LETTER

Response to "De-Conflating Religiosity/ Spirituality"

Submitted July 19, 2019; accepted August 12, 2019; published September 2019.

To the Editor: We would like to thank Drs. Roane and Harirforoosh for their response to our brief, which appeared in the *American Journal of Pharmaceutical Education*.[1] In our article, we state that "Pharmacy schools should find ways to acknowledge and support religiosity and spirituality of students and for promoting holistic patient well-being." In their response to our article, Drs. Roane and Harirforoosh state "That pharmacy schools should provide additional support for spirituality as a part of student wellness, and for training in spirituality assessment for patients is a sound, progressive step forward. Support for religiosity is not." They also express concern that we consistently "conflate spirituality and religiosity" in our article.

First, we would like to reiterate that spirituality and religiosity are two separate constructs, particularly when applied to the scientific literature. Religiosity is the more directly measurable construct; whereas, spirituality is a broader construct that is more indirectly and individually defined. There is certainly overlap and commonality between them; thus, they are often referenced together for general ease. Many patients may, in fact, view their religion as a means of expressing their spirituality. In our study, we assessed the results for data related to spirituality and religiosity separately. Additionally, separate statistical analyses were done for data related to each. However, we chose to group the two terms in the manuscript for ease of reporting results that were similar for both spirituality and religiosity.

In order to address the point of view that religiosity should not be supported by schools, we believe that it is imperative to review the definitions used in our article. Spirituality is defined as "a personal search toward understanding questions about life, its meaning, and its relationships to sacredness or transcendence that may or may not lead to the development of religious practices or formation of religious communities."[2] Religiosity is defined as the "extent to which an individual believes, follows, and practices a religion, either organizational (church or temple attendance) or non-organizational (praying, reading books, or watching religious programs on television)."[2] When spirituality and religiosity are viewed in these contexts, both have a place in the pharmacy school curriculum.

Roane and Harirforoosh purport that "spirituality, as opposed to religiosity is likely more relevant to the desired outcomes of pharmacy educational programs." As we stated in our article, numerous studies support the benefits of spirituality and religiosity on health. In fact, since religiosity is the more easily measured construct, more studies have focused on the impact of religiosity on health.

Furthermore, there is a growing body of literature that spirituality and religiosity can be beneficial to health outcomes. According to Zimmer and colleagues, the association between religion and health may be the result of three broad, but inter-related mechanisms: religious activity provides social support by bringing people with common values and interests together, which results in a larger quantity of social networks and in better quality of social interactions; religious denominations may encourage lifestyles that promote health (eg, meditation and mindfulness practices) and may discourage those that have a negative effect on health (eg, tobacco/alcohol use, or risky sexual behavior); and religious activity impacts psychosocial factors (eg, reduction of stress and provision of coping mechanisms).[3] There are some negative and indifferent studies on the impact of spirituality and religiosity on health outcomes, and these also should be considered when reviewing the evidence; although, the preponderance of evidence is positive.[3]

Roane and Harirforoosh support the idea of training students in spiritual assessments, but do not support the same for religiosity. However, the two are interrelated. Lucchetti and colleagues published a systematic review comparing 25 instruments used for obtaining spiritual histories in patients.[4] Of the topics that were most frequently included in each instrument, measures of religion were common, including: religious rituals and practices and their influence on treatment (17/25), religious affiliation (16/25), religious attendance (3/25), negative aspects of religion (10/25), religious rituals/practices and their influence on treatment (11/25), religious coping (17/25), religious support (19/25), option to discuss religious issues (17/25), and option to refer to the religious leader or chaplain (9/25). In fact, the Joint Commission requires institutions to address patients' rights to access religious and other spiritual services and assess and support their beliefs and preferences.[5] Thus, we feel that it is important for pharmacy schools to make students aware that patients have both religious and spiritual beliefs as these may certainly impact patient care and outcomes as

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evidenced in the literature. We are not condoning one religion or practice over another, but we do feel the goal is to make students and health care professionals aware of the many beliefs and practices that they may encounter in practice since these beliefs can have a significant impact on patient care and health outcomes.

Likewise, students and all health care professionals should acknowledge and be supported in their own religious and spiritual beliefs. We state in our article, "Due to the modest percentage (50%) of students [in our study] who felt that their pharmacy school supported their spiritual/religious beliefs, pharmacy schools should find ways to support students' religious and spiritual needs in the community and on campus, through student organizations, in recognizing religious observances, and in resources."

One of the origins of the word *religion* is actually from the Latin *ligare* meaning "to bind together."[6] Pharmacy schools, with or without a religious affiliation, are already finding ways to bind students with similar beliefs together through student organizations. There are currently 146 Christian Pharmacist Fellowship International (CPFI) student chapters across the Academy, with some schools having chapters at main campuses and satellite locations (Nena Lindrose, BS, CPFI Administrative Director, email communication, July 3, 2019). Additionally, Muslim student associations and Jewish student organizations are available at some pharmacy schools.[7-9]

Also, schools are choosing to promote student well-being by offering activities rooted in religion. For example, the Rhode Island College of Pharmacy implements regular yoga and meditation sessions for faculty, staff and students. The decision was influenced by the results of a study that Lemay and colleagues conducted at their institution to assess the effect of yoga and meditation on stress, anxiety, and mindfulness on pharmacy students.[10] In this study, certified Registered Yoga Teacher 200 (RYT200) practitioners and Shambhala Path Meditation Instructors from the faculty at Rhode Island College of Pharmacy led students in yoga and meditation practices. It should be noted that Shambhala Path Meditation is based on Buddhist religious principles. The researchers found a statistical decrease in anxiety and stress and a statistical increase in mindfulness. The authors concluded that "Higher education, including Colleges of Pharmacy, may consider the inclusion of holistic methods, such as yoga and meditation, to support student self-care."

We are delighted that our article has precipitated discussions about the role of spirituality and religion is pharmacy education. As we discussed in our article, the literature on spirituality and religion in pharmacy education is sparse. Pharmacy schools will need to consider how and where these topics are best addressed in their schools.

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