Religion
A Clinical Guide for Nurses
Elizabeth Johnston Taylor, PhD, RN, is an Associate Professor at the Loma Linda University School of Nursing, Loma Linda, CA. Dr. Taylor earned her MSN and PhD from the University of Pennsylvania and completed a postdoctoral fellowship at UCLA. She has received training in clinical pastoral education and spiritual direction. Dr. Taylor’s program of research explores spiritual responses to illness and nurse-provided spiritual care. She has written over 70 publications, including 2 books on spiritual care. Currently, she serves on the editorial boards of the Journal of Christian Nursing, Holistic Nursing Practice, and Home Healthcare Nurse.
To my parents

Madeline S. and Robert M. Johnston

Who taught me health-promoting religion by modeling for me how to dig roots deeply within a faith tradition while maintaining a broader perspective, and how to strive for a life where beliefs and practices are integrated and congruent.
## Contents

Contributors xi  
Reviewers xiii  
Preface xv  
Acknowledgments xvii

**I. RELIGION AND NURSING CARE**  

1. Religion at the Bedside: Why? 3  
   *Elizabeth Johnston Taylor, PhD, RN*

2. Talking With Patients About Religion 15  
   *Elizabeth Johnston Taylor, PhD, RN*

3. Assessing Religiosity 29  
   *Elizabeth Johnston Taylor, PhD, RN*

4. Supporting Religious Rituals 43  
   *Elizabeth Johnston Taylor, PhD, RN*

5. Legal Perspectives 59  
   *Elizabeth Johnston Taylor, PhD, RN*

6. Ethical Perspectives 75  
   *Elizabeth Johnston Taylor, PhD, RN*

7. Integrating Personal Religiosity With Professional Practice 87  
   *Elizabeth Johnston Taylor, PhD, RN*

**II. RELIGIONS: BELIEFS, PRACTICES, AND NURSING IMPLICATIONS**  

8. Anabaptist-Descended Groups: Amish, Brethren, Hutterites, and Mennonites 101  
   *Joseph J. Kotva, Jr., PhD*

9. Anglicans and Episcopalians 109  
   *The Reverend David T. Gortner, MA, MDiv, PhD*
viii  CONTENTS

10. Atheists  117
    David Silverman

11. Baptists  123
    The Reverend Peter Yuichi Clark, PhD

12. Buddhists  129
    Tony Toneatto, PhD, CPsysch

13. Christian Scientists  137
    Linda Kohler

14. Hindus  145
    Shukavak Dasa, PhD

15. IFCA International Christians  155
    The Reverend Joseph Smith

16. Jehovah’s Witnesses  163
    Miguel Murillo and Dennis Romain

17. Jews  171
    Rabbi Elliot N. Dorff, PhD

18. Latter-Day Saints (Mormons)  181
    Brent L. Top, PhD, and Lieutenant Justin B. Top

19. Lutherans  191
    The Reverend John Luoma, PhD

20. Methodists (Wesleyans)  197
    The Reverend Brenda Simonds, MDiv, BCC

21. Modern Pagans  205
    Carol T. Kirk, RN, BSN, MS, CLNC

22. Muslims  213
    Muhamad Ali, PhD

23. Orthodox Christians  221
    The Reverend John Matusiak, MDiv

24. Pentecostals  227
    Thomson K. Mathew, DMin, EdD

25. Presbyterians and Others in the Reformed Tradition  233
    The Reverend Marsha D. M. Fowler, PhD, MDiv, MS, FAAN

26. Roman Catholics  241
    Father Luke Dysinger, OSB, MD, DPhil

27. Seventh-Day Adventists  251
    Mark Carr, PhD
28. Sikhs 257
   Pashaura Singh, PhD

29. Unitarian Universalists 265
   The Reverend Susan Ritchie, PhD

Index 269
Muhamad Ali, PhD  Assistant Professor in Islamic Studies, Religious Studies Department, University of California, Riverside, CA

Mark Carr, PhD  Professor, School of Religion, Loma Linda University, Loma Linda, CA

The Reverend Peter Yuichi Clark, PhD  Manager of Spiritual Care Services at UCSF Medical Center and UCSF Benioff Children’s Hospital, San Francisco, and Associate Professor of Pastoral Care at the American Baptist Seminary of the West, Berkeley, CA

Shukavak Dasa, PhD  Priest, Shri Lakshmi Narayan Mandir, Riverside, CA

Rabbi Elliot N. Dorff, PhD  Distinguished Professor of Philosophy, American Jewish University, Los Angeles; Past President, Jewish Family Service of Los Angeles, Los Angeles, CA

Father Luke Dysinger, OSB, MD, DPhil  Assistant Professor of Moral Theology and Church History, St. John’s Seminary, Camarillo, CA

The Reverend Marsha D. M. Fowler, PhD, MDiv, MS, FAAN  Professor, Azusa Pacific University, Azusa, CA

The Reverend David T. Gortner, MA, MDiv, PhD  Professor of Evangelism and Congregational Leadership, and Director of Doctor of Ministry Programs, Virginia Theological Seminary, Alexandria, VA

Carol T. Kirk, RN, BSN, MS, CLNC  Lark, High Priestess of the Oak, Ash, and Thorn Tradition of American Wicca; and Gardnerian Priestess, Ravenhurst Coven

Linda Kohler  Christian Science nurse, and Manager, Christian Science Nursing Activities, The First Church of Christ, Scientist, Boston, MA

Joseph J. Kotva, Jr., PhD  Executive Director, Anabaptist Center for Health Care Ethics, Associated Mennonite Biblical Seminary, Elkhart, IN
The Reverend John Luoma, PhD  Visitation Pastor, Hope Lutheran Church, The Villages, FL, and formerly Professor of Historical Theology, Hamma School of Theology, Springfield, OH

Thomson K. Mathew, DMin, EdD  Professor of Pastoral Care and Dean, College of Theology and Ministry, Oral Roberts University, Tulsa, OK

The Reverend John Matusiak, MDiv  Media Coordinator, Orthodox Church in America, and Rector, St. Joseph Orthodox Christian Church, Wheaton, IL

Miguel Murillo  Hospital Liaison Committee, Riverside, CA

The Reverend Susan Ritchie, PhD  Professor of Unitarian Universalist History and Ministry, Starr King School for the Ministry, Graduate Theological Union, Berkeley, CA

Dennis Romain  Chairman, Hospital Liaison Committee of Lower North Island, New Zealand

David Silverman  President, American Atheists, Inc., Cranford, NJ

The Reverend Brenda Simonds, MDiv, BCC  Director of Spiritual Care, Methodist Hospital of Southern California, Arcadia, CA

Pashaura Singh, PhD  Professor and Dr. Jasbir Singh Saini Endowed Chair in Sikh and Punjabi Studies, Department of Religious Studies, University of California, Riverside, CA

The Reverend Joseph Smith  Hospital Chaplain Endorser, Chaplain’s Commission of IFCA International

Elizabeth Johnston Taylor, PhD, RN  Associate Professor, School of Nursing, Loma Linda University, Loma Linda, CA

Tony Toneatto, PhD, CPsych  Associate Professor, Department of Psychiatry, and Director, Buddhism, Psychology and Mental Health Minor Program, New College, University of Toronto, Toronto, Ontario, Canada

Brent L. Top, PhD  Department Chair and Professor, Church History & Doctrine, Brigham Young University, Provo, UT

Lieutenant Justin B. Top  Chaplain, U.S. Navy Naval Hospital, Jacksonville, FL
Lynn Callister, PhD, RN, FAAN  Professor Emerita, Brigham Young University, Provo, UT

Carl Christensen, PhD, RN  Dean, Buntain School of Nursing, Northwest University, Kirkland, WA

The Reverend Faye Davenport, RN, BA, BTh, MN, MEd  Senior Nursing Lecturer, Universal College of Learning; and Deacon, St. Peters Anglican Parish, Palmerston North, New Zealand

Anna Garton, RN  Mary Potter Hospice, Wellington, New Zealand

Russ Gerber  Christian Science Practitioner and Teacher, and Manager, Committees on Publication, Boston, MA

Patricia Gregory, RN  Staff Nurse, Northern California Eye Surgery Center, Citrus Heights, CA

Caz Hales, BNurs (Hons), PG Dip, RN  Lecturer in Clinical Nursing, Victoria University of Wellington, New Zealand

Marilyn Halstead, PhD, RN  Associate Professor Emeritus, Towson University, Towson, MD; Parish Nurse (Volunteer), First Presbyterian Church of Westminster, MD

Michael Hensley, RN  Kaiser Permanente, Calimesa, CA

Sharon T. Hinton, RN, MSN  Health Consultant, United Methodist Church General Board of Global Ministries, Floydada, TX

Harjit Kaur, MSocSc  Registered Clinical Counselor, Vancouver, British Columbia, Canada

Kathe Kelly, BSN, RN, OCN  City of Hope National Medical Center, Duarte, CA

Jacqueline Mickley, PhD, RN  Retired
Christina Miller, MS, MDiv, MA, RN  Nurse Coordinator for Palliative Care and Staff Chaplain, Sequoia Hospital, Redwood City, CA

Denise Miner-Williams, PhD, RN, CHPN  Research Assistant Professor, University of Texas Health Science Center, San Antonio School of Nursing, San Antonio, TX

Jessica Ongley, RN  Capital Coast District Health Board, Wellington, New Zealand

Eileen Schonfeld, BS ED, RN  Associate Chaplain, Akron General Medical Center; Volunteer Chaplain, Haslinger Pediatric Palliative Care Center, Akron Children’s Hospital; and, Co-Director, Caring Community/Bikkur Cholim of Temple Israel, Akron, OH

Savitri W. Singh-Carlson, PhD, RN  Assistant Professor and Graduate Program Director, School of Nursing, California State University, Long Beach, CA

Rani Srivastava, PhD, RN  Chief of Nursing and Professional Practice, Centre for Addiction and Mental Health and Assistant Professor, Bloomberg Faculty of Nursing, University of Toronto, Toronto, Ontario, Canada

Rilla Taylor, EdD, RN  Adjunct Professor, Florida College of Health Sciences, Orlando, FL

Anna Frances Z. Wenger, PhD, RN, FAAN  Professor Emeritus, Goshen College, Goshen, IN
Whenever looking at nursing texts describing the health-related beliefs and practices of various religions, I naturally always have a look at how my own religion of Seventh-Day Adventism is portrayed. I can remember learning from these sources that I should give more credence to the Old Testament of the Christian Bible, rather than the New Testament. (Wrong.) I also read that my religion prohibited smoking, alcohol, and the eating of pork and that a vegetarian diet was prescribed. I never read about the diversity of diets members actually eat and how this often varies with the cultural background of the adherent. I read about the facts that make my religion stand out as different from others, but I never read about why that was. I never read about how people within my religious tradition think about suffering and cope with illness—cognitively or socially.

Because I found erroneous and essentialized information that was incomplete and misleading about my religion, I figured that that must be true for the other religions described in the nursing literature. This book offers an attempt to correct for this dearth of nursing-relevant information about religions. The information in this book can help nurses to avoid being negligent to patients whose religiosity overtly and covertly influences their responses to health-related challenges and transitions. Furthermore, this book—alongside its conceptually oriented companion by Marsha Fowler and colleagues, Religion, Religious Ethics, and Nursing—works to redress the damage done by the prevailing discourse in the nursing literature that disparages religion in favor of a generic spirituality. Yet this book does try to not blindly promote religiosity. It recognizes its potential for harm as well as for good in the health care arena.

The focal point of this book is the splendid collection of 22 contributions from religionists who are not only experts about a faith tradition but also adherents of it (Section II). These contributions were generated by a list of around 20 questions that were posed to each contributor. After compiling these responses, I identified what I thought might be the nursing implications unique for each tradition. To increase the validity of these
pieces, nurses who likewise were adherents of these respective religions reviewed them to ensure accuracy and appropriateness of the contents for nursing.

Section I chapters that precede the contributions describing various religions offer context and guidance for clinical practice. An explanation on why patient religiosity is important for nurses to support is found in Chapter 1, as well as some brief contextual background about what religion is. Chapter 2 provides information about how to talk with patients about religion, a fundamental skill for respecting the religiosity of patients and their loved ones. Following on these communication skills is Chapter 3, which offers information about how to assess religiosity. Because religion at the bedside often manifests in overt rituals, Chapter 4 addresses how nurses can support such rituals. To ethically and legally integrate this information in clinical care, Chapters 5 and 6 offer legal and ethical perspectives, respectively. Because ethical nursing care in this regard requires an awareness of self and how personal religiosity (or lack thereof) influences caring, Chapter 7 provides discussion and opportunity for reflection about how a nurse’s religiosity inevitably has an impact on nursing practice.
Acknowledgments

Supporting me through this endeavor were family, friends, and even acquaintances I have never met in person. It warms the “cockles of my heart” to thank these gracious persons. This book is a product of collegial work with my friends and mentors who provided wonderful insights as this book began: Marsha Fowler, Barb Pesut, Sheryl Reimer-Kirkham, and Rick Sawatzky. I am also grateful to lawyers Roger Lang and Laura Fry, who helped me when I ventured into what for me was previously uncharted waters: legal perspectives about religion in nursing care. The feat of finding religionist contributors and nurse reviewers to represent 22 traditions took some effort. I am most grateful to numerous individuals who made this possible, including but not limited to Jackie Mickley, Kathy Schoonover-Shoffner, Kathy McMillan, and Larry Swinford. My “bosses” Marilyn Herrmann (Loma Linda University, Loma Linda, CA) and Brian Ensor (Mary Potter Hospice, Wellington, Aotearoa New Zealand) have supported this effort by kindly granting me flexibility with time. I am also deeply appreciative to Springer’s nursing publisher, Margaret Zuccarini, who warmly welcomed me to the Springer fold and has always given me good counsel. Finally, I want to thank my husband, Lyndon, and daughters, Elissa Lynn and Rilla Kathryn, for their sacrifices that have allowed me to complete this personally satisfying project.
Religion
A Clinical Guide for Nurses
INTRODUCTION

A New York City-based clinical nurse specialist was having serious complications from major abdominal surgery. She was physically and emotionally exhausted and anxious about not healing. Being Jewish, she thought having her nurse pray for her would be comforting. She was, however, very nervous about asking for prayer. She pondered for some time whether she should ask the nurse. Then, she pondered how she should ask the nurse. When her nurse next came to her bedside (to change an intravenous fluid), my acquaintance asked: “Um, if—if—it is okay with you, would you mind saying a prayer for me?” Her longing for spiritual sustenance and hopeful expectations for finding such with the aid of the nurse were dashed when the nurse appeared to look uncomfortable and stated, “I don’t do that.” The nurse quickly finished her task and left this bedside opportunity.

Contrasting true stories exist (Taylor, 2011). An English nurse was suspended from her duties because she asked a patient if she would appreciate a prayer at the end of a short home care visit to provide wound care. This recipient of care told the nursing agency that although she did not mind being asked, she thought this nurse’s religious offer could be upsetting to others. A Massachusetts nurse was similarly relieved of duties when she engaged a dying patient with AIDS in a discussion about repentance. This patient’s family reported that he had been distraught by this conversation.

These stories raise many questions. Should nurses ever offer religious “interventions” at the bedside? Is it right—or possible, or even helpful—for a nurse to respond to any patient’s religious queries or needs? If so, under what circumstances? Why, when, and how should a nurse address or support patient religiosity in a therapeutic and ethical manner?

These three stories also raise questions about the role of a nurse’s personal spiritual or religious beliefs in providing patient care. Can a nurse’s religiosity (or nonreligiosity) be surgically removed while on duty? If not, how ought a nurse’s personal spiritual or religious beliefs influence his or her nursing care? In addition to questions of ethics about introducing religion into the nurse–patient encounter, what are the legal boundaries for doing so?
These stories also illustrate the clinical reality of how religious practices and talk are sometimes comforting and appreciated by patients and sometimes discomforting and disconcerting to patients. Why might religious beliefs or practices be sometimes helpful and sometimes harmful? What mechanisms explain health-promoting or health-demoting religious beliefs and practices?

These questions are necessary to answer if a nurse is to give spiritually and culturally sensitive holistic care. The next seven chapters offer answers to these questions. The contextual information and clinical guidance these chapters provide will allow you to provide nursing care in this regard that is ethical, legal, and therapeutic.

REFERENCE

Religion typically is a taboo topic. Why should nurses risk embarrassment to broach the subject? For what reason should they bother to recognize religiosity in patients or in themselves?

Consider these scenarios: A Hindu wants her teeth brushed before breakfast. A Sikh preparing for surgery is distraught that his hair will be shaved. An atheist or neopagan patient may loathe having a chaplain visit. An Amish declines to make a treatment decision without consulting and praying with fellow believers. A bed-bound Muslim asks you for support to say daily prayers. A Buddhist is wishful about not being able to chant. A nurse colleague refuses to provide care for a patient because of a conscientious objection. Another coworker offers prayer to all her patients. Why? How do you respond ethically, legally, and therapeutically to such queries and circumstances?

Throughout this book, it is argued that when religion interacts with health and illness, it is requisite to effective and ethical nursing care to recognize this religion–health relationship. This chapter will review research and theory linking religion and health. This review provides a context and foundation for the ensuing chapters that propose how the nurse can provide religion-sensitive care.

**REASONS FOR RECOGNIZING RELIGION IN PATIENT CARE**

A number of reasons support why nurses should appreciate the role of religion as they provide health care.

**Many Patients Are Religious**

Whether caring for a patient from a first- or third-world country, it is more likely than not that they are religious. Furthermore, although this is a point that would be inappropriate to push, even nonreligious persons are often influenced by the religion of their parents or other sources of authority and society. Census data from English-speaking first-world countries indicate that the majority of people do identify themselves as religious. Conversely, self-reported nonreligiosity in the largest of these countries falls within a small and narrow range of 15%–18% (Department of Immigration and Citizenship, 2008; Kosmin & Keysar, 2008; National Statistics, 2010; Statistics Canada, 2001). Religiosity appears to be greater
among older rather than young adults, greater among women than men, and greater among African Americans and Latinos than Asians and those of European descent (Pew Forum, 2010a). Although a large majority of citizens report a religious affiliation, this does not mean they deem religion as important. In a Gallup (2010) survey of Americans, 56% believed religion was very important in their own life, whereas 25% believed it was fairly important, and 19% thought it was not very important. Likewise, 65% said religion was an important “part of daily life.”

Several recent trends have been observed in these countries. One is a trend in the movement from religious affiliation to none. While some “nones” are atheist or agnostic, many are simply “nothing in particular.” Indeed, an American survey found that of the 5% who do not believe in a God or universal spirit, only 24% called themselves atheist (Pew Forum, 2010b). Another trend is the increase in non-Christian adherents, which reflects immigration patterns. While Christianity remains the dominant world faith in these countries, there have been steady increases in the numbers of non-Christians, particularly among Muslims and Hindus (e.g., Statistics Canada, 2001). Although only 4% of the American population affiliates with a non-Christian religion, this group grew 50% between 1990 and 2008 (Kosmin & Keysar, 2008). Even within Christianity, there has been a shifting away from the historic mainline churches to evangelical and nondenominational churches (Kosmin & Keysar). Among religious Americans, there is also an increase in the mixing of multiple faiths (e.g., “hyphenated Christians”). For example, 35% of Americans occasionally or regularly attend services of a different tradition from their own. This mixing and matching of beliefs often involves mixing Christian beliefs with Eastern or New Age beliefs (Pew Forum, 2009).

Religiosity Is Associated With Health Outcomes

Research examining the relationships between aspects of religiosity and health generally (but not always) show positive linkages. Whether it is frequency of attendance at religious services, use of meditational prayer, high intrinsic religiosity, or some other indicator of religiosity, findings suggest that these indicators of religiosity associate with or predict health outcomes such as mortality, morbidity, adjustment to illness, and quality of life (e.g., Koenig, McCullough, & Larson, 2001; Levin, 2001).

Levin (2001) asserts six mechanisms for explaining how religiosity can contribute to good health. These include:

- **Religious proscriptions that support healthful lifestyles and behaviors.** For example, most religious traditions advocate that sexual intercourse be confined to a committed, covenanted, and monogamous relationship; this behavior, if adhered to, eliminates the possibility of sexually transmitted disease. Most religions also denigrate the abuse of alcohol
or nontherapeutic substances. Observant and conservative members of several religious traditions will respect proscriptions about food (e.g., Jews, Buddhists, Hindus, Muslims). These proscriptions, although varied, generally endorse ways of eating that are now understood to be healthful (e.g., vegetarian, not overindulging, avoiding meat with higher potential for disease). Epidemiological research has demonstrated Latter-Day Saints and Seventh-Day Adventists, who characteristically observe many of these health proscriptions, do live longer (Koenig et al., 2001).

- **Regular religious fellowship that benefits health by offering support that buffers the effects of stress and isolation.** For many who remain in a religious organization, it is the sense of belonging that may keep them affiliated. A faith community is like an extended family for many. Furthermore, within a society, a faith community often affords persons from different social strata an opportunity to equalize with those from higher and lower strata. This mechanism for obtaining social support allows isolated and marginalized—and healthy—individuals a structure for social safety, a place to weep and laugh with others, to give and take comfort, to belong. Although any family may have its “warts,” such a community typically offers social support. Krause and Ellison’s (2009) findings extend this assertion further. They observed that congregants who had negative encounters in their parish were more likely to have religious doubt and that suppressing doubts about religion was associated with poorer health. In contrast, congregants who attended a Bible study group (i.e., obtained better social support) were more apt to look for spiritual growth in response to a situation that raised religious doubt.

- **Participation in worship and prayer that benefits health through the physiological effects of positive emotions.** There has been considerable empirical effort during the past decade to explore the mechanisms that could explain the linkage between neurobiology and religiosity (Griffith, 2010). While much mystery exists about the biology of belief, it is known that worshipful experiences often create some degree of ecstasy, which in turn creates a physical state of well-being. Similarly, prayer can (but not always) contribute to an inner state of peace or joy. Such positive feelings of deep contentment or understanding affect body chemistry, stimulating health-promoting molecules of emotion and affecting physical well-being. Offering a glimpse into this process is a clever study done by Wiech et al. (2008) that allowed functional magnetic resonance imaging (fMRI) to compare the perceived intensity of induced pain on Roman Catholics looking at a picture of the Virgin Mary with that of nonreligious subjects looking at a da Vinci picture of the “Woman with Ermine.” The Catholic subjects perceived significantly less pain and were observed to have increased activation of the right ventrolateral
prefrontal cortex, known to be activated during times of cognitive control over pain.

- **Simple faith that benefits health by leading to thoughts of hope, optimism, and positive expectation.** For instance, most religions offer a way of making sense of why bad things happen to people, even good people (i.e., theodicies). Most religions also give believers hope in an afterlife. Many religions also provide a way of thinking about death that reframes the death in a positive light (e.g., death is sleep that ends at a second advent of Jesus, death allows the soul to go to heaven and be with God, death is a rebirth to a better existence).

- **Mystical experiences that benefit health by activating a healing bioenergy, or life force, or altered state of consciousness.** Whether it is a meditational state, a physically induced ecstasy (e.g., from religious dance or music or hallucinogenic substance), or a unitive moment (i.e., transient, random, experience of awareness of something greater or exceptional insight), esoteric religious experiences are accompanied by a sense of meaningfulness, happiness, and feeling of well-being.

- **Divine intervention that allows healing.** Although the divine is ultimately mysterious, and it is inappropriate and impossible to adequately test this assertion (Cohen, Wheeler, Scott, Edwards, Lusk, et al., 2000), many religious believers accept that the divine is omnipotent and involved with individuals in personal and intimate ways. Interpretations about how the divine intervenes in human life and earthly circumstances, of course, vary with religious tradition. Some believe that miracles continually occur as a natural result of divine laws of nature, while others accept that the divine can purposefully affect these laws to intervene and cause a magical miracle. This is illustrated in a case study of a woman with Huntington’s disease who visited Lourdes and perceived that the Virgin Mary spoke to her, telling her that she was cured (Moreno & de Yebenes, 2009). Although she continued to take her medicine, this woman was ecstatic about her “miraculous cure.” In subsequent examinations by two experts, a nearly complete elimination of dystonia and chorea were observed along with a 40% improvement (using a standardized score), but no cure genetically. These neurologists conjectured a placebo effect accounted for the “cure,” perhaps related to the known direct relationship between anxiety and chorea (Moreno & de Yebenes). Indeed, diverse views of divine intervention can produce varying perspectives such as “without medicine, God can cure me of my illness,” to “using natural pathways yet unknown, God can cure me,” or “using the miracle of human knowing about medicine, God can cure me of my illness.” Others may simply accept that “whether I survive cancer or not, the miracle is that I have been given breath today.”
These conjectures about how religion affects health suggest that religiosity is an important topic for nurses interested in health promotion and illness management.

**Religious Beliefs Influence Health Decision Making**

One’s religious beliefs can guide decision making by providing “an interpretive framework that helps to move forward in the face of overwhelming and intelligible circumstances” (White, 2009, p. 75). The growing body of evidence linking religious belief with health care decision making describes the influence of beliefs on varied decisions, from those related to pregnancy and genetic testing to cancer and HIV treatment (Taylor, 2011). Most of the research, however, illuminates how beliefs impact end-of-life-related decisions, such as those around resuscitation and prolongation of life and advanced directives and elder care planning.

**Religions Offer Coping Strategies**

Until around the turn of the century, health-related research documenting religious coping often did so by framing it in behavioral terms. That is, this research described how patients used prayer, reading holy writings, devotional and other religious practices to cope with illness (Taylor, 2002). (While many religious persons would argue that their practices are not used magically to gain outcomes, this may be true for some.) These religious coping strategies often buffer stress and provide much emotional comfort for believers.

More recently, however, this area of study is influenced by Pargament’s conceptualization of religious coping as comprising positive and/or negative beliefs (Pargament, Koenig, & Perez, 2000). Ano and Vasconcelles’ (2005) meta-analysis of 49 investigations exploring the relationship between religious coping and psychological adjustment to stress concluded that, in general, positive religious coping was associated with adjustment. Conversely, negative religious coping was associated with poor adjustment. This evidence calls nurses to support positive religious coping and consider how to address the deleterious effects of negative religious coping when it impacts health (Taylor, 2011).

**Religious Beliefs and Practices May Have Health Implications**

As this book will unpack, religious persons may practice rituals that have physical or mental health implications. These could include pilgrimages, ascetic practices, diets, “complementary” therapies, or other practices. Likewise, a religious patient will have religious beliefs about what causes illness, how to respond to suffering, what is life and death, and so forth. These beliefs will inevitably influence the way religious patients take care of their health. Furthermore, a health-related event may have religious
implications (e.g., a Hindu discharged from a hospitalization may participate in a ritual that symbolizes purification).

**Some Patients Want Nurses to Support Their Religiosity**

A few studies have surveyed patients about whether they would want their nurse to inquire about and be respectful of their spirituality and religion. While most patients do want clinicians to know about their spirituality, they do not view them as primary spiritual caregivers. Religious persons, as well as those who are experiencing life-threatening conditions, are especially eager for a nurse to discuss with them how best to support their religiosity (Taylor, 2007; Taylor & Mamier, 2005).

**Professional Mandates**

The Joint Commission (2008), the accrediting body from which most U.S. health care organizations seek approval, mandates that all patients receive a spiritual assessment. The Joint Commission recognizes religion as a salient aspect of a patient spirituality and advises that religion is to be respected and supported. Likewise, various nursing codes for ethical conduct specifically identify the religiosity of patients as a dimension of personhood the nurse must respect (see Chapter 6, Nursing Codes of Ethics).

Further endorsement for recognizing the salience of religion in nursing comes from NANDA International, which categorizes religious problems and strengths with diagnostic labels (Gordon, 2007). Although these diagnostic labels exist, nurses must be cautious about pathologizing patient religiosity. That is, although some religious problems may be unhealthful, religious distress can also be indicative of healthful spiritual maturation—spiritual growing pains perhaps. For example, a “dark night of the soul” is not depression, rather a spiritual dryness the person knows to be a gift that expands one’s understanding of God.

**THEORIES ABOUT RELIGION**

During the last half of the 19th century, social scientists began formally theorizing about how religions originate and function in society. Varied theories arose (Pals, 2006). For example, Freud portrayed religion as wish fulfillment resulting from neuroses. Marx viewed religion as a way of coping with class struggle. Others saw religion as a cultural system of symbols played out in beliefs and practices that create community or social cohesion (e.g., Durkheim, Geertz). Another theory about religion posits that it is economically driven; that is, religious beliefs that bring about advantages are chosen (Stark & Finke). Others have proposed that religious beliefs about the divine are anthropomorphic; that is, in response to ambiguity, humans project human attributes on nonhuman entities to create a personal god (Guthrie, 2007).
Social scientists also describe facets of religion with typologies. For example, Glock and Stark (1965) propose that religions have five dimensions: doctrinal, intellectual, ethical, private devotional and public ritual, and experiential. Wallace (1966) describes the typical components of religion as prayer (addressing the supernatural); music and artistic expression; physical manipulation of one’s psychological state; exhortation or addressing other humans (e.g., sermons); reciting the religion’s code or aspects of belief or history; touching that transfers supernatural power through contact; taboo or not touching certain things; simulation or imitating things; feasts; sacrifice (e.g., offerings); congregation; and inspiration (i.e., recognizing the divine in human experience). Troeltsch (1991) describes the primary types of religions. He suggests three: religious organizations that are inclusive and accommodate societal institutions; sects that demand voluntary commitment of members, are perfectionistic, and critical of the social milieu; and mysticism (an individual, spiritual religiosity).

Several religionists also offer theories about how religions evolve. Older theories describe progressive stages of organized religiosity (e.g., from individualistic and shamanistic religion to communal and collective to monotheistic and ecclesiastical) (Wallace, 1966). The recent trend, however, is to explain sociobiologically how religion exists in humans. This theorizing is informed by neurobiological science and psychology. One theory that has failed to receive further support is that there is a “God gene” that biologically explains why some people are religious (Pals, 2006). Currently, there is debate about whether research using fMRI that shows brain activity during religious experiences to be like the activity found during other human experiences (e.g., intimate interpersonal relating, cognitive coping) actually proves that religiosity is a by-product of culture or manifestation of how the human species adapts (e.g., Fingelkurts & Fingelkurts, 2009; Thomson & Aukofer, 2011).

Although some would argue that religiosity is irrational—a hijacking of the human mind or result of evolutionary misfiring (Thomson & Aukofer, 2011), all would agree that humans are very vulnerable to religious belief. Those who believe their religious experience is a result of a supernatural creative Entity, of course, can still accept that no matter how their religious experience manifests biologically in association with other cognitive processes, this vulnerability to belief is nevertheless valid and a gift allowing relationship with the divine.

Regardless, the sociobiological systems innate in humans do play an important role in religious behavior (Griffith, 2010), whether they explain religion as a by-product of adaptation or not. These systems for which humans are wired include:

- Attachment or the need to feel safe and close to a secure attachment figure (e.g., manifested in religious statements such as “God is my loving Father”)
Peer affiliation or the need for feeling safe and part of a cohesive group, such as a faith community

Kin recognition or having tradition-specific attributes and rituals that separate and unify adherents (e.g., dress, holy days, labels for religious kin like “brother,” “sister,” “elder”)

Social hierarchy (e.g., for theists, the ultimate “alpha male” is God; local congregations have some stratification of members)

Social exchange and reciprocal altruism that assures the believer that ultimately life will be good and fair (e.g., righteousness will be rewarded with a blissful afterlife, evil will be condemned at a final judgment).

These systems indeed allow humans to adapt to life’s challenges and protect our species.

Social scientists have theorized that religion will die due to modernization and secularization. This prediction, however, continues to be disproved (Hefner, 2009). While in some areas of the world ecclesiastical religion may be declining, overall, there has been an increase in religiosity globally. Religion, regardless of its causal factors, appears here to stay.

RELIGION DEFINED

Although over a century of scientific study of religion from the perspective of multiple disciplines has produced numerous theories, there is no one commonly used definition of religion. The definition accepted for this discussion about religion in patient care is that offered by Hill et al. (2000):

The feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term “search” refers to attempts to identify, articulate, maintain, or transform. The term “sacred” refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual. (p. 66)

This definition contains the criteria for spirituality. To define religion, Hill et al. suggest this definition of spirituality must be extended to also include or instead be “A search for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a context that has as its primary goal the facilitation of [the above criterion for spirituality]” and “the means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people” (p. 66). Thus, religion involves individuals seeking that which is ultimately sacred using prescribed means endorsed by a group.

Whereas the concept now labeled “spirituality” was until relatively recently considered an aspect of religion, most academics now distinguish spirituality from religion. Indeed, this distinction between spirituality and
religion is now common in the general public. Indeed, a few studies have documented that while the majority of Americans self-define as spiritual and religious, a substantial minority view themselves as spiritual but not religious (Grant, O’Neill, & Stephens, 2003; Zinnbauer et al., 1997). Although religion is typically thought of as institutional and objective while the very elastic and generic term spirituality is individual and subjective, these two concepts are deeply intertwined (Hill et al., 2000).

A CAVEAT: WHEN RELIGION HARMs

The evidence referenced above indicates that, overall, religion is good for one’s health. This, however, is not always true. If the product of religiosity is confusion, despair, isolation, helplessness, meaninglessness, detachment, or resentment, then that religiosity is causing harm (Griffith, 2010).

Pargament and others differentiate between religious coping that is positive or is negative (Ano & Vasconcelles, 2005; Pargament, Koenig, & Perez, 2000). Negative religious coping is exemplified by Demonic reappraisals (e.g., “Decided the devil made this happen”), reappraisal of God’s power (e.g., “Realized that God cannot answer all my prayers”), passive religious deferral (e.g., “Didn’t do much, just expected God to solve my problems for me”), and pleading for direct intercession (e.g., “Prayed for a miracle”). Thus, when a religious person holds beliefs that are not assuring or comforting, create unhelpful guilt or shame, instill passivity, or create a sense of abandonment, this is not healthful. Numerous studies have documented that such negative religious coping is correlated with poor adjustment during health challenges (Ano & Vasconcelles).

Griffith (2010), a Christian psychiatrist, offers an in-depth explanation about how religion can become harmful or healing. Griffith asserts that religion becomes harmful when one of three core roles of religion is prioritized over the others, diminishing personal spirituality (or “whole person relatedness”). That is, if any one of the roles of religion to ensure group security, strengthen the adherent’s sense of worth, or ease personal suffering becomes significantly more important to the believer than are the other two roles, then religion becomes harmful. Such imbalance is manifested then in religiosity that contributes to suffering, such as when one experiences the divine as an insecure attachment figure, when one searches for security primarily within a religious group, when one accepts religious beliefs to the exclusion of any alternative beliefs, or when a religious group protects only their own. Mental illness can also undermine religious experience. Griffith identifies how religious beliefs can be the vehicle expressing mental illness. Mood disorders, anxiety, and psychoses can distort religious experience as well.

Ultimately, religion becomes harmful when personal spirituality becomes diminished or dies (Griffith, 2010). Healthy personal spirituality involves: a whole person relatedness or “I/thou” relationship with the
divine; personal encounters with the sacred that stimulate creativity, reflection, and moral thinking; a dedication to being compassionate toward others and oneself; resilience; and an ability to prioritize the well-being of self and others over those of the religious group. Griffith’s observations confirm what some research indicates as well: It is a combination of positive religiosity and intrinsic personal spirituality that may be most adaptive and healthful (Taylor, 2011).

**PRIMARY PRACTICE POINTS**

- Research evidence indicates direct associations between religion and health.

- Nurses have many reasons for recognizing patient religiosity. These include the fact that religion is prevalent, that some religious practices have health-related implications, and that some health-related events have religious implications for adherents of some religions, and professional mandates.

- Religion serves many functions, from social cohesion to intrapsychic comfort.

- When religion lacks personal spirituality (whole person relatedness), it becomes harmful.

**REFERENCES**


