Religion, spirituality and medicine in Australia: research and clinical practice

Harold G Koenig

Studies demonstrating health benefits of religion are many and growing in number, and some claim the results are ripe for application in clinical settings.[1,2] However, others argue that the research is not nearly as good or consistent as portrayed, and caution against acting rashly on inconclusive evidence.[3,4] The goal of this supplement is to determine what this growing body of research means for Australian practitioners and patients.

Religion involves beliefs and practices related to the sacred, where the sacred is defined as God, the numinous (mystical or supernatural) or ultimate truth. Religion is a unique construct, different from other psychological and social phenomena. Spirituality, on the other hand, is more difficult to define, as its definition today has changed — from one based in religion to a more diffuse concept, self-defined by each individual. The result is that there is no widespread agreement on what spirituality means, producing a real challenge when trying to measure it.

Attempts to measure spirituality have taken two approaches:

- Asking questions about religious involvement;
- Asking questions about positive psychological characteristics, such as meaning and purpose in life, connectedness to others, peacefulness and high personal values.

There are two problems with the latter way of defining and measuring spirituality. The first is that atheists might claim that they are neither religious nor spiritual — yet argue, rightly, that their lives have purpose and meaning, that they experience connection with others, and that they maintain high personal values.

The second problem with defining spirituality in terms of positive psychological characteristics is that doing so produces a construct that is really a quasi-indicator of mental health. This makes it difficult or impossible to interpret research on the relationship between spirituality and health, especially mental health. Correlating a construct defined by indicators of mental health (spirituality) with another mental health construct (eg, wellbeing, life satisfaction, depression or anxiety) will always lead to an association between the two. Such an approach could also lead to false relationships between spirituality and physical health, given the strong links between mental and physical health.

The word spirituality, when used in research, should be restricted to those things that have something to do with the sacred (as defined above). If there is no connection with the sacred, then it should not be referred to as spiritual or spirituality. We already have psychological and social terms to deal with concepts that all humans have in common, regardless of belief, and I think we should keep these concepts distinct from religious terms. I realise that many others in both the United States and Australia will not share this opinion, including a number of authors who have contributed to this supplement. From a purely scientific standpoint, if we are to study the relationships between religion, spirituality and health, it is essential to have constructs that are clear and non-overlapping.

For these reasons, I refer mainly to religion when discussing relationships with mental and physical health. My definition of religion, however, is quite broad and means a lot more than just institutional religion or religious affiliation. Another reason for using religious language when discussing the research is that most published research has really been examining religion, even if it is presented and discussed in terms of spirituality.

However, when talking with patients in clinical practice, there are good reasons for using the word spirituality, rather than religion. Research shows that, while many patients do not distinguish between being religious or spiritual,[5] others feel alienated from institutional religion and see themselves more as spiritual than as religious. This may be particularly true for patients in Australia. The term spirituality is vague enough to allow patients themselves to define the playing field.

Why should religion and health be connected? The argument is a rational one. If religious people have a world view that gives hope and meaning in the face of stress and loss, if they have social support from other members of the religious community, and if they live healthier lifestyles by smoking less, drinking less, and making more conservative, less risky decisions in marriage, the workplace, and recreational activities, there is good reason to expect that they will have better physical health as well. All of these factors influence health in ways that are increasingly being understood through the field of psychosomatic medicine.[6] It should not be surprising, then, that in 2006 more than 70 published research studies examined the relationships between religion, spirituality and health, many finding positive relationships.[7]

The articles in this supplement review research on religion, spirituality and health relevant to Australian patients and practitioners and discuss the application of that research to clinical practice. Although not all of the research comes from Australia, the articles provide an important summary and background that will assist Australian researchers in designing and implementing future research. While most of the articles do not contain original research, they begin to address some of the research gaps identified by Peach in 2003.[8] Williams and Sternthal (*page S47*)[9] assess the importance of religion and spirituality to Australians and discuss the evidence for both positive and negative effects of religion on health. Eckersley (*page S54*)[10] looks at the relationship between spirituality, religion and health in a broad cultural context, while Wilding (*page S67*)[11] presents a case study to illustrate the meaning of spirituality at a personal level. The different approaches to spiritual assessment in health care practice are summarised by Rumbold (*page S60*),[12] and Winslow and Wehtje-Winslow (*page S63*)[13] raise a number of ethical issues relating to the provision of spiritual care. Jantos and Kiat (*page S51*)[14] present evidence on the health benefits of prayer, and D'Souza (*page S57*)[15] suggests ways in which clinicians can approach the subject of spirituality with their patients. Hopkins and colleagues (*page S70*)[16] focus on evidence-based strategies that could be implemented by church-associated organisations to reduce high-risk behaviours in young people, and, at the other end of the age spectrum, MacKinlay and Trevitt (*page S74*)[17] provide a model of spiritual tasks in later life.

The contributions presented here suggest that spirituality and religion are important to many Australian patients, and that the spiritual needs arising from religious beliefs should be identified and addressed as part of whole person health care. They also suggest that much more research in this area is needed in Australia. While some of the findings of US research may be applicable to Australian patients, there are important cultural differences between the two countries that may influence the relationship of religion to health and the needs of patients in this regard.

Competing interests

None identified.

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