Spirituality/Religion and Health
Research report (phase two)
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Sincere thanks to our colleagues at POWH and the Chaplaincy Department, and to
the many patients, family members and hospital staff who helped us with this
research.

This report (phase 2), the phase 1 report and the staff resource can be accessed on
the Diversity Health intranet site:
http://sesiweb/powh/diversityhealth/spirituality.asp or directly from any of the project
team.

To cite this document please use: Hilbers, J., Haynes, A., Kivikko, J., & Ratnavyuha.
2007 Spirituality/Religion and Health Research report (phase two). SESIAHS,
Sydney.

December 2007
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Defining Spirituality and Religion

What is Spirituality?

Spirituality is a broad concept, considered by some to be undefinable because it means something different for each individual (Rory, Ross & Maclean 2000, Tanyi 2002). Many regard spirituality as an internal process concerned with finding purpose and meaning in life (Miller & Thoresen 1999). Some see it as connection (Tanyi 2002), eg. connecting with a higher power, with an inner power, with each other, with the earth or with a universal energetic force. Others see it as “mystery, a sense that there’s more to reality than meets the eye, that there are forces at work in life and even beyond life” (Tacey 2003c).

What is Religion?

Religion is characterised as the institutionalisation of spirituality and involves adherence to shared beliefs and customary practices associated with organised movements (Miller & Thoresen 1999). It is often integrated into a whole community’s socio-cultural life (Schneiders 2000). Based on these definitions religion is considered to be more structured, formal, rooted in tradition and doctrine, with rituals taking place in a shared community of practice. In contrast, spirituality, is generally perceived as more fluid, eclectic and individual.

The relationship between Spirituality and religion

Spirituality and religion are in no way mutually exclusive. People can be both spiritual and religious, or spiritual but not religious (Dyson, Cobb & Forman 1997). Some argue that people can also be religious, but not spiritual. Within both spirituality and religion, there may be a very broad spectrum of belief and practice, and it may be affected by a variety of factors such as age (MacKinlay, 2001), gender (McBride 1998) and cultural differences (Helmen 2001). For example, the perception and expression of spirituality often differs between different generation cohorts within the same cultural group as older people tend to associate more with a traditional church, while younger people are inclined to adopt more eclectic, personal approaches (Tacey 2003a).

Terminology in this paper

This research adopts a broad, encompassing definition of spirituality as “… an inclusive term, covering all pathways that lead to meaning and purpose” (Tacey 2003a p.38) and “involving body and spirit, emotions and thought, activity and passivity, social and individual aspects of life” (Schneiders 2000 p.5). Despite the breadth of this definition, we do not generally use spirituality to refer to the diversity of people’s spiritual and/or religious beliefs and practices in this report. This is because the research instrument used the terms spiritual and religious intentionally (discretely in some questions, and as an either/or option in others (see appendix B). Therefore, we use the term spiritual/religious in most cases in place of the more cumbersome ‘spiritual and/or religious’ descriptor. This is deemed to encompass a person’s beliefs and whatever practices may be associated with these beliefs.
Spirituality/religion in contemporary Australia

Australian society comprises many belief systems. Spirituality/religion has always been interwoven into the lives of the Aboriginal Australians, and over the past 200 years migrants have introduced a wide range of religions. There is much diversity within each defined category. For example, Christianity, the current dominant religion in Australia, is experiencing increased divergence of core practices and beliefs (Bouma 2002). Buddhism, Islam and Hinduism are growing religions, as are ‘New Age’ and nature religions such as Gaia, Paganism and Wicca (Bouma 2002). Overall trends suggest that Australia also has a strong and growing secular population (ABS 2004).

Spirituality/religion is an important aspect of life for many Australians. For example, research shows that nearly three quarters of the population (74%) profess some form of religious affiliation, with higher proportions in rural areas (86%) and elderly populations (83%) (Peach 2003).

Although professed religiosity (particularly Christianity) is in decline, it appears that spirituality may be on the increase. As Bouma (2002) notes, the 2001 census recorded a significant increase in the category ‘religious belief inadequately described’. This suggests that although traditional religious affiliation is waning, Australians are increasingly turning to broad spectrum of eclectic beliefs and practices which researchers are yet to label. As Bouma puts it, “Spiritualities of choice as opposed to religions of birth are growing substantially in Australia” (2002 p.20). Tacey agrees, arguing that “Spirituality has become diverse, plural, manifold, and seems to have countless forms of expression, many of which are highly individualistic and personal. Spirituality is now for everyone, and almost everyone seems to be involved, but in radically different ways” (2003a p.38).

Spirituality/religion and Health: an overview

Contemporary western medicine is becoming increasingly aware of the significant links between spirituality/religion and health. There is a growing acceptance that understanding someone’s spiritual beliefs and practices can be a vital source of information about how they experience the world and how they deal with illness.

Spiritual beliefs and practices can affect:

- The way people understand health, illness, diagnoses, recovery and loss (Larson 1999, Johnson 2004)
- The strategies they use to cope with illness (D’Souza 2007, Williams & Sternthal 2007)
- Their resilience, resources and sense of support (Hebert, Jenckes, Ford, O’Connor & Cooper 2001, D’Souza 2007, Eckersley 2007)
- Decision-making about treatment, medicine and self-care (Higginbotham & Marcy 2006, Rumbold 2007)
- People’s expectations of and relationship with health service providers (Koslander & Arvidsson 2007)
- Their day-to-day health practices and lifestyle choices (Koenig 2001, Larson & Larson 2003)

Understanding a patient’s spiritual worldview helps practitioners to develop a better understanding of the patient’s wishes and needs and beliefs, which in turn assists in the development of informed and comprehensive treatment plans. It also provides opportunities for staff to strengthen their relationship with patients by showing respect for their spiritual/religious beliefs and supporting any practices patients wish to continue while they are in hospital (Higginbotham & Marcy 2006).

Spirituality/religion has been found to have a positive correlation with general wellbeing in both American and Australian research (George, Koenig & McCullough 2000, Kaldor et al 2004, Seeman, Dubin and Seeman 2007, Williams & Sternthal 2007) - particularly in the disability and rehabilitative context (Selway & Ashman 1998). Empirical studies have positively linked religiosity to stress reduction, recovery from illness, prevention of heart disease and hypertension, pain management, adjustment to disability and recovery from cardiac surgery (Post, Puchalski & Larson 2000, Koenig, Idler & Stanisku 1999, Lauver 2000). Caregivers have also been found to benefit from religious faith (Selway & Ashman 1998).

George et al (2000) assert a relationship between spirituality/religion and the prevention of mental health problems including reduced likelihood of anxiety disorder, depression and substance misuse. Recovery from mental illness has been linked to spiritual/religious involvement, for example, an Australian study which examined the spirituality/religion of people suffering psychological illness found that 79% of patients rated their spiritual beliefs as either important or very important, and 67% revealed that rituals helped them cope with psychological pain (D’Souza 2002). Results suggested that patients’ coping skills were enhanced when their beliefs and practices were incorporated into treatment because patients were “using something that they are comfortable with, something that they believe in and something that is sensitive and appropriate.” (D’Souza 2003)

In a follow up study of people recovering from alcoholism, Pardini, Plante, Sherman & Stump (2000) found increased coping skills and lower anxiety among those with religious or spiritual convictions. These authors also accounted for the important distinction between spirituality and religion (rarely made in the literature) finding that spirituality particularly contributed to greater optimism and perceived social supports, while religious faith was a positive predictor of resilience.

Health crises can often precipitate an emergence, consolidation or rejection of spiritual belief (Narayanasamy & Owens 2001). Lauver (2000) found that people who have experienced a major health threat or serious medical diagnosis report higher levels of spiritual wellbeing than those who have not.

A recent review of research evidence in the Medical Journal of Australia found a positive association between mortality and attendance at religious institutions (eg. going to church), with health practices and social ties being important pathways by which religion can affect wellbeing (Williams and Sternthal 2007). In the same journal, Eckersley (2007 p.54) argues that health benefits come from many sources,
but that “religions package many of the ingredients of health and wellbeing to make them accessible to people”. These ‘ingredients’ include social support, existential meaning, a sense of purpose, a coherent belief system and a clear moral code. Conversely, he notes that religion is not static and is itself shaped by changing social norms and values in ways that affects its teachings and social role. Other authors support this argument pointing out that our beliefs are also affected by family ties and social networks (Sherkat & Wilson 1995) and life events such as health crises, trauma and loss of a loved one (Pargament, Smith, Koenig & Perez 1998).

Other studies have examined the potential negative association between religious orientation and health. For example, Pargament & Mahoney (2002) argue religion may be harmful when people refuse to accept important new information because it conflicts with their beliefs. Similarly, Beers & Berkow (2000) found that certain beliefs and practices which are associated with some religious groups (eg. social isolation, self harm, refusal of prescribed treatment) may reinforce, and even promote, mental health disorders. Indeed, some practitioners find that pronounced religious beliefs can inhibit the identification of psychiatric disorders and thereby prevent people from obtaining appropriate psychological help (Halasz in D’Souza & Halasz 2002).

Some research suggests that negative health effects are related to particular belief structures. Kaldor et al (2004) found that ‘unreflective religiosity’ (a belief that it is wrong to question the church’s authority or texts) appears to be less positively related to wellbeing than other religious beliefs or practices. This supports Ryan, Rigby & King (1993) who suggest that people who actively choose spirituality/religion demonstrate better psychological outcomes than those who passively inherit beliefs.

### Key point

Spirituality or religiosity per se is not necessarily an indicator for better health outcomes because the relationship between beliefs, practices and health can be negative or neutral as well as positive. The critical factor therefore is not *if* someone is spiritual/religious, but *how* they are spiritual/religious. This may be influenced by a myriad of factors. This reminds us to avoid making generalised assumptions about people’s beliefs and practices because abstractions fail to recognise the value, power and diversity of spirituality/religion for different people under different conditions.

### Rituals, customs and practices

Rites and rituals occur in all known cultures and societies, and have always had a role in illness, health, loss and healing (O’Neill 2004). They can be simple practices such as lighting a candle, or profound formalised traditions such as conducting a sacramental ritual before dying. Rituals can be familiar, culturally shared activities or self-created activities that help make meaning, mark a transition, bring comfort or connect people to themselves, others, a higher power or a sense of sacredness. Today, there is increasing recognition of the positive contribution ceremonial activities such as meditation (Seeman, Fagan & Seeman 2003 in Pargament & Mahoney 2002), music, singing, prayer (Jantos & Kiat 2007, Maier-Lorentz 2004) and narrative (Cox 2001, Frank 2000) can play in enhancing health.
Research criticisms

Much of the research has sought to adopt an empirical approach that focuses on the biophysical effects of religion on health. Critics of these studies highlight the methodological problems in much of the research which tend to yield correlative evidence of effect only, rather than cause and effect, and often fail to control for confounding variables (Sloan, Bagiella & Powell 1999). Keonig et al (2001) conducted an extensive review of 1200 studies taking this critique into account and found in favour of a demonstrable beneficial effect on physical and mental health, as well as evidence of decreased health service use.

A further critique is that much of the research is American, and has focused exclusively on religiosity. To what extent do these studies apply in the Australian context? There are undoubted differences between the two countries that need to be accounted for; however, this report does draw on the American literature because Australian research into the relationship between spirituality/religion and health is still comparatively sparse (Peach 2003).

Barriers to Providing Spiritually Sensitive Services

Health services can be seen as microcosms of wider society in which staff, patients, and patients’ families represent the breadth of diverse community views. Therefore, reaching shared conclusions about how, and if, health staff should address patient spirituality/religion is a challenging task. Despite the fact that most practitioners feel they should be aware of a patient’s belief system (Monroe, Bynum, Susi, Phifer, Schultz, Franco, MacLean, Cykert & Garrett 2003), very few raise the subject themselves or feel confident discussing spirituality/religion even when the patient raises it.

The literature suggests a range of reasons for this:

1. A lack of understanding about the nature of spirituality/religion (Post 2000)
2. Lack of awareness of the importance of spiritual beliefs and practices for patients and their families (Jones in Barnett & Fortin 2006)
3. Lack of confidence by staff due to the misapprehension that they require expertise or specific knowledge about religious/spiritual/philosophical traditions and values (Post 2000)
5. Fear of projecting their own beliefs onto patients (Ellis et al in Barnett & Fortin 2006, Oldnall 1996)
6. Concerns about intruding into the patient’s personal life (Post at al 2000)
7. Confusion about whose role it is to raise and/or address matters of spirituality/religion (Oldnall 1996, Post 2000)
8. Lack of communication skills necessary to address the topic sensitively (Lo et al 2002)

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1 Australian research is growing though. See, for example, the Medical Journal of Australia, volume 186, number 10, which was published during the writing of this report.
9. Lack of time, often due to understaffing (Narayanasamy 2001)
10. An unconducive physical environment in which there is a lack of space, quiet and privacy (Narayanasamy 2001, Higgenbotham & Marcy 2006).

**Spirituality/religion in the hospital context**

Hospital attendance is not an everyday experience. It is a time of uncertainty when people can be confronted by pain, fear, physical fragility, mortality and dependence on others. This occurs in an often public environment isolated from usual support networks. Consequently, coping strategies and inner resources can be of greater importance than in everyday life and, for many people, spirituality/religion is a primary resource.

The relationship and interaction between the health service provider and patient can be influenced by the patient’s spiritual worldview. Their beliefs may affect their attitude toward their diagnosis/prognosis and treatment, towards Western medical practices in general, and to specific procedures such as organ transplantation, fertility treatment, birth, transfusion, resuscitation, dying, responses to death, immunisation and abortion. A patient’s beliefs may also dictate the conditions and frequency of certain practices at specific times of the day, week or year, and during particular stages in the health event. For example, some religions require prayer at particular times of the day, and most offer rites and rituals to support healing or to assist with transitions. These beliefs and practices are integral to the patient’s identity and wellbeing (Helman 2001) and should therefore be considered an important dimension of an holistic, person-centred framework.

As a public health facility, Prince of Wales Hospital is guided by government policy which clearly mandates that cooperation and religious tolerance should be promoted and encouraged to ensure the needs of our diverse community are met, and that health services should have the flexibility and capacity to respond to the diverse spiritual and religious needs of patients and their families (NSW Health, 2005).

**POWH research phase 1**

An overview of the research

The Spirituality and Health project, an initiative of Diversity Health and the Chaplaincy Department at POWH, commenced in April 2001. Phase 1 of the research involved qualitative interviews with hospital staff (9), chaplains (8), and patients (13, ten of whom had languages other than English as their first language). Information was collected on the importance of spirituality/religion to patients and staff, their views about the role it plays in health care, current spiritual/religious practices, and how spiritual wellbeing could be incorporated into service delivery at POWH.

Key questions that guided the research were:
- Do POWH patients and families feel that spiritual/religious beliefs and practices affect their health and care outcomes?
- If so, how important are these beliefs and practices?
• Should understanding and support of beliefs and practices be a fundamental aspect of patient-centred holistic care?
• If so, how can we support beliefs and practices in our various roles?
• Is it OK to ask people about their beliefs?
• How should health services respond to spirituality/religion in general?

The findings

Staff Views
Of the POWH staff who took part in the research all but one had spiritual/religious beliefs which they considered important in their lives. Staff tended to define spirituality/religion in terms of continuums rather than absolutes (see appendix A for a thematic analysis) and, although they all felt their beliefs shaped their approach to work and everyday life, they were clear about separating their personal spirituality/religion from that of the patient. Staff indicated a great deal of interest and openness towards the diversity of patients’ beliefs, and all respondents expressed non-prescriptive views regarding other people’s belief systems emphasising that it must be the patients’ belief system that guides any discussion of the topic.

Interviewed staff recognised the importance of spirituality/religion within a contemporary approach to patient care. They generally adopted a holistic view of health and saw spirituality/religion as having an important role in this mind/body/spirit relationship. Spirituality/religion was considered to guide a person’s response to ill health and recovery, and was generally accepted as a positive, health-enhancing attribute; however, some staff were concerned about the ‘spiritual distress’ that patients may experience following a poor diagnosis, and argued that the absolutist aspects of some religious practices may be potentially harmful.

It appeared from interviews that, despite their goodwill, staff were not confident in dealing with the subject and said they were unlikely raise it with patients. Some recalled a conversation that emerged from comments made by patients or, occasionally, from overt ‘clues’ such as patients praying or displaying religious personal items; but some admitted that even then their personal discomfort and/or lack of confidence about how best to proceed might cause them to ‘close down’ the conversation rather than responding in a facilitative manner. They felt there was no systematic approach to identifying and responding to the spiritual needs of patients, and their role was unclear.

Finally, staff participants pointed out that the spiritual needs of POWH patients were not necessarily accommodated, even when their religion had been identified and recorded on their medical chart. For example, there is limited ability to cater for specific food preferences or religious observances (eg. meditation, Ramadan, Yom Kippur), a lack of privacy for sensitive staff/patient discussions about beliefs and practices, and the need for opposite sexes to share some facilities causes discomfort and concern amongst many patients.

Patient Views
All the patients interviewed believed spirituality/religion contributed positively to health and the healing process. They identified this relationship in terms of strength, nourishment, security, hope, cleansing, acceptance and understanding.
Many patients identified as non-religious, but tended to hold strong personal philosophies which they felt impacted on their day-to-day life and general wellbeing. These beliefs also underpinned their assertion that all religious/spiritual beliefs should be respected.

Patients for whom English was a second language were more likely to state they had significant spiritual beliefs, and several discussed strong relationships with the church. Other interviewees talked about being spiritual and saw it as a more personal construct, unconnected to formal religion or a particular church, eg. “Spirituality is something that soothes my inner self and gives me strength”; and “it is a personal matter of approach.”

Some philosophies were common to all the interviewees, for example, the belief that a positive frame of mind and way of living will have a beneficial impact on health.

According to POWH patients, spirituality…

- “Strengthens one’s self being”
- “Helps us find some sort of understanding from the various problems which we come across in our life”
- “Gives me some sort of security in every day dealings”
- “Offers hope that you will overcome whatever comes along, whether this is it a bad situation or a sickness”
- “Helps you to accept any situation whether, it is good or bad, that comes to you”

Several patients highlighted the significance of prayer and the need to draw on their spiritual resources while in hospital, even though this was not acknowledged or supported by the medical environment. Some interviewees also expressed concern about their valued religious or spiritual practices being hindered by their illness or treatment.

None of the patients had experienced POWH staff raising the issue of spirituality/religion with them - nor did they expect it, for different reasons. Interviewees variously felt that it was “personal business”, or up to the patient to raise the subject, or unlikely to happen because staff do not see spirituality/religion as part of their business. One interviewee argued there is little reason to talk about spiritual matters because doctors and patients are unlikely to have a shared faith: “what’s the point…if we don’t have the same beliefs?… For a doctor to understand you, he must have the same feelings as you. Many doctors don’t believe in God.” This concern was echoed by other patients who felt that spirituality/religion was missing from their care and said they would like staff to attend to it. One regretted that “Doctors and nurses look after bodies, not souls”, while another expressed little hope in receiving spiritual care because “they never get involved in anything like that. The doctor or nurse should ask the patient, but no one asks”.

All interviewees shared the view that each patient’s perspective and general emotional needs should be respected, whatever their background and beliefs.
The role of chaplains

Chaplains who took part in the initial research all distinguished spirituality from religion and reported taking a non-denominational approach, eg. “Our job is to meet people where they are at…to make connections…to ‘walk’ with the patient”.

POWH clinical staff who were interviewed felt the role of chaplains is more clearly defined than that of clinicians when it comes to spirituality/religion. They saw chaplains playing an important supportive role that clinicians cannot address due to the pressures of a busy acute system and lack of specialist knowledge and skills. However, this study also found that the Chaplaincy service may be underused, for three reasons:

1. Patient interviewees who expressed a desire to talk with a chaplain had not been offered the service and were unsure how to access it.

2. Chaplains report that, despite their participation in the orientation program, staff are often unaware of their services or are hesitant to use them. Staff are most likely to call in chaplains during the end-of-life stage.

3. Staff who are aware of the service and committed to using it are constrained in their ability to identify need because the current admission form classifies beliefs according to major religions and therefore does not provide scope for patients to state beliefs which are non-traditional and/or spiritual but not religious.

Key points

- Spirituality/religious beliefs are associated with health outcomes – a view asserted in the literature, and by patients and staff at POWH
- For many, beliefs and practices are eclectic and individualised
- For many, beliefs and practices are of central importance in their lives
- Health staff do not currently gather data or ask questions which help us understand people’s beliefs, practices and wishes
- Health staff do not know how to ask about or respond to spiritual/religious issues
- There is confusion and discomfort about whose role it is to engage with beliefs or support practices

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POWH research phase 2: an overview

In May and June 2006 a hospital-wide Spirituality and Religion survey of patients and their families was conducted using a survey instrument developed and piloted by POWH staff (see appendix B).

Methodology

Theoretically, this study was informed by both positivist and interpretive paradigms, what Thoresen calls “methodological pluralism” (1999, p.291). The researchers value traditional scientific methods for scoping, establishing benchmarks, and allowing extrapolation, but also recognise the limitations of empiricism in delving into the myriad ways that people understand and experience their worlds (Grbich 1997). Therefore, the research did not attempt to test operationalised hypotheses, but was based on a series of propositional statements drawn from the literature review and amended in the light of findings from phase one. At the commencement of phase two these statements were:

1. Spirituality/religion is important in the lives of many patients and staff at POW
2. There is no single definition of spirituality/religion - patients and staff have a broad range of individual perspectives and practices
3. Many patients and staff believe there are links between spirituality/religion and health, both for themselves and others
4. Some patients engage in spiritual / religious practices which may have an impact on their health
5. Patients want the right to access their spiritual beliefs and practices when in hospital
6. Spiritual beliefs and practices should be supported as a dimension of patient-centred health care

A methodologically pluralistic review of these propositions strongly suggested mixed-method research that could employ both quantitative and qualitative measures. It was agreed that quantitative methods would enable us to capture a breadth of opinions and provide numerical data that would allow inferences to be drawn about POWH patients. A qualitative dimension was also deemed critical due to findings which strongly suggested that people’s spiritual/religious worldviews and practices are eclectic, individualised, evolutionary, and are articulated in very different ways. Only a qualitative approach could realistically begin to address this sensitive and complex socio-cultural phenomenon.

The intention was not to reveal the extent to which spirituality/religion impacts upon health, nor to examine the many dimensions that may effect this influence, but to explore our patients’ perspectives, find out what they do, and what they want from us.

The instrument

The instrument comprised 18 core items, most of which were phrased as closed-choice statements (responses were limited to ‘Yes’, ‘No’, or ‘Undecided’ boxes) or as multiple ordinal questions. Although most of the questionnaire could be completed purely by ticking boxes, all questions had an optional free text space so that answers could be clarified or expanded upon as desired.
Several items were entirely text-based requiring participants to define a term or complete sentences (eg. ‘When it comes to religion and spirituality/religion I would like this hospital to…’). This allowed respondents to reply in-depth and to take us in directions we might not have anticipated. The questionnaire also attempted to disentangle the concepts of religion and spirituality. There were non-identifying demographic questions at the end of the questionnaire.

Convenience testing of the draft survey was conducted with a range of colleagues, and on wards with patients and their families. The questionnaire went through ten formal amendments guided by on-going research and considerable deliberation amongst the four researchers. The instrument was translated and made available in four languages: English, Chinese, Arabic and Greek.

The survey

Survey participants (n=228) were approached throughout POWH over a period of four weeks (see appendix C for a list of wards and clinics that participated). Depending on the nature of the ward/clinic and preference of the staff, two choices of administration were available:

a) Questionnaires were left in a public place, usually on reception desks and in waiting areas, for patients and visitors to complete and place in an envelope, or
b) Patients and their families were approached by survey staff and asked if they would be willing to participate. Ward managers or other senior staff identified patients who should not be approached directly for the survey. This excluded patients who:
   • were very ill
   • were very tired
   • presented as distressed or emotionally unstable
   • had a significant cognitive impairment, including dementia or delirium
   • had an identified mental health problem (although mental health patients were able to self-select at outpatient clinics)
   • did not have a good understanding of English, Greek, Chinese or Arabic (unless a bilingual family member was available to help)

When approaching possible participants survey staff offered a choice: to either leave copies of the questionnaire and collect them later, or to read out questions and write the responses. In many cases, patients accepted the offer to have questions read out and their responses recorded by survey staff. This interview-style approach often led to patients generating conversation about their life experiences and their views of spirituality/religion and health - hence a more in-depth response to questions.

Data analysis

As hoped, the breadth of numbers permitted a hospital-wide generalisability, and the qualitative, open-ended questions and person-to-person components allowed the researchers to flesh out more detail and be guided by service users’ perspectives. This led to a rich yield of data that highlighted the complexity of the issues and enabled us to gain a deeper understanding of the diversity of people’s beliefs and practices.

The qualitative data was thematically coded and cross-referenced through two cycles of analysis by each of the four researchers. Discussions were held at the end of each
cycle to generate agreement on coding categories. The quantitative data was analysed with the support of a statistical epidemiologist from the Multicultural Health Unit.

Researching spirituality/religion and health: some issues arising

The following issues arose during the process of developing and implementing this research. Some are challenges we encountered, some were learning points, and others are simple observations. They are shared in the hope that they might assist others conducting research in this area.

Developing the instrument

A key consideration in the development of the survey tool was to ensure it was as inclusive as possible in order to capture the breadth and diversity of experience identified in the literature. Terminology was seen as a critical issue; hence, the strategic use of the term ‘spirituality’ as well as ‘religion’. Rather than predetermine the scope of the terms, participants were asked to define the concepts for themselves. This enabled respondents to identify and describe their beliefs more flexibly and personally than traditional surveys allow.

The ethics application

The Human Research Ethics Committee advised us that the topic of spirituality/religion and health, and our application to conduct research in this field, was very controversial. The application led to much deliberation and it took several months of clarification before it was approved. We were asked to provide additional assurance that patients would not be pressurised to participate. The committee also raised objections about the lack of terminology definition in the instrument, however they accepted our argument that definitions should not be provided so that participants could define the terms ‘religion’ and ‘spirituality’ themselves.

Weaknesses in sampling

Those participants who completed the questionnaire themselves needed to have a good level of literacy, and all participants were required to understand and engage with abstract philosophical concepts. This would have inevitably excluded some patients and visitors. The survey also failed to hear from patients and families who were very ill or distressed, patients from the correctional facility were not included, and we had few responses from mental health. It is unfortunate that these groups are not represented in the data since there is considerable evidence that spirituality/religion may be of greater importance during times of crisis and for people with depression (Kendler, Liu, Gardner, McCullough, Larson & Prescott 2003, Koenig 2001, Larson & Larson 2003, Post et al 2000).

Conducting the survey

Many patients and visitors wanted to talk about this topic and accepted our offer to read the questions aloud and write their responses. This facilitated wide-ranging conversations and, in some cases, led to referrals to chaplains and social workers. However, for some patients, visitors and staff this was a taboo topic: too private to discuss, or too risky to articulate due to perceived socio-political ramifications.

We found that people were more likely to fill in questionnaires when others around them were doing so. Therefore forms were sometimes returned in batches. This was particularly noticeable when staff dropped into clinics to hand out questionnaires and
a short-term ‘culture’ of form filling seem to develop, sometimes generating a brief
group discussion on the topic.

There were concerns that patients and visitors who saw themselves as ‘non-spiritual’
or ‘non-religious’ would be underrepresented, so the survey instrument, advertising
posters and the interviewers themselves actively encouraged this group. Analysis of
the findings suggest a broad representation was obtained in keeping with the 2001
census.

The research was polarising. Some staff viewed it as irrelevant to a public hospital,
while others saw it as extremely important and at the heart of their work. But staff
were generally helpful, despite an initial lack of enthusiasm from many.

Analysing the data
On reviewing responses it became apparent that some participants found one or
more of the questions confusing: questions 9 and 11 in particular.

Question 9 asked, ‘Have your beliefs changed during your life?’ The researchers
intended to invite reflection on a broad spectrum of change, eg. “have your ideas
developed; have you ‘journeyed’ spiritually?” But a minority of replies suggested a
more limited, fundamental interpretation of ‘change’, as though we were asking if
they had experienced a complete change or loss of faith. Replies that suggested this
included, “No. I’ve always been a Christian”, and “No, God is important”. Some who
ticked multiple boxes in question 8 (‘How would you describe your beliefs?’) also
answered ‘No’ to this question. We found this interesting because we speculate that
someone who describes themselves as Catholic, Protestant and Buddhist is likely to
have experienced some spiritual change or development in their life.

Question 11 asked ‘Do you do things which are connected to your spiritual and/or
religious beliefs?’ Many respondents said ‘No’ to this question but in answering
follow-up questions told us that they ‘did things’ regularly and that these practices
they were moderately or very important to them (in other words, only 69% said they
do things, but 74% said these things were important to them). We hypothesise that
this anomaly occurred because of the way the questions were phrased. In the first
question, when asking about doing rituals, we gave some examples of
spiritual/religious practices in order to provide a frame of reference which suggested
the breadth of possible practices. Some respondents may have interpreted this as a
comprehensive list of possible responses and so answered negatively because their
particular practice was not mentioned. However, when asked about their practices in
subsequent questions (with no examples given) they may have been freed up to
reflected on what they actually do and its importance, and so they answered
affirmatively. Consequently, the ‘Yes’ responses to question 11 (59.6%) are almost
certainly under-representative compared to the data from the subsequent questions
which ask about the frequency and importance of those practices, eg. for question
12, 78.9% of respondents identified a frequency for their practices varying from ‘less
than once a year’ (3.9%) to ‘daily’ (40.4%), while for question 13, 74.1% said their
practices were either ‘moderately important’ (24.1%) or ‘very important’ (50.0%) to
them. Therefore, the data presented in relation to the extent of patient/visitor
practices is sometimes drawn from questions 12 and 13, rather than question 11, as
they are considered more reliable.
POWH research phase 2: the findings

The sample

A total of 228 ‘clean’ questionnaires were returned. Of the 213 participants who stated their sex, 43% were male and 57% female. There was a broad spread across age brackets (see figure 1).

![Figure 1](image1.png)

Figure 1  **Age of survey participants**
(does not include 'Not Stated' responses)

Respondents were born in 35 different countries (see figure 2). After English, the major first languages spoken were Greek (14), Chinese languages (Mandarin, Cantonese, and other dialects – 8), Italian (6), Spanish (4) and Arabic (3).

![Figure 2](image2.png)

Figure 2  **Countries of Birth of survey participants**
(other than the 130 from Australia, and 14 not stated)
The translated Greek, Chinese and Arabic questionnaires were not widely used but 21.5% of overall respondents said they spoke a language other than English at home. This is comparable to the 2001 census where 21% of SESIAHS population spoke a language other than English at home.

As figure 3 below shows, a broad sample of patient status was obtained, with the higher numbers for clinic appointments and emergency reflecting the higher proportion of patient flow in those areas.

![Patient status](image)

**Participant definitions of religion and spirituality**

Question 6 asked participants to define religion by completing the sentence, ‘*To me, religion means…*’ Analysis of the narrative responses showed a variety of perspectives of religion as:

- A guiding framework which influences the way we live our lives (make decisions, act towards others, etc)
- God, or a broader concept such as ‘after-life’, ‘higher power’, ‘greater being’, or ‘other forces’
- A source of support including strength, hope, and comfort – these themes were used to describe the positive relationship between religion and wellbeing
- A sense of purpose and/or meaning
- A way of defining a person, eg. “*It’s who I am*”
- A social construct that is used as a method of social organisation, cohesion or control
- A connection with others who have shared beliefs/practices, or a connection to nature, or the universe, or God - helps create a sense of belonging
- An inner resource that supports personal development and a relationship with oneself
- The mechanism for putting beliefs into practice, offering rituals, traditions, institutions and communities of practice.
Most of these themes were also reflected when participants were asked to define spirituality, but were expressed differently. The following table highlights some areas of similarity and difference in respondents’ views.

**Figure 4  Some definitions of religion and spirituality**

<table>
<thead>
<tr>
<th>What is religion?</th>
<th>What is spirituality?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A higher power</td>
<td>• Inner strength</td>
</tr>
<tr>
<td>• Rituals</td>
<td>• Development of your inner self</td>
</tr>
<tr>
<td>• Beliefs in God</td>
<td>• My relationship with God</td>
</tr>
<tr>
<td>• Believing in the after-life</td>
<td>• Looking into one’s own soul</td>
</tr>
<tr>
<td>• Something formal to categorise a belief system</td>
<td>• Finding out who we are and why we are on this earth, finding out where we come from</td>
</tr>
<tr>
<td>• Something that can comfort me in times of need</td>
<td>• Peace, tranquillity, involving nature</td>
</tr>
<tr>
<td>• A traditional belief system</td>
<td>• Connection with the things you hold important in life</td>
</tr>
<tr>
<td>• A way of life. Believing that there is someone who will reward the good and punish the evil</td>
<td>• Having hope</td>
</tr>
<tr>
<td>• Belonging to a group of people who worship - believe in the same thing</td>
<td>• The belief that there is more to life than humanity</td>
</tr>
<tr>
<td>• A business built on superstition and fear</td>
<td>• Spirituality is the HOW of me. It is how I use my religiousness</td>
</tr>
</tbody>
</table>

Generally, there were more negative connotations about religion and more positive views expressed about spirituality; however some participants were unfamiliar with the term ‘spirituality’ and so were not able to offer a definition. Some saw religion as more divisive: “an excuse to persecute people for no reason”, “It is the reason for most of the war, pain and suffering in the world”, “exploitation by the clergy”, while spirituality was generally viewed as more inclusive: “openness, no boundaries, bigger picture, balanced, accepting all beliefs”, “sense of self, sense of community”. The overall trend was that survey participants generally saw religion as more formal, while spirituality tended to be seen as more fluid and personal. Interestingly, this is in keeping with the literature and is a reminder that spirituality and religiosity are not synonymous (eg. Beers & Berkow 2000, Koslander & Arvidsson 2007, Miller & Thoresen 2003, Schneiders 2003, Williams & Sternthal 2007).

Teasing out distinctions between religion and spirituality makes it harder to draw definitive conclusions; nevertheless, these differences are clearly significant for POWH service users and must be accounted for in any inclusive and responsive health care provision.
Spirituality/religion and health in general

Over 80% of respondents stated that health is affected by religious or spiritual beliefs, and that spiritual or religious beliefs become more important when a person is ill. Whether it is “God’s healing”, “providing comfort”, “inner strength”, “living right” or “a placebo”, nearly 74% agreed that spirituality/religion has an impact on the way that people view health and illness. They argued that it can:

- Act as a support (provide help in troubled times, give strength and peace): “Giv(es) me hope”, “Bring mental peace and confidence”, “Reassures me I am not on my own”, “Give comfort”
- Improve general wellbeing and positivity: “As a result of my faith I have remained healthy”, “You need to believe in something or someone, a process to get through”
- Assist in the healing process: “God can heal us spiritually, emotionally and physically”, “Help the doctors and the nurses with their work”, “Bring healing”
- Provide a guiding framework (guide health decision-making including how to maintain a healthy lifestyle and avoid risk factors, and a more general framework which influences the way that health and illness, and the world in general, is reflected upon and understood): “It’s protected me not to take alcohol, smoke, etc”, “People generally reflect on their lives when in hospital and become more aware…”, “In times of life’s difficulties one turns to one’s faith more strongly”
- Be seen as punishment (illness as divine retribution or an incarnation of sin): “All my wrong-doings in life are reflected in my poor health”, “It’s a fear that if you’re doing bad things in your life you would be punished through illness”, “Some may believe they are being punished because of sinning”, “If I felt my illness was divine punishment it might make me worse”.

Other respondents were less sure of the relationship between spirituality/religion and health. Some felt it depended on contextual factors such as circumstances and level of need, whereas others saw it as delusional and described any perceived impact as “a placebo effect”.

Personal experiences of spirituality/religion and health

The first section of the questionnaire focused on how people see spirituality/religion and health in general, while the second half explored people’s personal relationship to the topic. When asked if spiritual/religious beliefs had an effect on their health, nearly 46% said it did (see figure 5 below). They explained this relationship in terms of providing hope and support, “It has helped me in lots of ways – not directly so much – but reassures me that I am not on my own”, acting as a guiding framework, contributing to wellbeing (eg. increasing their happiness or reducing anxiety and stress), and giving them helpful practices such as meditation and prayer, “If I meditated it would be beneficial”.

17
Figure 5  Question 10: ‘Do you think your spiritual and/or religious beliefs have an effect on your health?’

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>104</td>
<td>45.6%</td>
</tr>
<tr>
<td>No</td>
<td>66</td>
<td>28.9%</td>
</tr>
<tr>
<td>Undecided</td>
<td>41</td>
<td>18.0%</td>
</tr>
<tr>
<td>Not relevant to me</td>
<td>13</td>
<td>5.7%</td>
</tr>
<tr>
<td>Not stated</td>
<td>4</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total</td>
<td>228</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

How people see themselves

Three quarters of people surveyed (74%) said they had spiritual and/or religious beliefs of some kind (see figure 6 below). This figure mirrors the 2001 census findings for religious affiliation (ABS, 2004). However, in the POWH survey, one quarter of these (24% of all respondents) did not identify as religious, only spiritual. These findings support increasing evidence that Australian society is becoming less religious, but more spiritual (Bouma 2002). This has implications for research and administrative data collection because health organisations tend to categorise people as either ‘religious’ or ‘not religious’ and design service delivery systems and patient-centered care models around these two options. Consequently, services may be neglecting a very large group of people who go unidentified.

Figure 6  Question 7: ‘How do you see yourself?’

The following table lists the categories used in the survey. This list was an amalgam of the predominant religious categories from the Australian Bureau of Statistics census, grouped in accordance with the trends in demographic survey questions. The ‘New Age’ category was given more prominence in this research than such a short list usually would to reflect its growing importance in the literature (Bouma 2002). ‘Personal spirituality’ was added based on the findings of the literature review.
**Figure 7**  Question 8: ‘**How would you describe your beliefs?**’

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal-Traditional</td>
<td></td>
</tr>
<tr>
<td>Buddhism</td>
<td></td>
</tr>
<tr>
<td>Other Eastern Religions</td>
<td>eg. Confucianism, Ancestor Veneration, Druse, Taoism</td>
</tr>
<tr>
<td>Christianity: Catholic</td>
<td></td>
</tr>
<tr>
<td>Orthodox</td>
<td>eg. Greek / Serbian / Russian Orthodox</td>
</tr>
<tr>
<td>Protestant</td>
<td>eg. Anglican, Baptist, Uniting Church, Presbyterian</td>
</tr>
<tr>
<td>Other</td>
<td>(please specify)</td>
</tr>
<tr>
<td>Hinduism</td>
<td></td>
</tr>
<tr>
<td>Islam / Muslim</td>
<td></td>
</tr>
<tr>
<td>Judaism</td>
<td></td>
</tr>
<tr>
<td>New Age or Nature Religions or Pagan</td>
<td>eg: Wiccan, Gaian, Shamanism</td>
</tr>
<tr>
<td>Personal spirituality, not necessarily connected to a religious community</td>
<td></td>
</tr>
<tr>
<td>Agnosticism</td>
<td>ie. uncertainty about the existence or nature of God</td>
</tr>
<tr>
<td>Atheism</td>
<td>ie. certainty that there is no God</td>
</tr>
<tr>
<td>Other</td>
<td>(please specify)</td>
</tr>
</tbody>
</table>

A total of 22% of participants selected more than one category in response to this question. This is an important finding because it supports previous studies which indicate that people’s beliefs (and identities) are more fluid and eclectic than standard categorisation allows for. Interestingly, in many cases, this eclecticism overlapped significantly with traditional religious affiliations. For example:

- 25% of those who selected ‘Protestant’ selected at least one other category
- 21% of those who selected ‘Catholic’ selected at least one other category
- 63% of those who selected ‘Buddhism’ selected at least one other category

Figure 8 (below) shows the spread of responses to this question.

**Figure 8**  Question 8: ‘**How would you describe your beliefs?**’

*Some respondents selected multiple affiliations and so are represented in more than one category*
This table shows the number of categories selected by participants.

**Figure 9**  **Question 8: ‘How would you describe your beliefs?’ by the number of boxes selected**

<table>
<thead>
<tr>
<th>Total number of boxes ticked</th>
<th>Number of responses</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>15</td>
<td>7%</td>
</tr>
<tr>
<td>One</td>
<td>164</td>
<td>71%</td>
</tr>
<tr>
<td>Two</td>
<td>38</td>
<td>17%</td>
</tr>
<tr>
<td>Three</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Four</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Five</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>228</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Changing beliefs**

Over half those surveyed explained their beliefs had changed over time. Many talked of a ‘deepening’ faith or spirituality based on personal development or life experience: “As my knowledge widens of the great mystery that is God my personal relationship deepens”, “My beliefs have strengthened over the years”. Some had rejected faith after a period of disillusionment (reaction to rules, dogma, perceived hypocrisy, abuse by an institution or religious leader): “I was raised in a Christian family, but became disillusioned when I recognized the paradox that god cannot be both omniscient and omnibenevolent when so many people are suffering - that and they hate me because I'm gay”, “I was brought up Roman Catholic, but as I grew older, I questioned the hypocrisy and exclusivity of the church”.

**Figure 10**  **Question 9: ‘Have your beliefs changed during your life?’**

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>130</td>
<td>57%</td>
</tr>
<tr>
<td>No</td>
<td>91</td>
<td>40%</td>
</tr>
<tr>
<td>Not stated</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>228</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Life events were a strong influence, both positively and negatively: “Experience has taught me first hand that there is a higher power”, “Life changes you and teaches you to be realistic”. For some, these events confirmed their worldviews: “When I had a heart attack I thought I was going to die. That would be the time to get religious - but it didn't happen then either!” Loss of health, lifestyle, a relationship – frequently a parent, child or partner – either enhanced faith or spiritual awareness or caused people to question their beliefs: “I was a non-believer most of my life until I became HIV+. Had no choice but to believe as it was my strength through a time that was potentially fatal and hopeless”, “When I lost my husband through death I reached for
my God more than any time in my life”, “[My beliefs] have changed since I have been in hospital”, “After my husband’s death, I became more agnostic”.

People identified aging / maturity, critical thinking and personal growth as factors contributing to change: “As I grew and matured, I view my religion differently, but still importantly”, “Developed through learning and experience as well as questioning”, “[As we age] we become more a believer than a follower”, “My beliefs have become more rational and questioning”.

A common theme was the development of a more personalised spirituality - ‘making beliefs mine’ rather than relying on received dogmas: “Was brought up in Catholic home and school but have abandoned strict observance and adherence to this faith for a more polytheistic or spiritual view”, “Greater appreciation of non-Christian relationship with God”. Another theme was greater acceptance of other faiths and practices: “[I moved] from atheism to being willing to listen to ideas”, “I become more receptive to others’ religions and beliefs”, “Less willing to pre-judge beliefs and enjoy my own”.

Communities of belief

Only 43% of respondents indicated they belonged to a community with shared beliefs; that is, had an intentional connection with a place of worship or spiritual group. This suggests there are a significant proportion of POWH patients who have beliefs which are important to them, but who do not necessarily have ready access to others with whom they can discuss their beliefs and share rituals. In many cases these patients may be less likely to have a conceptual framework or the words to articulate their beliefs, practices and wishes because they have not explored their beliefs or assumptions. This has implications for the support we offer patients in terms of referring to chaplains and encouraging the use of positive coping and support resources.

Figure 11  ‘Do you belong to a community with shared beliefs?’
What people want from hospital staff

Over 70% of those surveyed felt it was helpful for hospital staff to know about patients’ beliefs, and confirmed it was all right for staff to ask them. This contradicts the popular idea that patients find it intrusive to be asked about their spirituality/religion (Post 2000). Respondents argued that this knowledge is important for fundamental understanding and building relationships between staff and patients: “I think it helps staff to know where my head’s at”, “So they can gain a better understanding of you as an individual”, “[Because] it’s part of me and my life!”, “It is nice to know they care enough to ask”. Participants also felt this knowledge has a critical role in responsive patient care: “So they show respect for my needs and principles”; “[It is] better if they are informed so they can treat me appropriately”, “[So] the staff is aware of different customs”, “About what things are important and also rituals like what you can and can’t eat”, “Because if I get very sick a priest can be called”, “They have a right to know - maybe they can be more understanding of a patient’s needs”, “Because it helps me”, “A person’s state of mind is very important”. Some respondents saw it as an opportunity to share their beliefs and even proselytise to staff. Many expressed their willingness to discuss spiritual matters and wondered ‘Why not?’; however, several respondents pointed out that they had not been asked about their beliefs or practices and thought it was unlikely they ever would be.

Figure 12  Question 16: ‘When I stay in hospital it is all right for staff to ask me about my religious and/or spiritual beliefs’

A further 8% had not decided if it was all right for staff to about their beliefs. 10% said it was not all right to ask them. The reservations expressed by these respondents were varied. Some felt it depended on staff skills and attitudes, or how sick the patient was. Some viewed it as an unnecessary intrusion into personal matters, while others argued that it would be acceptable only if there was no discrimination or misunderstanding, and providing that staff did not engage in spiritual discussions in order to “preach”.

[Diagram showing response distribution: Yes 72%, No 10%, Undecided 8%, Not relevant to me 7%, Not stated 3%]
Chaplains

Nearly 40% of respondents said they would like to speak to a chaplain. They gave reasons such as a desire for:

- Support and comfort: “I feel they can offer comfort”, “Not only myself, but my family would find comfort in talking to a fellow Christian”, “I feel the support and care would help”

- Help with personal crisis, including serious illness and death: “If I was in palliative care - I believe they are very helpful, especially after seeing chaplain help my dad”, “If I get sicker, I might want to talk to one”

- Guidance (help making meaning, finding a sense of direction): “For understand why the lord has taken me down this path”, “For support and guidance”

- Shared rituals and prayer: “It’s strengthening to be with people who share your beliefs”, “For communion”

- Spiritual access (the chaplain as intermediary to God, able to facilitate healing or peace): “Ask for a prayer to be put up to the Higher One”, “I believe it can reduce my pain and suffering”

- Someone understanding to talk to: “To tell them my pain and my thoughts”, “Sometimes talking to a total stranger is the ‘best medicine’”, “Because I would appreciate them understanding the way I feel”, “Someone impartial but caring to talk to - they do a marvellous job!”

Chaplains were viewed as caring and empathetic, and available for conversations be they spiritual, philosophical or a social chat.

A further 17% of respondents thought they might like to see a chaplain depending on their situation or on the attributes of the chaplain. Some thought they may want support and comfort or someone to talk to, but would not want to be pressured about their beliefs. Some of those who were undecided mentioned respect, impartiality, and compatibility of ideas as prerequisites – strongly suggesting they might like to talk to a chaplain if they could be sure of these attributes.

Of those who said no, some had access to other religious/spiritual support – visitors from their individual church, mosque, synagogue or other community of practice.

Figure 13  Proportion of respondents who would like to talk to a chaplain

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>91</td>
<td>40%</td>
</tr>
<tr>
<td>No</td>
<td>66</td>
<td>29%</td>
</tr>
<tr>
<td>Undecided</td>
<td>38</td>
<td>17%</td>
</tr>
<tr>
<td>Not relevant to me</td>
<td>23</td>
<td>10%</td>
</tr>
<tr>
<td>Not stated</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>228</td>
<td>100%</td>
</tr>
</tbody>
</table>
Rituals, customs and practices

“Ritual is a marking of an ordinary person’s journey which tells them that it is significant and also that it’s gathered into the wider community of universal life and existence.” Dorothy Mcrae-McMahon, 2005

Three quarters (74%) of respondents said that they observed religious rituals and/or spiritual practices that were moderately or very important to them. These practices included meditation, prayer, listening to special music, worship (in a church, temple, mosque), eating and sharing special foods (also fasting), celebrating special days (with their faith community or with family and friends), reading special texts (scriptures and religious/spiritual resources), lighting candles, burning oils, ringing bells, communing with nature (walks on the beach, bushwalking, talking to birds), wearing special clothing or jewelry, dressing according to beliefs, and engaging in martial arts where their dojo was viewed as a sacred place. Several participants responded to this question by telling us they also donate money or volunteer on behalf of their religious community.

A total of 81% of respondents said rituals and customs can help people when they are ill because they:

- Provide a sense of wellbeing, contentment, peace and joy: “Give you inner peace”, “Provide comfort”, “Refresh the soul and allow patients to be in a more positive state of mind”, “They bring calm and peace to my life”
- Give support, strength and comfort: “Alleviate suffering”, “Give hope”, “I feel comfort in knowing I am part of something so special”, “I know they have kept me strong in times of crisis”, “Feeling there is some support in things and events that can’t be proved”, “Feel safe and close to God”
- Are relaxing: “Release of worry and anxiety - hand it over to the lord”, “Relaxation therapies”, “Because it helps me relax”
- Help with healing: “Calming, healing effect”, “Only prayer can help or heal people who are ill and suffering”, “It is important to connect via these things in order for healing and recovery process to occur”
- Help foster a sense of connection (to oneself, others, the Divine, a sense of community and belonging): “To connect with others which provides emotional support”, “Give me confidence in what I believe, make me feel connected to others”, “Feel good, makes me feel connected to the Lord spiritually”, “Togetherness”, “They help connect my spiritual world with a common teaching which others also follow”, “I feel part of a community”
- Offer guidance and facilitate reflection, meaning-making, increased awareness, understanding and acceptance: “I receive guidance from my ancestors and strength from place”, “Makes me actually think about them [my beliefs]”, “It helps me understand myself better”, “Helps myself feel and think more clearly/see things for what they are”
- Carry people through life events and transitions: “Assist the transition for both patient and family”, “I had Madonna in my head when my wife died of cancer”, “Ceremony, ritual and knowing what to say or do can really help”
- Are an opportunity to demonstrate and/or increase faith: “They are an acknowledgement of love”, “They honour God and allow the Holy Spirit to have a greater impact in my life”, “It’s an obligation”
• Can have a positive psychological impact, even if there is no basis for the belief or practice: “It can help people think its helping them - which is always good”, “Psychologically - not sure about any physical effects”, “Not necessarily curing but psychologically yes”, “Placebo effect only”

• Are fundamental to people’s identity and way of understanding themselves in the world: “They make my purpose for living”, “I’m simply obeying his commands”, “It’s just part of the ‘How’ I live my life”, “It helps form a structure to life and why we exist”

Prayer in particular was regarded as “a source of great consolation”. For some people rituals were something they did out of allegiance to tradition or out of habit rather than because of deeply held beliefs.

Question 14 asked, ‘Is there anything that you DON’T do, or try not to do, because of your beliefs?’ Respondents explained that their beliefs impact on decision-making about medical interventions (eg. blood transfusions), the food they eat, their day-to-day actions and healthcare practices (eg. avoiding ‘sin’, respecting the law, not using substances that may be harmful such as alcohol, caffeine or illegal drugs), and the way they treat others (including valuing others, doing good works, being respectful of difference, being forgiving and not harming anyone). Others mentioned general life behaviours (eg. “Be a good person”).

Half (55%) the respondents observed rituals on a daily or weekly basis, and nearly three quarters (74%) felt their rituals were of moderate or strong importance. Of this group, 68% said they would want to continue them in hospital for reasons such as: “It’s who I am”, “Because they are my life and get me through”, “For spiritual and emotional strength”, “To help my family cope with my illness”, “To feel safe”, “Helps reduce stress, helps with sleep”, “They are essential to my health and wellbeing - I also feel prepared should something go wrong”, “To help with the trauma of being hospitalised”, “Keeps me connected”, “To give thanks and ask for help”, “Keeps me calm”, “Gives me a positive frame of mind and I believe in prayer”, “They give me reason to live”.

Figure 14

Question 12: ‘How often do you do things that are connected to your religious or spiritual beliefs?’

- Daily 41%
- Weekly / several times a week 14%
- Monthly 1%
- Several times a year 13%
- Once a year 6%
- Less than once a year 4%
- Never 16%
- Not stated 5%
The theme of being able to ‘do what one normally does’ was prominent with explanations such as: “So I feel normal and balanced”, “Keep up the faith, whilst not in usual place”, “Something familiar in an unfamiliar environment”. Researchers conducting interviews with patients also concluded that, for some, rituals and practices provided a way of expressing their beliefs and values, of somehow asserting their identity in a clinical and sometimes dehumanising environment.

Respondents were asked what particular rituals they would like to continue with in hospital. Responses included access to a place of worship such as a chapel, special food, opportunity to pray and meditate (including reflection and listening to special music), celebrating special days, participating in ceremonies, wearing particular clothing, access to nature, candles and reading. Spiritual conversations or other opportunities for shared spirituality/religion was seen as important and included visits from hospital chaplains or from representative from their own place of worship/significance.

The findings highlight the importance of ritual in people’s lives, and illustrate how they are used as resources during ill health and other life crises. This suggests that health care professionals need to find ways of acknowledging and supporting people’s religious/spiritual practices as part of patient-centred (and family-sensitive) treatment and care.

What people want from POWH

Item 18 on the questionnaire asked participants to complete the sentence, ‘When it comes to religion and spirituality, I would like this hospital to . . .’ Responses showed that people want staff to:

Understand the health significance of their beliefs and practices: “Be aware of and respectful of my beliefs and practices, and acknowledge their contribution to my overall health and wellbeing”, “Understand that how we feel in our spirit has a tremendous influence on the external health of a person”

Ask about their spirituality/religious beliefs and needs: “Be more aware of people’s spiritual beliefs, to be able to talk about this would help”, “Inquire into my beliefs and factor that into my treatment strategy”, “Ask me what my religion is”

Know about and be respectful of the diversity of all beliefs, practices and wishes: “Accept all beliefs and not to judge”, “Be understanding to people’s beliefs and cultures”, “Respect my wishes”, “We need to know about other people’s beliefs and respect them”, “Have an understanding of most religions and spiritual beliefs and respect everyone’s belief”, “Use moderation and respect those who don’t want religion in their face”, “Allow me my privacy”, “Do not use emotional blackmail or shock tactics to coerce patients into treatments they reject because of their religious beliefs - consider alternative treatment”, “Be aware of different beliefs and customs and acknowledge the differences”

Support people in their religious/spiritual observance: “Enable people to continue with their religious practices without, of course, forcing anybody or disturbing other patients”, “Respect my beliefs and let me practice them”, “Allow me to practice my own customs and rituals”
Provide and facilitate access to resources, including chaplains: “Have a chapel or a place of peace and quiet where a person can meditate or pray”, “Have pastoral care workers available if I need them”, “Identify beliefs and get pastors appropriate”, “Offer it to me to accept or reject”

Provide a generally nurturing environment with an emphasis on patient-centred care: “Be compassionate to all”, “Let people express their feelings”, “Paint healing colours”, “Have a view of trees, some open windows so I can glimpse the natural world”, “Be aware of each individual”

Some respondents simply asked for staff to continue doing what they already do, while others preferred not to be asked and expressed a desire to be left alone.

Summary of major themes and findings

Throughout the survey several themes consistently emerged:

Religion and spirituality do play a role in health and health care decisions
Religion and/or spirituality is an extremely important part of life for many people, guiding their lifestyle choices and medical decision-making, and frequently gaining significance in situations of crisis, anxiety and pain. Therefore, it is an integral part of the health experience.

People’s beliefs and practices are eclectic and individualised
The survey findings support the view in the literature that, for many, spirituality/religion is personalised and influenced by a diversity of beliefs and practices from a range of religious and cultural traditions and contemporary movements which, themselves, often reclaim or reinvigorate ancient wisdom or practices from around the world (Tacey 2003c). Indeed, even within the same faith group or denomination there can be a huge diversity. Figure 15 illustrates this point:

Figure 15  A comparison of 4 responses from POWH survey participants

<table>
<thead>
<tr>
<th>How would you describe yourself?</th>
<th>How do you see yourself?</th>
<th>To me, religion is…</th>
<th>To me, spirituality is…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>Religious</td>
<td>“Something to ease the pain when close family die”</td>
<td>“Being kind to other people”</td>
</tr>
<tr>
<td>Catholic</td>
<td>Spiritual</td>
<td>“Strength and comfort that can be taken from a power greater than oneself”</td>
<td>“A path that when adhered to can bring over all happiness and wellbeing”</td>
</tr>
<tr>
<td>Catholic</td>
<td>Religious and spiritual</td>
<td>“The basic beliefs and standards of that church”</td>
<td>“Understanding that a body is separate to the spirit - together they are the soul”</td>
</tr>
<tr>
<td>Catholic</td>
<td>Not religious or spiritual</td>
<td>“Organised structure of beliefs generally forming a community”</td>
<td>“The belief that there is more to life than humanity”</td>
</tr>
</tbody>
</table>
Therefore, when it comes to understanding a person’s beliefs and practices we cannot rely on classifications such as ‘Catholic’ or ‘Christian Orthodox’ or ‘Muslim’, because traditional, neatly defined categories do not reveal meaning.

This is a reminder that language can be problematic and open to multiple interpretations; two people using the same familiar term may mean very different things by it. In order to support people’s powerful spiritual resources, we need to understand the role spirituality/religion plays in each patient’s life, from their perspective. This means that shared understandings need to be explored rather than assumed.

**Spirituality/religion as a resource**

Religious faith and spirituality, and the practices associated with these beliefs, can enhance health by offering hope, meaning, strength, comfort, guidance, stress reduction, a sense of connection, and a feeling of familiarity and safety in unfamiliar or frightening circumstances. Rituals help families as well as patients to cope with distressing situations, including dying and death. Practices such as meditation have also been shown empirically to have beneficial psychological and physiological effects (Williams & Sternthal 2007).

**People’s beliefs and practices evolve, and respond to life events**

Spiritual/religious beliefs and practices are not fixed. They change as a result of maturity, reflection and critical thinking, and in response to life events. Health problems/crises and loss can have a profound impact on beliefs, which means that spirituality/religion may be more significant during hospital admission than at other times.

**Respect**

Survey participants overwhelmingly asked that hospital staff show respect for everyone’s religious beliefs and practices. They also asked for “awareness”, “understanding”, “compassion”, “encouragement” and “support” in relation not only to their own beliefs and customs, but to the beliefs and customs of others as well.

**Most people want their spirituality/religion to be incorporated into their health care**

The survey results clearly show that the majority of POWH service users felt it was helpful for hospital staff to know a patient’s beliefs, and confirmed it was all right for staff to ask them. Many of those who expressed uncertainty said it depended on circumstances or the attributes of those providing care.

**Spirituality is a dimension of holistic, person-centred health care**

Spirituality/religion is clearly an aspect of ‘the whole person’, and the way we care for people must reflect this. Understanding and supporting patients’ beliefs and practices helps ensure that we:

- maximise patients’ resources
- understand their beliefs and views about their health situation
- consider their views and incorporate them into treatment plans
- facilitate authentic, caring dialogue
- provide spiritually sensitive care (eg, culturally appropriate food, supporting important rites and rituals, calling a Chaplain).

Respondents themselves emphasised the need for person-centred practice - for themselves and for others.
Implications for practice: some challenges

As this research shows, people’s religious/spiritual worldviews and practices are eclectic and individualised; they are evolutionary – shifting in response to personal development and life events; and the words, concepts and imagery used to express them vary from person to person. This presents some specific challenges for staff.

Eclectic and individualised beliefs and practices
- How do we ask the right question(s)?
- How do we document eclectic beliefs / practice meaningfully?
- How do we reach an understanding of those beliefs / practices and help our colleagues to understand them?
- How do we support them?

The changing nature of beliefs
Currently, we base our understanding of beliefs on a box on our admission form which asks patients to state their “Religion/denomination”. The answer (if one is given/taken) forms the basis of our understanding not only during that admission, but also for subsequent admissions. But:
- What if the patient’s beliefs and/or practices have changed since the last admission? How would we know?
- How do we know if they have changed during their admission (maybe in relation to diagnosis / prognosis, or as part of the reflective spirituality/religion that often takes place in response to major life events such as health crises)?

The complexity of language
Spirituality and religion are, for the most part, not tangible entities. Talking about them requires some abstract ideas and conceptual leaps – particularly when we are dealing with diverse beliefs and practices. Language is a powerful tool but it is used differently by different people at different times in their lives, conveying different values, and personal and cultural nuances. The same term can be seen by one person as inclusive and open to multiple meanings, but by the next person as excluding, oppressive and alienating.

So, how can we ask patients and families about their beliefs in a manner that is flexible and responsive but also specific and clear? This is includes ensuring we use interpreters where needed.

Including Spirituality
The survey clearly supports the argument that spirituality and religion are not synonymous, and that spirituality (as distinct from religion) is important to a significant proportion of our patients and families (24%, a quarter of the sample). This highlights the inadequacy of research and data collection processes which generally only focuses on religion (Rumbold 2007). Perhaps the tendency to collapse the concepts and focus on religion is partly due to the elusive nature of the concept of spirituality and the very individualised ways in which it is understood. Indeed, when survey respondents were asked to define ‘religion’ and ‘spirituality’:
- Some people didn’t see a distinction between religion and spirituality
- Some were very negative about religion but not spirituality
- Others were positive or negative about both equally – but still tended to describe them differently
• Some told us they didn’t understand the term spirituality
• Others left these definitions blank, even though they filled in free-text answers in other parts of the questionnaire
• Although there were overall trends in the way that people described the concepts, no two respondents described ‘spirituality’ in exactly the same way (whereas many participants described religion as “Believing in God” or “Belief in God”).

How can we develop inclusive methods of data collection that ensure we ask about spirituality as well as religion?

Cultural and political issues
This research generated a great deal of dialogue and emotion, perhaps influenced by the broader socio-political climate and the impact of religious discourse in the media and on international events. In interviews people linked their beliefs (either positively or negatively) to topics such as war, terrorism, Western military engagement in Iraq, the holocaust, the rise of Christian fundamentalism in the USA, and The Da Vinci Code (a popular book and film).

For some people spirituality/religion is a personal and taboo subject. For others, there are many deeply held assumptions and prejudices. Therefore, one of the major challenges in this area is, “How do we ask questions in a manner which does not offend or feel intrusive or threatening?”

Paradigms
Modern Western medicine is founded on the scientific method and privileges evidence-based solutions. The model favours empirically derived data, and sees the world in terms of external truths that are out there waiting to be discovered through rigorous testing; truths that can be wholly known and owned by humans. This way of seeing the world does not sit comfortably with spiritual/religious worldviews which are eclectic and individualised, which cross paradigms, which have different emphases and meanings, which are evolutionary – shifting in response to life changes and events, which have spiritual truths that will always transcend human ownership, and in which faith and feelings and personal experience replace facts. How can we straddle these differing world views and help those health professionals who remain bio-centric to value the role that spirituality/religion plays in health care?

A framework for spirituality sensitive health care practice

While the challenges outlined above are significant, they are far from insurmountable, particularly as health systems are increasingly moving towards holistic, patient-centred approaches which embrace a biopsychosocial model of care, which place a strong emphasis on collaboration and effective communication, and which focus on understanding health care needs from the patient’s perspective. Indeed, interviews with POWH staff suggest that they recognise the value of this approach, feel most comfortable it, and see it as their modus operandi. This is consistent both with the pastoral care model and with Diversity Health principles

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3 As Rumbold explains, in the “biopsychosocial framework... spirituality is related to quality of life and is thus one of the individual characteristics that shape health beliefs and motivations. It affects compliance and outcomes, and is thus legitimately an area of interest for clinicians”. (2007 p.60)
which take a strengths-based approach, one that recognises that the patient has the right to have control over their health and health care decisions. Therefore, given that health staff are already becoming more sensitised to the patient’s experience, and more skilled in relating to patients and families as ‘whole people’, it may simply be a question of supporting staff to (further) integrate the spiritual dimension into their current best practice.

Miller and Thoresen (1999) suggest 5 factors which are required for staff to adequately address the important relationship between spirituality/religion and health in the health care context:

1. **Patient-centred engagement**
   
   "Establish a non-judgmental, accepting, and empathic relationship with the client."^4

   The patient-centred approach allows patients to express what is important to them in their own time, using their own language. In this way generalisations are avoided, and values and priorities are not assumed but explored in discussion (Cox 2001). Just as clinicians are considered experts in professional knowledge, patients are recognised as experts in their own lives. As respected and informed partners, patients and clinicians are able to negotiate and plan actions collaboratively that are acceptable for both parties. Thus, patient-centred practice is conducted in participation with patients rather than done to them.

   In considering the spiritual/religious dimension of each patient, staff are sending an important message that they are concerned with the whole person. This enhances the opportunity for collaborative approaches between staff and patients, families and carers. Health professionals are the keepers of health care information, treatment and care. They are in a position of great power and authority which, as Puchalski (2001) notes, can be used beneficially to support patients by listening and supporting responsively, rather than leading.

   This engagement is particularly important given the inadequacy of current admission procedures in assessing and documenting patients’ beliefs and practices. For more information and a discussion of this issue see Haynes, Hilbers, Kivikko & Ratnavyuha. 2007, *Spirituality and Religion in Health Care Practice: a person-centred resource for staff at the Prince of Wales Hospital*. SESIAHS, Sydney. Available at: [http://sesiweb/POWH/DiversityHealth/PDFs/Spirituality_resource.pdf](http://sesiweb/POWH/DiversityHealth/PDFs/Spirituality_resource.pdf)

2. **Valuing and addressing patients’ spiritual worldviews**

   "An openness and willingness to take time to understand the client’s spirituality as it may relate to health issues."^5

   Addressing patients’ beliefs and practices involves responding to the clues patients give us about their spirituality/religion but also, in many contexts, actively asking about their beliefs and practices as part of the process of on-going engagement, assessment and care:

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^4 Miller & Thoresen 1990, p.10
^5 ibid
• **Being aware of and responding to patient cues.**

Cues can be implicit statements such as “I keep wondering why this is happening to me” or “Perhaps it was meant to be”, or explicit cues such as crossing oneself, holding rosary beads, praying, wearing faith-specific insignia or dress or making overt statements such as “I pray that I won’t have to make that decision” or “It’s in the hands of God”. Such cues give us an easy opening to ask further questions so we understand the patient/family member’s spiritual worldview and give them the opportunity to express their feelings and tell us of any way in which we can support them.

• **Judging if and when to ask strategic questions**

Depending on the context, clinicians have a responsibility to ask strategic questions in order to ascertain spiritual needs. Staff need to use their professional judgement and communication skills to develop suitable questions for their treatment context, and to use them selectively to gently facilitate discussion and avoid a feeling of ‘interrogation’. Questions should be used sensitively and supportively, and prefaced with a rationale which puts them in context, eg. “It can help us to provide better treatment and care if we understand your point of view”, or “Religion or spirituality is important for many people when they are in hospital, so I would like to ask you a question about it if I may”.

Staff may use indirect questions which do not assume a spiritual dimension, eg. “Where do you get your strength from?” or “Who or what supports you in life?”, or direct questions in contexts when the clinician considers that spirituality or religious belief is likely to play a significant role in their patient’s health, eg. “Do you have any religious or spiritual beliefs that you would like staff caring for you to be aware of?” or “Would you like to talk with someone about religious / spiritual matters?”

These questions facilitate improved understanding and thereby enable more accurate assessment, better treatment planning and more responsive service provision - all of which are crucial to positive outcomes.  

It is worth noting that much of the literature on religion and health, particularly in the American context, advocates using a standardised ‘religious assessment’ tool or inventory (Anandarajah 2001, Galek, Flannelly, Vane & Galek 2005). Such an approach can be limited. The use of standardised tools in relation to other health issues has been found to be culturally unresponsive because they do not accommodate for the range of worldviews and experiences (Helmen 2001). This involves making assumptions about what is valued and what is not, with an onus on the extent to which an individual fits in with the culture and practices of the system in which the questions are asked (eg. beliefs and practices may be seen as mainstream and acceptable, or as misguided and problematic). Additionally, quantifiable instruments employ a theoretical framework that sits uncomfortably with spirituality/religion. For example, it is highly unlikely that any assessment tool using prescribed questions could meaningfully capture and present the diversity of beliefs and practices revealed in the POWH research (Cobb 1998, Rumbold 2007).

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If we want meaningful answers, we have to ask appropriate, meaningful questions. This requires an emphasis on engagement and communication skills. Therefore staff are encouraged to integrate the consideration of spiritual matters into their everyday practice, using the same person-centred communication skills they employ when talking with patients and families about other issues. In this way, identifying and responding to spiritual needs becomes individualised, allowing staff to approach and respond sensitively to each patient in their context.

3. Sensitivity to cultural diversity and practices

“Some familiarity with culturally related values, beliefs and practices that are common among the client populations likely to be serviced”

It is undoubtedly useful to have an understanding of how religious beliefs may impact on attitudes toward Western health practices and specific medical procedures, and to have an overview of the documented beliefs and practices of the community’s major cultural groups; however, it is not practical for staff to learn everything about every community who uses their services, nor is it possible to apply this knowledge to patients as if they are part of an homogeneous group rather than individuals who may be engaging with religion and/or spirituality in any number of personal and shifting ways. This issue can be a major stumbling block for staff who request information about specific religious/cultural groups in the hope that the information alone will enable them to provide spirituality sensitive care. Pargament and Mahoney point out that, “In our efforts to help people, we have to be especially sensitive to the diverse ways they experience and express their spirituality” (2002, p. 656). Some cultural understanding is beneficial because it can provide a starting point, but it is not as important as the ability to engage the patient in supportive, non-directive discussion about their beliefs and practices, and the willingness to liaise with other relevant professionals in support of the patient’s spiritual care. As the familiar adage reminds us: Don’t assume, ask!

4. Self awareness and communication skills

“Comfort in asking and talking about spiritual issues with clients”

Although there is great diversity across health services, with spectrums of beliefs and practices similar to those of the wider community, the literature suggests that health professionals tend to be less religious than the general population (Faber-Langendoen & Karlawish 2000, Peach 2003), possibly due to a scientific worldview that does not generally include spirituality/religion. Nevertheless, the individual beliefs of health professionals should not impact on their ability or willingness to incorporate spirituality/religion into their practice since it is clearly a dimension of holistic care. Thus, personal beliefs are superseded by the over-riding philosophy of patient-centred care in which patient needs are not only medical, but “biopsychosocial-spiritual” (Rumbold 2007 p.60). Two key skills, currently being emphasised across training in the health-related disciplines, underpin the incorporation of spirituality/religion into care:

(1) Reflective practice in which the professional has an awareness of themselves and their impact on others, continues to learn in their day-to-day work, and puts their learning into action as improved practice. The reflective practitioner may feel

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7 Miller & Thoresen 1990, p.10
8 ibid
uncomfortable talking with patients about spirituality/religion, but will work to develop a way of thinking about and tackling the issue which facilitates best practice.

(2) **Person-centred communication skills** which convey empathy, respect, trustworthiness and a willingness to work collaboratively with patients and their families. The flexible, open and responsive dialogue associated with person-centred care allows the patient to guide discussion of spirituality/religion and the professional to listen actively and support, without fear of being presumptuous, directive or untrue to their own beliefs. Sensitivity to the patient’s context and their communication cues minimises the danger of misunderstanding, despite the complex nature of spirituality and the very different ways it is conceptualised and articulated.

5. **Consultation, referrals and teamwork**

“A willingness to seek information from appropriate professionals and coordinate care concerning clients’ spiritual traditions”

**Using chaplains**

Chaplains are a valuable but often underused resource at POWH. Indeed, as Post et al (2000) note, “Referrals to chaplains can be critical to good health care for many patients, and can be as appropriate as referrals to other specialists.”

Chaplains can be used by health professionals to:

- provide active listening, caring and empathy for patients, their families and carers
- offer support across whole-of-life, not just end-of-life
- facilitate rituals, group work and spiritual/religious services
- participate in team meetings and case conferences
- liaise with and arrange visits from religious representatives from the patient’s faith community
- provide spiritual/religious support for staff
- provide expert consultation on a breadth of spiritual and religio-cultural beliefs and practices

POWH Chaplains are trained professionals who work in accordance with both health and chaplaincy policies and procedures. Chaplains represent the major faiths and traditions (Christian, Jewish, Muslim, Buddhist, etc.) but are committed to the NSW Health pastoral care model which emphasises an holistic, non-judgemental, non-directive and supportive approach that is open to the diversity of lifestyles, practices and beliefs. It is important that staff are aware of this practice model because POWH research found that some patients were interested in speaking with a chaplain but had concerns they would be preached to, be judged due to their sexuality or lifestyle practices, be regarded as undeserving because they had ‘lapsed’, or that chaplains would only administer according to doctrine rather than listening and exploring on the patient’s own terms. Others believed chaplains only tend to patients when they are dying. Therefore, it may be useful for staff to let patients and family members know that chaplains are available for a range of services, including their main work which is to be with patients, listen to them and provide support.

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9 Miller & Thoresen 1990, p.10
Incorporating spirituality/religion into teamwork

An individual member of staff may have a meaningful conversation with a patient, but keep this knowledge to themselves. Holistic, person-centred practice means that the patient’s spirituality/religion should be part of the clinical record, unless the patient requests otherwise. This means that staff should clearly document patient needs, response to needs and outcomes; should handover any pressing issues; and should work collaboratively with the multidisciplinary team (and link with other agencies when required - chaplains can help with this) to ensure needs are met.

Ethical guidelines

Winslow & Wehtje-Winslow (2007 p.63-5) offer an ethical framework to help practitioners reflect on and make decisions about how to integrate spirituality/religion into their practice:

1. In order to provide respectful care, health care professionals should seek a basic understanding of patients’ spiritual needs, resources, and preferences
2. Respect for the patient requires that health care professionals follow the patient’s expressed wishes regarding spiritual care
3. Health care professionals should neither prescribe spiritual practices nor urge patients to relinquish religious beliefs or practices
4. Health care professionals who care for the spiritual needs of patients should seek to understand their own beliefs
5. Participation in spiritual care should be congruent with professional integrity (ie. staff should not say or do anything that is personally inauthentic or inconsistent with their professional role – including feigning convictions).

These guidelines underpin the practice framework and remind us that we have a duty to include spirituality/religion in our practice as a dimension of patient-centred model of care, but that we must also be attentive to the boundaries that guide this encounter, both personally and professionally.

Future directions

The research data will be used to develop education initiatives and data management proposals. A resource and action summary have been designed to support staff in their understanding of and response to the diversity of people’s religious and spiritual beliefs, practices and wishes.

Specific recommendations arising out of this research include:

1. **A hospital policy on spirituality/religion**
   Develop a policy which is representative of the diversity of views and includes practice guidelines that are flexible and responsive to individual and contextual needs.
2. Learning opportunities

Provide opportunities for education and dialogue about the role of spirituality/religion in health care. The Spirituality and Health Forum and associated workshop, Simple Rituals in Health Care, held in October 2005 established a foundation for future training, education and staff development to include:

- non-judgemental exploration of different paradigms
- continued dialogue about the roles and responsibilities of staff in relation to spirituality/religion
- discussion of practice frameworks presented in this report and in the staff resource with a view to amending them or building on them
- opportunities for staff to reflect on their own attitudes, beliefs and perceptions about how these impact on their practice
- staff practising spiritual/religious assessment skills such as active listening and facilitating discussion of spiritual worldviews (as outlined in the staff resource below).

3. Staff resource

Encourage staff to use the resource: *Spirituality and Religion in Health Care Practice: a person-centred resource for staff at the Prince of Wales Hospital*. Team discussion and professional development sessions may be organised to familiarise staff with the concepts and strategies outlined in this document.

4. Additional spirituality/religion resources

Create safe, respectful spaces for staff, patients, families and carers to explore and nurture their individual beliefs. One example is Soul Food, a monthly gathering combining meditation, shared reflection, the creativity of art and music, simple ritual, ancient wisdom and contemporary spirituality to create a unique experience in the hospital setting.

5. Data collection

Improve and refine the collection of data. The descriptor a patient uses on their admissions form has a direct impact on the services and information they receive (eg. visits from chaplains, information about the chapel, offers of special food). It is recommended that the ‘religion/denomination’ field currently in use on the admissions form be changed to:

1. Are you religious or spiritual?
   - Yes [ ]
   - No [ ]

2. If yes, please describe …………………………..

3. Please tick the box if you would you like this information withheld from the Chaplaincy Service [ ]

4. Please tick the box if you would like to see a chaplain while you are in hospital [ ]
Conclusion
This research provides some baseline understanding of spirituality/religion in the Australian health care context. It takes a broad perspective and begins to tease out some of the myriad ways in which patients and their families conceptualise and practice spirituality and religion, and how they would like health professionals to respond to the challenging issue of incorporating spirituality into mainstream health care practice. As such it provides useful information about the diversity of contemporary beliefs and practices which, in turn, can assist health care practitioners to develop more sensitised, person-centred practice that responds to the contextual and dynamic nature of this issue.
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Appendix A: Thematic Analysis (research phase 1)

Respondents talked about their spirituality on four major ‘subject’ axes. These are illustrated in Fig 1.

Fig 1: Principle themes arising from respondents’ description of their spirituality

<table>
<thead>
<tr>
<th>axis</th>
<th>ranged from … to …</th>
</tr>
</thead>
<tbody>
<tr>
<td>theological</td>
<td>exclusive → inclusive</td>
</tr>
<tr>
<td>locus of control</td>
<td>external → internal</td>
</tr>
<tr>
<td>emotional response</td>
<td>comfort → discomfort</td>
</tr>
<tr>
<td>action/practice</td>
<td>integrated → not integrated</td>
</tr>
</tbody>
</table>

Subjects tended to place themselves somewhere on a continuum from exclusive to inclusive for theological perspective, external to internal when placing themselves in a god-related control locus, comfortable to uncomfortable when describing emotions around spirituality and integrated to not integrated (or separate) when describing relationships between spirituality and everyday life.

Theological
In relation to the theological (or me in the context of the universe) axis, professed Christians and Jews tended to be exclusive – their focus was on a having a relationship with God/Jesus or God/Jewish community. Other subjects tended to include things not normally attached to organised religion, such as the environment or were eclectic in their position and integrated western and eastern philosophies. Similar to this, holistic positions were identified - recognising and valuing all belief systems. Also exploratory positions were voiced (e.g. questioning the meaning behind coincidences). An example of a holistic approach as voiced:

“… religion is like a tree, and the tree is the main cause of all the common ideas throughout all of the religions at the trunk of the tree and then the tree has branches, so one branch is Christianity, and another branch is Hindu, one branch is Voodoo, and one branch is Buddhist and so on and so forth. And the gardener is obviously a God or whatever you think the God to be…”

Locus of control
When discussing belief systems, respondents discriminated themselves on a kind of God-related locus of control. Externally driven belief systems either viewed the individual as subject to the God’s power (often Christian) or ‘sharing’ the universal with a or the God (often eclectic/holistic). Internally driven belief systems (e.g. atheist) did not recognise a higher power, and viewed all meaning and life force as coming from within. Individual control of destiny was fundamental to this position.

Another group was ‘neutral’ in relation to control – they just didn’t conceive their spirituality/relations with God in a ‘control/controlled’ mosaic. All respondents regardless of their appraisal of locus of control, expressed non-prescriptive views re
other people’s right to pursue their own belief systems. Very little outright dogmatism was encountered in the discussions.

*Emotional*
Many respondents discussed their emotional responses to spirituality. A continuum from emotional/psychic comfort to discomfort was identified. Comfort was equally distributed across all believing positions, though those in undecided and eclectic camps at times expressed worry about their position:

“I can’t bring myself to believe in god…I’m jealous of believers”

*Acting in the world*
Finally, the degree to which respondents’ belief systems were integrated into everyday behaviour was identified as a sentinel axis. Most saw their spiritual/religious beliefs to be key influencers of their behaviours/actions. For the Christians, this entailed a sense of trying to act in the way God would like – an ongoing will-based struggle to act well, if you like. For those with eclectics or more holistic world views belief was more of a ‘backdrop’ to action and action was not seen as entirely self- or will-driven. Notions of destiny were often brought into the talking by these respondents.
Appendix B: Survey Instrument

**Spirituality & Religion Questionnaire for Patients**
(and their family and friends) **at the Prince of Wales Hospital**

**What is this for?**

We are doing this survey because we want to improve our understanding of the religious and/or spiritual beliefs of the people who use this hospital. We also want to know how people would like their beliefs and practices to be considered when they are in hospital. This survey is part of a larger project called The Spirituality Project which was developed by Diversity Health and the Chaplains Service, and has been running at the Prince of Wales Hospital for several years.

**What would you like me to do?**

If you are a patient (even if you are just here for an appointment), or if you are the spouse, partner, relative or friend of a patient (and you are 18 or older), we want to hear from you. Please fill out this form and put it in one of the envelopes marked Spirituality and Religion Questionnaire. It should take you between 5 to 15 minutes, depending on how much you write. This survey is completely voluntary so you can complete as much as you like - all of it, or part of it, or none of it.

**You DO NOT have to be religious or spiritual to fill out this form. We want to hear from EVERYONE, no matter what your background or beliefs may be.**

**What will you do with the information in this questionnaire?**

We will use the results of this survey to educate hospital staff about what patients and their families want. It will help us to develop policies and procedures that meet the spiritual and/or religious needs of people who use the hospital.

Although you will not receive any direct benefits from filling in this questionnaire, we believe it will benefit patients, their families and hospital staff in the future because it will help us understand more about the beliefs and wishes of people who use the hospital.

**Will any of my private details be used?**

No. This form does not ask for your name or contact details or patient number, or any other information that would allow us to identify you. If you write in the blank spaces we may quote you, but we will not use any quotes that include identifying information.

**Can I talk to someone about this?**

Yes. If you have any questions or concerns, please contact us: Abby Haynes or Julieanne Hilbers in Diversity Health ☏ 9382 3306, or Jennifer Kivikko at the Chaplaincy Service ☏ 9382 2131. If you wish to make a complaint please contact the Ethics Secretariat ☏ 9382 3583, email kim.breheny@sesiahs.health.nsw.gov.au.
There are 18 statements and questions on this form. Please tick (✓) one box for each answer:

Tick **Yes** if you agree with the statement

Tick **No** if you disagree

Tick **Undecided** if you are not sure, or you think it depends

*After each statement or question there is some space for you to explain your answer or tell us more. You don’t have to write in this space, but if you do it will help us to understand your answers.*

**Religion and Spirituality**

This section is about religion and spirituality *in general*

1. **Spiritual or religious beliefs can have an effect on people’s health**
   - Yes ☐
   - No ☐
   - Undecided ☐

2. **Spirituality and/or religion becomes more important when a person is unwell**
   - Yes ☐
   - No ☐
   - Undecided ☐

3. **A person’s spiritual or religious beliefs influence how they view health and illness**
   - Yes ☐
   - No ☐
   - Undecided ☐

4. **Rituals and customs can help people when they are ill or suffering**
   *These may include traditional rituals and customs, or personally meaningful things. Some examples are: lighting candles, listening to special music, burning incense, prayer, holding a significant object, meditation, anointing with oil, ceremonies, walking on the beach, etc.*
   - Yes ☐
   - No ☐
   - Undecided ☐

5. **It is helpful for hospital staff to know about a patient’s religious or spiritual beliefs**
   - Yes ☐
   - No ☐
   - Undecided ☐
You and your beliefs

This section is about you and your personal beliefs and wishes. People see things very differently, so please try and tell us as much as you can to help us understand the way you see things:

6. Please complete these two sentences:

   For me, religion means............................................................................................................................
   .................................................................................................................................................................
   .................................................................................................................................................................
   For me, spirituality means...........................................................................................................................
   .................................................................................................................................................................
   .................................................................................................................................................................

7. How do you see yourself?

   Religious  ☑  Spiritual  ☐  Religious and spiritual  ☐  Not religious or spiritual  ☒

8. How would you describe your beliefs? Please tick the box or boxes that describe you best

   Aboriginal-Traditional  ☐
   Buddhism  ☐
   Other Eastern Religions eg. Confucianism, Ancestor Veneration, Druse, Taoism  ☐
   Christianity: Catholic  ☐
   Orthodox eg. Greek / Serbian / Russian Orthodox  ☐
   Protestant eg. Anglican, Baptist, Uniting Church, Presbyterian  ☐
   Other (please specify)  ☐
   Hinduism  ☐
   Islam / Muslim  ☐
   Judaism  ☐
   New Age or Nature Religions or Pagan eg: Wiccan, Gaian, Shamanism  ☐
   Personal spirituality, not necessarily connected to a religious community  ☐
   Agnosticism ie. uncertainty about the existence or nature of God  ☐
   Atheism ie. certainty that there is no God  ☐
   Other (please specify)  ☐

9. Have your beliefs changed during your life? Yes ☐ No ☒

Please tell us more about your answer so we understand it better:

   .................................................................................................................................................................
   .................................................................................................................................................................
   .................................................................................................................................................................

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10. Do you think your spiritual and/or religious beliefs have an effect on your health?
   Yes ☐  No ☐  Undecided ☐  Not relevant to me ☐

11. Do you do things which are connected to your spiritual and/or religious beliefs?
    (eg. observe special days, attend a place of worship, pray, perform simple rituals, eat special meals, meditate, wear special clothes or ornaments, go to ceremonies, recite special words)
   Yes ☐  No ☐  Undecided ☐  Not relevant to me ☐
   What are these things? ………………………………………………………………………………………………………
   ……………………………………………………………………………………………………………………………
   How do they help you feel more connected to the things you believe in? ……………………………………….
   ……………………………………………………………………………………………………………………………

12. How often do you do things connected to your religious or spiritual beliefs?
   ☐ daily     ☐ weekly     ☐ monthly    ☐ several times a year    ☐ once a year    ☐ less than once a year    ☐ Never

13. How important are these things to you?
    Very important ☐  Moderately important ☐  Not important ☐  Not relevant to me ☐
    ……………………………………………………………………………………………………………………………
    ……………………………………………………………………………………………………………………………

14. Is there anything that you DON’T do, or try not to do, because of your beliefs?
    Please explain…………………………………………………………………………………………………………
    ……………………………………………………………………………………………………………………………
15. When I stay in hospital I would like to continue with my usual customs or rituals
   Yes ☐ No ☐ Undecided ☐ Not relevant to me ☐
   If Yes, which ones? ..........................................................................................................................  
   ..........................................................................................................................................................  
   Why? ....................................................................................................................................................  

16. When I stay in hospital it is all right for staff to ask me about my spiritual and/or religious beliefs
   Yes ☐ No ☐ Undecided ☐ Not relevant to me ☐
   Why? ....................................................................................................................................................  
   ..........................................................................................................................................................  

17. When I stay in hospital I would like to talk to a chaplain or a pastoral care worker
   Chaplains and pastoral care workers are available to listen and be present with patients and their families. They represent the major faiths and traditions, but offer support to all people, whatever their backgrounds or beliefs
   Yes ☐ No ☐ Undecided ☐ Not relevant to me ☐
   Why? ....................................................................................................................................................  
   ..........................................................................................................................................................  

18. Please complete this sentence
   When it comes to religion and spirituality, I would like this hospital to ........................................
   ..........................................................................................................................................................  
   ..........................................................................................................................................................  
   ..........................................................................................................................................................  

Don’t go yet...
Please turn over and fill in the back of this questionnaire. The information in this final section is important and will help us understand the similarities and differences between different patients and visitors.
About you

Are you female or male?  Female ☐  Male ☐

Why are you here today?
☐ I have an appointment / emergency  (you have an appointment or are here in an emergency)
☐ I am a day patient  (you are here for a day-only procedure and will go home tonight)
☐ I am an overnight patient  (you stayed in hospital last night, and/or will stay here tonight)
☐ I am the partner or relative or friend of a patient  (you are visiting or here with a patient)

What country were you born in? .................................................................

What language(s) do you speak at home? ..................................................

Are you Aboriginal or Torres Strait Islander?  Yes ☐  No ☐

How old are you?
☐ 18 to 24  ☐ 25 to 34  ☐ 35 to 44  ☐ 45 to 54  ☐ 55 to 64  ☐ 65 to 74  ☐ 75 or over

Do you belong to a community with shared beliefs?
☐ Yes, a religious/spiritual place of worship (eg. church, mosque, temple, synagogue)
☐ Yes, a spiritual group (meeting informally with people who share my beliefs)
☐ Yes, both of the above
☐ No, I don’t belong to any community with shared beliefs
☐ Other (please explain) ..................................................................................

Please tick (✔) the box if you filled out this form for someone else  ☐

Is there anything else you would like to tell us about yourself, or about this topic?
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Thank you for helping us with this survey

Office administration

Ward / Clinic code:  Data input:
Date of administration:  Admin method:

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## Appendix C: Participating Wards and Clinics (research phase 2)

<table>
<thead>
<tr>
<th>POW hospital wards &amp; clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged care Acute - P2E</td>
</tr>
<tr>
<td>Aged Care Acute - P2W</td>
</tr>
<tr>
<td>Aged Care Rehab annex</td>
</tr>
<tr>
<td>Albion Street Centre</td>
</tr>
<tr>
<td>Cardiology - D3N and D3S</td>
</tr>
<tr>
<td>Coronary Care Unit - D3</td>
</tr>
<tr>
<td>Diabetes Centre</td>
</tr>
<tr>
<td>Emergency - D0</td>
</tr>
<tr>
<td>Endoscopy Day Only - CC2</td>
</tr>
<tr>
<td>Eye Clinic</td>
</tr>
<tr>
<td>Haematology Short Stay - P10</td>
</tr>
<tr>
<td>Haematology Unit - P10</td>
</tr>
<tr>
<td>Eora Dialysis Centre</td>
</tr>
<tr>
<td>Kidney Care Centre - PW3</td>
</tr>
<tr>
<td>Kiloh Centre - mental health</td>
</tr>
<tr>
<td>Haemodialysis PB 3W</td>
</tr>
<tr>
<td>Mental Health Rehab - Euroa</td>
</tr>
<tr>
<td>Neuropsychiatry - Euroa</td>
</tr>
<tr>
<td>Oncology - P4E (P1W)</td>
</tr>
<tr>
<td>Oncology Day Centre - H2</td>
</tr>
<tr>
<td>Orthopaedics - P7W</td>
</tr>
<tr>
<td>Outpatients Department</td>
</tr>
<tr>
<td>Patient Discharge Lounge - P4W</td>
</tr>
<tr>
<td>Perioperative / Day Surgery- D1</td>
</tr>
<tr>
<td>Plastic surg, ENT &amp; Ophthalmology - P7E</td>
</tr>
<tr>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Rehab general - P1W</td>
</tr>
<tr>
<td>Renal Unit - P9W</td>
</tr>
<tr>
<td>Respiratory &amp; Infect Diseases - D4</td>
</tr>
<tr>
<td>Respiratory Outpatients</td>
</tr>
<tr>
<td>Ambulatory Day Treatment Centre</td>
</tr>
<tr>
<td>Spinal Rehab - CS1</td>
</tr>
<tr>
<td>Stroke Unit - P3E</td>
</tr>
<tr>
<td>Waves and AIM (Community Health groups)</td>
</tr>
</tbody>
</table>