

Commentary

A Commentary on Michael King. “The Challenge of Research into Religion and Spirituality.” *Journal for the Study of Spirituality* 4 (2014): 106–20

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Abstract: King’s publication based on a key note presentation at the 2014 *British Association of the Study of Spirituality* (BASS) conference, a well written and thought provoking paper, leads us to consider the contribution of this critique of spirituality research to contemporary debates on the topic. The views expressed within the paper are important and foster debate about the validity of research in the field of spirituality and religion. However, at the same time, this debate is reminiscent of the negative responses sometimes expressed about research publications in this field. At the same time, it must be recognised that there is a view held that there is an extra yard stick required for researchers in this field, who can be subjected to much higher standards and expectations than other researchers simply because of the topic and the deep seated conflicting views that advocates and critics hold. This paper considers the merits and challenges of this paper in light of this.

Keywords: spirituality; religion; evidence-based practice

1. Background

King’s [1] publication, based on a keynote presentation at the 2014 *British Association of the Study of Spirituality* (BASS) conference, was well written and thought provoking. King’s paper argues that although there is a body of published research in existence, which attempts to demonstrate a positive association between religion and health, that such findings could possibly be and often are, inflated. He contends that in essence, the health gain from attending to the spiritual or religious needs of service users is extremely limited, and that spirituality divorced from religious practice may indeed be associated with a worsening of mental and emotional well-being of a person.

2. Discussion

Although King admits that research into this whole realm is on-going and expanding, he identifies a number of pitfalls, which are presented in relation to the current on-going research [1]. He argues

that research into spirituality and spiritual practices is poorly conducted and that the personal religious or spiritual beliefs of the researcher may act as an influencing factor in the way research is done or interpreted. Consequently, according to King, research in this area is somewhat enigmatic as it is complex, difficult to undertake, challenging to interpret and is problematic in terms of measurement and comprehension [1].

He further cites within his paper that given that there is no one agreed definition of religion or spirituality, this inevitably leads to difficulty in the undertaking and interpretation of any research into the area [1]. He cautions within this piece to be mindful of the theoretical and methodological pitfalls that researchers in the field spirituality face. He also cautions within this paper of the need to have rigorous research standards, as are common to all fields of research, in order to ensure that the research is balanced, objective and unbiased. Indeed, this call for scientific rigour is well founded. However, King seems to suggest that those who support the need to attend to people's spirituality tend to be somewhat overly enthusiastic and driven by an agenda which involves a burning desire to prove that spirituality has intrinsic health benefits that need to be tapped into.

Arguably, however, this close inspection of the validity of research into spirituality and religion deserves a better balance. There is a risk of King's paper being interpreted as an echo of popular negative rhetoric and negative media attention that often accompany research publications in the area [2]. The core argument of the paper—that studying religion, spirituality, and health can be challenging—reverberates throughout the literature, and it is not clear from King's [1] paper what additional information is being brought into the debate.

The paper to considers spirituality and religion as distinct entities [1]. Indeed, an "instrument that could distinguish between [both]" is described ([1], p. 107). This dualist type of research model and methods used and presented by King may lead to an incomplete evaluation of the situation rather than the holistic assessment that is required. While this approach echoes contemporary thinking, separating religion from spirituality is problematic [3]. Attempts to separate out spirituality from religion, for example, by defining spirituality as *meaning making*, often the central construct of modern understandings of spirituality [4] is challenged when this conceptualisation of spirituality (meaning making) is indistinguishable from psychological mechanisms [5]. Additionally, at a more fundamental level, we argue that religion and spirituality are interlinked and that spirituality should be examined "in the context of religious involvement" ([3], p. 2630).

It is also clear in the paper that distinguishing between religion and spirituality in the research describing use of the Royal Free Interview for Religious and Spiritual Beliefs (RFIRS), placed respondents in a position where they had to make a clear distinction between religion and spirituality. This is interesting because doing so is problematic for most people. The RFIRS's categories of "religious"; "spiritual"; "religious and spiritual"; and "neither religious nor spiritual" compelled respondents (by the definitions provided) to consider "religious" as synonymous with involvement in the public rituals of the institutional churches. However, many people would consider themselves religious even without such active involvement in organized religion. Indeed as society is becoming more and more secular and diverse, religious practice is becoming more a private affair [6]. Additionally, people are more commonly becoming what are called "fusers" selecting religious or spiritual practices depending on their needs ([7]; [8], p. 828). King's [1] use of the RFIRS categories thus provide much to debate.

Indeed King [1] appears to find the separation (of religion and spirituality) challenging too. Although primarily aiming to treat spirituality and religiosity as distinct entities, King uses the terms religion and spirituality interchangeably ([1], p. 107, lines 4–9):

"Christianity might also suggest that giving love inevitably involves suffering on the part of the person who loves. Spiritual people may love more and suffer more." ([1], p. 109)

There are also many other interesting debates opened up by this paper. Summarising from his prior research on the topic, King notes that those people who had described themselves as spiritual (but

not religious) appeared (over the course of longitudinal studies) to be more vulnerable to emotional illness [1]. However, at the same time, the definitions provided for “spiritual” as specified within this research, *i.e.*, believing in a “power or force” that influences life and “communication with spiritual powers” would not necessarily differentiate the spiritual from the delusional by King’s own admission ([1], p. 107). Certainly, there is evidence that those who were spiritually inclined were more vulnerable to emotional illness, or those with mental illness were more likely to declare their spirituality. Indeed, these findings suggest that those with a spiritual outlook are nearly twice as likely to have a mental health problem.

At the same time it is notable in this context that King [1] appears to underplay the influence of spirituality and religion on health. He reports, and yet does not explore in any depth, a very important finding from his own research—that those with a religious outlook are much less likely to use illegal drugs or abuse alcohol. Moreover, the primary focus of the reporting was that “those with a spiritual view of life appeared to be vulnerable to mental and substance misuse disorders” ([1], p. 109), perhaps due to the startling and serious nature of this finding. However, the following conclusion, which was based on a single study only, ought to have included a caveat regarding the positive effect of religious involvement on alcohol and illegal drug consumption:

“Our conclusions from this study were that neither a religious nor spiritual life view was protective against major depression. In contrast, it appeared that those with a spiritual life-view had an elevated risk. Although not all our results reach statistical significance, the most striking finding was that there was no advantage in terms of mental health for those with a religious life-view. There was no indication in all this research that religion or spirituality was particularly good for mental health (bar an important advantage in use of drugs and alcohol).” ([1], p. 110)

A significant and positive effect of religious involvement on alcohol and illegal drug consumption has many potential benefits for society given the well-established association with crime and the mental and physical illness associated with substance abuse [1]. This is indeed a positive finding from within this discussion [1], and something that warrants further research. The potential negative influence of religious involvement on a person’s mental health is of concern, but however as the findings from the particular study King [1] cites are mostly not significant this too warrants further exploration.

It is interesting that within King’s [1] debate he considers positive findings in the relationships between religion, spirituality and health to be due to differences in “religious freedom” and the “predominance of Protestantism in the US.” This echoes Paley’s [9] assertion that the US is more “religious” than the UK or other parts of Europe and therefore the research findings are possibly not transferable. However, these claims may require a little more debate and discussion within the study of spirituality and religion. It may be that the dynamics of the way religion affects health in regions of the world that are less religious at the societal level, may be different than in more religious populations. Indeed, in China where religion has been discouraged for decades, for example, research indicates that depending on how the data are analysed (modelled), religious involvement may have either a significant negative effect on mental health or a significant positive effect (when the indirect effect of religion on purpose in life and social support are considered) [10].

King [1] provided a summary of much of the research evidence on the benefits of religion and spirituality in health to date. However, as most of this is at least 13 years old, it would be useful to expand on this debate by incorporating the burgeoning research in the field of spirituality that has mushroomed considerably in the past 10 years [11]. King quite rightly points out that few of these reviews were systematic. However, it is clear that many of the more *recent* research that he reviewed did in fact take a systematic approach [2,12]. Additionally increasingly stringent academic requirements of journals means that the publication of systematic and high quality reviews are on the increase. Notably, the absence of systematic reviews is reflective of many other healthcare fields from the same period. The benefits of organised religion are understandably called into question given that these benefits can be attributed to other aspects of religious practice, for example the social support it provides.

King highlights for example regarding positive effects of organised religion on cardiovascular health that appeared in one in one literature review that he examined [1]. He states that: “it is likely that benefits arise from group activity and the social support that stems from belonging to a religious community...[thus] are not necessarily or specifically linked to religious involvement” ([1], p. 112). Note, however, that the benefits of religious attendance on mortality persisted even after controlling for social support and other explanatory and confounding factors. Clearly, the social aspects of religious beliefs and behaviour are key to the overall benefits to health, but they explain only a relatively small portion of that mortality benefit (about 10%) [13,14]. Again there are important aspects of the potential benefits of religious activity on health that require further exploration.

Many of King’s [1] criticisms of the research on religion and spirituality are valid and indeed well-understood, such as the lack of agreed definition of religion and spirituality across the studies (a common finding for other psychosocial variables in the social and behavioural sciences). However, his account of “fishing” trips (within the data collected on religion and spirituality) and his mention of unidentified “theological flaws” seem a little harsh and not fully supported by the evidence he presented [1]. Critical of correlational analysis for example, this has been accepted as the basis for health evidence in many epidemiological studies including those establishing that cigarette smoking causes lung cancer [15]. While these are valid methodological issues for any research study, there is limited substantive evidence supporting King’s [1] argument that this is any worse in the religion, spirituality and health field, than in any other research field in the social and behavioural sciences. There is perhaps an inclination in this paper, as is common, to subject researchers of religion and spirituality to higher standards and expectations than other researchers simply because of the topic and the deep seated conflicting views that advocates and critics hold [15]. We also wonder whether King’s own bias is evident here. Ultimately each researcher brings their own beliefs to their research and enquiry and it is hard to separate from these. Indeed King [1] suggests that “investigators’ bias” and “strong personal beliefs” of religion and health researchers have affected the design of studies in this field and the interpretation of their results ([1], p. 106). Yet strong personal beliefs in research are not uncommon among researchers in other fields as well, and are often the basis for their research hypotheses. Given the sustained effort needed to develop, fund, and carry out a research study, most research would probably not be carried out without investigators’ belief in and commitment to their research questions. Again, religion-health researchers are not an exception in this regard. The key is for researchers to design their studies in a way so that their own personal biases do not affect the results. We argue that there is a natural bias that accompanies the research process, and that is why there is an ethical commitment, even informal, of researchers of being rigorous in methods selection, data collection, analysis and publication.

Research about spirituality and religion is crucial in order to better understand this phenomenon and utilize it as a resource to provide better healthcare. Viewing a complex research topic as a challenge should motivate investigators to conduct better quality research, not be discouraging or limiting. Whether we are qualitative or quantitative researchers, there will always be aspects related to the study of spirituality, religion and health that will challenge us given the complexity of these relationships. There is an acknowledged difficulty conducting research on this topic and applying it to clinical practice due to the many different religious belief systems involved and the cultural contexts in which they occur. In some respects, spirituality will always be deeply subjective, but there are ways to objectify and study the contribution that it makes to patients’ wellbeing and health and this is what should drive more research and its translation into practice.

Even though research about spirituality and health are important and challenging, there is another area which is may be even more important and needs to be given more attention: the importance of spiritual care. It is important that criticisms of research into spirituality and religion do not undermine the valuable practice of spiritual care by chaplains and other healthcare workers. Inconsistencies in understandings and contributions of spirituality and religion in research is not synonymous with difficulties in addressing patients’ and families’ needs in practice [5]. Within the hospital environment

the need to be treated in a more holistic manner that considers the whole person becomes more necessary. Spiritual distress, for example, which can occur in more than one third of hospitalised cancer patients, is associated with increased pain, depression and suffering and needs to be recognized and treated in order to improve patient symptoms [16–18]. When a person finds himself or herself in a hospital, they have come into a world that is alien to them. They are strangers, they may become fearful and unsure of what lies ahead, and may be faced with the reality of suffering and death. Medical technology can increasingly sustain and prolong life. Within such an environment there is a need to address the spiritual distress that lies within [17,18]. Swinton ([19], p. 162) states in his article, which appears in the same issue (as King), that “just because it is made up [spirituality in healthcare] does not mean that it is not real and does not matter”. He argues that substantive evidence of the benefits of religion and spirituality in healthcare are not prerequisites to making meaningful impacts in practice. Pastoral encounters by chaplains, for example, are not scientific engagements or theories or formulae to be proved or not proved but rather they are personal and intuitive experiences that have qualitative benefits [20]. In such an environment, spirituality and religion can in many ways become the primary concern of patients and families who face challenging circumstances. Holistic care helps patients and their families look deep inside and tap into their own inner resources. They are empowered to search for meaning and purpose in the current reality of their lives. Through the expression of religion at critical times in illness patients and families may also garner hope, courage, strength and gain a sense of peace that facilitates them to cope with the incredible emotional demands on their person [21].

3. Conclusions

Religion and spirituality are not at their core scientific disciplines. It is difficult to “prove” scientifically that spiritual needs have to be attended to. The reality of walking the wards is not quantifiable, and journeying with a person through their darkness and into the light is what a chaplain/spiritual caregiver does each day [22]. Sitting with the tears, which eventually turn to a smile is not a proven theory but it can be felt and witnessed [7]. This leads to the kind of *subjective* experience, rather than *objective* evidence, that gives meaning to a person’s life and bolsters their faith. Empowering a person to accept the grimness of their situation and to walk forward with courage and strength is difficult to quantify, and outcomes-based research in this field is at its infancy [8]. Knowing intuitively, deep within the crevices of your heart and soul, that you have helped another person face a day they never thought they could, is what the spiritual and religious aspects of health-care is all about. The real challenge involves how chaplains and other health professionals can utilize the spiritual and religious beliefs of patients’ beliefs, which as noted above vary widely, to improve their overall recovery [22]. We believe that academics and practitioners need to spend some time now on embracing the reality of the existence of spiritual and religious needs in health care practice, the potential to improve recovery if addressed and developing evidence based ways of improving practice. There has been a lot of academic navel gazing in this regard [9]. It is time now to move beyond the “official rhetoric” and “actually facilitate and enable meaningful spiritual care” for patients ([23], p. 801). At the same time, King’s [1] important paper facilitates researchers and clinicians to engage in detailed debate about key elements of research enquiry, and methodological issues, in this research field that may serve to invalidate findings. If clinicians are providing and facilitating spiritual care with the belief that there are intrinsic benefits to this, then this belief ought to be based on best available evidence. Certainly in healthcare practice chaplains, nurses and other health professionals see the benefit of supporting patients spiritual needs. However, what is needed, in conjunction with this, is a rigorous evidence base to support practice. More research and systematic enquiry needs to be carried out that explores the benefits of spirituality and religion to health and recovery. Research is also needed to explore spirituality and religion as a means of coping with illness and death but also as a catalyst for enhanced spiritual experiences during pregnancy and childbirth. However, at the same time, while critical debate is healthy, clinicians and scholars need to avoid undermining the potential importance of spirituality and religion in healthcare because of the perceived absence of rigorous evidence [19].

Individualised person centred care is at the centre of modern healthcare. It ought to be the person who is receiving healthcare that determines the importance of religion and spirituality rather than the healthcare worker determining whether or not there is sufficient existent evidence to render these topics viable and valuable in the healthcare setting.

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Abbreviations

BASS British Association of the Study of Spirituality

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