Burkhart and Schmidt 2012). Results suggested better acceptance of health conditions, a sense of acceptance and adherence to treatment. Therefore, the training and preparation of health professionals for the application of RSIs should be included in studies. Likewise, religious leaders and spiritual counselors should be prepared in order to address the diseases, especially mental health, since this constitutes an important strategy for avoiding negative outcomes that the punitive religious approach can promote. Evaluating the direct and indirect influence of facilitators in RSIs could help understand their role in non-double blind interventions.

Finally, for the fourth item, properly considering and describing the procedures used in the participant allocation sequence, the losses to follow-up during the study and the statistical analysis can allow better quality RSIs.

The international guidelines on non-pharmacological clinical trials (CONSORT) suggests basic prerequisites for this research, since both facilitator and participant are aware of the treatment being provided (Boutron et al. 2008). The guidelines emphasize the importance of other points, such as the evaluator being blind to participant's outcomes. An individual who does not know the allocation procedure or intervention to which participants were submitted can help to minimize biased results.

Another important point to consider is the randomization and allocation sequence, which should be performed by an independent person who has no knowledge of or influence on participants' eligibility. Randomization eliminates bias in treatment allocation, making it easier to blind the investigator to patient allocation while its random assignment allows the use of probability theory to explain the likelihood of difference in intervention outcomes (Schulz et al. 2010). There are several ways of performing the allocation, from randomization blocks to computer programs, and the most convenient and least costly approach for the study in question can be elected. The choice of procedure and its description in scientific articles can therefore make a difference in the structure and quality of the study.

The structure of protocols, the number of sessions and duration of interventions and follow-up should be pre-programmed and described in the articles, since homogeneity of intervention of the groups is also an important item to consider in CONSORT, helping to minimize bias and ensure clear results.

In the present review, 90% of the selected studies scored low risk of bias, according to the Cochrane scale adopted. This indicates greater robustness of the results found, demonstrating that, despite the methodological challenge, many authors

have sought to minimize the bias of their investigations and devise clear and rigorous scientific investigations about the impact of R/S on health.

6 Conclusion

Clinical trials designed to assess the effects of RSIs on mental health have pointed to clinical benefits, regardless of the models adopted, including reduction in anxiety symptoms and satisfaction with the proposed approaches. The lack of standardization of protocols and outcomes leads to the need for further investigation on the topic and its impact on complementary treatment in mental health. Likewise, the importance of describing every item used to design the RSIs protocols and the strategy/knowledge of the applicator should also be emphasized.

Rigorous research, with adequate and sound methodologies, should be encouraged in order to understand the most appropriate ways of working with RSIs as complementary health treatment and to provide further evidence for this emerging field.

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Impact of Religion and Spirituality in Older Persons



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Abstract The world's population is rapidly aging. This phenomenon imposes several challenges to the modern society, since the older population is very heterogeneous and the aging process is multifactorial and multidimensional. In order to adapt and cope with the physiological and pathological aspects of aging, older adults frequently use several coping mechanisms, including their spiritual and religious beliefs. This chapter will provide an overview on the relationship between spirituality/religiosity (S/R) and health in the aged; including the increase of spiritual/religious beliefs in older adults and the relationship between S/R and well-being, quality of life, social support, mental and physical health. We will also present the possible mechanisms for this relationship, the role of religious struggles and the clinical implications for geriatricians and gerontologists. In summary, there is a consolidated scientific production in this field, pointing to a generally positive influence of S/R on several health outcomes, such as lower levels of depression, better cognitive functioning, lower morbidity and mortality, better functional status and higher scores of quality of life and well-being. Nevertheless, some patients could have a negative influence of S/R on their medical outcomes (increasing mental health problems and even mortality). The mechanisms for this relationship are not totally elucidated and studies include cortisol levels, inflammatory and immuno-

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logical markers. Health professionals dealing with older persons should be aware of the spiritual and religious beliefs of patients in order to provide a more comprehensive and holistic care.

Keywords Spirituality · Religion and medicine · Geriatrics · Older adults

1 Introduction

The world's population is rapidly aging. This phenomenon imposes several challenges to the modern society, since the older population is very heterogeneous and the aging process is multifactorial and multidimensional. If on the one hand, some older persons remain socially active, with high levels of autonomy, and with good physical and mental health capacity; on the other hand some older persons present chronic illnesses, physical impairments and poor mental health and quality of life which demands high costs of care and financial impact for families and society (Prince et al. 2015).

In order to adapt and cope with the physiological and pathological aspects of aging, older adults frequently use spiritual and religious beliefs (Bjorklof et al. 2013). MacKinlay (2017) proposes that ageing may be seen as a “spiritual journey” through the search for meaning. Likewise, Crowther et al. (2002) believe that the positive use of spirituality may be part of the successful aging model of Rowe and Kahn (1987), which would be composed by the maintenance of physical and cognitive function, the engagement in social and productive activities and a positive use of spirituality.

In this chapter, we will advance further in this field of knowledge, presenting an overview of the influence of spirituality and religiosity (S/R) in the older population and bringing the scientific evidence and the clinical implications for this relationship.

2 Older Adults' Religious and Spiritual Beliefs

Most studies show that older adults have higher levels of spiritual and religious involvement than other age groups. In the last decades, with the increase in the number of scientific articles concerning this issue, it was possible to understand further the relationship between late life and S/R (Moberg 2012).

In the book “Aging and spirituality, spiritual dimensions of aging theory, research, practice, and policy” (Moberg 2012), the authors described the relationship between aging and an increase in spiritual and religious beliefs. Overall, two points of view are described. The first one implies that people tend to become more spiritual as they grow older, since S/R are not static, and will be strongly influenced by life experiences. The second point of view highlights the “theory of continuity”, in which individuals are predisposed to keep most of their habits and preference from

young adult life, not meaning that there is no possibility of change. According to this latter view, inherent aspects of life such as environment, lifestyle, social support, relationships and others can influence older adults beliefs.

Despite these two points of view, most researchers still believe that S/R are important dimensions of older adults’ lives (Sayre-Adams 2004; Moberg 2012; Levin et al. 2011; Zimmer et al. 2016; Lucchetti et al. 2011c). Evidence suggests that the majority of older adults consider themselves religious and spiritual and that S/R have an influence on their lives. Zimmer and colleagues (Zimmer et al. 2016) investigated the beliefs of the 13 most populous countries in the world (60% of the world population), using the 2015 version of the World Values Survey. The overall results showed that 70.7% of people with 60 years and over consider themselves religious persons. The five countries with the highest proportion of people (≥60 years old) who considered themselves religious were: Pakistan (100%), Nigeria (94.3%), Turkey (93.3%), Brazil (87.8%) and Mexico (84.1%). The two countries with the lowest proportion were: China and Japan with 16.6% and 30.1% respectively.

Below, we will use some of the data of the World Values Survey (<http://www.worldvaluessurvey.org/WVSONline.jsp>) in order to compare older adults with other age groups (Table 1).

Table 1 Importance of religion for life and age group of the four countries with largest population in world values survey data, 2010–2014

Country/ age	Very important %	Rather important %	Not very important %	Not at all important %	No answer %	Don't know %
China						
Up to 29	2.1	6.7	35.8	47.5	0.8	7.1
30–49	2.2	6.8	30.8	50.9	0.6	8.7
≥50	3.5	10.6	23.8	49.7	0.9	11.4
Total	2.6	8.0	29.6	49.8	0.8	9.2
India						
Up to 29	64.4	26.3	5.8	2.7	–	0.8%
30–49	66.0	24.9	6.4	1.5	–	1.3
≥50	71.0	21.4	3.9	1.5	–	2.3
Total	67.1	24.2	5.5	1.8	–	1.4
USA						
Up to 29	29.5	32.0	17.9	20.0	0.5	–
30–49	36.7	27.8	20.7	13.5	1.3	
≥50	48.5	26.1	16.5	8.5	0.4	
Total	40.4	28.0	18.2	12.7	0.7	–
Brazil						
Up to 29	43.8	40.2	11.3	4.7	–	–
30–49	53.2	37.1	6.3	3.1	0.2	0.1
≥50	55.3%	37.0	5.5	2.3	–	–
Total	51.5	37.9	7.3	3.2	0.1	0.1

Note: See the data on: <http://www.worldvaluessurvey.org/WVSONline.jsp>

We can observe that, with exception of China, those older than 50 years old from Brazil, USA and India reported more frequently that religion was very important to their lives in comparison to younger groups.

Other authors using other databases also found the same results. Bengtson et al. (2015) conducted a longitudinal study (35 years of follow up, baseline: 1970 – wave 8: 2005), including 3400 subjects from 420 families of different generations living in California, USA. They found religiousness in general tends to increase as people grow older, with exception to church attendance, which shows a decrease due to physical limitations. Other studies have also found this increase in S/R, as persons get older (Markides 1983; Blazer and Palmore 1976; Hunsberger 1985). These results support that S/R seem to be important factors in the lives of older adults.

In the following sections of this chapter, we will provide some scientific evidence for the relationship between spiritual and religious beliefs and different health outcomes.

3 Spirituality/Religiosity and Mental Health of Older Adults

According to the World Health Organization (WHO. Mental health and older adults 2017), approximately 15% of people with 60 years and over suffer from mental disorders. Social, economic and biological factors may influence the mental health of any person; however during old age these factors seem to have a greater influence.

Studies have shown that S/R may influence the prevalence of mental health problems in this age group. Koenig (2012) evaluated 3,300 quantitative studies published between 1872 and 2010 and found that four out of five publications in this field (80%) have some relationship with mental health outcomes (e. g. coping with adversity, positive emotions, well-being, happiness, optimism, depression, among others).

In fact, studies carried out in the last decades have helped to explain the impact of S/R in older adults' mental health. Religious behaviors and spiritual beliefs increase positive feelings such as meaning, purpose, connectedness, well-being, peace, hope and forgiveness among older people (Koenig 2012). However, religious struggles can also be responsible for negative feelings like bitterness, revenge and fear (Pargament et al. 2011). These two factors can influence many problems that compromise older adults' mental health, such as depression, anxiety, unhappiness, drug use/abuse, and stress (Krause 2011; Koenig 2012). In order to provide a better overview of these findings, we will show below some studies in this area.

In regards to depressive symptoms, an US longitudinal study (Sun et al. 2012) including community-dwelling older adults carried out between 1999 (n = 999) and 2003 (n = 624) examined the effect of religiosity on depressive symptoms in a 4-year follow up. At the baseline, older adults who had higher religious attendance had fewer depressive symptoms and, at follow-up, subjects who had higher intrinsic religiosity had a steady decline in depressive symptoms over the 4 years. However, those with lower levels of intrinsic religiosity had a decline in depressive symptoms in the first 2 years followed by an increase of depressive symptoms.

A Korean longitudinal study (Roh et al. 2015) with 6,647 non-institutionalized older people found that those who engaged in religious activities weekly had a 22% reduction of their depressive symptoms in 3 years of follow up. Same results were found by a Canadian National Longitudinal Survey (1994–2008) (Balbuena et al. 2013), which included 12,583 representative middle-age persons. Monthly religious attenders had 22% lower risk of depression compared to non-attenders. Another study (Braam et al. 2004) including 1,840 Dutch community-dwelling older adults found a negative association between church attendance and depressive symptoms even after adjustments. In general, studies indicate that S/R are associated with lower levels of depression (Koenig 2012) and a faster remission rate in depressive patients (Koenig et al. 1998).

Concerning suicidal ideation, although we have few studies carried out in older adults, we have strong evidence that S/R is associated with lower levels of suicide attempt and suicide behavior in all age groups (Wu et al. 2015; Lawrence et al. 2016). A recent meta-analysis (Wu et al. 2015) suggests that the results of those with more than 45 years old is stronger than those with less than 45 years old. We found one study specifically addressing older adults and including 248 participants diagnosed with depression. Authors found that greater church attendance was significantly associated with lower suicidal ideation (Rushing et al. 2013).

Another important factor that we must highlight in this area is the cognitive function, since the decline of this function directly affects the mental health, especially among the older population. In 2017, a systematic review (Hosseini et al. 2017) was published on the association between S/R involvement and cognitive function among middle-aged and older adults. Seventeen studies were included with a total of 35,741 subjects and 82% showed a positive association between S/R involvement and better cognitive function.

Other mental health problems such as anxiety, bipolar disorder and psychosis are still little investigated in this age group. A study found that the majority (66–83%) of the 66 Americans evaluated mentioned the preference to incorporate S/R into the therapeutic treatment for anxiety and depression (Stanley et al. 2011). Other studies investigating specifically older adults are welcome.

Summarizing this section, there is good evidence that S/R is associated with mental health in older adults, particularly depression and cognitive functioning. Although there are different traditions and practices among countries, which could potentially influence these outcomes, the results are robust and maintained.

4 Spirituality/Religiosity and Physical Health of Older Adults

At the beginning of this chapter we mentioned several factors that compromise the physical health of the older population, such as chronic diseases, physical and mental impairments, loss of family members and loss of social and economic status (Prince et al. 2015).

Within this context, S/R may have a positive impact on several physical diseases that have a high prevalence in the older population, such as cardiovascular disease, physical impairments, pain and somatic symptoms. There is also an important association between S/R and survival (Koenig 2015), including three systematic reviews concerning this issue (Chida et al. 2009; Powell et al. 2003; Lucchetti et al. 2011d; McCullough et al. 2000). However, the type of religiosity used is associated with positive or negative results. Pargament et al. (2001) has found that higher religious struggle (Wondered whether God had abandoned him/her or Questioned God's love for him/her) at baseline were predictive of greater risk of mortality in a 2-year follow up of older adults.

The possible mechanisms for this S/R-physical health relationship are (Oman and Thoresen 2005):

- Health behaviors: most religious affiliations do not recommend excessive consumption of alcoholic drink, discourages smoking, and does not allow the use of illicit drugs, usually encouraging healthy behaviors.
- Psychological states: S/R can trigger positive feelings that can influence mental health outcomes.
- Coping: S/R can stimulate positive coping against situations that may compromise physical health (e.g. aggressiveness and diligent behaviors).
- Social support: S/R can offer a group that promote greater social support and with a strong positive influence on physical health.

With the increase of the longevity of the population, it is evident the growth of researches that assess the impact that spirituality/religiosity on the older adults' physical health (Zimmer et al. 2016). A cross-sectional survey conducted by the "Survey of Health, Aging and Retirement in Europe (SHARE)" between 2004 and 2005 with 16,557 people with 50 or more years (mean = 64.10, SD = 10.5) from 10 European countries identified that a low number of behavioral risk factors for chronic diseases (i.e. high body weight, smoking, physical inactivity and risky alcohol consumption) was associated with the religious education that they had received from their parents and with a high frequency of prayer (Linardakis et al. 2015).

Same results were found by a US longitudinal study (Berges et al. 2010) with 2,620 non-institutionalized Mexican Americans aged 65 and older. Subjects with regular religious attendance at baseline had a 30% reduction in the odds of developing Activities of daily living (ADLs) problems over 7 years compared to the non-regular attendance group, even after adjusting for physical and mental health. Finally, a study including 1,423 US older adults (Hybels et al. 2014) found that more frequent attendance was associated with fewer ADLs, instrumental ADLs, and mobility limitations.

Other studies also showed that there is an association between higher spirituality with self-reported good health status (Daaleman et al. 2004); self-reported religiousness with lower levels of pain (Lucchetti et al. 2011a); higher self-reported religiousness with less hospitalization (Lucchetti et al. 2012) and religious attendance with less medical illness burden (Koenig 1998) in older persons.

Concerning cardiovascular disease, there is growing evidence that S/R may have a protective effect (Lucchese and Koenig 2013). However, studies in older adults are few. A recent study (Charlemagne-Badal and Lee 2016) including 9,581 older Seventh-Day Adventists found that intrinsic religiosity was strongly related to lower hypertension rates even after adjusting for demographics and lifestyle variables.

The possible mechanisms for the influence of S/R on the lower morbidity and mortality rates come from the healthy behaviors and psychosocial support that religious and spiritual beliefs may provide. We encourage researchers to carry out longitudinal studies, in order to increase evidence of the interrelation between S/R and the physical health of older persons. Clinical trials should also be conducted to assess the effect of the use of some spiritual/religious interventions in this age group (Goncalves et al. 2015).

5 Spirituality/Religiosity and Social Support of Older Adults

Social support is another important determinant for the development of better outcomes in physical, mental health and quality of life of the older adults across cultures (Belanger et al. 2016). There is solid evidence of the positive association between spirituality/religiosity and social support. This becomes more evident among the older age, in which religious organization is the second most common source of support after the family support (Koenig 2015).

In many situations, the religious community is the extension of the family. It is the place where older people have confidence, especially in difficult situations. It is also the place where religious behaviors and spiritual beliefs are practiced and shared, which could have repercussions to the health and quality of life (Paloutzian and Park 2014).

Krause (2006) published a longitudinal study on the impact of social support came from the church's members and mortality of 1,500 US older adults. The results showed a negative correlation between social support and mortality. Despite this relationship, studies have shown that even controlling for social support the effects of S/R on health still persist (Chatters et al. 2015; Corrêa et al. 2011).

6 Spirituality/Religiosity, Quality of Life and Well-being of Older Adults

Quality of life and well-being are important markers of successful and active aging. According to the World Health Organization (Whoqol 1995), quality of life is an individual's perception in the context of their culture and value systems, and includes their personal goals, standards and concerns. For the WHOQOL Group, the physical, psychological, social and environmental domains are essential for the

quality of life of adults and also for older adults (Power et al. 2005). Among the older population, there are still other important domains such as the sensory abilities, autonomy, past present, and future, social participation, death and dying and intimacy (Power et al. 2005).

Within this context, S/R are important components of the quality of life for any age group (Skevington et al. 2013). Several studies point to a positive association between spirituality/religiosity and better perception of quality of life in several aspects (Panzini et al. 2017). For example, higher levels of organizational and intrinsic religiosity were associated with better perceptions in the physical and mental components of the health-related quality of life of 911 Brazilian older adults (Abdala et al. 2015). Positive spiritual/religious coping strategies were also associated with a better mental health component and social function of the health-related quality of life of 200 community-dwelling residents in Iran (Heydari-Fard et al. 2014).

In Brazil, a study identified that the positive strategies of spiritual/religious coping were associated with a better perception of the quality of life of 77 nursing home residents and 326 community-dwelling residents (Vitorino et al. 2016a) and in South Korea, a study (Moon and Kim 2013) investigated 274 older persons and revealed that religiosity and spirituality had significant effects on quality of life among Protestants and Catholics elderly, but not in Buddhists.

Finally, an US study (Lawler-Row and Elliott 2009) investigated 425 older adults (more than 50 years old) and found that spiritual wellbeing and prayer contributed to the prediction of psychological wellbeing, subjective well-being, physical symptoms and depression, even when the contributions of age, gender, healthy behaviors and social support were included.

In conclusion, even though there are several studies that support that S/R enhance quality of life and well-being of older adults, there is a need of further studies on this relationship, including longitudinal studies, since both quality of life and spiritual and religious beliefs may change over time.

7 Possible Mechanisms Associated to S/R Outcomes

Several authors are investigating the possible mechanisms involved on the relationship between S/R and the outcomes presented in this chapter (Lucchetti et al. 2011b).

Among the proposed mechanisms, two studies have assessed the role of religiosity in the levels of interleukine-6 (IL-6). IL-6 is associated with lower levels of successful aging, higher levels of frailty and higher morbidity and mortality (Ershler and Keller 2000). Lutgendorf et al. (2004) investigated 557 older persons and found that religious attendance was significantly related to lower mortality rates and lower IL-6 levels, and IL-6 levels mediated the prospective relationship between religious attendance and mortality. Koenig et al. (1997) also found in 1,718 older adults that those with higher levels of spirituality showed lower levels of IL-6.

Concerning levels of inflammatory markers, a study (Ferraro and Kim 2014) investigating a representative sample of 3,005 older adults in the United States

found that, although religious attendance was not related to C-reactive protein – CRP (an inflammatory marker of cardiovascular disease) among the White respondents, attendance was associated with lower CRP and change in CRP over time among the Black respondents. Another study (Hybels et al. 2014) including 1,423 older adults found that religious attendance was associated with lower levels of interleukin-6, soluble vascular cell adhesion molecule, and D-dimer.

In Greece (Anyfantakis et al. 2013), 195 primary care middle-aged and older patients (mean age 66 years old) were followed for 4 years and higher levels of religiousness were associated with lower levels of serum cortisol. Finally, a Japanese study (Imamura et al. 2017) evaluated 317 community-dwelling older persons and found that serum oxytocin levels were negatively associated with strength of belief in life after death.

Although we have some studies trying to elucidate the mechanisms by which S/R are associated with health outcomes, more studies are needed in this age group.

8 Spiritual and Religious Struggles “Red Flags” Among Older Adults

Although the proportion of S/R benefits is usually high, some people may also experience the negative influence that S/R have on their lives (Peres and Lucchetti 2010). S/R can be used as coping strategies to deal with stressful situations during life. These strategies are usually positive (85% of the time), helping to face stressful situations during the life (i.e. positive spiritual/religious coping) (Pargament et al. 2000). These positive spiritual/religious coping strategies are associated with better outcomes in physical and mental health and quality of life (Pargament et al. 2011).

On the other hand, there are also dysfunctional strategies, which are associated with the punitive side of religion and beliefs (i.e. negative spiritual/religious coping or spiritual struggles) (Pargament et al. 2000, 2011). For Stauner (2016) the term religious struggles is used as “tension and conflict about sacred matters within oneself, with others, and with the supernatural”. For these authors, religious struggles have three dimensions: “Interpersonal” (related to religious struggles and their relatives, friends or some religious group), “Intrapersonal” (relation to people’s own struggles, their beliefs, religious doubts, and the look for the meaning of life) and “Divine/Demonic” (related to conflicts with God, or other Higher Power) (Stauner 2016).

Spiritual/religious struggles have been negatively associated with mental and physical health outcomes (Exline et al. 2014; Stauner 2016). Krause et al. (2017) conducted an interesting nationwide face-to-face survey in the USA including three age groups (1,008 participants were 65 or more years old). Authors identified that younger adults presented higher levels of spiritual struggles when compared to middle-aged or older adults and these spiritual struggles were negatively associated with self-rated health. Another US study (Pargament et al. 2001), evaluated 596 older inpatients and found that higher religious struggle scores were predictive of

greater risk of mortality in a 2-year follow up. Finally, a Brazilian study (Vitorino et al. 2016b) investigated 77 older nursing-home residents and found that spiritual and religious struggles were associated with a worse perception of quality of life.

Since there is a relationship between spiritual and religious struggles and health outcomes, geriatricians and gerontologists should pay attention to the “warning signs” of these negative behaviors, also known as “red flags” (Pargament et al. 2011).

9 Proposed Model for the Impact of Spiritual and Religious Beliefs in Older Persons’ Lives

As described above, there is promising evidence on the relationship between S/R and older persons’ lives, including successful aging, health risk behaviors, quality of life, well-being and physical and mental health.

Figure 1 presents our proposed model to explain this impact (Fig. 1).

10 Role of the Geriatrician/Gerontologist in Addressing Spirituality

As previously reported, the aging process is a challenge moment for the individual. There are several losses during this process and the death appears as a recurrent issue. In this context, questions about religious and spiritual values and practices may be very important. A Brazilian study (Lucchetti et al. 2011a) including older adults found that, although more than 87% believed that the doctor should question their religious/spiritual beliefs, only 8.7% had ever been asked about their beliefs. These results are in line with a recent systematic review (Best et al. 2015) including all age groups that showed 70.5% of patients thought it was appropriate for the doctor to enquire about spiritual needs in at least some circumstances.

However, although most doctors believe they should discuss S/R issues with patients, few address these beliefs in clinical practice (Best et al. 2016). The most common barriers are lack of knowledge, lack of training and fear of imposing own beliefs (Best et al. 2016; Lucchetti et al. 2013b; Osorio et al. 2017). Appropriate training is needed for these health professionals in order to achieve a more holistic and integrative care.

Geriatricians and gerontologists should be aware of the functional and dysfunctional beliefs and discuss them when possible or refer to other specialists such as chaplains, psychologists or religious leaders. The recognition of patients’ beliefs could help in the treatment adherence and even in the outcomes of the geriatric care.

We recommend that health professionals use spiritual history tools (e.g. FICA, FAITH, SPIRITUAL) to address older adults in order to identify their religious affiliations, the importance of their faith, the spiritual resources they have, how their

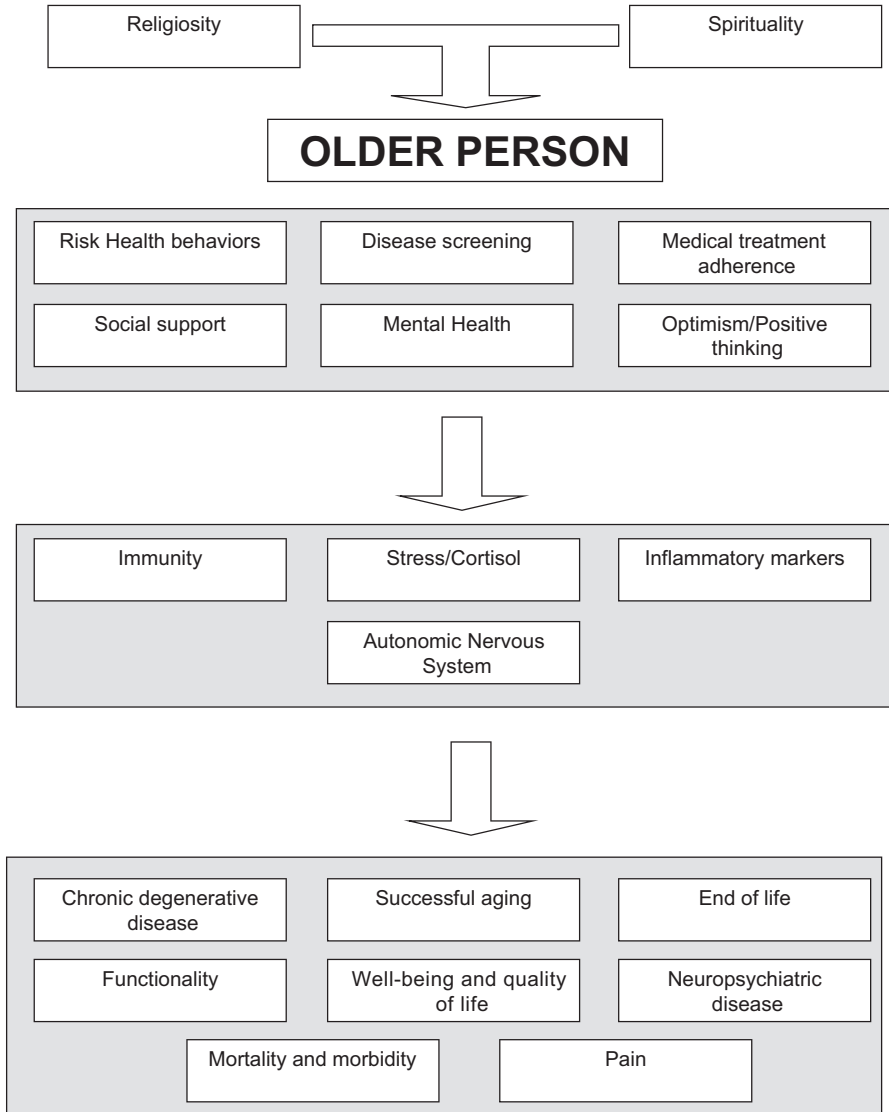


Fig. 1 Proposed model for the influence of Spirituality and religiosity on older persons physical and mental health

religion can influence the medical treatment, their end-of-life care (that will be discussed in another chapter of this book) and how the health professional can help in providing all spiritual resources (Lucchetti et al. 2013a; Moreira-Almeida et al. 2014). This understanding could result in a more holistic care, valuing different cultural backgrounds and religious traditions and practices.

11 Conclusion

The search for meaning in later life becomes more real for many older people, with questions of meaning, transcendence and hope becoming important. This chapter revealed that there is a promising and consolidated scientific production for the relationship between S/R and health in older persons, showing positive outcomes most of the time. The mechanisms for this relationship are not totally elucidated and further longitudinal studies and clinical trials are welcome.

Health professionals dealing with older persons should be aware of the functional and dysfunctional spiritual and religious beliefs of patients in order to provide a more comprehensive and holistic care.

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Part II
**Clinical Implications of Spirituality,
Religiousness and Health**

Religiousness, Spirituality and Health in Secular Society: Need for Spiritual Care in Health Care?



Niels Christian Hvidt and Elisabeth Assing Hvidt

Abstract Secularization impacts most cultures and seems to be spreading still. What can we learn from the most secular nations in the world on how secularization impacts the relationship between religiousness, spirituality and health? Does secularization mean that religious and spiritual considerations during crisis vanish? Or is it rather the opposite, that there is ever more religious and spiritual insecurity, distress and seeking when health care has no space or language for it? We depart from state of the art in secularization theory, suggesting secularization does not remove existential, spiritual and religious needs, but that such needs are to be seen as fundamental aspects of human being and suffering. From this theoretical vantage point we present Scandinavian social science research that portrays the complex impact secularization has on spiritual care. We present recommendations on how to conduct research in secular culture using *The Meaning-Making Matrix* as a heuristic, theoretical and practical tool, ending with reflections on what implications the research should have for spiritual care in secular culture.

Keywords Secularization · Faith and health · Existential needs · Religious needs · Spiritual care · Communication

1 Introduction

When people in secular societies are confronted with serious or life-threatening illnesses, what meaning orientations do they hold on to? Or which coping strategies do they make use of? Research aiming at answering these and similar questions has received a growing interest in recent years, and both quantitative and qualitative studies have been conducted investigating secular-existential, religious and/or

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spiritual meaning orientations utilized by individuals in Scandinavian societies in connection with illness (Ahmadi 2006; Assing Hvidt 2013a; Assing Hvidt et al. 2012; Ausker et al. 2008; Balslev van Randwijk 2010; Bess Boelsbjerg 2010; Kappel Kørup 2016–; Kuseyri 2014–2016; la Cour and Hvidt 2010; Moestrup 2010–2014; Nissen et al. 2017; Pedersen et al. 2013b; Prinds Rasmussen 2010–2014; Schrøder 2011–2014; Toudal Viftrup 2009–2014).

Conventionally, secularization theories would lead us to presume that religious and spiritual cognitions and practices were of little or no significance to Danish patients (Beckford 2003). We would also presume that secular existential values and beliefs centering on the meaning of life, freedom, loneliness and death would be particularly meaningful to Danes in that they are embedded in a secular culture where traditional religious meaning systems and explanatory models have been declining (la Cour and Hvidt 2010).

Recent secularization theories are, however, based on large-scale scientific studies, international surveys such as World Values Study or – in a narrower European context – the European Values Study (Andersen and Lüchau 2004). Although quantitative studies reveal interesting findings about certain expressions of religion in late modernity (e.g. belief in traditional dogma, frequency of religious practice etc.), such general religious dispositional variables say little about the specific existential, religious and spiritual meaning orientations that people might be likely to employ in every day lived situations and conditions, such as living with life-threatening illness, disability or other life crises. Thus, a still growing Scandinavian research body finds that the taken-for-granted theories about the non-importance of religiousness and spirituality for modern, secular individuals no longer reflect the actual lived reality among those people who are living illness- and crisis situations.

In modern times, there has been a tendency of defining the science-based approach (so fundamental for modern health practice) in stark contrast to the universe of faith: “You should know, not believe!” so the saying goes. The consequence often is an attitude that states that the universe of faith has nothing to do with health care but should merely refer to the “private sphere”. The problem with this often-biased approach is that it does not consider the evermore well-established evidence-based knowledge that the hospital is among the places in modern secular societies where people think most about existential conditions and religious and spiritual needs.

In this chapter¹ we will argue that there is more to secular individuals’ religious and/or spiritual orientations than the mere question of belief or unbelief,

¹The chapter builds upon and incorporates parts of earlier research and writing on the issue of this chapter, including

1. Assing Hvidt E. Existential meaning orientations. A humanistic-qualitative investigation of Danish people in cancer rehabilitation. [PhD]. Odense: University of Southern Denmark; 2013;
2. Hvidt NC. Meaning Making and Health in Contemporary European Society. In: Appel K, Danz C, Potz R, Rosenberger S, Walser A, editors. Religion in Europe today. Perspectives from social sciences, law, hermeneutics and philosophy of religion. Religion and Transformation in Contemporary European Society, Vol 1. Vienna: Vienna University Press; 2012. p. 173–90;
3. Hvidt NC. Placebo, tro og helbred: Om betydning af tro for helbred og for patienters oplevede sygdomsforløb. *Månedsskrift for Praktisk Lægegering*. 2015;667–75.

conventionally measured in quantitative surveys. Especially when examining the segment of a secular population that is made up of people who are suffering from illness and crisis, the picture is more complex and multi-levelled. We will also argue that in order to meet the existential, spiritual and religious needs of those people who struggle with illness and disability, we need to investigate in depth how these needs relate to specific contextual and cultural traditions and heritages.

The characteristic relationship between religious identification, including church affiliation, and personal faith of a secular country oftentimes called the least religious country in the world (Zuckerman 2008) shall be described in more detail in the following.

2 Religious Transformation, Spirituality and Health

The search for meaning seems to be a significant component in the discussion of religious transformation in contemporary European culture. Religious meaning systems have had and continue to have tremendous impact on the way sufferers seek to make sense of often senseless suffering, of making sense when all other narratives of meaning and comfort seem to silence. This may well be one of the reasons why the great secularization theories have failed: No other meaning system seem as powerful as religious ones do, especially in the face of death, and as we are often reminded, science as the trump of secularization has not just yet been able to annihilate death, which in many ways is what religion proposes to do.

Historically there has been a tremendous confluence of religion, health and healing. This holds for Christianity as for most other world religions (Woodward 2000), although religious leaders believe the attention to this interplay have been hampered by secularization. In a very influential article, Aram I. Keshishian, Catholicos of the Armenian Orthodox Church in Lebanon and for decades the moderator of the World Council of Churches, made a statement in which he lamented the extent to which the church had lost the healing dimension of the church:

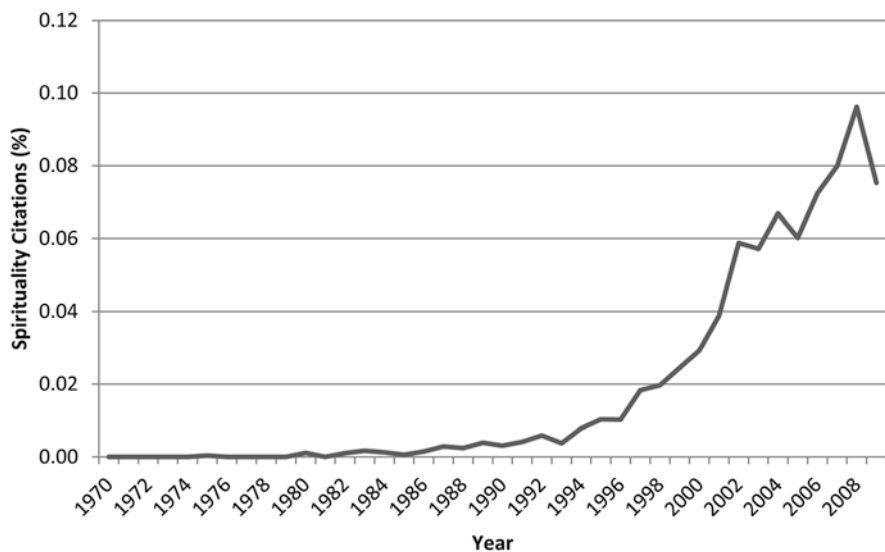
Healing belongs to the very *esse* (being) of the church. The church is endowed by God's grace and power of healing. Hence, the prevailing missiological misconception that considers healing a "specialized ministry" of the church and neglects it as a core element needs to be corrected by an ecclesiological understanding that perceives healing to be integral to the church's being, manifested through its sacramental life, diaconal action and evangelistic outreach (Aram I Kishishian 2005).

The reason why this appreciation of the Church's healing dimension has been ignored is that the concepts of healing and of salvation have both become too narrow, Aram I argues. The New Testament understanding, where they could be understood almost as synonyms, has been lost: "This relationship has been impaired during the enlightenment, secularization and the growing of scientific impact in the fabric of Western thought. It also has to do with the growing specialization of the different field of care for man with health care, psychological care and spiritual care as the three most important."

However, in recent years, despite the notion of earlier secularization theories, there has been a return to earlier times' interest for faith and health. The number of scientific articles about faith related issues has also been rising dramatically in medical and psychological journals internationally during the past 25 years to the point that Hall, Koenig and Meader speak of an “explosion” (Fig. 1) (Hall et al. 2004).

Research suggests that healthy religious beliefs and practices are positively associated with increased quality of life, risk of disease, longevity, and in particular coping with crisis. Proposed explanatory factors include life style, social support, powerful coping resources, and possibly the importance of keeping the Sabbath. In a recent Danish sample involving 10.000 Seventh Day Adventists, we found that they had up to 80% lower risk of life style related cancer diseases compared to the Danish population (Thygesen et al. 2012a).

Research in meaning making when confronted with serious stressors of disease and crisis has come out as particularly significant for the health profession in its attention to the increasingly complex needs of patients in globalized society, both bodily, psychological, social and existential. Such research has long been on the agenda in religious societies such as USA where findings indicate that increased attention to existential, spiritual and religious needs during disease and crisis may improve the quality of life of patients. Religious, spiritual and secular issues and needs and their significance for dealing with crisis are topics that more recently have even found their way onto the medical and psychological research agendas in societies far more secular than USA, albeit in somewhat different ways (Balboni et al. 2007).



Spirituality: proportion of total Medline citations.

Cook CCH. Spirituality and Health. *Journal for the Study of Spirituality*. 2012;2(2):150-62.

Fig. 1 Figure shows the growth in publications on “Spirituality” on the primary medical database, Medline, relative to the general growth of published articles

3 The Characteristics of Religion/Spirituality in Secular Culture: The Case of Denmark

It is clear that there are enormous cultural and religious differences between the USA and Europe, which as has been pointed out in recent publications needs to be adequately accounted for when doing research in either cultural settings (Paley 2008).

The tight normative link between a Christian identity, the belief in theological propositions and a religious practice no longer holds for the majority of Danes. Past Gallup Surveys have shown that together with Estonia and Sweden, Denmark is among the least religious countries in the world with only 19% of the population answering that religion was an important part of their daily lives (Gallup 2010). However, when asked anonymously, as has happened for 30 years through the “European Value Survey”, only 7% of Danes are “convinced atheists”, 21% are “non-believers”, while 72% declare themselves to be “believers” (Gundelach 2011). Approximately half of them believe in a “personal god”, the rest in “a higher power”. Although membership rates are decreasing, with 88.2% of the population being members in 1992 against 76% as of January 2017 (Kirkeministeriet (Ministry of the Danish Church) 1990–2016), the relatively high number is still puzzling to many a social scientist. Danes can in many ways figuratively be said to be the people in the world with the highest level of “passive” church membership, just as one can speak of being a passive member of a sports club when having broken an arm.

Furthermore, a low participation rate of only 2% of Danes attending Church at least once a week together with a fairly high number of people using the church for transition rites such as baptism, confirmation, wedding and funerals, express further inconsistencies in how people relate to the national church as a religious institution. Research from the sociology of religion suggests Danes remain members of the State Church, although they do not practice, because membership in Denmark signifies and implies some sense of belonging that is not concrete and does not entail religious involvement but rather symbolizes a sense of spirituality, of belonging to something divine. It is the *Ahnung* of which the poets of the Golden Age wrote and which the Golden Age artists such as Caspar David Friedrich often depicted as a church lying in the misty distance of the shifting and so often painful experiences of human beings. Thus, this “membership” seems to be about more than churching: it is about cultural and ethnic attachment, but for many, it also symbolizes a belief that there is “more between heaven and earth.”

Social scientists have put forth numerous possible explanations for the relationship between a high membership rate and thus identification with the national church on the one hand and low participation in the church’s theology and practice on the other. “Belonging without believing” is one way of trying to capture the pattern dominant in the Scandinavian countries where people value the cultural heritage of Christianity and identify with the national church without actually believing in God in a way that corresponds to the church’s theological propositions. Instead they have a wide variety of questioning and skeptical takes on Christianity but believe in “something” (“Christian atheists” is another such concept with a similar

meaning). “Belonging without believing” is the inverted slogan of the British sociologist of religion Grace Davie’s theory “Believing without belonging” originally intended to apply to the pattern in the UK where a large majority declare some faith in God but do not attend services in the Anglican Church (Davie 1994; Davie 2006a). Thus “belonging” as well as “believing” has to be taken as soft variables describing a continuing attachment of large numbers of people to their national churches whether or not they attend these institutions on a regular basis (Davie 2006b; Voas and Crockett 2005). Looking at statistics from Denmark, one would get the impression that the dictum “believing without belonging” (Davie 1994) for Danes would rather be “believing and belonging without practicing”!

Another term “vicarious religion”, also borrowed from Davie, was intended to capture “a notion of religion performed by an active minority but on behalf of a much larger number, who (implicitly at least) not only understand, but, quite clearly, approve of what the minority is doing” (Davie 2006a). According to this understanding the small minority of practising members keep the national church afloat on behalf of the majority of inactive members who like to keep a door open in case of some future needs (either festive or grievous) (Taylor 2007).

A similar concept is “fuzzy fidelity” referring to the large number of “fuzzy Christians” who continue to value the services provided by the churches that they no longer attend – being neither regular churchgoers nor consciously non-religious (Voas 2009). On Danish ground, social researchers explain the high membership rate by the fact that membership gives access to the popular transition rites (Sundback 2000; Warburg 2005) where the most used transition rites are the church funeral (79.8% in 2012), baptism (69.2% (year group 2010)) and confirmation (73% of a year group in 2011). Others suggest that the high membership rate is due to the fact that membership is usually acquired through infant baptism being a popular ritual and belonging to the tradition of many Danish families (Rosen 2009; Zuckerman 2008). Furthermore, they suggest that since membership must be actively relinquished, most Danes continue to pay church taxes (amounting to less than 1% of annual income) either because of laziness, indecisiveness or possibly because they after all want to contribute to the maintenance of the church buildings as cultural monuments (Rosen 2009; Zuckerman 2008).

The picture where membership to the national church is portrayed as a cultural rather than a religious membership is the interpretation of an interview-based study of religiosity in Denmark conducted by an American sociologist, Phil Zuckerman (Zuckerman 2008). He argues on the basis of 150 in-depth interviews conducted in both Denmark and Sweden that Danes participate in rituals without believing in them and that this participation is to be seen as a part of what he calls “cultural religion” (Zuckerman 2008).

In line with the argument of “cultural religion”, a couple of Danish sociologists of religion have argued that the Nordic national state churches fill out a civil religious function (Andersen and Lüchau 2004; Sundback 2000). In arguing thus, they refer to the American sociologist Robert N. Bellahs theory propounded in 1967 (Bellah 1967) saying that Americans embrace a common national faith. This faith he calls a “civil religion” with certain fundamental beliefs, values, holidays, and

rituals parallel to, or independent of, their chosen religion and having a cohesive force that fosters social and cultural integration. Inspired by this research, the Danish sociologists Ole Riis and Margit Warburg suggest that many Danes express their affiliation to Denmark through their membership in the national church whose head is the Queen of Denmark (Riis 1985; Warburg 2005). Thus Riis writes: “The membership expresses an adherence to the Danes’ civil religious community more than to the Christian parish” (our translation) (Riis 1985).

A Danish qualitative investigation about Danes’ belief in the greater Copenhagen area showed that Danes distinguish between different belief categories. One category is “belief” which refers to what people themselves believe in, usually poorly articulated personal feelings and reflections that reside in the inner life of each individual. Another category was “religion” referring to something institutional that does not have any necessary bearing on the beliefs. “Tradition” was another category that referred to something that was happily observed but in a form where the traditions had become devoid of their religious content (Rosen 2009) (p. 159). What Rosen finds in her dissertation titled: “I’m a believer – but I’ll be damned if I’m religious”, is that peoples’ beliefs are private, personal and subjective and that “they have been withdrawn into the inner lives of the individuals” (Rosen 2009).

With this key finding, Rosen confirms a vast body of literature pointing to a change in what people perceive as “sacred” and to a development in Western societies where alternative beliefs have replaced orthodox ones. As a result of this development people have become increasingly “spiritual but not religious” (Fuller 2001). The British sociologists of religion Paul Heelas and Linda Woodhead have argued that a “spiritual revolution” has taken place in what they call an “inner-life spirituality”, which has become more widespread than beliefs in a personal, transcendent God (Heelas 2009; Heelas and Woodhead 2005). With this thesis, they oppose spirituality to religion and define spirituality as a kind of autonomous engagement in assembling one’s own personal outlooks through a kind of “bricolage” which is opposed to a simple surrender to church authority and institutionalized religiosity (Heelas and Woodhead 2005). Charles Taylor (Taylor 2007), in commenting upon the effects of what he calls a “new spiritual landscape”, writes in *A Secular Age* that:

...the gamut of intermediate positions greatly widens: many people drop out of active practice while still declaring themselves as belonging to some confession or believing in God. On another dimension, the gamut of beliefs in something beyond widens, fewer declaring belief in a personal God, while more hold to something like an impersonal force; in other words a wider range of people express religious beliefs which move outside Christian orthodoxy (Taylor 2007) p. 513.

Thus most social scientists and sociologists of religion agree that traditional religious belief and practice have declined in the past century in most countries in the Western world giving way to beliefs that are results of a personal, spiritual instinct being particularly related to the search for individual wholeness and harmony (Taylor 2007) p. 507.

As the research in meaning making and religious/spiritual coping has indicated (Koenig et al. 2012), the search for a meaningful orientation is particularly evident in connection with severe illness and crisis where the individual can lose her/his orien-

tation in the wake of the sudden confrontation with death and meaninglessness. Research conducted during the past decade in a Scandinavian research context of faith and health seem to confirm both tendencies: That illness and crisis lead to an intensified search for meaning and that religion and spirituality exist as possible existential meaning orientations albeit in highly individualized and non-traditional forms.

4 Empirical Findings on the Relationship Between Spirituality/Religiosity and Illness in Secular, Scandinavian Countries

A growing number of quantitative as well as qualitative studies made in a Scandinavian secular context have investigated the relationship between religion/spirituality and illness. Research moves in three distinct, though related, main fields: 1. The significance of faith for health and 2. The significance of faith for the experience and management of disease and 3. The significance of disease for existential, spiritual and religious development, which we can refer to as: *Crisis faith*.

In this section, partly based on former publications (Assing Hvidt 2013b; Hvidt 2015; Hvidt et al. 2016; Thygesen et al. 2012b), these three main fields will be presented briefly with reference to selected research that has taken place in recent years, which again will lead to consideration of how we can understand the essence of existential meaning-making (including religious and spiritual) among patients in secular culture.

4.1 The Significance of Spiritual/Religious Faith for Health

First, research shows that people with religious and spiritual beliefs and related practices and lifestyle have a lower illness incidence than non-religious individuals (Koenig et al. 2012). Thus, a cohort consisting of 12,000 Danish seventh Day Adventists and Baptists has a significantly lower overall cancer incidence (Standardized Mortality Ratio 63% for Men, 74% for Women, All Numbers Significant). The difference is significantly greater in lifestyle-related diseases such as lung cancer (34% for men, 44% for women) (Thygesen et al. 2012b). Significant disease reduction has been found for a number of other diseases, including cardiovascular disease, and although the effect is primarily attributed to the group's religious lifestyle, other factors such as placebo can of course not be ruled out. In the so-called Glostrup Cohort, consisting of 734 men and women born in 1914, women who once indicated to go to church have a lower risk of dying 20 years after (Hazard Ratio 73%) (La Cour et al. 2006). In the Glostrup Cohort, the effect, even when corrected for known confounders, is such that the cause is not so obviously identified in religious lifestyle: the women who attended church had higher BMI and similar consumption of tobacco and alcohol. Regardless of etiology, there is thus

substantial international and now also Danish research that confirms a connection between faith and health.

The Norwegian theologian Torgeir Sørensen has also investigated the relationship between religion and health in a Norwegian context using a population-based sample from the Nord-Trøndelag Health Study, Norway (Hunt 3 Study). Sørensen et al. (Sørensen et al. 2011) investigated the sample's largest disease groups: Cardiovascular and lifestyle-related diseases, cancer and mental health. They found significant relationships between religiosity and both physical and mental health: Religious attendance was associated with lower diastolic and systolic blood pressure after adjusting for relevant variables. The results from the cancer study indicated a higher prevalence of "Seeking God's Help" after a shorter time since diagnosis among men. No association was observed in multivariate analyses between "Seeking God's Help" and "Life Satisfaction" or "Disease-Specific QoL" in long-term cancer survivors (Sørensen et al. 2012). Results from the mental health study showed that attendance at church/prayer house was associated with lower depressive symptoms (Sørensen et al. 2012). However, the research design utilized (cross-sectional) did not allow for any elucidation of causal relationships between the variables included in the analyses.

4.2 The Significance of Religious/Spiritual Faith for Experience and Management of Disease

In Denmark, a growing number of studies show that belief and reflections about existential, spiritual and religious issues are being intensified in connection with illness. Ten completed PhD projects and several senior projects from Odense, Copenhagen and Aarhus with association To Danish (and since 2012 Nordic) Network for Research in Faith and Health (7) have provided insight into the existential, religious and spiritual considerations and needs of Danish patients and relatives and how health professionals understand and support them. The studies indicate that disease crisis rarely turns an atheist into a believer or a believer into an atheist. It is rather such that disease activates or intensifies a (potential) belief people carry with them often without having played a particularly active role before. This seems to be particularly true of Denmark where religion is regarded as one of the biggest taboos in Denmark, has limited importance in public space, and is only rarely dealt with or spoken of by the average Dane (Gundelach 2011; Zuckerman 2008). Even existential needs are rarely discussed by Danes among each other, not even with the closest family. A possible explanation for Danish religious inactivity would be that Danes, more than any other people, experience a high degree of life control and therefore rarely feel the need for a God or a faith to support them in their everyday lives.

In Sweden, Ahmadi found on the basis of a qualitative study including 51 cancer patients that they tend to seek spirituality-oriented coping methods rather than religious ones connected to an institution (Ahmadi 2006). For example, connecting to

nature as a sacred principle was of great significance in the coping process. Ahmadi concludes that the findings showing that Swedish cancer patients turn mostly to spiritual coping resources demonstrate the importance of considering the influence of culture on the coping methods when investigating the relationship between faith and health (Ahmadi 2006).

In Norway, Torbjørnsen et al. (Torbjørnsen et al. 2000) showed that religiousness had been activated in a sample of both religious and non-religious (atheists and agnostics) post-treatment Hodgkin's lymphoma patients after the onset of the illness and that religion had functioned as a coping resource. Another follow-up study in Norway in which 15 Hodgkin's disease survivors were interviewed in order to investigate their religious and/or spiritual coping showed that an often-used coping method was perceived support from God mediated through nature (Torbjørnsen 2011).

The tendency that people in Northern, secular culture lean toward individual spirituality, rather than organized religion is evident in most of the Scandinavian studies. Even for people adhering in religious minority groups such as Pentecostals, the need for having individual, spiritual needs met was evident. Thus a Ph.D.-study by Toudal showed that Pentecostal Christians participating in group therapy for mental health issues were in it in large part to meet their personal spiritual needs, although they found the religious group they participated in to be a good setting for their spiritual gratification (Viftrup et al. 2016). This echoes Charles Taylor's assessment that even classic churchgoers have individual, spiritual needs met through religious means (Taylor 2007) p. 515.

Studies show that although Danes live in what may be the world's least religious culture they still have religious and spiritual feelings and needs, expressed in a surprisingly high prevalence of prayer among first time mothers of which over 65% professed to be "praying to God"; interestingly, there was not much difference in terms of prayer prevalence among mothers having at-term babies and pre-term babies (Prinds et al. 2014; Prinds et al. 2016). Furthermore, among women partaking in the Århus breast cancer cohort, 83% professed to "believe in God" and 34,5% believed their faith had a positive influence on their disease (Pedersen et al. 2013a).

A large questionnaire examining the relationship between four dimensions of health and a number of existential, religious and spiritual/religious practice variables sampled from 480 Danish hospital patients in 2006 showed that levels of existential and religious thoughts and practice heightened, especially in the time period of 1–3 months after the onset of illness, when illness turned worse and most predominantly among women and the youngest age group (younger than 36 years) (la Cour 2008). Furthermore, a Danish survey investigation from 2006 ($n = 1.518$) showed that almost one-third of the respondents found that secular, spiritual and religious issues had not been sufficiently dealt with during the course of their cancer illness (Grønvold et al. 2006). A Danish survey confirms that a larger proportion (83%) of Danish breast cancer patients report believing in "a God or higher spiritual being" than the general Danish population (around 65%) (Pedersen 2009; Pedersen and Zachariae 2008).

A study among a group of severely ill lung patients (lung cancer and chronic obstructive lung disease) in Denmark ($n = 111$) showed that almost two-thirds

(64.8%) reported having some belief in God and/or a spiritual power (Pedersen et al. 2013b). A qualitative investigation among patients with chronic obstructive lung disease supported these quantitative findings in that the data from in-depth interviews showed that existential and spiritual phenomena, e.g. hope, trust and meaning, played a crucial role in the daily coping of the patients (Ilkjær 2012). Another qualitative investigation with 21 young leukemia and lymphoma patients examined whether, and how, religiosity was altered or maintained in connection with the illness (Ausker 2012). One of Ausker's findings was that the beliefs that patients entertained prior to the illness (both religious and nonreligious) strengthened after falling ill. Furthermore, religious beliefs were found to be particularly meaningful through social relationships (Ausker 2012).

4.3 The Impact of Disease on Existential, Spiritual and Religious Development: Crisis Faith

It is of little surprise that many people who experienced being struck by disease and crisis have started thinking about the existential, spiritual and religious dimensions of life and have found faith or that the faith they had has matured (Sittser 2004). Religious beliefs and practices take on new dimensions to the point of being often reshaped when people are struck by suffering or traumatic experiences.

This is confirmed in a survey by S. R. Cohen and colleagues who asked both healthy people and oncology patients what was important to their experienced quality of life (Cohen et al. 1996). They asked about four dimensions: Physical, psychological, social and existential wellbeing. Those who were healthy reported that all four dimensions were of equal importance to their quality of life. When asking the oncology patients, one might expect that they—suffering severe bodily pain—would place physical well-being at the top of their list. However, it was the fourth dimension of existential well-being that topped the list. Cohen's survey thus suggests that existential considerations, including religious belief, are of greater importance than other issues concerning quality of life when life is threatened by death. Similar results regarding quality of life have been found even in secular countries such as Finland (Hintikka 2001).

When life is threatened by death people think about the life they have lived and are reminded that the lifespan on earth has a limit. The threat of death has often been seen as the greatest threat of atheism along the dictum: "There are no atheists in foxholes"² or as in the words of Arthur Hugh Clough (1819–1861):

And almost everyone when age,
Disease, or sorrows strike him,

²Apparently the quote "can be traced to Lieutenant-Colonel William J. Clear in a story of Bataan's final weeks, delivered during the "Army Hour" program over the NBC Red Radio Network in 1942" Wikipedia contributors, "Atheists in foxholes," https://en.wikipedia.org/wiki/There_are_no_atheists_in_foxholes

Inclines to think there is a God,
Or something very like Him.” (Thielman 1998)

Researchers argue that there is likewise little apparent atheism left among patients enrolled in those hospital units that handle life threatening diseases such as cancer or coronary crises (Pargament 2002). As M. E. Cavanagh writes, “The cancer counterpart to the dictum ‘There are no atheists in foxholes’ is “There are no atheists in oncology and bone-marrow transplant units” (Cavanagh 1994).

Ironically, the health care sciences, that have been associated with anti-religious bias (Post 1992), have contributed strongly to the growing need of existential and religious sensibility in hospital settings. For the immense advancements of medicine have kept increasing the group of those who have been threatened by death through diseases such as diabetes, cancer, coronary illness, etc. that would have led to death without medical knowledge and intervention. This group, the so-called survivors, constitutes a new social group in first world countries. Its growing requires enhanced attention to religious needs.

As the results of the aforementioned Scandinavian studies show, it would be wrong to set the equals between lack of religious language and practice – and absence of faith. Basic faith in “something bigger” can be activated when experiencing loss of control in relation to crisis, especially illness, either in one’s own or in the immediate family, as many of the results from the aforementioned research studies show.

In this way, one can rightly call Danish faith “crisis faith”. Apparently, nothing seems to make Danes think more of their faith than crisis and illness, and nowhere are they confronted more with disease than at the hospital. This is confirmed in several studies, including the aforementioned questionnaire-based study at *Rigshospitalet*, Copenhagen’s main hospital, where it is clear that disease intensifies belief considerations in proportion to the seriousness of the disease (Ausker et al. 2008; la Cour 2008) just as Danish research suggests that clear existential beliefs have an impact on the quality of life of patients and illness experience.

Although all societies in Scandinavia have their unique and complex characteristics stemming from historical, social- and cultural developments, there is a pattern which seems to run athwart in research on faith and health in secular Scandinavia, namely that a severe illness and crisis tends to intensify existential concerns and may elicit religious and spiritual beliefs and practices as sources of meaning making. Just as it is now clear that disease intensifies existential, spiritual and religious considerations, issues, needs and seeking, and that religious and spiritual beliefs through various pathways are positively linked to health, it seems imperative to pay attention to patients’ existential, religious and spiritual beliefs when dealing with disease, symptom control, experience of treatment and fear of death (Koenig et al. 2012).

Results from a research project about Danish cancer patients’ existential meaning making and existential needs document that although positioned within a highly secular context, a cancer diagnosis leads to concerns and questions of an existential and spiritual nature: “Why me?” “How can I find meaning, hope and faith in the future?” Or “Where can I get help to cope with my illness?” (Assing Hvidt et al. 2013). Research results have furthermore been able to clarify that seriously ill

Danish patients experience unmet needs for supportive communication concerning existential problems. Where supportive relations are present and where subjective emotional experiences can be processed – what has been termed a “relational home” (Assing Hvidt 2013b) the patients experience positive health outcomes, such as increased psychological and existential well-being as well as pain relief. A relational home may include different dimensions in various situations and contexts, including an existential and metaphysical dimension in which God/a higher power may provide emotional support similar to that obtained in human relationships. These research results suggest that training Danish health professional in communication about existential and spiritual issues with cancer patients will lead to beneficial health outcomes for the patient as a result of the qualified doctor-patient communication.

5 A Meaning-Making Matrix of Existential Needs in Secular Culture

To better open and study this particularly secular “faith pomegranate”, we in the aforementioned Network of Research in Faith and Health departed from international research on existential meaning-making and care, which is informed by two primary traditions:

The first is the primarily North American research in religious coping. This research tradition has the great advantage that it has a strong empirical foundation, especially in the health sciences. The disadvantage of it is that it is based on a cultural context where religion is a part of everyday life to a much greater degree than is the case in Western Europe. It is thus not easy to transfer the American research results to a European context.

The second research tradition is rooted in the existential philosophy and psychology. It is, despite its starting point in the very religious Søren Kierkegaard, characterized by a rather a-religious approach, and is primarily centered on secular sources of meaning such as family, work, activities, etc. It is also characterized by being associated with limited empirical research.

Departing from the aforementioned Danish research, it became clear that a combination of the best European and American approaches would be preferable so that clinicians should keep in mind that existential meaning stems from both secular, spiritual and religious dimensions.

Secondly, we found in the Network, like other Danish researchers, a useful theoretical starting point in the work of American sociolinguist Joshua A. Fishman according to whom meaning-making moves in three related dimensions: 1. Knowing: The conscious beliefs that give cognitive content to the human meaning. 2. Doing: The actions and rituals that people associate with these beliefs, and 3. Being: The significance and “life” that lies in these beliefs.

These dimensions are essential for existential meaning dimensions, whether they be secular, spiritual or religious. Danes score quite low on the first dimensions knowing and doing: Danes are not particularly used to thinking about the cognitive content of the faith, and only few actively practice their beliefs. On the other hand, Danes’ rather unreflected beliefs have a major significance in relation to the third aspect of being: how to understand themselves and their life foundation. Thus, it seems that most Danes will be able to say about themselves: “I’m not very religious, but I believe in something – I do not really know what it is, but it matters a lot to me.”

In the further work of mapping Danish existential orientations, we found it meaningful to link the above secular, spiritual and religious meaning domains with Fishman’s dimensions (knowing, doing & being) so that we end up with a conceptual matrix that we have dubbed *The Meaning Making Matrix* (MMM) and that is being used in Nordic research as a methodical, heuristic and theoretical framework (Fig. 2) (la Cour and Hvidt 2010).

6 Systemic Attention

The emerging international and Danish research in the field confirms that spiritual care may in particular instances involve calling a priest or a hospital imam. However, the wider existential and spiritual care is in no way reserved to the religious specialists, but should be seen as an integral part of broader patient-centered care, not as a palliative add-on, but rather as *the very heart of patient-centred care* involving all health professionals! Such care requires broad attention to care within the remits of available time and practice, no less in today’s multi-cultural and globalized era where consideration to ethnic and religious minorities is more important than ever. Just as the so-called PLISSIT model (Fig. 3) in the 70s established a broad

Fig. 2 The MMM couples the meaning making dimensions of knowing (cognition), doing (practice) and being (importance) with the secular, spiritual and religious meaning making domains which produces a matrix of nine fields that are important for the overall process of meaning making

Meaning Making Matrix (MMM)
Dimensions

	Knowing	Doing	Being
Secular			
Spiritual			
Religious			

Domains

la Cour, P., & Hvidt, N. C. (2010). Research on Meaning-Making and Health in Secular Society. *Social Science & Medicine*, Volume 71, 1292-1129.

Annon JS. The PLISSIT model: a proposed conceptual scheme for the behavioral treatment of sexual problems. *Journal of sex education and therapy*. 1976;2(1):1-15.

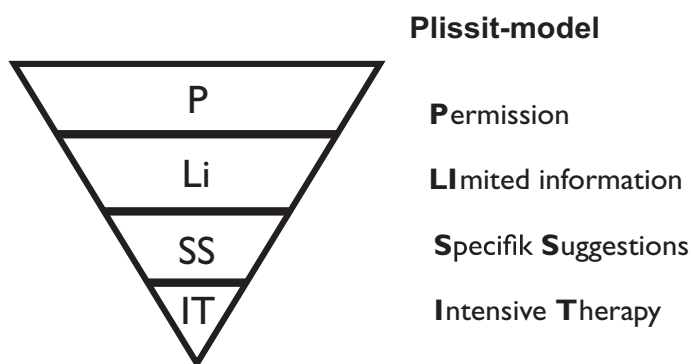


Fig. 3 The Plissit model has been used to reduce taboo around sexual problems

awareness of especially cancer patients' sexual problems that – at the time – were still considered tabooed, so we in modern day healthcare should, by analogy, sharpen the general and systemic awareness of patients' existential and spiritual dimensions. The PLISSIT model could be analogous in the following way: All health professionals need to be aware that existential themes are permitted (P in PLISSIT) in the clinic, and limited information (LI in PLISSIT) about patients' existential orientations and needs should be part of standard patient need assessments. Some members of the clinic might have obtained more training in existential and spiritual care and might provide specific suggestions as to the existential and spiritual considerations patients might present with (SS in PLISSIT) while in cases of spiritual distress and struggle patients could be referred to chaplains or psychologists who might be able to provide more intensive therapeutic assistance (IT in PLISSIT).

The aforementioned studies show that most patients wish to talk to a wider range of health professionals about their existential considerations and needs, that these needs are multifaceted and that they cannot and should not be separated from the general psychosocial needs (Hanson et al. 2008). However, the studies also indicate that patients rarely talk to their therapists about these issues, probably because they do not expect them to be an integral part of normal patient care.

This is confirmed by a study of PAVI (the former Palliative Knowledge Center, now National Knowledge Center for Rehabilitation and Palliation) (Rådgivende Sociologer Aps 2013). Here it becomes clear that Danish palliative patients have a number of psychosocial, including existential needs, but rarely talk to healthcare professionals about this. Thus, much suggests that there is a discrepancy between supply and demand as regards existential and spiritual care. A number of studies report professional barriers to spiritual care basically related to 1. Lack of time, 2. Lack of education and knowledge, 3. Biomedical socialization and as a consequence

4. Uncertainty about patients' and own existential orientations and needs (15) (Hvidt et al. 2017). In order to avoid entering into the often painful and resource-consuming existential aspects of care, it is easier to seek shelter behind what we could call the *clinical shield*.

In order to address this area of deficiency research studies developing course programs and communication tools for Danish health professionals in so-called "existential communication" are currently conducted, at first targeting Danish general practitioners (Assing Hvidt et al. 2016; 2017) but with the ambition of covering most medical specialities (Prinds 2017; Steinfeldt 2017; Toudal Viftrup 2017-). International research confirms that health professionals need training in three areas that said course programmes seek to provide (Paal et al. 2015): 1. *Knowledge* about the existential needs of patients (which is provided through readings and lectures), 2. *Practice* which is provided through role-playing, theatre-methods and the use of question guides and 3, *Self-reflection* which is provided through the use of self-awareness enhancing exercises such as the Sources of Meaning Card Method (somecam.org) and sharing in groups.

7 Conclusion

As we have seen in this chapter, patients' existential, religious and spiritual needs in secular culture significantly impact their experience and management of disease. However, the support of such needs is sporadic and random, and primarily developed within the palliative field. The research suggests that patients want, but rarely expect or ask that their physician address existential, religious and spiritual needs. Therefore, much suggests that a more proactive approach to opening psychosocial and existential subjects may have a positive effect on the disease progression. The Meaning Making Matrix is presented as a clinical tool that reminds us of the meaningful fields in which patients in secular cultures seek meaning as they experience and cope with the difficult moments of life. We hope this very simple model can arouse reflection and further discussion. Results from on-going intervention research on the implementation of existential communication in health care will provide us with important results about the possible effects of such patient- and professional-centred initiatives in secular culture.

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Fostering Well-being: Spirituality and Creativity in Clinical Practice



Leticia Oliveira Alminhana and Claude Robert Cloninger

Abstract Well-being is the fruit of the development of maturity of character. Well-being can be fostered through spiritual development involving the search for self-transcendent meaning in a clinical approach that is creative and person-centered. Since Plato's Chariot Allegory, well-being is understood not as the absence of impairment, but as a dynamic complex of adaptive systems and causes. In line with both Greek philosophy and neuroscience, the Temperament and Character Inventory (TCI) is an evidence-based model of personality in which maturity of character is the expression of the creative profile (that is, the combination of high self-directedness, cooperativeness and self-transcendence). The development of a creative profile with strong intrinsic conviction about what is spiritually meaningful is the key to flourishing and resilience despite stressful life events and ultimate situations like suffering and death. Consequently, person-centered therapists can develop their own spiritual awareness and creative perspective in order enhance their effectiveness in fostering the well-being of their clients in clinical practice.

Keywords Spirituality · Well-being · Maturity · Creative profile · Temperament · Character · Flourishing · Personality

1 Introduction

In this chapter we want to share some theoretical and empirical tools to understand and access mental health, well-being and spirituality. To do so, we cannot simplify the concepts and make it as “Fostering well-being” would be a receipt for happiness. Also we could not state that everybody should develop themselves

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through spirituality, because, otherwise we would be excluding agnostics and skeptical or, worse, we would be imposing them an ideological perspective of faith. Saying that, we are assuming a very well-known and evidence-based theory of personality, named “The Psychobiological Model of Temperament and Character”, as our ground to understand spirituality and well-being. In this model, spirituality is understood as a very complex personality system, involving self-aware consciousness and search for meaning. In other words, it means that we can develop ourselves beyond the limits of our individual self and even beyond families and own community values, including the planet, the whole universe. Spirituality is linked to Self-transcendent capacity, to self-aware adoption of all-embracing values and virtues. It is a measure of flexibility and creativity, as the ultimate level in the character development of a person.

We start this chapter with the new approaches to understand mental health and mental illness, based on personality traits. This is to contextualize the relevance of considering personality dimensions when you need to address a diagnosis on Personality Disorders, for example. But it is also important to understand the well-being perspective and, finally, the creative and self-aware process of reaching mental health and spirituality. We will also use a little of Greek philosophy with Plato’s metaphors to amplify the personality approach of spirituality, grounding it with ancient wisdom about human psyche. In the end of the chapter, we present an integrative approach to diagnosis, which includes the person as a whole, focusing in the Creative/Spiritual Self-aware profile of character maturity, named “Person-centered integrative diagnosis (PDI)”. It’s very important to notice that our integrative perspective for well-being and spirituality is not only a very useful evidence-based tool to clinical approach, but it is also a personal pathway that all of us, mental health practitioners should assume in our daily life.

2 Plato’s Model of the Human Psyche: TCI Dimensions and Its Interactions with Personality Disorders, Well-being and Spirituality

Currently, some practitioners advocate a diagnostic approach to personality disorders (PD) that takes a “dimensionally-flavored categorical system” by providing clusters of common characteristics (Oldham 2015). As we can see in DSM-5, PD’s in cluster A are described as odd and eccentric, in cluster B, dramatic and emotional and in C, fearful and anxious (American Psychiatric Association 2013). Suggesting a possible dimensional/trait based approach, DSM-5 also proposes an “Alternative Model of Personality Disorders” in which diagnosis considers the level of severity of traits referred to as a sense of self (i.e., self-directedness) and interpersonal functioning (i.e., cooperativeness). Some studies support the validity of the Alternative Model in clinical and general samples (Few et al. 2013), but there is not wide acceptance due to its failure to satisfy advocates of either categorical or dimensional

approaches. It is a categorical-dimensional hybrid that lacks of a coherent theoretical foundation. Nevertheless, the alternative model's description of healthy personality features has a strong scientific basis from work on the relationship of character traits to well-being except that the alternative model neglects the importance of self-transcendence for well-being (Cloninger 2013).

It's noteworthy that psychiatric manuals seem to be moving in the direction of historical research in mental health and personality features, probably reaffirming early Greek philosophical perspectives, such as Plato's ideas about the human psyche (Cloninger et al. 2017). When we describe psychological characteristics and try to classify them into categories of clinical symptoms and disorders, we can be unaware of the most fundamental issue: understanding the nature and aspects of human mind. As a phenomena in the world, many philosophers and thinkers tried to describe human personality when it is associated with impairment but may neglect the description of its basic functional aspects.

In Plato's metaphor of the charioteer in *Phaedrus* (Plato 1952), we see the most important elements to describe emotions in psyche which still determine psychological and philosophical views nowadays (Zhu and Thagard 2002). In Plato's Republic, the soul has three independent parts: reason, spirit and appetite, which are represented by the charioteer, the white horse and the black horse, respectively (Wagner 2001). The charioteer represents reason or the intelligent and judicious mind, the white horse is a metaphor for the spirit and feelings which are easily directed by the charioteer and guided by reason. The black horse is a symbol for the unconscious, irrational emotions that are guided by unruly appetites (Wagner 2001; Cloninger et al. 2017).

Plato's allegory of the soul (or psyche) describes its three aspects (reason, feelings and appetites) in a way that brings together the basic human challenges that emerge in a person's search for health and well-being (Cloninger et al. 2017). Many centuries later, Saint Augustine reinterpreted Plato's metaphor, including a theological interpretation for the two forces leading human will: virtues and vices (Wetzel 1992). Although in the past, virtue was associated with wisdom and happiness, while vices such as gluttony and sloth were linked to sin and evil, modern views about human mind would define virtue and vice in terms of healthy and unhealthy personality configurations (Cloninger 2010).

For current psychiatry, "gluttony" can be understood as addiction or substance dependence and "sloth" as depressed mood or affective flatness. Moreover, such characteristics can be described as personality traits even when they are not part of a mental disorder. In this sense, personality traits can be adaptive or not, depending on the sense of self (e.g., identity and self-directedness) and interpersonal functionality (e.g., empathy and intimacy) as suggested in the guidelines of the Alternative Model of Personality Disorders (American Psychiatric Association 2013).

Dimensional and functional approaches for Personality Disorders as in the alternative model of DSM-5 are well-known perspectives to understand mental health in terms of personality traits. One dimensional-trait approach is the seven-factor model of personality, developed by Cloninger et al. (1993). The Psychobiological Model of Temperament and Character is a neuroscience-based theory which not only

describes personality features, but also presents them as a structural-functional system with three aspects: one comprising emotional drives elicited by basic emotional stimuli; a second, linked to intentional goals and social relationships; and the third is self-awareness capacity as a creative search for meaning and well-being. Cloninger's ternary model names each one of these aspects of personality structure as: (1) Temperament, (2) Character (especially self-directedness and cooperativeness), and (3) Identity (especially related to self-transcendence, which involves expansion of self-aware consciousness beyond the individual self) (Cloninger et al. 1993; Cloninger 2012).

In this Model, Temperament is comprised of fundamental traits linked to behavioral activation and dopaminergic system (Novelty Seeking); to behavioral inhibition and serotonin system (Harm Avoidance), to behavioral maintenance and norepinephrine system (Reward Dependence) and to behavioral persistence system (Persistence) (Cloninger 1994, 2004). Character traits are Self-directedness and Cooperativeness; Identity trait is Self-transcendence. Temperament is the inherited predisposition or foundation of emotional life that is moderately stable throughout life, whereas Character and Identity are levels of maturity that are also heritable in part but develop substantially in adapting to social pressures and other personal experiences across the lifespan (Cloninger 2004, 2012).

Self-directedness is described in terms of autonomy, resourcefulness, and self-acceptance; Cooperativeness is the capacity to be empathic and helpful; Self-transcendence is self-awareness, identifying with what is beyond the individual self, which requires cultivating a creative and spiritual perspective. Self-transcendence is the means to expanding one's sense of identity beyond the individual self, thereby producing an Identity that is the integration of all three aspects of personality and, to a greater or lesser extent, inclusive of personal awareness of participation in a greater whole, such as humanity, nature, or the cosmos (Cloninger et al. 1993; Cloninger 2004, 2012).

The ternary model with seven dimensions can be quantified by using the Temperament and Character Inventory (TCI) (Cloninger et al. 1993). TCI's reliability has been confirmed in more than 25 countries around the world along with its validity to measure personality in terms of Temperament, Character and Identity (Gutiérrez-Zotes et al. 2005; Hori et al. 2008; Goncalves and Cloninger 2010; Vangberg et al. 2013).

Based on an integrative theory, the TCI is a comprehensive instrument that assesses neurobiological and psychosocial features of personality from a general developmental perspective that permits a nonlinear and dynamic approach. In this sense, Cloninger's model brings together neuroscience, social science, and philosophy as we can see in Plato's allegory of the charioteer (Plato 1952; Cloninger 2004; Cloninger and Zohar 2011).

The TCI offers an empirical support to assess Plato's conception of psyche with a tripartite approach, where appetites, feelings and reason/intuition can be well represented by consideration of Temperament, Character and Identity (Cloninger et al. 2017). As we can see in prior studies, personality profiles are a result of different combinations of inherited and learned traits, with neuroscience and psychometrics

providing rigorous empirical evidence. For this reason, we can show the correspondence of Plato's metaphor of the appetites (which are associated to self-gratification desires – black horse) to the TCI. In the TCI, appetites can be assessed quantitatively by the Novelty Seeking (NS), Harm Avoidance (HA) and Reward Dependence (RD) dimensions (Cloninger 2010; Cloninger et al. 2017).

On the other hand, spiritual feelings or the desire to preserve order and values (Plato's white horse), can be assessed by Cooperativeness (CO) and Persistence (PS) dimensions. Finally, the purposeful wisdom of a reasoning and intuitive charioteer who can guide feelings and appetites in a healthy direction can be assessed by Self-directedness (SD) and Self-transcendence (ST) in interaction (SDxST) (Cloninger 2010; Cloninger et al. 2017). Consequently, when the white horse listens and follows the guidance of the charioteer, the person functions as a creative character (who is high in all three character traits) who is able to self-regulate the unruly black horse in order to enjoy a good and happy life.

TCI's Model not only supports the Chariot Allegory of Plato, but also is in line with the description of a healthy personality in the Alternative Model of Personality Disorders from DSM-5 (Few et al. 2013). The sense of self and interpersonal functionality is covered by Temperament and Character features of self-directedness and cooperativeness, respectively. However, empirical research also has shown that Self-transcendence is important despite its neglect in the alternative model (Cloninger 2013). Self-transcendence is important for two main reasons: first, TCI's theoretical model distinguishes automatic intelligence that is intuitive or directly perceived from analytical intelligence that is based on logical inference from assumptions. Second, it adds the conception of a third level of personality development, related to Self-aware Consciousness, Creativity, Meaning/Spirituality and Happiness (Cloninger 2004, 2012).

The ternary approach, based in philosophical and neuroscientific evidence, is important for effective understanding and treatment of Personality Disorders (PD) (Cloninger 2010). According to DSM-5, dimensional perspectives claim that PDs are a result of impairment in functioning and pathological personality traits (Few et al. 2013; American Psychiatric Association 2013). According to TCI's Model, pathological traits are the consequence of imbalance in Temperament and Character's maturity, which results in dysfunctional sense of self, interpersonal disabilities and absence of Self-awareness, Meaning/Spirituality, Creativity and Health (Cloninger et al. 1997). Cloninger has shown that the structure of the TCI is the same in both general and clinical populations, so the TCI dimensions can be used to measure both normal and abnormal personality traits. There are not different traits underlying healthy and unhealthy personalities. The difference is how well character has matured so as to self-regulate temperament drives. Therefore character dimensions can be developed and can buffer the irrational drives of extreme temperament profiles (that is, extremely low or extremely high scores in NS, HA, RD and PS) (Cloninger 2004).

That means you can have a predisposition to anxiety and impulsiveness (viz., high HA and NS), but if you are mature (i.e., have high scores in the character dimensions of self-directedness, cooperativeness), you will have a protective char-

acter profile that self-regulates this predisposition, thereby protecting you from mental illness and PD, even if you have weak spiritual development. If you have a creative character profile, you may be flourishing (i.e., have superior health with a full state of physical, mental, and spiritual well-being, not just the absence of a personality disorder). In other words, the development of character and spirituality are keys to cultivating health, which includes physical, mental, and spiritual well-being. Thus, the TCI provides a way to broaden and expand contemporary approaches to the fostering of health and well-being by recognizing the ternary nature of human nature and the path to well-being (Cloninger and Zohar 2011; Cloninger 2012).

The “protective profile” is actually a measure of the rulers in Plato’s philosophy in terms of a Happy, Healthy and good life. In the TCI’s theoretical and empirical approach, it means to be Self-directed, Cooperative and Self-transcendent, all together (SDxCOxST). In other words, the Creative profile, which fosters a life that is self-aware with spiritual meaning and purpose is a protective profile against mental illness, anxiety and depression (Cloninger et al. 2017). At sect. 3 we will see how a Creative profile can foster well-being and spiritual meaning.

3 Creative/Spiritual Personality: The Key for Well-being

In the last decades, a number of studies observed the relationship between creativity, divergent thinking, imagination, intelligence and, sometimes, risk for developing mental disorders. Most of them investigated association between magical thinking, unusual experiences and beliefs under the heading of “schizotypy” as a trait observed both in psychopathological states and in general population (Holt et al. 2008; Claridge 2010; Mason and Claridge 2015; Alminhana et al. 2016).

According to Nettle and Clegg (2006), some aspects of schizotypy might explain the continuity of schizophrenia and its heredity through the age-old association between psychopathology and creativity (Nettle and Clegg 2006). A study compared schizotypy profiles with poets, artists, mathematicians, general population and psychiatric patients (Nettle and Clegg 2006). The group of artists and poets presented high scores of unusual experiences above the general population and similar to those of psychiatric patients. However, artists and poets did not present absence and superficiality of affection nor the loss of volition (anhedonia), characteristics of psychopathological processes (Nettle and Clegg 2006).

Increasing in creativity and spirituality was highlighted by Fisher and Mohanty (2004), presenting behavioral and neurophysiological evidence that positive schizotypy (high unusual experiences and low cognitive disorganization, anhedonia and impulsivity) would be associated with high creativity scores and increased activities in the right brain hemisphere (creative, non-verbal thinking) (Fisher and Mohanty 2004). A positive schizotypy profile, was considered a multidimensional phenomena leading to mental health when associated with well-being outcomes (intelligence, creativity and happiness). Such creative profile has being recognized as a kind of “Benign Schizotypy” and people with this feature are called as “Happy

Schizotypes” (McCreery and Claridge 2002; Schofield and Claridge 2007; Holt et al. 2008; Alminhana et al. 2016).

When interacting with the Psychobiological Model of Temperament and Character, many studies found the following personality profile for schizotypy: high Harm Avoidance (HA), low Reward Dependence (RD); low Self-directedness (SD) and Cooperativity (CO) and high Self-transcendence (ST) (Bayon et al. 1996; Daneluzzo et al. 2005; Bora and Veznedaroglu 2007; Hori et al. 2014). One study, tried to understand interactions between schizotypy, temperament and character in clusters of profiles. They did a latent profile analysis and observed the following configuration: the “high-positive schizotypy/adaptative” group was low in HA and high in SD, CO and ST; but the “high-schizotypy/maladaptive” group was high in HA and low in SD and CO (Hori et al. 2014).

It seems that adaptive profiles are associated to character maturity, which can be identified as protective personality traits against mental disorders (Alminhana et al. 2016; Alminhana et al. 2017). Compared with another 13 personality inventories, in a longitudinal study with more than 700 adults, TCI was the strongest predictor of well-being and clinical health outcomes (Grucza et al. 2007). More than this, high SD, CO and ST (character maturity), combined have been the most important predictors of physical, mental and social well-being, including perception of health and happiness (Cloninger and Zohar 2011).

We can ask why character maturity is so important to mental and physical health outcomes. A parsimonious explanation is that character maturity and especially the creative profile identifies adaptive skills of mental self-government in terms of the person with herself, with others and beyond the individual self, leading to creativity and spirituality (Cloninger et al. 1993) as well as virtue, which is closely related to the creative profile (Cloninger 2010; Cloninger and Cloninger 2011). All these together foster emotional self-regulation abilities, as cognitive flexibility, compassion and self-awareness. Maturity leads to a high level of creativity to cope with life’s challenges, keeping optimism, resilience and happiness (Cloninger and Cloninger 2013). Isn’t it what we should call “mental health”, or more generally health and well-being?

So, a creative/self-aware personality profile describes a person with purpose in life, with high sense of community and self-transcendence (which can be expressed by spirituality or more generally a commitment to a meaningful and realistic perspective of life) (Cloninger and Cloninger 2013). That’s the reason why we can have mental health and an adaptive profile even when we have some features that could increase risk for psychosis if not regulated by character (Hori et al. 2014). A divergent thinking, imaginative and intelligent person can have troubles in emotional regulation or not, depending on the level of maturity, creativity, spirituality/self-awareness she/he develops to guide the chariot of his/her life (Cloninger and Cloninger 2013). A mature and creative “charioteer” will guide his horses wisely, using psychological flexibility to find many ways to have a meaningful, satisfying, and healthy life. On the other hand, the immature charioteer will be blind to the countless possibilities to cope with life’s stressful events.

4 Fostering Creative/Self-Aware Profile or How to Promote Person-Centered Clinical Practice?

The dimensional approach for mental disorders intends to enhance diagnostic usefulness by providing clinical information about people who present a need for care (Os et al. 1999). However, clinical practice can't be settled in the pathological extreme of "severity" of traits and functionality impairment. Dimensional perspective is a result of systematic empirical observation of the presence of psychotic-like traits in general population. That's why mental health and mental illness can be different aspects of the same spectrum. For example, adaptive schizotypal traits can be viewed as the healthy extreme of schizotypy spectrum. High maladaptive schizotypy is in the same spectrum, but in the illness extreme (Hori et al. 2014).

When we look only for the "impairment" perspective we are not really looking at the person as a whole. The "need for care" is related to the complex balance between functioning/wellness and disability/disorder. Cloninger et al. (2012), claims that health and illness are "complex adaptive systems of causes" which may be unified in a "person-centered integrative diagnosis" (PID). Such integrative diagnosis considers the ternary aspects of human being: temperament, character and identity/self-transcendence. Extensive work has shown these dimensions to be the causal components, which generate a complex web of feedback interactions and well-being or ill-being as the outcomes. The complex adaptive system of causes considers physical, mental, social, and spiritual dimensions as inseparable and mutually interdependent aspects of health/illness and well-being/ill-being (Cloninger et al. 2012).

PID is in line with qualitative approach of modern dimensional diagnosis, which covers the whole interactions of traits, improving diagnosis and focusing in the person (Widiger and Thomas 2007; Barch et al. 2013; Van Os 2015). However, it focus attention on multidimensional profiles of the whole person, rather than on individual traits. This is particularly crucial regarding well-being because the health of people who report high scores on Self-transcendence depend on whether they are also grounded in reality, as indicated by scores on other character traits. The Schizophrenia spectrum and Alternative Models for PDs are pointing to complexity, multi-causal and deep interactions between personality traits and disposition towards psychopathology. Moreover, clinical practice and empirical evidence has shown the person centered perspective as essential for effective treatment in which the therapist and patient have a shared goal and relate to one another with hope, empathy, and authenticity (Cloninger and Cloninger 2011).

An integrative approach enables health professionals to recognize levels of Psychological Maturity (SD, CO and ST), which is linked to Flourishing and Resilience as complementary processes (Cloninger et al. 2012). Depending on maturity, people can flourish and develop a meaningful, purposeful and happy life. Flourishing is usually measured in terms of well-being (Seligman 2012), but it's vital to distinguish the ability to set and achieve goals (high SD), to be good in interpersonal relationships (high CO), from the development of a creative search for spiritual meaning. Optimal health and flourishing depend on the combination of all

three aspects of character: (i.e., high SDxCOxST) (Cloninger et al. 2012). As we can see, Flourishing is not a synonymous with success, but is reached only when Self-aware consciousness and virtues are guiding our chariots, going beyond self-centered goals and inspired by interconnected/self-transcendent values.

Flourishing is the capacity to rise and develop potential (i.e., flourishing is the fruit of self-actualization), and is most easily cultivated in a healthy nurturing environment (Seligman 2012). In contrast, Resilience is the ability to maintain health despite stressful environments (Herrman et al. 2011). Both, Flourishing and Resilience are measured in terms of personal and social competences (SD and CO). However, a resilient person with Psychological Maturity is high in awareness, self-transcendence, acceptance and openness to change in front of challenging life situations (again, high SD, CO and ST). In philosophy, post-Hellenistic stoicism resemble a virtuous and mindful life, which is natural guided by Logos (Psychological Maturity) and its moderation of pathos (Temperament, instinct, appetites) (Boys-Stones 2001).

Health practitioners unaware of the particular process underlying well-being/ill-being, will use many techniques without effectiveness. Moreover, to consider creative profiles is to understand the impact of “motivation to change” in the therapeutic field (Cloninger and Cloninger 2011). People don’t change old habits without a good shot of motivation, which comes from different challenges in the objective life combined with self-awareness, and with Psychological Maturity in the subjective life. In other words, a person will only commit to the hard work of changing habits and lifestyle if they are genuinely motivated to attain something of even greater value, something that they are willing to make sacrifices to attain.

The question is: can you know what are your client needs looking only into Statistical Manuals or Treatment Manuals? No, you can’t. You have to attend her/his authentic needs, noticing what can motivate her/his change. Moreover, you must not impose your goals on other people. Rather you have to help them explore their experiences to identify what they find personally satisfying and meaningful. Person-centered integrative diagnosis means you are really listening to this unique human being in front of you, paying attention to her/his needs, sufferings, and potential, abilities, wisdom. Manuals can help in this process, but not alone, as the therapeutic alliance still the strongest predictor of outcomes in psychotherapeutic treatment (Norcross and Wampold 2011).

Finally, if the therapeutic alliance is the most evidence-based tool, there are huge implications about the role of therapist self-development in the clinical practice. How can we foster well-being in our clients/patients if we are not attentive to our own levels of Psychological Maturity? To get to know ourselves better, to recognize our own need to cultivate a creative character profile, can be useful to enable us to help others to do the same. Although many clinicians are working hard in their personal and interpersonal competences, without Self-aware Consciousness and spiritual awareness, they are unlikely to go beyond socially sanctioned Character improvement. They will not be flourishing and resilient because they still depend on what other people value without being aware of their own potential. Self-aware Consciousness implies in meaning, fulfillment, which arises from intuition of what are the fundamental values for you to flourish in your life (Cloninger and Cloninger 2013).

Optimal preparation for integrative therapy involves not only the development of Self-directedness and Cooperativeness, but also Self-Transcendence. Many techniques can be useful in improving the creative character profile, and they can be experienced in a variety of ways, involving growth in awareness of one's body, thoughts, and soul. To learn to give of ourselves to others respectfully, hopefully, and authentically, we must first learn who we are and what we are able to give. So, let's end this chapter asking simple questions that you may find useful to practice by yourself with love, hope, and faith in silence:

- What are your needs?
- What conditions help you develop as the person you aspire to be?
- What is meaningful for you in your life?
- What experiences in your life have brought you the most long-term satisfaction, even if they involved some pain or sacrifice?
- Did you ever feel connected with something that was more than yourself?
- Are you able to pay attention to the wisdom inherent in all three aspects of your being (body, thoughts, and soul)?
- If you are a non-religious person, what does the concept of “spirituality” mean for you? Perhaps, for example, you are a scientist dedicated to the search for Truth, or a physician dedicated to caring for others.
- What does the concept of “spirituality” mean for your clients?

5 Conclusion

We are all on a path searching for health, happiness, and meaning. Both therapists and patients are progressing along their own paths to well-being. We can help our patients when we enter into a person-centered dialogue with them, genuinely listening to their current situation and encouraging them to identify what they really value. Then we can work together in a person-centered way to cultivate well-being in a way that is satisfying and productive for all involved. Spirituality and creativity will grow together when we are able to flourish as human beings, fostering maturity with autonomy, empathy and meaning.

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Spirituality in Psychiatric Care: An Example of Spiritually Integrated Psychotherapy



James W. Lomax and Nathan Carlin

Abstract This chapter illustrates an example of “spiritually integrated psychotherapy” by drawing on a case from the first author’s practice. The chapter also includes a discussion of how research literature may be applied to a particular clinical situation in specific moments and over time. The case is supplemented by literature from religious studies to address the positive and negative aspects of religiosity on a larger scale. The chapter ends with some early work on the personal consequences of sanctification of professional activities for the professional.

Keywords Spirituality · Spiritually integrated psychotherapy · Spiritual struggles · Positive and negative religious coping · Sanctification

1 Introduction

As George Valliant asserted in *Spiritual Evolution* (2008), there seems to be a basic and biologically *mediated* predisposition in human beings to seek out a loving attachment with something far greater than self—an attachment that seems possible in spite of the spectrum of imperfections in our human self. In many but not all persons this search has been expressed in specifically religious or spiritual language and institutions. For many this quest is extremely important (“*sacred*”). It also becomes something that must be fiercely protected from various real or perceived threats or interferences, one reason we have so many religious wars—more on this below.

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Mental health professionals are frequently consulted by people whose search for that special connection have had problematic consequences or expressions. These consequences are sometimes in the form of specific psychopathology, but also may be a more “ineffable” feeling of loss, alienation, incompleteness, or desperate hunger for that connection.

It is important to respect this seeking and the efforts to achieve or protect it and to listen appreciatively to the religious or spiritual language that is most meaningful to our patients as they attempt to communicate their desires *and* their distress.

We will use a clinical story to anchor this communication and describe how key elements of the research and scholarly literature may be applied to a particular patient over time. We will describe the perspectives of religious studies scholars and conclude with recent work describing the consequences for “seeking the sacred” in professional and personal life.

2 An Illustrative Clinical Story

The case begins with an example of how a shared “sacred moment in psychotherapy” unfolds and then discusses how that “moment” helped to attenuate insecurity resulting from a series of developmental interferences and became translated in a longer term treatment effort to help the patient manage interpersonal and intrapsychic conflicts. The story describes a patient communicating a previously undisclosed “anomalous/paranormal/sacred” experience (Lomax et al. 2011; Lomax and Pargament 2011). For some of us, these are “Sacred Moments” to be treasured and shared in the right relationships regardless of their ultimate (ontological) meaning.

“Mary” was a mid-career ICU cardiologist and had been in treatment for over a year when the following session occurred. Her psychiatric diagnosis was major depression. She was distressed by a long series of disappointments in her personal and professional life. A significant element of her developmental history is that she had a series of emotionally severe developmental interferences beginning with rather extreme and somewhat odd failures of “self-object function” (acceptance, mirroring, and affirmation) by both parents. Repetitively she would come to them with an idea, thought, accomplishment, or feeling to which they would respond dismissively, accusingly, or in other ways that made her feel foolish or “inappropriate.” She felt herself to be particularly unloved and unappreciated in comparison to her younger brother. He was favored and incomprehensively supported (by both parents, but especially her mother) in spite of behaviors that ranged from disagreeable to illegal and frequently quite dangerous for her and her family. (Managing a sense of “unfairness” when good and desired things and relationships happen to “bad” or competitive others is a frequent source of spiritual struggles.)

Mary had attempted treatment with several psychiatrists and other professionals before referral for a more intensive psychotherapy. We were meeting twice a week at the time of the following session. She was a faculty member of a department led by an internationally famous physician, Dr. C, who directed a major research pro-

gram. More importantly to this story, however, Dr. C. had also possessed an incredible, almost mythic ability to make not only faculty and residents, but also staff and students, feel important and valued members of “The Team.”

The following are “Process Notes” from this pivotal session.

Mary: “I feel pretty good today. I do not have much to say ... You keep saying that I don’t trust you, but I think I am trying as hard as I can to do that.”

Therapist: “It seems like you take my observations, especially those related to the difficulty of our project, as a criticism or a statement that you should be somehow different than you are.”

She then described a recent paper she had written about her work on death. That interest was her response to her family’s avoidance of discussions about deaths in their family. For her, this particular avoidance was one of a series of interactions that frustrated her desires for intimate, shared connections with important attachment figures. She had been academically successful, but terribly lonely and desperately seeking “sacred connections” to important others as a young professional.

Mary: (With a bit of hesitation) “I have had other experiences that I am not comfortable talking about.”

Therapist: “What do you think is making you uncomfortable?”

Mary: “Well, they *are* strange and I don’t know how to feel about them. Does anyone ever talk to you about things like that?”

Therapist: “I think you are afraid that I am going to make you feel worse, silly, or inappropriate.”

Mary: “Yes, and here’s something weirder and am not sure I can talk about this. (She begins to cry.) You know I felt very close to Dr. C. (her beloved academic mentor). Before he died, we all knew he had cancer. I asked to meet. I wanted him to know how much he meant to me. Actually, he spent most of that time comforting me! At the end, I told him I loved him and gave him a kiss on the cheek. He gave me a kiss back and said that he loved me also. As I left, I tried to help him with his chair. He laughed and said ‘I’m not dead yet!’” “Later that month I was in Alaska with my fiancé. I didn’t have email access. About 2:00 PM that day, close to the time when Dr. C. was dying in Houston, we were dog sledding out on a glacier with nothing but snow around us. I got off the sled. It felt like Dr. C. was standing next to me. I felt him and heard something like his voice inside me saying: ‘Yes, I’ve died, but I love you. I will always love you, and you will do well.’ Of course, I began to cry just like I am now, but I got back on the sled to finish the ride. I didn’t say anything about this to my fiancé. I was concerned he would think I was too weird. The next day, I called my mother. She began the phone conversation by asking ‘Have you heard?’ I said: ‘Yes, I heard’ (but, nothing else). She mentioned when Dr. C. died. It was right before I had that experience. I still couldn’t

talk about it to anyone. (This event had actually happened months before *the* session being discussed.)” “After the ship arrived in Anchorage, my fiancé and I took a trip to Denali National Park. Mount McKinley is famous because it can be so difficult to see the top of the mountain. When we got there, the mountain, of course, was covered in clouds. I stood there and asked Dr. C. to move the clouds off the mountain as a sign to me that he was alright. Of course, nothing happened immediately, but 2 h later, the clouds cleared for three whole days. Everyone there said they had never seen anything like it. For me, that was very special.”

Therapist: “That was very special indeed.”

Mary: (Crying a bit more intensely) “I have never told anyone about this till now. Those moments will always be special to me.”

Therapist: “They should be. It’s a very beautiful love story.”

Mary: “It is also surprising to me. Does this routinely happen?”

Therapist: “The sort of love that you had with Dr. C. is hardly routine.”

Mary: (Crying a bit more heavily and a bit irritated with my version of “neutrality”) “But do other people have experiences like this with people who have died?”

Therapist: “Only if they are extremely lucky.”

Mary: “I had lunch with my dad today. His Parkinson’s is getting worse. Even a very small thing I say that could possibly be construed as a criticism makes him so labile. The conversation went well, but it took quite a bit of effort on my part.”

Therapist: “That effort *and love* is even more remarkable because you provide him empathy, attention, and love in a way that, for whatever reason, he couldn’t consistently give you as a little girl.”

Mary: (Getting up from the couch and smiling though still with a lot of tears) “I’ll probably cry the rest of the afternoon. Thank you for letting me tell you this. I may even tell my fiancé now.” (She did, but almost a year later.)

Therapist: “Stories like this get richer when told in safe relationships to the right person. Clearly today has been a major step and probably both of us are thinking about how you started the session with the protest that you didn’t have much to say. (Patient chuckles.) Something like this is, of course, incredibly important. Try to capture wherever this session goes inside you to bring it back so we can know about it together.”

Mary: “Thank you very much” (leaves).

3 Connecting the Clinical Story to Research Findings on Paranormal/Sacred Experiences

Jeffrey Kripal provides important historical and research perspectives on paranormal experiences. Experiences like the one just presented (a) are rather common and have stimulated scientific and scholarly discussions reflective of the time in which they occurred; (b) may be considered similarly to discussions of “the sacred”; (c) tend to be very meaningful for those who experience them; (d) often occur with the loss of emotionally significant figures and/or love relationships; and (e) if shared constructively, may help in the healing of traumatic loss (Kripal 2010; Lomax et al. 2011).

Such extraordinary experiences like this patient had can be observed in the history of religions. Toward the end of his psychobiography of Jesus, for example, Donald Capps (2000) suggests that the appearances of Jesus after his death either “originated in dreams—where he appeared to the dreamer—or that the creation of such stories was comparable to the involuntary production of dreams” (pp. 263–264). Capps adds that these appearances were not “driven by ideological purposes of conscious political strategy” (p. 264). He also notes Ernest Hartmann’s view that dreaming can serve a quasi-therapeutic role in resolving or working-through trauma or stress (States 1993, p. 27). The appearances of Jesus to those who loved him, if understood as dreams or like dreams, would have had a healing effect for them. Capps writes:

For those close to Jesus, dreams may well have had a quasi-therapeutic role in the sense of integration and healing in resolving the trauma of Jesus’s sudden death by crucifixion. In addition, he may have appeared to them in dreams, and such appearances would have been experienced as contingent, unmotivated by the dreamer, and thus as initiated by Jesus himself. In these two ways, dreams would have enabled the bereaved to mourn their loss, but also to affirm that he had not abandoned them. (p. 265)

For the disciples, just like the patient in the case discussed above, such a sacred contact with someone after death was extremely lucky.

It is more difficult to say with certainty that the world is lucky for the disciples of Jesus having had these experiences, eventually leading to Christianity becoming the largest religion on the planet. In the foreword to Raymond Lawrence, Jr.’s *Sexual Liberation: The Scandal of Christendom*, Capps (2007) notes a time when he was having lunch with a seminary colleague, who was an expert in church history. Capps asked his colleague: “How do we know that the best views prevailed and the worst ones went down to defeat?” (p. xiii). He continues:

His look told me that he had heard some dumb questions before, but this one was in a class by itself. “Do you seriously think that God would let that happen?” He didn’t wait for an answer but instead signaled that he had to go to class. (p. xiii)

The answer to this question is not obvious. While sacred moments and religious movements can play positive roles in the world, the reverse is the case as well.

Therefore, as articulated so thoughtfully by William James (1985) in *The Varieties of Religious Experience*, religion must be judged by its fruits.

4 The Sacred Moment as a Significant Aspect of Psychotherapy and Psychoanalysis

Kenneth Pargament suggests that sacred moments are *identifiable* and *have tremendous power* in peoples' lives. He also notes by addressing sacred moments in treatment, practitioners may enhance the therapeutic *alliance* and, in turn, the *effectiveness* of treatment (Pargament 2007).

5 Qualities of Sacred Moments

Sacred moments can encompass any human experience of transcendence, boundlessness, and ultimacy (Pargament and Mahoney 2005), experiences of the kind just described. *Transcendence* refers to things set apart from the ordinary, the immediate, the everyday: like the sign she requested and received from her mentor, Dr. C., following his death or the highly unusual clearing of clouds off the top of Mount McKinley. *Boundlessness* has to do with perceptions that go beyond the limits of ordinary time and space. Mary "hears" her mentor tell her: "Yes, I've died, but I love you, and I will always love you." *Ultimacy* refers to perceptions of deep truth, "the really real." Because they are perceived as absolutely true, absolutely real, sacred experiences can have tremendous authority and legitimacy. They may be written indelibly into human memory. For Mary, one would *hope* and *try to help* her to hold on to the memory of her spiritual encounter with Dr. C. for the rest of her life. In part, the chances of that resource enduring is determined by the way it is told, received, and experienced in key relationships.

Research survey studies reveal that a majority of people who experienced the death of a loved one report a continued connection with them: hearing a voice, feeling a touch, sensing a presence, or catching a glimpse of the deceased (e.g., Sormanti and August 1997).

6 Sacred Moments May Have Consequences in People's Lives

Empirical studies suggest that the emotions related to the experience of sacredness have a variety of implications. Vaillant (2008) considers these and related emotions as part of an adaptive, evolutionary impetus for spirituality. These *positive, spiritual*

emotions (such as love, awe, joy, etc.) are linked with significant psychological, social, and physical benefits.

Finally, sacred moments can become organizing forces that lend coherence to disparate thoughts, feelings, actions, and behaviors. Sacred moments—if usefully internalized—*can serve* as pivotal points in time that lead to fundamental, life-changing transformations. Consider again the message received by the patient from her former mentor—“I will always love you.” A message of this kind could have a profound and lasting impact for someone with a history of troubled relationships with her primary attachment figures.

7 Such Extraordinary (Sacred) Moments Should Be Addressed Directly in Treatment

It is paradoxical that people are often most reluctant to discuss those experiences that hold greatest power. Mary admitted that she was uncomfortable talking about these experiences and had never shared them with anyone before. This discomfort reflects fears about how others, including her therapist, might respond to these experiences. These fears are not ungrounded, given the history of antipathy of mental health professionals to religion and spirituality. When Mary went on to ask whether other people have similar experiences with people who have died, and the response, “Only if they are extremely lucky,” turned out to provide an affirmation that helped move the therapy to a deeper, more profound level. In fact, it helped bring the sacred moments Mary had experienced outside of therapy into the therapeutic relationship itself in what might be considered a “corrective emotional experience.” Such therapeutic experience can help to heal developmental interferences from unfortunate experiences at earlier “critical periods” of developmental vulnerability/opportunity.

8 Spirituality as Attachment Seeking

From a psychological perspective, the “spiritual” dimension of religious participation can also be seen as an expression of “attachment behavior.” Of course, the term “spiritual” is used to mean very different things, including “beliefs,” i.e., cognitions. At least one definition of spirituality, however, in both the medical/scientific and religious/theoretical literature is to refer to a type of “*seeking* behavior” satisfied by relationships of a particular quality—spirituality as seeking the sacred (Pargament 2013). Whatever “actually happened” on that mountain top at the time of her mentor’s death, this patient “added something of personal significance” to it (Meissner 1984). Our therapeutic job is to help Mary nurture and use it in our relationship and in her life.

9 Religion as Individual and Group “Cognitions” or Beliefs

In contrast to spirituality-as-attachment, formal religious organization and particularly religiously-based moral or ethical reasoning can be considered as expressions of the human capacity to order experience and to predict outcomes (Wolford et al. 2000). The psychoanalytic concept of *mentalization*, as described by Peter Fonagy and Jon Allen (Allen and Fonagy 2006), argues that such cognitive ordering of perception includes affective states and allows us to create a set of working theories about the minds of other peoples’ intentions, motivations, and plans. This ability to “keep an other’s mind in mind” allows us to function successfully in a complex, interdependent society and informed the therapeutic actions just described.

10 Religious Acts and Activity

For clinical purposes, a third “variety” of religious experiences may be considered to be the domain of religious activity and community participation. Active religious participation is more likely to be health promoting than passive religious participation. Activity that reflects the psychological capacity for “generativity” seems to be of particular value in this regard (Burgener 1994; Vaillant 2002). Not only the “being in” community, but also “doing for” others seems health promoting. Thus, knowing what our patients “do with” their anomalous, religious, or spiritual experience is important in assessing the healthcare consequences of such experiences.

11 Problematic Aspects of Religion: A Caveat

But it is important to be aware of problematic aspects of religion and/or the sacred. In *Moral Purity and Persecution in History* (Moore 2000) Barrington Moore, Jr. provides a thoughtful and incisive critique of monotheism. He writes: “Monotheism, in the straightforward sense of belief in one God and only one God, was apparently invented only once in human history. It necessarily implies a monopoly of grace and virtue to distinguish its adherents from surrounding and competing religions. The competition was, and has remained, fierce and cruel” (pp. ix–x). The idea of monotheism, Moore observes, is found in the Old Testament/Hebrew Bible. This allegiance to one God, where outsiders were coded as impure and contaminating, led to religious violence so as to protect God and God’s people from pollution—religious violence directed towards those outside of one’s religion. Moore also observes that there has been religious violence within monotheistic religions—for example, in sixteenth-century France, Protestants and Catholics butchered each other all in the name of fidelity to their own version of monotheism. This is intra-religious violence.

Given these problematic dynamics of various religious traditions, one might be tempted to conclude that it would be best to leave religion behind altogether, promoting secular ideologies instead. However, the various revolutions of the twentieth century—Stalinism, Maoism, and Nazism—took more lives than all of religious warfare of human history combined, in large part because industrialization has made mass killing easier. Still, secularization is no safeguard against violence. Moore drives this point home by focusing on the French Revolution. In the eighteenth century, a new, secularized monotheism emerged that was no less violent than religious monotheism; those who were not true believers in the revolution were considered evil, and they were executed. Moore writes:

The behaviors that surfaced in the French Revolution were the familiar ones of militant monotheism. There was the usual demonization and dehumanization of actual and potential opponents. Revolutionaries perceived them as outsiders, threats to human society who should be expelled and killed. (p. 103)

King Louis XVI was beheaded on January 21, 1793, by secularists who had the clarity and conviction of fundamentalists.

Moore (2000) also addresses non-Western religions, such as Hinduism and Buddhism. He asserts that, while polytheism did lead to tolerance for a time, when confronted by other monotheistic traditions such as Islam, these religions quickly became violent. Moore writes that “a central conclusion of this study [is] that militant, organized persecution was a product of monotheism, and largely absent in Asia, [nevertheless] offers no grounds for hope [because] Asian societies now offer no refuge for romantic escapism” (p. 133). In other words, there is no easy polytheism that can safeguard against violence.

12 Clinical Consequences and Implications of a “Good Enough” Shared/Sacred Experience

The various problems potentially—and historically—associated with religion make it even more worthy of our clinical attention for what was once an anomalous experience of an individual or small group (e.g., the disciples of Jesus) later becomes a template for larger groups (e.g., Christianity). Indeed, to be truly worthy of our attention, there should be significant treatment *outcome implications* of how the therapist deals with these “very important”/sacred experiences. Our shared experience of her sacred/paranormal encounter with her mentor during the snow storm seemed to be an important building block of a more secure attachment within our therapeutic space building a foundation from which she could better address intrapsychic and interpersonal challenges.

A bit over a year after that event, several things occurred over approximately a 6 week period which initiated an important and clinically useful extension of the therapeutic relationship. We encountered opportunities to “revisit clinical periods of development” and make practical use of that earlier “moment” in our relationship.

These events were precipitated when Mary came upon an article, “The Gift of Depression,” written by a patient with depression whom she speculated was also a patient of mine (Goddard-Finegold 2009). Mary found this article irritating and somewhat threatening, particularly a comment made by the author that a psychiatrist might need to refer a patient to someone else if overstimulated (positively or negatively) by the patient. This made her worry whether she was “too competitive” (both in general and particularly as revealed by her response to the article). She feared that her response would make me “like her less”—especially if I was aware that, in her fantasies, the amount of rage she felt in general and at specific times *in* our relationship—especially about my version of therapeutic neutrality and abstinence—made her want to “use curse words and throw things.” Revisiting this developmentally “critical period” within our treatment relationship might result in a repeat of the rejection, dismissiveness, and abandonment-in-favor-of-others that she had experienced in her childhood.

From time to time Mary had begun to send poems that she had written in response to various things that had come up in our sessions. She slowly came to know (with some relief) that her therapist was quite interested in the poems and not disturbed by her creative reflections upon and constructions of her experiences and our relationship. The poetry elegantly captured important human struggles experienced within the analytic relationship. He would ask her to describe how the poems were evoked and how they developed inside her. During this particular period, she wrote a poem entitled “Moonflower” about the tentative and fragile blossoming of the small flower.

I open each evening
under covers of dark.
Little layers, little husks—
a soft silk unraveling.

It hurts me! This revealing,
this self-shucking.

A black aster in a bed
of bleached-pure sheets,
I’m a thin stalk bent on
her own growth, broken
into red mouth-blooms.

Primroses do not describe me.

I used to enjoy violets,
accepting pruning like pale lilac.

But you have been permissive
of my more unruly wishes.

I dream of wild heliotrope.
A surge of heady wonder!
I wind and entangle myself
as I climb against you—

an explosion of hyacinth,
a profusion of white azalea.

The poem was surprisingly (especially to her) positive and reflected her sense of growth and some increasing tolerance of her unruly wishes. She noted that the “permission” of her analytic relationship allowed her to potentially become something beautiful (like a moonflower), but it also involved an experience of herself which was far less “controlled,” albeit more authentic or “real.” She was quite concerned that the unfolding of that “new” self could be dangerous for both of us.

However, as we worked through her concerns about her unseemly aggressiveness historically, in current relationships, and in the transference, her urges became less frightening and she became more curious about them. She reported even feeling “peaceful with herself.”

As this evolved, she “found [herself] praying again after a long period of time.” Her prayers included requests for “protection of the persons she considers closest.” She also noted that she felt “closer to God” and was somehow a bit less worried about her new found happiness “being destroyed” by God. She even had the thought that her therapist wanted her to have a baby in spite of her frequently expressed concerns about not wanting to “torture a baby the way she felt tortured as a little girl.” Her thought seemed to be an important affirmation that she (and what she might produce) was loveable and worthy of continuation—a positive internalization of our therapeutic relationship.

As we explored how it was that her childhood fantasies often involved “religious ideas,” she recalled and reported newly available, positive memories about her relationship with her maternal grandmother. This grandmother was “very religious and very kind to me.” They would read religious picture books and the Bible together. She specifically recalled the story of Elijah’s ascension in the dessert. Her fantasies about the story quickly included her own childhood wish to be rescued like Elijah, whisked away in a chariot with elegant, muscular horses. These memories seemed connected to the hope that our treatment relationship would—a bit more dramatically than possible—help transform or extract her from the enmeshed misery she experienced.

As we were discussing her memories of Biblical stories, she wrote and sent the poem “Prowler” with a cover note: “This one just came out of me in response to our talks regarding my aggressive nature. I thought you would enjoy it.”

In the middle of the fete
I stood apart
and surreptitiously sharpened
my painted claws
on the stem
of my glass
like any well-preened lynx.

I thought of leaving after
the last sip of wine,
until a passing waiter
offered me a center-cut chop
of roast human
on a silver salver.

Dry-aged and whiskey-fed
at the height of authority,
marbled through with fat
from long days behind the desk.

In the following session, she reported being pleased with herself and the poem. She noted this piece had to do with her “sort of liking our discussion about my aggressiveness.” The poem had “come to her” while she was preparing a dinner involving a “center cut pork chop.” She described the essay as “writing about herself as a cat devouring people in authority.” She recalled how as a little girl she had wanted to be a vegetarian. We connected this wish to be a vegetarian to her “belief” that her aggressiveness and “hunger” for connectedness made her an unlovable, bad person who should be either removed or denied. However, she also noted that in spite of her concerns about aggression, she gets “really aggravated” when she is “not allowed to participate.” She decided that her aggressiveness and competitiveness is often “borne out of feeling unworthy” (which had complicated her personal and professional life). With some embarrassment, she then revealed her wish to be greeted at her sessions with, “How nice to see my favorite patient!” instead of, “Won’t you come in?”

The imagery of “Prowler” revealed important elements of her fantasy life and specifically imaging herself “morphing into a big cat or dragon” and stalking or killing “self-centered people” who excluded her or treated her as undesirable. In her fantasy life, she would have the power to seize what she longed for (both “things” and special relationships) when those were denied her. Such thoughts were sometimes followed by a sort of “verbal tic” in which she felt compelled to repeat the names of the intrapsychically “endangered” others in a private setting, like her closet. We were eventually able to discuss this “tic” and other behavioral retreats as an attempted “undoing” of her aggressive wishes.

Our discussion of the essay seemed lively and quite facilitatory of our work, but was soon followed by another email with the subject line: “Apology.” In this note, she “confessed” that she had looked up an “Introspections” piece her therapist had written (Lomax 2004) about how he had become a psychoanalyst after failing to become a professional baseball player. She also confessed that she found that story “confusing” (i.e., disappointing). She discussed it with her “rather athletic” physician husband. (By this time, she had married her fiancé who had been with her in Denali.) Her husband “understood it right away” and “explained” that both baseball and medicine involved extensive persistence and careful strategic planning. She had felt “really badly” that she had even wondered about the article which she was sure was “none of my business anyway.”

The therapist responded that she seemed *hungry* to know more about him, but afraid that her curiosity would devour or end their relationship, instead of becoming a useful internalization of it. Therapeutic anonymity was indeed frustrating and anger-provoking for her: It felt like excluding her which provoked doubts about her desirability.

Eventually, we connected our exchanges about her preemptory wishes for affirmation and curiosity (that had seemed to her to be evidence of her badness) to previous exchanges about her use of religious language in her relationship with her grandmother. This conversation led her to describe her little girl experience of *communion* (related to the internalization process in dynamic psychotherapy). She recalled how as a little girl she was not allowed to participate in communion at her

church. However, she had frequently been able to “steal the crackers” and eat them later. This “prowling” was her effort to “know” cognitively, and to feel emotionally connected to what she felt was missing and to participate in a relationship and activity from which she felt excluded—consuming symbols of the “body of Christ” offered on a silver platter.

She took some solace from appreciating how her personal “hunger” to seek union with an idealized other in the transference relationship was not all that different from the Christian sacrament expressing the desire to “take in” or “seek union” with the body and blood (bread and wine) of Jesus.

As what seemed like an attempt to take solace from her efforts to achieve tolerance of imperfections in herself and others, she wrote about her experience of falling asleep and her “imagined flight in white air without wings to the you I need you to be (father, brother, husband, son).” Significantly, her piece concludes that “With trepidation I trust” (both herself and her therapist).

13 Clinical Consequences of Sacred Moments: Another Caveat

The wishes to be desired, pursued, and sought are pretty human. In secular music, George Gershwin wrote about the importance of having “Someone to Watch Over Me.” In religious organizations such longings are also captured in hymns and rituals. An example is Psalm 42: “As a deer longs for flowing streams, so my soul longs for you, O God! My soul thirsts for God, for the Living God. When shall I come and behold the face of God?”

Christians celebrate the sacrament of communion as a symbolic taking in of the blood and body of Jesus and, for some Roman Catholics, the bread and wine actually *become* the body and blood of Christ (i.e., the doctrine of transubstantiation). The ritual of communion is sometimes accompanied by hymns like “Jesus Thou Joy of Loving Hearts,” attributed to Bernard of Clairvaux. The not so subtle third verse of this hymn is: “We taste Thee, O Thou living Bread, and long to feast upon you still; We drink of Thee, the Fountainhead, and thirst our souls from Thee to fill” (not all that different from “Prowler”).

The poem “Prowler” communicates “hunger” to know more and to be known, desired, and included captures in words a natural attachment “appetite” mediated by what Jaak Panksepp describes as the seeking system of mammals (Panksepp 1998). Unfortunately, a series of little girl experiences led her to feel “weird and inappropriate” when the expression of her appetites for contact, union, communion, or even a “simple” understanding were met with dismissive and abrupt rejections. The apparently far more favored status of a difficult, disruptive, and demanding brother in spite of her desperate efforts to be “the good child” were activated when she discovered a paper written by someone she inferred was another and perhaps more favored patient.

A “good enough therapeutic relationship” allows the “revisiting” of such developmentally “critical periods” in ways that help our patients to feel more confident and curious about their dispositions *and* their experience with important others. One desired product of a treatment relationship is the internationalization of a more supportive, less critical partner with whom to face the ambiguities of life—a soothing, gratifying, and encouraging internal object relationship instead of a persecutory, humiliating, and punitive one.

Approaching termination, Mary reflected that her therapist had helped her appreciate “*the value of boringness.*” The analysis had helped her to “recapture” her fiancé as a reliable potential husband and father of their children. Her reflection on “boringness” seems a sort of compliment tempered by her frustration at therapeutic neutrality. If the therapeutic alliance is adequate and the treatment relationship survives the inevitable tests of safety and security, “imagined flights” like those of my patient are put into words first in the treatment relationship and then translated into the rest of life.

14 Practical Points for Professionals

During verbal presentations about “sacred moments,” a common experience is that someone in the audience would comment during the discussion period, “I had one of those but haven’t ever talked about it.” Then other audience members would share similar stories. This led one of us (Lomax) to a project focusing on the consequences of seeking and discussing the sacred from the perspective of the mental health provider.

In the project, we utilized a fairly standard research survey of professionals to request descriptions of “important moments in their work with a patient over the past year.” Somewhat surprisingly, 55.5% of our responders indicated that the “moment” in treatment was “sacred” to them (using a non-theistic definition of sacred, a psychological and not theological use of the term). As Pargament and Mahoney (2005) have documented, people rather commonly “sanctify” many aspects of their everyday lives including key activities and relationships. Sanctification of such strivings correlates with higher levels of purpose, meaning, and joy (Mahoney et al. 2013), but also leads to greater distress if what has been sanctified is either lost or betrayed.

Also somewhat surprising was that a significant portion of the sample who characterized their important moment as “sacred” described themselves as agnostic or atheist or “religiously unaffiliated.” The consequences of sacred moments for the therapist included a variety of provider gains: enhanced work motivation, improved therapeutic relationship gains, but *not* burnout improvement (as assessed by the short burnout measure of Maslach). Therapist comments about these experiences were particularly compelling and included statements such as “It was like time had stopped and we were two vulnerable human beings connected at a very deep level ... I felt honored to be a part of it” Such moments tended to emerge out of a safe, secure

therapeutic alliance and with patients or clients who are experiencing a general sense of unease and tension in their life just prior to the “moment” (Pargament et al. 2014).

Healthcare professionals may find that sacred moments are what make our work most meaningful and worthwhile and what sustains us through the challenges of a career that often involves pain and personal or functional loss. Similar moments are probably found in a variety of other helping relationships as well as in intimate friendships and family. Part of the reason why we did not find any improvement in the Maslach Burnout scale may be that such moments are generally *not* shared in the professional environment and may not even be an acknowledged part of the therapist identity or purpose. One form of meaningful continuing education might be to provide “spaces” for colleagues in which such sharing takes place. These activities would be time consuming, but potentially important if they are simultaneously very professional (respecting the privacy and confidentiality of patients), but also very personal (an opportunity to talk about real experiences and the “honor” that we experience in our helping professions).

Also, it seems helpful to consider our therapeutic relationships as both sacred and artificial (Lomax and Gabbard 2004). They are sacred in that they can provide invaluable repairs or corrections for ideas, emotions, aims, and goals that have caused enormous suffering. In happy circumstances, the therapeutic learning gets translated into important new activities and relationships proving a more gratifying and generative future. They are “artificial” because of what we “do” with such moments. They are used as a means to an end and “asymmetric” in ways that are frustrating for patient and therapist alike. We only “talk about” powerful loving emotions in the treatment relationship; we do not *act* on them as would be natural in “ordinary” relationships. A danger for sacred relationships is that they can be exploited or betrayed with the consequence of a painful desecration (Pargament and Mahoney 2005) for our patients and ourselves.

Finally, and very briefly, let’s note the difficult clinical decision about using patient communications between sessions. These were in emails. The use of such electronic communications is a very difficult challenge for medicine in general and psychiatry in particular (DeJong et al. 2012). Mary made excellent use of this boundary crossing or extension. However, it comes at a cost for both therapist and patient and can be a slippery slope leading to a boundary violation. Such use should be made in documented consultation with colleagues you trust—especially those willing to tell you when they think you are making a mistake.

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Spiritual Care: The Role of Health Care Chaplaincy



George Fitchett, Annelieke Damen, Cheryl Holmes, Allison Kestenbaum, and Steve Nolan

Abstract Professional chaplains play an important role in addressing the religious and spiritual needs of patients in healthcare. This chapter offers an overview of their work worldwide with attention to variations associated with national context. A description is given of, among others, the contemporary context in which chaplains operate and emerging issues for the future; models for spiritual care in healthcare including the distinction between spiritual care generalists and specialists; chaplains' training, competencies, certification and registration; chaplains' ethical practice, scope of practice and quality indicators; screening and assessment tools, interventions and outcomes; and finally research into chaplaincy. At the end of the chapter resources are offered for more detailed descriptions of spiritual care in various national contexts.

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1 Introduction

Illness, injury and finitude raise religious, spiritual, and/or existential issues for many people. For example, a US adolescent receiving a stem cell transplant told an interviewer, “Well, I know that He is there and He is helping and there is a reason why I have to go through this” (Ragsdale et al. 2014). A Taiwanese older adult with terminal cancer said, “Living is a daily battle for an old dying person; I simply can’t stay independent like I used to be. Religious support has been like cool drink of water and a crutch to help me on my daily walk through the desert” (Shih et al. 2009). Finally, a Scottish patient referred to a Community Chaplain Listening chaplain told an interviewer, “It was great... I only spoke to him [the chaplain] for a while. I was very very down that day, I was in a terrible state and the doctor did help because he was supportive, he suggested I talk to the chaplain and I am a totally unreligious person in the world and I was very wary of that, but he was dead nice. I walked in suicidal and I walked out full of hope between him and the doctor” (Bunniss et al. 2013). There is a growing body of evidence of the importance of religion and/or spirituality in coping with illness. For example, among over 8000 cancer survivors in the US over two-thirds responded “quite a bit” or “very much” to the item “My faith or spirituality has helped me through my cancer experience” (Canada et al. 2013).

There is also research from diverse national and clinical contexts describing spiritual/existential needs and religious/spiritual pain or distress. For example, among a sample of 203 older medical rehabilitation patients in Switzerland, two-thirds had some unmet spiritual needs, and 22% had unmet spiritual needs rated as severe (Monod et al. 2012). In a sample of 202 British women with newly diagnosed breast cancer 53% reported some religious or spiritual struggle (Thuné-Boyle et al. 2011). In a sample of 168 Chinese patients from Shanghai 10% had strong needs for prayer, 17% had strong needs for inner peace, and 20% had strong needs for giving and generativity (Büssing et al. 2013). A growing body of research in diverse national and clinical contexts indicates that religious/spiritual struggle or pain is frequently associated with higher emotional distress, poorer quality of life, and poorer functional ability (Boscaglia et al. 2005; Pargament et al. 2004; Ramirez et al. 2012).

In light of this it is clear that whole person health care must be attentive to the religious, spiritual, and existential issues associated with illness and injury for the patient and their loved ones (Puchalski and Ferrell 2011). This is especially the case in situations where such issues compromise recovery or adjustment to illness. In such cases consideration should be given to a referral to a professional chaplain or other spiritual care provider. The recognition of the importance of spiritual care in palliative care provides a model for other areas of clinical care (Puchalski et al. 2009).

The aim of this chapter is to describe how spiritual care is provided to address the religious, spiritual, and existential concerns of patients and their caregivers. We begin with a description of several contemporary issues in culture and in health care

and their influence on spiritual care. This is followed by a description of models for spiritual care and of those who provide spiritual care. We include here descriptions of the training and qualifications of health care chaplains from several national contexts. Next we describe what chaplains do including their assessments, interventions, and work with interdisciplinary teams. The chapter closes with a description of important issues for the future of health care chaplaincy. We have attempted to note some of the national variation in spiritual care in health care but limited space precludes comprehensive coverage of those differences.

As we begin, it is important to clarify some key terms. Important consensus definitions of spirituality have been reported (Puchalski et al. 2014). In those statements meaning-making is a central aspect of spirituality. In some cultural contexts, such as the Netherlands, this approach to spirituality includes people who describe themselves as agnostics or atheists. In this chapter we will use spirituality in this broad sense. In our view spirituality and religion are related, but different, concepts. Both include ‘the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred’ (Hill et al. 2000, p. 66). Religion’s unique distinguishing feature from spirituality is its inherent organizational nature – that the ‘means and methods (e.g., rituals or prescribed behaviors) of the search receive validation and support from within an identifiable group of people’ (Ibid.). It is also important to note there is some diversity in the term used for the professionals who provide spiritual care in health care. In most contexts such persons are referred to as chaplains or professional chaplains. In order to be more inclusive some national contexts have replaced the term chaplain with spiritual care provider or spiritual caregiver. We use all these terms in this chapter.

2 The Contemporary Context of Health Care Chaplaincy

Health care chaplaincy refers to spiritual care provided within health care systems which are described as “all activities whose primary purpose is to promote, restore, and maintain health” (World Health Organisation 2000). This includes activities delivered across multiple levels: primary, secondary, and tertiary health care.

Health systems themselves function within, and are impacted by, wider societal changes. These include global inequalities in life-styles and access to basic living standards. Dr. Chan, the recent World Health Organisation Director-General reported that, “in 2010, the USA alone spent US \$124 billion on cancer care. Worldwide, some 30 countries, including 15 in sub-Saharan Africa, do not possess a single radiation therapy machine” (Chan 2013). The contrasts between health systems can be stark, but they also face many similar challenges. These include increasing economic pressures and growing demands upon health care as a result of the rise in chronic lifestyle illnesses, ageing populations and technological advances. Contemporary spiritual care in health care is also being shaped by multiple factors the two most important of which are economic pressures in health care and complex changes in the religion and spirituality of the people being served.

There is a move within health systems for services to demonstrate value by incorporating measures of outcomes based on quality of care and patient experience of care. This is partly in response to patients identifying the lack of compassion in their health care experience (Firth-Cozens and Cornwell 2009). The advent of patient-centered or person-centered care in health care is a direct response to this focus on quality of care and patient experience. This creates an opportunity for health care chaplaincy. Patient-centered care requires that the focus is on the whole person, including their beliefs, preferences and values, and is grounded in respect and compassion (Australian Commission on Safety and Quality in Health Care 2011; Firth-Cozens and Cornwell 2009). Professional health care chaplaincy is called to take up the challenges of meaningful outcome measures that demonstrate the value of spiritual care's contribution to patient-centered care (Handzo et al. 2014). Some progress has been made through international collaboration in the development of quality indicators for spiritual care (HealthCare Chaplaincy Network, HCCN 2016), the development and evaluation of a spiritual care taxonomy in the USA (Massey et al. 2015), and further research on The Scottish Patient Reported Outcome Measures for spiritual care (Snowden and Telfer 2017).

With migration and the numbers of refugees and those seeking asylum, Western democracies have increasing numbers of people from different cultures and faiths brought together in diverse communities. Creating and maintaining social cohesion is a challenge in these multicultural and multifaith communities, as is ensuring health services are equipped to respond to diverse health care needs.

In many places there is a move away from traditional religious affiliations, with both increasing secularization on the one hand and a growing interest in spirituality on the other. David Tacey (2012) explores this nexus and identifies "what we are seeing today are the primal stirrings of spirit, without the social institutions or forms into which spirit can be clearly recognized. The secular and religious are irritated by this inchoate condition of spirit, because it unsettles established orders" (Tacey 2012, p. 477). Attitudes towards religion and religious belief continue to change as demonstrated in census data collected in many Western countries. Increasingly data demonstrates a decline in recognizable forms of religious identification and practice and a parallel rise in those who claim no faith affiliation (Australian Bureau of Statistics 2011; British Religion In Numbers 2015; Pew 2015). This has given rise to growing numbers of people who report no religious affiliation ('nones') or who identify as 'spiritual but not religious' (Mercadante 2014). There are many reasons for these changes. The shifts in societal attitudes towards equality and sexuality have not been reflected in the behaviors and attitudes of those representing religious institutions. In more recent years the uncovering of abusive behavior by religious leaders, particularly those involving children, has diminished the Church's standing for people from many countries. The religious forms and influence of the past are changing and this impacts profoundly on health care chaplaincy. Chaplaincy must renegotiate its relationships with the authority of religious institutions, its response to people from many cultural backgrounds and faith traditions, its place in the health

system and re-think the role of the chaplain. Christopher Swift (2014) describes the changing paradigm for chaplaincy in the United Kingdom,

One of the questions facing chaplaincy is that if faith-specific forms of belief are in decline, should chaplaincy continue to be faith-based and denominationally delineated? Just as chaplaincy bodies and individual chaplains describe their role as those able to meet increasing levels of non-religious spiritual needs, the question arises as to why the vast majority of these chaplains are required to be religiously authorised. As time goes on, I suspect that this will become a growing question and one ever more difficult to answer with credibility (Swift 2014, p. 178).

While attitudes about religion and spirituality are changing recent research in diverse national contexts suggests patients are interested in spiritual care. A study of 94 palliative care inpatients in Korea found that two thirds felt it was appropriate for staff to address their religious/spiritual issues (Kang et al. 2012). In a US study of 202 general medical surgical in-patients, one-third expressed a desire for a visit from a chaplain (Fitchett et al. 2000). A study conducted among 364 patients in an out-patient oncology clinic in Israel, where spiritual care in health care is relatively new, found that 25% were definitely and 16% possibly open to a spiritual care visitor (Schultz et al. 2014). In this study, prior experience with a spiritual care visitor was a strong predictor of interest in spiritual care. A study conducted among 331 medical patients in Switzerland found that 86% accepted the offer of a visit when it was made by the chaplain while only 38% responded positively to a nurse's offer to have a chaplain visit (Martinuz et al. 2013). Personal experience with a spiritual care provider may play an important role when unfamiliarity or negative stereotypes are common (Kelly 2007). A large study of satisfaction with spiritual care in the US included reports of patients' expectations of chaplains (Piderman et al. 2010). Among these 1591 former patients, 78% desired a chaplain visit because it reminded them of God's care and presence. Other things that were valued by more than half the respondents included: offer support to family or friends (71%), be with me at times of particular anxiety or uncertainty (69%), pray and/or read scripture or sacred texts (62%), and listen to me (59%).

In her speech to the 38th World Hospital Congress, Chan (2013) stated that while we have seen major shifts in the burden of disease and rapid advances in technology worldwide in recent times, health care systems have remained 'stuck in a previous century' (Chan 2013). The same critique could be ascribed to the religious institutions today. It seems that health systems globally are heeding the challenge for transformation towards patient-centered care and quality of care (Reich et al. 2016). Chaplains are engaged with interfaith and 'no faith' spiritual care and are found working across the whole spectrum of the health system. Whether in hospitals, aged care, community settings, palliative care, or mental health care, the challenge for health care chaplaincy remains the same. Chaplaincy needs to ensure that the models emerging in this contemporary health care context contribute to the transformation that seeks to re-humanize health care. This will happen through the provision of compassionate, person-centered spiritual care integrated as a fundamental component of the health system (Puchalski et al. 2014).

3 A Model for Spiritual Care

There are many similarities and best practices in how spiritual care is provided around the world. However, there is no universal standardized approach to spiritual care in health care (Jankowski et al. 2011; Massey et al. 2015; Vlasblom et al. 2014).

The framework of spiritual care specialists and generalists is a helpful way to understand spiritual care provision in health care settings. While the chaplain may be considered the specialist in spiritual care, ideally all health care providers have general knowledge about spiritual needs and resources and how they intersect with medical care. For example, it can be very effective for a physician to be a spiritual care generalist who is able to recognize and affirm a patient's spiritual needs and resources, and as indicated make a referral to a chaplain (Handzo and Koenig 2004; MacLean et al. 2003). Spiritual care may also be provided by community clergy or volunteers from various faith and spiritual traditions.

A well-described framework is the Marie Curie Cancer Care Spiritual & Religious Care Competences for Specialist Palliative Care (MCCC 2003). Formulated with the assumption that all staff and volunteers provide spiritual care, this model consists of four levels of competencies, starting with those that should be achieved by all caregivers, progressing in specialization to chaplains. The first three levels include staff and volunteers that have (1) casual contact with patient and/or families; (2) required patient care duties; or are (3) members of the multidisciplinary team. They are examples of spiritual care generalist. The fourth level consists of spiritual care specialists whose primary responsibility is to provide spiritual care. This model also describes the competencies – knowledge, skills and actions – that are expected of caregivers at each level.

4 Background of Professional Chaplains: Training, Competencies, Certification and Registration

Across nations, and sometimes within nations, there is considerable diversity in the training and competencies expected of chaplains and in whether they are licensed or certified and by whom. Here we describe how these issues are handled for four national contexts: Australia, the Netherlands, the United Kingdom, and the United States.

4.1 *Australia*

Clinical Pastoral Education (CPE) is the most commonly recognised training for professional chaplains, based on the US model originally brought to Australia in the 1960's. The national professional association Spiritual Care Australia (SCA) was

launched in 2010 and has two levels of membership for professional chaplains, 'certified' and 'certified advanced' (www.spiritualcareaustralia.org.au). These membership levels are the first attempts in Australia to define training requirements. Certified level membership requires tertiary level education with supervised training equivalent to one unit of CPE, while certified advanced membership requires post-graduate level studies and supervised training equivalent to two units of CPE. Membership in SCA is not mandatory and therefore these standards are not necessarily a requirement for employment as a chaplain. SCA published the first national Standards of Practice in 2014. Prior to that the Australian Capital Territory (ACT) had produced Standards for Pastoral Care (www.pastoralcareact.org.au) and a Capabilities Framework for Pastoral Care and Chaplaincy was available in Victoria. Spiritual Health Victoria published a new Capability Framework for Spiritual Care Practitioners in Health Services in 2016 (www.spiritualhealthvictoria.org.au). This framework is based on two key workforce capability documents in Australia that for the first time aligns spiritual care capabilities under the same domains used to describe the capabilities of other health professionals. This has resulted in the recognition of spiritual care practitioners in Victoria as allied health professionals. There is currently no national certification or registration process for chaplains in Australia.

4.2 Netherlands

Dutch spiritual caregivers work in health care as well as other contexts such as the military, prisons, law enforcement and as independent practitioners. They are trained in an overall 1- or 3-year Spiritual Care Master of Arts program at several universities, either in a non-denominational program or in a program affiliated with a specific religion or worldview such as Buddhism, Christianity, Hinduism, Humanism or Islam. Their training consists of theoretical knowledge (e.g. methodologies of spiritual care, philosophy, psychology, ethics, religious and philosophical source texts, narrative theory and theory of meaning making) and of practical skills (e.g. counseling training, conducting spiritual assessments, performing and developing rituals, facilitating group work, guiding moral case deliberations, and conducting research) including a several month internship.

As a requirement for employment, spiritual caregivers need to be endorsed by a Protestant, Catholic, Humanist, Muslim, Jewish, Hindu or Buddhist faith/ideological organization, or, if they wish to be non-aligned, by a special council (Council for Institutionally Not Endorsed Spiritual Caregivers, *Raad voor Institutioneel-Niet-Gezonden Geestelijk Verzorger*, <http://vgvz.nl/sectoren/sing-institutioneel-niet-gezonden/>) that verifies their spiritual competence. In addition spiritual caregivers are required to be part of the professional association for spiritual caregivers (*Vereniging van Geestelijk VerZorgers*, www.vgvz.nl) and listed in the Dutch quality register for spiritual caregivers (*Stichting Kwaliteitsregister Geestelijk Verzorger*, www.skgv-register.nl).

The Dutch professional association for spiritual caregivers published their first National Standards of Practice in 2002 (*Beroepsstandaard Geestelijke Verzorging*, http://vgvz.nl/wp-content/uploads/2016/06/beroepsstandaard_definitief.pdf), and revised this in 2015.

4.3 *United Kingdom*

Historically, UK health care chaplains have been recruited from clergy, whose ministerial formation and pastoral practice has been supplemented by some experience in a health care setting. However, the ambition for professional recognition led the College of Health Care Chaplains to develop a Bands and Duties Framework (UKBHC 2015). Developed in accordance with the National Health Service, this framework specifies training requirements for each band. Thus, entry level chaplains (Band 5) require a Bachelor's degree, while a lead chaplain (Band 7) should be a postgraduate and have 5 years' chaplaincy experience. Access to academic courses specific to health care chaplaincy is typically through distance learning (www.ukbhc.org.uk). An on-line introductory training course for newly appointed chaplains is also available (learn.ukbhc.org.uk). Nonetheless, the specified training requirements remain indicative not mandatory – indeed, an advertisement posted at the time of writing put a prospective Band 6 chaplain's ability to reach the hospital in less than 1 h as a higher priority than their academic training! Despite the widely held view that modern health care chaplaincy aims to care for people of all faiths and none, UK chaplains continue to require authorization by a faith/belief community. This is being challenged by UK humanist groups and, as highlighted above, it is an arrangement that is demanding renegotiation.

4.4 *United States*

Four units of CPE accredited by the Association for Clinical Pastoral Education, Inc., is the primary training for professional chaplains in the United States. A unit of CPE typically consists of at least 400 h, with a minimum of 100 h of didactic instruction. The remaining hours include direct clinical practice and individual and group supervision.

There is ongoing conversation about what education for professional chaplaincy ought to be (Fitchett et al. 2015). Some argue that chaplains' training and credentialing ought to be parallel to other allied health disciplines. Meanwhile, the major chaplaincy certifying bodies in the US share common standards which require masters level theological education, four units of CPE, a year of fulltime chaplaincy work experience and a packet of essays and a peer interview to receive board certification (Ford and Tartaglia 2006; also see [Resources](#) below, Council on Collaboration 2004). Faith group endorsement has also been required for chaplaincy board certifi-

cation but several humanist chaplains have recently been certified. Additional specialty certifications (e.g., hospice and palliative care) have begun to be developed.

5 Ethical Practice and Respecting Diverse Beliefs

There are several layers of ethical consideration built into chaplaincy training and practice. Because many chaplains work in interfaith settings, a primary ethical requirement in many national contexts is that chaplains respect and are curious about all patients' spiritual and religious beliefs. They must also refrain from any kind of proselytization (See [Resources](#) below for Standards of Practice of the different national contexts). Other ethical considerations relating to boundaries in relationships may be set by institutions, chaplaincy certification and registration organizations, and CPE training centers. In addition, many chaplains learn about ethical practice as a spiritual caregiver in their theological studies. Most professional chaplaincy organizations have clear protocols to report and investigate ethical violations and concerns.

6 Other Spiritual Care Providers

Community clergy and other faith community leaders and lay leaders can be a critical source of spiritual care to people in health care (VandeCreek and Mooney 2002). No matter the size of a chaplaincy department in a hospital or other health care setting, there will always be a need to reach out to community clergy and religious leaders to meet unique needs of patients and their families. Many hospitals have contacts in the local community who are available to visit patients, perhaps to meet a sacramental or ritual need or simply just to provide familiarity and comfort (Hays et al. 2011). Many patients have clergy from whom they would like to receive support during a hospitalization or to assist with health care decisions (Balboni et al. 2017). When in the midst of a health crisis or facing the end of their life, some people without a current religious affiliation feel drawn back to a religious or spiritual practice that was once a part of their life (Lee 2002; Thiel and Robinson 1997). In such cases community clergy or faith community leaders can be contacted by the health care institution and may provide great comfort. However, some caution should be taken as there is evidence that community clergy maybe unfamiliar with the health care setting, uncomfortable around people with serious illnesses and ill-equipped to provide spiritual care for them (Goodhead et al. 2016).

Volunteers and lay visitors. Some spiritual care departments make use of trained volunteers. Spiritual care may also be provided by lay visitors, individuals who usually identify with a particular faith tradition (Guckenberger 1988). They may feel a personal calling through their faith community to visit with the sick or may do so as part of their service to and with their house of worship. The amount of training and

skill level of such visitors differs widely. The only consistent factor may be that which the health care institution requires for them to work in the setting, such as training in patient confidentiality and infection control. Spiritual care volunteering is a pathway for some to pursue chaplaincy as a professional vocation. Trained volunteers have been used to visit new patients, provide them with information about the hospital's spiritual care services, and conduct a preliminary screening of spiritual need (Derrickson 1995).

Other health care professionals As mentioned previously, some health care professionals such as doctors, nurses, or mental health providers, consider spiritual care to be part of their role (Koenig 2014; MacLean et al. 2003; Puchalski et al. 2009). This may include taking a spiritual history or in some cases praying with a patient (Ehman et al. 1999; Post et al. 2000). Some are grounded in a particular religious or spiritual practice. Others may have a general interest in the spiritual and existential concerns and suffering of their patients and work to address this as part of their role. Some may have formal training in providing spiritual care (Zollfrank et al. 2015).

7 What Chaplains Do: Scope of Practice

The scope of chaplaincy practice is so broad that an account of what chaplains do risks being an exhausting list of interventions. A US study, the first 'to systematically document and analyze the actual interventions of chaplains in multiple health care institutions' (Handzo et al. 2008, 50), identified 17 different types of chaplain intervention. Using data from 30,995 chaplain visits, gathered over a 2-year period at 13 health care institutions in the Greater New York City area, the researchers categorized nine interventions as religious or spiritual (hearing confession or amends; faith affirmation; theological development; performing a religious rite or ritual; providing a religious item; offering a blessing; praying; meditation; and other spiritual support) and eight as general or not specifically religious (crisis intervention; emotional enabling; ethical consultation/deliberation; life review; patient advocacy; counseling; bereavement; and empathic listening) (Handzo et al. 2008).

More recently, an Australian review of 203 articles that had interest in what spiritual care practitioners do, detailed an even greater variety of spiritual care interventions (Morgan 2015). The review highlighted the key role chaplains play in pediatric palliative care, ICU, and particularly in hospice and end of life care. In these settings (and others not highlighted in the review) chaplains provide: spiritual assessment; spiritual and religious care of patients and relatives; support the dying and their families; offer presence; support end of life decision making; hold religious services; provide funeral and memorial services; and offer bereavement support. In addition, the review noted that chaplains frequently address particular conditions, such as pain, divine struggle, cancer, heart failure, cardiac surgery, mental health/psychiatric conditions, including, for example, generalized anxiety disorder, and provide dignity therapy. Alongside their patient-facing work, chaplains may support the spiritual and religious care needs of staff and volunteers, participate in debrief-

ing staff, serve on medical ethics committees and play an active part in interdisciplinary team meetings.

Despite inventories developed by specific chaplaincy departments or for specific research projects, there is no standardized description of the services provided by chaplains. This situation compromises communicating what chaplains do, and its potential value, to health care colleagues and decision makers. It also essentially prevents research about chaplain activities across institutions let alone nations. There have been some efforts to develop standard descriptions of chaplain activities (Gibbons et al. 1999). Colleagues in Australia have developed descriptions of chaplain activities that are consistent with the ICD format (Carey and Cohen 2015). The Chaplain Taxonomy by Massey et al. (2015) represents the most comprehensive effort to describe what chaplains do. The development of the Taxonomy included a literature review, retrospective chart review, focus groups, self-observation, experience sampling, concept mapping, and reliability testing. The current published version includes 100 activities representing intended effects, methods, and interventions. A process has been proposed for reviewing suggested revisions to the Taxonomy that will hopefully give it the rigor and flexibility to become a standard nomenclature for chaplain activity (<http://www.advocatehealth.com/chaplaincy-research>). A similar lack of consensus exists for what chaplains should document regarding their care in patient records. One US study found wide variation in the templates that have been developed for chaplain documentation with many departments using templates provided by electronic medical record vendors and others developing custom templates (Tartaglia et al. 2016).

8 Ministry of (Hopeful) Presence

These studies may document the scope of chaplaincy practice, but the detail of how chaplains actually work, or how they should work, is debated. A Scottish study, not included in the Australian review, explored the simple question: ‘What do Chaplains do?’ with 44 Scottish chaplains and concluded that, for chaplains,

The task of meeting spiritual needs is facilitated through the *process* of the chaplain seeking out people who require their services, *identifying* the nature of the particular need, and *responding* to that need through forms of spiritual practice, some of which are informed by the chaplains’ theological and spiritual tradition, but others that call for chaplains to expand on and move beyond this core knowledge base. (Mowat and Swinton 2007, p. 33)

This research invites the observation that, at least for Scottish chaplains, the significant spiritual intervention chaplains provide may be the presence of the chaplain. This view resonates with many chaplains. Brown-Haithco describes the chaplain’s role as that of ‘a consistent and supportive presence, a constant companion who is willing to walk alongside [patients or] staff during critical times in their vocational space as well [as] in their personal lives’ (Brown-Haithco 2012, 210); and Nolan (2012) calls the chaplain a ‘hopeful presence’. However, what some chaplains call “presence” ministry is being criticized as too concerned with process

and insufficiently interested in outcomes that can be measured and against which chaplains can be held accountable.

Among those advocating Outcome Oriented Chaplaincy (VandeCreek and Lucas 2001), Handzo regards outcomes as an essential component of the emerging model of professional chaplaincy, requiring chaplains to be ‘a great deal more focused and intentional in their practice than they have been previously’ (Handzo 2012, 22). With others, Handzo has issued ‘An International Call to Action’ (Handzo et al. 2014) urging chaplains to adopt an outcomes approach, claiming that otherwise chaplains risk jeopardizing the full integration of spiritual care into health care and of making themselves redundant. Superficially, there seems little to dispute. However, Handzo and his colleagues explicitly propose chaplains actively construct ‘an ‘evidence informed’ profession with replicable and predictable outcomes’ (Handzo et al. 2014, 48). Nolan has criticized this proposal. While he accepts the view that chaplaincy should be ‘evidence informed’, he claims ‘replicable and predictable outcomes’ are tied to the ambition to have standardized schedules of spiritual care interventions that would be ‘an unnecessary distortion of spiritual care’ (Nolan 2015; Handzo and Nolan *in press*).

9 Screening and Assessment

Regardless of whether chaplains are process or outcome focused, the competencies and capabilities of their professional bodies’ commits them to assessing and addressing the spiritual needs of the people for whom they care. Spiritual assessment is problematic. As mentioned earlier, while several national and international consensus definitions for spirituality have been proposed (Puchalski et al. 2009; Puchalski et al. 2014), there is still considerable diversity in what is to be assessed. Health care professionals frequently ‘say the word “spiritual”, but in their head are *thinking* “religion”’ (Gordon et al. 2011, 5). Such confusion of ‘spirituality’ with ‘religion’ seems apparent in some of the most widely known spiritual history-taking and assessment tools. The FICA tool, for example, enquires about the person’s *Faith*, the things that *Influence* them or are important to them, their *Community* and the things they need their health carers to *Address* for them (Puchalski and Romer 2000). Similarly, the HOPE tool asks about a person’s sources of *Hope*, their involvement in *Organised* religion, their *Personal* spiritual practice and the *Effects* each of these areas may have on their care (Anandarajah and Hight 2001). This confusion of categories may seem insignificant, but ‘if you ask religious questions at the beginning of a spiritual assessment, you will get “religious” answers to all of the spiritual questions’ (Gordon et al. 2011, 72).

The ambition of effectively assessing spiritual need, pain and distress, including spirituality and religiosity, has generated a considerable literature (Fitchett 2012; Holloway et al. 2011; Lucchetti et al. 2013). Holloway et al. (2011) grouped their analysis of approaches to assessment into four main groups: recognition or identification; measurement (mainly used in research); narrative or biographical (spiritual

history taking); and life domain. Despite the investment in developing spiritual assessment tools (e.g., Benito et al. 2014; Selman et al. 2012), Holloway et al. (2011) note a degree of skepticism exists, particularly within the UK literature, about the efficacy and appropriateness of assessment for spiritual care (see also Clarke 2013). To a degree, this skepticism is echoed by McSherry and Ross, who, despite advocating the development of a generic spiritual assessment tool for incorporation into health care practice, conclude that no one assessment tool will be entirely effective, and that spiritual assessment is more a case of the health care professional's awareness of, and sensitivity to, the spiritual dimension, their ability to pick up on and respond to patients' cues (McSherry and Ross 2010, 165).

If effective spiritual assessment is dependent upon the skill and experience of health care professionals, this suggests the kind of competency based model of assessment advocated by Holloway et al. (2011). Accepting the idea that every worker has a responsibility for identifying and responding to spiritual need, Holloway et al. suggest a four-tier model similar to the MCCC (2003) model mentioned previously (for example NICE 2004), in which staff and volunteers at Level One, who have 'casual contact' with patients and families or carers are made aware of their responsibility to care for spiritual needs, while those at Level Two are trained to screen for spiritual need/pain/distress (particularly helpful here is the work of Fitchett and Risk (2009) on screening for spiritual distress). Responsibility for taking a spiritual history would rest with members of the multidisciplinary team (Level Three), and complex spiritual needs would be referred to spiritual care specialists (Level Four), normally the chaplains.

10 Function as Members of Health Care Team

The identity shift that began in the US in the 1940s has been moving ever more rapidly since the 1990s. Many chaplains now see themselves less as representatives of local religious communities and more as health care professionals (Woodward 2001), although they are not everywhere officially accepted as such. UK chaplains have not been granted status as allied health care professionals. A consequence of this is that, while they function as part of the inter-disciplinary team, in contrast to the practice in the US and other contexts (Goldstein et al. 2011), UK chaplains are denied access to patient records. This has the 'effect of distancing them from other health workers – and multi-disciplinary meetings' (Swift 2014, 58). For this reason, in 2015 UK chaplains formed the UK Board of Healthcare Chaplaincy, whose remit includes maintaining a voluntary register of accredited health care chaplains, as a step towards exploring accreditation with the Professional Standards Authority. In a similar way, most Canadian chaplains are currently regarded as unregulated health care professionals, leaving their role undervalued as they may be considered non-essential and expendable (Handzo et al. 2014, 45). (An interesting and important exception are health care chaplains in the Canadian province of Ontario who are becoming members of the College of Registered Psychotherapists of Ontario,

CRPO). The vulnerable status of chaplains, in particular their integration into health care, has been an important motivating factor behind the 'International Call to Action' (Handzo et al. 2014).

11 Quality Indicators

Part of the process of maturing as a profession has been the development of professional competencies and capabilities, professional codes of practice and professional standards (See Cooper et al. 2010, for the report of one of the few published projects designed to establish chaplain competencies). Another piece of the jigsaw making up the professional picture has been added with the report of a set of indicators against which the quality of chaplaincy spiritual care might be determined. Developed by the New York-based HealthCare Chaplaincy Network, which convened an international panel to develop recommendations (HCCN 2016), the indicators include structural and process indicators, and recommends outcomes. These are supported by metrics, aimed at measuring performance, and evidence-based tools suggested to quantify the metrics. The value of the indicators is yet to be proven, but, if they fulfill their purpose, they should strengthen the case for valuing chaplaincy.

12 Emerging Issues for Health Care Chaplains

Among the challenges for chaplains in the coming years there are three we wish to note. The first is the need for research to help inform and evaluate chaplains' care. A research-informed approach to chaplaincy is relatively new, but is gaining wide acceptance (Fitchett and Grosseohme 2012; Snowden et al. 2017). Research about chaplain's care is growing and a number of reviews have been published (Galek et al. 2011; Jankowski et al. 2011; Kalish 2012; Morgan 2015; Mowat 2008; Pesut et al. 2016; Proserpio et al. 2011). Notable areas of research include descriptions of what chaplains do (Massey et al. 2015), and protocols for spiritual screening and assessment (Fitchett and Risk 2009; King et al. 2017; Monod et al. 2012). The research about chaplain interventions and outcomes associated with chaplain care is presently limited (Bay et al. 2008; Marin et al. 2015; Piderman et al. 2015; Snowden and Telfer 2017) but remains a priority especially in light of economic pressures on health systems around the world. Efforts are underway among national and international chaplaincy organizations to advance chaplain research literacy and chaplaincy research (See [Resources](#)).

Chaplaincy case studies are an important area for chaplaincy research. Thirteen cases have been published since 2011 (Cooper 2011; King 2012; Risk 2013; Fitchett and Nolan 2015; Nolan 2016), with 17 currently in press. The cases have value in

terms of training new chaplains and the continuing education of experienced chaplains, and also in educating other health care professionals and the wider public about what health care chaplains do. Case studies provide one way for chaplains to begin to engage in research. But they also lay a foundation for further research, and could form a basis for the kinds of investigations that would lead to testing the efficacy of a spiritual care intervention (as in an RCT).

The second challenge for chaplains is, as noted earlier, responding to changing patterns of religious involvement and spirituality in their various national contexts. Chaplains, and the health systems in which they work, are having to learn about the diverse and sometimes unfamiliar religious beliefs and practices of the new immigrants they serve. At the same time, secularization has brought a significant decrease in religious involvement to many nations. However, lack of religious affiliation or practice does not mean lack of interest in spirituality or lack of spiritual or existential needs in the face of illness or injury (Fuller 2001; Heelas and Woodhead 2005; Partridge 2005). In the coming years chaplains will be faced with adapting to these diverging trends in religion and spirituality.

The final challenge for chaplains is defining their contributions to the new contexts in which health care is provided. In most countries, health care chaplaincy has been primarily associated with the inpatient hospital or with places that provide care for dying patients (Cadge 2012; Swift 2014). As the emphasis in health care continues to switch to helping people stay well, or at least out of the hospital, and to more ambulatory care the role of spiritual care needs to be clarified. Several interesting models of community-based spiritual care in the UK have been reported (Kevern and Hill 2015), including the Community Chaplain Listening project in Scotland (Bunniss et al. 2013). Exploring whether there is a place for chaplains' spiritual care in these contexts is an important near-term challenge for chaplains in many nations.

13 Summary

Many religious faiths have long traditions of addressing the religious and spiritual needs of those who are ill or suffer injury, offering them healing, guidance, comfort, and hope. These needs persist despite significant changes in health care and society. Professional chaplains play an important role in identifying and addressing these needs in contemporary health care, in many cases addressing them directly, in other cases in collaboration with local religious leaders or other members of the health care team. Following other health professions, chaplains have begun to use research to help develop and evaluate their care. An important challenge for chaplains in the coming years will be developing research that helps describe the outcomes associated with their care and enables the full integration of spiritual care in healthcare.

Resources – Websites for Spiritual Care Organizations

Australia

www.spiritualcareaustralia.org.au

- Standards of Practice 2013

www.spiritualhealthvictoria.org.au

- Spiritual Care Providers (Faith Community Appointed) Credentialing Framework 2015
- Spiritual Care in Victorian Health Services: Towards Best Practice Framework 2016
- Spiritual Care Minimum Data Set (SCMDS) Framework 2016
- Capability Framework for Spiritual Care Practitioners in Health Services 2016
- Heart and Soul Matters: A guide to providing spiritual care in mental health settings
- Documenting Spiritual Care in Patient Medical Records: a best practice resource

www.pastoralcareact.org

- Standards of Practice for Pastoral Care 2013

<https://anzacpe.com/>

- ANZACPE is the umbrella organisation for the various associations of Clinical Pastoral Education in Australia and New Zealand

Europe

<http://www.enhcc.eu/>

- European Network of Health Care Chaplaincy (ENHCC)

www.chaplaincyresearch.eu

- European Research Institute for Chaplains in HealthCare (ERICH)

The Netherlands

www.vgvz.nl

- Professional Association of Spiritual Caregivers: Vereniging van Geestelijk VerZorgers (VGVZ)

http://vgvz.nl/wp-content/uploads/2016/06/beroepsstandaard_definitief.pdf

- National Standards of Practice: Beroepsstandaard Geestelijke Verzorging

<http://vgvz.nl/sectoren/sing-institutioneel-niet-gezonden/>

- Council for Institutionally Not Endorsed Spiritual Caregivers: Raad voor Institutioneel-Niet-Gezonden Geestelijk Verzorgers (SING)

www.skgv-register.nl

- Quality Register for Spiritual Caregivers: Stichting Kwaliteitsregister Geestelijk Verzorgers (SKGV)

http://www.eapcnet.eu/Portals/0/Clinical/Spiritual%20care/Publications/SpiritualCareGuideline_English_2014.pdf

- Spiritual Care Guideline

United Kingdom

UK Board of Healthcare Chaplaincy

www.ahpcc.org.uk/employment/guidelines/

- Association of Hospice and Palliative Care Chaplains
- Chaplaincy Guidelines

www.ahpcc.org.uk/wp-content/uploads/2014/07/spiritcomp.pdf

- Marie Curie Cancer Care Spiritual & Religious Care Competencies for Specialist Palliative Care

www.ahpcc.org.uk/wp-content/uploads/2014/07/compaudittool.pdf

- Assessment/Self-Assessment Tools

www.ukbhc.org.uk/chaplains/guidance

- Chaplaincy Guidelines

www.ukbhc.org.uk/chaplains/professional_conduct

- Chaplaincy Code of Professional Conduct

www.ukbhc.org.uk/chaplains/standards

- Chaplaincy Standards

www.ukbhc.org.uk/chaplains/competencies

- Capabilities and Competences for Healthcare Chaplains

Canada and the United States

Canada

www.spiritualcare.ca

Canadian Association for Spiritual Care (CASC) is a national multifaith organization committed to the professional education, certification and support of people involved in pastoral care and pastoral counseling.

United States

www.professionalchaplains.org

Association of Professional Chaplains
Standards of Practice
Chaplaincy Board Certification

www.acpe.edu

Association for Clinical Pastoral Education
Accreditation of CPE programs and certification of educators

www.nacc.org

National Association of Catholic Chaplains (NACC)
An association of pastoral ministers who participate in the church's mission of healing. Its mission is to promote professional development and support services for its members.

www.najc.org

Neshama: Association of Jewish Chaplains (NAJC)
A professional organization for Rabbis, Cantors and other Jewish professionals that seeks to enhance the kedusha of Jewish Chaplains that they may provide quality Jewish, religious and spiritual care.

www.navac.net

National Association of Veterans Affairs Chaplains (NAVAC)
A professional organization of chaplains in the Department of Veterans Affairs and its affiliates. NAVAC provides opportunities for continuing education in pastoral care; serves as a certifying body; and serves as an advocate in seeking to encourage professional collegiality, personal growth, and the professional development of VA chaplains.

http://www.professionalchaplains.org/files/professional_standards/common_standards/common_code_ethics.pdf

Council on Collaboration (2004, North American Chaplaincy Organizations)

Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students

www.healthcarechaplains.org

HealthCare Chaplaincy Network

A global health care nonprofit organization that offers spiritual care-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve patient experience and satisfaction and to help people faced with illness and grief find comfort and meaning--whoever they are, whatever they believe, wherever they are.

www.transformchaplains.org

The Transforming Chaplaincy Project

This project, funded by grants from the John Templeton Foundation and the major professional chaplaincy organizations in the US, aims to better equip healthcare chaplains to use research to guide, evaluate, and advocate for the daily spiritual care they provide patients, family members and colleagues.

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Understanding Clinical Chaplaincy Approach to Biomedical Ethics: An Imminent Need and a Challenge



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Abstract While we, the medical community, have recognized “Spirituality” as a vital component of health, we have not yet clearly defined the term “spirituality” for clinical education, care, and research. Though we have a robust clinical spiritual care program called Clinical Chaplaincy and, though chaplains work so closely with us, medical professionals, we have not yet conceptualized the framework of Clinical Chaplaincy process nor understood how patients are healed through it. With my year-long clinical chaplaincy residency training I realize that only through our experiential understanding we will be able to conceptualize the pieces of the chaplaincy-puzzle. I also, consider that as medical students, you need to be introduced to the “research lab” where the initial understandings of chaplaincy processes are being generated. A complete clinical “Verbatim case report” of the Clinical Chaplaincy process is provided for the reader to inductively study the “qualitative data” of the spiritual care process. This chapter is meant to provide (1) a comprehensive understanding of a clinical chaplain-patient interaction, (2) to highlight how chaplains guide and accompany their patients in their “mindful walk” through their pain and struggles (3) to finally arrive at a deeply and empathetically centered spot within oneself from where (4) the patient would draw his/her own meaning and purpose in the painful loss leading to their healing. The focus in this chapter is to highlight how the chaplain guides the patient through the ethics of medical decision-making process. In this, the mindfulness-based processes of clinical chaplaincy will also be studied.

Keywords Chaplaincy · Medical ethics · Theology · Religion · Spirituality

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1 Foreword

When it comes to ethically controversial clinical decision-making, physicians refer to their personal religions and spiritual (R/S) ideals to guide them. Whereas, board certified clinical chaplains are trained through four units/1-year of Clinical Pastoral Education (CPE) process to provide R/S interventions in health care. Naturally, they may be considered as clinical spiritual care experts (Puchalski 2013) and, it is from the clinical chaplains that medical professionals need to learn how R/S guidelines can be applied in ethically challenging clinical care situations. In this chapter we will see how, a ACPE-trained-chaplain's spiritual care is attuned to deal with ethical dilemmas in medical decision-making processes.

However, I want to be upfront to inform the readers that the chaplaincy process as described in this chapter is not yet standardized across CPE training programs. The "Chaplaincy principle that I prescribe to, which states that "It is the Divine that heals the patients in a chaplaincy process and not the chaplain" is also not universally accepted among chaplains. In addition, many of the chaplains, including me, believe in using their (Spiritual) Self as the fundamental therapeutic tool in their chaplaincy process. The non-acceptance of the universality of these principles and/or fundamentals among clinical chaplains is because of the theological and/or philosophical differences between the theistic, non-theistic and atheistic traditions in which the chaplains are groomed. Notwithstanding the challenges described above, the evinced desirable clinical outcome of the chaplaincy process has inspired clinicians to advocate for Spiritual Care training (the CPE) be incorporated into the curricula of medical schools and clinical residency programs (Puchalski 2014a, b, Jackson-Jordan et al. 2018, Andrews 2006). Needless to say, just as how we, medical professionals, would include a therapeutic substance (such as a medication) into our clinical repertoire only after thoroughly investigating its pharmacological properties--similarly, the clinical chaplaincy process and its "healing principle" have to be thoroughly understood before fully incorporating it into our medical tool-kit or curricular programs. In this chapter, I will present a specially chosen ethically challenging clinical chaplaincy case study aiming to (1) help the reader familiarize with clinical chaplaincy process, (2) provide an opportunity for the reader to "witness" how a chaplain supports a patient through her religious and/or spiritual (R/S) distress and the resulting tough ethical-decision-making process, and then (3) demonstrate how to inductively analyze the qualitative data to arrive at the framework of clinical chaplaincy or spiritual care process.

I have provided "Call-out Boxes" to challenge, inspire and guide the reader to contemplatively understand the frameworks of chaplain's spiritual care process. Though I have listed a bunch of "learning objectives" for the reader, I will consider the aim of this chapter to be fulfilled even if it can merely provoke the reader's interest and intrigue about clinical chaplaincy process.

2 Learning Objectives

Readers will learn to:

1. *Identify a rationally arguable approach to studying the methodological framework of chaplain's spiritual care process:*
 - a. *Learn how systematic study of chaplain-patient interaction can provide a mindfulness-based Contemplative Neuroscience framework.*
 - b. *Inductively analyze the qualitative data to identify how chaplain's utilize their "Self," in their spiritual care process. This would then open-up our avenues for developing theological framework of the Clinical Chaplaincy process.*
 - c. *Identify the need to study interreligious theology and gain skills in contemplative neuroscience to before we can incorporate CPE into Medical School curriculum and Psychiatric Residency training programs.*
 2. *Understand the differences in the services offered by clinical chaplains vs. clergy/physicians:*
 - a. *Understand that both chaplains and religious scholars aim to guide their patients through their R/S struggles.*
 - b. *Understand the ways in which CPE-trained chaplains' spiritual care process is different from S/R interventions of religious professionals (pastors, imams etc.).*
 - c. *Understand how the prayer is a very technically sophisticated spiritual care tool of chaplains that needs a proper CPE training before a physician can apply in his/her clinical practice.*
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3 Introduction

3.1 Introduction to How Chaplaincy Relates to Biomedical Ethics

Ethics, in general, is understood as the subject that deals with our feelings of "rights and wrongs" in human behavior. Such feelings are usually grounded in our religious/spiritual (R/S) beliefs (Curran and Lisa 2014) and, CPE-trained chaplains are considered as spiritual care experts among clinicians. Hence, along with courses on biomedical ethics, courses on Theology/religious studies should also be a part of medical school curriculum. Since, bioethics is a "thread" that runs through medical education, clinical training as well as patient care activities of physicians, medical students who are interested in biomedical ethics need to gain clinical chaplaincy skills as well. This chapter is to guide the reader to understand the chaplaincy framework and/or processes (Call-out Box 1).

Call-out Box 1 AMA's Alliance with Religious Professionals Care Vs. Clinical Chaplaincy [Historical Context]

Clinical chaplaincy Education (CPE) and clinical spiritual training programs were established around 1925 in United States. "Clinical Chaplains," graduates of a year-long CPE-Residency training program, are certified by federal accreditation organizations such as Association for Clinical Pastoral Education (ACPE) and Board of Chaplaincy Certification Inc. (BCCI).

US Courts of Law uphold that only CPE-certified religious professionals may hold jobs in federal-government establishments such as Veterans-Affair Hospitals and Military despite public litigations that invoke United States Constitution's First Amendment (i.e. separation of "State" and "Church," Sullivan 2014.)

Instituting a Committee on Medicine and Religion (CMR) at the American Medical Association (AMA) was an instance of how medical professionals attempted to develop an organized engagement with Religion/ous professionals (1961 to 1974). However, that engagement failed because of contentious debate regarding abortion (Kim et al. 2014) between medical and religious professionals; CMR was eventually disbanded.

Challenging questions:

What is the difference in the way CPE-certified Vs. other (non-CPE trained) religious professionals provide R/S care to clinical patients?

3.2 Introduction to Chaplain's Spiritual Care Process

Clinical chaplains, irrespective of their religious and/or spiritual (R/S) formation undergo a 1-year Clinical Pastoral Education (CPE) and Residency-training to provide spiritual care ("deep-empathetic listening presence") in an interreligious setting, i.e. to patients from diverse R/S backgrounds. CPE training enables chaplains to embody their scriptural-theological concepts as they provide spiritual care to their patients. Such an embodied R/S care eliminates the need to use religious doctrines or commandments, theological constructs, and spiritual principles in instructive ways to guide their patients. As you (the reader) study the clinical case, pay attention to how a CPE-trained chaplain's approach differs from that of a religious clergy (such as, Jewish-Rabbi, Christian-Pastor/priest, Muslim-Imam, Hindu-Pujari and Buddhist-Shraman) (Call-out Box 2).

Evan as you (reader) begin to wonder, what could be the difference in a clinical chaplain's approach versus that of a religious pastor! I have to advise you (the reader) that there are similarities between a devoutly religious scholar's approach to scriptural studies (Evans 2014) and a clinical chaplain's spiritual care process. Both are deep-contemplative approaches and such contemplative spiritual care process can be understood only by a reader who enters a meditative state by centering him/herself. Having stated that, I would encourage readers to use their personal meditative techniques/skills to center themselves and enter a meditative state of mind before beginning to read the next section of this chapter, i.e. clinical case-verbatim (Call-out Box 3).

Call-out Box 2 Who are Religious Professionals and Vs. Clinical Chaplains?

	Religious professionals (Christian-priests/pastors, Muslim-imams, Jewish-rabbi, Buddhist-shraman, Hindu-pujari etc.)	Clinical Pastoral Education (CPE) Trained Clinical chaplains/spiritual care providers
Education	A 2 or 3-years Masters degree from Seminary schools accredited by ATS (Association of Theological Studies)	A 3-years Masters degree from an ATS accredited seminary schools is mandatory for Board Certification as a clinical chaplain and/or to apply for Supervisory Chaplaincy training program.
Clinical training	Many of the Christian seminary schools mandate their students to complete one unit of CPE during their Master’s degree.	Clinical chaplains: Clinical Pastoral Education (1-year Residency training program) – accredited by ACPE
	This is not true for religious education in other faith traditions.	Clinical Chaplain Supervisors: Supervisory Chaplaincy Training (3–5 years) – accredited by ACPE
Employed by	Religion specific institutions.	Medical hospitals and Clinical centers
Clinical activities	Provide sacraments	Provide deep listening presence/ empathetic embodied care
Prayers	Ritualistic	None or according to patient’s religious tradition.
Clinical advice	Dogmatic, i.e. according to religious rule-book/s.	None. They do not provide any advice based on their cognitive skills or verbal counselling. Their spiritual care process is informed by their lived scriptural-theological knowledge

Call-out Box 3 Meditative Processes in Clinical Chaplaincy and Devout Reading of Scriptures

What are the Meditative processes involved in clinical chaplaincy and devout reading of scriptures?

See Sect. 6 for answer.

4 The Body

In this section, beginning with a brief summary of a clinical case I will provide a detailed chaplain-patient interaction, in verbatim. Typically, a CPE student (a Chaplain-Intern or Resident) would present such a verbatim to his/her Supervisor as a CPE classroom-educational activity. The presentation is for the purpose of receiving feedback from his/her CPE-Supervisor and fellow students, usually 5–6 of them in that CPE cohort. The feedback received from the Supervisor and peers helps in chaplain's spiritual formation. Such "Verbatim presentations" is one of the, if not the most, important pillars of the CPE training program.

4.1 *Staff Nurse's Referral "Note" for Chaplain's Consultation*

The nurse from the obstetrician's office calls the hospital chaplain (C) and briefs him about the patient. The nurse says: Chaplain Krish, we have a patient (P), Ms. Andria in the out-patients' clinic. [Tertiary care medical center.] She is 38-year-old gravida 2, para 1 in her 7-month of pregnancy; she has been irregular with her follow up visits with the obstetrician. Screening tests in her previous visit had revealed Down's syndrome. Further ultrasound examination had also revealed Tetralogy of Fallot. Her obstetrician has educated her about the prognosis of her pregnancy and of the babies with Tetralogy of Fallot. She was advised abortion as an option among other medical measures. Andrea has been emotionally disturbed and had spent the entire month, since her last visit, reading more about the medical condition of her unborn child and became very prayerful. The patient is very mentally-emotionally disturbed. I saw her cuddling with a Bible and I thought she would benefit from a chaplain visit. Can you please visit with her? She has some abdominal cramps and Dr. XYZ, our obstetrician is considering admitting her to the Obstetrics-floor.

4.2 *Approaching the Patient*

The chaplain receives a referral from the nurse and then proceeds to have a visit to perform his/her own professional assessment. S/he would, first, gather other vital information from medical records. All along, the chaplain would remain mindful of how all that information about the patient is informing him/her about the patient, whom s/he has not yet met. In that the chaplain would become aware of the assumptions, biases and pre-determined solutions that his/her mind may be churning even before meeting with the patient. In order to meet the patient at his/her own mental-emotional state the chaplain would spend few moments in a meditative state before entering the patient's room. S/he would visit the patient with a curious mind. A very mindful reader would have already noticed several thoughts, memories, and

emotions that may be triggered in her/his mind as s/he had read through the above clinical case summary. Further, as you read the chaplain-patient interactions, (in verbatim) your mind will be bombarded with numerous thoughts, questions, doubts, and concerns along with their associated emotions. Please stay aware of all your mental activities without becoming judgmental about any of those thoughts or feelings that get triggered – this is mindfulness (Ludwig and Kabat-Zinn 2008; Williams et al. 2007).

4.3 Clinical Chaplain-Patient Interaction in Verbatim

After exiting patient’s room, the chaplain would carefully recollect all verbal (patient’s spoken words “P” and his/her own spoken words “C”), as well as nonverbal conversations such as their observations (O) of facial expressions and the body language of the patient as well as their own and also other events that may take place, such as intrusions by the nurse or other surrounding events of significance that occur in the vicinity of chaplain-patient interaction. Chaplains also record their personal mental events such as thoughts and emotions as well as their own physical sensations as subjective (S) “data” of their clinical case study. These clinical “events” (“P,” “C,” “O,” and “S”) are numbered and coded to study as qualitative data. Clinical chaplains present their “Verbatim” to their Supervisor and peers as a group-education activity, as part of their CPE training.

4.4 The Verbatim

C1	Hi Andrea. My name is Kris. I am a chaplain rotating in the ER. Your nurse suggested that you may like to talk to a chaplain. Is it a right time to visit with you?	
	S1	a. I was anxious, as I walked towards patient’s room. I was curious as to what could be the reason for a spiritual care referral to a 38-year-old. b. Several worrisome thoughts crossed my mind, I looked at all of them and kept them aside and focused on the patient.
	O1	Patient was sitting in a chair next to her bed. She looked her age. Her tummy also looked at 8 months pregnant and she was physically comfortable. She looked up, greeted me with a smile and nodded, as if to say “yes” for my visit.
P1	Hi chaplain. Thanks for coming. I needed to talk	
	O2	She had a gentle low voice. As she spoke, she motioned her hand to point at a chair next to her indicating me to take a seat. I nodded, saying “thanks” and sat down.
	S2	I felt she was still in the middle of her sentence, she had only paused as I sat down. I wondered what she was about to say. I remained humble as I waited in silence.

(continued)

P2	Last month, I had an abdominal ultrasound and other tests to see how my baby is growing. We came to know that our baby has Down's syndrome. [pause] she also has some severe heart problem. [long pause]	
O3	Her face turned very worrisome as she shared about her baby's problems. Finally, lowered her eyes and bent her head down before becoming silent.	
S3	a. Her statement shocked me and worried me. I did not expect it to come so quickly in the visit, though I should have expected--usually patients are slow to reveal the most painful part of their story. I became curious and my mind started to wander into all my previously read medical literature on the prognosis of Tetralogy and other cardiac conditions associated with Down's syndrome--how should I answer to console her?	
	b. I kept my curious thoughts aside to focus on the mother's worries. I felt sad and my chest started to feel heavy. I looked at my emotional feelings for a moment and kept them aside to focus on the patient. Most importantly, I was feeling sad and worried. It was tough being in that situation with her.	
C2:	Aww! It feels sad. I am so sorry. It must be very hard going through all this.	
O4	a. There was pain in my tone, I could hear it myself. My face reflected my sad feelings. My shoulders drooped a bit.	
	b. She looked at me with her sad face. I looked back at her empathetically, reflecting her sadness.	
S4	a. I tried to understand how it feels going through such a difficult pregnancy. I felt sad for the unborn baby and also felt helpless. I reflected to remember my sister-in-law going through similar pain, after her gestational ultrasound at 35 weeks revealed baby with anencephaly. It was a very painful for the entire family.	
	b. I kept my story aside focused on the patient. I wondered what she must be feeling through all this.	
P3	Yes, I feel so sad. I don't know what I can do to help my baby. [pause]	
O5	She looked very stressed-out as she spoke.	
S5	Aww! She is feeling helpless. I felt there is something scary that she is trying to tell me. I stayed silent for a moment and said...	
C3:	Aww! It feels helpless.	
P4	Yes, I feel helpless. I pray a lot asking the Lord to save my baby. I have always been very religious. [long pause] My friend in the church choir says I may have sinned [pause] for the Lord to punish me with this...	
O6	Her face turned pale. She looked at me with a pitiable face as if asking me to say "that's not true." I reflexively believed, but gently shook my head as if to say "no, that's not how God works."	
S6	a. Aww! That's kind of cruel for someone to say, in tough times. I did not know how to respond. I could think of saying many soothing statements, such as "no, that is not how God works" or "God cannot be so cruel" or something to make herself reflective. But...	
	b. I kept all my thoughts and impressions aside and wanted to stay reflecting on the hurtful feelings (Call-out Box 4).	

(continued)

C4	Aww! That feels really painful, [pause] haa!
O7	a. I was lost in the feeling of her pain and hurt. b. I saw her looking deeply at my painful expression. c. [Long pause] I just stayed there feeling her pain.
S7	I could see several thoughts intruding into my consciousness, which included a couple of past clinical experiences with abortion, a couple of abortion related discussion in my own family etc. I looked at each one of them and brushed them aside even as they emerged a wee bit.
P5	a. It is very painful to hear it from a good friend. [After a long pause] b. I have worked as a pediatric nurse for several years now. I took care of so many tender babies in the neonatal floor...[pause]. I have always been good to everyone and never hurt anyone, [pause] why would God punish me?
O8	a. My eyebrows raised and facial expressions changed (as if appreciatively saying “wow”) immediately when I heard her tell about her professional work and positive character. b. Her voice was so soft and her tone was humble, even as she spoke so strongly about her positive character. I observed how she was able to raise questions from within. c. She kept looking at me as if waiting for answers for her question. But, I wondered if her question could be rhetorical and self-reflective!?
S8	a. Inside my head: “Wow! So, you were a nurse!” I became very appreciative of her self-boosting feeling about her professional work. She is trying to feel good about herself-not worthless. It felt good to hear her move away from a “negative,” painful situation to something positive in this patient’s story, as if trying to hold on to a strong tree branch and stop myself from “drowning in her grief.” b. I reflectively thought, is this what the patient is trying to do, trying to move away from an overwhelmingly painful mental state to a positive-comfortable space in mental-self? If that is so, I wanted to let her wander off from her pain. c. Could she possibly be harboring anger towards her God. I also thought of affirming her feelings/question about God and say, “no God will not punish good people” or “I don’t know, why God would do it” etc. But, she did not express such fear. d. I kept looking at all my thoughts and emotions. Wondered if she is aware of similar processes in her mind, and, if so, wanted to support her
C5	[long pause]. There are so many thoughts and feelings running in your head.
O9	a. I had a wide range of mixed expressions, changing like colors on my face; appreciation for her great job as a nurse, pitiable face as well as fear of a brewing “war” with her personal God. b. Slowly, I saw her moving her gaze back to herself as if becoming self-reflective. I kept silent reflecting
S9	a. I kept empathetically feeling all that feelings that she may be going through having shared so many things. I was still not sure if all that she said were “mere loud, rhetorical and self-reflective thoughts.” b. I felt she is now ready to say something again. I brushed aside all the thoughts and feelings that were running amok in my head.
O9	c. She looked at me keenly then lowered her eyes and returned to make an eye contact with me, and said...

(continued)

P6	Yes. There are too many thoughts in my head. [she paused]
O10	a. She took her left hand to her forehead and massaged a bit, then shook her head and turned away towards the Television that was mounted on the wall. b. I turned towards the television too-I wanted to go along with the patient to where she could feel mentally comfortable. I could see the movie “Harry potter and the Sorcerer’s Stone” was playing on the television. I could see my patient’s face cheering up.
S10	I was happy too. I like Harry Potter movies, in fact I like all kinds of magical-mystical stories. I was getting engrossed in the movie-scenes that was playing on the screen, then suddenly, within a moment she asks...
P7	Have you read this novel?
O11	She was focused on the television even as she was questioning me.
S11	I was taken aback, that she spoke about the novel when we were actually watching the movie version. I was pleasantly surprised because I had actually bought the entire set of 7-Harry potter novels to read but did not.
C6	Noo, actually! I had the entire set of 7 volumes but never read any. I gifted them away to my niece. She is big fan of Hermione.
O12	A casual-friendliness appeared in my tone and an embarrassed smile, that I had not read the novels. She looked up at me and smiled a bit, it looked appropriate.
S12	a. I was happy to note she has a reactive mood and wide range of affect. b. I was conscious of this entire conversation on Harry Potter moving our discussion away from the vital clinical care. I kept aside all my thoughts on patient’s current medical needs aside and, moved along with patient’s need to focus/distract herself onto something else (Call-out Box 5).
P8	Yes. Hermione is my favorite too. Actually, my daughter resembles her. She is very smart, there are lots of interesting things said about her in the printed story than in the movies.
O13	Both of us were still looking at the movie. I was enjoying, so was she.
S13	Hmm she is interested in reading novels. Does she read stories to her daughter? I was thinking ways to redirect the patient to her painful story, but only when she is ready.
C7	Yes, true. Hermione reminds me of my nieces too. They are two and both are very smart, the elder one is a voracious reader. The younger one wants her mother (my sister-in-law) to read the stories aloud to her. I have done that a couple of times. It’s fun.
O14	I stayed focused on the TV screen, and, from the corner of my eye saw the patient too was focused on the TV.
S14	I wanted to gently move the patient back to her own story. I was curious how she will respond to that. I waited anxiously. I resisted turning towards the patient and/or say anything further to move the patient back to her story, if she didn’t want to.
P9	Yes, she likes me reading it out to her. My daughter actually resembles Hermione a bit, she is smart, bubbly and curly hair. She has started to do cart wheels.....[long pause]
O15	I turned towards her. She was kind of frozen, still facing the television but actually not looking at it.
S15	a. I felt connected when she said “yes.” I remembered how storytelling to little kids can be fun. I kept my thoughts and feelings aside and focused on patient. b. I wondered why Andrea looked frozen – she must be thinking about something. Has she returned to think about her pregnancy condition? I kept my assumptions aside and focused on the patient.

(continued)

C8	You are thinking something.
O16	I said it so gently, and I merely said what I saw of her, without expressing my assumptions. I stayed looking at her empathetically.
S16	a. I did not want to disturb or pull her out of her mental preoccupation. However, I also wanted to make her become aware of what she is doing. b. I wondered how she may react to my gentle nudge.
P10	Yes. [pause] I was thinking about this second daughter (referring to her unborn child). I thought of her to be as smart as my first. My husband and I had a lot of plans for her.
O17	She became pensive with a sad face. She moved both her hands on her belly as if holding her baby.
S17	a. Aww! I felt sad. I don't have to ask her about the obvious; she must be thinking about her baby with Down's syndrome, who are known to have lower IQ. b. I wondered about the patient and her husband's feelings – it could be as if all their plans for their future with her new baby were shattered. c. Does she know that some of those mentally challenged babies may have exceptional talents like musical-savants? I kept aside all my thoughts and questions and focused on the feelings she may be going through.
C9	Aww! It is so sad
O18	a. I expressed my sadness as I felt it, in expression. I did not say anything further. My face was sad and empathetically looking at her. b. She looks at me and her eyes started to well-up with tears. She lowered her eyes. She looked extremely sad.
S18	I was feeling her sadness. It is every parent's wish to have a bright child, I thought, but, what can we do when things don't turn the way we imagine? I had several thoughts brewing up-I kept all of them aside and stayed with my feelings.
O18	c. Long pause. I stayed with the patient, silently and empathetically feeling her feelings.
P11	a. Yes. It feel very sad, but I will go through it. [pause] b. My doctor suggested that I should opt for an abortion. [Long pause]. c. My husband can feel my pain but, he asks if it is worth going through all this pain, unpredictability and suffering? I am not sure if that is the right thing to do.
O19	She looked at me as if questioning. I looked back at her empathetically.
S19	a. Aah! She has a tough situation to deal. b. She is again asking for my advice. She has already told me that she wants to help her baby and is praying to save her, so she wais not wishing to abort. Did the physician's advice change her mind?
C10	What do you think is the right thing to do?
O20	I asked a self-reflective question to redirect her to become mindful but, even as I was questioning/making my statement she started sharing more of her story
S20	I felt as if she was being urged from within to speak

(continued)

P12	<p>a. My husband and I met our pastor in the church-I asked him if I have sinned, for us to have come to face this problem? He said: [Pastor:] “I cannot answer that question, I am not sure.”</p>
	<p>b. [Patient talking to her chaplain in the hospital says] But, he was against our doctor’s advice. He [pastor, [pause] said: Abortion is like killing a baby and, that would be a sin. Become prayerful and ask the Lord to show you the way.”</p>
	<p>c. [Patient talking to her chaplain in the hospital says] My husband did not like our pastor’s advice. But, I did not feel our pastor was mean. He is a kind man, and we have known him for several years now (Call-out Box 6).</p>
O20	<p>She looked at me as if wanting to have a second opinion from me, on abortion as a choice. Her eyes were keenly looking at me with intense question, and as if pleading me to answer and advice [on abortion.]</p>
S20	<p>a. Now, with her expressions, it was clear that she was actively seeking my advice though she did not use questioning words. I felt she was able to experience my empathy for her.</p> <p>b. Her pastor’s advice remembered me of my father’s advice to my uncle (father’s younger brother) when he came home one day to seek my father’s advice abortion for an unplanned pregnancy. My father had advised him against abortion--that child has now grown up into a much more able adult than his sibling from a planned pregnancy. This informed me how I have grown respectful of the life of unborn-unwanted babies.</p> <p>c. I knew this was not time to reflect on the entire situation that we have gotten into, empathizing with one another. She had been very active, as if, mentally calculating the pros and cons following her physician’s advice. Is it time support her thinking process? Ha! “It is going to be so tough to say in words what is already so painful in feelings,” I said to myself.</p> <p>d. I brushed aside all thoughts, feelings and even the feeling that I am going to advise another person (discriminate me from her. I decided to feel my own feelings in wordy expressions and let my patient hear the words that she wants to hear.</p>

(continued)

C10	<p>a. [I paused and uttered] Oh boy! This is tough. From the beginning, I felt you were wanting to help and save the baby. Your main concern, I thought, was how to help your baby's heart problem. But, after your doctor's advice you were probably shaken.</p> <p>b. You are very close to your expected date to deliver the baby. You can go by prior plan of completing your full term and let the nature decide. If the baby survives the troubles of her delivery then you have done your first duty as a mom. You will be happy your prayers have worked. Your cardiologist will have better options to care for her heart condition once she is out of the womb. I am sure, you will also be able to take care of her in a better way--so, she has better chances. If she grows up to be a healthy adult she will be thankful for giving her the life. If things don't turn out the most positive and desirable way then you can be proud of giving the best chance to your baby. I have seen parents having a naming and other religious ceremonies before burying a stillborn baby. We can discuss about such things if and when such situation arises. Your baby has a heart problem but she is doing okay as of now--your obstetricians will do their best to deliver her. At this point I believe we can be prayerful and rest a bit. I hope this helps. [pause]</p> <p>c. It is so painful to be in your situation. [pause] We are expected to draw meaning and purpose out of our painful life experiences but, [tiny pause] it is indeed so very tough to go through all that you are undergoing and make meaning out of them. [I paused and thought-out loudly] "we can advise others better only when we have their experience." You have been a pediatric nurse, and have been very kind and compassionate to others, who had gone through similar pain as you are now going through. [I paused, shaking my head gently I uttered] I wonder for what purpose the Lord puts us through tough times</p>
O21	<p>a. I said with my eyes keenly locked empathetically with hers [maintaining professional distance] and, intermittently with my eyes closed in prayer, but throughout I remained prayerful. I kept it short.</p> <p>b. I said all that I did in a very gentle voice. I delivered it all slowly, keeping aside my painful emotion and, tried my best to not choke-up.</p> <p>c. I saw her nodding and her eyes getting wet. She may have noticed my eyes becoming wet and, my pain in my voice, though I was successful in maintaining my composure.</p>
S21	<p>a. I wanted to say something that is useful for her and, at the same time I wanted to stay self-reflective in my advice. I prayed that she becomes self-reflective to hear her own deep inner-thoughts and feelings in what I spoke.</p> <p>b. I wanted to remind her of the best times in which as a compassionate person she may have helped others in similar situations-and wanted her to reflectively give similarly compassionate advice to herself.</p> <p>c. I kept it brief and fell silent (Call-out Box 7).</p>

(continued)

P13	My baby!!! [pause] she is going to have a challenging life. [pause, eyes started to well up and she burst into tears]
	[Long pause] Can you please pray for me?
O22	<p>a. She spoke very slowly, pausing after each sentence she made. Her eyes started to tear up slowly and soon started to sob uncontrollably.</p> <p>b. My eyes were numb at this point, I could barely stop revealing my emotional state. Now, as I write this (outside patient’s room) I let go off my control and indeed couple of tears rolled down by my cheeks.</p>
S22	<p>a. I felt happy that I was able to help her arrive at her own decision, with me “merely pointing at the moon.” She found her own meaning and purpose in her pain and suffering.</p> <p>b. I was also happy to see her becoming vulnerable to ventilate all her feelings and breaking down. [These I have learnt as good signs of spiritual healing--the decisions, conclusions and/or meaning and purposes that one arrives at are spiritually based and sacred acts and not mere intellectual activities.]</p>
C11	Let us pray:
	<p>Dear Lord, I raise Andrea up towards you to show your grace and bless her in this tough time that she is in. You are aware of the pain that she is experiencing now; you know she is eight-months pregnant now and that she has been told about her baby suffering from Down’s syndrome. You know Andrea’s concern and pain that her baby may not be as smart as her elder daughter, You also know this unborn baby has major heart problem and doctors have told her about the difficulty in the successful completion of this pregnancy and survival of the baby after birth. As a Creator, who gave birth to this world you know the anxieties, worries and pain of this mother. Please be with her and give her the strength to endure this pain [pause]. Andrea had been a very compassionate nurse in the pediatric floor and had provided empathetic advice to mothers who had similar problems. Now, in this hour she is unable to guide herself through her own struggles. Please be with her to guide her. We are all expected to draw meaning and purpose out of our painful life experiences but, [tiny pause] it is indeed so very tough to go through all this and make meaning out of them. Our mind fails to console our emotions. Andrea and her husband had a lot of beautiful plans for this 2nd baby that they are expecting but, you had different plans for them. We are weak to grasp your intent and purpose behind the plans that you have for us. Some of your plans are tough for us to handle, please be with us we struggle through them. We are weak without your constant gaze upon us. Please lay your hands on Andrea, her husband and her entire family to lift them up from this pain and struggle. Please be with the doctors and nurses, grant them the wisdom to care and heal her. In your name we pray (Call-out Box 8).</p>
O23	<p>a. Slowly, as we progressed through the prayer she stopped sobbing.</p> <p>b. Patient closely followed all that I said in the prayer by intermittently repeating my words. She finally said “Amen” after I finished the prayer.</p> <p>c. I had my eyes closed and hands folded, following patient’s gesture. Finally I opened my eyes, looked at the patient and nodded with a smile, as if to say, “good that you followed the prayer well.” Patient nodded in return.</p> <p>d. After the prayer, I left patient’s room wishing her a “good night.”</p>
S23	I kept thinking how she felt with my visit and, how I could have been better with my advice that she was seeking. I wanted to follow-up the next day to check with her and, to know how she is doing.

Follow-up visit (Next day, 10.00 AM. Patient was now moved to the obstetrics floor):

(continued)

C12	Hi Andrea. [pause] Good morning. I just stopped by to see how you are doing. [Pause] I hope I am not disturbing you both.
O23	a. She was chatting with a gentleman, sitting next to her bed. I guessed, he could be her husband. He looked at me, I nodded at him as a greeting and, he nodded back pleasantly. b. I was hesitant to enter the patient’s room and very gently addressed her as I approached very humbly.
S23	I was anxious as to how she would receive me and respond to me.
P14	No, no. You are not disturbing. Please come in. (turning towards her husband she says) This is the chaplain. I was telling my husband about your visit. Thanks for visiting me. I slept like a baby last night. Thanks, it was as if you opened my window for a fresh breeze. My baby [pause] [incomplete sentence]. I think I was [pause] [starts to sob]
O24	a. Patient starts to sob. Her husband consoles her by placing his hands on top of her hands that were on her lap. b. She wipes her tears and gently and shyly looks up at me with a tiny smile of embarrassment on her face. I smile back at her nodding, as if to encourage her to ventilate her thoughts.
S24	I was curious what she was about to say. I had my undivided attention towards her.
P15	(She continued where she left before (P14) My baby, [pause] she is going to have a challenging life. [pause, eyes started to well up and she burst into tears] She is going to be not as smart as her elder sister. [pause] She is going to have a major heart problem to deal with. [pause] I have seen several parents go through it. I have advised many of them. [pause] May be, it is my turn to live through it and experience the pain ... so that I can advise others better. [pause, sobs] I will do my best to care for her as the best mom. One day, she may feel happy that I had atleast given her a life and not aborted her. I may not give her a best life but, I will give her something to live with. [long pause, tears rolling down her cheeks] I think I was very selfish and not thinking about this poor unborn baby [uncontrollably sobbing]. My husband and I have decided that we will take care of her as much as we can and as long as we are alive. We will bring her up the same way as we did with our first daughter. [Pause and sobs].
O25	She sobs and becomes silent.
S25	I thought “wow! She is so honest and vulnerable. I just wanted to congratulate her on that.
C13	a. Wow! You are so brave. Thanks for sharing your thoughts and feelings. I admire your vulnerability. [pause] I am also glad that you have made your decisions. [pause] b. And, I also want to say that you were not selfish. Right from the beginning, you told me that you wanted to save the baby. You wanted to help her and, you were very prayerful. You had some doubtful moments, I guess because of the medical advice, the poor prognosis due to her heart problem etc. Such doubts are but, normal. And, it is also normal for every parent to wish for a healthy baby. So, you were okay. c. You stayed very strong through these tough days. That, I guess is the strength from your prayers, you should be proud of yourself

(continued)

P16	(She smiled and replied) Thanks for your kind words, Yes. We have now decided to our best to our baby. I think I am strong enough and my husband is very supportive too.
	Husband: Yes. Thanks for helping us through this. It has been a great relief for us.
	Patient: Yes. I greatly appreciate your visit. You helped me clear all the clutter in my head and I felt so peaceful. Now, I can think straight and make my decisions. Thanks you so much.
O26	She looked straight at me with a pleasant smile on her face, though with obvious evidence of having cried a lot.
C13	I am so happy that you have felt better and my visit was helpful. I will now let you go.
P17	Yes, it was very helpful. Thanks
C14	Thanks for having me. You both have a good day,
O27	I waved my hand, to say “bye,” as I turned to step out of patient’s room. Patient also waved and smiled at me, returning my smile.
P18	Husband: Thanks for stopping by, pastor. You have a good day, too.
	Patient: “He is my doctor.”[I overheard my patient saying, as I walked towards the nurses’ station].
S26	I was so thrilled to hear that. As I wrote my clinical notes, I wondered, “how could the Divine have played Its role in this healing process!!!”

Call-out Box 4 What are the Freudian Psychoanalytic Process That Can Be Seen in the Clinical Chaplaincy Process?

Freudian psychoanalytic “Free association” process requires the therapist to:

- Have an Ungrounded attention and Unintentionality
- Apathy without Therapeutic Ambition
- Low activation of attention
- Discard one’s own Therapeutic Expectations or Therapeutic Tendencies

Challenging question: Can you identify such “Psychoanalytic Free Association” pattern in the Chaplaincy process in this case study?

See Sect. 6.

Call-out Box 5 Deep-Listening Skills and Emotional Insight

Inductive understanding of chaplaincy process

- (a) Why did the patient move away to watch the movie, all of a sudden?
- (b) Why did the Chaplain decide to move along with his patient to watch the movie in the middle of his clinical visit?

Challenging Qn: What are the “healing opportunities” that I, as a chaplain, missed in this interaction?

See Sect. 6.

Call-out Box 6 CPE vs. Non-CPE Trained Pastoral Care

Challenging question: How does the chaplain’s spiritual advice differ from that of the clergy?

See Sect. 6 for answer.

Call-out Box 7 Chaplain Vs. Clergy Vs. Physician Advice in Ethical Dilemmas (Abortion for Congenital Anomalies)

How should we advise patients when they face ethical dilemmas?

What did the chaplain do when he “advised” his patient about abortion?

See Sect. 6.

Call-out Box 8 Prayer, as Chaplain’s Therapeutic Tool

Facts:

Challenging questions.

See Sect. 6.

5 Qualitative Analysis

In this section, being grounded in the clinical case and drawing from its qualitative data, I will discuss the possible intrapsychic processes of the patient as well as the chaplain to study the methodology in Spiritual Care. I will use the framework of “Transpersonal-Mindfulness” (Ramakrishnan 2015; Parameshwaran 2015) to illustrate the empathic meeting points in this chaplain-patient interaction that could have led to the patient’s healing. The Transpersonal-framework of clinical chaplaincy process has four stages: (1) Chaplain’s mindfulness, (2) Chaplain’s transpersonal mindfulness, (3) Patient’s facilitated-mindfulness and, (4) Patient’s facilitated transpersonal mindfulness. Needless to say, in real-time, during the interpersonal empathic interaction these four stages run simultaneously and are intertwined.

5.1 *Chaplain's Mindfulness and Chaplain's Transpersonal-Mindfulness*

At S3b, the chaplain touch based with his sadness. He could do it because he was able to set aside other thoughts and feelings of his own (S3a) to focus on the patient and feel the possible feelings of sadness, which she had not expressed in P2. Similarly, the chaplain was able to disentangle himself from all his thoughts and feelings, to step back and feel the feelings of helplessness (C3) and pain (C4), which are reflective feelings of the patients.

Patients who are in the acute state of loss, as in this case, are usually “living in their stories” that they share. “Living in their story” means their pain is embodied, i.e. they have become one with the pain and, with that they suffer. Phenomenologically speaking, when the chaplain felt the sadness in that situation he too had embodied the same pain. It is in that sense, that chaplaincy is an embodied care. Stepping back into his/her own skin to become aware of the patient’s pain and suffering of the patient as a first-person experience is what I call as the chaplain’s transpersonally-mindfulness. The vital aspect of the chaplain’s mindfulness that involves non-judgmental presence is *epochē*, the Greek term for suspending our thoughts and emotions that leads to judgments. At every moment in the chaplaincy process one can see how the chaplain sets aside all his thoughts and feelings (S1b, S3b, S4b, S6b, S7, S9b, S12b, S15a, S15b, S17c, S18, S19c, S20c, O21b) to focus and be available to patient’s thoughts and feelings. The “setting aside” of thoughts and feelings is a mental process but it impacts the cerebral process itself and in that sense, it is a pre-cerebral process which signifies the chaplain approaching the meditative state that is “beyond mindfulness.” It is in that deep (“beyond mindful”) meditative state that the chaplain becomes deeply empathetic to patient’s thoughts and feelings. Transpersonal mindfulness helps the chaplain to be gentle with the patient--first, he lets the patient move away or escape from her pain by getting distracted towards the movie (Harry Potter) playing on her Television (O10a, b) and, then gently facilitates the patient’s return to her own story (C6-P9, C7-P10).

However, I would also highlight how the chaplain also got caught in his painful thoughts and emotions--in O7, the chaplain, self-reflectively writes: “I was lost in the feeling of [patient’s] pain and hurt.” “Getting caught” in one’s own emotions is loss of mindfulness. Losing one’s mindful-meditative state leads to decreased ability to tolerate the pain and, with that, the chaplain tries to move/distract himself to that part of the patient’s story which is not painful, or that which is positive, such as patient’s praiseworthy story of caring for neonates (P5, O8a). Having got distracted, the chaplain begins to make assumptions about “patient’s fear of God” and projects his assumption on the patient (S8b, c). Having become mindless, he had lost his focus on the patient and misses the point that the patient had clearly expressed in P5. From patient’s non-verbal questioning as seen in O8c, one may paraphrase P5 as “why would God punish me, actually he should reward me for the good work as a neonatal nurse.” This is one of the places (in the Verbatim) where the chaplain had clearly missed the opportunity to answer the patient’s question. A chaplain’s best answer to such a question (P5: “Why would God punish me?”) however, would be

a re-directing statement such as “what do you think, do you think he is punishing you?” which would help the patient become self-reflective and facilitate their mindfulness.

5.2 Patient’s Facilitated-Mindfulness and Facilitated-Transpersonal Mindfulness

Crucial to patient’s healing in chaplaincy is the step in which the chaplain facilitates her mindfulness (C2-5, C8-9). Such a facilitation is needed because, patients in their acute stage of grief and pain are in an embodied state, i.e. as said above they “are living in their stories.” Becoming mindful is the process of disembodiment, i.e. health-disentanglement from one’s physical body. It is healthy because the individual remains empathetically connected with the physical self, in that s/he will be able to perceive the pain because of the psychic and/or phenomenological processes but, will not suffer from the loss and pain. It is the chaplain’s job to facilitate the patient’s mindfulness --examples of such facilitated mindfulness are P3 (“Yes, I feel sad”), P4 (Yes, I feel helpless), P5 (It is very painful), P6 (Yes, there are so many thoughts in my head) and so on. As can be seen in P9, such a facilitation helps the patient to return from her distractions (watching the movie, Harry Potter) to face the pain in her current life, where the chaplain immediately provides an empathetic support (C9) and facilitates her into mindfulness (P11a). However, she is well supported on return to her story. In the deepening of the meditative state they reach “beyond mindfulness” to their “Centeredness,” which is believed as the spiritual core of one’s “Beingness.” These are the phenomenological processes.

Beginning with her consultation (P1) and, revealing her troubling concerns (P2, heart problem of her unborn baby, P5-her friend’s comment in Church choir, and P11b-her physician’s suggestion and P12-her pastor’s advice), this patient had continuously sought for advice from the chaplain--both, verbally (P5) and non-verbally (O8c, O19, O20). Most possibly, she was trusting that I will provide her the supporting answer that she was seeking. A closer look at the interaction revealed how (O7b) this patient could have felt her chaplain’s genuine empathy for her pain and struggles. That probably explains the trust and the rapport that she had developed very early in the visit. The qualities, such as trust, rapport which signify one’s ability to feel connected or the ability to feel empathic feelings of the other are signs of transpersonal mindfulness. This patient had an appreciable nature of seeking appropriate help from religious and/or other professionals for her current problem. Even though her Church pastor’s advice was doctrinal and unempathetic, she did not mind his straight-forward advice. She could still read the kindness of her pastor mind/heart. Such an ability to read the chaplain’s mind is transpersonal mindfulness. When both, the patient and her chaplain reach the stage of transpersonal mindfulness then they are empathetically united with each other and in that is the perfect healing. I believe this happened when the patient had once again placed her full trust in chaplain to guide her (O20) and, chaplain had guided the patient merely by bol-

stering her own strengths of reflective thinking and religious-spiritual wisdom (C10b, c). I have learned that the ability to ventilate our vulnerable feelings and breaking down into tears (as seen at P13) are good signs of spiritual healing. The decisions, conclusions and/or meaning and purposes that one arrives at are spiritually based and sacred acts and not mere intellectual activities.

6 Discussion

This chapter is primarily meant to illustrate the clinical chaplaincy process and its methodology of transpersonal mindfulness. However, it also focused to address the ethically challenging decision-making process in clinical medicine. The following is the brief.

6.1 *The Chaplaincy Process, Its Future Grounded in Interreligious Theology and Neuroscience*

The transpersonal-mindfulness framework of the clinical chaplaincy process well applied to the clinical case studied here validates the chaplaincy methodology described elsewhere (Ramakrishnan 2015; Parameshwaran 2015). It is important for readers to refer to these publications to understand the possible neurophysiological mechanisms that may apply to the clinical case studied here, in this chapter. Advancing our understanding of chaplain's spiritual care process as a scientifically verifiable and evidence-based methodology is crucial for the inclusion of CPE in Medical School curriculum and/or Psychiatric Residency training.

However, it is to be noted that the chaplaincy process is steeped in religious-spiritual methods such as Mindfulness, *epochē* and Centering, which are typically employed by devout scholars to encounter the Divine in their scriptural studies (Kopacz et al. 2017, Evans 2014). Does that mean, we need to invest ourselves in the understanding of the theological concepts for deeper insights into the chaplaincy process? The answer may be in the affirmative. While clinical researchers question the ethics of secularizing the term Mindfulness, which has its roots Eastern religious tradition for its application in clinical therapeutic programs (Harrington and Dunne 2015) we, based on our chaplaincy experiences can argue that religious-theological constructs need not be considered as inherently divorced from practical scientific reasoning and logic. Further, piggybacking on Mindfulness researchers (Knabb 2012, Crane 2017) we need to learn how to skillfully broaden the practical theology of chaplaincy by drawing on diverse religious scriptures. Chaplaincy would then be able to provide (1) the practical grounding to bridge theoretical constructs drawn from across religious scriptures as well as (2) validating them through the research methods of contemplative neuroscience.

6.2 *Brief Discussion About Prayer as a Spiritual Care Tool and Ethical Issues Related to It*

Prayer is an important spiritual care tool in a chaplaincy process. A patient's request for prayer can be for a range of reasons: at the most positive extreme, a request for prayer (as seen at P13) is allegorically a request for a "soft and safe lap (of the Divine) to fall into" when the patient has become vulnerable and starts to break down. At the other extreme, a patient may ask for a prayer as a polite way of requesting the chaplain to end his/her visit, in which case we may not witness emotional outpouring of the patient and we will definitely not see a rapport and/or empathy in the chaplain-patient interaction.

The chaplain's prayer is meant to (1) provide the comforting cushion for the purpose of easing the pain from the vulnerable break down (2) it is a technical spiritual care tool which requires a well-trained clinical chaplain to use it in his/her deep empathic state to (3) hold the patient in the deeply centered spiritual "sweet-spot" into which s/he was led by the chaplain. (4) A prayer is meant to keep the patient connected with the Divine that is already present in the embrace. In that sense, a prayer can be considered as the end of the spiritual care journey. Of course, (5) the prayer will be better said in a tone and pitch that is soft, humble, devotional and soothing to the ear. However, not all chaplaincy visit need to end with a prayer for it to be considered as effective. In other words, the prayer can be the moment in which the patient is made to stay deeply mindful of all her painful thoughts, vulnerable feelings, other psychological weaknesses and spiritual as well as patients' psychosocial and spiritual strengths (C11). The reader or a chaplaincy-novice should also be aware that a prayer is (1) not an opportunity for the chaplain to present his/her knowledge of the scriptural texts/verses, (2) prayer is not meant to appease the divine (3) it cannot drag the patient away from being in the present moment and, least of all (4) it is not a moment or opportunity for any prescription for the patient, (5) The chaplain may include patient's wishes in his/her prayer but they should not be outlandish, impractical or requesting a miracle and, (5) definitely, it cannot be disturbing or unsettling, for instance, we cannot draw the patient to religiously or theologically unfamiliar terrains.

Needless to say, patients may wish and/or request their physicians pray with them during their clinical visits and hospital stays. In their wish-fulfilment, the patients may feel connected with their physicians (MacLean et al. 2003, Koenig et al. 2017). However, the reader may recognize how a chaplain's prayer is a highly technical spiritual care tool and, hence the usage a prayer by a physician or a therapist untrained in CPE process and/or not empathetically connected with the patient may derail the therapeutic process. Some may even considered praying for/with the patient by a medical professional untrained in spiritual care as unethical and or a breach of professional boundaries (Pool and Cook 2011).

6.3 *Summary and Conclusion*

The case study presented in this article is from a very basic chaplaincy visit. The ethical dilemma related to abortion presented in this case is not a very complicated one but, very common in clinical practice. The role of a clinical chaplain is to meet the religious and/or spiritual (R/S) needs of the patients while advising them about the practical aspects of a clinical situation. In that the clinical chaplaincy process is primarily aimed to bolster the R/S strengths of the patient, which in itself is one of the three clinical outcomes of spiritual care. Patients' increased R/S strength would heal the mental-emotional pain and alleviate his/her suffering, which is the second outcome of chaplaincy process. Finally, having a calm and undisturbed mind, the patients will be empowered to work through their R/S struggles self-reflectively and, with that they will overcome their ethical dilemmas to arrive at their own medical decisions that meet the realistic expectations.

As one can see, the verbatim consists of not only the verbal interactions of the chaplain and the patient, which informs us of the clinical history of the patient and his/her psychopathological status, but also about the chaplain's intra-psychic or mental-emotional processes that underlie his spoken words and behavior during the spiritual care process. The most vital aspect of a chaplain's CPE training is in presenting such a verbatim case to his/her peers and supervisor in a classroom setting. The feedback from the supervisor and the CPE peers is mostly to help the chaplain-presenter reflect and understand his/her intrapsychic processes underlying the verbal and physical/facial expressions of the spiritual care process. These CPE-group-feedback sessions has a profound impact on the psychic makeup of Chaplain Residents to bring about a spiritual transformation needed to provide spiritual care. Such an experience of a CPE-group verbatim session cannot be captured in writing, it can only be experienced. I will encourage the readers to form small-groups to roleplay the chaplaincy case study provided in this chapter to experientially understand the chaplaincy process.

Acknowledgments I had presented this verbatim case report to two of my CPE Supervisors, Rev. Dr. Garrett Starmer (ACPE Supervisor at Spiritual Care dept., Harborview Medical Center, University of Washington and Rev. Landon Bogan (ACPE Supervisor at Spiritual Care dept., Stanford Medical School, Stanford University) for their critical feedback. Using their feedback, I have developed a semi-standardized chaplaincy case study that is presented in this chapter. My heartfelt gratitude to both, Garrett and Landon, without their feedback this chapter would not have turned out in the way it has.

Self-Assessment Questions

In this section, I have provided three clinical case scenarios, which you have to study to understand what kind of religious or spiritual intervention would benefit the patient. In the fourth exercise, you are being asked to develop a simulated clinical case by pairing up with your classmate, to role-play a clinical patient and his/her

chaplain, to experience a clinical chaplaincy situation. Finally, you are being asked to visit an actual clinical patient as a volunteer-chaplain or chaplain-intern to provide spiritual care. You would benefit from presenting your clinical verbatim to a chaplain supervisor in your hospital, if any.

Case-1: A 58-year old staunchly religious Muslim patient was brought to the ER with drowsiness, disorientation, shakiness, sweating, headache and pale skin. Initial blood work revealed severe hypoglycemia. On detailed history patient revealed that though he was taking his diabetic medications properly he was also fasting because that was the month of Ramadan.

Question: What would you do in this situation? What kind of intervention is needed here, a religious-counselling or a spiritual care process?

Guidance: Refer to John W. Ehman's UPenn resource on "*Religious Diversity: Practical Points for Health Care Providers.*" http://www.uphs.upenn.edu/pastoral/resed/diversity_points.html

Case-2: A 29 year old mother was nervous seeing her 5 year old daughter being rolled towards the operation theater for an emergency appendectomy. While talking to the anesthetist the mother informs that they are Jehovah Witness and blood transfusion is a taboo according to their faith tradition. The anesthetist allays the mother's anxiety saying it is a minor surgery and he is not expecting a dire need for blood transfusion. But, he also adds that in case of a complication with excessive blood loss the surgical team may decide to offer blood transfusion.

Question: Did the anesthetist attend to the patient's mother appropriately and honestly? What kind of intervention is needed in such situation, a religious-counselling or a spiritual care process?

Guidance: Refer to John W. Ehman's UPenn resource on "*Religious Diversity: Practical Points for Health Care Providers.*" http://www.uphs.upenn.edu/pastoral/resed/diversity_points.html

Case-3: A 63 year old female retired oncology nurse was now admitted with a new diagnosis of lymphoma. She was seen tearful and rolling her rosary most of the day since her admission. A deft nurse approached her and quickly does an assessment of her spiritual care needs. The nurse discovers that one of the patient's church prayer group member had apparently suggested her to discuss with the priest for atonement of possible sin she may have committed in her past and, that her lymphoma was God's punishment.

Question: What kind of intervention, Religious or Spiritual care, does this patient need?

Spiritual Care exercise-4: Pair up with your classmate. One of you need to role-play as a clinical patient and share a painful event from your life (share a real event if you feel comfortable or concoct a painful story) with the chaplain (role-played by the other classmate in the pair). The "patient" should share his/her story in bits as it may unfold in your interaction with the chaplain. The "chaplain" may follow the mindfulness-based clinical chaplaincy methodology as he interacts with his "patient." After the "clinical visit" the "chaplain" should prepare a verbatim case report in the format provided in [Table 2](#) and present it to a chaplain supervisor in your medical college hospital.

Spiritual Care exercise-5: Visit an actual clinical patient in your medical college hospital as a volunteer-chaplain or chaplain-intern to provide spiritual care. After the spiritual care visit prepare a case report in verbatim (follow the format provided in Table 2) and present it to a chaplain supervisor in your medical college hospital.

Key Terms and Definitions

The goal is to explicitly and intentionally add new terms to the students' vocabularies.

1. Chaplain = a clergyman officially assigned to provide religious/spiritual services to members in institutions such as military, hospitals, schools and, prisons.
2. CPE = Clinical Pastoral Education (See Call-out Box 1)
3. ACPE = Association for Clinical Pastoral Education. (<https://www.acpe.edu/>)
4. Board of Chaplaincy Certification Inc. (BCCI).
5. Seminary = an education institute for the training of candidates for the priesthood, especially refers to Roman Catholic Christian tradition. Its equivalent, for example, in Islam would be a "Madrasa" and "Veda Paṭhaśālā" in Hinduism.
6. Seminarians are students in seminary schools.
7. Theology is the study of the Divine/God, Its nature and Its relation to the human beings and the world. But, it is also referred to the study of religious faith, practice, and experience of the "Divine" through one's religious activities.
8. Religion is a set of beliefs that is held by an organized group of individuals concerning the cause, nature, and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs of that community.
9. Spirituality is a term that refers to all kinds of meaningful activities that affect the human spirit or soul as opposed to material or physical things: It may refer to human search for the sacred in their blissful experiences in the interconnectedness with other humans beings, animals and or the nature. People understand "spirituality" as different from the construct of "religion" and, relate it to acts of compassion and selfless altruistic activities through which they connect with the nature. Thus, "Spirituality" has been defined in numerous ways but, researchers argue that its definition is still not applicable for clinical research and education purposes.
10. "Mindfulness" is a meditative state of observing one's own thoughts and feelings without judging them good or bad. The term "mindfulness" is derived from Buddhist meditative practices but, it can be seen in the Hindu meditative practices that predates Buddhist tradition and it can be seen as a universal practice in the meditative techniques in the mystical traditions of all religions in this world.
11. "Centering meditation" is a term that is developed from the Christian traditions. One can understand how mindfulness process leads the meditator to "center him/herself," retracting oneself from all the distractions of the worldly thoughts and worries.
12. "The Cloud of Unknowing" is a meditative state in which the meditator is said to "glimpse" the Divine experientially. This is described a Christian mystical meditative practice in which one has to abandon all discriminatory intellect by surrendering one's mind and ego identities.
13. Epochē = Suspension of judgment (Greek). This is considered as decisive in avoiding emotional disquiet to reach "ataraxy."
14. Ataraxy = mental calmness. This is considered as "a must" for religious, scriptural studies. This is also considered as the starting point for empathetic, embodied understanding of the other, i.e. phenomenological process of using the "Self" in the study of the other.

(continued)

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15. Religious professionals have assigned titles such as Priest, Pastor, Minister, Deacon etc. in Christian religions/denominations. Within a religion/denomination there are different terms to denote different hierarchical positions of that religious profession. Similarly, there are different terms in other religious traditions as well.
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16. Priest = Can be a “generic” term for clergyman authorized to perform sacred rites in a religious tradition. In certain Christian traditions, such as Anglican, Eastern Orthodox, or Roman Catholicism, “Priests” rank below a “Bishop” and above a “Deacon.” “Pastor” is an equivalent position in protestant tradition. Imam = a Muslim religious/spiritual leader in the Shiite tradition. Purāri = equivalent term for “priest” in Hindu religion; Rabbi= Jewish religious leader trained to lead religious congregation ceremonies and also expound Jewish law; Shraman)
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17. Immanent = existing or operating within, inherent.
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18. Transcendent = beyond or above the range of normal or physical human experience
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19. Metacognition, put simply, is curiously thinking about one’s thinking or questioning them. More precisely, it refers to the processes used to plan, monitor, and assess one’s understanding and performance. Metacognition includes a critical awareness of one’s own thinking and learning about oneself through his/her self-reflective processes. Metacognition is thus a part of one’s meditative process.
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20. Theory of Mind: Using our emotional experiences, when we intuitively conceptualize the existence of a non-observable entity called as the “mind” then we are said to have a theory of mind (ToM). Further, this ToM helps us deduce that other individuals also have a mind, and that helps us understand possible thoughts and feelings of others.
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21. Mirror-Neurons are a set of neurons that are active not only during an individual’s cognitive and motor functioning but also when that individual sits merely observing the behavior of others. They are called “mirror neurons” because they not only respond to the observed physical activities of other individuals but also involuntarily resonate or mirror the feelings of others.
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22. Transpersonal-Mindfulness is described as a chaplain’s ability to transcend the “ego-centric self” to understand the thoughts and feelings of the patient in a first-person experience to provide the embodied care during chaplaincy.
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23. Trance-state is an altered state of consciousness that is characterized by easy suggestibility and ready and empathic compliance to the wishes/request of the other. There is an apparent absence of response to external stimuli. This state is popularly seen induced by hypnosis or entered into through a religious-meditative practice.
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Recommended Readings and Weblinks

1. John W. Ehman. “*Religious Diversity: Practical Points for Health Care Providers.*” http://www.uphs.upenn.edu/pastoral/resed/diversity_points.html
2. Publications of Anton T. Boisen and publications on Boisen by other scholars that came after him.
3. Select spirituality-related publications compiled by John W. Ehman, listed as: “*Spirituality & Health: A Select Bibliography of Medline-Indexed Articles Published in 2015*” (<http://www.uphs.upenn.edu/pastoral/resed/bib2015.pdf>)
4. Alternatively, students will benefit from reading publications by current leading scholars in “Medical Spirituality” such as Russell D’Souza, Harold G. Koenig, Christina Puchalski, Robert C. Cloninger, Kenneth Pargament, George Fitchett, Curtis Hurt and Kevin J. Flannelly.
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Appendix

Table 1 This (below given) is a typical format in which a clinical chaplain records his/her verbatim for CPE-group presentation. The format given in the “Body” of this chapter is for the purpose of aesthetic-reading. Students should follow this format to write their verbatim reports of spiritual care visit only after completing their visitation with the patient and exiting patient’s room

Chaplain (C) and Patient (P) interaction in verbatim	Objective (O) findings of the chaplain	Chaplain’s subjective (S) thoughts and feelings
C1: Hi Andrea. My name is Chris. I am a chaplain rotating in the ER. Your nurse suggested that you may like to talk to a chaplain. Is it a right time to visit with you?	O1: Patient was sitting in a chair next to her bed. She looked her age. Her tummy also looked at 8 months pregnant and she was physically comfortable. She looked up, greeted me with a smile and nodded, as if to say “yes” for my visit.	S1: (a) I was anxious, as I walked towards patient’s room. I was curious as to what could be the reason for a spiritual care referral to a 38-year old. (b) Several worrisome thoughts crossed my mind, I looked at all of them and kept them aside and focused on the patient.
P1: Hi chaplain. Thanks for coming. I needed to talk	O2: She had a gentle low voice. As she spoke she motioned her hand to point at a chair next to her indicating me to take a seat. I nodded, saying “thanks” and sat down.	S2: I felt she was still in the middle of her sentence, she had only paused as I sat down. I wondered what she was about to say. I remained humble as I waited in silence.
Verbatim truncated		

Table 2 Clinical Chaplaincy Verbatim-Exercise table: Choose a partner in your class who would be willing to share a painful (real or made-up) story and interact with him/her empathetically. After completing your interaction, take some time to organize the entire interactions in the following tabular framework for your practice as a spiritual care provider. Present this case to a clinical chaplain supervisor in your hospital

Chaplain (C) and Patient (P) interaction in verbatim	Objective (O) findings of the chaplain	Chaplain’s subjective (S) thoughts and feelings
C1: What did you, as the “chaplain” say (write it in verbatim)	O1a: What did you observe of the patient?	S1a: what thoughts do you have now. What thoughts, feelings and memories (from your own life) were triggered in your mind, and feelings or emotions arose in you as you saw or heard the patient?
	O1b: What did you observe of yourself behaving in the presence of the patient?	S1b: what did you think about the patient or what did you feel about the patient as you saw or heard him?
	O1c: Did you notice any other happening in that clinical setting that may have influenced your interaction with the patient?	S1c: What did you do with all your thoughts and feelings?
P1: How did your “patient” respond?	O2a: same as above	S2a: same as above
	O2b: same as above	S2b: same as above
	O2c: same as above	S2c: same as above
C2: What did you say/ do next?	O3a: same as above	S3a: same as above
	O3b: same as above	S3b: same as above
	O3c: same as above	S3c: same as above
Continue to write down the entire interaction till you tell us about the end of your visit.		

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Spiritual Care at the End of Life



Bianca Sakamoto Ribeiro Paiva and Carlos Eduardo Paiva

Abstract Concerns of a spiritual nature often arise at the end of life and may significantly affect the desire to live. Caring for a person with a terminal illness is often accompanied by religious, spiritual or existential needs, concerns and questions. In this chapter, the authors highlighted the main spiritual needs of the patient with an incurable chronic disease, as well as those of their family caregivers. They also highlighted the main limitations of spiritual care during end-of-life and how health-care professionals can include this care into their daily clinical practice. It is emphasized that the spiritual evaluation can be conducted in different ways; each professional can determine the most appropriate method for their routine. Some mnemonic tools have been developed to help healthcare professionals when taking the spiritual history. However, the important factor in this evaluation is that it should be broad, complete and not limited merely to religious aspects.

Keywords Spirituality · Spiritual care · End of life · Palliative care · Health care

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1 Introduction

Spirituality is considered an essential condition for life. The need for meaning is what helps individuals make sense of their experiences; people who feel unable to find meaning often experience a sense of emptiness and hopelessness (Ross 1995; Peres et al. 2007).

Spirituality is characterized as the ability to love and to forgive, to look beyond current circumstances and transcend suffering (Rousseau 2003). It is a subjective experience that occurs both within and outside the context of religious traditions and is defined not by a set of beliefs about humanity (Peterman et al. 2002) but as a means by which people understand and live, keeping in mind their meaning and supreme value (Muldoon and King 1995; Puchalski et al. 2009). Spirituality is a dimension that is very important to human beings and becomes essential as life approaches its end (Wachholtz and Keefe 2006).

The importance of spirituality in the dying process is already well documented. However, researchers seek to more precisely define the significance of spirituality in the process of dying, as it concerns a subjective dimension that individuals may perceive in different ways (Stephenson et al. 2016). Moreover, the process of dying inevitably raises questions of a spiritual and existential nature (Sulmasy 2002; MacLeod 2003; McCord et al. 2004) and may provide an opportunity for spiritual growth (Cobb 2002) to patients, their family members (Murray et al. 2004), and all those who care for them.

Concerns of a spiritual nature often arise at the end of life and may significantly affect the desire to live. Caring for a person with a terminal illness is often accompanied by religious, spiritual or existential needs, concerns and questions (Emanuel et al. 2015).

Many people stricken by chronic diseases use a variety of strategies, including spirituality/religiosity, to cope with their condition. Patients use spiritual/religious coping mechanisms to alleviate stress caused by the relationship between sickness and the possibility of death, which can directly improve these individuals' quality of life and death (Peteet and Balboni 2013; Koenig et al. 2001; Johannessen-Henry et al. 2013).

It is recognized that patients' quality of death is improved when they are spiritually well and receive spiritual care (Balboni et al. 2011; Delgado-Guay et al. 2011; Hui et al. 2011). When spiritual needs are attended to, patients experience less pain, depression and anxiety (Delgado-Guay et al. 2011). In addition, studies indicate that those who receive spiritual support are generally referred more often to palliative care (PC) services rather than receive aggressive forms of treatment (Balboni et al. 2011).

Thus, PC is one of the approaches to patient treatment that allows their spiritual dimension to receive care. PC is an "...an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (Hall et al. 2011; Hui et al. 2013). Because PC incorpo-

rates the concept of caring rather than only curing, it is understood as a “new” method of caring for patients, especially at the ends of their lives, and develops and reestablishes the doctor-patient-family relationship as the basic element (Hui et al. 2013). The promotion of spiritual care aids the patient in facing the disease, significantly improves their quality of life and can even prevent or mitigate certain diseases (Nelson et al. 2002; Tarakeshwar et al. 2006; Molzahn 2007).

The relationship between spirituality and religiosity has become essential in the daily practice of health professionals. When the health professionals understanding the importance of spirituality, religiosity and personal beliefs in the clinical practice, it's possible leading to improvements in their relationships with patients (Balboni et al. 2013).

1.1 Patients' Spiritual Needs at the End of Life

End-of-life care requires effort from not only the health team but also family caregivers. The multidimensional demands of these patients wear on both the patients and all those involved in caring for them. It is frequently observed that during the daily care routine, both family caregivers and health professionals need to experience the spiritual dimension in a more contemplative way; many of them draw on spirituality and religiosity as a way to cope with daily problems and difficult situations.

A patient's knowledge of his or her approaching death and what is to be expected is seen as a prerequisite for a “good death” (Smith 2000). The concept of a “good death” has been discussed and used in the context of end-of-life care and has certain basic features that include, among others, a painless death, respect for the patient's expressed and recorded wishes (living will), the right to die in the place of one's choosing (in the presence of family and those who are dear to them), the absence of aggressive treatments at the end of life, putting one's affairs in order and especially resolving emotional issues involving loved one (Emanuel and Emanuel 1998; Clark 2002). In addition, it is important to consider the manner in which the person faces death, thus steering clear of expectations about the dying process, which is something subjective and dynamic, often involving specific cultural and spiritual aspects (Walter 2003).

A study of 75 patients with advanced stages of cancer showed that 78% of the patients said spirituality/religiosity was important, especially in their experience of dealing with the illness (Alcorn et al. 2010). Additionally, another study showed that patients who said their spiritual needs were not being addressed by the medical team were more likely to express negative evaluations and dissatisfaction with the general quality of the care they were receiving (Williams et al. 2011).

Balboni et al. (2011) conducted a prospective study of 339 outpatients with advanced cancers that were followed until death. Interestingly, the authors found that medical care for patients whose end-of-life spiritual needs were neglected cost, on average, US\$2441 more than care for the patients whose spiritual needs were attended by the medical team.

In a cross-sectional study in a tertiary care cancer hospital in São Paulo State, Brazil, 1050 participants were included (525 cancer patients and 525 health care

professionals). Both groups answered the generic quality of life (QOL) instrument from the WHO (the WHOQOL-Bref) and the WHOQOL-SRPB instrument (the spiritual, religious and personal beliefs module developed by the WHO). The spiritual QOL scores were compared between patients undergoing different treatment modalities. In general, patients undergoing curative treatments (adjuvant and neoadjuvant treatments) reported higher spiritual QOL scores than those receiving palliative care only. The patients with cancer reported worse spiritual QOL in advanced clinical stages than those patients with early clinical stages, likely because they were undergoing a period with a high burden of emotional and physical symptoms. Patients that received palliative anticancer treatment reported intermediate values of spiritual QOL, suggesting a decrease in spiritual QOL scores over time as the patient becomes aware of his incurable disease. Professionals working in Palliative Care and the Intensive Care Unit reported higher scores of spiritual QOL than those working in places where death occurrence is a rare event. These findings can be identified in a conceptual framework of this study (De Camargos et al. 2015) (Fig. 1).

Approximately 90% of patients with advanced cancers refer distressing spiritual struggles and seeking spirituality (Pearce et al. 2012). Unfortunately, these spiritual needs are often supported minimally or not at all by the medical system (Balboni et al. 2011) potentially influencing the spiritual QOL in a negative way. Each patient should be viewed individually, with its own history and personal cultural background. Thus, each one has its own coping resources when facing end of life. Many

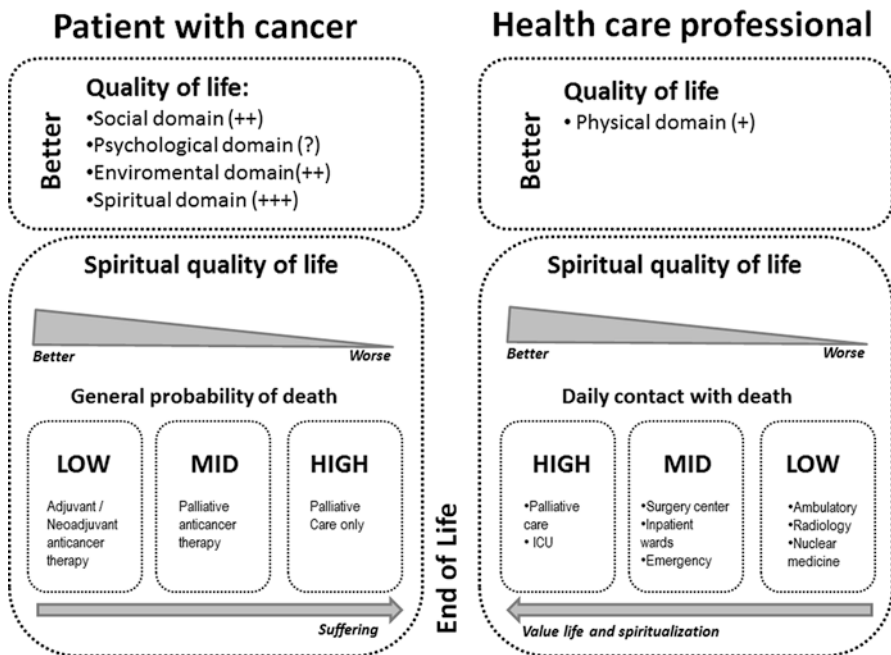


Fig. 1 Conceptual framework of the study findings

are able to go through the process of dying with less suffering, and can achieve personal growth through suffering. The key question is to identify those who will benefit from spiritual care and those whose existential and psychological suffering can be mitigated by PC.

The results of the cited studies lead us to Viktor Frankl's observation that "man is destroyed not by suffering, he is destroyed by meaningless suffering" (Frankl 1984). Spirituality helps give meaning to people's suffering and helps them find hope even when the present moment brings them hopelessness and desperation (Puchalski 1999). In the initial stage of a disease, the patient may hope for a cure. When a cure is no longer possible, the patient may hope for time to achieve important goals before their life ends, allowing them to die in peace. Thus, health professionals need to become spiritually involved with their patients, providing them spiritual support.

Despite recognizing the importance of caring for the spiritual needs of patients and their family members, most health professionals receive no specific training in offering this care. Therefore, they often neglect to provide spiritual and religious care to these individuals. Health professionals even claim that spiritual care should be provided by specific professionals like chaplains or by the patients' religious institutions (Balboni et al. 2013).

1.2 Family Members Who Provide End-of-Life Care to the Patient

The personal experience of a chronic illness should not be isolated from the family's life history, as it occurs in a particular spiritual/religious and cultural context and is permeated with values related to the perception of the process of becoming ill (Surbone et al. 2010). Values expressed by individuals who take on the responsibility of caring for family members include hope, dignity, solidarity, strengthening family ties and strong interpersonal involvement, often extending until the end of life (Sand et al. 2009).

In the scenario of palliative cancer care, in which patients and family caregivers (FCs) transition from the end of curative treatment to palliative treatment, spirituality and religiosity can be a coping strategy that helps patients and FCs deal with the illness and with current and future changes and that may even affect the symptoms, particularly those related to emotional state and quality of life (Peteet and Balboni 2013).

In an exploratory descriptive and qualitative study conducted in Brazil, Paiva et al. (2015), interviewed 30 FCs of advanced cancer patients undergoing PC exclusively to understand the influence of spirituality and religiousness in the lives of these FCs. The results of that study indicated that spirituality and religiousness were coping strategies frequently used by these FCs. The FCs' perceptions fell into four distinct categories: increase in faith and strengthening of closeness to God, rethink-

ing of life issues, negative interference in extrinsic religiosity and quest for religiousness to gain strength or support. Spirituality and religiousness represent positive coping strategies and help these FCs maintain the hope and strength to continue caring for their loved one (Paiva et al. 2015).

1.3 Limitations of Spiritual Care at the End of Life

As already mentioned, spiritual care is important and affects the lives of those who receive this care. Nevertheless, despite studies showing the importance of spiritual care, many professionals still do not routinely include it in their clinical practice. The rarity of spiritual care offered by a health team raises questions; possible explanations include concern about the appropriateness of spiritual care (Sloan et al. 2000; Monroe et al. 2003), lack of time (Curlin et al. 2007) and insufficient training (Rasinski et al. 2011), both during academic preparation and as health professionals. However, few studies have explored the specific reasons why spiritual care is often missing from end-of-life care. These data are needed, as they make it possible to identify the factors that contribute to the rarity of spiritual care and make it easier to provide it at the end of patients' lives, taking into consideration their quality of life and death (National Consensus Project 2009).

A classic survey-based multisite study conducted by Balboni et al. (2013)²⁶ included 75 patients (73% response rate) and 339 nurses and physicians (63% response rate). The study aimed to identify the factors that contribute to the rarity of spiritual care provision by nurses and doctors during patient end-of-life care. More than 80% of nurses and physicians reported that spiritual care should at least "occasionally" be provided along the course of care of advanced cancer patients (Balboni et al. 2013).

An online survey assessed the provision of spiritual care by 69 Australian oncologists. Although the majority reported that their patients needed spiritual care, only 45% considered themselves able to meet this need. The obstacles found included lack of time and lack of knowledge about spiritual aspects of health. Twenty-five percent had received some prior training on spirituality, and only 7% considered that training adequate (Kichenadasse et al. 2016). Along the same lines, another online survey of members of the Multinational Association of Supportive Care in Cancer (MASCC) found that only 33.6% of the respondents reported offering adequate spiritual care. This finding is noteworthy, considering that the MASCC is an organization focused on care and support for patients with chronic diseases (Ramondetta et al. 2013).

1.4 Spiritual Evaluation and Spiritual Care

Before performing an adequate spiritual evaluation, the health professional must first conduct a critical and mature review of his or her own religious traditions, beliefs and practices, positive and negative experiences with religiosity and spirituality and true ability and interest in evaluating another person's spirituality. Evaluating the spirituality of a patient with an incurable chronic disease facing imminent death is an additional way to better understand the patient and to identify potential "targets" for multidisciplinary therapies to ameliorate their suffering and to improve the quality of life for both patients and their families.

Before performing an adequate spiritual evaluation, the health professional must first conduct a critical and mature review of his or her own religious traditions, beliefs and practices, positive and negative experiences with religiosity and spirituality and true ability and interest in evaluating another person's spirituality. It is often best to delegate this task to someone else. Evaluating the spirituality of a patient with an incurable chronic disease facing imminent death is an additional way to better understand the patient and to identify potential "targets" for multidisciplinary therapies to ameliorate their suffering and to improve the quality of life for both patients and their families.

As a whole, the spiritual evaluation includes three different processes: spiritual screening, spiritual history, and spiritual assessment. Spiritual screening involves a quick check for a spiritual crisis that would lead to an immediate referral to a spiritual specialist. Taking a spiritual history uses broader questions to gain a better understanding of the patient's spiritual needs as well as to identify any spiritual distress. It can be conducted in different ways; each professional can determine the most appropriate method for their routine. The important factor in this evaluation is that it should be broad, complete and not limited merely to religious aspects.

Several instruments have been developed to aid the doctor taking a spiritual history. The FICA Spiritual History Tool (Borneman et al. 2010) is a widely used validated instrument that begins with questions about faith and beliefs (F = faith) and goes on to evaluate their importance to the patient (I = importance), the role of the patient's faith community (C = community) and, finally, how the patient would like the health professional to address spirituality in the course of care (A = address in care). Another frequently cited instrument is HOPE. This instrument proposes the following sequence for evaluation: sources of hope and meaning in life (H = hope) (Anandarajah and Hight 2001), participation in organized religion (O = organized religion), investigation of spiritual practices and beliefs (P = personal spirituality and practices) and the effects of spirituality on medical care and end-of-life decisions (E = effect on medical care and end-of-life issues). Other tools such as Open Invite Mnemonic, SPIRITual history and FAITH have been developed and have been useful in clinical practice (Maugans 1996; Neely and Minford 2009; Saguil and Phelps 2012). The spiritual history should be recorded in the patient's medical records and available to other members of the health care team. Frequently, the spiritual history may become significant at a later point in the patient's development and may be

reviewed and re-evaluated by the same professional or by other members of the health care team. Although FICA seems to be the most widely-used tool in PC, according to a recent review, HOPE is likely the most comprehensively one to be used in the end of life context (Blaber et al. 2015). Table 1 shows the available tools with some sample questions.

Spiritual care can be defined as interventions that aim to facilitate the integration of body, mind and spirit to achieve a state of integrity and health and a sense of connection with the self, with others and/or with a “higher power” (American Nurses Association and Health Ministries Association 2005). Essentially, clinicians should recognize that their role is to treat the person as a whole – body, mind, and spirit; to identify the patient’s and family members’ suffering in all possible dimensions; and to track their needs and respect their beliefs and difficulties. The spiritual assessment involves more in-depth evaluation and spiritual care and should ideally be conducted by spiritual specialists, like chaplains (a cleric or a person representative of a religious tradition) or any other health-care professional with extensive training and clinical pastoral education. Other healthcare professionals are seen as essential for offering general spiritual care (Astrow et al. 2001). In fact, all clinicians should be encouraged to evaluate their patient’s spirituality, to identify and treat spiritual suffering and to provide the most appropriate spiritual support. It is recommended that PC services develop a means for screening spiritual needs in an ongoing manner and criteria for referring patients for specialized evaluation. In addition, it appears to be important that doctors be encouraged to broach spiritual matters with patients under their care, receive training for this and have the opportunity to visit their patients in the presence of a chaplain (Gomez-Castillo et al. 2015). Another aspect worth mentioning is the fact that addressing the patient’s spiritual needs is likely to improve and strengthen the relationship between the health professional and the patient.

One of the approaches used to alleviate the spiritual suffering of patients in end-of-life PC is life review therapy, which includes the intention to resolve past conflicts, making it possible to give new meaning to the person’s life and to bring peace to the suffering person. A recently published meta-analysis aimed to assess whether interventions involving life review were effective in alleviating psycho-spiritual suffering at the end of life. The grouped analysis of eight studies determined that this intervention was able to improve the meaning of life and spiritual well-being (standardized mean difference [SMD] = -0.33), general distress (SMD = -0.32) and overall quality of life domains (SMD = -0.35) (Wang et al. 2017).

A meta-analysis of the Cochrane group published in 2012 aimed to assess the impacts of interventions that include religious and spiritual aspects on improvements in the quality of life in adult patients with terminal chronic illnesses. Five randomized clinical studies were grouped; two included meditation practices, and three involved multidisciplinary care, including the service of a chaplain or spiritual assistant. No benefit for quality of life was found. However, based on the studies examined, the authors of the meta-analysis were unable to determine what percentage of patients in the treatment groups received religious/spiritual interventions, nor was it possible to determine whether the participants in the control group received

Table 1 Available tools for the health professionals to serve as a guide when taking the spiritual history

Tool/domains	Sample questions
FICA spiritual history tool	
F – faith and belief	Do you consider yourself spiritual or religious? Do you have spiritual beliefs that help you cope with stress? What gives your life meaning?
I – importance	What importance does your faith or belief have in your life? Have your beliefs influenced how you handle stress? Do you have specific beliefs that might influence your health-care decisions?
C – community	Are you part of a spiritual or religious community? If so, is this a support to you? (Communities such as churches, temples, and mosques can serve as strong support systems for some patients.)
A – address in care	How should your health-care provider address these issues in your health care? (referral to chaplains, clergy, and other spiritual care providers)
HOPE	
H – sources of hope, meaning, comfort, strength, peace, love and connection	What are your sources of hope, strength, comfort and peace? What do you hold on to during difficult times? For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life’s ups and downs; is this true for you? If the answer is “yes,” go on to O and P questions. If the answer is “no,” consider asking: Was it ever? If the answer is “Yes,” ask: What changed?
O – organized religion	Do you consider yourself part of an organized religion? How important is this to you? Are you part of a religious or spiritual community? Does it help you? How?
P – personal spirituality/practices	Do you have personal spiritual beliefs that are independent of organized religion? What are they? Do you believe in God? What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)
E – effects on medical care and end-of-life issues	Are you worried about any conflicts between your beliefs and your medical situation/care/decisions? Would it be helpful for you to speak to a clinical chaplain/community spiritual leader? Are there any specific practices or restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products)
SPIRITual	
S – Spiritual belief system	Do you have a formal religious affiliation?
P – Personal spirituality	Can you describe the beliefs and practices of your religion or spiritual system that you personally accept?
I – Integration with a spiritual community	Do you belong to any spiritual or religious group or community? Is it a source of support?
R – Ritualized practices and restrictions	Are there specific practices that you carry out as part of your religion/spirituality? What significance do they have for you?

(continued)

Table 1 (continued)

Tool/domains	Sample questions
I – Implications for medical practice	What aspects of your religion/spirituality would you like me to keep in mind as I care for you? Are there any barriers to our relationship based on religious or spiritual issues?
T – Terminal events planning	As we plan for your care near the end of life, how does your faith impact your decisions? Are there particular aspects of care that you wish to forgo or withhold because of your faith?
Open invite	
Open (i.e., open the door to conversation)	May I ask your faith background?
	Do you have a spiritual or faith preference?
	What helps you through hard times?
Invite (i.e., invite the patient to discuss spiritual needs)	Does your spirituality impact the health decisions you make?
	Is there a way in which you would like for me to account for your spirituality in your health care?
FAITH	
F – Faith/spiritual beliefs	Do you have any particular faith, religious or spiritual beliefs? What helps you cope in times of stress or illness?
A – Application	In what ways do you apply your faith in your daily life? Is prayer or meditation important to you?
I – Influence/importance of faith in life, in this illness and on healthcare decisions	How do your faith and spiritual beliefs influence your life? Are they important to you? How do your faith and spiritual beliefs influence you in this illness? Do your beliefs influence or affect your healthcare decisions that would be helpful for me to know about?
T – Talk/terminal events planning	Do you have anyone you can trust to talk to about spiritual or religious issues? Do you have any specific requests if you were to become terminally ill?
H – Help	Is there any way I or another member of the healthcare team can help you? Do you require assistance or help with prayer? Would you like to speak to a chaplain? Would you like to discuss spiritual issues or your beliefs with your doctor?

any sort of religious or spiritual intervention. Thus, despite the negative results, the question is still open for further studies (Candy et al. 2012).

The healthcare approach of spirituality in the PC context seems to be of utmost importance for both patients and their family caregivers. The spiritual screening and the collection of spiritual history can be conducted by any health professional, however, it is recommended to be deep assessed (if necessary) by chaplains or other trained professionals. Further studies are warranted to define the most appropriate model of spiritual care in PC according to different patients and in different cultures.

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Incorporating and Teaching Spirituality into Medical Education: An Overview of the Field and Possible Educational Strategies



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Abstract Resulting from the increasing scientific evidence on the correlations between spirituality and health (S/H), important institutions such as the World Health Organization, American College of Physicians and Association of American Medical Colleges have already formally recommended the approach of spirituality in clinical practice. In addition, most US and UK medical schools have already included S/H contents in their curriculum, students and medical teachers believe this issue is important to clinical practice and there are several studies showing promising results on the incorporation of S/H courses or strategies to medical students. This chapter will provide a brief panorama on the S/H field, aiming to bring an update overview of the development of the field, the current scientific evidence, the most common educational strategies and initiatives used, the S/H curriculum goals, objectives and general competences. Future challenges of this field are to create an international consensus including the minimum required competences that a

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medical student should learn concerning S/H, to increase the number of S/H content worldwide and to provide high-quality and continuing training for teachers and students.

Keywords Spirituality · Medical education · Religion and health · Educational models · Medical students

1 First Things Coming First: Why to Teach About Spirituality in Medical Schools?

It is probably the case that many chapters in the book have already covered some of the reasons to insert spirituality into the curriculum of medical schools worldwide. However, it seems opportune to reflect deeper on those reasons before going any further once they lead straight to the main topics that we will argue as the most important ones to be covered in medical curriculum.

Spiritual and religious (S/R) topics gained some notoriety in health debates in the 1960s–1980s, when epidemiologists published some data revealing that people with high-attendance to religious services presented lower mortality rates and better health outcomes (Koenig 2012). Since then, the field of S/R and health is constantly growing and consolidating in the scientific community (Lucchetti and Lucchetti 2014). A recent search (performed in June 06, 2019 by this chapter's authors) for the terms (spiritual* OR religio*) in *Pubmed* revealed 72,830 articles and most of the studies show positive associations between different health outcomes and S/R, empathizing how important this topic is in clinical practice.

Probably, the most important reason to approach spirituality in clinical scenarios is that S/R beliefs can influence quality of life and both physical and mental health. Concerning physical health, different studies have correlated S/R beliefs with lower levels of blood pressure, less postoperative complications (Lucchetti et al. 2011b), lower levels of C-reactive protein (King et al. 2001), and lower cognitive decline rates (Kaufman et al. 2007). Interestingly, some meta-analyses suggest that people with higher S/R beliefs have a reduction of about 18–25% in mortality rates. This impact is similar to that of fruit and vegetable consumption on cardiovascular events and the use of statins for dyslipidemias (Lucchetti et al. 2011a). Evidence related to the impact of S/R on mental health is even more robust. Higher S/R beliefs are associated with lower levels of anxiety, depression, substance use and abuse, suicide attempts and higher quality of life (Moreira-Almeida et al. 2014).

Concerning the impact of S/R in clinical practice, many patients would like to have their S/R beliefs addressed by their physicians. When analyzing several studies related to this topic, a systematic review showed that 70% of patients want doctors to address these issues (Best et al. 2015). Nevertheless, other systematic review found that only 16%–32% of physicians address such issues in clinical practice (Best et al. 2016). The most common barriers that prevent physicians from talking to their patients about this topic, are the lack of time, lack of training, fear of imposing religious beliefs to patients, fear of offending patients and difficulty to identify patients who want such approach. We emphasize that the last three barriers are

strongly related to the lack of training (Curlin et al. 2007; Lucchetti et al. 2013; Mccauley et al. 2005; Tomasso et al. 2011). Nevertheless, the first two barriers could also be related to the way students may use their own coping strategies (Balboni et al. 2015) as it will be discussed further in this chapter.

Another reason for giving some space to S/R content in medical education is that religious beliefs and practices often influence medical decisions. Patients may (or may not) accept blood transfusion, vaccines, prenatal care and interventional measures at the end of life depending on their beliefs. An study with 177 patients from an outpatient clinic revealed that almost half (45%) of them considered that their religious beliefs would influence medical decisions if they became seriously ill (Ehman et al. 1999).

Many patients also make use of their faith, spirituality or religion to deal with stress and negative life challenges, such as illness. Such use has been named “spiritual/religious coping” (Panzini and Bandeira 2007). Thus, patients may make use of positive S/R coping strategies such as seeking comfort in religious literature or negative coping strategies such as seeing disease as God’s punishment. A study with 337 outpatients from Duke University Hospital found that 90% of them used their religion to cope with their illness. Furthermore, about 40% of them indicated that it was the most important factor contributing in their coping process. (Koenig 1998)

From the data presented here and throughout this book, it seems reasonable to argue that physicians should be prepared to identify S/R beliefs and needs, as well as patients’ spiritual coping strategies. In order to do so medical students should be prepared during their undergraduate training.

1.1 Introducing S/R Content in Medical Schools

Resulting from the increasing scientific evidence on the correlations between spirituality and health, important institutions such as the World Health Organization, American College of Physicians and Association of American Medical Colleges have already formally recommended the approach of spirituality in clinical practice (AAMC 1999; Group 2006; Moreira-Almeida et al. 2014). Following such recommendation, important education institutions began to introduce content on S/R in their regular curricula.

In the US panorama, there was an impressive growth of initiatives recently (Puchalski et al. 2014a). In the 1990s, only three medical schools had courses approaching spirituality; nowadays, around 90% of them approach S/R topics. (Koenig et al. 2010) In this scenario, the “GWish Spirituality and Medical Education Program” has been the most important responsible for the support and increase of spirituality in the US medical schools. Initiatives at the University of Missouri, Kansas City (USA); Brown Medical School, Rhode Island (USA) and Duke University, North Carolina (USA) are also worthy of note.

In the United Kingdom, Neely and Minford found that 59% of the British medical schools already include topics on spirituality and health (S/H) in their curricula, either electively (80%) or compulsory (50%) (Neely and Minford 2008). On the same line, emerging countries have increasingly demonstrated their potential for

including spirituality in medical education. In India, a country with a strong cultural and spiritual background, this discussion has gained ground in medical centers as the Adibhat Foundation for Integrating Medicine and Spirituality in New Delhi (Ramakrishnan et al. 2014). In Brazil, approximately 40% of medical schools have content related to H/S, although only 10% of them had a specific course dedicated to this subject (Lucchetti et al. 2012b).

In a paper published in 2012, a broad panorama of teaching Spirituality in Medical Schools, based on publications of all parts of the world was given and demonstrated a predominance of studies in US and Canadian medical schools in detriment of other parts of the world such as developing countries (Lucchetti et al. 2012a).

1.2 Brief Summary of S/H Studies in Medical Education

In the last decades, several initiatives have been published in this area of research. Although this part of the chapter will discuss some of the studies dealing with S/H in medical education, our objective is just to provide some of this evidence, including studies describing educational strategies or courses, as well as, S/H opinions and attitudes of teachers and students.

Concerning S/H courses, Table 1 provides 15 studies, which incorporated spirituality in medical schools. We can note that most studies have shown positive results, despite the fact that few of them had a control group and only one study was a randomized controlled trial. More studies are needed in order to understand how and when spirituality should be incorporated in the medical curriculum.

1.3 Medical Students and Teachers' Opinions Towards S/H

There is also some evidence showing that medical students', medical teachers/staff and even medical director believe spirituality is important in clinical practice and in education. A study carried out at the medical university of Vienna with 1400 students (Rassoulilian et al. 2016) found that 75.6% of the students agreed that religiousness/spirituality might have an effect on how cancer patients cope, 85.9% would consider talking with their patients about religious/spiritual beliefs if patients wish to do so and 86.3% would involve chaplains if they feel it is necessary.

Another study including 1300 students and 106 Faculty at Queen's University Belfast Medical School (UK) (Harbinson and Bell 2015) found that most students supported availability of spiritual interventions for patients, 90% felt that faith/spirituality was important to some patients and 60% agreed that this influenced health. However 80% felt that doctors should never/rarely share their own spiritual beliefs with patients and 67% felt they should only do so when specifically invited.

Table 1 Evidence of spirituality and health courses

Author, year	Country	Participants	Strategy	Results
Anandarajah et al. (2007); Anandarajah et al. (2007)	USA	10 fourth-year medical students	17-h elective on spirituality and patient care	Medical students rated the elective positively and increased their knowledge of spirituality and medicine
Gonçalves et al. (2016)	Brazil	50 first and second-year healthcare students	8-month theoretical and practical training	Students felt more comfortable and tended to believe the patient liked the approach, felt better and more motivated
Frazier et al. (2015)	US	166 first-year medical students	3 h of chaplain rounds	Most students (63%) wrote that spiritual care needed and had positive opinions concerning S/H
Schonfeld et al. (2016)	US	70 four-year medical students	S/H month-long rotation	Student feedback for the course was uniformly positive
Perechocky et al. (2014)	US	21 medical students	Shadowing a trauma chaplain during an on-call shift	90% of respondents agreed or strongly agreed they learned about the chaplain’s role in the hospital and that the experience was useful
Talley and Magie (2014)	US	250 medical students	Lectures, panel discussions, role-playing, and training in the use of a spirituality assessment tool	Students were sensitive to patients’ spiritual needs, assessed patients’ and their own spiritual needs and appropriately used chaplain services
Lennon-Dearing et al. (2012)	US	53 healthcare students	1 day S/H workshop	Students were able to take a spiritual history, understand the role of clergy and chaplains and rated well the workshop
Ellman et al. (2012)	US	217 healthcare students	An online interactive, case-based learning module, and a simulation workshop	Students perceived that the program met its learning objectives and highly rated the program
Barnett and Fortin (2006)	US	137 medical students and residents	2-h workshops with lecture, discussion, and role-play	Increases in agreement regarding the appropriateness of inquiring about spiritual beliefs, competence in taking a spiritual history, and knowledge of available pastoral care resources

(continued)

Table 1 (continued)

Author, year	Country	Participants	Strategy	Results
King et al. (2004)	US	146 first-year medical students	Spiritual history-taking curriculum with theory, practice history taking, and standardized patient scenarios	65% of students were able to recognize the patient's spiritual concern, the attitude survey has increased and 94% answered correct the test
Musick et al. (2003)	US	192 medical clerkship students	Two groups with identical theoretical classes. Group 1 worked on a S/H problem-based learning case and group 2 not	Students' from group 1 rated higher their knowledge of taking a spiritual history. However, the spiritual history taking was similar
Culliford (2009)	UK	27 third-year medical students	8-week theoretical course	High satisfaction (78%) between students
Sandor et al. (2006)	US	316 nursing and medical students	Course designed to provide scientific evidence in the field and on how to take a spiritual history	There was an increase in perceived importance of spirituality in practice and reduced dogmatic perception on the theme
Ferreira et al. (2016); de Carvalho Ferreira et al. (2016)	Brazil	305 first to forth years medical students	"Transversal "module on spirituality and health based on 8 encounters with theoretical contents	80% of students rated the module as 'good' or 'very good' and 96.30% reported that participation in the module will influence their future medical practice
Osorio et al. (2017)	Brazil	49 first and second year healthcare students	Randomized trial with an intervention Group (a theoretical-practical course in S/H) and a control group (waiting list)	Intervention group had higher scores of knowledge, better attitude and demonstrated more ability in obtaining a patient's spiritual history when compared to the control group

A Brazilian multicenter study including 3630 medical students from 12 medical schools (Lucchetti et al. 2013) found that students believed spirituality has an impact on patients' health (71.2%) and that this impact was positive (68.2%). The majority also wanted to address S/R in their clinical practice (58.0%) and considered it relevant (75.3%), although nearly one-half (48.7%) felt unprepared to do so.

In the USA results were similar, 254 medical students at the Creighton University School of Medicine (Guck and Kavan 2006), indicated that religiousness and spirituality were considered important, spiritual practices were seen helpful for acute and mental health conditions as compared to chronic or terminal conditions and students believed that patients could benefit from spiritual practices more than they could for their own health conditions.

Medical teachers have also positive views towards S/H. A Brazilian study evaluated 53 teachers (Mariotti et al. 2011) and found that most of them (72%) believed that faith or spirituality can positively influence the treatment of their patients, 62.3% wanted to address spirituality with patients and 50% believed that it is important for a medical school to prepare students for this issue. However, only 43.4% reported they feel prepared to address this issue, 27.8% have ever mentioned this issue in their classes and 92.3% felt that the Brazilian medical schools are not giving all required information in this field. Same results were identified in another Brazilian study which evaluated 44 teachers (Banin et al. 2013) and found that 61.4% believed that spirituality influence positively in health, 59.1% frequently address this issue and 58.1% believe medical students should be prepared to discuss spiritual beliefs with patients. However, 95.5% believed Brazilian medical school were not providing the required information in this field.

Finally, two studies addressed how medical school directors valued S/H in Brazil and the USA. Most Brazilian directors believe that S/H is “very important” to be taught in medical schools, followed by 35.6% who found “somewhat important” and 10.5% who found “of little importance” (Lucchetti et al. 2012b). Concerning the US directors, 43% indicated that their institution needed more S&H curricular content and only 25% would open additional curricular time (Koenig et al. 2010).

All these studies underscore that S/H is considered an important issue to medical students, teachers and directors. However, there is a concern on how to appropriately incorporate this theme in a time-restricted curriculum.

2 Methodological Considerations on How to Teach S/R in Medical Schools

Possibilities involving the process of inserting S/H content in medical schools need to be discussed. The inclusion of specific, compulsory or elective courses, as well as study groups or tutorial modules should be performed using a systematic approach, identifying the core competences which should be acquired, defining the teaching strategies and endowing with a logical sequence.

One of the easiest ways to start a S/H discussion in a medical school is to offer single courses, symposiums, workshops, journal clubs or specific discussions. Although this is a limited approach, It can have important impact in demystifying some stereotypes that this issue could bring to the academic community. However, many of these strategies are located in the elective areas of medical curricula and, perhaps because of this, they face some difficulties to strength themselves when faced with traditional curricula contents.

Another way of including S/H in the curriculum is through an elective or compulsory course. Compulsory courses allow a wide-ranging approach and information access to all students, independent of cultural backgrounds and/or prejudices. In this perspective, compulsory curricular proposals seem to be the most effective

strategy to disseminate knowledge on S/R and expanding the possible interest of students that at first would not be willing to participate in an elective course due to misconceptions on the topic. However, as it is common for new paradigms that come to the curricular discussion scenario, it seems reasonable to also invest time and effort to stimulate elective initiatives (as the ones we will present in this chapter) or introducing the topic inside existing courses in the medical curricula, as a first step, in order to allow the theme to gain visibility between teachers and staff.

In this scenario, two considerations may be valuable. First, it is important to avoid the clash between traditional curricular topics, such as the anatomy, pharmacology and physiology chairs, against an innovative educational content such as S/H. But, it might be a good strategy to insert topics related to S/R in existing courses, such as Ethics course, Integrative medicine, Palliative Care and the Clinical skills course. Table 2 presents a proposal that could be developed in such course: three theoretical meetings, followed by practical training performed alongside with the already existing practical clinical skills activities, such as bedside teaching encounters. The second point related to the teaching-learning methodologies adopted. It is necessary to expand pedagogical practices and overcome models that do not contemplate students' autonomy. Active methodological strategies represent a feasible option, since they are directed to the production, sharing and use of tools that are close to the needs of those who learn and teach.

In the words of Calman (2008): “most doctors (professors/tutors) do not have the background to facilitate learning on the theoretical aspects of the subject, but they do have extensive clinical experience of how such topics impact on the care of patients. Linking this experience with those of people with wider backgrounds in ethics or spirituality may provide a useful model for teaching.” (Calman 2008) Also, one option to overcome the lack of knowledge that many professors present could be to offer training courses at national medical education congresses or continuing S/H training to medical schools' staff.

Other possibility is the use of an elective “transversal” model of teaching (same topics are offered to students from different levels of training) (de Carvalho Ferreira et al. 2016). This strategy may allow memorization of contents and a deeper discussion between students. An example of topics included in this strategy can be found in Table 3.

Table 2 Propose content to introduce S/H in existing medical courses

	Topics
Session 1 (2 h)	Defining: What is spirituality and religiosity? Why is it important to address spirituality with patients?
Session 2 (2 h)	When is it appropriate to address spirituality in clinical practice Tools to approach spirituality in clinical practice
Session 3 (2 h)	Limits and barriers: When can religion be harmful? Religious and spiritual coping

Table 3 Possible topics that can be included in an elective “transversal” model of teaching

	Topics	Teaching method
Session 1 40”	Health care models: Magical-religious, biomedical, integral – biopsychosocial	Team-based learning (TBL)
Session 2 40”	Conceptualization: Spirituality, religiosity, religion, faith and belief;	Team-based learning (TBL)
Session 3 40”	Spirituality in the therapeutic process – part I: Psychoneuroimmunology and epigenetics	Lecture and debate
Session 4 40”	Spirituality in the therapeutic process – part II: Physical and mental health	Lecture and debate
Session 5 40”	Spirituality, humanization and medical humanities	Lecture and debate
Session 6 40”	Spirituality and finitude	Lecture and debate
Session 7 40”	Spirituality in clinical practice – part I: Spiritual anamnesis	Team-based learning (TBL)
Session 8 40”	Spirituality in clinical practice – part II: FICA Questionnaire (I)	Lecture and debate

3 Teaching S/R Topics Using Active Learning Strategies

Historically, the training offered in health related courses has been based on the use of traditional methodologies, which usually has a more passive learning. In the last decades, active learning has emerged as a very promising strategy (Prober and Heath 2012; Tosteson 1990). Considering that graduation process lasts only a few years and professional activity remains for decades, it becomes essential to reflect on methods that empower students and give them co-responsibility during the learning process. The active teaching and learning methodologies emerge in this scenario pointing out that the act of learning must be a constructive and, above all, a significant process (Prober and Heath 2012).

In dealing with H/S, some medical schools have focused on fostering the thematic using active methodologies and strategies. Problem-Based Learning (PBL) is a teaching tool that focuses on developing students’ autonomy and valuing their prior knowledge. In PBL students are divided in small groups and are presented with different problems that aim to generate doubts or imbalances and evoke necessary reflections to lead to the search for creative solutions (Onyon 2012). This strategy has already been used by some institutions teaching S/H (Musick et al. 2003; Puchalski and Larson 1998).

Team-Based Learning (TBL) is another active learning strategy. It was developed by Larry Michaelsen in the 1970s. Its theoretical foundation is based on constructivism and it values collaborative work as a mean to find solutions for realistic and contextualized problems. It differs from PBL in its simpler execution dynamic: TBL dispenses individual spaces or tutors for small group. Three principles are fundamental to TBL: (1) Building and managing teams appropriately; (2) Student's responsibility for pre-activity studying and teamwork performance; (3) Execution, in teams, of tasks that promote learning, interaction and development of learning objectives (Michaelsen and Sweet 2011). This could be a promising strategy to teach S/H in larger groups of students.

In an attempt to contemplate different domains of learning, such as attitudes and practical performance, the "Role Play" tool emerges. On such technique an actor plays a patient with needs and issues often encountered in clinical scenarios. Role play allows students to experience different practical situations leading to learning and possible evaluations of systems and actions proposed as objectives. This strategy has already been used by different institutions to teach S/H (Anandarajah et al. 2007; Barnett and Fortin 2006; Bell et al. 2010; Pettus 2002).

Another important educational strategy is the chaplain shadowing. Shadowing a chaplain can help the medical student to understand the role of a chaplain, which is considered a broader role than performing rituals and supporting patients and families dealing with death (Frazier et al. 2015). There are some successful strategies using chaplain shadowing to teach S/H (Anandarajah et al. 2016; Frazier et al. 2015; Graves et al. 2002; Perechocky et al. 2014).

Other possible active learning strategies can be used, such as blended learning (distance learning and on-site classes), flipped classroom (inverted classrooms), case-based learning, mindfulness training, portfolio, student presentations, self-reflective writing, and video interviews, among others (Puchalski et al. 2014a).

Interdisciplinary approaches (religious studies scholars, sociologists, anthropologists and religious leaders) are also welcome in the teaching strategies in an attempt of broaden the discussion of this topic, fostering different views and different cultural perceptions.

Finally, there are some methods that could be used to evaluate clinical competences in S/H, such as OSCE (Objective Structured Practical Examination) and the use of SP (standardized patients). OSCE method seeks to evaluate, in a role-simulation environment and clinical competence in a planned, structured and objective way. It directly observes students' performance when performing different practical skills. In the process, students were challenged to recognize spiritual needs, to experience physician-patient communication and to reflect on strategies to approach S/H in clinical settings. The OSCE has already been used to assess skills in S/H (Ledford et al. 2014; McEvoy et al. 2014) and SP encounters are also used to train and assess skills acquisitions in S/H (King et al. 2004; Osorio et al. 2017).

All these methods should take into account the "hidden curriculum" as presented in a previous work carried out by Balboni et al. (Balboni et al. 2015). According to the authors, medical students R/S beliefs could result in positive and negative outcomes. S/R beliefs could potentially protect against some challenges in medical

training (i.e. less emotional stress, compassion, work-life balance, relationship strife) but also could intensify other challenges (i.e. stress for knowledge acquisition, self-doubt and disillusionment). Likewise, these students may use different coping strategies during training, in a sense that non-S/R students are more likely to mention a repressive coping style, compartmentalization and a higher self-protection, whereas S/R students tend to use prayer and faith as a central coping mechanism.

4 Teaching S/R Topics Through “Health and Spirituality Academic Leagues”: A Brazilian Initiative

In the last section of this chapter, we presented some learning strategies to teach S/H. In this section, we will present a Brazilian initiative that may be interesting to get known by other countries. In a scenario of increasing emphasis of S/R content in medical schools, it is evident the difficulty that some professors have to be open to content outside the mainstream medical curriculum. Thus, students who desire to study S/H may find prejudice and misunderstanding in some of their professors and tutors’ opinions. Aiming to change this scenario, many students in Brazil have pioneered initiatives to study the subject through the “Health and Spirituality Academic Leagues” (HSALs).

An academic league is a project designed and executed by students who are seeking to learn more about a topic usually not covered in regular curricula. It consists of theoretical and practical activities, as well as research and extension initiatives. Students voluntarily sign to participate and are followed by a teacher who helps them to manage the activities. The HSALs gained great prominence in Brazilian medical schools. In Brazil, academic interest on the topic is increasing, but it has not been followed by curricular transformations. That is probably the reason for the country to count with around 40 Academic Leagues studying the interface between S/H. Such academic leagues develop its theory training using active and/or traditional teaching-learning methodologies. Many topics are covered such as myths and truths involving science and spirituality, definitions involving spirituality, reasons to address spirituality with patients, empathy and compassion in patients’ care, students’ own spirituality, bioethics of early and late life, mind and brain interface, near death experiences- NDEs, among other (Gonçalves et al. 2016) (Table 4).

Other than theory, students may also perform practical training, such as practical role-play training on how to conduct a spiritual history as well as visits to the hospital in order to take a spiritual history with hospitalized patients. A study revealed that most HSAL students felt comfortable taking the spiritual history after this training (Puchalski and Romer 2000). Another study showed even better results in a HSAL initiative. Students were randomized and evaluated before and after receiving theoretical and practical training. Students in the intervention group (participating in HSAL activities) presented higher scores on theoretical knowledge about

Table 4 HSAC course outline

	Topics	Teaching method
Session 1 (2 h)	Myths and truths involving science and religion	Lecture
Session 2 (2 h)	What is spirituality?	Lecture, group discussion
Session 3 (2 h)	Why is it important to address spirituality with patients?	Lecture
Session 4 (2 h)	How can we approach spirituality in clinical practice?	Group reading of scientific papers, lecture
Session 5 (2 h)	When is it appropriate to address spirituality in clinical practice?	Lecture
Session 6 (2 h)	What may result from the spiritual approach in clinical practice?	Lecture
Session 7 (2 h)	Limits and barriers approaching spirituality: When can religion be harmful?	Lecture, discussion
Session 8 (2 h)	Religious and spiritual coping	Guest speaker, discussion
Session 9 (2 h)	FICA spiritual assessment tool	Lecture, group discussion
Session 10 (2 h)	Palliate care: Dealing with conflicts	Guest speaker
Session 11 (2 h)	Bioethics and early life: Abortion and research on embryonic stem cells	Lecture
Session 12 (2 h)	Bioethics and end of life: Euthanasia and organ transplantation	Lecture
Session 13 (2 h)	Interface mind and brain	Guest speaker
Session 14 (2 h)	Near death experiences- NDEs	Guest speaker

Retrieved from Gonçalves, L. M et al. [2016](#)

H/S, had better attitudes towards S/H and scored higher in the SP encounter taking a spiritual history than a control group (waiting list) (Osorio et al. [2017](#)) It seems that offering theory follow by practice activities is one of the most prominent and feasible strategies to teach spiritual related-topics during medical education.

5 S/H Curriculum Goals, Objectives and General Competences

There are several competences that should be met in a S/H curriculum. In a recent article, Puchalski et al. (Puchalski et al. [2014a](#)) have included the minimum required competences to be acquired by medical students, the possible teaching methods and the performance assessments. There are 6 core groups of competences, described below:

- **Health care systems:** Apply knowledge of health care systems to advocate spirituality in patient care (9 competences such as “Compare and contrast spiritual resources in different health care systems ”and “Discuss how the legal, political, and economic factors of health care influence spiritual care ”).
- **Knowledge:** Acquire the foundational knowledge necessary to integrate spirituality in patient care (12 competences such as “Differentiate between a spiritual history, spiritual screening, and spiritual assessment “and “Locate and evaluate spiritual/religious information resources both online and in print“).
- **Patient care:** Integrate spirituality into routine clinical practice (10 competences such as “Perform spiritual screening at appropriate times” and “Make timely referral to a chaplain or spiritual counselor”).
- **Compassionate presence:** Establish compassionate presence and action with patients, families, colleagues (6 competences such as “Discuss why serving the patient is a privilege “ and “Discuss how you as a provider may be changed by your relationship with the patient”).
- **Personal and professional development:** Incorporate spirituality in professional and personal development (6 competences such as “Explore the role that spirituality plays in your professional life” and “Identify your sources of spiritual strengths”).
- **Communications:** Communicate with patients, families, and health care team about spiritual beliefs (6 competences such as “Communicate professionally with spiritual care providers and other team members about the patient’s spiritual distress or resources of strength” and “Practice deep listening—hearing what is being communicated through and between the words, the body language, and the emotions”).

6 A Call for the Development of International Curricular Guidelines

Medical education in S/H is a relative new field. The first initiative (an elective course) was launched in 1992 (Puchalski et al. 2014a). In 1996, the Association of American Medical Colleges (AAMC) launched the MSOP initiative providing a definition of spirituality and proposing how it might be integrated into patient care and medical education (Puchalski et al. 2014a; Puchalski and Larson 1998). Other initiatives of a consensus in the field were followed (Puchalski et al. 2009, 2014b) and, in 2011, the George Washington Institute for Spirituality and Health proposed the creation of a common framework in the form of competency domains with which to understand and assess spirituality in the medical school curriculum, entitled “GWish’s National Initiative to Develop Competencies in Spirituality for Medical Education”.

The field is consolidating and we believe it would be appropriate to create an international consensus including the minimum required competences that a medical student should learn concerning S/H worldwide. Although this consensus could

help standardizing the field, we believe that each institution could add topics that are relevant to their context, including cultural and social backgrounds. This may be an important further step in the field and can help to booster the teaching of S/H in medical education.

7 Conclusions

This chapter provides an overview of “Spirituality and Health” in medical education. Although spirituality is a new field, it stands out as an important topic to be incorporated into medical undergraduate and graduate training. Several studies, initiatives and different educational strategies have been published in the last decades proving further evidence for this training. Future challenges of this field are to create an international consensus including the minimum required competences that a medical student should learn concerning S/H, to increase the number of S/H content worldwide and to provide high-quality training for teachers and students.

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