The Practice of Spirituality & The Practice of Medicine: Worlds Apart or Overlapping

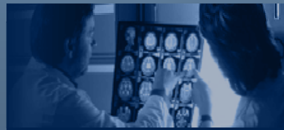
Harold G. Koenig, MD

Departments of Psychiatry and Medicine

Duke University Medical Center

GRECC VA Medical Center

Center for Spirituality, Theology and Health



Overview

Historical background
Religion and coping with illness, loss and change
Brief review of research on religion and mental health
Brief review of research on religion and physical health
Latest research
Applications to clinical practice
Applications to community health

Historical Background

1. Care of the sick originated from religious teachings
2. Until recently, health care delivered by religious orders
3. First hospitals built & staffed by religious orders (378 AD)
4. Most of physicians in colonies were also clergy
5. Not until mid-20th century that true separation developed
6. All health care disciplines striving to be "scientific"
7. Religion seen as irrelevant, neurotic, conflicting with care
8. Spiritual needs of patients are often ignored
9. Relationship is improving, but remains controversial

Sigmund Freud
Future of an Illusion, 1927

"Religion would thus be the universal obsessional neurosis of humanity... If this view is right, it is to be supposed that a *turning-away from religion is bound to occur with the fatal inevitability of a process of growth*…If, on the one hand, religion brings with it obsessional restrictions, exactly as an individual obsessional neurosis does, on the other hand *it comprises a system of wishful illusions together with a disavowal of reality, such as we find in an isolated form nowhere else but amentia, in a state of blissful hallucinatory confusion*…"

Sigmund Freud
Civilization and Its Discontents

"The whole thing is so patently infantile, so incongruous with reality, that to one whose attitude to humanity is friendly it is painful to think that the great majority of mortals will never be able to rise above this view of life."

These views, however, were not based on systematic research, but rather on clinical experiences and personal opinion

Religion and Coping with Illness/Loss/Fear

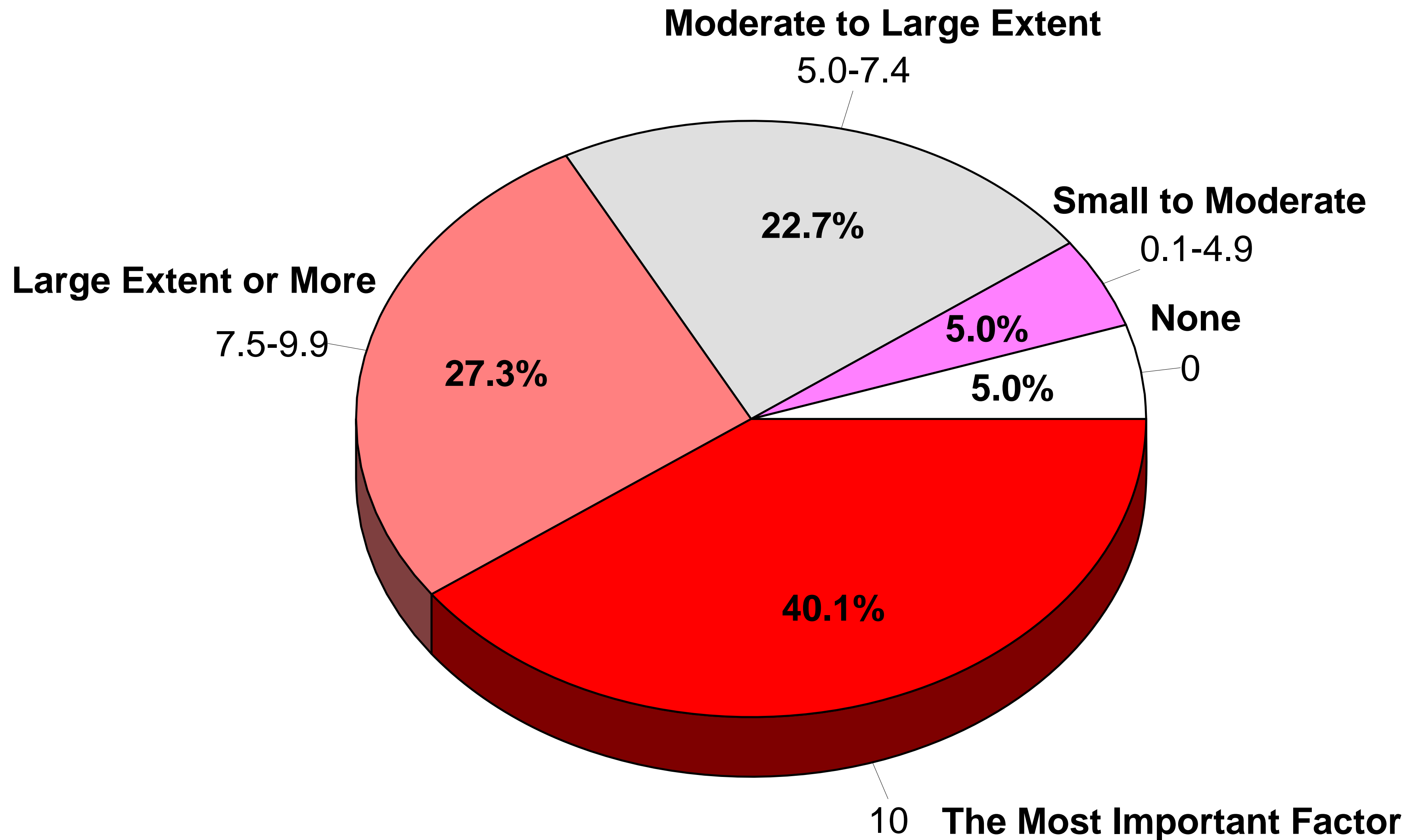
1. Many persons turn to religion for comfort

2. Religion is used to cope with problems common among those facing illness, loss, changes:

   - uncertainty
   - fear
   - pain and disability
   - loss of control
   - discouragement and loss of hope

Self-Rated Religious Coping

(On a 0-10 scale, how much do you use religion to cope?)



Responses by 337 consecutively admitted patients to Duke Hospital (Koenig 1998)

Stress-induced Religious Coping

America's Coping Response to Sept 11th:

1. Talking with others (98%)
2. **Turning to religion (90%)**
3. Checked safety of family/friends (75%)
4. Participating in group activities (60%)
5. Avoiding reminders (watching TV) (39%)
6. Making donations (36%)

Based on a random-digit dialing survey of the U.S. on Sept 14-16

New England Journal of Medicine 2001; 345:1507-1512

Does it work?

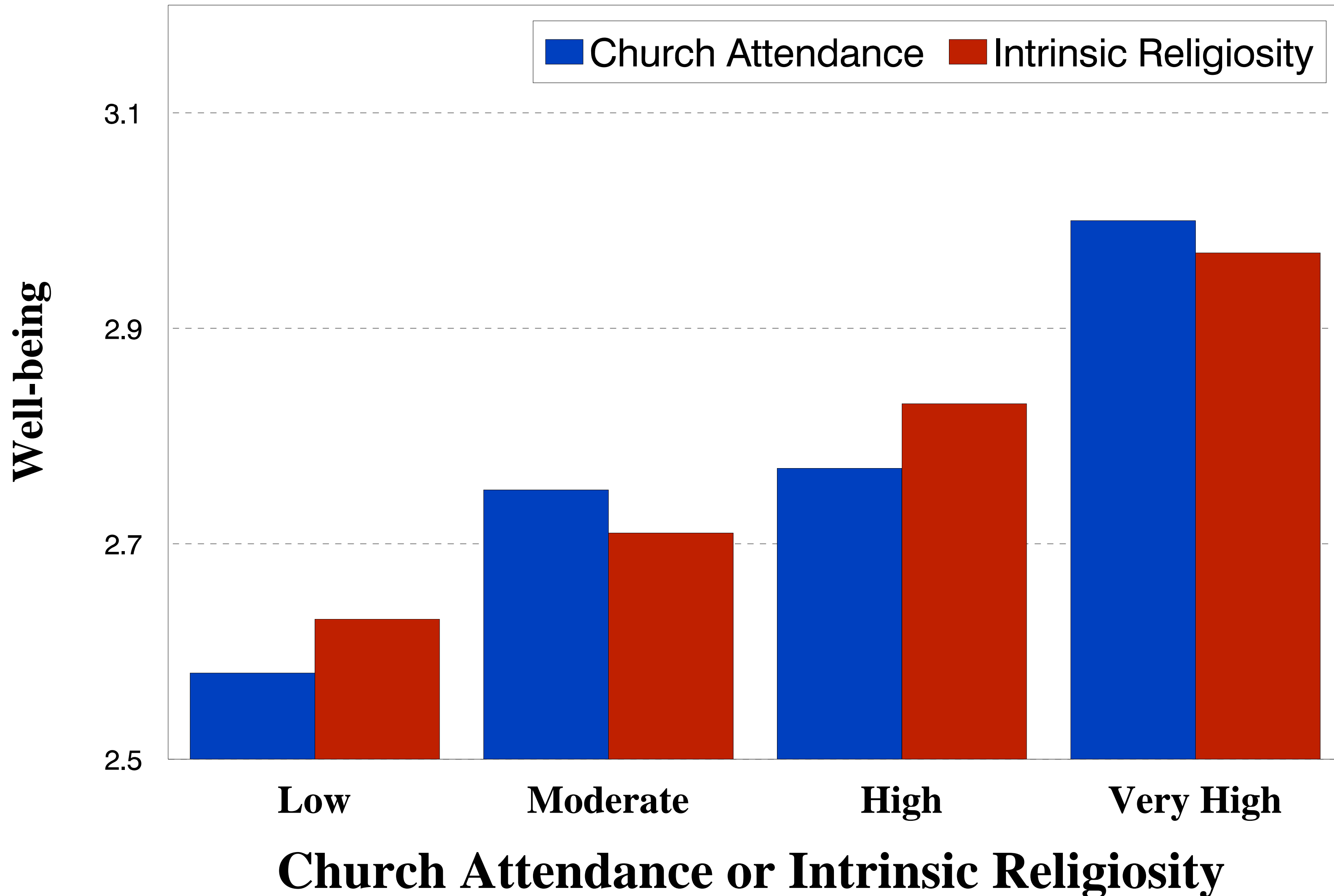
How effective is religion in helping people to cope?

Brief Review of Research on

Religion and Mental Health

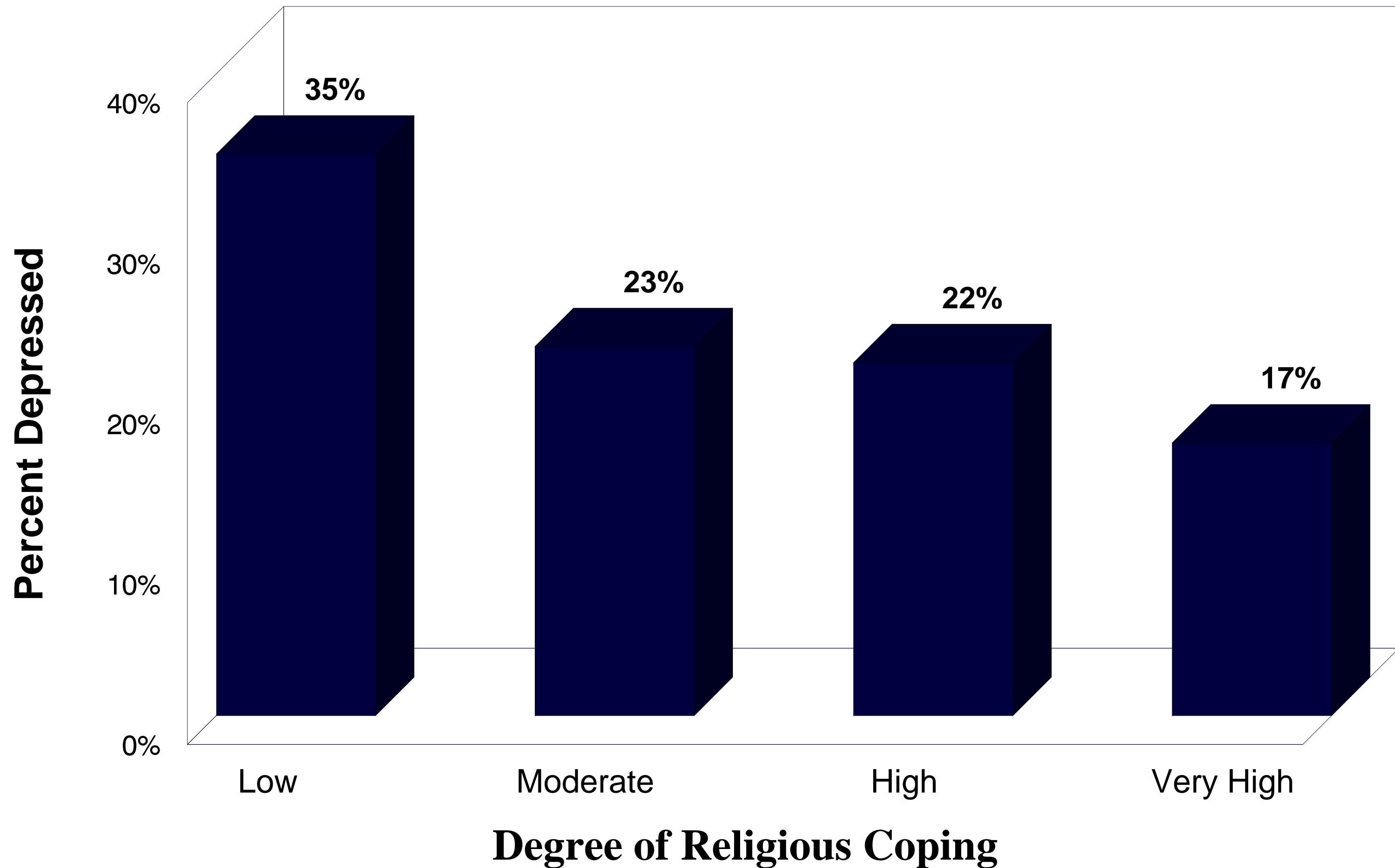
Religion and Well-being in Older Adults

The Gerontologist 1988; 28:18-28



Religious categories based on quartiles (i.e., low is 1st quartile, very high is 4th quartile)

Religion and Depression in Hospitalized Patients

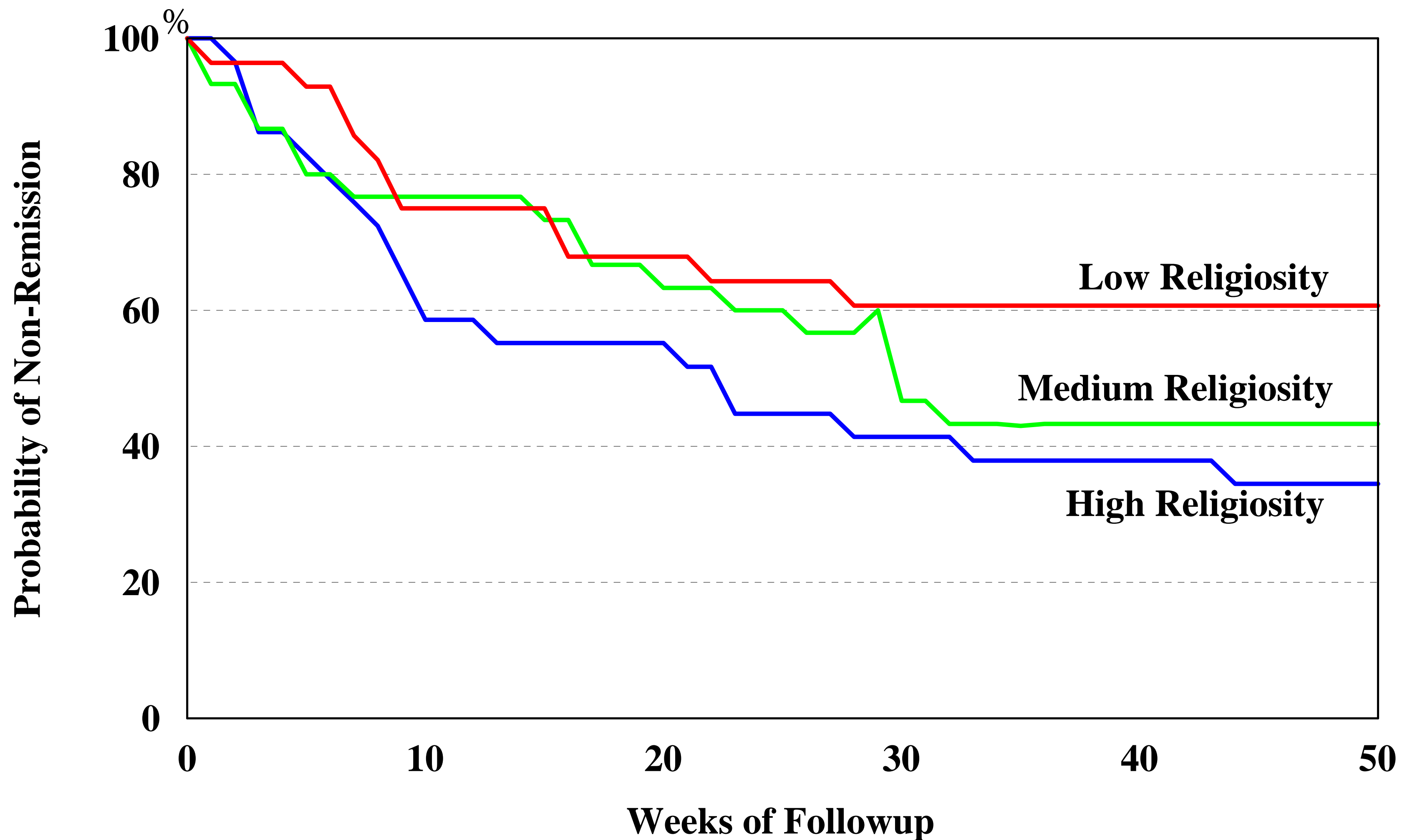


Geriatric Depression Scale

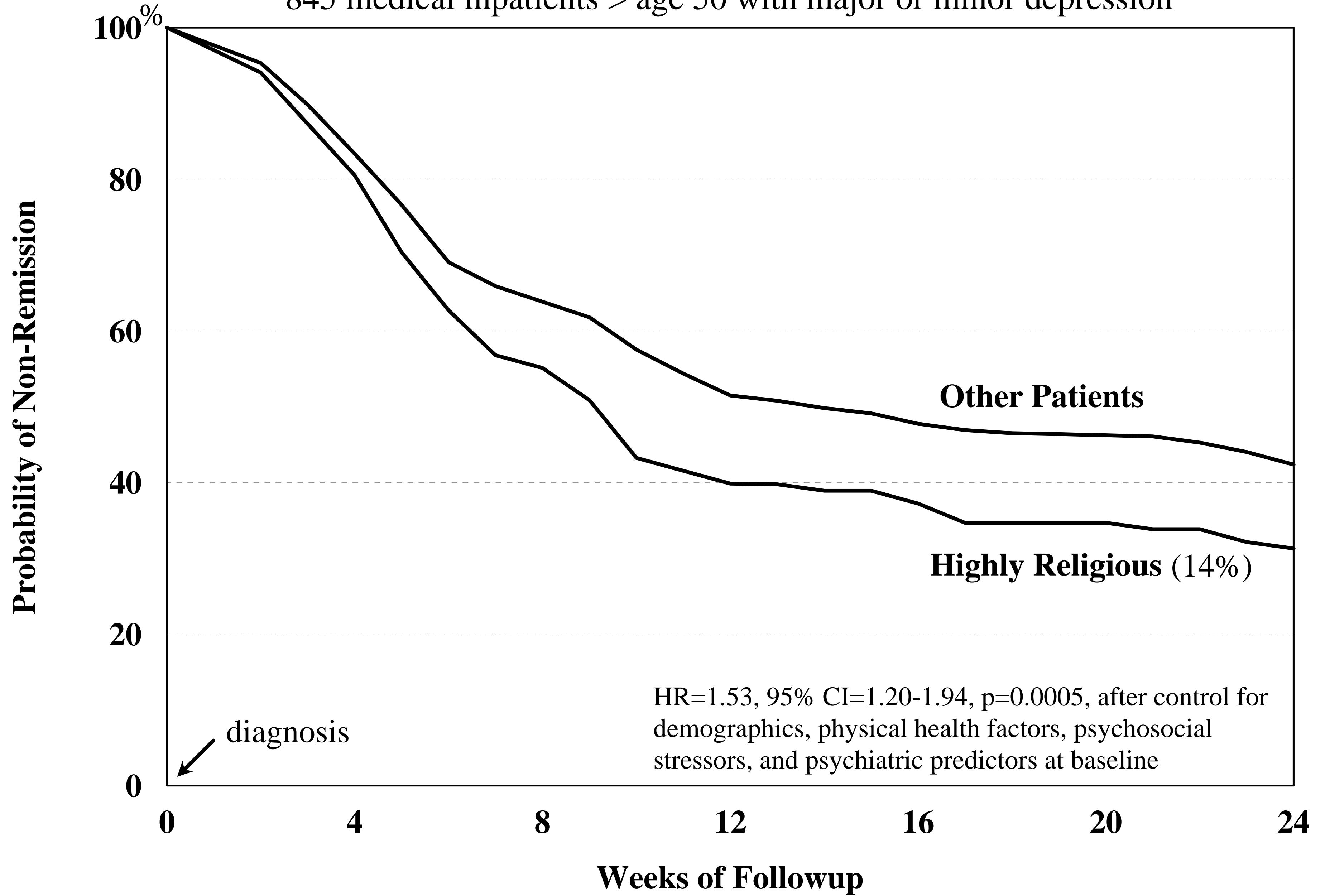
Information based on results from 991 consecutively admitted patients (differences significant at $p<.0001$)

Time to Remission by Intrinsic Religiosity

(N=87 patients with major or minor depression by Diagnostic Interview Schedule)

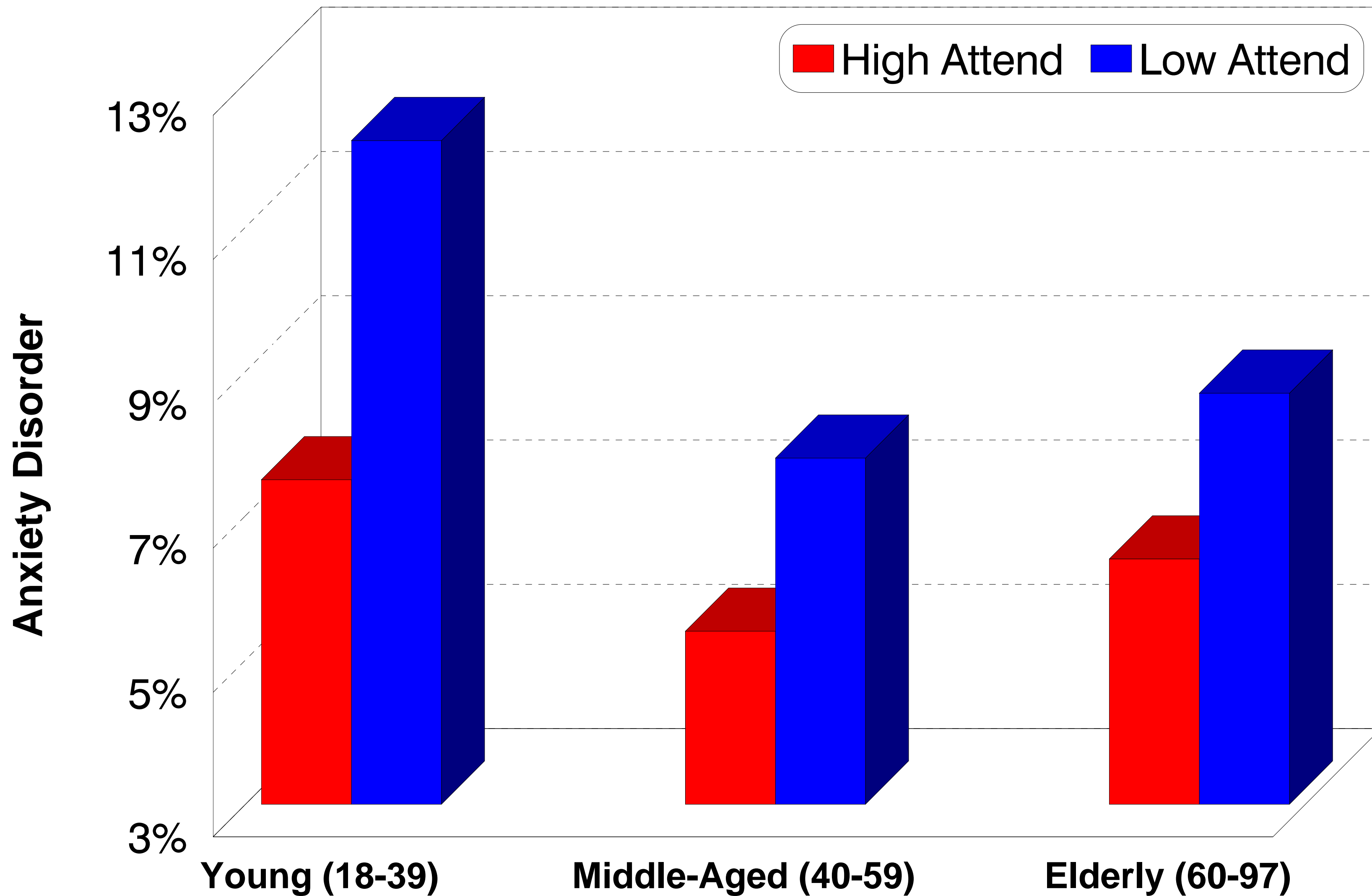


American Journal of Psychiatry 1998; 155:536-542


845 medical inpatients > age 50 with major or minor depression
100%
80
60
40
20
0
Probability of Non-Remission
Other Patients
Highly Religious (14%)
HR=1.53, 95% CI=1.20-1.94, p=0.0005, after control for
demographics, physical health factors, psychosocial
stressors, and psychiatric predictors at baseline
diagnosis
0
4
8
12
16
20
24
Weeks of Followup

Church Attendance and Anxiety Disorder

(anxiety disorder within past 6 months in 2,964 adults ages 18-89)



Koenig et al (1993). Journal of Anxiety Disorders 7:321-342

Religion and Mental Health: Research Before Year 2000

1. Well-being, hope, and optimism (91/114)
2. Purpose and meaning in life (15/16)
3. Social support (19/20)
4. Marital satisfaction and stability (35/38)
5. Depression and its recovery (60/93)
6. Suicide (57/68)
7. Anxiety and fear (35/69)
8. Substance abuse (98/120)
9. Delinquency (28/36)
10. Summary: 478/724 quantitative studies

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

Attention Received Since Year 2000

Religion, Spirituality and Mental Health

1. Growing interest – entire journal issues on topic

(J Personality, J Family Psychotherapy, American Behavioral Scientist, Public Policy and Aging Report, Psychiatric Annals, American J of Psychotherapy [partial], Psycho-Oncology, International Review of Psychiatry, Death Studies, Twin Studies, J of Managerial Psychology, J of Adult Development, J of Family Psychology, Advanced Development, Counseling & Values, J of Marital & Family Therapy, J of Individual Psychology, American Psychologist, Mind/Body Medicine, Journal of Social Issues, J of Health Psychology, Health Education & Behavior, J Contemporary Criminal Justice, Journal of Family Practice [partial], Southern Med J)

2. Growing amount of research-related articles on topic

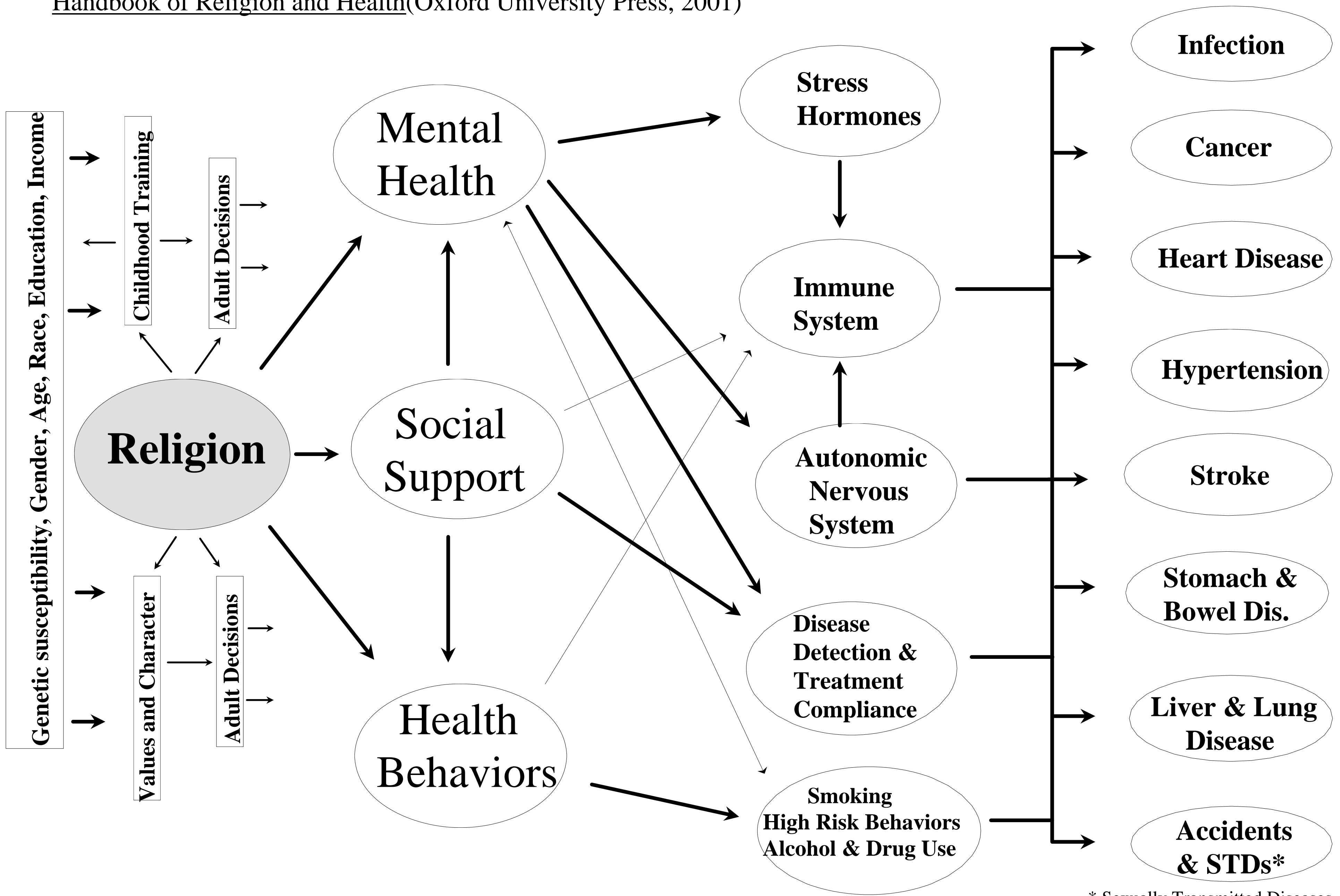
PsycInfo 2003-2007 = **4,714** articles (3362 spirituality, 2702 religion)
PsycInfo 1996-2000 = **1,945** articles (1318 spirituality, 810 religion)
PsycInfo 1991-1995 = **1,132** articles (627 spirituality, 553 religion)
PsycInfo 1981-1985 = **351** articles (2 spirituality, 349 religion)
PsycInfo 1971-1975 = **441** articles (4 spirituality, 438 religion)

PsycInfo 2000-2008= **7,145** articles (4,588 spirituality, 3,456 religion)
PsycInfo 1865-1999= **6,282** articles (2,047 spirituality, 4,506 religion)

Religion and Physical Health

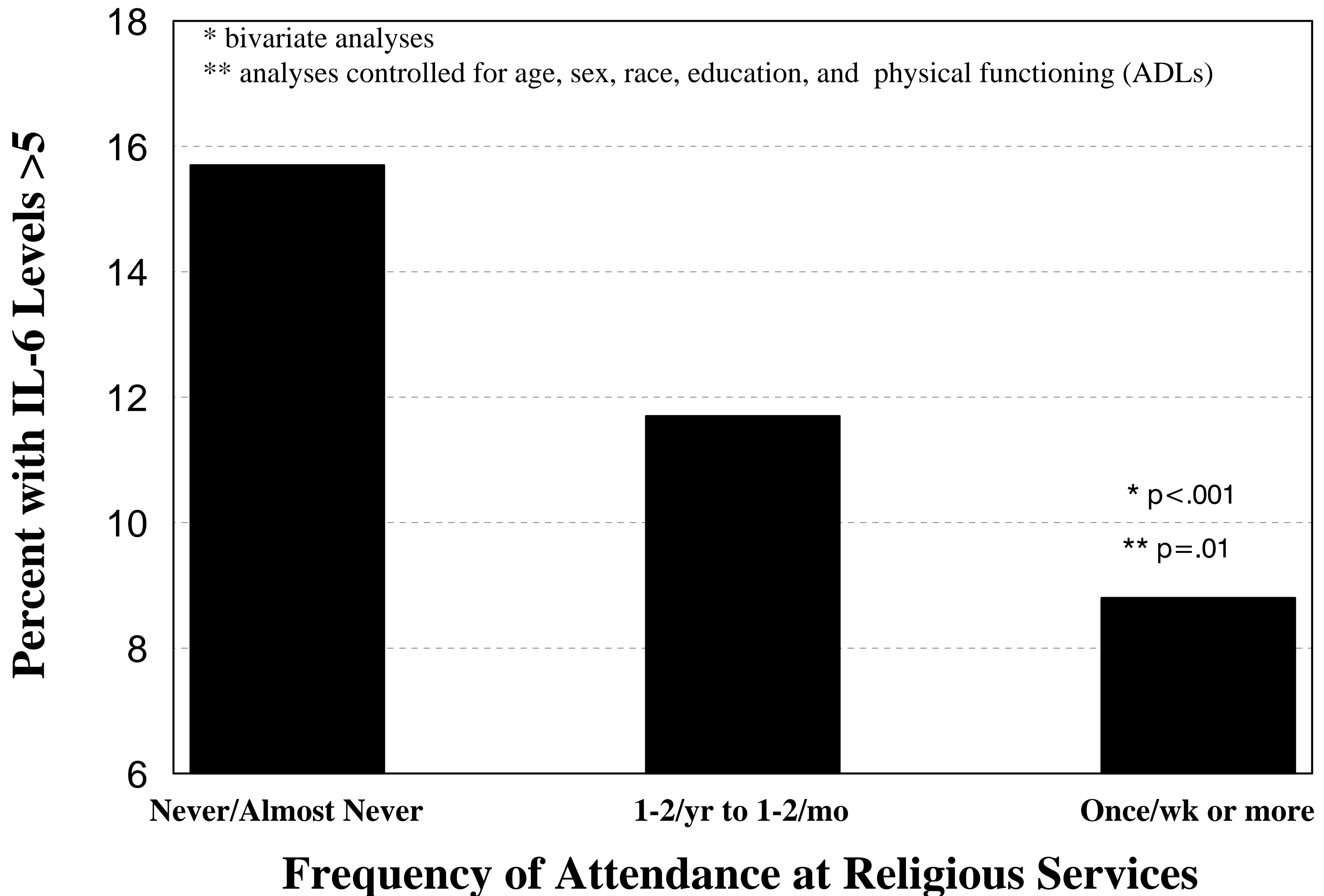
Model of Religion's Effects on Health

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



Serum IL-6 and Attendance at Religious Services

(1675 persons age 65 or over living in North Carolina, USA)

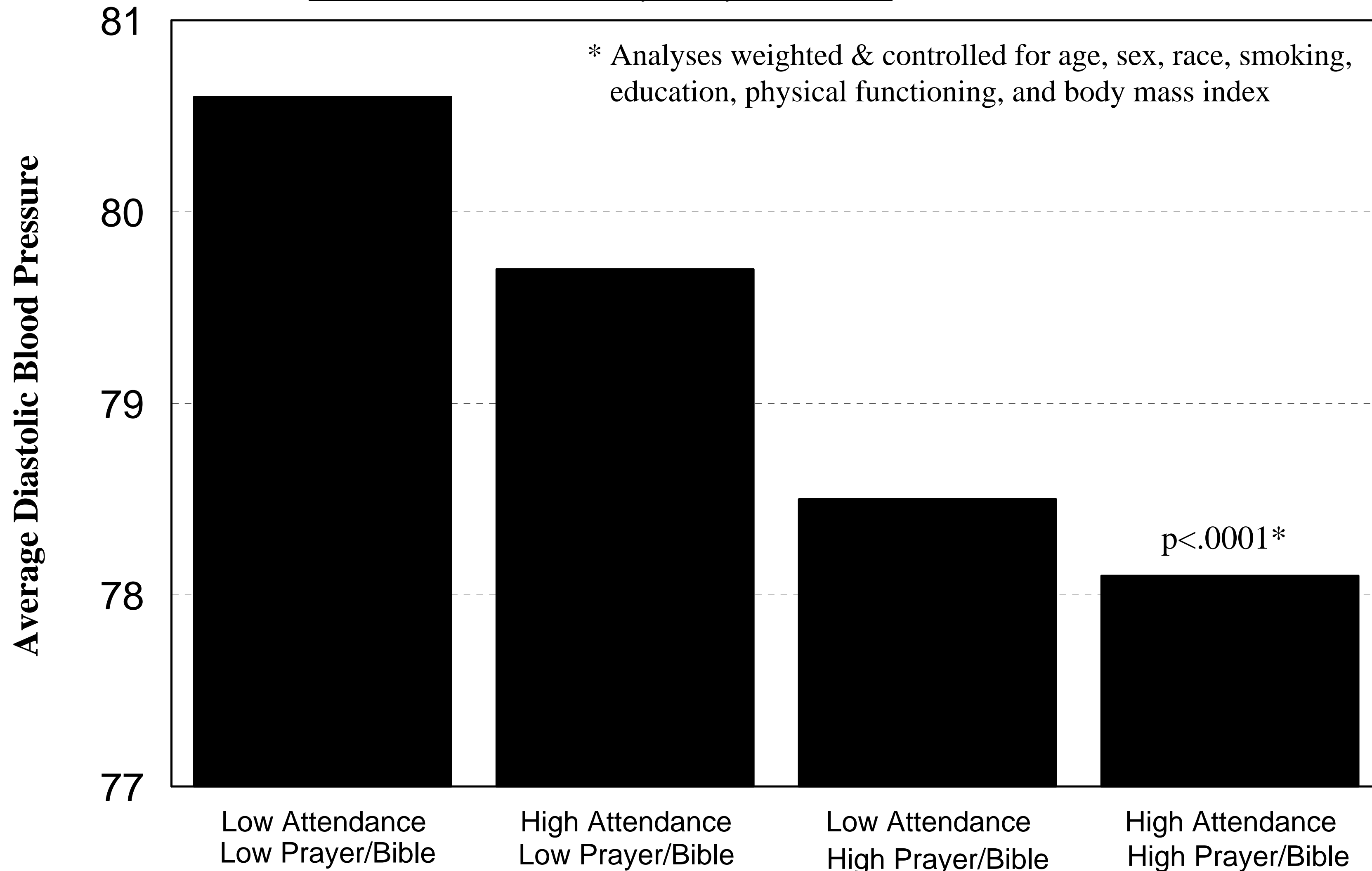


Citation: International Journal of Psychiatry in Medicine 1997; 27:233-250

Religious Activity and Diastolic Blood Pressure

(n=3,632 persons aged 65 or over)

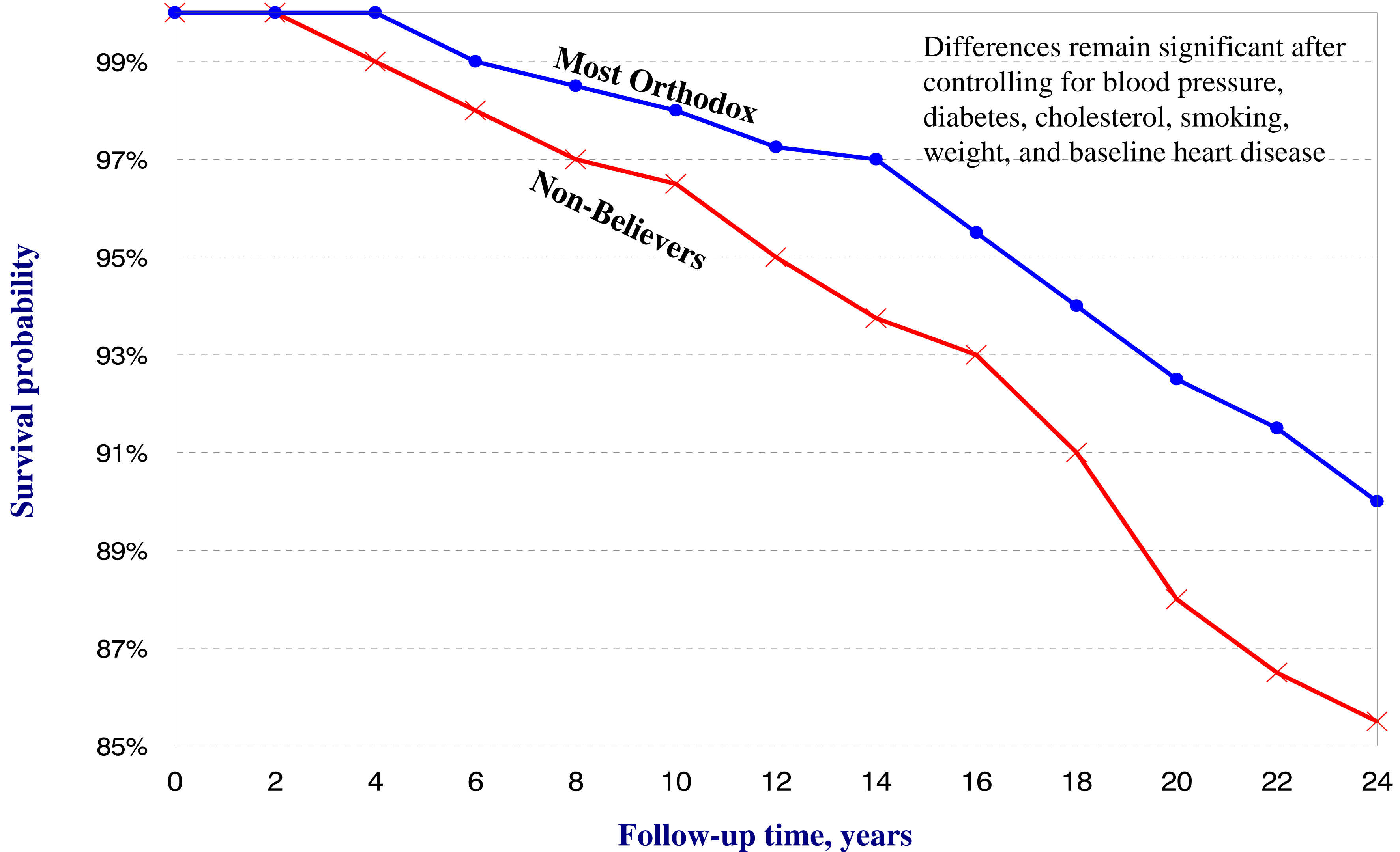
Citation: International Journal of Psychiatry in Medicine 1998; 28:189-213



High = weekly or more for attendance; daily or more for prayer
Low= less than weekly for attendance; less than once/day for prayer

Mortality From Heart Disease and Religious Orthodoxy

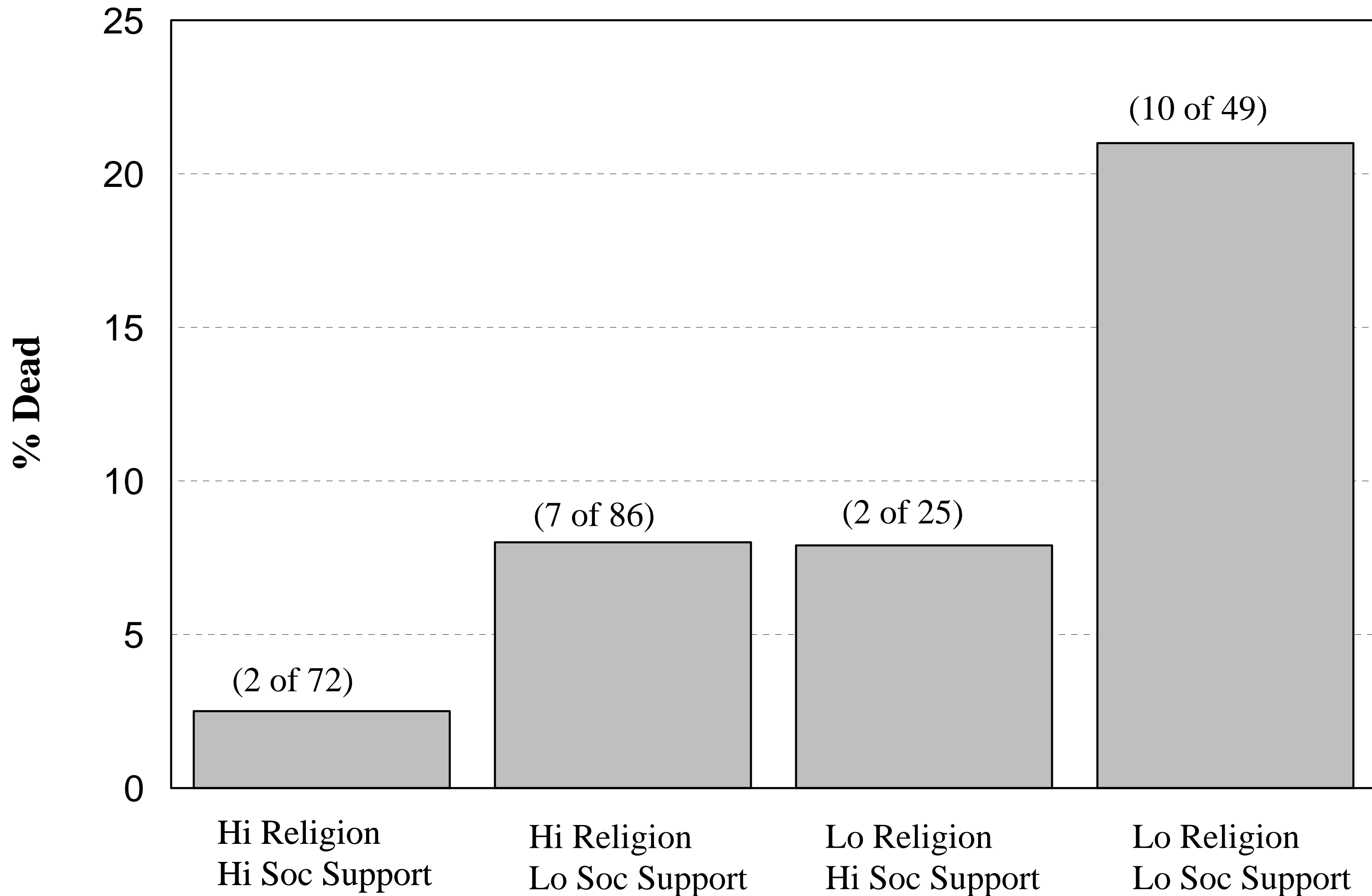
(based on 10,059 civil servants and municipal employees)



Kaplan-Meier life table curves (adapted from Goldbourt et a l 1993. Cardiology 82:100-121)

Six-Month Mortality After Open Heart Surgery

(232 patients at Dartmouth Medical Center, Lebanon, New Hampshire)



Citation: Psychosomatic Medicine 1995; 57:5-15

Summary: Physical Health

- Better immune/endocrine function (7 of 7)
- Lower mortality from cancer (5 of 7)
- Lower blood pressure (14 of 23)
- Less heart disease (7 of 11)
- Less stroke (1 of 1)
- Lower cholesterol (3 of 3)
- Less cigarette smoking (23 of 25)
- More likely to exercise (3 of 5)
- Lower mortality (11 of 14) (1995-2000)
- Clergy mortality (12 of 13)
- Less likely to be overweight (0 of 6)
- Many new studies since 2000

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

Recent Studies - Physical Health Outcomes

- Religious attendance associated with slower progression of cognitive impairment with aging in older Mexican-Americans
Hill et al. Journal of Gerontology 2006; 61B:P3-P9; Reyes-Ortiz et al. Journal of Gerontology 2008 (in press)

- Religious behaviors associated with slower progression of Alzheimer's dis.
Kaufman et al. Neurology 2007; 68:1509–1514

- Fewer surgical complications following cardiac surgery
Contrada et al. Health Psychology 2004;23:227-38

- Greater longevity if live in a religiously affiliated neighborhood
Jaffe et al. Annals of Epidemiology 2005;15(10):804-810

- Religious attendance associated with >90% reduction in meningococcal disease in teenagers, equal to or greater than meningococcal vaccination
Tully et al. British Medical Journal 2006; 332(7539):445-450

Recent Studies - Physical Health Outcomes

• HIV patients who show increases in spirituality/religion after diagnosis experience higher CD4 counts/ lower viral load and slower disease progression during 4-year follow-up
Ironson et al. Journal of General Internal Medicine 2006; 21:S62-68

• Religion and survival in a secular region. A twenty year follow-up of 734 Danish adults born in 1914.
la Cour P, et al. Social Science & Medicine 2006; 62: 157-164

• Nearly 2,000 Jews over age 70 living in Israel followed for 7 years. Those who attended synagogue regularly were more likely than non-attendees to be alive 7 years later (61% more likely to be alive vs. 41% more likely to be alive for infrequent attendees. Gradient of effect.
European Journal of Ageing 2007; 4:71-82

Over 70 recent studies with positive findings since 2004
http\\:www.dukespiritualityandhealth.org

Applications to Clinical Practice

Spirituality in Patient Care, Second Edition
Templeton Foundation Press, 2007

Review published in **JAMA** 2008; 299:1608-1609

Why Address Spirituality: Clinical Rationale

1. Not dependent on research alone; even without research, integrating spirituality into patient care has value

2. Many patients are religious, would like it addressed in health care

3. Many patients have spiritual needs related to illness that could affect mental health, but go unmet; mental health affects physical

4. Patients, particularly when hospitalized, are often isolated from religious communities (requiring others to meet spiritual needs)

5. Religious beliefs affect medical decisions, may conflict with treatments

6. Religion influences support and care in the community

How to Address Spirituality: The Spiritual History

1. Health care professionals should take a brief screening spiritual history on all patients with serious or chronic medical illness

2. The physician should take the spiritual history

3. A brief explanation should precede the spiritual history

4. Information to be acquired (next)

5. Information from the spiritual history should be documented

6. Refer to chaplains if spiritual needs are identified

Health Professionals Should Take a Spiritual History

1. The screening spiritual history is brief (2-4 minutes), and is not the same as a spiritual assessment (chaplain)

2. The purpose of the SH is to obtain information about religious background, beliefs, and rituals **that are relevant to health care**

3. The goal of health professionals is to treat illness, maintain health, and foster well-being – not to promote religion or spirituality

4. If patients indicate from the start that they are not religious or spiritual, then questions should be re-directed to asking about what gives life meaning & purpose and how this can be addressed in their health care

JCAHO Requirements

Spiritual Assessment

Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?

A: Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organization's to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.

http://www.jointcommission.org/AccreditationPrograms/HomeCare/Standards/FAQs/Provision+of+Care/Assessment/Spiritual_Assessment.htm

New JCAHO Report

One Size Does Not Fit All: Diverse Populations Pose Special Health Needs: Joint Commission Report Provides Tool to Assess and Overcome Language, Cultural Barriers
http://www.jointcommission.org/NewsRoom/NewsReleases/nr_04_21_08.html

April 21, 2008, 57 page report emphasizes need for:

- Developing an infrastructure for cultural competence
- Integrating cultural competence into organizational systems
- Integrating cultural competence into patient care
- Assessing cultural needs of patients
- Monitoring cultural service utilization
- Using data to improve cultural services
- Promoting staff awareness through training, dialogue, support
- Creating an environment that meets patients specific needs
- Working together within the hospital
- Building bridges with other hospitals
- Engaging the broader community

“religious” mentioned 30 times,”religion” 15 times, “spiritual” 14 times

Information Acquired During the Spiritual History

1. The patient's religious or spiritual (R/S) background (if any)
2. R/S beliefs used to cope with illness, or alternatively, that may be a source of stress or distress
3. R/S beliefs that might conflict with medical (or psychiatric) care or might influence medical decisions
4. Involvement in a R/S community and whether that community is supportive
5. Spiritual needs that may be present and need to be addressed for health reasons

Activities Besides Taking a Spiritual History

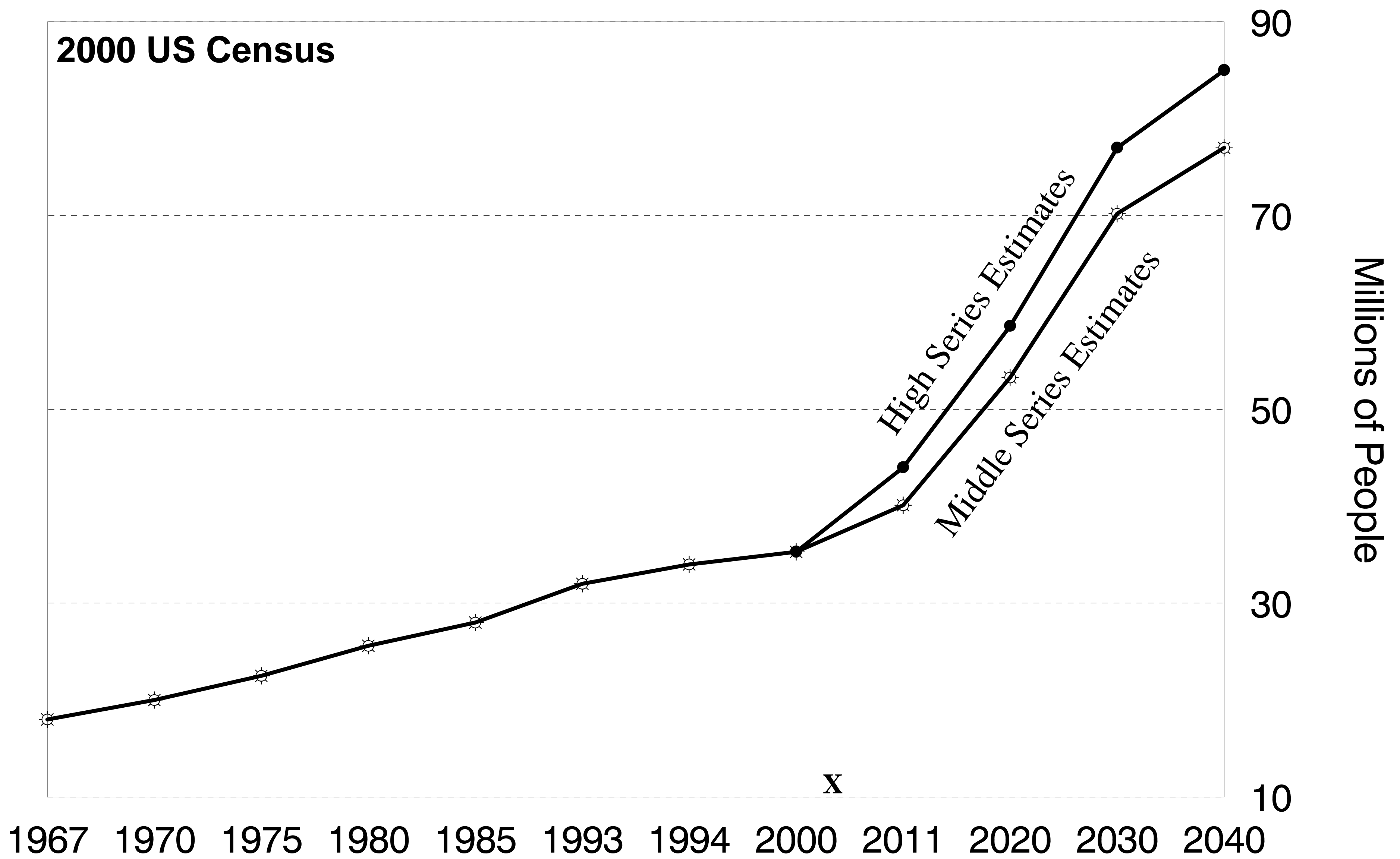
1. Support the religious/spiritual beliefs of the patient (verbally, non-verbally)
2. Ensure patient has resources to support their spirituality
3. Accommodate environment to meet spiritual needs of patient
4. Provide care with compassion, kindness, treating pt as unique individual
5. Pray with patients (?)
6. Prescribe religion (?)

Limitations and Boundaries

1. Do not prescribe religion to non-religious patients
2. Do not force a spiritual history if patient not religious
3. Do not coerce patients in any way to believe or practice
4. Do not pray with a patient before taking a spiritual history and unless the patient asks
5. Do not spiritually counsel patients (always refer to trained professional chaplains or pastoral counselors, unless you have pastoral counseling training)
6. Do not do any activity that is not patient-centered and patient-directed

Applications in the Community

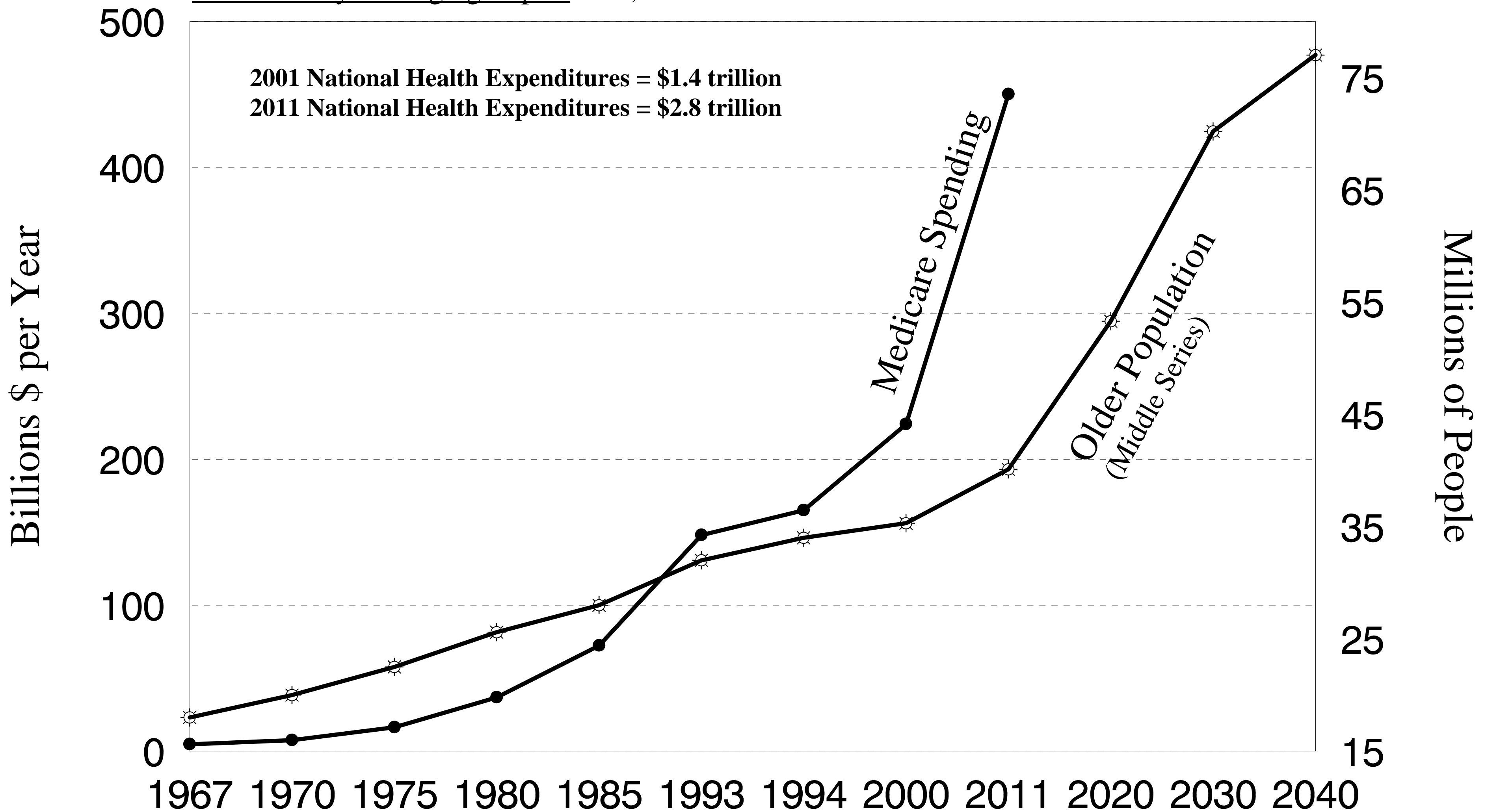
1. Rapidly aging population
2. Decreased number of caregivers (support ratio)
3. Increasing costs of health care
4. Limited government capacity to continue to fund care
5. Issues related to providing health care in the community


Projected growth of the U.S. elderly population {> 65)
2000 US Census
High Series Estimates
Middle Series Estimates
Millions of People
90
70
50
30
10
X
1967
1970
1975
1980
1985
1993
1994
2000
2011
2020
2030
2040

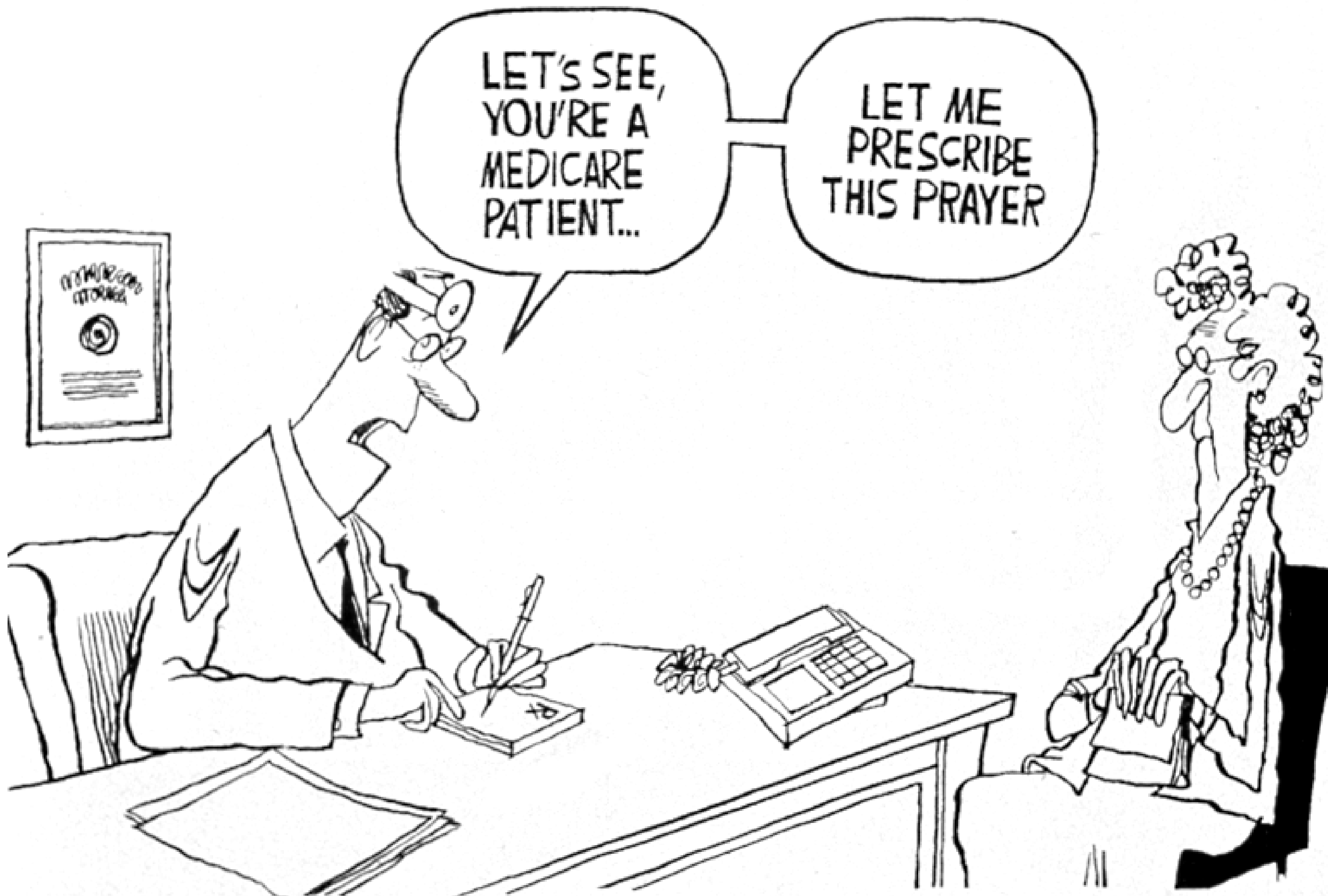
Dang!... Now where was I going?

Superman in his later years

The Dilemma: Spending on Future Health Care in the USA



Projected growth of the elderly U.S. population and Medicare spending. Medicare data from **Office of the Actuary & Bureau of Data Management & Strategy, Center for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services** (March/April 2002).


LET'S SEE, YOU'RE A MEDICARE PATIENT...
LET ME PRESCRIBE THIS PRAYER

Central Domestic Issue at This Time

"There are no silver bullets. There is no single item—technology, disease management, tort law – that is likely to prove to be the answer to aligning incentives, providing high-quality care at reasonable costs, and financing it in a way that's economically viable…Rising health-care costs represent the central domestic issue at this time. [Over the next 50 years, if nothing is done] the cost of Medicare and Medicaid will rise from 4% of the gross domestic product (GDP) to 20% -- the current size of the entire federal budget."

– Douglas Holtz-Eakin, PhD, director of Congressional Budget Office (CBO).

Source: Health Care Congress sponsored by the Wall Street Journal and CNBC, Washington, DC; quoted in Clinical Psychiatry News, vol. 33, no. 4, p 86, April 2005

Faith Community-Health System Partnerships

1. Health care originated from religious teachings/values

2. The church has an obligation to care for the poor, the sick, the elderly

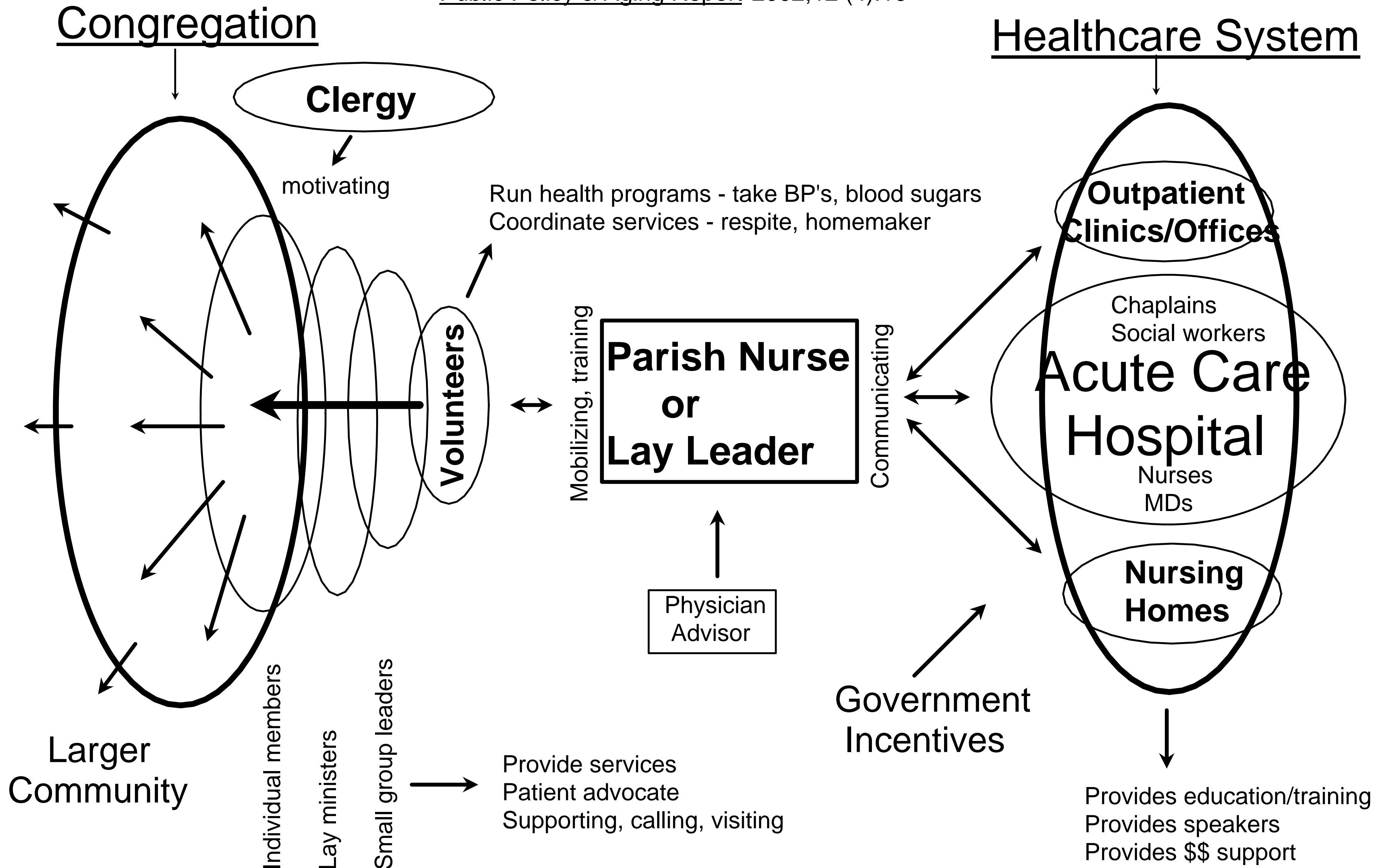
3. Both faith communities & health systems will face a common problem: the care of the aging sick

4. Why not begin now to form partnerships with hospitals to maintain/improve the physical health of faith communities and provide care to the needy

Prevention and Management of Disease

Primary, Secondary, and Tertiary

Public Policy & Aging Report 2002;12 (4):16



Further Resources

1. *Medicine, Religion and Health (Templeton Press, Sept 2008)
2. *Spirituality in Patient Care (Templeton Press, 2007)
3. Handbook of Religion and Health (Oxford University Press, 2001)
4. Healing Power of Faith (Simon & Schuster, 2001)
5. Faith and Mental Health (Templeton Press, 2005)
6. Psychoneuroimmunology & the Faith Factor (Oxford University Press, 2002)
7. Handbook of Religion and Mental Health (Academic Press, 1998)
8. Faith in the Future: Religion, Aging & Healthcare in 21st Century (Templeton Press, 2004)
9. The Healing Connection (Templeton Press, 2004)
10. Duke website: http://www.dukespiritualityandhealth.org

Summer Research Workshop

July and August 2009
Durham, North Carolina

5-day intensive research workshops focus on what we know about the relationship between religion and health, applications, how to conduct research and develop an academic career in this area (July 20-24, Aug 17-21, 2009) Leading religion-health researchers at Duke, UNC, USC, and elsewhere will give presentations:

-Previous research on religion, spirituality and health
-Strengths and weaknesses of previous research
-Applying findings to clinical practice
-Theological considerations and concerns
-Highest priority studies for future research
-Strengths and weaknesses of religion/spirituality measures
-Designing different types of research projects
-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

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

Summary

1. The church was the organization that initiated health care
2. Religion is a powerful coping resource
3. Religion is related to better mental health
4. Religion is related to better physical health, great longevity, and longer ability to function
5. Reasons exist to integrate spirituality into patient care
6. There is an urgent need for faith community-health system partnerships, with parish nurses central to this effort

Discussion