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Searching for a missing element of the concept of holistic health: The conceptualization of spiritual illness and its implications for the well-being of older people

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Abstract

Although the World Health Organization (WHO) does not formally refer to spiritual health in its constitution, it seems to accept that health among the older people has a spiritual aspect. Studies conducted in recent decades have examined the issues of spiritual well-being, spiritual health, spiritual assessment, spiritual healing, and spiritual care. However, there has been hardly any research on or discussion of spiritual illness over the same period. This paper provides a preliminary definition of spiritual illness that is grounded in both theory and practice. As the concept of spiritual illness gains formal recognition, so too will the physical, mental, social, and spiritual well-being of older people (or all people) be enhanced by the appropriate clinical diagnosis, referral, and treatment of people who suffer from spiritual illness.

Key words: spiritual health, spiritual illness, holistic concept of health

Introduction

"Better late than never" "The first step to health is to know that we are sick"

The provision of holistic health care services that not only focus on patients' physical symptoms, but also on their other problems and hidden issues, has today been accorded a level of priority that is unprecedented in the history of our health system (WHO, 2008). However, is our concept of holistic health complete? Are we sure that we have not missed any meaningful and important elements of this concept? If the answer to either or both of these questions is 'no', one of the priorities in further developing the health system is to find the missing element(s) of this concept.

Since 1946, the constitution of the World Health Organization has defined health in terms of its physical, mental, and social aspects (WHO, 2006). Though a proposal to add the fourth aspect of health - spiritual well-being, was declined at the 52nd World Health Assembly held in May 1999 (Sein in WHO, 2006), the WHO seems to accept the spiritual aspect of health among the older people (WHO, 2000). This paper will provide a preliminary definition of spiritual illness. Some examples of spiritual illness and their significance to the well-being of older people will be discussed.

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Spiritual well-being and spiritual health

The concepts of spirituality, spiritual well-being, and spiritual health are gaining increasing recognition by medical practitioners and mental health professionals (Brady et al., 1999; Kearney & Mount, 2000). Spiritually healthy older people are likely to experience positive feelings, exhibit positive behaviour, and have positive cognitions of their relationships with themselves, others, the transcendent and nature. A spiritually healthy person is also likely to strive for things including the meaning and purpose of life or existence, the will to live, direction in life, love, forgiveness, truth, beauty, trust, a sense of identity, contentment, joy, respect, positive attitudes, inner peace and harmony, creativity, and transcendence beyond the here and now in search of some higher power or God (as defined by the individual)/something greater than oneself (Burkhardt & Nagai Jacobson, 2000; Laukhuf &Werner, 1998; Ross, 1995;Vance, 2001; Young & Koopsen, 2005).

A preliminary definition of spiritual illness

Although the topics of spiritual well-being, spiritual health, spiritual assessment (Gomez & Fisher, 2003, 2005a, 2005b; van Dierendonck, 2005), spiritual healing (Benor, 1995; Cox, 2003; Kimbrough & Drick, 1991; Kreidler, 1995), and spiritual care (Lemmer, 2005; McGee, 2000; Wright, 2008) have been widely discussed and researched over the last few decades, our review of the extant literature has found a paucity of academic discussion or study which focuses on the term 'spiritual illness'. On the face of it, this situation does not appear to be logical.

Kreidler (1995) built on the ideas of others (Ammerman & Hersen, 1990; Bass & Davis, 1988; Courtois, 1988; Dickenson, 1975; Gershon & Straub, 1989; Miller, 1984) in proposing that patients who are spiritually ill have no life dreams, creativity, or vitality; are neither able to give or accept love nor to trust themselves or others; neither view life and life events as meaningful nor perceive themselves as capable of facing them; feel life is a pain to be further endured; and do not live life to the full in spite of their existence. Kreidler's explanation of spiritual distress echoes the characteristics of a spiritually unhealthy person as defined above.

Based on Kreidler's (1995) work, we propose a preliminary definition of a person who suffers from spiritual illness may displace one (or more) of the following features.

1. The person has negative feelings, exhibits negative behaviour, and/or displays negative cognitions of relationships with him/herself, others, the transcendent, or nature;

2. The person does not strive for a wide range of meaningful things including the meaning and purpose of life or existence, the will to live, direction in life, love, forgiveness, truth, beauty, trust, a sense of identity, contentment, joy, respect, positive attitudes, inner peace and harmony, creativity, and transcendence beyond the here and now in search of some higher power or God (as defined by the individual)/something greater than oneself.

3. The person is obsessed with (or cannot get rid of) a wide range of undesirable things (which are of the opposite nature to the meaningful things described above), such as attempts at self-harm or to commit suicide, the will to kill, aimlessness in life or in behaviour, hatred and revenge, falsity, ugliness, distrust, forsaking one's identity, dissatisfaction, sadness and/or worry, disrespect, negative attitudes, inner struggle and dissonance, immutability, and searching for some evil power/something smaller than oneself (e.g., materialism).

4. The spiritual disturbance from which such people suffer is likely to cause clinically significant distress or impairment in social, occupational (academic), or other important areas of functioning.

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The significance of spiritual illness to the well-being of older people

If health professionals recognize the concept of spiritual illness, examples of spiritual illness, and their significance to the well-being of older people, formal referrals will be made and suitable intervention could be provided to enhance the well-being of older people. The following provides some examples of spiritual illness and their significance to the well-being of older people.

Lack of a will to live

Research findings show a consistent pattern that higher hopeless level, suicidal risk, and desire for a hastened death have been found among terminally ill populations than the general population (Breitbart et al., 2000; Kleepsies et al., 2000). Breitbart and colleagues (2000) reported that spiritual well-being is inversely correlated with a desire for a hastened death in terminally ill cancer patients. Appropriate hope-based interventions plus appropriate symptom control may enhance their willingness to live.

Aimlessness in life or in behaviour

In a recent case study (Nagaratnam et al., 2006), a 72-year-old woman who had a medical history that included a blocked cerebral artery presented with isolated global dysphasia without hemiparesis. During the study period, the patient was able to perform all daily living activities, but was impulsive and stubborn, displayed pressured speech and incoherency, wandered aimlessly, was annoying to others, and was resistant to suggestions. As her neurological examination was unremarkable, no further suitable medical intervention was considered for the patient. The patient was later referred to mental health services. Interventions which assisted the patient to seek purposes in life and to engage in purposeful activities helped improving her mental and spiritual well-being.

Hatred and revenge

In comparison with younger people, older people are usually more able to forgive (Subkoviak et al., 1995). However, a very small number of older people are never able to rid themselves of their hatred or the urge to take revenge against people who have offended them (Girard & Mullet, 1997). Suitable intervention can be provided to enhance older people's ability to forgive. Studies supported that people who forgive are happier, have improved functioning, less death anxiety, enhanced life satisfaction and less depression and somatic symptoms (Krause & Ellison, 2003).

Distrust

Distrust is the opposite notion of trust. One important way in which the well-being of older people can be greatly affected is where they distrust health care professionals and the healthcare system. It directly influences patient satisfaction, adherence to treatment, and the formation of partnerships aimed at promoting health and disease management. Patients who harbour this form of distrust may be burdened by anxiety, and having to cope with the difficulties of navigating the health care system, and may be confused by the complexities of modern medicine (Mascarenhas et al., 2006). The fundamental role of trust has been emphasized in contemporary healthcare. Healthcare professionals could enhance trust with older people by treating healthcare as a collaborative process in which patients take a more active role. The idea of passive patient as recipient of care has to be replaced by the informed and active patients.

Forsaking one's sense of identity

Having a sense of identity refers to having a sense of continuity in one's different roles and contexts in life from the past to the present and to having a sense of history about one's life. Although every individual constructs a sense of identity in a unique way, this can be greatly influenced by subtle comments

or evaluations made by others about one's performance. For example, a demented person's sense of identity is threatened by the deterioration of memory and mental functioning and by institutional care regimes when familiar objects, people, and routines are removed. Interventions designed to maintain a patient's sense of identity should include two important components: a detailed knowledge of the patient's history and the ability to respond to the uniqueness of the patient (Redfern & Ross, 2005).

Inability to dispel dissatisfaction

Older people are sometimes obliged to face new situations in later life that make them dissatisfied. One common situation in this context is involuntary relocation or institutionalization, whereby relocated older people lose an extensive network of friendship ties and convenient access to many community facilities (e.g., markets, health clinics, banks, transportation, etc.). The loss of friends not only results in loneliness, but also fosters insecurity, because older people may depend on their neighbours or friends for help in the event of an emergency. Older people who are forced to move because of urban renewal projects have been found to be less well-adjusted and more dissatisfied and to suffer from greater levels of depression, sadness, and negative feelings (Ng, 2001). When relocation is inevitable, ways to facilitate older people's orientation and adaptation to new environment may enhance their mental, social, and spiritual well-being.

Sadness and/or worry

Although a high proportion of older people have many worries, such as those related to a low income, potential health problems, physical suffering, or concerns about their future living situation (Levasseur et al., 2009), health professionals do not usually refer overly worried patients for treatment solely on that basis, even if their worries are excessive. This is because a propensity for excessive worry is considered to reflect merely one of the extreme poles of the range of personality types (Hudson and Rapee, 2004). Furthermore, older people who worry excessively tend to learn to live with their problem and seldom seek professional help (Fuentes & Cox, 1997). Appropriate intervention to assist older people who worry excessively to understand their worries and ways to manage their emotion and to cope with their problems may improve their mental, social, and spiritual well-being.

Inner struggle and dissonance

Inner struggle and spiritual dissonance can be manifested in many ways. In a study of medically ill hospitalized older people, poorer health (measured according to variables such as number of medical diagnoses, impairments in activities of daily life and self-rated health) was associated with indicators of religious struggle, including reports of anger at God, feeling punished by God, and believing that the devil was at work in the illness (Koenig et al., 1998). In another study of medical rehabilitation patients, patients' anger at God was predictive of poorer physical recovery four months later (Fitchett et al., 1999). Fitchett and colleagues found that a greater degree of religious struggle among older patients with an illness was a predictor of declining health and a greater risk of mortality. Religious struggle was measured by the negative religious coping subscale, which covers punishment of God, interpersonal religious discontent, demonic reappraisal, spiritual discontent, and questioning of God's powers (Pargament et al., 2001 & 2004). Older patients who show signs of inner struggle and spiritual dissonance should be offered interventions to clarifying their beliefs and faith in God and finding the meaning of life.

Immutability

When the aging process takes its toll on wits and intelligence, people may need more order and organization in life

with increasing age. Some older people find it difficult to cope with change in their daily lives and show symptoms of immutability. Immutable older people give the impression that they are less effective and optimistic than their peers. With minimal or no creative activity to fuel their lives, they have no way to escape from the monotony of daily life and the problems and hardships it brings, and often suffer from a reduced sense of their own value (Pufal-Struzik, 1992). It is recommended that older people who show symptoms of immutability are provided with meaningful activities that are related to their hobbies and interests to enhance their mental and spiritual well-being.

Conclusion

Ignoring the need to formalize the concept of spiritual illness and to recognize it in our health system does nothing to advance human health. In an effort to challenge this inertia, this paper provides a preliminary definition of spiritual illness that is based on our current understanding of the known aspects of human health (i.e., physical, mental, social, and spiritual) and fills the gap in the concept of holistic health.

Based on the definition of spiritual illness proposed in this paper, we suggest that in the near future, health professionals and academic researchers devise a detailed, comprehensive system for the systematic diagnosis of spiritual illness that incorporates diagnostic features, associated features, and differential diagnoses for each form of spiritual illness. Health professionals and academic researchers also conduct systemic studies aimed at further analyzing, describing, and elaborating on each form of the spiritual illness covered by the system. This will allow health professionals to base their diagnostic and intervention practices on a more complete concept of health that incorporates all of its aspects: physical, mental, social, and spiritual.

摘要

雖然世界衛生組織仍然未將「靈性健康」正式加入於其憲章之中，世衛似乎接受長者健康應該有靈性的層面。在以往數十年的學術研究裡，對靈性健康、靈性評估、靈性治療，及靈性照顧等觀念都有相當多的探討。但在同一時段裡，卻鮮有關於靈性疾病的學術探討或研究。這篇文章初步爲靈性疾病提供理論上及操作上的定義。當靈性疾病這個觀念被正式確認後，透過爲患有靈性疾病的人士提供適當的臨床診斷、轉介及治療，長者（甚至全人類）的身體、精神、社交及靈性健康便能得以提升。

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