Integrating Religion/Spirituality into Clinical Practice: An Overview

Harold G. Koenig, MD

Professor of Psychiatry and Associate Professor of Medicine

Duke University Medical Center, Durham, North Carolina USA

Distinguished Adjunct Professor, King Abdulaziz University, Jeddah, Saudi Arabia

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Overview

1. Definitions
2. Early research (prior to 2010)
3. Why is religion/spirituality related to health?
4. Latest research
5. What are the clinical applications?
6. Why aren't physicians addressing patients' spiritual needs?

Definitions

Religion

Beliefs, practices, and rituals related to the Transcendent, where in Western traditions, the Transcendent is also called God, Allah, HaShem, or a Higher Power, and in Eastern traditions, the Transcendent is variously called Vishnu, Krishna, Buddha, or concepts such as Ultimate Truth or Reality. Religion may also involve beliefs about spirits, angels, demons, or other supernatural forces. Religions usually have doctrines about life after death and rules to guide behavior during the present life to prepare for the life to come. Religion is often organized as a community and maintained as an institution. Religion, however, can also exist outside of an institution, and may be practiced alone and involve private expressions of devotion to the Transcendent. At its core, religion involves an established tradition that arises out of a group of people with common beliefs about and rituals concerning the Transcendent.

Spirituality

There are many definitions for spirituality, whose definition has been changing over time. According to the traditional definition, spirituality is the core of what it means to be religious, i.e., those who are deeply religious, whose lives are consistent with the devout beliefs professed, involving a dedication and surrendered to the Divine as understood. The modern definition, however, has expanded the concept of spirituality to include not only those who are deeply religious, but also those who are superficially religious and those who are not religious at all (i.e., humanists, secular).

Main points

1. Spirituality is an ideal term to use in clinical settings when talking to and engaging with patients, where patients should be allowed to define this term for themselves.

2. Religion is more useful construct when conducting research that seeks to identify specific characteristics that prevent disease or alter disease course.

Research on Religion/Spirituality & Health

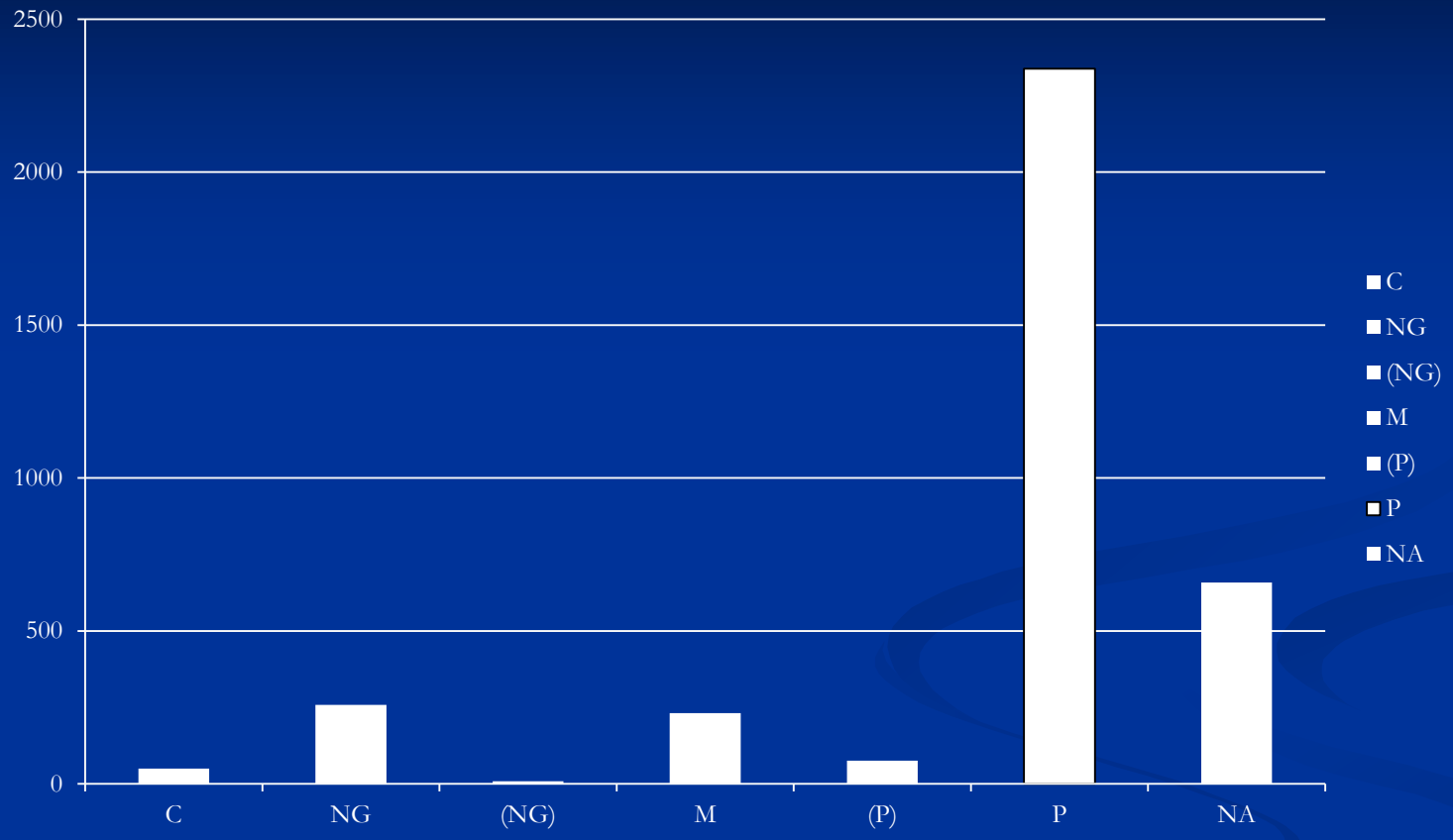
(systematic review 1940's-2010 of all quantitative research published in peer reviewed academic scientific journals in the English language listed in PsychInfo and Medline)

This research is documented in:

Handbook of Religion and Health , 1st ed (Oxford University Press, 2001)

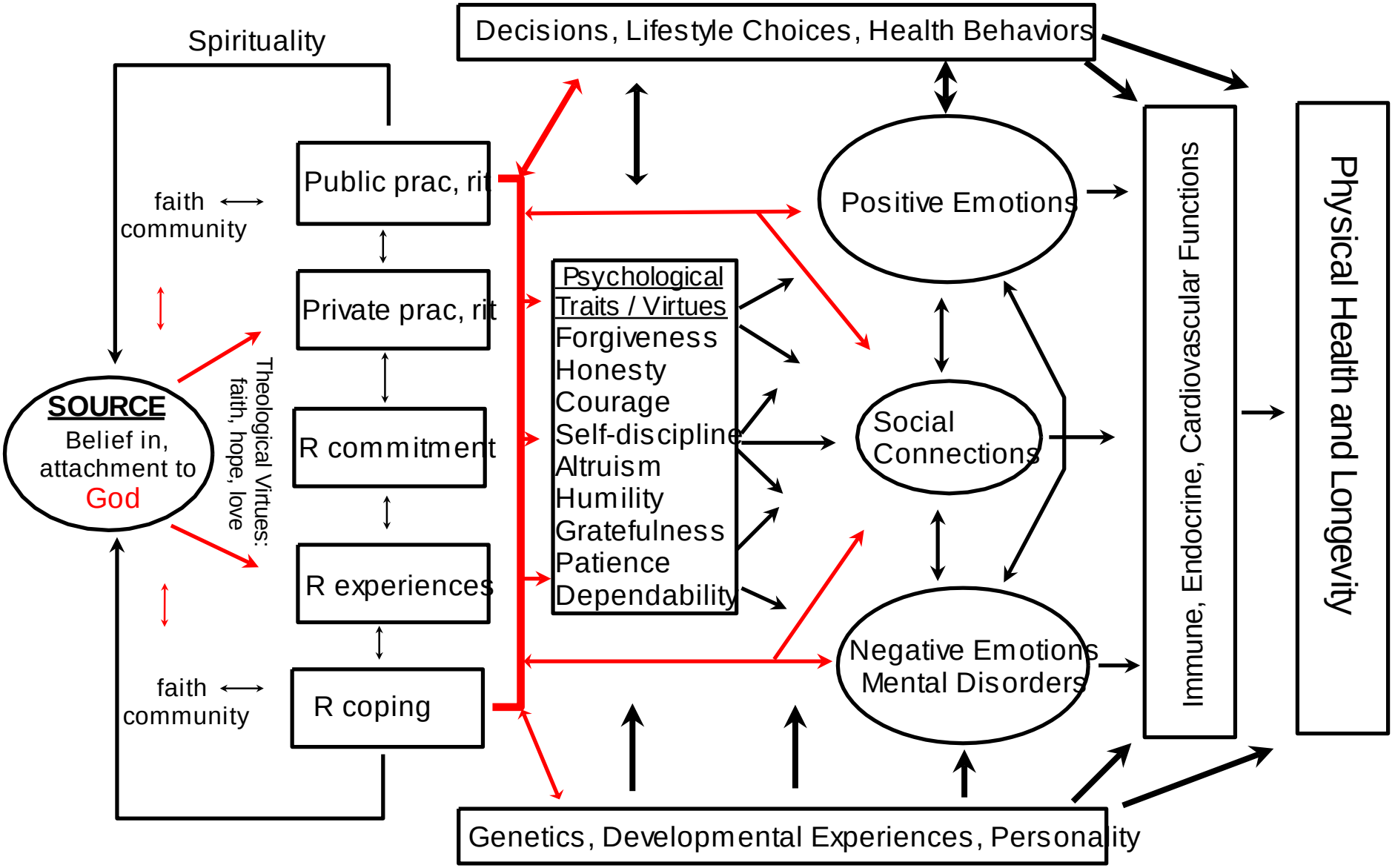
Handbook of Religion and Health, 2nd ed (Oxford University Press, 2012)

The Relationship between Religion and Health: All Studies



Number of studies includes some studies counted more than once (see Appendices of 1st and 2nd editions of Handbook of Religion and Health). Prepared by Dr. Wolfgang v. Ungern-Sternberg

Theoretical Model of Causal Pathways



*Model for Western monotheistic religions (Christianity, Judaism, and Islam)

Why is Spirituality Relevant to Patient Care?

1. Many patients have spiritual needs related to illness (next slide)
2. Religion influences coping with illness and may affect the emotional state of the patient and motivation towards recovery
3. Religion affects health behaviors and likely influences medical outcomes
4. Religious beliefs of patients influence their medical decisions
5. Religious beliefs of physicians influence their medical decisions
6. Standards of care require that cultural and spiritual beliefs be respected
7. Religion influences health care in the community

Many Patients Have Spiritual Needs Related to Illness

In a multi-site study by Harvard investigators, 230 patients with advanced cancer were surveyed. Most (88%) considered religious to be at least somewhat important. However, 47% reported that their spiritual needs were minimally or not at all supported by their religious community and 72% said their spiritual needs were minimally or not at all supported by the medical system (doctors, nurses or chaplains). Furthermore, spiritual support provided by their medical team or religious communities was associated with significantly higher quality of life ($p=0.0003$) (Balboni et al, 2007).

Balboni et al. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. Journal of Clinical Oncology 25:555-560

Not Addressing Spiritual Needs is *Expensive*

Multi-site, prospective study of 345 patients with advanced cancer who were followed to their death. They found that intensive, expensive, futile life-prolonging care (mechanical ventilation or resuscitation in last week of life) was significantly more common among those with high levels of religious coping (Phelps et al, 2009).

Phelps et al. (2009). Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer JAMA 301 (11), 1140-1147

When these investigators examined who among those using religion to cope were using more expensive health services, they found that this was primarily among those whose spiritual needs were not being addressed by the medical team. Among high religious copers whose spiritual needs were to a large extent or completely supported (vs. not supported), the likelihood of receiving hospice increased 5-fold ($p<0.005$) and of receiving aggressive care towards the end of life decreased by 72% (range 21% to 96%) ($p=0.02$)

Balboni et al (2010). Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. Journal of Clinical Oncology 28:445-452

Very Expensive

Patients reporting that their religious/spiritual needs were inadequately supported by clinic staff were less likely to receive a week or more of hospice (54% vs 72.8%; P = .01) and more likely to die in an intensive care unit (ICU) (5.1% vs 1.0%, P = .03).

Among minorities and high religious coping patients, those reporting poorly supported religious/spiritual needs received more ICU care (11.3% vs 1.2%, P = .03 and 13.1% vs 1.6%, P = .02, respectively), received less hospice (43.% vs 75.3% ≥1 week of hospice, P = .01 and 45.3% vs 73.1%, P = .007, respectively), and had increased ICU deaths (11.2% vs 1.2%, P = .03 and 7.7% vs 0.6%, P = .009, respectively).

EOL costs were higher when patients reported that their spiritual needs were inadequately supported ($4947 vs. $2833), particularly among minorities ($6533 vs. $2276) and high religious copers ($6344 vs. $2431)

Balboni et al. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 117(23): 5383-5391

Clinical Applications

- Take a spiritual history -- talk with patients about these issues
- Respect, value, support beliefs and practices of **the patient**
- Identify the spiritual needs of the patient
- Ensure that someone meets patients' spiritual needs (pastoral care)
- Pray with patients if patient requests
- Work with the faith community, if patient consents

From: Spirituality in Patient Care (Templeton Foundation Press, 2013)

Contents of the Spiritual History

CSI-MEMO Spiritual History[1]

1. Do your beliefs provide comfort?

2. Are your beliefs a source of stress?

3. Do you have beliefs that might influence your medical decisions?

4. Are you a member of a faith community, such as a church, synagogue, or mosque? If yes, is it supportive?

5. Do you have any other spiritual concerns that you'd like someone to address?

[1]Adapted from Koenig HG (2002). JAMA 288 (4): 487-493

Activities Besides Taking a Spiritual History

1. Support the religious/spiritual beliefs of the patient (verbally, non-verbally)
2. Ensure patient has resources to support their spirituality
3. Accommodate environment to meet spiritual needs of patient

Spiritual Care

The way health care is provided – by physicians, nurses, social workers, counselors, physical therapists, occupational therapists, dieticians, etc. – can be Spiritual (recognizing the Sacred nature of the person and the Holy obligation and privilege that health professionals have)

What does this mean?
-providing care with respect for the individual patient
-inquiring about how patient wishes to be cared for
-providing care in a kind and gentle manner
-providing care in a competent manner
-taking extra time with patients who really need it

This is not easy to do

Challenges to Providing Spiritual Care

1. Increased volume of medical knowledge (HP responsible for)
2. Increased emphasis on technology in medicine
3. Increased need to document and deal with EMR
4. Increasingly complex patients with complex medical problems that go with chronic illness in an aging population
5. Must also address needs of the caregiver and family
6. Increased time spent dealing with insurance companies, their reluctance to pay for medications or procedures
7. Greater and greater struggle to get reimbursed
8. More and more patients to see in less and less time (patients more and more dissatisfied, increased pressure of lawsuits)

The Result:

1. HPs feeling harried and time-pressured
2. Medical errors, unnecessary tests, reduced patient compliance
3. HP has problems at home because of demands of work
4. Medicine / nursing becoming just a job for the pay
5. Lost sense of “calling” or why went into medicine / nursing
6. Not caring anymore
7. Coping by turning to alcohol or drugs
8. Burnout – no time, no desire, and no capacity to provide spiritual/compassionate care (40% of primary care physicians would leave medicine if they could)

To provide Whole Person spiritual care, the health professional needs to be a whole person

Health professionals have needs too:

Physical
Emotional
Social
Spiritual

When these needs are not met, ability to provide spiritual/compassionate care will suffer

Physical Needs of Health Professional

1. Regular exercise
2. Healthy diet and optimal weight
3. Regular check-ups
4. Limit alcohol use
5. Time for rest

Emotional Needs of Health Professional

1. Able to comfortably handle the anxiety and stress involved in health care

2. Absence of depression and exhaustion

1. Able to cope with the loss of patients or inability to cure a patient's illness (without withdrawing)

4. Able to empathize and care about patients, rather than de-humanize them

5. Having a sense of purpose and meaning when caring for patients

6. Having the capacity to be caring, kind, and compassionate

Social Needs of Health Professional

1. Need time with family – spouse and children
2. Need time with friends and colleagues outside of work
3. Need supportive interactions with colleagues during work

Spiritual Needs of Health Professional

1. For many, though not all, need to express and practice a religious faith

2. Need to develop spiritual resources through quiet time spent in prayer, meditation, scripture or inspirational reading, participation in faith community

3. Meditation, prayer, or "practicing the presence of God" will help HP achieve a relaxed, open state that fosters compassion and increases energy

Meditation

1) Meditation can help develop spirituality and increase compassion

2) Physicians should have the freedom to choose what type of meditation they wish to practice, i.e., one that is consistent with their religious faith

3) The vast majority of physicians are likely to be Christian

4) There are many forms of Christian meditation

Books on Christian Meditation

1) Christian Meditation: Experiencing the Presence of God
(by Finley, a former Trappist monk & student of Thomas Merton)

2) Closer than a Brother: Practicing the Presence of God
(Winter, Shaw Publishers)

3) Centering Prayer (Fr. Thomas Keating)

Spiritual care not only depends on physicians and other health professionals

The Hospital System Must Make it Possible to Provide Spiritual Care

Hospital System Changes that might facilitate HPs providing Spiritual/Compassionate Care

1) Give HP the time to provide competent physical, emotional, social, and spiritual care (i.e., fewer patients)

2) Hire adequate staff that can help with doing the "busywork" (documentation, checks, assistance with EMR, writing prescriptions, etc.) so that this does not use up HP time

3) Focus on scheduling, decrease "no shows", improving patient flow, structure clinic setting in a way that minimizes HP downtime, simplify EMR

4) Hire adequate numbers of social workers and chaplains

5) And most important…

Provide training on how to deliver spiritual/compassionate care

Balboni et al (2014) examined 11 potential barriers to spiritual care (SC) among 339 oncology nurses and physicians providing care to incurable cancer patients at four Boston academic medical centers. Participants were presented with 11 reasons for not providing SC: not enough time, lack of private space to discuss, inadequate training on how to do so, personally uncomfortable, R/S not important to them personally, SC done better by others, patients don't want SC from health professional (HP), would make patients feel uncomfortable, power inequity between patients and HP, discomfort due to differing beliefs between HP and patient, and not part of professional role.

Provide training on how to deliver spiritual/compassionate care

Results:
The majority of nurses and physicians indicated a desire to provide SC (74% of nurses and 60% of physicians). The two most significant barriers to providing SC for both nurses and physicians were lack of time (72%) and **inadequate training** (61%).

In regression analyses, for physicians predictors of not providing SC were (1) personal discomfort discussing spiritual issues, (2) don't believe patients want SC from HP, and (3) worry that patients would feel uncomfortable (all $p<.005$).

Researchers concluded that "SC training as the critical next step" to meeting national care quality standards in this area (which call for the assessing and addressing of spiritual needs of dying patients).

Citation: Balboni MJ, Sullivan A, Enzinger AC et al (2014). Nurse and physician barriers to spiritual care provision at the end of life. Journal of Pain & Symptom Management, E-pub ahead of print.

Summary

- There are many scientific and financial reasons for assessing & addressing the spiritual needs of patients
- But, there are many challenges to providing whole person care that includes the spiritual dimension
- Lack of training is one of the most important
- HPs who are not whole themselves may have difficulty providing this type of care
- Health care system has a role to play in enabling HPs to provide spiritual care
- Collaboration as a team is essential for success, with the physician as the leader of that team

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The Center was founded in 1998, and is focused on conducting research, training others to conduct research, and field-building activities related to religion, spirituality, and health. In addition, we serve as a clearinghous for information on religion, spirituality and health, and seek to support and encourage dialogue between researchers, clinicians, clergy, and others interested in the intersection.

Goals & Focus

The three main goals of the Center are:

- Conducting interdisciplinary research on spirituality, theology and health
- Training and supporting those wishing to do research on the topic
- Building a community of researchers, clinicians, clergy, and others interested in dialogue and discussions related to spirituality, theology and health
- Informing the public about relationships between religion, spirituality and health

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Summer Research Workshop

August 11-15, 2014

Durham, North Carolina

5-day intensive research workshop focus on what we know about the relationship between spirituality and health, applications, how to conduct research and develop an academic career in this area ($1100 tuition). Leading spirituality-health researchers at Duke, the Veterans Administration, and elsewhere will give presentations:

-Strengths and weaknesses of previous research
-Theological considerations and concerns
-Highest priority studies for future research
-Strengths and weaknesses of measures of religion/spirituality
-Designing different types of research projects
- Primer on statistical analysis of religious/spiritual variables
-Carrying out and managing a research project
-Writing a grant to NIH or private foundations
-Where to obtain funding for research in this area
-Writing a research paper for publication; getting it published
-Presenting research to professional and public audiences; working with the media

Partial scholarships are available for the financially destitute

If interested, contact Harold G. Koenig: Harold.Koenig@duke.edu

Discussion