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PRACTICES AND CONCEPTS

Using spiritual care to alleviate religious, spiritual, and moral struggles arising from acute health crises

Utiliser des soins spirituels pour atténuer les luttes religieuses, spirituelles et morales découlant de crises sanitaires aiguës

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Summary Extensive research on religious coping demonstrates that aspects of religion and spirituality may help or harm people going through life crises and trauma. Many people experience religious, spiritual, and moral struggles in coping with crises. While some people are able to draw upon aspects of their religious, spiritual, or moral orienting systems to experience growth in the midst of such struggles, for many people religious, spiritual, and moral struggles are associated with poorer health and well-being. I argue that research on religious, spiritual, and moral struggles ethically compels medical care providers to provide holistic comprehensive care of acute health crises, such that people's beliefs, values, and ways of coping become resources and not liabilities. Healthcare providers, ethically mandated to 'do no harm', risk medically neglecting patients by ignoring the religious, spiritual, and moral struggles arising from their acute health crises. What might spiritually oriented care of religious, spiritual, and moral struggles look like? The concept of moral orienting systems is described as a way to practice evidence-based and intercultural care of religious, spiritual, and moral struggles arising from acute health crises.

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MOTS CLÉS
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Maladie grave

Résumé Des recherches approfondies sur l'adaptation religieuse démontrent que certains aspects de la religion et de la spiritualité peuvent aider ou nuire aux personnes qui traversent, dans leur vie, des crises et des traumatismes. De nombreuses personnes rencontrent des difficultés religieuses, spirituelles et morales pour faire face aux crises. Bien que certaines personnes puissent s'appuyer sur des aspects de leurs systèmes d'orientation religieuse, spirituelle, ou morale pour connaître une croissance au beau milieu de telles luttes, de nombreuses personnes luttent pour leur santé et leur bien-être. Je soutiens que la recherche sur les luttes religieuses, spirituelles et morales oblige éthiquement les prestataires de soins médicaux à fournir des soins complets et holistiques en cas de crise sanitaire aiguë, de telle sorte que les croyances, les valeurs et les moyens de s'adapter deviennent des ressources et non des passifs. Les fournisseurs de soins de santé, qui ont pour mandat éthique de « ne pas nuire », risquent de négliger médicalement leurs patients en ignorant les luttes religieuses, spirituelles et morales découlant de leurs crises sanitaires aiguës. À quoi pourraient ressembler les soins orientés spirituellement par des luttes religieuses, spirituelles et morales ? Le concept de systèmes d'orientation morale est décrit comme un moyen de mettre en pratique des soins interculturels et fondés sur des données probantes pour les luttes religieuses, spirituelles et morales découlant de crises sanitaires aiguës.

Introduction

Extensive research on religious coping demonstrates that aspects of religion and spirituality can promote well-being or exacerbate suffering for people going through life crises and trauma [1]. The critical question guiding research in psychology of religion is ''not *whether* religion and spirituality are good or bad, but rather *when, how, and why* they take constructive or destructive forms?'' [2, pp. 7-8]. In the 1980s, psychologists of religion went beyond research using single, global items to measure religion and spirituality (such as self-ratings on religiousness). Such research now assumes that religion and spirituality are multidimensional: ''made up of a myriad of thoughts, feelings, actions, experiences, relationships, and physiological responses which serve many purposes and yield a number of consequences'' [2, p. 5].

Psychological research on religion and spirituality has drawn upon evolving definitions of religion and spirituality. Toward the end of the last century, spirituality was used more widely in the United States and Canada, taking on more meanings previously associated with religion, such that religion and spirituality became polarized:

> *religion as institutional versus spirituality as individual, religion as external and objective versus spirituality as internal and subjective, religion as old versus spirituality as new, religion as structural versus spirituality as functional, religion as fixed and frozen versus spirituality as flexible and dynamic, and even religion as bad versus spirituality as good [2, p. 11—2].*

In the United States and Canada behavioral health providers and chaplains rely upon Pargament's definition of spirituality and religion because it encompasses research on the ''extraordinary multiplicity and diversity of religion and spirituality'' [2]. Pargament describes spirituality as a search for the sacred. He defines the sacred as:

> *...things that are holy, set apart from ordinary aspects of living...encompass[ing] not only God, divine beings, or a transcendent reality but also other aspects of life that take on divine character and significance by virtue of their association with a higher power [3, p. 122].*

Religion is understood as ''the larger social and institutional context in which the search for the sacred take place'' [3, p. 122].

There is now a wealth of research measuring specific aspects of religious beliefs and practices that are functionally and proximally related to health and well-being in helpful and harmful ways. Research on religious coping is based upon Lazarus and Folkman's 1984 transactional description of coping as ''the process of managing demands (external or internal) that are appraised as taxing or exceeding the resources of the person'' [4, p. 283]. Coping is understood as a dynamic process in which people respond to a demanding situation with primary cognitive appraisals of whether the situation is benign, threatening, or life-enhancing. Secondary appraisals marshal one's resources for coping, such as one's relational network, one's global and contextual beliefs and values about the demanding situation, one's problem-solving skills, and other resources, such as financial resources, behavioral coping habits, and spiritual and religious practices. People use problem-focused coping to try and manage the external demands of a situation. Emotion-focused coping is used to try and regulate one's emotional response to the demanding situation.

This process model of coping is the foundation for research on how people draw upon aspects of their spirituality and religion to cope with stress in ways that promote well-being and/or exacerbate suffering. Pargament describes this process of coping by using an overarching metaphor of spirituality as a search for the sacred with pathways and destinations [5,6]. ''The search for the sacred refers to the processes of discovery of the sacred, efforts to conserve or hold on to the sacred... and attempts to transform the sacred when internal and external pressures insist on change'' [3, p. 122]. Park uses a process model of religious coping to do research on religious and spiritual meanings and values in coping. Her meaning-making model of coping describes how stress arises when global meanings (beliefs, goals, and sense of purpose) about a demanding situation do not align with the contextual meanings made in the process of coping. For example, patients faced with an acute health crisis immediately ask questions about whether and how this crisis 'fits' with their overall beliefs, values, and sense of purpose (e.g., that one's life has a purpose; that one's body and humanity is good; that God is good). Distress arises when there is a discrepancy between global beliefs and the situational ways they are trying to understand and cope with the acute health crisis.

Meta-analyses of the role of religion and spirituality in cancer patients found that religion and spirituality are associated with overall physical well-being, functional well-being, and physical symptoms. A nationally representative sample of adults in the United States ($n = 1871$) was used to measure whether meaning plays a mediating role in the association between stress and health. Three dimensions of meaning were measured: ''coherence (e.g., ''I have a system of values and beliefs that guide my daily activities''), significance (e.g., ''I feel like I have found a really significant meaning in my life''), and purpose (e.g., ''In my life, I have clear goals and aims'')'' [7, p. 777]. Higher meaning was associated with better self-reported health (across self-reported minor and major health concerns and overall health measures), which, in turn, was associated with better immune system functioning.

Religious, spiritual, and moral struggles may arise, propelling people to either conserve or transform their beliefs, values, and ways of coping. Pargament's descriptions of spirituality as a search for the sacred and Park's meaning-making model have been used to comprehend the extensive research on how aspects of religion and spirituality may help or harm people in the process of coping. Recent research on religious and spiritual struggles has been facilitated by the development in 2014 of the Religious and Spiritual Struggles (RSS) Scale [8], which measures three kinds of struggles:

- divine struggles with a judging and/or angry distant God;
- interpersonal struggles (such as fears of being judged/shunned by one's community or religious authorities; anger about religious hypocrisy and moral betrayal);
- and intrapsychic struggles (such as moral struggles, doubts about ultimate meanings, self-condemnation, and feeling unforgivable).

The RSS builds upon previous research on religious struggles [9] and extensive research using Pargament's negative religious coping scale [10]. Studies on religious and spiritual struggles demonstrate their frequency for people of many major religious orientations, including atheism [11—14]. Religious and spiritual struggles are common in serious illness. Fitchett et al. [15] found that 15% of diabetic outpatients ($n = 71$), congestive heart failure outpatients ($n = 70$), and oncology inpatients ($n = 97$) reported moderate or high levels of struggles, which were associated with higher levels of depressive symptoms and emotional distress.

In a two-year longitudinal study of 268 hospitalized, medically ill elderly patients, Pargament et al. measured ''positive methods of religious coping (e.g., spiritual support, benevolent religious reframing, collaborative religious coping, congregational support)... [and] negative methods of religious coping (e.g., spiritual discontent, punitive religious reframing, self-directing religious coping, congregational discontent)'' [16, p. 715]. Religious and spiritual struggles predicted increased depressed mood and poorer physical functioning and quality of life [16,17]. Most importantly, chronic religious and spiritual struggles were associated with a 19 to 28% increased risk of dying. Three items measuring chronic divine religious struggles that continued over two years predicted increased risk of mortality: ''Wondered whether God had abandoned me'', ''Questioned God's love for me'', and ''Decided the devil made this happen'' [17, p. 1881].

This brief review of research demonstrates the need for evidence-based spiritually oriented care of religious and spiritual struggles. After their review of research on such struggles, Abu-Raiya, Pargament, and Exline conclude that ''health care providers, who strive to deliver effective and religiously and spiritually sensitive treatment, cannot avoid this potentially influential aspect in the lives of their clients'' [18, p. e126]. Indeed, one could argue that research on religious, spiritual, and moral struggles ethically compels medical care providers to provide holistic comprehensive care of acute health crises, such that people's beliefs, values, and ways of coping become resources and not liabilities. Healthcare providers, ethically mandated to 'do no harm', risk medically neglecting patients by ignoring the religious, spiritual, and moral struggles arising from their acute health crises. What might spiritually oriented care of religious, spiritual, and moral struggles look like? The concept of moral orienting systems is described as a way to practice evidence-based and intercultural care of religious, spiritual, and moral struggles arising from acute health crises.

Evidence-based, intercultural care of religious, spiritual, and moral struggles

Research on religious coping demonstrates the need for evidence-based spiritual care that is literate in the relevance and meaning of research on the ways that religious and spiritual beliefs, values, and practices help or harm people, especially in coping with religious, spiritual, and moral struggles [2,19,20]. While chaplains would seemingly be best equipped to integrate research findings into their spiritual care of patients, before 2008, evidence-based spiritual care was not a standard of practice. The term itself was introduced in 1998 by O'Connor and Meakes [21], who

provided decades of leadership in educating and training chaplains in providing evidence-based care. The 2009 standards of practice published by the Association of Professional Chaplains (APC) adds this standard on evidence-based care: ''the chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research'' [22, p. 1]. A similar standard was required of chaplains in the National Health Service in the United Kingdom, as Fitchett et al. note [19]. In 2016, the Spiritual Care Association, an affiliate of the Health Care Chaplaincy Network, launched their own chaplaincy education, training, and certification for evidence-based spiritual care.

Many chaplains trained before 2008 were not required to know and use research on religious coping and struggles, although now many seek to practice evidence-based care. In a survey of healthcare chaplains working in the Department of Veterans Affairs (VA) ($n = 440$), the Department of Defense (DoD) ($n = 164$), and civilian settings ($n = 169$), Fitchett et al. found that chaplains from all three contexts ''strongly endorsed an evidence-based approach to chaplaincy.'' While 75% of VA and DoD healthcare chaplains and 42% of chaplains in civilian settings rated their practices to be evidenced-based, over 50% in VA and DoD samples and 94% in the civilian sample wanted their care to be more evidence-based [19, p. 144]. Now that provision of evidence-based care is a requirement for chaplains meeting standards for professional certification by organizations in the United States, Canada, and the United Kingdom, the challenge is how to help them go beyond research literacy to fluency in drawing upon research in person-centered intercultural spiritual care that takes into account each person's particular religious, spiritual, and moral struggles and the specific intrinsic beliefs, values, and practices that could be resources in seeking well-being in the midst of acute health crises.

Intercultural spiritual care in healthcare settings must practice cultural humility [23] in honoring the complexity of cultural identities, understood as ''those commonalties around which people have developed values, norms, family life-styles, social roles and behaviors in response to historical, political, economic, and social realities'' [24, p. 8—9]. Pastoral theologian Emmanuel Lartey [25] first used the term intercultural to describe spiritual care that takes into account ''the complex nature of the interaction between people who have been influenced by different cultures, social contexts and origins, and who themselves are enigmatic composites of various strands of ethnicity, race, geography, culture and socio-economic setting'' [25, p. 13]. An intercultural approach to spiritual care respects people who may or may not identify with religious or spiritual beliefs, practices, communities, or traditions. Intercultural spiritual care is ethically necessary within health care, military, educational, and community settings. It is especially relevant for people who are spiritually fluid or religiously multiple: ''shaped by, or maintaining bonds to, more than one spiritual or religious community at the same time'' [26, p. 1]. As Bidwell notes, religious multiplicity is now more common in the United States and Europe, while ''in other parts of the world, religious multiplicity has long been a norm. As more and more people transgress religious boundaries, this multiplicity becomes more visible'' [26, p. 2].

Chaplains combining an evidence-based and intercultural approach to spiritual care of religious, spiritual, and moral struggles will find useful this mid-twentieth century adage coined by the American anthropologist Clyde Kluckhohn and psychologist Henry Murray: that every person is in certain respects like all other people, like some other people, and like no other person [27]. Evidence-based care requires chaplains to see commonalities between a patient and ''all people''—that is, the people in research samples used to develop and norm measures of religious coping—and ''some people'' who, research demonstrates, find particular aspects of religion and spirituality helpful or harmful. Such research helps chaplains pay attention to whether a patient experiences the kinds of religions, spiritual, and moral struggles measured by negative religious coping scales and the Religious and Spiritual Struggles Scale. In developing such scales, researchers use a pluralist approach to religion and spirituality that respects differences yet seeks to find common ways across traditions to measure aspects of religion and spirituality. Those who do not 'fit' into norming samples who, in the United States, commonly hold beliefs in God and also in the devil may question the validity of all research measures of divine struggles with God and demons. They may be inclined to dismiss findings from the landmark two-year longitudinal study on chronic negative religious coping and mortality among medically ill patients cited earlier. While it may not be hard to see how elders in the United States, a group highly likely to endorse beliefs in God, would struggle with wondering whether God had abandoned them, many health care professionals would easily question whether their patients are like those in this sample whose endorsement of demonic struggles—''Decided the devil made this happen'' [17, p. 1881] predicted increased mortality. Such questions could make healthcare professionals, especially those outside of the United States, discount research on religious struggles that measure demonic struggles.

Combining an evidence-based approach with an intercultural approach helps chaplains and all medical professionals move back and forth from seeing patients as like all people, some people, and no other person. While the predictive power of statistical probabilities, especially in using data bases to predict outcomes for patients with particular combinations of diagnoses, makes medical care more likely to see patients through categories that group them, an intercultural approach is essential for building trust, especially at the outset of care and for patients with shame- and guilt-based chronic religious, spiritual, and moral struggles. When healthcare professionals convey compassionate respect that their patient is ''like no other'' then patients are more likely to trust in the process of care, and experience the compassion of caregivers, conveyed as much through body language as words, as 'holding' their struggles, even when such struggles are not articulated.

Moral orienting systems and the role of body-aware practices orienting systems

A helpful organizing concept for combining an evidence-based approach with an intercultural approach can be found

in Pargament's' notion of orienting systems that may be religious, spiritual, or moral. An orienting system ''consists of habits, values, relationships, belief and personality...[and] contains both helpful and unhelpful attributes, resources, and burdens... Spirituality is one aspect of the general orienting system [that] contributes to the individual's framework for understanding and dealing with the world'' [3, p. 130]. The values, beliefs, practices, emotions, and relationships of orienting systems shape how and whether struggles lead to wholeness or brokenness [1, p. 379]. When demanding situations, like an acute medical crisis, overwhelm an individual's and relational systems abilities to cope, then deeply held moral values and beliefs may be threatened. Behavioral coping practices that used to offer relief—especially spiritual practices that connected one with a sense of goodness and/or transcendent dimensions and/or being—may become unavailable and even intensify distress.

Orienting systems include both global beliefs and values about suffering, hope, and the purpose of one's life, and situational meanings about, for example, an acute health crisis. Orienting systems are multilayered, with values, beliefs, and coping practices from childhood, family, and cultural systems forming a bedrock/embedded orienting system often re-energized emotionally under acute/traumatic stress [28,29], either by emotions like love and compassion that connect people with goodness in their bodies and relational systems, or by shame and guilt that make people feel judged (particularly by God) or shunned. As moral psychologist Jonathan Haidt argues, such emotions energize moral orientations, especially in acutely stressful situations, shaping beliefs, values, and behaviors much more directly than rational moral reasoning [30,31].

When a health crisis is acute, traumatic, and/or life-threatening, then spiritual care may need to begin with helping patients find practices that calm them. Acute stress, which can, over time, become posttraumatic stress, immediately impacts one's body, activating complex, interacting physiological stress responses that often overwhelm one's capacity to cope. Research on traumatic stress—notably Stephen Porges' polyvagal theory [32] details the neurophysiology of acute stress and trauma responses. This theory explains how trauma survivors, as well as those experiencing acute stress, may find that body-aware calming practices help them shift out of an orienting system to their crisis/trauma energized by fear, shame, and/or guilt, into an orientation energized by compassion, which Porges describes as an evolved somatic capacity to be relationally connected [33,34]. As trauma psychologist Bessel van der Kolk notes, ''The polyvagal theory legitimates the study of age-old collective and religious practices such as communal chanting, various breathing techniques, and other methods that cause shifts in autonomic states'' [35].

Building on research on the role of body-centered practices in trauma care, evidence-based spiritual care of acute health crises might begin by helping patients find and use body-aware calming practices that help them experience their bodies—even in the midst of serious illness—as good. Without ongoing experiences of the goodness of their bodies, patients will have difficulty spiritually integrating their experience of serious illness in more flexible and differentiated ways—essential dimensions of life-giving spiritual integration and wholeness, as research demonstrates [1,3]. When patients can find and use body-aware practices that calm their stress responses to illness, they are more likely to experience self-compassion, with ripple effects physiologically, emotionally, relationally, and in self-transcendent ways. This encompassing experience of compassion helps patients embrace the fear, and perhaps guilt, shame, and anger, ignited by the acute stress of serious illness. Instead of withdrawing from social support under the duress of such isolating emotions, patients using body-centered practices will be more likely to reach out to trusted others. By sharing their struggles, patients may gain insight into life-limiting dimensions of childhood and cultural orienting systems that coalesce under acute stress and give rise to religious, spiritual, and moral struggles, such as feeling unloved or judged by God (if they were raised in theistic traditions). They may also gain insight into life-limiting beliefs and values shaped by social oppression (for example, sexism, racism, and classism) that intersect, intensifying self-judgment arising from shame associated with aspects of one's social identity. With compassionate insights into the ways that intense stress-based emotions coalesce life-limiting beliefs and values, patients may then have a choice between automatically living out stress-based orientations to their illness, or intentionally practicing more life-giving values and beliefs, capable of bearing the weight of their suffering and offering realistic hope. ''The task of putting profound suffering into perspective can require grappling with larger questions... Suffering makes many patients realize that they are uncertain or ambivalent about their philosophy of life ....'' [36].

Helping patients find body-aware calming practices is often challenging, given the ways that so many people's responses to stress are inextricably linked with habitual ways of coping through all kinds of consumption. Habitual consumer coping conditions people to experience physiological and emotional responses to stress as cues/triggers to use social media, computer games, food, and addictive substances, which they may have limited access to in the midst of a medical crisis and/or hospitalization. While consumer coping provides momentary relief and/or pleasure, in the long run it exacerbates the anxiety, anger, shame, and guilt underlying acute stress, increasing the likelihood of social isolation. Consumer coping often numbs people to their bodies' stress responses, which makes it harder for them to find ways to cope with the physical pain and discomfort that may come with the stress of an acute health crisis. When health professionals and chaplains suggest exploring and using calming practices that help patients pay attention to and self-regulate their bodies' stress responses, patients may feel like health providers are speaking an unknown language. Given the pervasiveness of consumer coping, health professionals may be ill equipped to describe the benefits of finding body-aware calming practices. If health care providers' body language convey stress, they will not be able to 'walk the talk' of convincing patients to find and use calming body aware practices.

Using an intercultural, evidence-based approach to spiritual care helps patients from any and all religious, spiritual, and moral orientations find ways to experience goodness and compassion amidst the acute stress of serious illness. Intercultural care that respects the unique and particular beliefs,

values, and coping practices of patients challenges the dominance of medical ways of talking about suffering and hope, that often 'translate' into statistical probabilities. Sociologist of religion Wendy Cadge [37] demonstrates that hospital chaplains often use medical ways of talking about religion and spirituality with patients. An intercultural approach that explores body-aware practices and orienting systems can be easily implemented in more secular contexts, such as Canada and Europe, as Schumann and van der Geugten in the Netherlands demonstrate, in their description of the ways that pastoral counselors ''as professionals in domains of existential meaning'' can help trauma survivors search for ''orienting systems in moral space [that] are 'believable visions of the good''' [38, p. 405].

Conclusion

How does intercultural, evidence-based spiritual care help patients in the midst of an acute health crisis share and bear the weight of their suffering? Given the prevalence and negative health outcomes of religious, spiritual, and moral struggles, health care teams risk neglect by not finding ways to holistically help such patients. Chaplains using intercultural and evidence-based approaches can model how to help patients find intrinsically meaningful body aware practices that calm them, and help them experience self-compassion. While finding and using calming practices is challenging in consumer cultures, the benefits are potentially life-changing when embodied and relational goodness transform life-limiting orientations to illness. The process of care outlined here could easily be transposed to enhancing self-care of medical professionals and fostering resilience amidst the moral stress of providing adequate healthcare in the twenty-first century.

Disclosure of interest

The author declares that she has no competing interest.

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