

# A spiritual dimension is important for many patients

Today it is generally accepted that an illness should be understood on the basis of a biopsychosocial model in which the patient's thoughts, feelings and social relationships are of significance. But life also has a fourth dimension – the spiritual and existential. In our opinion, simple, open-ended questions on personal beliefs when taking the case history as well as in other clinical contexts can result in better patient treatment.

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The existential or spiritual dimension incorporates the basic values of patients, their thoughts on what gives life meaning and religious or non-religious worldview. It also includes beliefs about what happens after death. The aim of this article is to discuss whether these aspects of human life are also relevant for doctors in their encounters with patients, and to provide advice on how to handle the spiritual and existential dimension.

Numerous studies have been carried out internationally of the interaction between religious beliefs and health, and the needs of patients for the health service to follow up existential needs (1, 2). However, in Norway little research has been conducted into this field. The results of studies conducted in other countries among patients with particular beliefs cannot be generalized and transferred to other cultures and religions indiscriminately. Nevertheless, in our discussion of this topic it is natural to include studies from other Western countries whose culture and religion are similar to our own.

## A desire for spiritual/existential topics to be brought up?

In a study conducted at the Department of Oncology of the University Hospital of Northern Norway, 18 patients with incurable cancer were interviewed about their

religious beliefs (3). Seventeen patients said that they believed in God, and 15 said that they prayed. The interviews carried out as part of the study resulted in four patients expressing a wish to be put in touch with the hospital chaplain while two patients were put in touch with the Salvation Army and the Norwegian Humanist Association respectively. The authors concluded that many patients at an advanced stage of illness wanted the topic of faith to be brought up, but that this ought to be done with respect and on the patient's terms. The study also shows that it is not only patients with a religious faith who may feel the need to talk about their view on life.

In another Norwegian study carried out in a random population of cancer patients in different oncology departments, 642 patients completed a questionnaire on alternative treatment (4). The study included five questions about religiosity. Out of the 600 who answered the questions, 246 (41%) patients described themselves as «believers» and 236 (39%) as «non-believers», while the remainder were uncertain. Just under half of the patients in the study believed that patients in their situation should be offered the opportunity to have contact with a clergyman.

In another Norwegian questionnaire study, 183 patients who were being treated for Hodgkins disease at Oslo University Hospital Radiumhospitalet were asked 45 questions about religion (5). Altogether 107 (58%) replied, 32 (30%) of whom regarded themselves as religious/believers. Forty patients (37%) stated that their beliefs had changed as a result of the illness, and the majority (33 out of 40) had become stronger in their faith. Fifty-eight patients (54%) had prayed to God for healing. Half of them stated that they did not feel that the offer of spiritual guidance during their hospital stay was adequate.

In a questionnaire-based study from a pulmonary outpatients' department at an American hospital, 177 patients were asked about religiosity and illness (6). Half of the patients described themselves as religious

and as many as 90% reported that they believed that in some cases prayer could affect the outcome of the illness. Two-thirds of the patients said that they would have appreciated being asked whether they had religious beliefs when the case history was taken, while 16% had no wish for this to be done. However, only 15% of the patients had been asked whether their faith would affect their medical decisions, for example in the case of life-prolonging treatment.

## View of life affects treatment preferences

Patients' views of life can affect their treatment preferences. This applies in particular to decisions made as life draws to a close. In a study at an American pulmonary outpatients' department, 45% of the patients claimed that their religious faith would affect their decisions on treatment in the case of serious illness (6). Religious notions can also have an impact on patients' compliance with advice on medical treatment. Jehovah's witnesses, who reserve the right to refuse blood transfusion, are a well-known example of this.

## Existential crises and religious coping strategies

In the case of serious illness, both religious and non-religious patients ask themselves about the meaning of what they are undergoing. This may challenge their existential worldview and entail an existential crisis in which there is a need to talk to a fellow believer or spiritual adviser. In a UK qualitative study, 45 cancer patients were interviewed about how they interpreted the pain that accompanied the cancer disease (7). One group experienced that the pain was an expression of God's testing their faith, as in the story of Job in the Bible (8), and the other group felt that the pain was an expression of divine punishment.

A religious coping strategy is the application of religious beliefs or religious practices in order to reduce emotional stress and suffering. This has been studied in the case of patients with chronic pain in particular



Illustration Elin Karlsnes

(9). Among the positive religious coping strategies are the reading of religious texts, spiritual support, participation in religious meetings or rituals, help to forgive, and learning coping strategies from spiritual role models. Negative religious coping strategies can include regarding pain as a divine punishment and focusing on demons as the cause of the illness. In some research literature, prayer is categorized as a passive and unworkable coping mechanism while more recent research indicates that prayer is often an active and useful strategy (9). Therefore, in our view a mapping and assessment of religious coping strategies are relevant for this patient group.

#### **The feeling of guilt and reconciliation**

A qualitative study of 23 Swedish patients with chronic obstructive pulmonary disease revealed that one of the issues that most absorbed these patients was the feeling of guilt linked to the apprehension that the disease was self-imposed due to smoking (10). Even though corresponding data are not available for other diseases, there is reason to assume that the feeling of guilt can also be a key factor for other patients suffering from life-style related illnesses. Since an increasing proportion of diseases

in the population are life-style related, the extent of feelings of guilt and their significance for the patient should be assessed. The feeling of guilt may be linked both to family relationships and to the relationship with the divine. This and other factors may have harmed the patient's relationships. When important relationships are damaged, the patient will be best served by repairing them through reconciliation. The health service can help the patient to identify and recognize the problem so that the process of reconciliation can begin.

#### **Causal connections between religion and health?**

A number of studies have attempted to conduct an empirical investigation of the connection between religiosity and somatic health (1, 2, 11). The majority have been carried out in the Western world on patients with Christian beliefs, and a number of methodological factors make it difficult to establish causal connections. A review of this field showed that only one of the nine hypotheses on such causal connections was supported by research, namely the hypothesis that frequent participation in religious gatherings is associated with reduced mortality (2). Even though a causal connec-

tion between active religiosity and good health has been established in the general population, there are no findings in prospective studies of patient groups that religiosity in itself increases survival.

#### **Spiritual case history**

Spiritual and existential issues, then, are important for many patients suffering from serious illness, and a number of patients would like doctors and other health workers to bring up such issues. In our opinion it is useful in some cases for the doctor to map the patient's spiritual situation by means of a simple «spiritual case history». For example, the doctor can ask whether the patient has religious beliefs and whether the patient's outlook on life influences his/her ability to cope with the ongoing illness. Further questions are whether the patient's beliefs are of importance in the choice of treatment and if the patient wants to be put in contact with the hospital chaplain or another spiritual adviser. It is important that doctors do not force their own beliefs on patients. Spiritual topics must be mapped with sensitivity to the patient's views and with respect for the patient's wishes. In practice, taking a spiritual case history can be time-consuming. Furthermore, it may

be challenging that doctors do not possess professional skills in mapping and dealing with existential topics.

For many patient contacts, a spiritual case history will not be relevant. Depending on the situation and the issues in question, the doctor must be capable of switching between a reductionistic and symptom-focused approach and a holistic approach that includes spiritual and existential aspects. We believe that a spiritual case history has special relevance for patients with serious illnesses, a limited life expectancy, or chronic illness with major loss of function or high symptom intensity. In addition, it is useful when admitting patients to a hospital or nursing home and before major surgery. On occasion a spiritual case history can strengthen the doctor-patient relationship by heightening the patient's perception of being cared for as a complete human being.

The doctor may choose to follow up the existential aspects of the patient's illness or leave this to a nurse or others in the treat-

ment team. The question «Who has helped you previously?» can often help to identify resource persons such as family members, friends, a local clergyman or others who can be brought in. If the patient and the doctor share the same faith and establish a spiritual fellowship, this must take place on the patient's terms since the doctor's role is to be a doctor and not a hospital chaplain.

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