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What is the point of spirituality?

For the anonymous anyone death is a fact of life and entirely unobjectionable. For the loved one, it is an offense, and for oneself it is unthinkable.[1]

Medicine, metaphysics and practical life are ... silent about the human significance of death.[1]

Two papers in this issue look at spirituality: Best et al.[2] on the challenge it presents to contemporary medicine and Vermandere et al.[3] on a method for taking a spiritual history. Both hold the general view that spirituality is an important component of a person's engagement with illness, but neither defines exactly what is being examined. *Prima facie* this is odd, which raises questions about whether spirituality is conceptually different to psychology or a philosophy of life, whether it has utility in medicine and whether the lack of an agreed definition matters.

Pinning down the content of human experience can be challenging. For example, suffering, love and pain are part of what forms us, are recognised when experienced from within and sometimes when seen from without, yet they remain elusive elements of our personhood. The same goes for spirituality, which is underrepresented in the discourses of modern medicine and in secular, western culture more generally. So perhaps we should approach spirituality from another place, the uncompromising and ubiquitous space in which everyone must face their own meaning; the place and time where reconciliation, transcendence, what has and might have been, beliefs about continuity and other personal truths all reside. It is in this space that spirituality, if it has any utility, must surely have something useful to contribute.

While most people acknowledge the proposition of their own eventual death, generally it remains hypothetical so long as the business of life protects from its emotional corollary: those unbearable apprehensions that characterise death anxiety. Here is denial at work: the healthy, universal and instinctive distortion of reality that permits unwelcome thoughts of extinction to remain unthreatening and under apparent control in the basements of one's mind. While no one knows precisely when death will come, for those with diagnoses expected to kill in months rather than years, reality is harder to control. Under these circumstances, denial may act as a buffer during adjustment, but it may also fall away precipitously, leaving the person exposed to the truth, or become buttressed, taking on a rigid quality. So for some, knowledge of a short prognosis can result in immersion in loss, with its deep and raw emotions (Cassell's[4] idea of 'suffering'); for some others, denial seems to freeze in the moment of first diagnosis, so that the armaments of therapeutics once taken up against mortality cannot be relinquished, despite their subsequent burden and increasing futility.

Such death anxiety seems a cogent example of a universal spiritual concern and yet, despite the ubiquity of dying, its acknowledgement falls outside the comfort zone, and sometimes even the consciousness, of most clinicians. Within palliative care, however, the routine incorporation of spirituality into care is seen perhaps most clearly in Cicely Saunders' Total Pain model. Saunders emphasised 50 years ago that pain was a compound experience that included spiritual and psychological elements, but she did not define these terms. The question of whether hard distinctions exist between spirituality, psychology and philosophy remains, although experience using the model suggests that Saunders' ideas have practical value if nothing else. In Saunders' time, there was an unambiguous association between spirituality and religion, but this has loosened and formal religious expression now is rightly considered a subset of a pluralistic ontology of 'all-things-spiritual'. From a psychological standpoint, emotive phrases such as a person having 'turned their face to the wall' imply a person who is suffering and embracing death, while existentialist philosophy, which examines issues such as one's meaning in the universe, ultimate aloneness, human freedom and responsibility,[5] seems to be spirituality stripped bare.

Etymology demonstrates that the elusiveness of the term spiritual is not new, even though classical Greek distinguishes 'spirit' from 'soul'. Soul (*psuchē*), from which we get psychology and so on as the seat of emotion and feeling, stems from the active verb 'to breathe' (*psuchō*): the soul requires some action to engage and implies volition and free will. Conversely, 'spirit' comes from the noun for 'wind' (*pneuma*), the thing that is being breathed. In other words, according to these Judeo-Christian and Greek foundations of Western thinking, spirituality and psychology are distinct but entirely interdependent concepts.

What of attempts at definition in the medical literature? There have been many. The European Association for Palliative Care (EAPC) task force consensus definition of spirituality reflects a descriptive approach:

> Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred.[6]

So it seems that, like pain, suffering and dignity, spirituality is unique to individuals in themselves and is 'what that person says it is'; when shared by others, it is also a source of collective identity. The strength of the EAPC definition is that we can leave it to the person to use the term more or less however they wish; the weakness is that it is so broad as ultimately to be meaningless. This is unhelpful for research of a certain kind, but whether this matters depends upon one's epistemology and in what one is interested.

It matters empirically for trade in the sceptic's currency of externally verifiable facts. The development of a biomedically coherent research base is probably unattainable while multiple definitions, or none, are employed in different studies. This leaves the area vulnerable to being shelved as not being proper evidence-based medicine. Best et al's.[2] systematic review acknowledges this difficulty but does not engage it.

However, definition does *not* matter if the epistemology is holistic, where the currency enables trade with externalists: investigators prepared to reach beyond the provable so as not to miss the plausible and who recognise and value knowledge from experience. Vermandere et al.[3] try to do this with their *ars moriendi* model, but a combination of low recruitment and elements of their methodology means we are left not knowing whether this approach has credence: we don't know, for example, whether the failure to see an impact of spiritual conversations lies with the clinician's skill, the measurement tools, the fact that history taking alone is diagnostic and may not be therapeutic or whether the underlying concept of spirituality is flawed. This is disappointing.

Elsewhere, we have suggested a practical framework for approaching suffering (empirically untested), which has an echo of *ars moriendi*.[7] It encompasses physical symptoms and limitations, psychosocial issues and spiritual/existential concerns (we don't differentiate these), if the person wishes to address them. Our view is that, from first principle, in addition to being important in and of themselves, the purpose and fundamentals of palliative care (such as pain control) are a prerequisite and means to a person being able to process what is occurring – the uncertainty of their deterioration and dying – for, while not everything that is distressing must be confronted, some unconscious, inescapable agonies or tensions escalate if they remain unrecognised and unresolved. We call the place in which such transformation may occur 'decision space'. This term has a certain optimistic dynamism to it, but it also reminds us that, as well as the potential for benefit, care must be taken: such an approach is not without cost to the person should defences fall uncontrollably. Deciding, say, to relinquish or retain a bitter grudge, or continue or forego chemotherapy, necessarily means surrendering another option (and being responsible for that choice). As Yalom[5] points out, the root of the word 'decide' (*cædere*) stems from the Latin to cut off or slay (cf. homicide and suicide). It takes courage and can be a dangerous business.

What of the future? These two approaches to spirituality, the empirical and the experiential, both matter and need to converge. Best et al.[2] join a queue of those (including us) calling for an agreed definition, or failing that, a standardised taxonomy of spirituality. Vermandere et al.[3] have tried to evaluate a practice that has intuitive appeal, but, in our view, need a more robust method.

Whatever its name, there seems to be this peculiar aspect of living which most call spirituality, the point of which, ultimately, lies in what it has to say about the human significance of death and the life that leads up to it. We must not dispense with this.

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