Spirituality & Health in a Fragmented World

Professor Christopher C.H. Cook

Department of Theology & Religion
Durham University
Abbey House
Palace Green
Durham
DH1 3RS

23 October 2012

Abstract

In a fragmented world, which lacks coherent and integrated ways of understanding spirituality and health, there is nonetheless a growing research evidence base which supports the importance of spirituality and religion as variables of interest in the aetiology and treatment of a wide range of health related conditions and disorders. Controversies concerning the interpretation and application of this evidence base easily polarise in such a way as to polarise immanent and transcendent concerns. Spirituality, which is itself a fragmented concept, has been understood in a crude way as being concerned with the transcendent pole of this debate. An approach to research and practice is needed within which both immanent and transcendent concerns are addressed and which serves to reduce rather than increase the fragmentation of the concepts which govern our shared understanding of spirituality and wellbeing.

To live in a fragmented world is not the same as to live in pluralistic world (Wilson, 2010, pp.13-25). The western world offers a variety of cultures, lifestyles, faiths and traditions to live by which are often represented as options available for consumer choice, according to whichever rational or other principles we might wish to adopt as a basis for our selection. However, this plurality, in itself, does not necessarily imply fragmentation. Different people and cultures can nonetheless live in harmony, share much in common and even find a sense of wholeness, belonging together, or unity. Fragmentation is not so much a matter of plurality and difference as of brokenness, division, disunity, and incoherence. It is a loss of wholeness.

Fragmentation might take many forms, but the idea of a fragmented world suggests a world that is suffering from something more adverse than a constitution of variety, difference and pluralism. Indeed, it might well be argued that variety, difference and plurality are not at all adverse but rather, if properly negotiated, can enrich a sense of wholeness and unity. A fragmented world is one which lacks this sense of enrichment, which is divided within itself, and which is at some fundamental level incoherent. The fragments that we encounter within such a world do not easily fit together. Perhaps they even derive from different worlds and thus never belonged together. They lack any kind of agreed framework within which they can be reassembled.

In fact, although the distinction is important, I am not sure that pluralism and fragmentation are so easily separated. Postmodernity is characterised by a lack of shared metanarratives, in place of which we find a plurality of narratives about such things as reason, truth, history and the self. It is also characterised by a plurality of languages, or ways of talking about reality, each of which is differently situated and socially constructed (Vanhoozer, 2003, pp.9-13). It is this plurality of available narratives and languages that turns pluralism into fragmentation and which denies the framework within which coherence might be restored. Fragmentation is thus, I would suggest, pluralism of a particular kind, a kind which fosters incoherence and disunity, especially in terms of mutual self-understanding.

We might encounter this kind of fragmentation in a variety of forms. In *After Virtue*, Alasdair MacIntyre (1981) describes a form of moral fragmentation which has left us with pieces and fragments that offer a semblance of morality but which lack any unifying conceptual scheme or integrating matrix. Worse still, we seem to have a collective amnesia for the trauma that shattered our shared morality in the first place. We are left with parts of a coherent morality (or of coherent moralities) but with no understanding of how to reassemble them into a coherent whole. The process that MacIntyre describes for morality can, I think, be seen also in other areas and aspects of our common life. Amongst these, I wish to suggest, spirituality and health are of particular importance and concern.

Spirituality

Spirituality is in many ways a unifying concept. It has emerged in recent years as a way of talking about an aspect of human experience which is arguably universal, which reaches across the boundaries of faith traditions, and which is even identified with amongst many

who would not consider themselves in any sense to be religious (Sims and Cook, 2009, C. C. H. Cook, 2004, Roof, 1999). However, it is also fragmented and fragmenting. There is no universally accepted definition of this concept, and it appears to be susceptible of varying interpretation. Some people do not self-identify as spiritual in any sense and amongst those who do their spirituality may take widely varying forms. For some, spirituality is emphatically not about religion, a concept which they find to be almost the opposite of spirituality, and for others it is impossible to describe their spirituality without reference to their religion.

If there is a coherence to the concept of spirituality, it is arguably concerned with transcendence (Cook 2013, *in press*). I have written elsewhere of the problems that arise when spirituality is understood in a crude sense that separates it from, and opposes it to, the immanent order of things and of the plurality of understandings of transcendence that abound, not least in the healthcare literature (Cook 2013, *in press*). However, I think it is still true to say that the plurality of understandings of transcendence that are commonly employed do have a sufficient "family resemblance" to each other to represent something of a coherent core to the concept of spirituality. When transcendence is understood properly in a more sophisticated sense of inherent relationship to immanence, I think that the coherence of this core is further reinforced. However, the plurality can often give an appearance of fragmentation and, conversely, the fragmentation is often misinterpreted as pluralism.

Charles Taylor has written of a "nova effect", an explosion of new ways of finding transcendence in a secular age which is suffering from a "malaise of immanence" and, generally speaking, is closed to transcendence (Taylor, 2007). If spirituality is associated with a quest for transcendence, which for many people it is, this goes some way to explaining why there is so much interest in spirituality, and in new expressions of spirituality or new ways of exploring spiritual concerns. However, the multiplicity of ways of finding transcendence in a secular society also creates a fragility of meaning. We are all more aware than ever before of the different meanings that others find, within spirituality or religion or elsewhere. Whilst this is affirmed by society, each person being encouraged to find their own meaning, the multiplicity of mutually contradictory and incompatible meanings that emerge creates an environment of mutual invalidation. Meaning becomes "fragile", and that which is fragile – I would add here – is easily fragmented.

I think that Taylor's account of things (which I have necessarily oversimplified here) goes a long way to helping us to understand the importance of spirituality in a fragmented world. On the one hand, I would suggest, spirituality is a part of the problem. Our understanding of spirituality is not only plural, but is also fragmented. That is, we not only have different conceptions of what spirituality looks like (that is, we follow different spiritual traditions), but we also lack a shared, coherent, and integrated, understanding of what constitutes spirituality. We also lack any universally shared appreciation of one another's spiritual traditions as belonging to any (currently fragile) understanding of spirituality that we do have.[1]

[1] This is increasingly evident, but it is still far from universal. The fragmentation is evident both in differences of appreciation of spiritual traditions belonging (or not) to a shared dimension of

On the other hand, however, I think that spirituality is a part of the solution and that it offers a potentially therapeutic response to the malaise of immanence that Taylor describes. The problem, according to Taylor, was not the existence of a plurality of traditional ways of engaging with a transcendent order, but rather the fragility of meaning that arose in the context of the malaise of immanence. Spirituality emerges, I would suggest, as a potentially unifying concept which provides a degree of integrity to the human quest for meaning in a secular age of the kind that Taylor describes. It might be seen to render meaning less fragile (although it is not the only framework within which this might happen), and it also potentially provides a framework within which people belonging to a plurality of traditions (including atheistic traditions) may be seen as pursuing a common quest.

It remains to be seen whether the fragmenting tendency within spirituality will prevail, and thus it will come to be seen as lacking any integrity and coherence in today's world, or whether the unifying tendency will prevail, and thus it will provide some degree of coherence and a reduction of fragmentation.

Health

In the context of a society which incorporates many spiritualities, and in which a common definition of spirituality currently remains elusive, it might be thought difficult or impossible to do any kind of research which could be capable of providing any general information about the ways in which spirituality impacts upon health. Not only is there a problem in defining spirituality, but there has also been considerable debate as to whether or not spirituality should itself be understood as an aspect of health. Thus far, despite debated amendments, attempts to adjust the World Health Organization (WHO) definition of health to include spiritual, alongside physical, psychological and social wellbeing have not met with success, albeit the WHO Quality of Life Research Instrument, WHO-QOL, does contain questions on spirituality. But it is not clear whether spirituality should be seen as an additional dimension of health, or rather as a separate variable that impacts upon, and thus is manifested in, physical, psychological and social aspects of wellbeing.

The WHO definition of health, as it stands, affirms that health is not merely the absence of disease, but it is not entirely clear what it is does affirm it to be:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[2]

Well-being is often either defined in turn as being concerned with health (eg Anderson et al., 2004), or else is defined subjectively (Eid and Larsen, 2008). In the former case, the definition becomes circular and uninformative. In the latter, it is subject to the plurality of

---

spirituality, and also in the strongly held views of those who deny any such thing as spirituality (at least for themselves, if not more generally).

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948

perspectives that individuals and cultures bring to bear, and to the fragility of meaning to which these perspectives are subject in the kind of secular age that Taylor describes. It is thus potentially fragmented. If it is not fragmented, I would suggest, this is because the immanent frame of reference that Taylor describes is imposed in such a way as to exclude reference to any transcendent dimension. However, as soon as transcendence and meaning are seen as important to human wellbeing they are subject to the process of fragilisation that Taylor describes and thus health itself becomes a fragmented concept in a fragmented world.

Health, or in a more general sense wellbeing, is also a concern of different and overlapping interest groups including health professions and communities (including those of complementary and alternative medicine as well as mainstream medicine), faith communities (and newer spiritual traditions), and academia. Within academia many departments now have their own interests in health, and this includes the humanities as well as the social and natural sciences.[3] Health (and also spirituality in the context of health) is thus the province of many individuals, disciplines and organizations.[4]

There is thus both plurality of interest in health, and also fragmentation of meaning (inasmuch as we have no agreed definition of wellbeing that incorporates both spirituality and the bio-psychosocial dimensions of health). Despite these potential problems, spirituality has attracted increasing interest in recent years in healthcare research.

Research on Spirituality and Health

A search of Medline citations reveals that increasing numbers of papers on spirituality have been published in the healthcare literature since the early 1980s, rising from zero in the 1970s to several hundred per year in the early 21st Century (see Figure 1).

[3] See, for example, Barritt, 2005 for one account of how the humanities can contribute to healthcare.
[4] This is evident also in our understanding of key related concepts, such as that of the self. The process of fragmentation has left us without a coherent or integrated understanding of what selfhood is (see Martin and Barresi, 2006, pp.297-304).

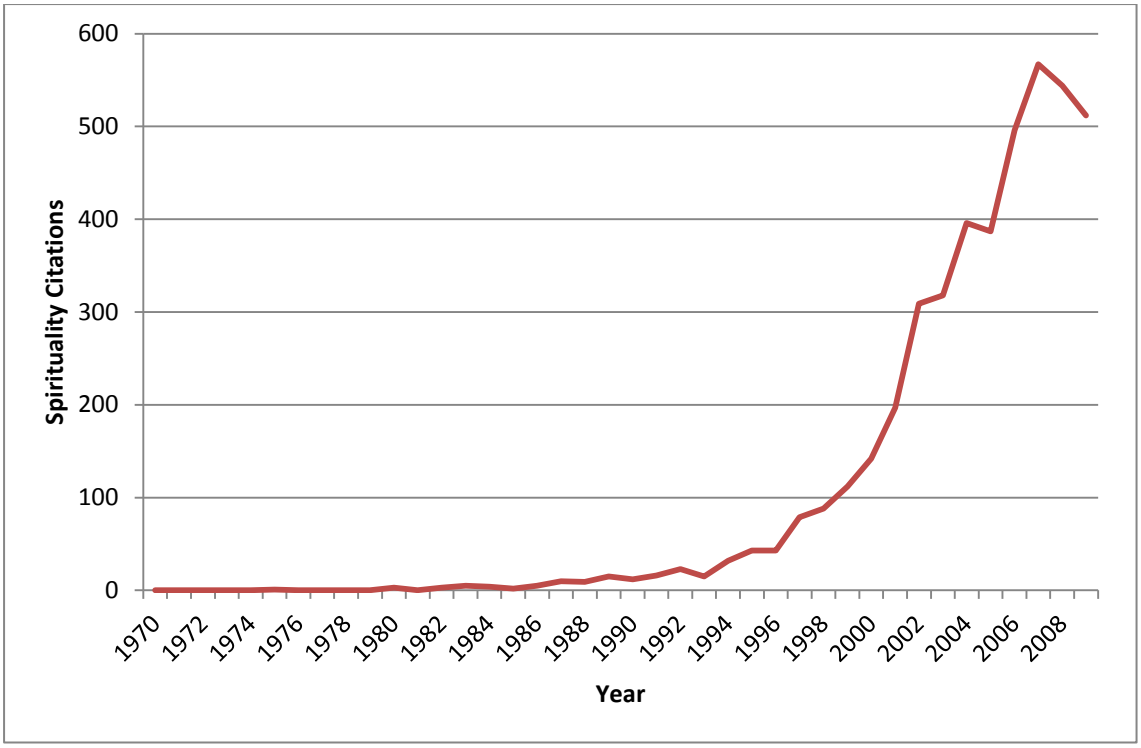

Figure 1: Spirituality - Medline Citations

The Medline database is growing in size year by year, but the number of publications on spirituality is also seen to be increasing when taken as a percentage of papers in the total database (see Figure 2).

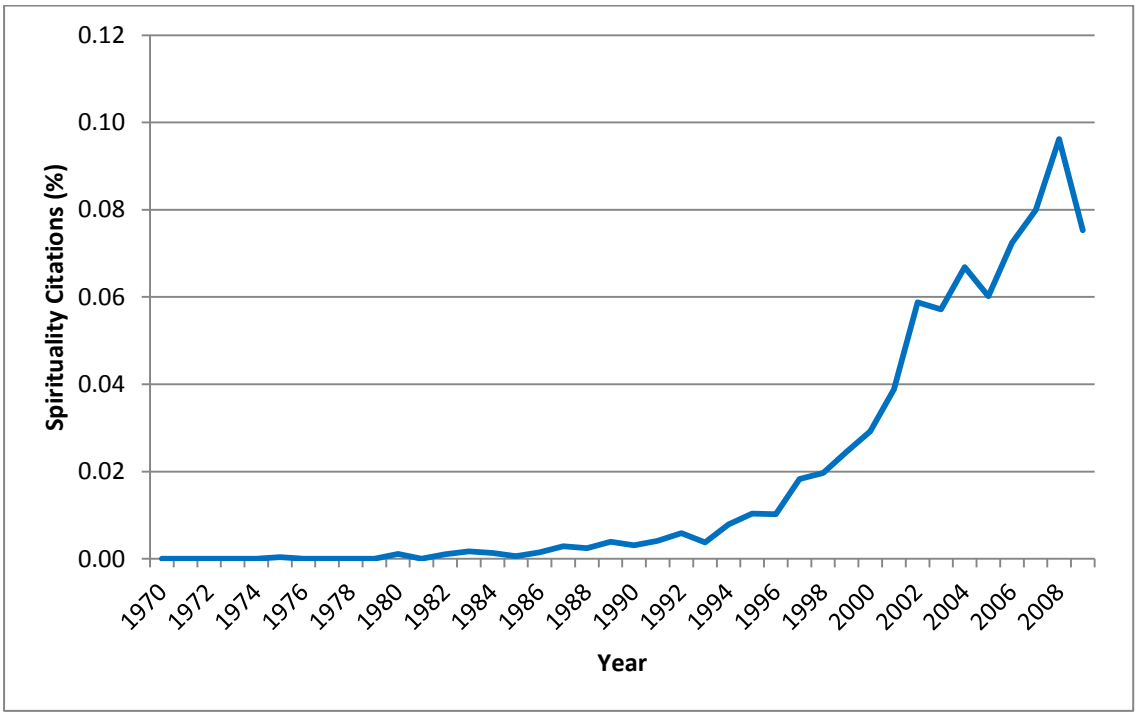

Figure 2: Spirituality – Proportion of total Medline Citations

The most comprehensive and systematic attempt to date to review the literature on religion/spirituality and health is the influential *Handbook on Religion and Health*. When the first edition of this widely cited and influential *Handbook* was published in 2001 (H. G. Koenig et al., 2001), 1200 empirical research papers on religion and health were reviewed. The general conclusions were that religion is associated with better health, and is predictive of better health. Spiritual interventions were generally associated with better outcomes than in control groups. However, it was also acknowledged that the methodology of many of the studies reviewed left much to be desired, and that sometimes, contrary to the general conclusions of the editors, religion could be harmful to health. The *Handbook* was the most cited book or article on religion and health since Allport and Ross published their paper on Personal religious orientation and prejudice in 1967 (Allport and Ross, 1967).

In 2012, a 2nd edition of the *Handbook* was published (H.G. Koenig et al., 2012), and this provides evidence of the continuing growth of the literature in both quantity and quality. Reviewing studies in the decade since the first edition was published, it summarises the findings of over 2100 quantitative empirical research studies examining the relationship between religion and health, a review which the authors estimate includes about 75% of the extant quantitative research. Studies were ranked for quality on a scale of 1 to 10, a system which overall suggests that actually the quality profile has not changed much since the first edition was published. The authors explain this on the basis of the increased number of journals specialising in this area that have appeared over the last 10 years and which, they suggest, have initially been willing to accept lower quality papers. Balancing these papers, they point out, a higher number of high quality papers have also been published during the period in question, and these studies address many of the methodological concerns associated with earlier research.

The editors make a strong case for preferring religion (or religiosity) as a research variable, rather than spirituality (H.G. Koenig et al., 2012, pp.45-46). Arguably the former is easier to operationalize in research design, with items such as church attendance or frequency of religious practice being easier to measure objectively, although it has to be said that the concept of religion is not a lot easier to define than is spirituality. Perhaps more importantly, spirituality is very difficult to measure without being confounded with other variables.

The findings of the 2nd edition of the *Handbook* are that at least two thirds of the studies reviewed demonstrate an association of spirituality / religion with more positive emotions, less emotional disorders, better social connections, and/or healthier lifestyle. For many studies, better quality of design is associated with increased likelihood of finding a positive relationship. However, the strength of the relationship is often only weak to moderate, and the authors attribute this to three factors. Firstly, there is commonly an incongruity between reported beliefs and lifestyle. Belief and behaviour are often context dependent and the reported beliefs and behaviours measured in research may often not be lived out in all areas of life (eg at work or in other areas of life apart from the faith community). Secondly, the relationships between religion and health are complicated by factors such as genetics, developmental and other environmental variables, and the effects of ageing. Some

confounding variables are difficult to measure, and others may yet not have been identified. Religious coping also comes to the fore when people are unwell, and so they may report more religious beliefs and behaviours when they are ill – thus reducing the observed strength of any positive relationship between religion and health. Thirdly, the authors recognise that poor quality research design is still a problem, and may well reduce the strength of observed effects and associations and/or increase the chance of finding no association.

Objections

Internationally, one of the strongest critics of the place of spirituality in healthcare in recent times has been Richard Sloan. Sloan's arguments, summarised in his book *Blind Faith: The Unholy Alliance of Religion & Medicine* (Sloan, 2006), are raised on scientific, ethical and practical grounds.

Sloan's scientific concerns overlap with the acknowledged weaknesses of the evidence listed by Koenig et al in *The Handbook of Religion and Health* and one has to form one's own judgements as to whether Sloan or Koenig et al take the more sober view of the evidence. Whilst it would be quite unfair to compare Sloan's *Blind Faith* with the systematic review of the evidence provided by the two editions of *The Handbook*, it is clear that the latter do at least attempt to review the whole field as objectively as possible. Much of the evidence was indeed gathered in the course of research designed to answer different questions than those posed by spirituality and religion, and the methodology employed in many studies would be considered poor by today's standards (as the editors of *The Handbook* acknowledge). This does not make it irrelevant, but simply behoves future researchers to do better, to focus their research attention more directly, explicitly and carefully on spirituality and religion. Similarly Sloan's claim that patient demand for attention to spirituality has been over-estimated would be a good reason for doing more research on what mental health service users actually do want in regard to their spiritual care. It does not mean that patient demand, or the views of service users, can simply be ignored.

Sloan's ethical objections must be taken very seriously indeed. If even some of the examples that he gives of proselytising in clinical practice are well founded, then this alone is cause to be concerned (although it should be noted that these are examples taken from the US and not the UK). He also argues cogently that reference to religion can be associated with guilt, and that it can sometimes undermine compliance with medical care, although these would seem to be reasons why clinicians might need to be more aware of the influence of religion upon health and the practice of medicine (especially psychiatry), rather than ignoring or excluding it. Whether with appropriate professional safeguards and clarification of the boundaries of good practice the giving of attention to spirituality in healthcare need be an invasion of privacy, a violation of patient autonomy, a trivialising of religious experience, or food for religious factionalism might be much more debatable than Sloan seems to allow, but no doubt debate about such things is good and there is a need to draw attention to the possible ethical boundary violations that should be avoided.

Finally, Sloan's practical objections are concerned with the impossibility of deciding between which are good or bad spiritual beliefs, from a purely healthcare point of view, the lack of medical time to devote to spiritual concerns, and the lack of adequate training of physicians to undertake the task. Good counter-arguments exist on all of these counts. It is difficult but not impossible to identify harmful forms of spirituality, and some are very easily identifiable (Crowley and Jenkinson, 2009). A spiritual history, at least of a preliminary kind, is not necessarily time consuming (Culliford and Eagger, 2009) and adequate training is increasingly recognised, and provided, as needful.

Sloan presents the arguments against an unquestioning acceptance of the benefits of addressing spirituality in healthcare. This reminds us both that there are such arguments - and that they need to be taken seriously – and also that there are those, such as Sloan, who disagree with interpretation of the research evidence concerning spirituality and health, and who object to closer integration of spirituality in healthcare. Such a critique of spirituality in healthcare is helpful, and researchers will do well to address the concerns that Sloan has raised. However, Sloan's account of things focusses on the immanent frame (except where it seeks to exclude the transcendent) and does not leave much space for expressions of transcendence in healthcare. This might be seen by some as an appropriate boundary between the secular and the transcendent, but it might also be seen as a symptom of the malaise of immanence that Taylor describes.

Spirituality and Health in a Fragmented World

Within a world that is both plural and fragmented, there may yet be coherent and unfragmented worlds that are internally consistent, and which present coherent alternatives. I would suggest that such an alternative is provided, for example, by the Orthodox Christian tradition, within which physical, psychological, social and spiritual aspects of wellbeing are united in a coherent and integrated understanding of the transcendent and immanent orders (Christopher C.H. Cook, 2011). It has been suggested that Islam, Buddhism and Hinduism present similarly coherent alternatives within the plurality of western society. However, the existence of such alternatives does not undo the fragmentation of the secular western world and, if Taylor is right, the existence of these alternatives perhaps even further contributes to the fragilisation of meaning that is at the heart of the problem.

Within Taylor's account, the nova phenomenon seems to make sense of why spirituality (or, perhaps better, diverse and new spiritualities) has become of such interest in recent decades. The world of healthcare is but one domain in which this has been observed. However, people who are facing adversity, including the adversity of ill health, do draw on transcendent (spiritual and religious) resources as a means of coping (Pargament, 2011) and so we might expect this area of our common life to be one within which these concerns will be seen as especially acute. Recent controversies about the place of spirituality in healthcare might be taken as evidence in support of this (Cook 2013, *in press*). I am not convinced,

however, that the arguments on which the debate is currently focussed, important though they are, actually address the heart of the problem.

If Taylor's account of things is correct, we should not expect that arguments which essentially serve to defend the privilege of the immanent frame of reference – however cogent – will be helpful. Rather, it is likely that they will contribute to a deepening of the collective sense of a malaise of immanence that is at the root of the problem. This in turn is likely to result in counter-arguments in support of transcendence, counter-arguments which are only likely to further polarise perspectives of immanence and transcendence in a crude and unhelpful way. It is hard to know what the final outcome of a polarised debate of this kind would be, but it is difficult to see how it can be resolved in a constructive or satisfactory way.

At the heart of the matter, I would suggest, are the fragilisation of meaning and the fragmentation of understandings of spirituality and wellbeing, that are associated with the kind of secular age that Taylor describes. If this is in fact the case, then a more constructive way forward for this debate might comprise an exploration of how coherent frameworks of meaning, spirituality and wellbeing might be constructed within which our common life might be pursued. The kind of coherent framework that is needed should acknowledge both the immanent and the transcendent aspects of spirituality, and also needs to find a way of restoring some degree of wholeness to our fragmented understanding of health and wellbeing. In theory at least, I think that concepts of spirituality which seek to incorporate immanent and transcendent perspectives and practices in a creative tension, rather than in polarised mutual contradiction, might serve to support such a way forward. However, in practice, it is not clear how the objections of those who deeply object to the concept of spirituality can best be addressed.

The Handbook of Religion and Health, in common with much of the critique and controversy surrounding spirituality and healthcare, focuses on practical, scientific and professional concerns. Whilst asserting the importance of transcendence, *The Handbook* also occupies a very immanent frame of reference for reviewing, critiquing and summarising the research that has been undertaken to date. This is not meant to be a criticism, for it is hard to know how things could be otherwise. Scientific research is needed, and must be evaluated on its own terms. It does also seem to show that spirituality and religion (as concerned with the transcendent) are good for human wellbeing. However, this in itself does not provide the coherence or integration of meaning that seems to be needed as a remedy for the problem of fragmentation.

A constructive and realistic way forward would therefore seem to require ways of creating a conversation that acknowledges immanent and transcendent aspects of spirituality in a creative tension, and which also provides a coherent and integrating framework within which to conduct scientific, professional and ethical debate about spirituality and healthcare. Such a way forward might be pursued both by giving more attention to theology, religious studies and the humanities within professional and scientific practice (Dein et al 2012, *in press*) and also by the undertaking of research which draws together proponents of the opposing viewpoints in a creative and constructive way, rather than by reinforcing

polarised and antagonistic points of view. Ironically, at least for those who argue for the importance of transcendent perspectives, this will need to involve empirical research which investigates the nature and extent of actual clinical dilemmas. However, there is also no doubt that a more critical philosophical and theological engagement with research and practice is needed. Both this research, and the empirical research that is being advocated here, will need to pay attention to the ways in which meaning is found outside of spiritual, religious or transcendent frames of reference, as well as within them.

Conclusion

Fragmented concepts of spirituality and wellbeing, reflected in recent controversies concerning spirituality and health, present a challenge to clinicians seeking to define good practice and potentially impact adversely upon the coping resources which people draw upon in times of illness and adversity. A polarised debate, within which scientific research is set against transcendent sources of meaning, is only likely to exacerbate the fragmenting process. More research is needed which draws upon the resources of theology and the humanities, and which understands spirituality as concerned with both transcendent and immanent frames of reference.

References

Allport, G. W. & Ross, J. M. (1967) Personal Religious Orientation and Prejudice. *Journal of Personality and Social Psychology,* 5**,** 432-443.

Anderson, S., Butterfield, J., Daintith, J., Holmes, A., Isaacs, A., Law, J., Lilly, C., Martin, E., Mckeown, C., Stibbs, A. & Summers, E. (2004) *Collins English Dictionary,* Glasgow, Collins.

Barritt, P. (2005) *Humanity in Healthcare: The Heart and Soul of Medicine,* Oxford, Radcliffe.

Cook, C. C. H. (2004) Addiction and Spirituality. *Addiction,* 99**,** 539-551.

Cook, C. C. H. (2011) *The Philokalia and the Inner Life: On Passions and Prayer,* Cambridge, James Clarke.

Crowley, N. & Jenkinson, G. (2009) Pathological Spirituality. In Cook, C., Powell, A. & Sims, A. (Eds.) *Spirituality & Psychiatry.* London, Royal College of Psychiatrists Press. 254-272.

Culliford, L. & Eagger, S. (2009) Assessing Spiritual Needs. In Cook, C., Powell, A. & Sims, A. (Eds.) *Spirituality and Psychiatry.* London, Royal College of Psychiatrists Press. 16-38.

Eid, M. & Larsen, R. J. (Eds.) (2008) *The Science of Subjective Well-Being,* New York, Guilford.

Koenig, H. G., King, D. E. & Carson, V. B. (2012) *Handbook of Religion and Health,* New York, Oxford University Press.

Koenig, H. G., Mccullough, M. E. & Larson, D. B. (2001) *Handbook of Religion and Health,* New York, Oxford.

Macintyre, A. (1981) *After Virtue: A Study in Moral Theory,* London, Duckworth.

Martin, R. & Barresi, J. (2006) *The Rise and Fall of Soul and Self,* New York, Columbia University Press.

Pargament, K. I. (2011) *Spiritually Integrated Psychotherapy,* New York, Guilford.

Roof, W. C. (1999) *Spiritual Marketplace: Baby Boomers and the Remaking of American Religion,* Princeton, Princeton University Press.

Sims, A. & Cook, C. C. H. (2009) Spirituality in Psychiatry. In Cook, C., Powell, A. & Sims, A. (Eds.) *Spirituality and Psychiatry.* London, Royal College of Psychiatrists Press. 1-15.

Sloan, R. P. (2006) *Blind Faith: The Unholy Alliance of Religion and Medicine,* New York, St Martin's Press.

Taylor, C. (2007) *A Secular Age,* Cambridge, Belknap.

Vanhoozer, K. J. (2003) Theology and the Condition of Postmodernity: A Report on Knowledge (of God). In Vanhoozer, K. J. (Ed.) *The Cambridge Companion to Postmodern Theology.* Cambridge, Cambridge University Press. 3-25.

Wilson, J. R. (2010) *Living Faithfully in a Fragmented World: From after Virtue to a New Monasticism,* Eugene, Oregon.