Spirituality Assessment In Health Care

In Examining a Patient's "Objects of Devotion," the Clinician May Find Clues to an Unhealthy Lifestyle

BY GARY L. PATTON, PhD

Dr. Patton is director, pastoral care, St. Mary's Hospital, Huntington, WV.

Spirituality is a concept increasingly discussed by various professional disciplines. Nursing, medicine, mental health, and even business are addressing the topic of the human spirit. Even people who have fundamental questions about spirituality seem to be asking those questions more often and more publicly.

Definitions of spirituality are many, yet each of them seems to focus on two general principles. Spirituality has to do with:

- Finding meaning and purpose in life
- Developing awareness of and allegiance to something sacred

When a person lives according to these principles, life generally goes well. However, a person's spirit may be unhealthy. Just as we periodically need to assess our physical health, we need to assess our spiritual life as well. A person may experience a problem in any aspect of life. Although disease and discomfort are usually more evident when they occur in the body or mind, they can also occur as disruptions of the spirit (or soul).

Spiritual Assessments

Spirituality assessments can help us identify spiritual problems. Such assessments can range from lengthy written inventories, on one hand, to brief verbal inquiries, on the other, with various other kinds of surveys in between. However, several questions apply to them all: If spirituality involves privacy and personal choice, as it obviously does, why attempt an assessment of it? Who should do the assessing? Can spiritual assessments be useful to clinicians?

Why Assess Spirituality?

Spiritual assessments are not intended to impose one person's values, beliefs, or practices on another. Indeed, the person doing the assessing views the assessed person's expression of his or her spiritual life as a matter of personal choice—and respects it as such. But just as a medical patient needs a physician's help in diagnosing a physical or mental problem, so people with spiritual problems need to have them assessed. People often sense that something is not well with them (or at least not as they would prefer it to be) without knowing how to identify or correct the problem. Hence assisting people with this essential aspect of their health is both appropriate and necessary for professionals. The expression of spirituality is a very personal matter, but people suffering from spiritual conflicts or seeking answers to questions about spiritual experiences often require assistance from others.

Who Should Do Spiritual Assessments?

Although chaplains, pastoral counselors, and clinically trained clergy are usually those whom people ask for help with spiritual issues, they need not be the only ones. In some cases, pastoral care professionals are simply not available to conduct spiritual assessments. In other cases, the person seeking the help may be uncomfortable speaking to someone closely identified with organized religion.

For these reasons, health care facilities may consider training other health care professionals to do assessments. A physician in an exam room, a nurse in a clinic, a therapist in an office—all can be taught how to conduct an initial assessment. If the assessment indicates that further intervention is necessary, the clinician can then consult those professionally trained in pastoral care.

True, clinicians sometimes say that they are uncomfortable talking with patients or clients about spiritual issues. Precisely because of such concern, health care organizations should encourage collaboration between their pastoral

care professionals and those involved in medical, nursing, and psychiatric care. Through dialogue, patient care conferences, collaborative training, and in-service sessions, pastoral care professionals can show their clinical colleagues how to perform spirituality assessments.

> Not all "objects of devotion" are healthy, according to Erich Fromm.

What Type of Spiritual Assessment?

One method that clinicians can use is based on a concept developed by the psychoanalyst Erich Fromm.

In *The Revolution of Hope,* Fromm argued that all human beings have what he called an "object of devotion."[1] Although this "object" varies from person to person, in each case it gives meaning to the person's life and compels his or her devotion. Fromm believed that by observing a person's life closely, one could discern his or her object of devotion.

Everyone reveres his or her object of devotion, Fromm argued. However, not all objects of devotion are healthy, even if they are viewed with a sense of reverence. An object can compel devotion without necessarily being worthy of it. Indeed, the simple fact of devotion says more about the devoted person's attention and loyalty than it does about the actual worth of the object itself. When people talk about the objects of their devotion, they sometimes describe addictions or destructive practices. J. W. Fowler's "stages of faith" concept demonstrates how faith can grow and change over time.[2] One can use the format of Fowler's "stages" to think about how people accommodate the objects of devotion in their lives and behavior.

Evaluating Objects of Devotion

Here are some guidelines for distinguishing a healthy object of devotion from one that is not. These criteria, although open for study and possible revision, provide at least a general framework for spiritual assessments. A healthy object of devotion will:

- Provide a sense of peace and serenity
- Enhance self-understanding and enlightenment/insight
- Increase energy and liveliness
- Promote hope and encouragement
- Preserve a sense of integrity

Research has shown that, in humans, mental health and spiritual health are directly related to physical health.[3] This does not mean that *all* disease necessarily has a spiritual or mental cause. But it does at least suggest that if health care providers are to serve people in the most comprehensive manner possible, they should routinely assess the way patients' objects of devotion influence their health.

Patients certainly see the connection between spiritual health and physical health. In one study, 77 percent of hospitalized patients said that attention to spiritual needs should be included as an aspect of medical care.[4] Ninety-four percent of those patients said they believe that spiritual health is as important as physical health.

If one pays attention to a person, one soon gets a sense of what gives meaning and purpose to his or her life. What people find time for will indicate something about the things they are devoted to. This is especially true in times of stress: The practices people engage in then are frequently an indication of what is most sacred to them. The pastimes people regularly follow for enjoyment or in seeking a sense of ecstasy may offer insight into their objects of devotion. At times, such practices, beliefs, and experiences can become very special—indeed almost sacred—to those who turn to them.

As clinicians come to understand this concept, they may feel more comfortable talking to patients about what really holds their attention and loyalty. The topic affords the clinician a natural entry into a discussion of behavior that—because it risks disease or injury—threatens the patient's health. Note that such conversation is not about right and wrong from the professional's point of view. Conversation, rather than a judgmental lecture, can help the patient understand the risks and dangers involved in his or her object of devotion.

Although obviously connected, spirituality and religious activity are not the same thing. People who have no formal religious affiliation may still have objects to which they are devoted. The theologian Paul Tillich once observed that "some-

thing is holy to everyone. Even to those who deny that they have experienced the holy."[5] In some cases, a person's object of devotion can lie *outside* his or her religious affiliation. For example, an individual who regularly attends church may nevertheless find his or her greatest fulfillment in long hours of work. A person who has a strong belief in God may nevertheless engage repeatedly in addictive behavior. Many people who say they have religious faith nevertheless spend a lot of their time and money on other interests.

Attempting to identify and understand objects of devotion is *not* to judge the people involved, to impose different values on them, or to imply that they are hypocritical. The intention behind identifying objects of devotion is, rather, to help people:

- Understand a very practical expression of their spiritual lives
- Learn how to identify for themselves the forces that guide their life and behavior
- Know how to differentiate between healthy and unhealthy objects of devotion

A Case Study

I once talked to a man about his consumption of alcohol. "Frank" was adamant that he was not an alcoholic. I assured him that my intent was not to try to persuade him one way or the other.

I asked Frank to tell me about a typical week in his life. With obvious and appropriate satisfaction, he described his work ethic (which was good) and his time management (which was responsible). Not only did he go to work every day, Monday through Friday, he arrived on the job early and worked overtime.

I then asked him about his weekend activities. He explained that after working hard and fulfilling his responsibilities, he felt he deserved some leisure time—and accordingly spent time on Friday and Saturday nights drinking alcohol. I asked him how he spent Sundays. Sunday, Frank said, was the day when he relaxed. He did not drink on Sunday, in order to be able to work productively on Monday.

I then asked him, "What if we were able to take Friday and Saturday nights out of your week, so that you could not use those days as you do now?" Frank's face fell and his body stiffened. "I couldn't handle that," he admitted.

"Could it be that your time and plans are guided by alcohol more than you realize?" I asked him. After thinking about it a few moments, he somberly agreed that he might have a problem with alcohol after all.

Depending, of course, on how one reads the dynamics of that encounter, one might describe it either as a judgment of Frank or as a simple assessment of behavior and thought intended to help him recognize what he was actually devoted to. Certainly Frank was not devoted to alcohol alone; he had many convictions and loyalties that served him and his family well. Even so, his lack of awareness concerning the way alcohol was guiding his life kept him from being fully autonomous. Once Frank became aware of his alcohol dependency, he grew much more autonomous—and healthy as well.

Asking the Right Questions

Certain questions are especially useful in discerning objects of devotion:

- What gives your life meaning?
- Where do you find joy and fulfillment?
- Where do you turn in times of stress or disappointment?
- What gives you a sense of peace and serenity?
- What helps you cope with boredom and daily living?
- What do you do in your leisure time?

These are but introductory questions, of course, and one cannot make quick assumptions solely on the basis of responses to them. On the other hand, such questions offer a way of fleshing out a medical history. Answers to them might well give the clinician insight into a patient's recurrent infections, for example. They might provide that bit of information that enables the clinician to diagnose a patient's vague but persistent complaints of physical discomfort. Finally, answers to such questions frequently reveal mental anguish that, although easy to classify as depression or anxiety, does not respond well to psychotropic medication (or to psychotropics alone).

In looking *past* the patient's complaints and trying to understand the devotions of his or her life, the clinician may turn up data that help make sense of those problems. Could, for example, one patient's anxiety be related to his habit of constant worry, itself caused by an overly materialistic view of life? Could another patient's frequent infections stem from poor nutrition resulting from her attempt to maintain herself at a weight the culture regards as attractive? Close observation often discloses objects of devotion that are clues to more obvious complaints and maladies. Not every disease can be linked to an object of devotion, but many can.

The object of a person's devotion can be anything that holds his or her attention and loyalty. Such things as drugs, sexual practices, alcohol, risky behaviors that induce a sense of excitement, even work are potential objects of devotion. The Latin

phrase *ad dicere*, which can be interpreted as "to give oneself up for," conveys the idea of addiction. Over time, as Fromm suggests, some thing or some activity can become increasingly prominent on a person's list of priorities.[6] On one hand, this thing may be life giving and growth promoting. On the other hand, it may be something risky, controlling, or destructive.

The object-of-devotion concept signals a return to holistic medicine.

Dealing with such questions would seem to fall within the scope of health care. Although clinicians do not want to control their patients' beliefs, they probably would like to guide them toward healthier lives by helping them choose healthy objects of devotion. Elliott Ingersoll stressed the practicality of this goal when he wrote that "an adequate description of spirituality must refer not only to peak experiences, but also to the ordinary experiences of everyday living and their behavioral correlates."[7] Clinicians can address these ordinary experiences and behavioral correlates by assessing a patient's object of devotion.

Abraham Maslow coined a term that is especially pertinent to a discussion of objects of devotion. His word "desacralization" describes what happens when people, trying to inoculate themselves against the pain of disillusionment, deny the importance of higher values.[8] Maslow's concept underlines the fact that some people fail so completely to find a sense of meaning and purpose in their lives that their will to live is weakened. Humans are capable of losing a sense of the value that objects, places, rituals, relationships, experiences, or beliefs once had for them. I liken such a loss to the intense spiritual disillusionment that sometimes causes people to give up their goals in life or to pursue them in destructive ways. Obviously some decisions of this kind will not be healthy.

A Return to the Holistic Tradition

This topic merits further discussion elsewhere. I will merely note here that unhealthy objects of human devotion provide much of the expensive, unnecessary burden borne by today's U.S. health care system. Substance abuse, eating disorders, excessive work, gambling, indiscriminate sex, and gang activity—all of which reflect what those involved in them unconsciously regard as sacred—pile overwhelming financial costs on our nation's hospitals and clinics. The social cost is great, too, because such problems often result in premature death or compromised quality of life.

The object-of-devotion concept is significant not because it is new, but because it signals the rediscovery of an approach that was once traditional. For centuries, health care professionals used spirituality to assess patients' concerns in a holistic and practical way. Now, using the object-of-devotion concept, they can do so again. The concept is inclusive because it allows the clinician to help patients participate in the assessment—in a sense, to assess themselves. It thereby increases the possibility that the patient will accept the assessment's findings and comply with recommended treatment and lifestyle changes. Those changes will in turn enhance the life and growth of the patient, of which spirituality is a vital part. □

NOTES

1. Erich Fromm, *The Revolution of Hope: Toward a Humanized Technology*, Harper & Row, New York City, 1968, p. 62.
2. Eugene Kelly, Jr., *Spirituality in Counseling and Psychotherapy*, American Counseling Association, Alexandria, VA, 1995, pp. 70-71.
3. See, for example, Larry Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine*, Harper Collins, San Francisco, 1993; D. A. Matthews, *The Faith Factor: Proof of the Healing Power of Prayer*, Penguin Putnam, New York City, 1999; and H. G. Koenig, *The Healing Power of Faith: Science Explores Medicine's Last Great Frontier*, Simon & Schuster, New York City, 1999.
4. Dana King and Bruce Bushwick, "Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer," *Journal of Family Practice*, October 1994, pp. 349-352.
5. Paul Tillich, *Theology of Culture*, Oxford University Press, New York City, 1959, p. 9.
6. Fromm, p. 119.
7. R. E. Ingersoll, "Spirituality, Religion, and Counseling: Dimensions and Relationships," in *Counseling: The Spiritual Dimension*, Mary Thomas Burke and Judith G. Miranti, eds., American Counseling Association, Alexandria, VA, pp. 5-18.
8. Abraham Maslow, *Farther Reaches of Human Nature*, Viking, New York City, 1971, p. 49.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September-October 2001