Spirituality, Science and Person-Centred Care

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34.1 Introduction

Spiritual and religious practices are important in most peoples' lives around the world. The sense that there is more to life than what we can grasp, measure and control is common. Spiritual practices and religious belief (R/S) are regarded as purveyors of culture, and understanding of these is intimately linked to the maintenance of health and the experience of illness. They cannot be ignored in any comprehensive person-centred assessment even in secular cultures. Researchers have produced over 3300 empirical studies on the connection between R/S and health. Findings show an association between R/S and health outcomes, mostly positive [31, 33]. Most patients want clinicians to address R/S, but few do [17, 35].

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Since clinicians need to assess and learn how to deal with all factors that impact health, we need to deal with R/S in clinical practice, regardless of whether we are religious, antireligious or agnostic. Worldwide important health organisations have created sections on R/S and/or recommend assessing R/S in clinical practice.

34.2 Definitions of R/S in a Post-Modern World

Existential questions such as: What is true reality? Is there intelligence behind the universe? How then should I live? have been asked and answered throughout the ages. Different societies have developed their own world views, which give a coherent answer to such questions, and form the cultural basis for daily life [25]. About 84 % of the world's population self-identify is 'religiously affiliated' [53]. A further percentage of those unaffiliated would describe themselves as 'spiritual but not religious', hence for many of our patients R/S will be a significant part of their lives. In the Western democracies the secularism hypothesis—that societies inevitably become less religious as they develop [9]—has been challenged by the heightened visibility of religious groups and the recognition of the social capital found in communities of faith [16, 24].

Formerly in English, 'spiritual' referred to those who were highly committed to their religion. 'Spiritual' would not have made sense outside of a community of faith and practice. In the last 30 years 'spiritual' has become a separate category, often placed in opposition to religion. Thus spirituality is considered warm, friendly and inclusive, religion is seen as cold, hard and rule bound. Many, particularly in high-income countries, would now say that they are spiritual but not religious [15] or neither spiritual nor religious.

Multiple definitions of spirituality are found in the research literature. Some of the definitions focus on existential meaning [51]. Other definitions of spirituality are broader and include aspects of positive mental health [54]. Researchers need to be careful that any definition of spirituality does not exclude those with severe and enduring mental illness (SEMI); spiritual practices are often cited as helpful in recovery from SEMI [11].

In many definitions of spirituality aspects of positive mental health are subsumed within the definition [41], this inclusiveness is useful in clinical practice to draw attention to a significant area of life [66]. However, it makes 'spirituality' difficult to research; it is very easy to 'prove' that spirituality is good for your mental health if this is assumed in the definition of spirituality. Given these problems most researchers look at religion rather than spirituality, investigating the dimensions of religious belief, religious practice and individual spiritual experiences.

Religion refers to a collection of beliefs, practices and rituals related to the transcendent and sacred, arising out of an established tradition and from a community with common beliefs and practices. The definition of religion can be more easily operationalised for research purposes and allows for replication of research results in different populations. Most of the research on religion and health has come from North America and reflects the effect of religious involvement in a democracy where religion

is highly regarded. Caution is needed when comparing results internationally, since countries vary in their tolerance of religious diversity, and the social implications of holding a minority world view differ from being in the majority; the experience of being Muslim in Cairo is different to being Muslim in Canberra. One would predict that religious adherence might have a different impact on the individual's health depending on the country studied. However, the major findings have been fairly consistent in more recent studies, throughout cultures and countries [33].

34.3 Research on Spirituality/Religion and Health

Research into the impact of religion and spirituality on health has developed and broadened over the last 20 years, with clarification of terms and approaches. Much of the research follows Evidence-Based Medicine, investigating the spiritual practices or religion as if they were a medication. A systematic review of double-blind placebo-controlled trials of the intervention would be the gold standard [49]. Clearly, it would not be practical or ethical to undertake randomised trials of religious faith and experience. When RCT are not feasible, longitudinal cohort studies can provide good quality evidence, and there are several such studies in this field [33]. Most early papers on religion and health were cross-sectional so could only demonstrate an association, being hard to define causal direction. For example, if we find that the number of currently depressed people is higher in the temple than in the general community this could mean temple attendance makes you depressed, or it could mean that people turn to their religious roots when depressed.

Religious commitment level can be established through religious activities (e.g. time spent in prayer or meditation, attendance at meetings, reading scriptures) [33]. However, simply measuring frequency of attendance at religious services and rituals conflates those who are 'true believers' and those who are 'just going along with the crowd'. We have to differentiate between those who are personally invested and committed to the religion for its own sake, and those who attend the worship place purely for social and business reasons, since the health impact may vary. This is the difference between intrinsic and extrinsic religiosities [2].

There are many scales looking at different aspects of R/S [36]. For example, Duke University Religion Index (DUREL), has 5 items, and the more comprehensive Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) has 38 items covering 11 dimensions of R/S. The WHO Quality of Life questionnaire (WHOQOL-SRPB) briefly covers spiritual, religious and personal beliefs [60].

34.4 What Do We Know About the Impact of R/S on Health in General, and Mental Health in Particular?

Much of the research and debate on religion and spirituality has come from the US, which remains a predominantly religious nation. [22]. In the US those who attend church services regularly are less likely to die in the next year than non-attenders,

controlled for physical health [37]. In a large US poll, Jewish people reported the highest well-being, those with no religious adherence the lowest well-being [22].

A US study followed up over 30 years showed a correlation between attending religious services weekly, living healthier lives and being more likely to recover from depression [63]. There is a correlation between various indices of religiousness and speedier recovery from depression associated with physical illness [32]. A cohort study of over 7000 elders in the US shows that the more religious are less likely to develop depression and more likely to recover from an episode [56]. In a US longitudinal study of 114 10-year-old children those who identified that R/S were important to them had one-quarter the risk of major depression over the next 10 years. Those who had a high risk for depression, because one of their parents had experienced depression, had one-tenth the illness rate of those who did not value R/S [39]. African-Americans have one-third lower rates of depression than whites matched on demographic and health behaviours. This variance can be explained by attendance at religious services [55]. High salience of religion correlates with less prevalence of depression in Palestinian Muslim youth [5], Australian elders [50], Brazilian bipolar patients [64] and Dutch adults [38].

Several studies have shown that those who adhere strongly to a religion are at a lower risk of suicide than those with weaker or no faith. A large US case control study showed attendance at religious activities had a protective effect against suicide in a 'dose-dependent' manner [48]. A cohort study with a US nationally representative sample (n = 20,014) showed that frequent religious attendees were 68 % less likely to die by suicide over the next 16 years [30].

34.5 Religion and Psychosis

A recent review article shows a mixed picture on the interactions of religion, spirituality and schizophrenia [28], with spiritual practices being valued by patients in their recovery, but often seeming to contribute to late presentation and poor treatment concordance. US caregivers generally perceive religion as helpful to those with schizophrenia [62]. For patients with SEMI, involvement in communities of faith, when not driven by psychopathology, predicts better outcomes [7, 40, 67].

34.6 Religious Coping and Stress

At times of difficulty people commonly turn to spiritual practices for support, comfort and inspiration, e.g. Buddhist practices after the South Asian Tsunami [29]. Abrahamic practices after the 9/11 attacks in the US [58] and Japanese religions after the 2011 earthquake [46]. Religious coping is important in different physical illnesses [33]. The frequency of religious coping in a country parallels the numbers who indicate 'religion is important to me' [13]; the highest rates on this poll were in the Middle East and Asia, slightly lower in the US, with the lowest scores in Scandinavia. Moroccan Muslim religious practices were increased in 95 % of 1600

people following first cancer diagnosis [19], whereas in Demark 74.2 % of 97 patients following a myocardial infarction said they received 'no comfort whatsoever' from religion [6]. Religion helped children to cope with PTSD in Switzerland [70] and being an adolescent refugee from Bosnia Herzegovina [65].

34.7 Spiritual Experiences

Although spiritual experiences (SE) are found in the origins of most spiritual traditions and are still prevalent nowadays, this subject has received much less attention from researchers. Studies on SE can have significant clinical and theoretical implications. From the clinical perspective, SE may impact mental health and may resemble dissociative and psychotic symptoms (e.g. trances, hearing voices, visions). SE are usually not related to mental disorders and some criteria have been proposed to differentiate SE from mental disorders with religious content such as: lack of suffering, lack of social or functional impairment, compatibility with the patient's cultural background and recognition by others, absence of psychiatric comorbidities (negative or disorganisation symptoms), control over the experience, and personal growth over time [42].

The neurobiological correlates of SE and their implications for the understanding of mind–brain relationship have been examined. Trance and meditative states have revealed complex patterns of brain activation discarding more simplistic views such as the "God spot" [52]. SE such as meditation, mediumship, end of life and near death experiences, often involve altered states of consciousness, reports of anomalous experiences and of consciousness beyond the body. So, these SE may provide the empirical basis for advancing the debates regarding mind–brain relationships [43].

34.8 Mechanisms of Interaction Between Spirituality, Religion and Health

The following factors are important (after [12]):

(a) Communities of faith provide social and emotional support, particularly for those living with mental illness or learning disabilities.
(b) Religious groups provide practical and economic support.
(c) Attendance at religious meetings and services keep people physically active.
(d) Many religious and spiritual traditions teach against risk behaviours—sexual promiscuity, alcohol excess and drug usage.
(e) Religion and spirituality are positively associated with relationship stability, positive personality and psychological traits [33], purpose and meaning in life [69] and increased social capital [34].

(f) Religions generally provide a narrative of hope and eventual positive outcome. Such positive emotions and cognitions are linked to better immune, endocrine and cardiovascular functioning [33].

34.9 Negative Effect of R/S on Health and Well-Being

Religion may have negative effects on health. Specific teachings may discourage using modern medicine, e.g. the Jehovah's Witness prohibition on blood transfusion, and avoidance of psychiatric care by Scientologists [27]. Mental illness may be misidentified by religious teachers as weakness, wrongdoing or spiritual failings leading to feelings of guilt and failure. Major mental illness may be misidentified as possession by spirits, demons or *djinn*; the practices to free the person from such spirits can lead to distress and suffering, as well as delaying definitive treatment. Predatory leaders occur in all human groups, particularly those with weaker accountability structures, e.g. new religious movements. Religious fundamentalism sometimes leads to terrorist violence, however many instances of alleged religious war or terrorism actually reflects political, economic and other social conflicts [4]. Whilst many have suffered from intolerant religious groups, we would maintain that such deplorable things are considerably overwhelmed by the positive impact of the religions, in terms of personal and community quality of life, political activity and voluntary work [8].

34.10 Religion and Spirituality in Medical History

Islamic medicine flourished over 1000 years ago and was the most advanced in the world at that time. The mentally ill were cared for in the general hospital, the first of which was established in Baghdad in the ninth century followed by hospitals in Damascus, Aleppo and in Cairo [1]. The Bimaristan Al-Arghun in Aleppo is considered the most remarkable example of both Islamic architecture and the oldest hospital in the world [23]. It was converted from a princely palace into a hospital for the insane in the fourteenth century, where they were treated with humanity, music, dance and theatre performances as well as the scent of flowers, gurgling of fountains and harmonious architecture.

Ancient Indian philosophies including Upanishads are rich in their references to the theme of spirituality and health [14]. Charaka who had practiced and taught 'Ayurveda' (the 'Science of life') in ancient India had referred to positive mental health and had said absence of disease alone is not sufficient, but leading an ideal life should be the goal. Spirituality is deeply embedded in the Indian and South Asian culture, so much so, that the practice of mental health and psychiatry without understanding the strong spiritual foundations will not be ideal [61].

In Europe many hospitals were built from the Christian imperative to 'love your neighbour as yourself', and were often staffed by people with religious motivation and sustaining of their caring role. Nursing sisters were originally literally sisters of a Christian religious order—nuns, or deaconesses, including Florence Nightingale. Many American and Canadian hospitals were founded by nursing nuns [47]. In Brazil, Spiritist hospitals provide much of the inpatient mental healthcare for the poorest [57].

34.11 Implications of Faith and Spirituality for Person-Centred Medicine

All the world religions provide a metaphysical framework to develop and sustain care and compassion [3]. A failure of compassion was named in the enquiry into a recent UK hospital scandal [20]. Compassion entails thinking, feeling and will. We intellectually recognise when someone is suffering, we emotionally 'feel their pain' and we choose to act to relieve their suffering. Empathy requires self-awareness and sensitivity to others; Compassion adds in the specific desire to act to relieve suffering [26]. Basic counselling skills should be taught to all practitioners, time made available to truly care for patients, and staff be supported and cared for as well as patients, through individual and small group work [59]. Any neglect of the R/S dimension to health care provision is a degradation of those key tasks of medicine linked to care, recovery and compassion.

One model of person-centred primary health care was developed by a general practitioner in Geneva, Paul Tournier (1898–1986). Having suffered in his own life, he saw the suffering of his patients not only in the biomedical dimension but also in their personal existence. Predating psychosomatic medicine, Tournier took time to listen to his patients personal plight, encouraging them to integrate spiritual aspects in their coping with illness. This Medicine of the Person "…puts the emphasis on awareness of patients as whole persons, with places in their community and society" [68]. His approach continues to inspire physicians around the world, with annual meetings on the topic of person-centred medicine [21].

Engel's [18] Biopsychosocial model does not necessarily pay attention to aspects of life to do with values, meaning and purpose which for many people are derived from R/S. Person-centred care requires clinicians to be aware of these aspects of patients' lives.

34.12 Guidelines for Integration of R/S in Clinical Practice

While there are multiple epidemiological studies showing the relationship between R/S and health, there are fewer studies about the applications of R/S in clinical practice. Most researchers agree on the need for taking a spiritual history, where the clinician explores the importance and practical implications of R/S in patients' lives and illnesses. Patients value attention to their spiritual wellbeing.

Some general principles for integration of R/S in clinical practice follow [10, 45]:

- Open-minded approach with genuine interest and respect for patients' beliefs, values and experiences.
- Clinicians need to explore their own world view and R/S history.
- Emphasise universal values of all faiths: justice, kindness, love, compassion, forgiveness.
- The approach needs to be patient centred, not prescribing nor imposing.
- Collaborative approach exploring potential useful spiritual resources available or already developed by patients.
- Refer to religious/spiritual resources in the community.

34.13 Research Priorities and Plans

There is an urgent need for more sophisticated studies that address gaps in the available knowledge. Some possibilities include:

(a) Expand studies to a more diverse geographical and cultural base.
(b) Conduct more studies in clinical populations.
(c) Explore the impact of spiritual and spiritually integrated treatments.
(d) Investigate the mechanisms through which religious involvement and spiritual-related treatments may affect health.
(e) Study spiritual experiences, their roots, differentiation from mental disorders and implications for the understanding of mind.
(f) Develop clinical applications of the currently available epidemiological data about the interconnection between religion and health [44].

34.14 Conclusions

Research in the field of Spirituality, Religion and Person Centred Medicine is complex from a linguistic, conceptual and methodological perspective—and care must be taken to properly define and operationalize these subject areas.

Religious beliefs, spiritual practices (R/S) and existential meaning-making are pertinent to the maintenance of health, to increased longevity and to the amelioration of illness, not only in Low and Middle Income Countries (LMIC) but also in post-enlightenment High-Income countries. Our experience from Brazil, the Middle East and South Asia would confirm that the world of Spirits and their involvement with day-to-day living is taken for granted in those religious countries.

Person-Centred Care can be facilitated by sensitivity to the religious and spiritual dimensions of human life and the human search for meaning as well as by an awareness of the interconnections of body, mind and spirit.

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