Clinical

Sources of wellbeing: sharpening a sociological tool for diverse populations

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Abstract

Undergraduate paramedics studying health sociology routinely reported that they could not see the relevance of a topic judiciously added to the curriculum by Australian universities ten years ago: spirituality. The topic aimed to help students better serve their patients through an understanding of attitudes, reactions and subtle influences on health. However, when discussions shifted to the more concrete concept of religion, students became more engaged and wrote essays which revealed a deeper understanding of ethnicity, culture, and its effect on paramedic practice. Religion had been regarded as a blunt instrument in other disciplines such as nursing and social work, which utilised spirituality as a more inclusive concept. Yet for paramedics it was religion that was the key to seeing the difference in the way some patients made decisions, grieved, expressed modesty or faced death, and how religious beliefs shaped responses to treatment and transport. Shared common knowledge of religions emanating from classroom discussions helped students find strategies for their future career. Students found no difficulty in seeing religion as a definitive element in contemporary society.

Key words
- Ethnicity
- Paramedics
- Religion
- Spirituality
- Social determinants of health
- Sociological imagination

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A decade ago, to encourage students to look beyond biomedical cause and effect, a model was developed to teach health sociology to paramedics in Australian universities (Kitto, 2004). It was an extension of Mills’ (2000) classical concept of the sociological imagination, which demonstrates how personal problems are often an extension of public issues (Reeves, 2011). For example, students can be taught to imagine how the global financial crisis affects breakfast tables in Brixton, Belfast and Salonika through subtle financial stress, job uncertainty and unemployment. Anxiety and income directly impact health and access to services. Teaching paramedic students to think deeply about the social determinants of health promotes empathy, equity, resilience and cultural sensitivity in patient care.

While Mills (2000) suggested that individual destiny was influenced by social milieu and the historical moment, Australian sociologist Evan Willis (2004) gave theoretical coherence to Mills’ construct by suggesting four domains which could be used to analyse events and circumstances: culture, history, structure and critique. The addition of the domains of spirituality and emotion to Willis’ model was thought to be useful by sociologists teaching paramedics because both domains were gaining recognition as significant determinants of wellbeing.

Workplace wellbeing as emotional elements of health has been thoroughly linked by research to efficacy, purpose and respect, all of which are harbingers of health or morbidity (Wilkinson and Marmot, 2003). Spirituality in its broadest sense is discussed in the teaching of nursing, aged care and social work, and it has led to practices such as the inclusion of pets in residences and music in therapy.

Students preparing to become paramedics at Charles Sturt University found the concept of spirituality was too vague for them. Yet when they discussed religion, they could see implications for their future practice.

This article will suggest that although spirituality is a more socially acceptable approach to discussing arcane aspects of health, religions succinctly addresses the complexity of practising as a paramedic in parallel cultures globally in a post 9/11 world. It is often presumed that students have a loyalty to comparative values, and that religion is a dangerous subject for classroom discussion. However, shifting the discussion to religion enabled students to examine fundamental values and imagine the role of those priorities in the health service needs of various population groups.

A review of the spirituality literature reveals a lack of clarity and substance by comparison to
Mills’ analysis of hegemonic institutions that impose values and constraints on the lives of communities. Mills’ proposals on the power of institutions in the lives of individuals finds resonance in Marmot’s (2010) longitudinal studies of health in hierarchical organisations. In other words, institutional religion has specific authority in ways that influence health servicing.

**Learning about the complexity of patients and their problems**

Discussions of specific religions are a gateway to topics such as inclusiveness, prejudice and tolerance, consent and the patients’ rights to choose. Such discussions provides students with more sympathetic insight into events where paramedics may feel obstructed or intimidated by family members, where treatment is refused, or where a crowd gathers to express violent grief. While students are commonly aware of the legal consent issues surrounding a Jehovah’s Witness’ refusal of blood transfusion, they are rarely aware of hidden porcine and bovine medical products that impact Jews, Muslims and Hindus. Students may be aware of the dietary restrictions, but unaware of prolonged fasting practices in many religions. For paramedics, the cultural beliefs surrounding covered women, male modesty, mental illness and death, are significant. Raising student awareness is more important than a comprehensive education in world religions, and this can be achieved through research essays and literature searches.

The usefulness of talking about religion in one classroom became evident when Muslim students expressed their concern about the social housing of elderly people in Western societies. They associated family care of elderly people with the family values of their religion. When students began to trace their own values and beliefs it led to constructive analysis of the role of culture, religion and social values in health care. Issues of modesty, diet, drug and alcohol use, grieving, death and the uptake of transport and interventions, could be linked to specific cultural expressions of religion. Worrying incidents from clinical placements where women refused to undress and the police were called to quell a ‘riot’ of mourners, were explored in a new light. From these concrete discussions students could explore strategies to defuse such encounters and obtain cooperation with specific religious communities.

Although the field of spirituality is burgeoning, it has been applied to health therapies rather than urgent events in chaotic venues where paramedics work among the diverse populations found in most Western cities. Spirituality lacks the specificity to develop culturally sensitive paramedics.

**Distinguishing spirituality and religion**

Spirituality began to receive the attention of scientific enquiry at the beginning of the 21st Century in the wake of decline and disenchantment with organised religion. There is extensive research evidence linking wellbeing to religiosity (George et al, 2000; Curlin et al, 2007; Holt, Clark and Klem, 2007; Cohen, Yoon and Johnstone, 2009; Georgellis, Tsitsianis and Yin, 2009), and some authors suggest a distinction is impossible because many people do not distinguish between their religious beliefs and spiritual practices (George et al, 2000).

Some subtle distinctions in the connection between religion and wellbeing are evident in the mechanics of belonging to organised religion, such as supportive social structures and systematic teaching. Individual spirituality exists both beyond and within organised religion, so that although it is impossible to confine or define spirituality and

**Figure 1. Discussions of religions gives paramedics the insight to handle culturally sensitive situations in an appropriate way**
religion as exclusive domains, it is important to separate spirituality from intellectual adherence. It is better understood as a dynamic personal expression of informal porch theology (Jensen, 2005), which is the popular ideas and practices adherents develop outside of their place of worship.

"Paramedics can express respect by enquiring about the beliefs and cultural practice of families...The simple acknowledgement or inclusion of people can defuse volatile situations"

One early definition of spirituality included the National Institute of Healthcare Research (NIHR) suggestion that it was: 'the feelings, thoughts, experiences and behaviours that rise from a search for the sacred,' (George et al, 2000) which was aimed at helping direct cohesive research. The core idea of spirituality as a search for meaning was reiterated following a systematic search and analysis of more than 76 articles and 19 books from a 30 year period which had definitions of spirituality or contained research on spirituality and wellbeing (Tanyi, 2002). Just by typing the word spirituality into the commercial Highbeam databases linked to the NIHR website, more than 57,000 articles including newspapers and magazines can be found dealing with manifold aspects of spirituality and health. However, the NIHRs suggested definition betrays its Western Christian intellectual influences, in that it precludes primitive animistic and deliberately intuitive New Age spiritualities and Eastern religions that are more experiential than cognitive, and have no tradition of a spiritual search for meaning. These fluid expressions of spirituality offer no guidelines for patient care because there are few compulsions and consequences for non-compliance.

By comparison, divergence from the beliefs of organised religions to which individuals subscribe, often have visible and predictable impacts on wellbeing. People who have rebelled against the proclamations of churches, synagogues and mosques may become socially disenfranchised, as well as suffering personal struggles of conscience that lead to depression and anxiety. In some cults the practices can lead to destructive health outcomes, such as those associated with what is described as spiritual healing (Hickey and Lyckholm, 2004).

Extreme Christian sects who oppose bio-medical interventions such as antibiotics and immunisations (George et al, 2000), and who avoid hospitals for birthing, have produced statistical anomalies in perinatal mortality and childhood diabetes deaths (Asser and Swan, 1998; Hughes, 2004). Adherence to institutional religions can be equally distressing, such as when church membership troubles have a negative impact on the psychological health of adherents (Ellison, et al, 2009). Unresolved religious dilemmas during chronic illness have been found to be a significant predictor of mortality in a longitudinal study (Pargament et al, 2001). However, despite the potentially destructive influence of organised religion, research shows that religious affections are associated with a sustaining spirituality that enhances wellbeing. Spiritualities on the fringes of organised religion are used to relieve tension. Communities retain the benefits of an organised religion without subscribing to its constraints. These curious hybrid communities connected to every major religious movement, may account for some of the difficulty in defining spirituality and in observing consistency of practice.

The benefits of a positive personal religion

One of the world's leading academics on health and spirituality is Harold Koenig, who is attached to Duke University Medical Centre. He makes little distinction between religion and spirituality. More than 60 studies were conducted at Duke University which demonstrated the connection between spirituality and wellbeing, particularly among older and chronically ill patients. In one early study 90% of the 337 patients consecutively admitted to the Duke Medical Centre in North Carolina, said they used religion to cope. The fact that the university is situated in an American bible belt creates difficulty with Koenig's concept of spirituality. He asserts that religious beliefs are a mechanic of wellbeing by promoting optimism, reduced substance abuse, reduced suicides, reduced anxiety, better recoveries and greater marital satisfaction. However, he writes about a dynamic personal religion characterised by elements shared with spirituality, particularly prayer (George et al, 2000; Koenig, 2000; 2004; Johnstone, Glass and Oliver, 2007).

The idea that religion promotes holistic wellbeing emerges in many studies, such as those concerned with income and life satisfaction (Georgellis et al, 2009), but the emphasis was on an active religiosity characterised by prayer and a community of faith, rather than doctrinal adherence or performance of liturgy.
Organised religion, ethnicity and elder health

There is little doubt that some ethnic groups express their religious affiliations with more intensity than others. Some studies that purport to explore spirituality in particular communities are in fact a simple evaluation of that intensity of engagement with organised religion. For example, ethnic difference in the use of spirituality in the management of chronic illness was the topic for a study by Harvey and Silverman (2007). The subjects were 88 chronically ill older (>65 years) Americans, both black and white, who lived in Pennsylvania. A closer examination of the spirituality framework used shows it was based on the idea of God as healer or enabler of healing through doctors. Furthermore, 68% of participants had a protestant religious affiliation, 27% were Roman Catholic, and 3% were Jewish. It is clear that cultural and religious beliefs are strongly entwined, making distinction difficult, and intensity of expression may be culturally linked (George et al, 2000).

Building on the concept that religiosity is positively associated with health, Holt et al (2009) used mixed methods for a telephone survey of spirituality among 400 randomly selected African Americans in the counties of Alabama, including the rural South, which is known for its high levels of religious affiliation. The selected demographic was characterised by membership of Baptist churches (66%), and the highest levels of religiosity were measured among older women, as had been anticipated. Southern Baptists avoid alcohol, cigarettes and drugs, and pray for God’s help in maintaining a moderate diet. This spirituality, which sounds like religion, does not preclude more traditional medical consultations.

In a telephone survey of 3728 Latinos living in the United States (Reyes-Ortiz et al, 2009) whose religious affiliations were not canvassed, 69% regarded spirituality as very important to their health, 60% had prayed for healing, 49% had asked others to pray for their healing, and 6% had visited a curandero, spiritual healer, or shaman. The research again showed older women were more inclined to spiritualities and less likely to consult a curandero. The positive influence of spirituality on ageing, women’s wellbeing, mental health and cognitive functions (Sullivan, 1998; Vahia et al, 2010) affirm spiritual strategies in those disciplines that are able to address spiritual needs therapeutically (Snodgrass, 2009), and imply a need to respect beliefs for the wellbeing of patients generally.

Discussion

A reluctance to approach religion is reported among medical practitioners who are now being urged to consider ‘whole person health care’ (Koenig, 2004). Religion, ranging from the shared scriptures of Judaism, Islam and Christianity, to the multitude of little understood animisms of Asia, is a powerful social structure in the lives of many. To retain the popular but esoteric term, spirituality, with its diversity of meanings and interpretations, does not assist paramedics in identifying religious laws and practices that are fiercely defended by communities of belief.

As Voyce (2007) suggests, since 9/11, the sacred is no longer separate from the secular, and in all its guises religion has a high profile in the contemporary world. Asking post 9/11 generations to inform themselves about religion is probably less confronting than before that era, when religion seemed to be vanishing. Religion is a tool for investigation, analysis and explanation of nuances of the human condition, and at the level of health sociology the truth of religions is irrelevant.

Unfortunately, religion is a subject surrounded by taboos (Giddens, 2009) that too often silence discussion, leading to inadvertent offence and conflict. Paramedics can express respect by enquiring about the beliefs and cultural practice of families. By ascertaining what is important to a family and giving commentary where possible when a person is transported, a body removed or a paramedic must remove clothing, cross-cultural bridges are built. The simple acknowledgement or inclusion of people can defuse volatile situations.

Conclusions

Mills’ concept of the sociological imagination has been applied by generations of scholars to analyse the intersection of history, social structures and political policy with the problems of individuals. Health sociology, which is concerned with the social determinants of health, is incomplete without deep insights into the way in which deeply held beliefs and practices influence health behaviour, social support systems, attitudes to life and death, procreation, sexuality, diet, medical interventions and personal mood, personality and relationships, stress, and coping. The inclusion of the domain of religion provides students with a wide-angle lens for the exploration of contemporary social health. Much germane research has been labelled as spirituality, although little of it really falls outside expressions of various organised religions. Religion as a topic is capable of capturing those elements of social life that were once too embarrassingly personal for an allied health professional to contemplate, and which fell between the cracks, or were relegated to the domains of the theologian, ethicist or psychologist.
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Key points

- Basic understanding of religion and spirituality can enable paramedics to see the difference in the way patients make decisions, grieve, express modesty or face death.
- Knowledge of various religious beliefs can help paramedics appropriately shape responses to treatment and transport.
- Paramedics can express respect by enquiring about the beliefs and cultural practice of families.
- By ascertaining what is important to a family and giving commentary where possible when a person is transported, a body removed or a paramedic must remove clothing, cross-cultural bridges are built.
- The inclusion of the domain of religion provides students with a wide-angle lens for the exploration of contemporary social health.

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