



# Keeping up to date

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## Health Promotion and Spirituality: making the implicit explicit

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### Abstract

This paper considers the place of spirituality in health promotion. Growth in the spirituality and health literature has led healthcare professions across the globe to consider the nature of spirituality and spiritual care. This has rarely occurred in health promotion. For many, spirituality goes to the core of being human and is more than a religious framework; for others, spirituality is meaningless. In New Zealand, partly due to the contributions and aspirations of Māori, spiritual concerns are understood as an essential component of health. The paper argues that, due to growing evidence and a principled approach, attending to spirituality in health promotion is an ethical imperative, critical to our reflective practice

and necessary for comprehensive planning, action and evaluation. This paper aims to strengthen the debate and encourage health promoters to consider spirituality in their work.

### Introduction

Spirituality is a controversial topic. Therefore it is important to approach this topic sensitively; for some, it goes to the core of what it means to be human, while for others it may be meaningless. In whatever way one understands spirituality, there has been a significant growth in research in the health literature, but this is not reflected in the health promotion literature (Vader, 2006). In New Zealand, health promotion largely seems to ignore the spiritual dimension, with the exception of work by and with Māori (Rochford, 2004) and Pacific peoples (Counties Manukau District Health Board, 2005).

The paper argues that taking spirituality seriously and explicitly in our health promotion work is an ethical imperative. It is argued that doing so fits with the international mandate that health promotion is based on an "inclusive concept of health..., encompassing spiritual well-being" (WHO, 2005). The paper draws on the author's research based in tertiary care settings (Egan, 2009) and considerations for health promotion more broadly in the absence of published work on this issue.

### What is spirituality?

Central to the literature and debate about spirituality is 'what does it mean?' The dominant position in the literature is that spirituality is not the same as religion; with spirituality being a broader, more individually understood and expressed concept compared to religion, which



Richard Egan

is more institutionally understood. For most New Zealanders the role of religion has waned in terms of direction and participation. Perhaps the best way to express contemporary spirituality is with qualifiers to cover its eclectic and broad nature: for example 'atheist spirituality', 'feminist spirituality' or 'religious spirituality'. Each of us may have our own qualifier or fit into one of many. Understanding spirituality generally includes better understanding religious spirituality. International studies confirm a range of commonalities among definitions which indicate a move towards the existential or non-religious end of the continuum. Meaning and purpose are the most common elements in spiritual definitions. New Zealand research has affirmed we largely believe spirituality to be important, inclusive and eclectic, but more research is needed (Eames & Cayley; Egan, 2009; Outside - Looking In; Researching the perceptions of non-churchgoers, (2003 February). Common

*Continued on page 11*

### Keeping up to date - 34 edition

Welcome!

*Each issue tells you about a current research, evidence and thought on an important issue for your work in health promotion. All articles are peer reviewed.*

This edition, is on spirituality and health promotion. We are thankful to Richard Egan, the author of the article. We also acknowledge the reviewers.

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definitional elements in the national and international research include: 'meaning and purpose', 'beliefs', 'values', 'identity', 'awareness', 'relationality', 'connectedness', 'religion', and the 'transcendent' (Egan, 2009). The 'supernatural' is seldom referred to in the academic literature on health and spirituality, which may suggest an empirical bias; one reviewer of research in this area notes the marginalization of the supernatural (Berry, 2005).

Suffice it to say that the semantic debate and need for further research about what spirituality means will continue. There is a need to have some common language to be able to discuss, research and attend to spiritual needs; the following 'map of the terrain' is suggested by the author to help this conversation,

*Spirituality means different things to different people. It may include (a search for): one's ultimate beliefs and values; a sense of meaning and purpose in life; a sense of connectedness; identity and awareness; and for some people, religion. (Egan, 2010)*

This statement suggests spirituality may be understood individually and collectively. Spirituality is about searching for, understanding and experiencing 'what matters most' in our lives and in our communities. Thus, what is ultimately meaningful, our core beliefs, connectedness (for some to the unseen), who we are and why we exist, are all aspects of the spiritual terrain.

## **Spirituality's contribution to health**

Essential to understanding spirituality is noting that to some degree it is artificial to compartmentalise it from other aspects of health and well-being. But, like physical health, it is important to understand it and its contribution to well-being. The peer reviewed literature on spirituality and health is dominated by the palliative care, nursing and psychology disciplines (Egan, 2009). The majority of this research comes out of the US, followed by the UK and Canada. The language and definitions used depend on the field of study and country and cultural differences. Up until recently, the research focused on Caucasian, Christian participants and often examined religious aspects of their lives. Quantitative research dominates the field. However, a growing body of qualitative research is developing, particularly in the palliative care field. The best evidence for positive associations between spirituality and other health outcomes is in the Quality of Life (QoL) literature. For example, Cotton, Levine, Fitzpatrick, Dold, & Targ (1999).

show spirituality (as measured by FACIT-sp) is a significant predictor of quality of life in cancer patients, even after controlling for demographics, disease characteristics and psychological adjustment (Cotton et al. 1999). The majority of review articles claim there is growing evidence for "the hypothesis that religiosity/spirituality is linked to health related physiological processes - including cardiovascular, neuroendocrine, and immune function - although more solid evidence is needed" (Seeman, Dubin, & Seeman, 2003, p. 53). Some studies show negative effects of spirituality, particularly as they relate to being punished by God.

## **Why is it an issue for health promotion?**

The re-emergence of spirituality as an issue for society, health and health promotion stems from our current context; key issues include the spiritual environment, evolving models of health, Māori contributions, and community needs.

The spiritual environment argument comes from basic public health; what happens upstream at a societal level effects communities and individuals downstream. Thus, like the importance of clean water and air, it is important to have a positive spiritual environment to enhance personal spirituality. While difficult to prove, a number of prominent people and researchers have argued that in the West there is a spiritual vacuum or spiritual chaos (Bluck, 1998; Hornblow, 1999; Leibrich, 2002; Tacey, 2003). In the recent report, *Common Cause: The Case for Working with our Cultural Values*, Compton (2010) argues this in terms of the need to examine and be explicit about our values at a political and civil society organisational level. Social epidemiologist Richard Eckersley argues, based on his understanding of the research for a debate "about how we are to live and what matters in our lives." (Eckersley, 2004, p. 17). Part of Eckersley's answer is a renewed focus on the 'why' of life, incorporating spiritual and holistic views. As Eckersley argues: "... a vast consumer society has grown to minister to the 'empty self'; and religious cults and fundamentalist movements flourish as people struggle to find what society no longer offers" (Eckersley, 2004, p. 6).

Central to this spiritual chaos is meaninglessness, a state considered by Frankl to be at the centre of many of society's and individuals' dysfunctions (Frankl, 1984). The philosopher Charles Taylor argues that much of the world is "without meaning" and the contemporary state of collective meaninglessness is unique in history (Taylor, 2007). This crisis of meaning may be exemplified by such

factors as suicide, self harm, individualism and rampant consumerism (Eckersley, 2004). There is no research measuring this so-called spiritual vacuum in New Zealand, but arguably the consequences are evident (e.g. a high rate of suicide, Ministry of Health, 2009). It is because of the 'whole population' nature of this 'problem' that a public health/health promotion response is necessary.

The re-emergence of spirituality in health is partly a reaction to the bioreductionist focus in medical care: that is, a system whose sole or dominant focus is on physical aspects of health (Laura, 2009). This is not intrinsically wrong, but becomes so when other aspects of well-being are ignored or dismissed as irrelevant. The biomedical model in medicine is slowly changing to incorporate a 'bio-psycho-social-spiritual' model. Many medical schools, particularly in the US, now teach mandatory courses on spirituality underpinned by a broad definition and an evidence informed approach to spiritual care (Puchalski, 2001). How do we, in health promotion, respond to this re-emergence?

Māori models of health have enabled health promoters to expand their vision of what health is about, including spirituality. Theoretical models or frameworks such as Te Whare Tapa Wha (Durie, 1998) and Te Wheke (Pere, 1997) give a clear lead about working from a holistic paradigm, thereby affirming the need to consider the spiritual domain.

As part of the New Zealand health promotion competencies, a level one health promoter should have knowledge of "wairua" or spirituality as part of the "four cornerstones of Māori health" (Health Promotion Forum, 2000, p. 14). In *Building on Strengths*, the New Zealand mental health promotion strategy, spirituality is named as both a dimension of Te Whare Tapa Wha and wellness (Ministry of Health, 2002). This is also affirmed in the *New Zealand Health and Physical Education curriculum* where spirituality/wairua is named and defined within well-being/hauora and taught in many state schools (Ministry of Education, 1999). Mason Durie suggested that "Te taha wairua is generally felt by Māori to be the most essential requirement for health" (Durie, 1998). To not consider spirituality in our health promotion work is to ignore central concerns of many Māori and therefore not meet te Tiriti commitments.

A further reason why spirituality is an issue is individuals and communities are asking for it to be considered in various health contexts. The best evidence for this is in primary (Murray, Kendall, Boyd, Worth, & Benton, 2004), palliative (Egan, 2009)

and mental healthcare (Macmin & Foskett, 2004). From a health promotion point of view, the parallel issue is 'what about the spiritual needs of the communities we work with?'

There is very little research on spirituality in health promotion. Peer reviewed publications that do exist are often editorials, conflate religion with spirituality, or may include spirituality as a survey item. A notable study in Ireland examined how health promoters understood and actioned spirituality (Fleming & Evans, 2008). The results showed that while many believed spirituality to be an important part of health promotion, there were very few who put it into practice. Further, an editorial in the *Journal of European Public Health* sums up the often published arguments, "this dimension is almost totally absent from discussions of public health and health promotion in Europe" (Vader, 2006).

This dearth of research is despite calls for attention to spirituality for decades. In 1988, Halfdan Mahler, then Director-General of the World Health Organization, acknowledged the importance of individual and community spirituality (Mahler, 1988). The same year Raeburn and Rootman called for spiritual needs to be considered in health promotion action (Raeburn & Rootman, 1988). Further in 1986 Kickbusch acknowledged spirituality as a component of well-being (Kickbusch, 1986).

An alternative position to the research/evidence informed approach is a principled-based approach. The place of spirituality in healthcare is developing, not only because of the research, but also because models of health that include spirituality are increasingly acknowledged in pre-service training for healthcare professionals, in policy and guidelines (National Institute for Clinical Excellence, 2004) and in national strategies. For example, the *Guidance for Improving Supportive Care for Adults with Cancer in New Zealand* (Ministry of Health, 2010, pp. 44-45) contains a two page section on spiritual care. Further, in a recent WHO statement on health promotion, the *Bangkok Charter*, it states explicitly that spirituality is part of an inclusive concept of health (WHO, 2005).

## Doing it?

Making the implicit explicit may be the first step to bring spirituality to the fore in health promotion. That is, it is important to affirm and understand that some of our current work inevitably is affected by and affects the spirituality of all involved. For example, when a health promoter asks herself what is my worldview and ethical considerations regarding this project, and

the same questions are asked of those with whom she is working, the spiritual domain is being canvassed. Additionally, bearing in mind the 'map of the terrain' above, whenever we consider the belief, values, meaning and purpose, relationships and connectedness of ourselves and those with whom we work, we are considering the spiritual domain.

Health promotion planning tools help to facilitate the process of attending to spirituality. Spiritual matters can be incorporated into the ideal processes of planning: needs assessment with community as partners, a theoretical and ethical base, clear goal and objective development, actions that follow logically from the planning, and evaluation throughout. In the first instance it is about making space for spirituality—explicitly considering it in needs assessment. That may mean highlighting spirituality in government strategies (it is there) and looking for it in the literature; and asking questions of experts and community stakeholders about beliefs, values, identity, 'what matters most'.

A 'determinants of health' approach to needs analysis is also a point of entry for the spiritual domain. This may entail thinking broadly about the spiritual environment and asking ourselves, our funders and the communities with which we work, questions about the kind of society we want to live in and what really matters to us. Health promotion work needs to transcend the dominant lifestyle disease approaches (i.e. the focus on smoking, alcohol, nutrition and physical activity) and rather pick up on the spirit of the times that calls for new ethical approaches that incorporate spiritual concerns of individuals and communities in settings. As noted above, some health promotion work does these things, especially Māori and Pacific approaches, but they are in the minority.

When considering how to bring spirituality into our health promotion work there may be a series of questions to consider: do we have a sense of our own spirituality?; how is spirituality promoted in our public health/health promotion organisations?; what are the core values and beliefs of health promotion and how do they reflect spiritual aspects of health?; how do we understand the spirituality of those we work with?; how might our programmes promote spiritual well-being?; and how might we measure effectiveness in this domain?

## Conclusion / Challenges

Spirituality has re-emerged as an issue because of our contemporary context in which global and local events and ways of thinking challenge our sense of meaning and

purpose. As health promoters we are called to respond to the needs of communities, especially the least privileged. Spirituality concerns are basic needs, perhaps the most basic, thus demand our attention.

So what needs to happen? I argue for consideration of how our public health/health promotion organisations incorporate spirituality into their organisational well-being. We need to consider how to make space for spirituality at all levels of our health promotion work, led by community need, but taking care not to compartmentalize and bureaucratize spirituality. Reflection is needed on how to act ethically and take care never to proselytise or push our own spiritual agendas. How might we raise our gaze and challenge the societal structures that inhibit spiritual well-being. Finally questions remain about appropriate training, resources, capacity and New Zealand based research to address spiritual needs.

There are still many questions to be considered, research to be done, and innovative approaches needed, to further understand spirituality in health and health promotion. New Zealand has the potential to lead the world with health promotion with a spiritual focus, particularly because of Māori and Pacific health promotion. We know making space for the spiritual dimension in people's lives does not take suffering away (Egan, 2009) but it does help find meaning in an ever-changing and anxious time. This paper hopes to challenge the sector to consider the place of spirituality in health promotion.

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*Continued on page IV*

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When writing or talking about spirituality I believe it is important to situate one's own spirituality. I come from a New Zealand pakeha tradition, my ancestors mainly hail from Ireland, and we arrived in New Zealand from the mid 1800s. I come from a Catholic background, though not practising, I am culturally a Catholic. My beliefs now are eclectic, with influences from both Christian and Buddhist belief systems. I understand well-being holistically and believe there is reasonable evidence that spirituality is a significant contributor to that well-being. I write this article from the point of view of health promoter and academic. I worked as a health promoter for five years and am currently a teaching and research fellow in the Department of Preventive & Social Medicine, University of Otago, Dunedin. Email: richard.egan@otago.ac.nz

Some editorial or debate pieces do exist in peer reviewed journals (Hawks, Hull, Thalman, & Richins, 1995; Vader, 2006). A search in the journal *Health Promotion International* between the years 1986 to 2010 found only five articles (key word 'spiritual' in the 'title' and 'abstract' domains). Of these, one was a review, one an editorial, and the other three reported on health promotion interventions that included, but not focused, on spirituality. When the search was extended to the 'text' of articles, 67 hits were found. This is indicative of other journal and database searches. The health promotion literature does not focus on spirituality, but it may be included as a survey item or part of a framework in studies that consider: health promotion and QoL (Rana, Wahlin, Lundborg, & Kabir, 2009), complementary and alternative medicines (Hill, 2003), indigenous peoples (Mundel & Chapman, 2010), health promotion in other cultures (De Leeuw & Hussein, 1999), within various models/debates (e.g. salutogenic (Eriksson & Lindstrom, 2008), well-being (Carlisle, Henderson, & Hanlon, 2009), community health/ QoL (Raphael, 2000), 'contact with nature' theory (Maller, Townsend, Pryor, Brown, & St Leger, 2006), and workplace health (Downey & Sharp, 2007). This list represents countries across the globe and many of these papers are editorials. There are very few original papers reporting on evaluation or research focussing on spirituality and health promotion.