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Yoga Research and Spirituality: A Case Study Discussion

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Abstract

There is growing evidence that yoga can be beneficial as an aspect of self-care for people with arthritis. However, yoga may be less acceptable to those from different cultures, socioeconomic backgrounds, and racial/ethnic identities. While implementing a feasibility/acceptability pilot study of yoga as self-care in minority communities, the subject of spirituality surfaced. This commentary shares the experience of the researchers and yoga teachers collaborating on the study and the larger conversation that ensued following the withdrawal of one of the study participants. It is an attempt to start a relevant and needed dialogue around yoga research as an integrative health modality, and why the underlying body-mind-spirit approach to yoga may some-times serve as a barrier to participation for diverse populations suffering from arthritis.

> "Science is not only compatible with spirituality; it is a profound source of spirituality."
>
> —Carl Sagan

This commentary serves to open a dialogue around our experience with yoga research and why the underlying mind-body approach may serve as a barrier to participation for some. Within this paper, we share a participant's decision to withdraw from an ongoing pilot study, Yoga as Self-Care for Arthritis in Minority Communities (Middleton et al., 2013), and the reverberating discussions that followed.

Case Study

A 59-year-old Spanish-speaking, Hispanic female from El Salvador enrolled in a rheumatology natural history study was referred to the yoga study after completing a clinic

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visit. She self-identified as Catholic and was diagnosed with rheumatoid arthritis. After completing all baseline questionnaires and physical assessments, she attended the first yoga class. She returned to the second class to say she would not be returning for religious reasons and left her equipment. She called later to say the yoga studio made her uncomfortable and she thought the teacher's beliefs were being imposed on her. She specifically did not like doing yoga in front of a statue (Patanjali) that seemed "diabolic." She went on to explain that she thought it was going to be something different and did not feel the yoga would help her.

This experience caused us to retrace our steps. Prior to obtaining Institutional Review Board clearance, instructions were given to remove "spiritual" aspects of yoga from the clinical trial. It was not immediately clear which would be considered cultural versus "spiritual" practices. The decision was ultimately made that no music would be played, there would be no chanting "OM" or bowing to say "Namaste," and the Sanskrit names for yoga poses would not be used. Still, there was a desire on the part of the researchers to stay true to a basic yogic philosophy and not become a low-impact, stretching, exercise class.

However, some questions surfaced after this experience. Was it naïve to think that by removing some "spiritual" aspects of the yoga we could keep it from bumping up against anyone's religious beliefs? How could we ensure that, while yoga is not a religion, it still allows room for spiritual experiences, should they emerge?

We were offered space in a Kundalini studio after attempts to rent other studios accessible to all participants. The question surfaced, is there a "culture" that comes from being in some yoga studios as opposed to a gym or other spaces? Should we cover the statue, or would that suggest there was something inappropriate about it? If asked, we would explain any of the statues or pictures—specifically, that Patanjali is an influential figure within some yoga traditions and he is not a god or deity. Was it better to discuss concerns if they arose, or preemptively as a studio orientation?

When considering the mind-body connection, the "mind" component is not only about mental health but may also include spirituality; not addressing spirituality may miss a vital component that contributes to overall well-being. To help ground our discussions, we sought a definition of spirituality within the realm of clinical research:

> Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another. (AAMC, 1999)

The psychophysiological benefits of yoga have contributed to the rationale for its clinical use as a therapeutic intervention (Khalsa, 2004). According to Bussing et al. (2012), the majority of research on yoga focuses on its psychophysiological and therapeutic benefits, while the spiritual aspects are rarely addressed (Bussing, Hedtstuck, Khalsa, Ostermann, & Heusser, 2012). We noted that attempting to integrate an intervention with Eastern origins

into a minority population from Western cultures may be more of a challenge to navigate than originally anticipated. As stated by Quilty et al. (2013), “given the reported spiritual aspects of yoga and its use in fostering improved mental health, barriers that involve the individual’s sense of connection with the practice may be of importance to researchers implementing or evaluating yoga programs.”

The demand for yoga in the U.S. is growing (Barnes, Bloom, & Nahin, 2008) and evidence shows yoga can be beneficial for people with arthritis (Moonaz, Bingham, Wissow, & Bartlett, 2015). Because yoga is a mindfulness practice, the movement sequences or quiet time spent focusing on the breath may bring up unsettled feelings related to physical, emotional, or spiritual domains. For some, this kind of self-exploration may only be acceptable within a religious context. A literature search using “yoga research” and “spirituality” yielded few references (Bussing et al., 2012; Macdonald & Friedman, 2009; Quilty et al., 2013). While Quilty et al. (2013) cover the concept of spirituality, the majority of their respondents were white, female, and college educated (Quilty et al., 2013), which has been documented as the norm for most yoga users in the U.S. (Birdee et al., 2008).

While the reasons are not clearly documented, yoga may be less accessible and/or less acceptable to those from minority backgrounds (Middleton et al., 2013). However, the lack of minority participation in research is a historically documented phenomenon (Hussain Gambles, 2003; Ojha, 2008; Shavers Hornaday, Lynch, Burmeister, & Torner, 1997; Wendler et al., 2006). This pilot yoga study was designed specifically to examine the feasibility and acceptability of recruiting English- and Spanish-speaking minority patients receiving rheumatology care from a National Institutes of Health (NIH) Community Health Clinic located in the Washington, DC area (Middleton et al., 2013). A previous Health Behaviors and Health Beliefs study conducted within the same clinic population showed only 4.6% were using yoga for their arthritis symptoms (Middleton et al., 2013; Wallen et al., 2012). Ironically, this previous study showed that 52% reported using spiritual/mind-body modalities such as prayer, drawing upon religious or spiritual beliefs, and attending religious services (Wallen & Brooks, 2012). Experience from this previous study also showed the need to be sensitive to cultural beliefs in order to encourage research participation.

The conclusion was finally reached that we should remain transparent about the yoga intervention being offered through our informed consent documents and process. No other enrollees who have taken yoga classes in this study to date have related personal discomfort with the yoga being offered. Participants are given time to consider the provided information before deciding to enroll. They are also informed that they can withdraw at any time, for any reason. Ultimately, it is not clear if this scenario illustrates a difference between those who seek yoga themselves versus being referred by a clinician, or if expectations differ for a clinical trial compared to a community-based class. Participants may have anticipated that the classes would be more of a physical “intervention” to assist with their arthritis, instead of also eliciting thoughts about mindfulness and spirituality. Yet, there may be some for whom it is uncomfortable and their comments should be documented as part of the research.

Although this experience is with one participant, we believe the yoga research conversation should be informed by the perspectives of those with differing opinions, without dismissing them as isolated concerns. There must be space for the perspectives of those who are apprehensive, choose not to participate, and question the "fit" of yoga with their own cultural beliefs. While there needs to be continued research to show the effectiveness of yoga for diagnoses such as arthritis, there is also a need to discern the acceptability and perception of yoga among those from diverse cultures and backgrounds.

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