Kasper Sipowicz, Ph.D.
The Maria Grzegorzewska University in Warsaw
Department of Interdisciplinary Disability Studies
Marlena Podlecka, M.A.
Institute of Psychiatry and Neurology in Warsaw
Department of Neuroses, Personality Disorders and Eating Disorders
Tadeusz Pietras, Ph.D., D.Sc. in Medical Sciences, Prof. of MU of Lodz
Medical University of Lodz
Department of Clinical Pharmacology,
1st Chair of Internal Medicine

Meeting the spiritual needs of hospital patients

Zaspokajanie potrzeb duchowych pacjentów

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The witnesses of the Cross and Resurrection of Christ have handed on to the Church
and to mankind a specific Gospel of suffering. The Redeemer himself wrote this Gospel,
above all by his own suffering accepted in love, so that man "should not perish but have eternal life"
Apostolic Letter Salvifici Doloris of the Supreme Pontiff
John Paul II (VI, 25).

Abstract: The holistic paradigm of human perception induces a special way of understanding the disease and the therapeutic process. The suffering resultant from experiencing the disease is observable in both the somatic and the spiritual areas, because both these aspects of existence permeate each other. It is essential for clinical practice to identify and address the needs of religious patients, as numerous scientific studies show a close association between the spiritual wellbeing and the health condition. It is currently assumed that faith in God can be an effective catalyst for the treatment process. The issue of meeting the spiritual needs of patients is an underestimated problem in modern medicine, because it is often forgotten that health means the mental, physical, social and economic welfare of the subject as well as spiritual wellbeing. The last factor is a prerequisite for the individual's health to the same extent as the other ones. This should always be remembered both in clinical practice and in the education of medical students.
Key words: disease, therapeutic process, spiritual wellbeing, spiritual needs

Abstrakt: Holistyczny paradygmat postrzegania człowieka indukuje szczególny sposób rozumienia choroby i procesu leczenia. Cierpienie wynikające z doświadczania choroby dostrzegalne jest zarówno w obszarze somatycznym, jak i duchowym, bowiem oba aspekty istnienia przenikają się wzajemnie. Dla praktyki klinicznej niezwykle istotne jest rozpoznawanie i zaspokajanie potrzeb religijnych pacjentów, jako że liczne badania naukowe wskazują na ścisły związek między dobrostanem duchowym a stanem zdrowia. Współcześnie przyjmuje się, iż wiara w Boga stanowić może skuteczny katalizator procesu leczenia. Kwestia zaspokajania duchowych potrzeb pacjentów jest jednak niedocenianym problemem we współczesnej medycynie, ponieważ często zapomina się, że zdrowie oznacza nie tylko psychiczne, fizyczne, społeczne i ekonomiczne dobro pacjenta, ale także jego duchowe samopoczucie, które jest warunkiem zdrowia jednostki w takim samym stopniu, jak inne. Należy o tym zawsze pamiętać zarówno w praktyce klinicznej, jak i podczas kształcenia studentów medycyny.

Słowa kluczowe: choroba, proces terapeutyczny, duchowość, potrzeby duchowe

Introduction

A person experiencing severe stress, often exceeding the adaptability of the specific individual, seeks relief in prayer (Sipowicz, Najbert, Pietras, 2017). The need to turn to the realm of the sacred occurs both in believers and in non-believers. Even a folk proverb: "When in fear, turn to God" confirms that this specific regularity has been observed for centuries. From the dawn of history, people have sought the support of Providence, especially when the situation in which they found themselves exceeded their abilities. The diseases, which affect everyone – both the poor and the rich, are a particular type of stressor.

1. The concept of health and disease in the aspect of human spirituality

Analyzing the concepts of understanding health and disease over the centuries, it can be noted that the commonly applicable general paradigm of treatment has its origin in the contemporaneous beliefs concerning communication between the body and soul. Before "the Wiseman's glass and eye" managed to convince humanity that in accordance with the Cartesian dualism the body should be perceived as a machine whose failures can be repaired according to certain algorithms, the man was understood as a psychosomatic unity. For Hippocrates, the disease was synonymous with the imbalance of the "humors" present in the human body, and therefore the treatment process was limited to restoring the proper harmony of those "humors". In turn, in the Middle Ages, the disease was seen as a result of violation of the divine laws, and the therapy focused predominantly on abandoning the disastrous habits and renunciation of what was sinful (Bishop, 2000).

The current approach postulates the departure from the dominant in the 20th century biomedical perception of the disease as a purely somatic dysfunction, requiring the use of specialized methods of "repair" of the organism (Heszen, Sęk, 2007). Although the concepts in ancient times and in the Middle Ages seem archaic now, the underlying holistic perception of a human being proves to be surprisingly up-to date – the microcosm of human existence cannot be reduced to vegetative processes only. Hence, in the preamble to the Constitution of the World Health Organization, a reductionist definition of health as the absence of disease was abandoned, defining it, according to the biopsychosocial model, as a condition of full physical, mental and social welfare.

This type of optics opens up a completely new horizon of perception of the disease and related conditions, as well as of the treatment process. The human body and soul cease to be understood as parallel phenomena without any tangent points. As John Paul II mentions in the apostolic exhortation "Familiaris Consortio" of 22.11.1981, the man is a spirit

embodied, and therefore a soul, which is expressed through flesh. Both dimensions of existence remain with each other in a mutual relationship, and this reflection proves to gain a growing scientific significance today, setting a very interesting and complex field of exploration for, emong others, psychology of health and medicine.

Abandoning the idea of a man struggling with the disease as a mechanism requiring repair, we discover the spectrum of spiritual phenomena closely coupled with the somatic functioning. The belief in God, as a dimension of human spirituality, can be both a predictor of health and a determinant of therapy. Increasing emphasis is currently laid on the concept that the treatment process should also include meeting the spiritual needs of the patients (D'Souza, 2007).

2. Spirituality and health – mutual conditionality

The search for correlations between health and spirituality is a relatively new phenomenon, but fully justified on the ground of empirical research (Miller, Thoresen, 2003). A particular manifestation of the growing trend is the emergence of postulates concerning the extension of the definition proposed by the WHO to include the recognition of spirituality as one of the aspects of health (Heszen, Sęk, 2007; Oman, Thoresen, 2005).

Faith in God, as a sign of human spirituality, is particularly ephemeral in the area of scientific research. Remarkable cognitive delicacy is required in the search for the mechanisms of influence of this multidimensional construct on the health condition and the course of treatment of somatic and psychiatric disorders. It is necessary to find a specific "bridge" that connects the soul with the body, through which both these areas of human existence are inducing each other. The knowledge accumulated so far has been conceptualized by Doug Oman and Carl E. Thoresen (2005) in a model showing the influence of faith in God on the somatic wellbeing of man, as follows:

faith in God ⇒ intermediary mechanisms ⇒ physiological indicators ⇒ somatic health

Somatic wellbeing is described in the presented concept by reducing the mortality rate among the population of religious individuals by up to 25-30% (Powell, Shahabi, Thoresen, 2003). Studies indicate that religiosity may reduce the risk of stroke, cardiovascular diseases, infectious diseases and malignant tumors (Koenig, 2001), as well as delays the emergence and progression of physical disability in elderly people (Idler, Kasl, 1997). It is also emphasized that religious commitment constitutes a more effective health predictor than a catalyst for treatment (Powell, Shahabi, Thoresen, 2003). The question of the correlation of faith and the intensity of pain experienced by the patients remains unresolved. The

explorations carried out in this area show both the impact of prayer that is relieving in character (Turner, Clancy, 1986; Florell, 1973) as well as increasing pain sensations (Koenig, 2001).

The physiological indicators, determining directly somatic wellbeing, include mainly blood pressure, immune and neuroendocrine functions. Research shows that religious commitment can contribute to reducing hypertension (Oman, Thoresen, 2005), raising the immunoglobulin A level (McClelland, 1988) and the lymphocyte count (Woods, Antoni, Ironson, Kling, 1999), as well as decreasing the cortisol levels (Katz, Weiner, Gallagher, 1970).

The intermediary mechanisms should be perceived as a kind of bridge connecting the soul and the body. The groups of these factors are differentiated in nature, permeating one another and reinforcing one another's impact. They include, among others:

- inducing positive mental states (i.e. hope, joy), contributing to the reduction of the "allostatic load" (McEwen, 2005);
- developing the individual style of coping with the stress resulting from experiencing the disease;
- generating health-related behaviors resulting from respect for the carnal and regulating motivation to use medical services;
- social support of a religious community.

Other concepts describing a subtle thread combining religious experiences with health can also be found in the literature in the field of psychology of religion. Today, however, due to the lack of research in this field, their status is recognized as that of potential mechanisms. It is also not excluded that some of them should be understood as empirically unrecognizable ephemerids (so-called superempirical mechanisms or "psi"' mechanisms) (Oman, Thoresen, 2005).

It seems particularly interesting to implement Bowlby's theory of attachment in this area. According to Lee A. Kirkpatrick (1999), a profound relationship between man and God fulfils all the criteria defining the relationship between the child and the parent, based on analogous psychological mechanisms. Thus, God, as a figure of secure attachment style, becomes a "safe haven" for a believer, which is directly associated with a higher psychological wellbeing.

Looking more broadly at the model presented by Oman and Thoresen (2005), it should be noted that the immediate area affected by the intermediary mechanisms is human mental health, the condition of which induces physiological indicators, and thus somatic wellbeing. Although this concept does not explicitly take mental wellbeing into account, however, according to Lisa Miller and Brien S. Kelley, (2005) it organizes the most important channels through which the effect of religious commitment on the mental state of the individual is exerted. Therefore, the authors of this paper propose to enrich the model of Oman and Thoresen (2005) as follows:

faith in God	⇒	intermediary mechanisms	⇒	**mental health**	⇒ physiologic-al indicators ⇒	**somatic health**

3. Religious strategies for coping with disease on the ground of intermediary mechanisms

Suffering can be considered a phenomenon in which medicine meets religion on the common ground. However, the orientation of both areas is different. While treatment is aimed at elimination of suffering, faith in God makes it bearable. Chiara Lubich rightly concludes that suffering is for a man experiencing illness a sound of bells summoning him to prayer[1].

Adopting a religious perception optics allows us to construct a coherent and logical vision of the world (Krok, 2014), thus providing a line of interpretation of the disease and the associated suffering. The self-therapeutic effect on the individual is considered to be one of the basic functions of religion (Chlewiński, 1982). Faith in God satisfies the constituent need to find the meaning of life and the values of transcendent situations, gives a sense of security in the face of uncertainty and transience, and brings hope (Wandrasz, 1998), enabling to preserve the mental equilibrium.

Kenneth I. Pargament, Harold, G. Koenig and Lisa M. Perez (2000) developed a detailed typology of a religious strategy to cope with stressors, which undoubtedly include the experience of the disease. Among the methods described by them, we can find active, passive and interactive pathways in the cognitive, behavioral, interpersonal and spiritual fields (Pargament, Ano, Wachholtz, 2005), which can be systematized as follows:

1) *Search for meaning and significance* – interpreting the experiences of the disease as potentially beneficial in a spiritual aspect; perception of the disease as a punishment by God for the committed sins, or as the impact of demonic forces; belief that God is in power to influence the disease.
2) *Search for control* – partnership/cooperation with God; passively awaiting God's intervention; actively letting God to take control; prayer for intercession – waiting for a miracle; gaining a sense of control through own initiative.
3) *Seeking relief in closeness with God* – support through experiencing God's love and care; diverting attention by engaging in religious activities; spiritual purification through religious commitment; connection with the transcendent forces; expressing doubt in relation to God under the direct influence of a stressor (expressing spiritual doubt); striving to conform in own behaviour according to the principles of faith.

[1] https://pl.wikiquote.org/wiki/Chiara_Lubich, access: 09.10.19

4) *Seeking closeness with other people and with God* – support from clergy and members of the community; providing support to other persons; expressing dissatisfaction with the relationship with God and with other people under the direct influence of a stressor (expression of interpersonal and religious bitterness).
5) *Seeking personal transformation/life transformation* – finding a new direction of life through faith in God; religious conversion; forgiveness as an escape from anger, fear and feelings of injury.

It should be noted that religious strategies for coping with suffering can take both positive and negative forms, which depend on the individual dimension of the relationship with God. Research suggests that the "secure" style of this spiritual interaction is correlated with better somatic health, while the "insecure" type of bond implies a less efficient adaptation in the transcendent situations, resulting in worse somatic health condition (Pargament, Smith, Koenig, Perez, 1998).

4. Ministry of the hospital patients

In opposition to the cool distance of the reductionist vision of medicine, the necessity of systemic enrichment of the treatment process by providing the patients with spiritual support is emphasized more and more frequently. The man exists as a psychosomatic unity, and the dichotomy of the body and soul in the health system care bears the hallmarks of depersonalization, leading to multiplication of suffering experienced by the patients, and not to its reduction.

The studies conducted by Harold G. Koenig (2004; according to: Bejda, Lewko, Lankau, 2016) among hospital patients demonstrated that for 90% of sick people faith in God is the main strategy for coping with disease-related experiences, for 40% religion brings hope in the fight against disease, while for 60% is an important factor in making the decisions concerning the therapeutic process.. Experiencing the disease-related suffering is directly associated with the presence of special spiritual needs which cannot be underestimated in the treatment process. Nowadays, there is a desire to oppose the ideological and structural marginalization of the role of hospital chaplains (Norwood, 2006). Not only full incorporation of the priest into the therapeutic team, but also sensitization of the medical personnel to the spiritual needs of patients has been postulated (Klimasiński, Ziemkiewicz, Neuman-Klimasińska, 2017).

The concordat between the Holy See and the Republic of Poland of 28 July 1993, in art. 17, para. 1 provides pastoral care for "(...) persons in penitentiary, educational, resocialization, health and social care facilities, as well as other such establishments." Also art. 53 para. 2 of the Polish Constitution guarantees the right to benefit from religious assistance at the place where the person is located, while the Act of 6th November 2008

Patients' Right and the Commissioner for Patients' Rights contains a section entitled "Right to pastoral care", in which the legal regulations have been specified. The hospital chaplain is a diocesan or a monastic priest appointed by the diocese bishop appropriate for the location of a healthcare facility. In Polish conditions, there is one chaplain employed full-time per 500 patients (Jachimczak, 2003).

The role of the chaplain is to provide the patients with spiritual and pastoral care (Pontifical Council for Health Care Ministry), 1995). Studies carried out in Polish hospitals and hospices show the following forms of pastoral care: the Holy Mass, the Rosary prayer, meditating on scriptures, reading religious books, service of the cross, sacraments, individual prayer and conversations with the priest (Mickiewicz, Krajewska-Kułak, Kędziora-Kornatowska, Rosłan, 2011; Mickiewicz, Krajewska-Kułak, Kędziora-Kornatowska, Muszyńska-Rosłan, 2011). It is also the duty of the chaplain to provide spiritual support to the non-believers who express such a need (Bejda, Lewko, Kulak-Bejda, 2017).

The essence of the hospital chaplain's ministry is therefore evangelization of the disease (supporting the patients in discovering the redeeming sense of suffering experienced in communion with Christ), the celebration of the sacraments as the signs of the invigorating and regenerating grace of God and the benefit of the therapeutic strength of charity through service and Communion (Pontifical Council for Health Care Ministry, 1995).

Conclusion

The need to meet the spiritual needs of patients is an undervalued problem in modern medicine. It is often forgotten that health means mental, physical, social and economic welfare of the subject as well as spiritual wellbeing. The last factor is a prerequisite for the individual's health to the same extent as the other ones. This should always be remembered both in clinical practice and in teaching medical professions.

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