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"*A Vital Christian Presence in Social Work*"

RELIGION, SPIRITUALITY AND HEALTH: RESEARCH AND CLINICAL APPLICATIONS

Harold G. Koenig, MD

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Religion, Spirituality and Health: Research and Clinical Applications

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Overview

Defining ambiguous terms
Coping with illness
Research on religion and mental health
Research on religion and physical health
Further resources

Defining Ambiguous Terms

Clinical Applications vs. Research: A BIG, BIG difference

Religion vs. Spirituality vs. Humanism

Religion

– involves beliefs, practices, and rituals related to the 'sacred," where the *sacred* is that which relates to the mystical, supernatural, or God in Western religious traditions, or to Ultimate Truth or Reality, in Eastern traditions. Religion may also involve beliefs about spirits, angels, or demons. Religions usually have specific beliefs about the life after death and rules about conduct that guide life within a social group. Religion is often organized and practiced within a community, but it can also be practiced alone and in private. Central to its definition, however, is that religion is rooted in an established tradition that arises out of a group of people with common beliefs and practices concerning the sacred.

This definition is generally agreed upon, and is distinctive and separate from other social and psychological phenomena. This means we can measure it and correlate it with mental, social, and physical health.

Religion vs. Spirituality vs. Humanism

Spirituality

- more difficult to define than religion. It is a more popular expression today than religion, since many view the latter as divisive and associated with war, conflict, and fanaticism. Spirituality is considered more personal, something individuals define for themselves that is largely free of the rules, regulations, and responsibilities associated with religion. In fact, there is a growing group of individuals categorized as “spiritual-but-not-religious” who deny any connection at all with religion and understand spirituality entirely in individualistic, secular humanistic terms. Everyone is considered spiritual, both religious and secular persons. This contemporary use spirituality is quite different from its original meaning.

Because there is no common, agreed upon definition, and because “everyone” is considered spiritual, measurement for research purposes is problematic.

Concerns About Measuring Spirituality in Research

1. Spirituality is either measured as religion, or as positive psychological or character traits

2. Positive psychological states include having purpose and meaning in life, being connected with others, experiencing peace, harmony, and well-being

3. Positive character traits include being forgiving, grateful, altruistic, or having high moral values and standards

4. Atheists or agnostics may deny any connection with spirituality, but rightly claim their lives have meaning, purpose, are connected to others, practice forgiveness and gratitude, are altruistic, have times of great peacefulness, and hold high moral values

Concerns About Measuring Spirituality

5. Can no longer look at relationships between spirituality and mental health (since spirituality scales confounded by items assessing mental health)

6. Can no longer examine relationships between spirituality and physical health (since mental health affects physical health)

7. The result of #5 and #6 is meaningless tautological associations between spirituality and health

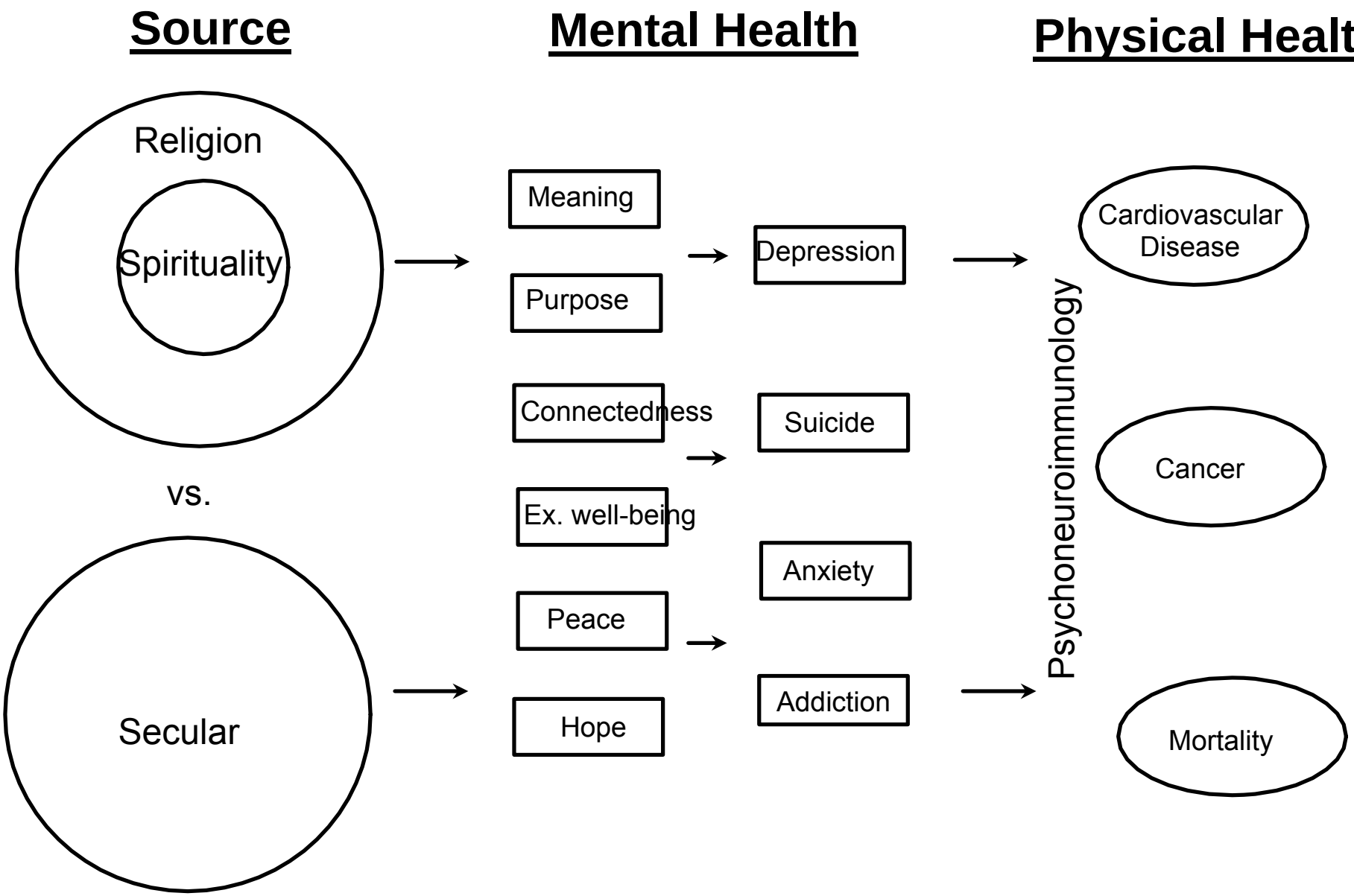
8. Can no longer study the negative effects of spirituality on health, since positive effects are predetermined by the definition of spirituality

9. Confusing to use religious language (spirituality or that having to do with the spirit) to describe secular psychological terms

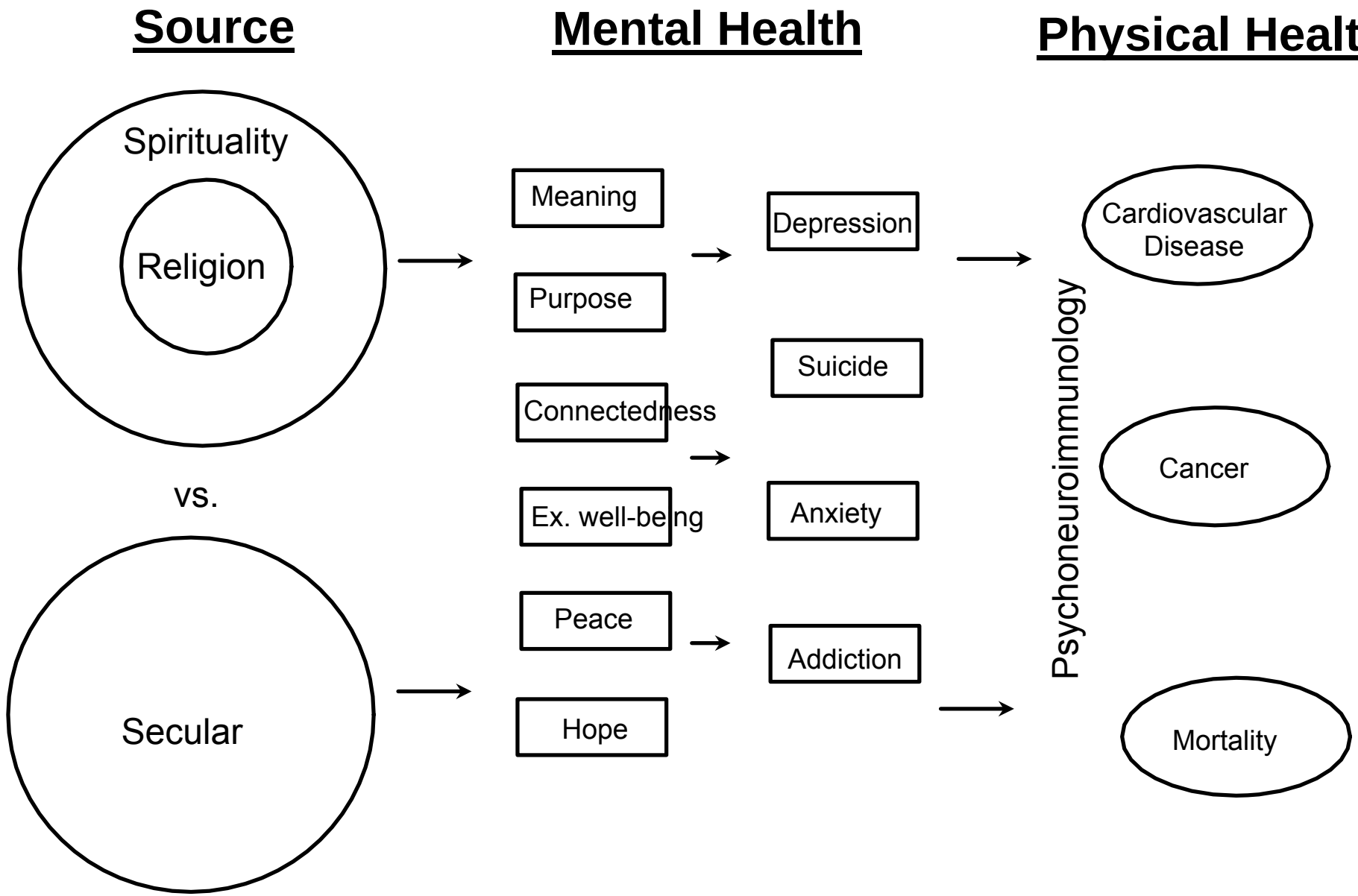
(see "Concerns about measuring 'spirituality' in research." Journal of Nervous and Mental Disease, 2008, in press

Spirituality: An Expanding Concept

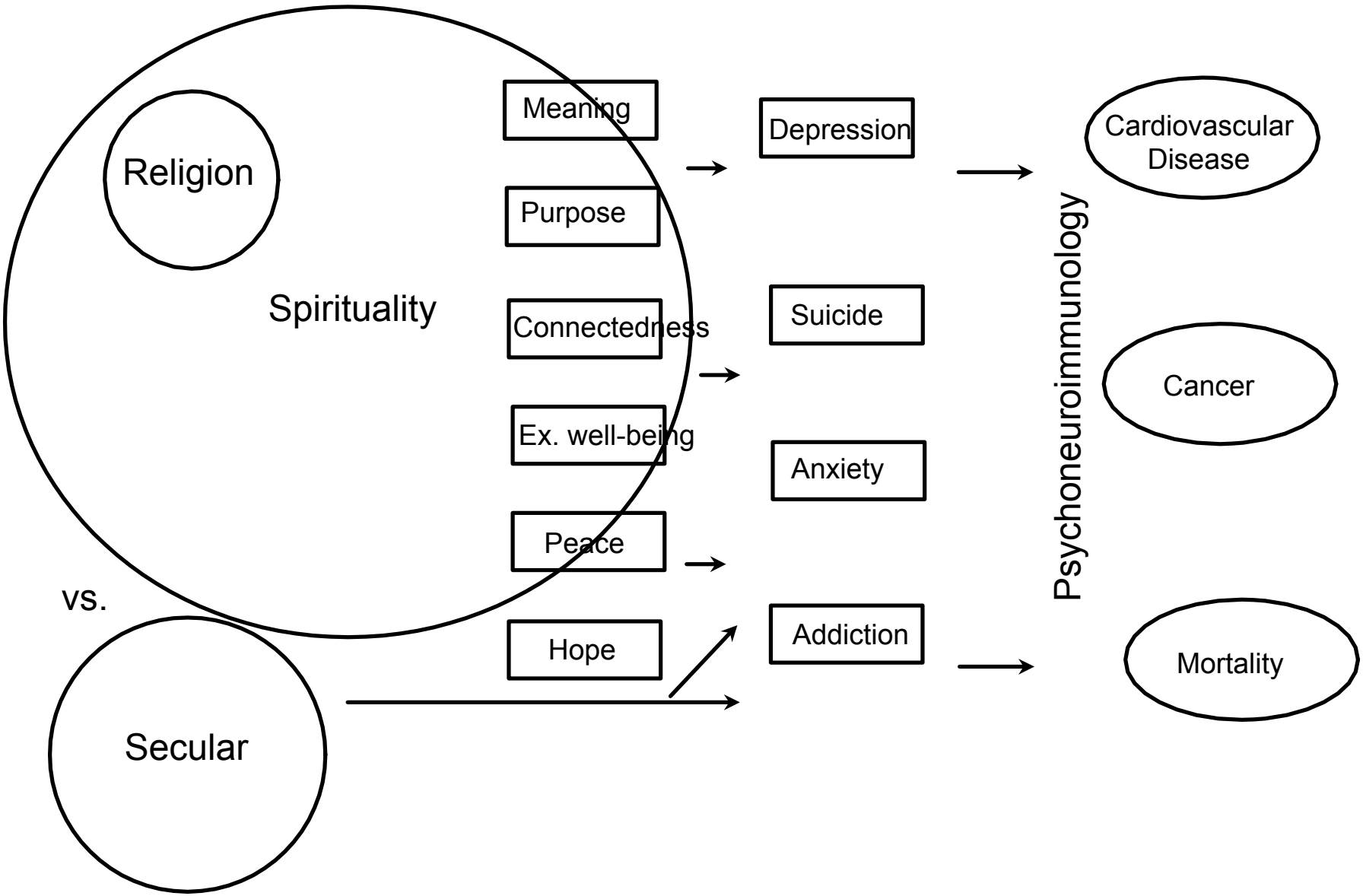
Traditional-Historical Understanding



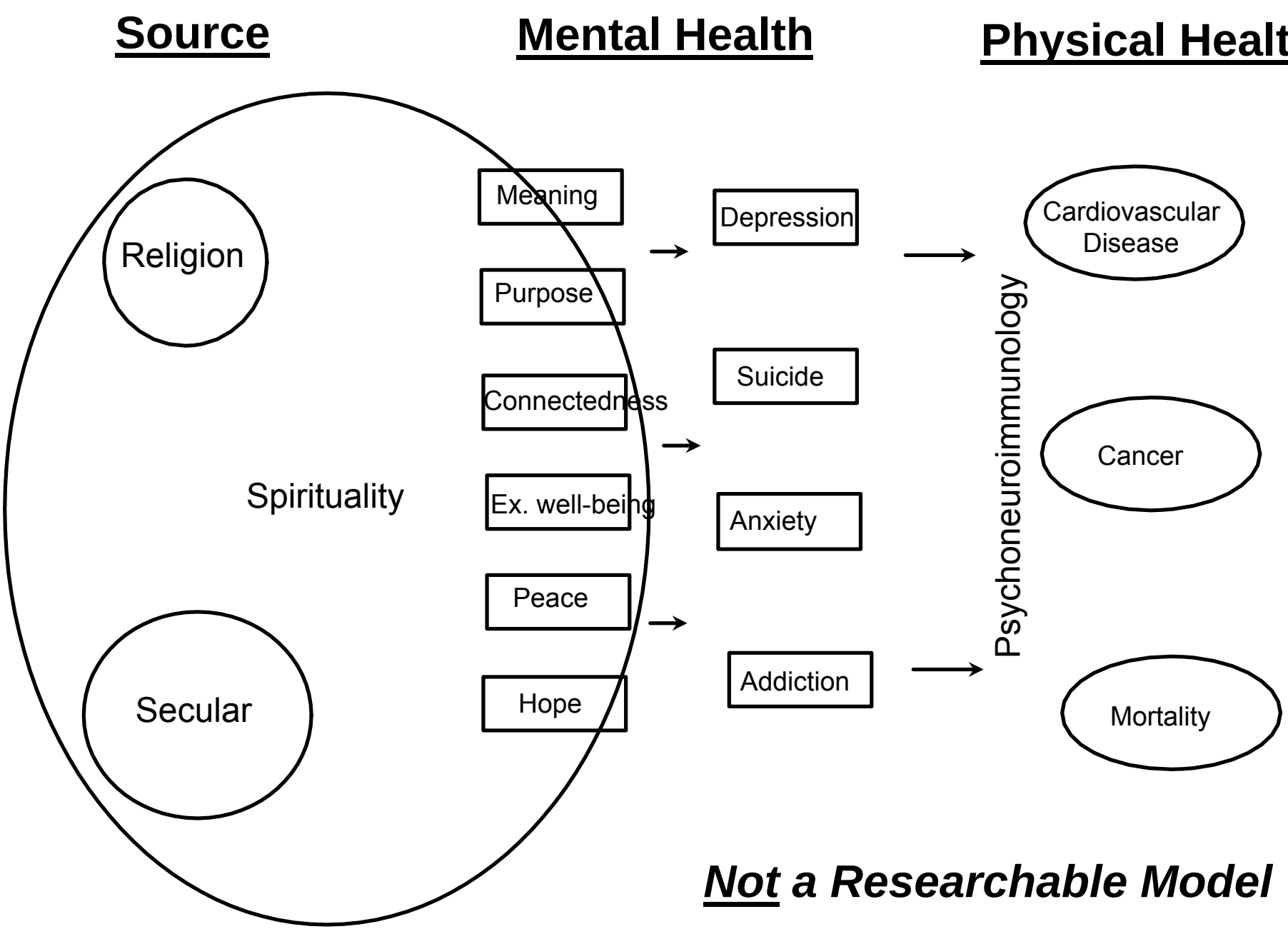
Modern Understanding



Modern Understanding - Tautological Version



Modern Understanding - Clinical Application only



<u>Not</u> a Researchable Model

In summary

1. When talking about research, I will talk in terms of RELIGION (as a multi-dimensional concept)

2. When conducting research, spirituality should be understood in traditional terms – as a subset of deeply religious whose lives and lifestyles reflect their faith (ideal models: Mother Teresa, Martin Luther King, Gandhi, Siddhārtha Gautama, etc.)

3. When clinical applications are considered, the term SPIRITUALITY should be used, where spirituality is broadly inclusive and self-defined by patients themselves

Religion and Coping with Illness

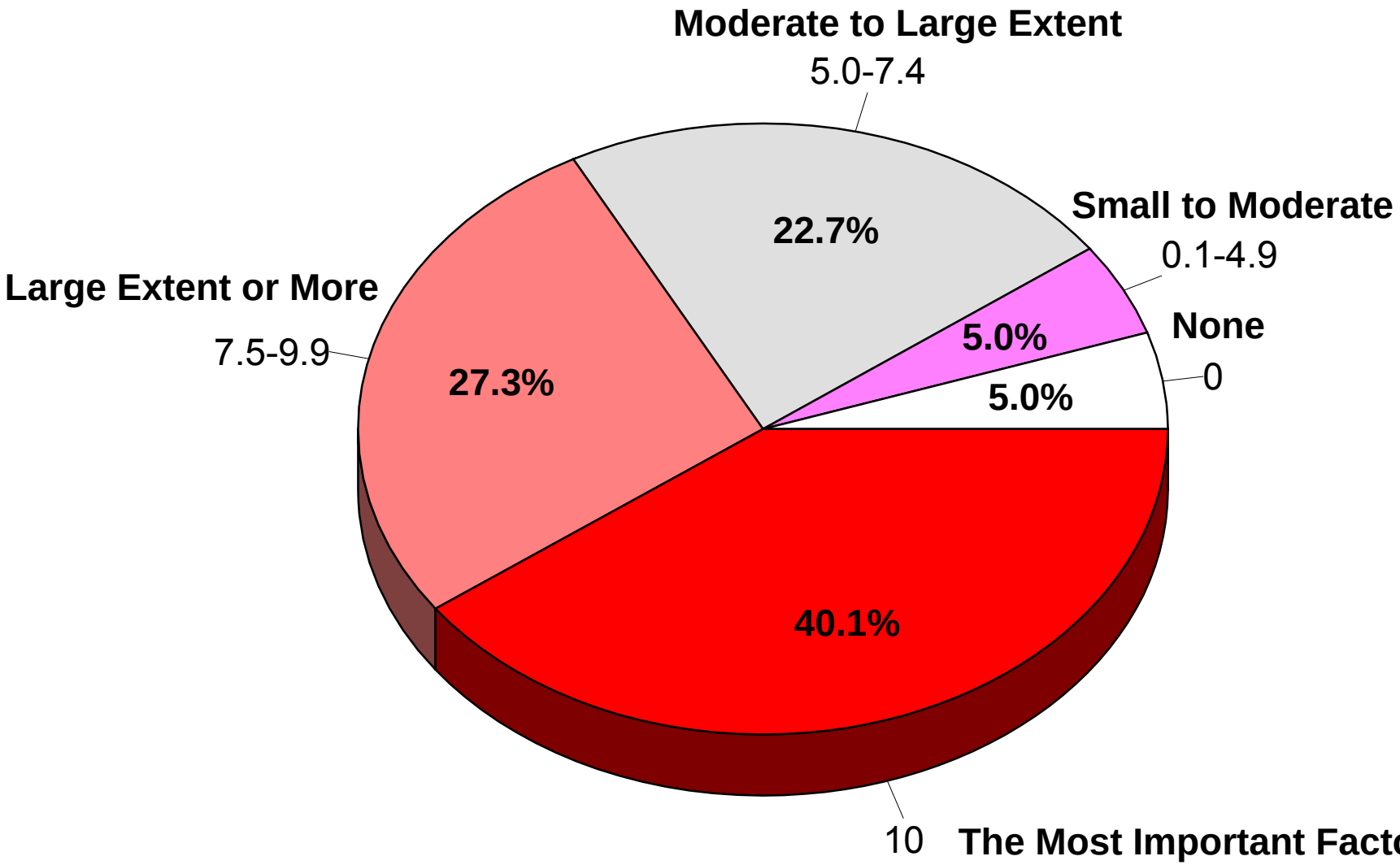
1. Many persons turn to religion for comfort when sick

2. Religion is used to cope with problems common among those with medical illness:

   - 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)

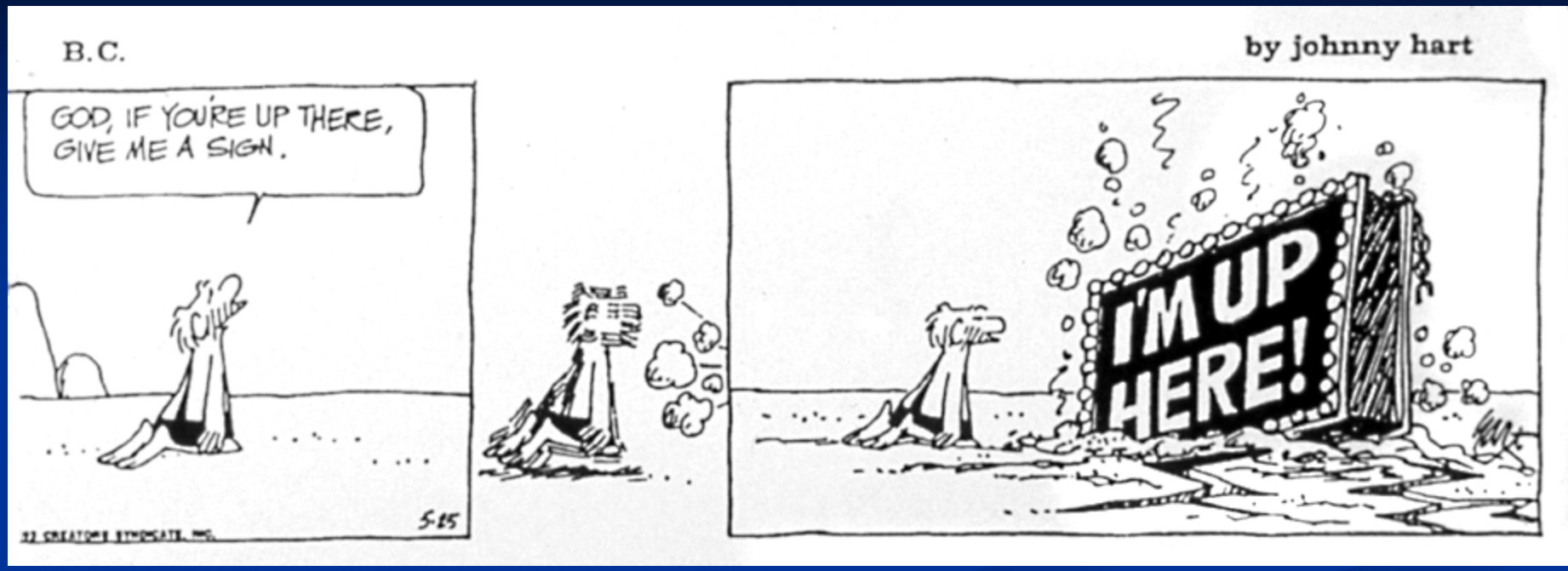
Stress-induced Religious Coping

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


B.C.
by johnny hart
GOD, IF YOU'RE UP THERE, GIVE ME A SIGN.
I'M UP HERE!

Religion and Mental Health

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

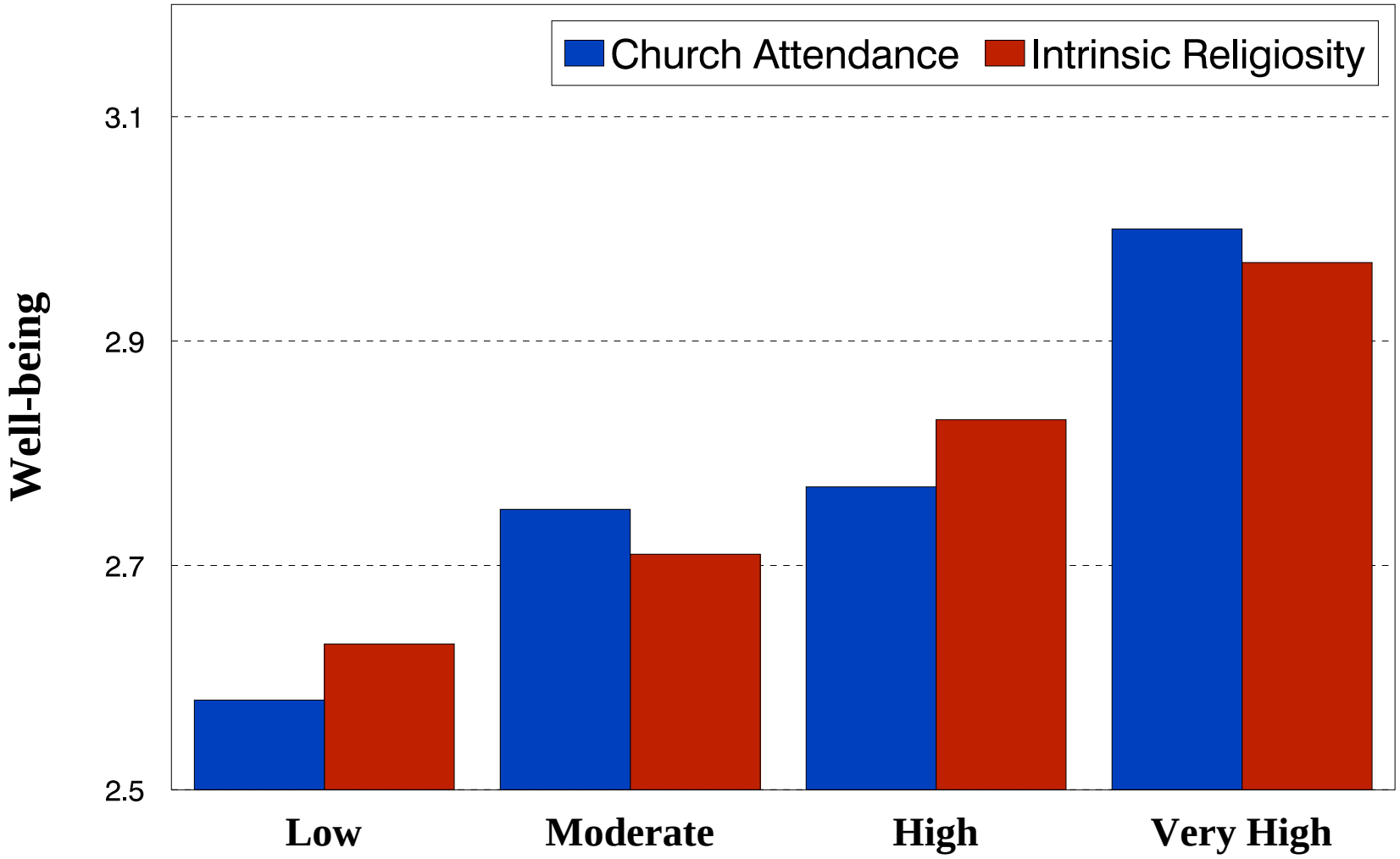
"The whole thing is so patently infantile, so incongruous with reality, that to one whose attitude to humanity is friendly it is painful to think that the great majority of mortals will never be able to rise above this view of life."

Part of a presentation given by Rachel Dew, M.D., Duke post-doc fellow

Religion and Mental Health Research

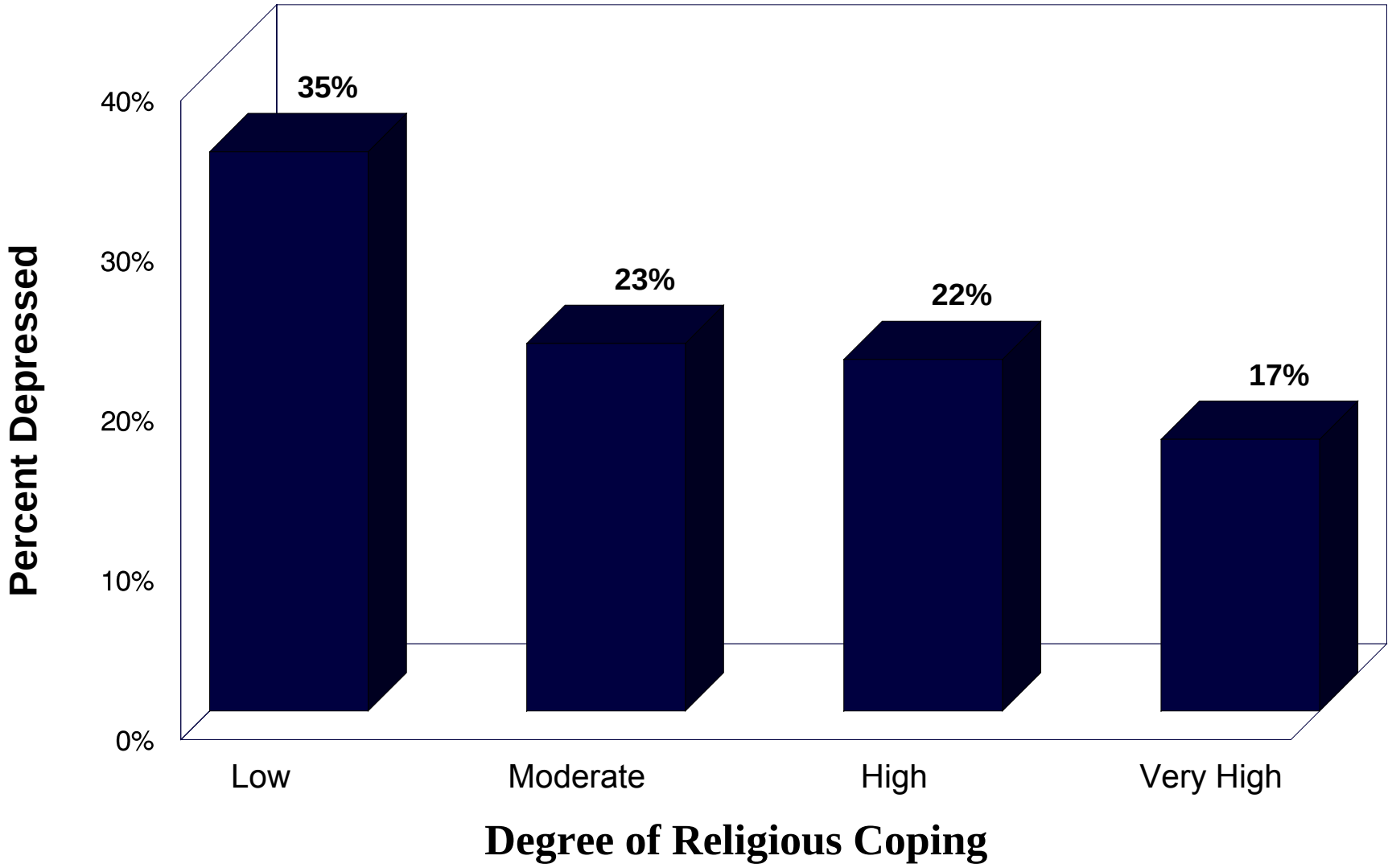
Religion and Well-being in Older Adults

The Gerontologist 1988; 28:18-28



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

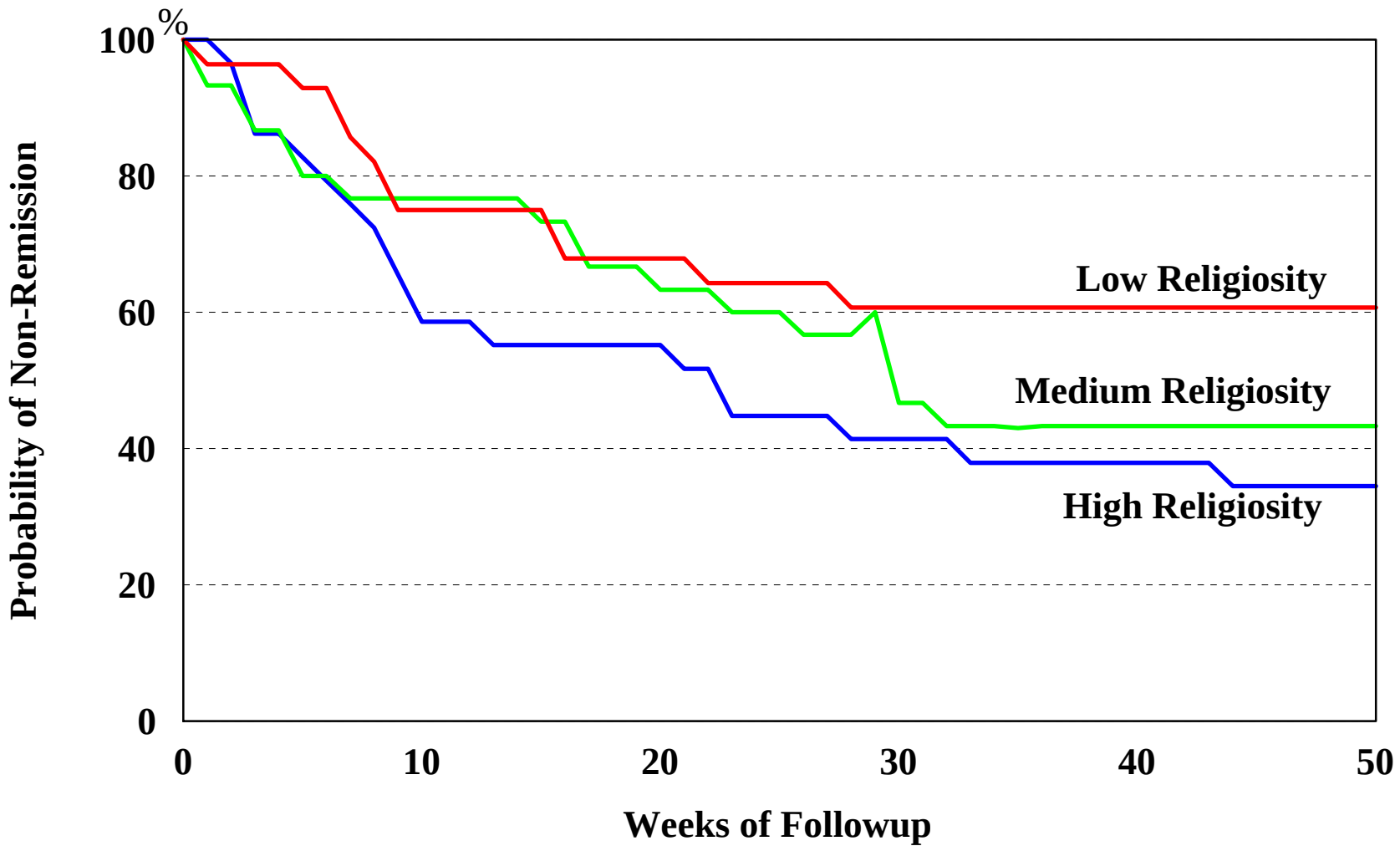
Religion and Depression in Hospitalized Patients



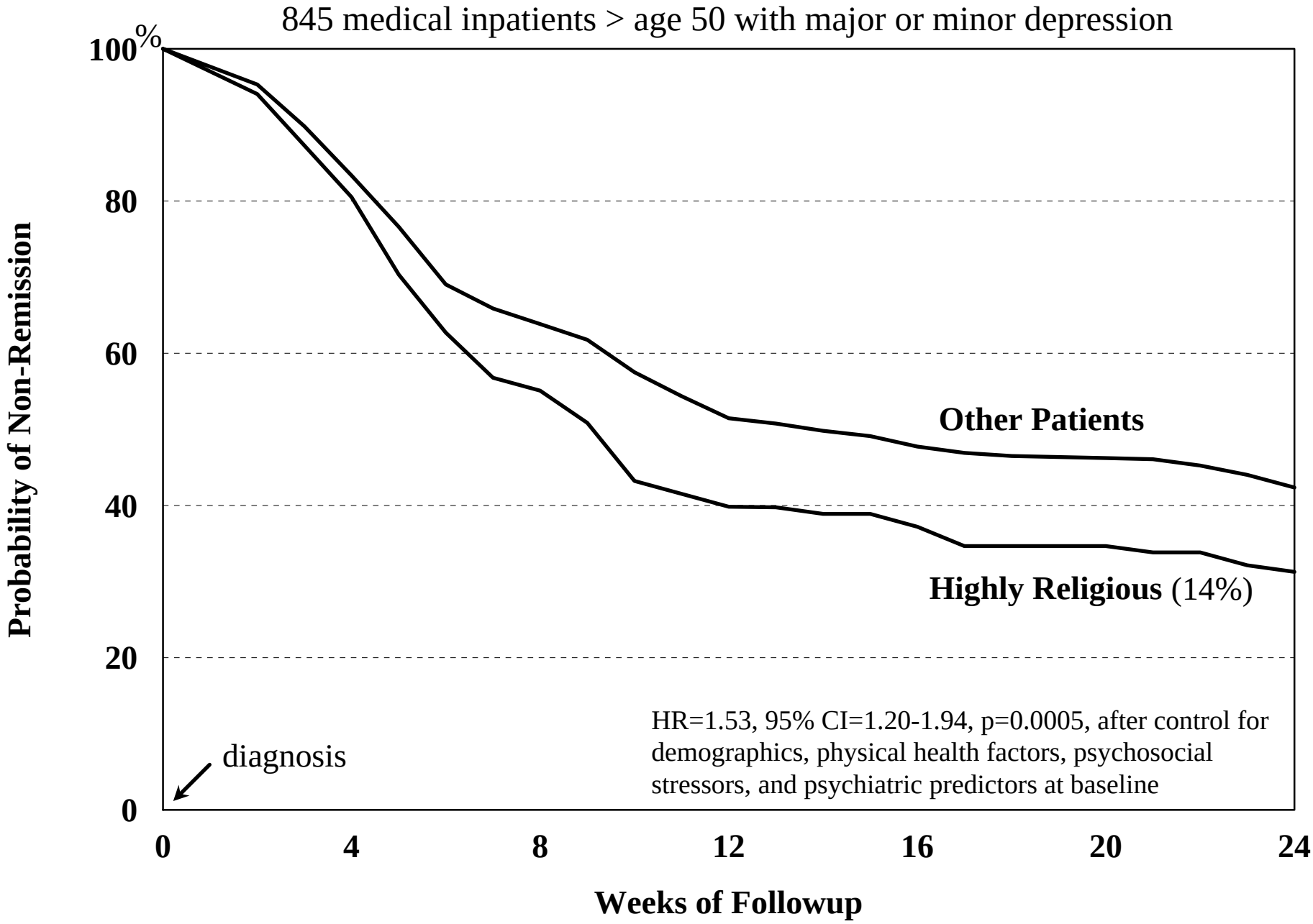
Geriatric Depression Scale
Information based on results from 991 consecutively admitted patients (differences significant at p<.0001)

Time to Remission by Intrinsic Religiosity

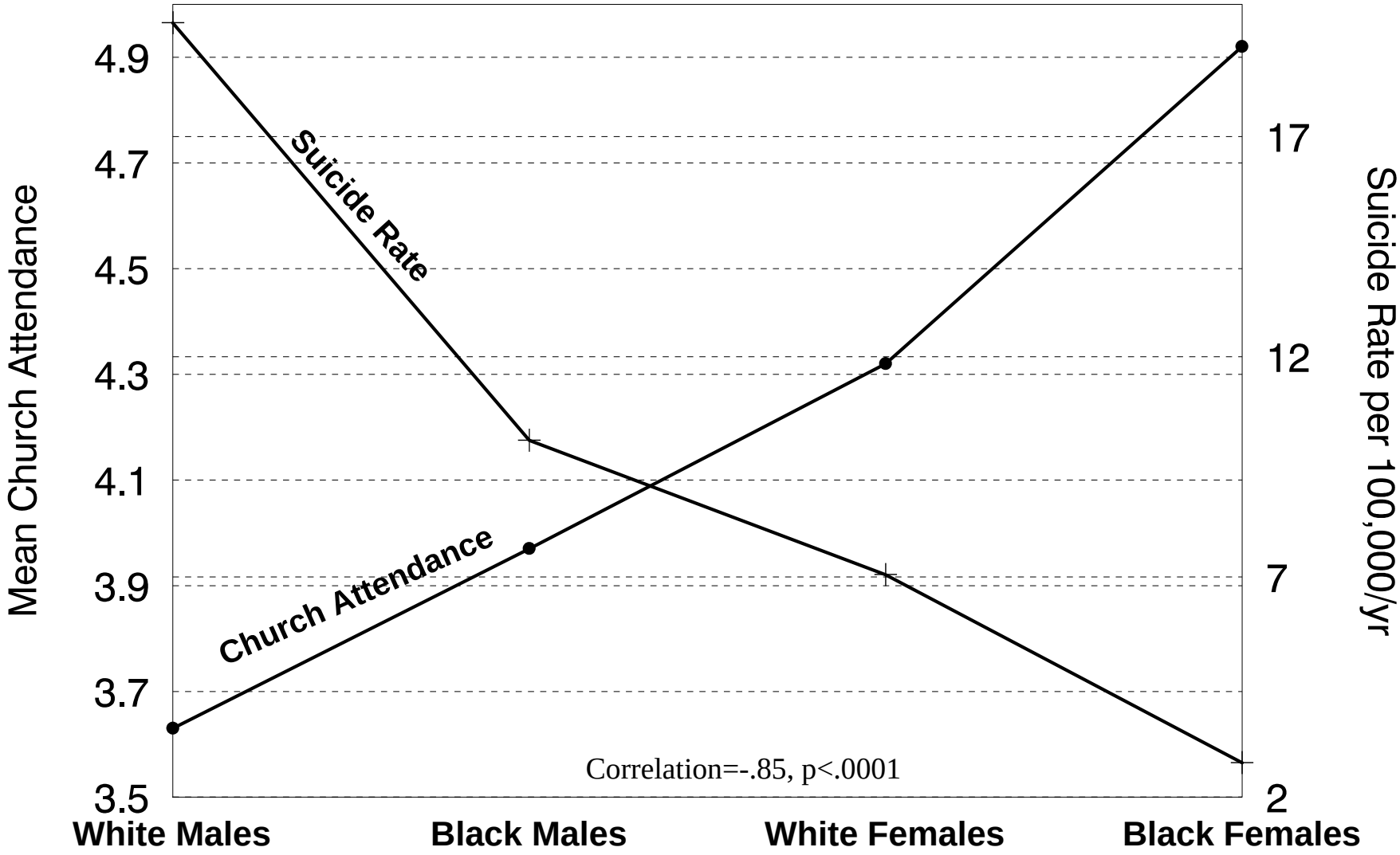
(N=87 patients with major or minor depression by Diagnostic Interview Schedule)



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

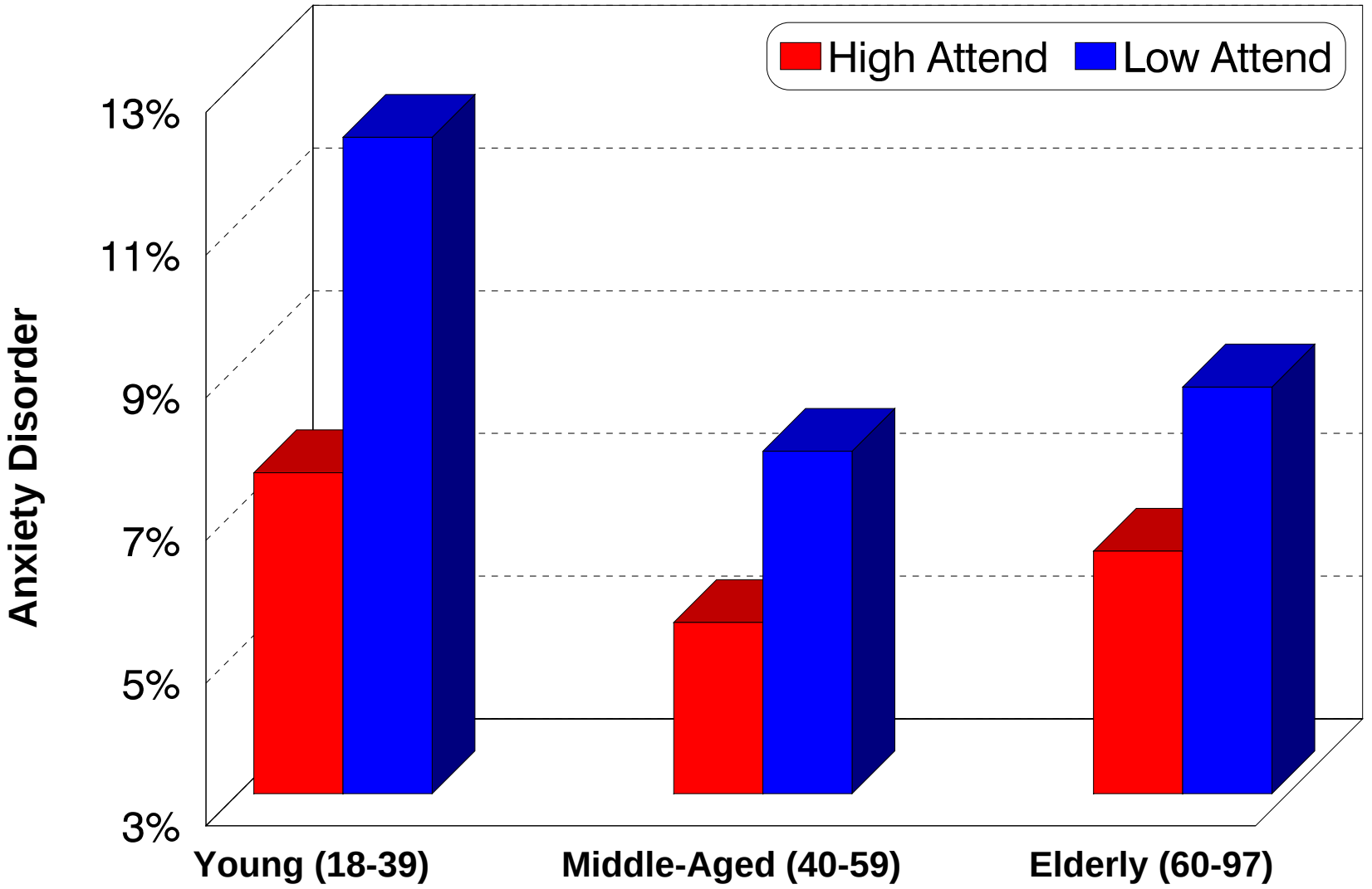
Church Attendance and Suicide Rates



Martin WT (1984). Religiosity and United States suicide rates. J Clinical Psychology 40:1166-1169

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

KUDZU


ARE YOU PLAGUED BY DOUBT? DO YOU QUESTION THE EXISTENCE OF GOD? IS YOUR FAITH CHALLENGED BY THE VICISSITUDES OF MODERN LIFE?
DO YOU THINK THE CHURCH IS FULL OF PHONIES AND HYPOCRITES?
YOU MAY SUFFER FROM GENERAL SPIRITUAL ANXIETY DISORDER!...
TRY PRAY-ZAC!... THE EXCITING NEW OVER-THE-COUNTER PHARMACEUTICAL NINE-OUT-OF-TEN MINISTERS RECOMMEND!

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)

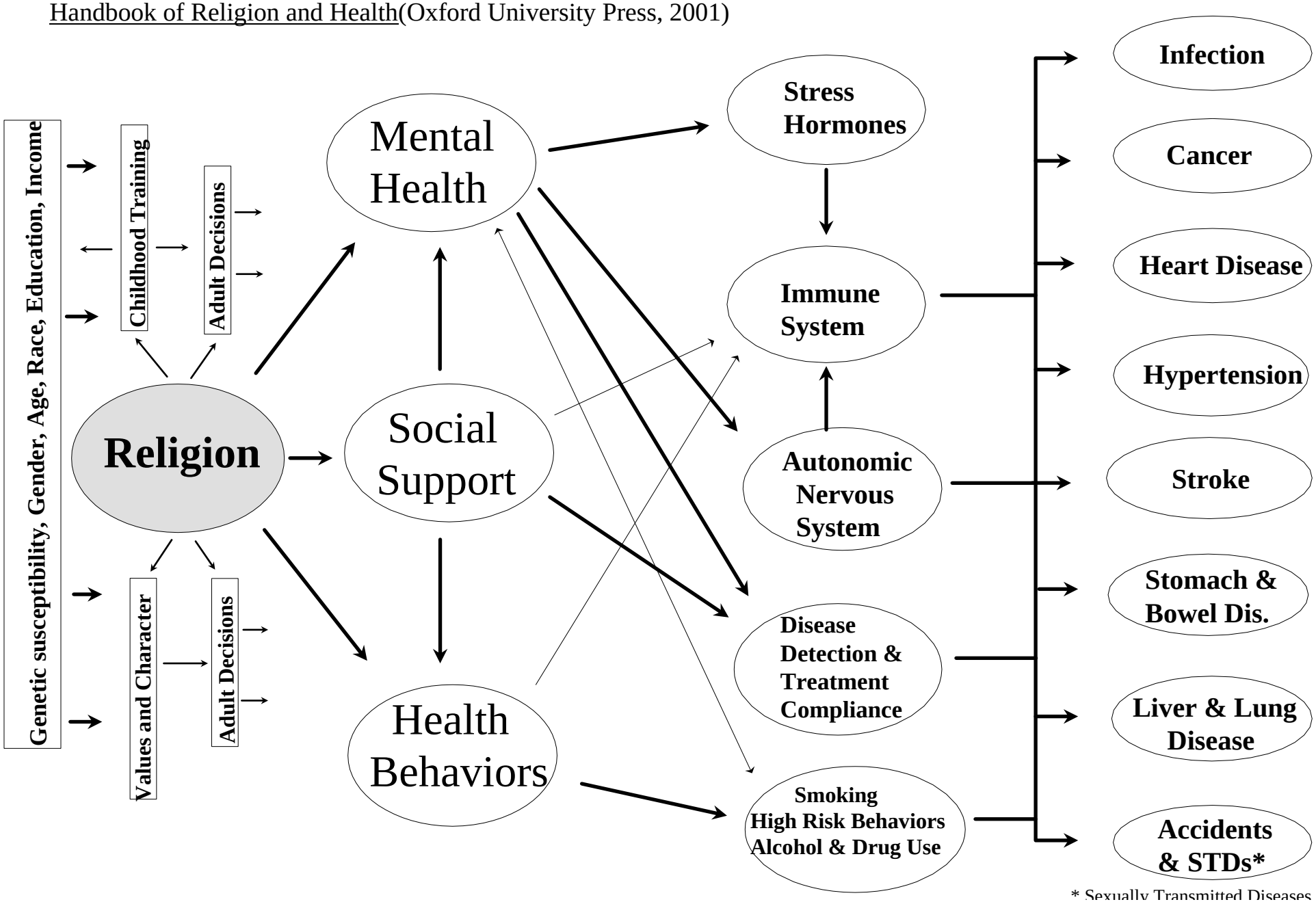
2. Growing amount of research-related articles on topic

   PsycInfo 2001-2005 = **5187** articles (2757 spirituality, 3170 religion) [11198 psychotherapy] 46%
   PsycInfo 1996-2000 = **3512** articles (1711 spirituality, 2204 religion) [10438 psychotherapy] 34%
   PsycInfo 1991-1995 = **2236** articles (807 spirituality, 1564 religion) [9284 psychotherapy] 24%
   PsycInfo 1981-1985 = **936** articles (71 spirituality, 880 religion) [5233 psychotherapy] 18%
   PsycInfo 1971-1975 = **776** articles (9 spirituality, 770 religion) [3197 psychotherapy] 24%

Religion and Physical Health

Model of Religion's Effects on Health

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

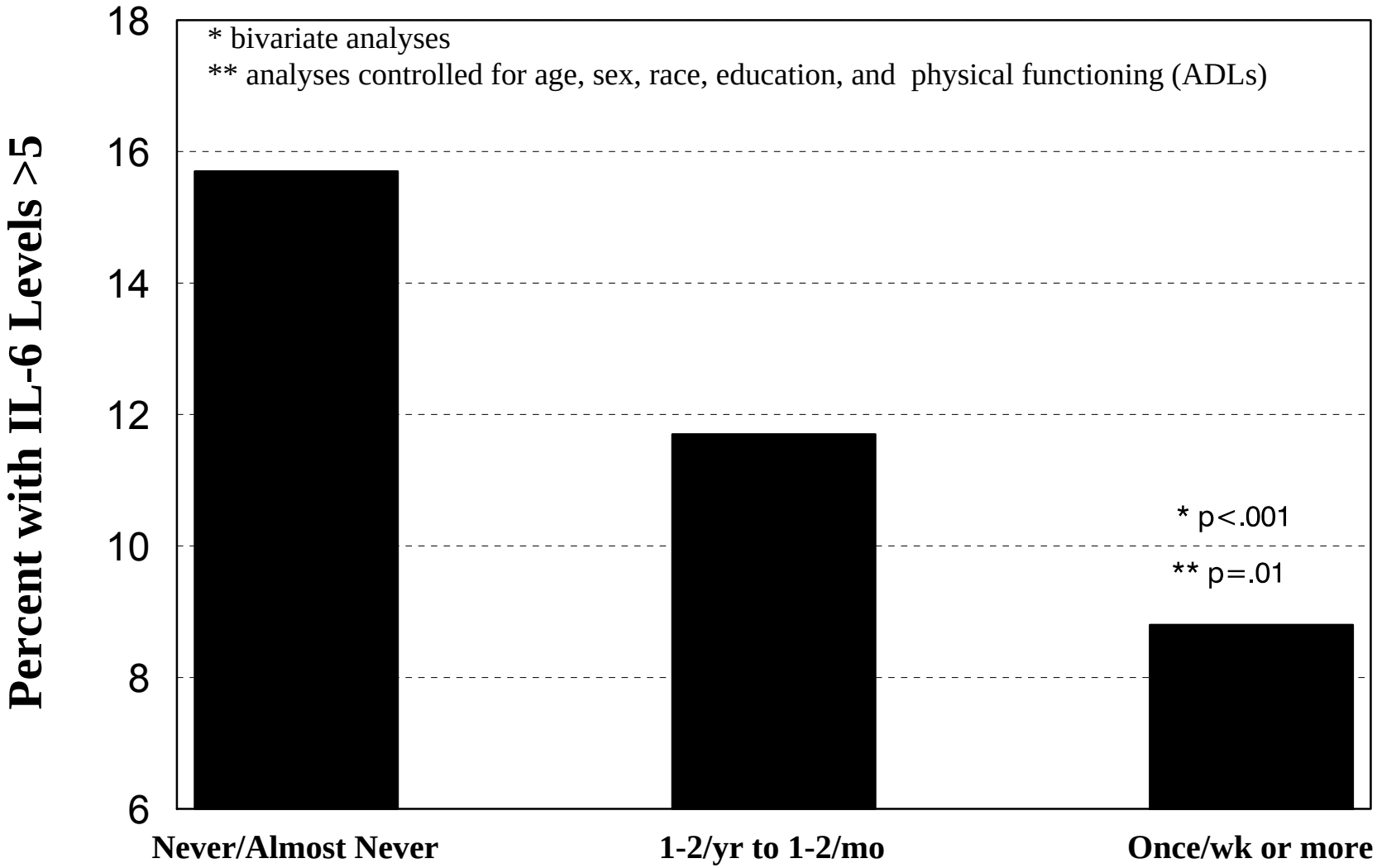


Religion and Physical Health Research

1. Immune function (IL-6, lymphocytes, CD-4, NK cells)
2. Death rates from cancer by religious group
3. Predicting cancer mortality (Alameda County Study)
4. Diastolic blood pressure (Duke EPESE Study)
5. Predicting stroke (Yale Health & Aging Study)
6. Coronary artery disease mortality (Israel)
7. Survival after open heart surgery (Dartmouth study)
8. Overall survival (Alameda County Study)
9. Summary of the research

Serum IL-6 and Attendance at Religious Services

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

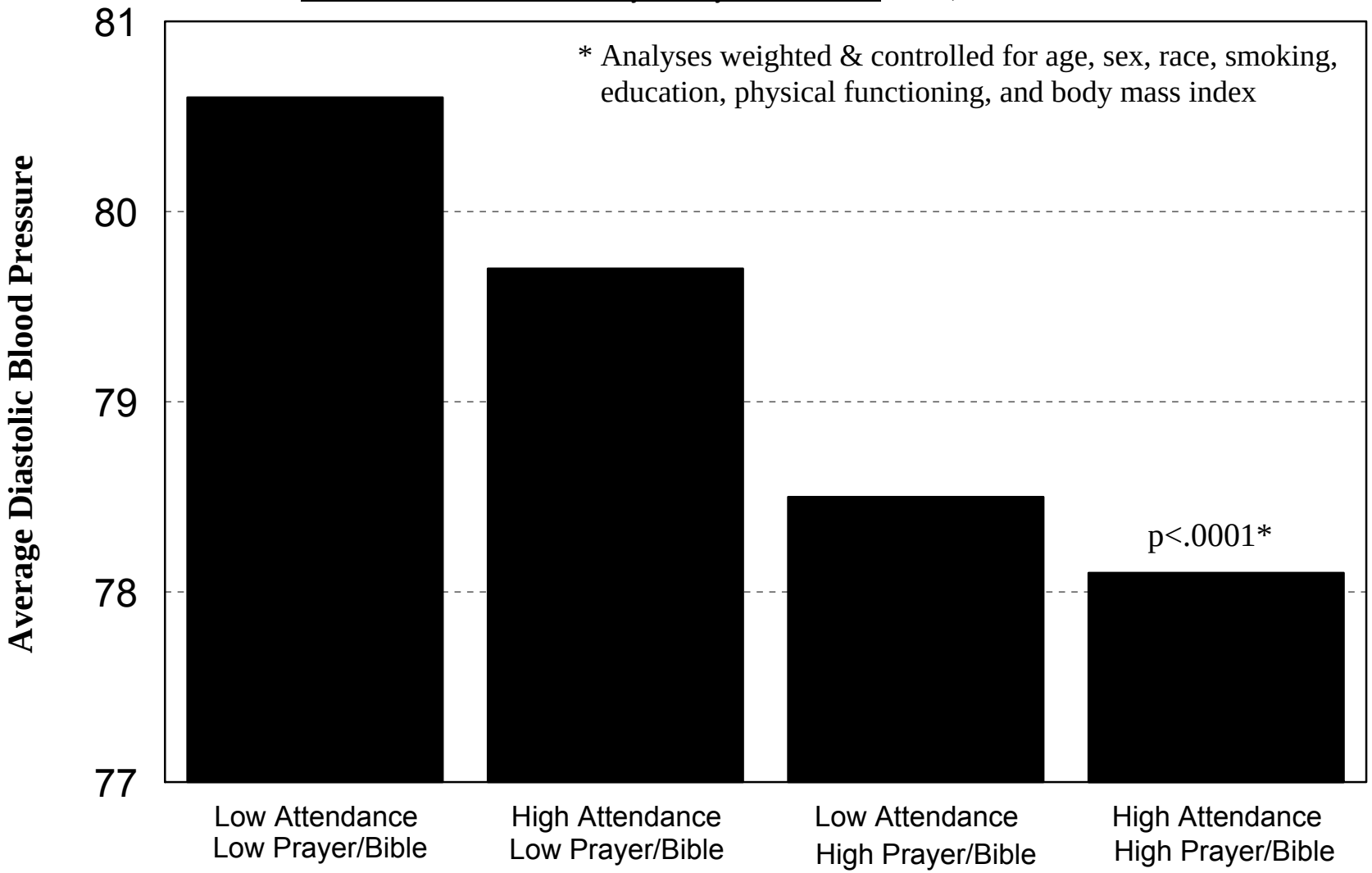


Citation: International Journal of Psychiatry in Medicine 1997; 27:233-250

Religious Activity and Diastolic Blood Pressure

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

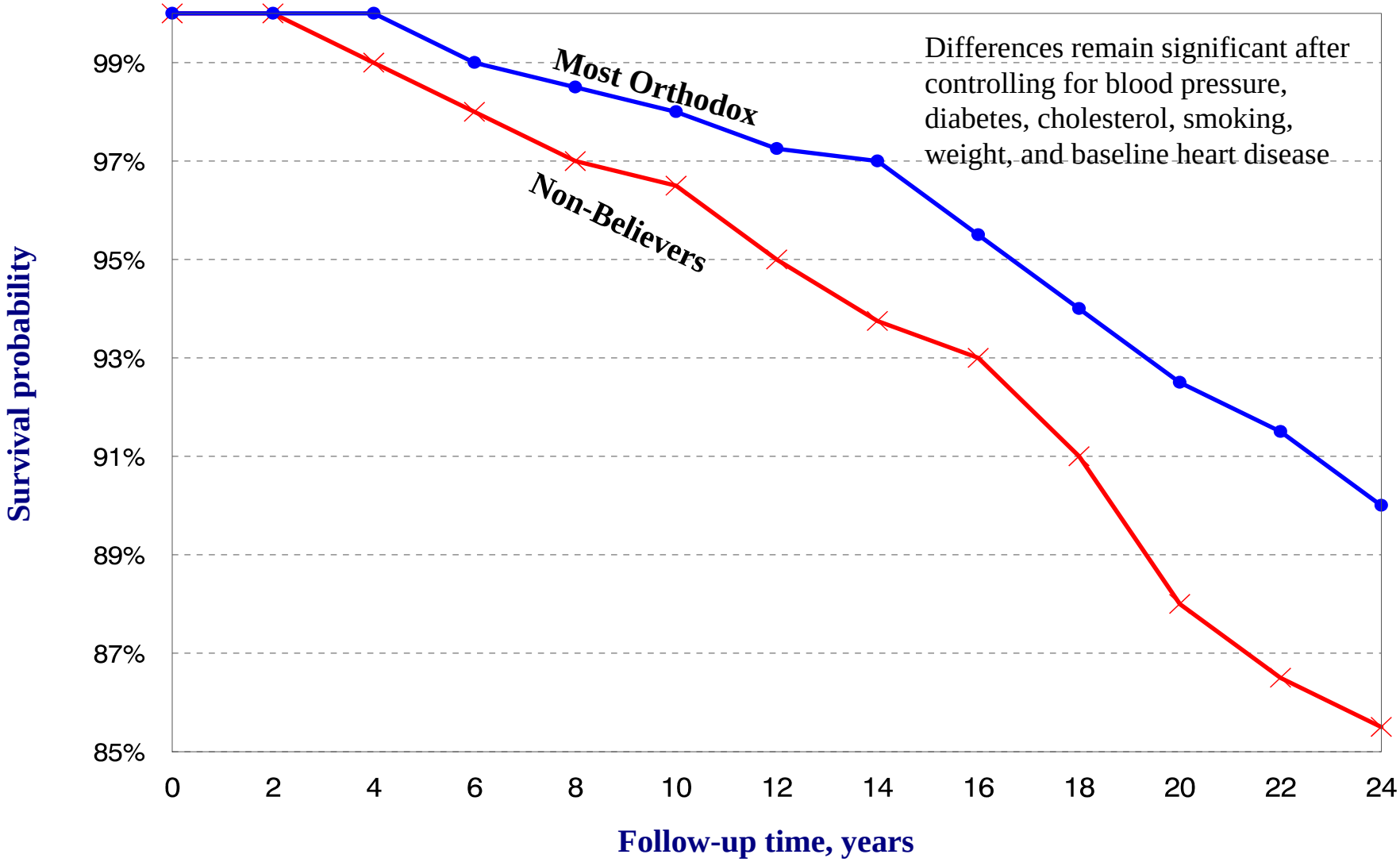
Citation: International Journal of Psychiatry in Medicine 1998; 28:189-213



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

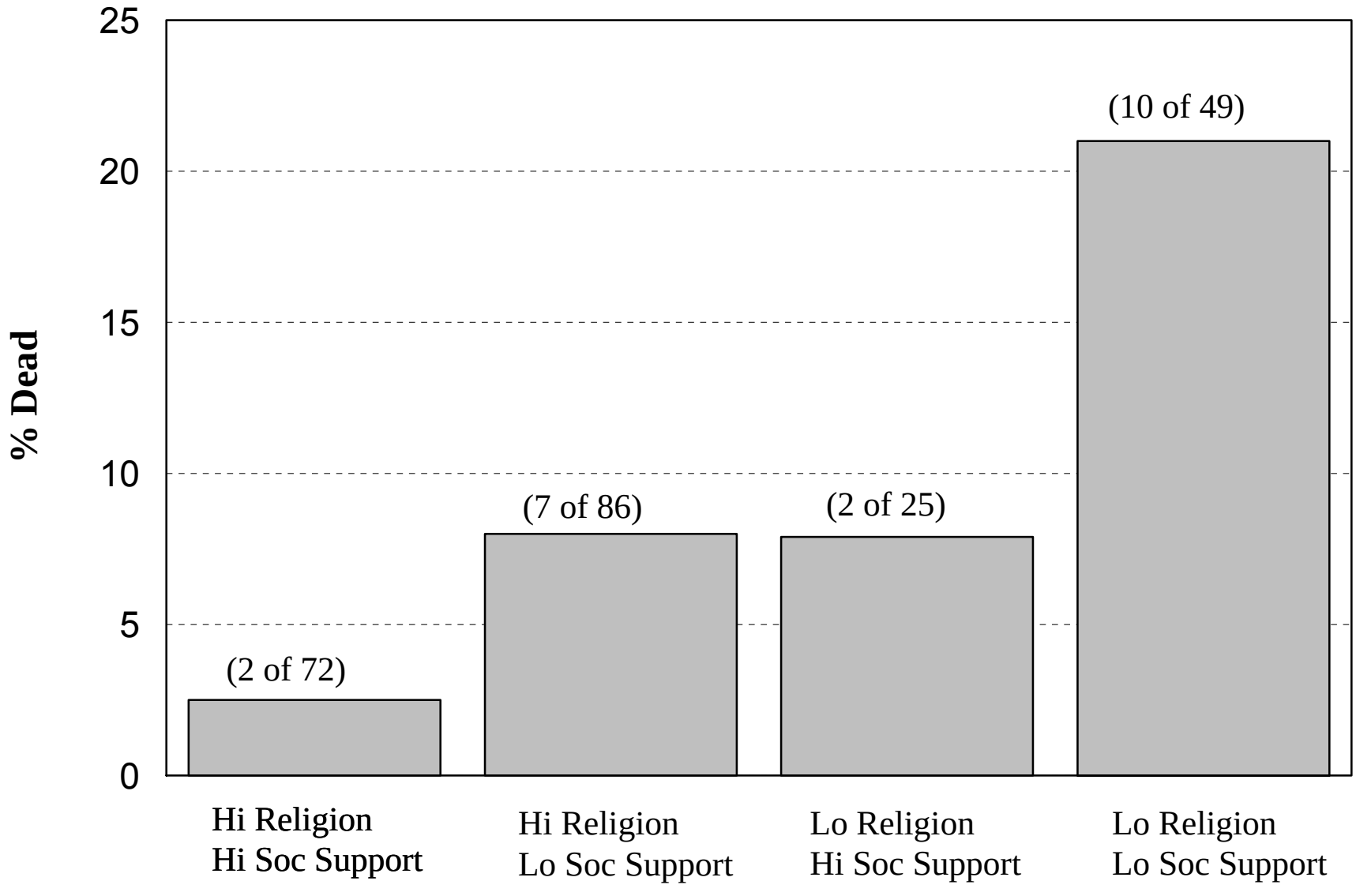
(based on 10,059 civil servants and municipal employees)



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 lower mortality in Mexican-Americans. Hill et al. Journal of Gerontology 2005; 60(2):S102-109

- 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 2007 (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

• Higher church attendance predicts lower fear of falling in older Mexican-Americans
Reyes-Ortiz et al. Aging & Mental Health 2006; 10:13-18

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 4:71-82

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

Religious Struggle

444 hospitalized medical patients followed for 2 years

Each of 7 items below rated on a 0 to 3 scale, based on agreement. For every 1 point increase on religious struggle scale (range 0-21), there was a 6% increase in mortality, independent of physical and mental health
(Arch Intern Med, 2001; 161: 1881-1885)

- Wondered whether God had abandoned me
- Felt punished by God for my lack of devotion
- Wondered what I did for God to punish me
- Questioned the God's love for me
- Wondered whether my church had abandoned me
- Decided the Devil made this happen
- Questioned the power of God

Further Resources

1. Spirituality in Patient Care (Templeton Press, 2007)
2. Handbook of Religion and Health (Oxford University Press, 2001)
3. Healing Power of Faith (Simon & Schuster, 2001)
4. Faith and Mental Health (Templeton Press, 2005)
5. The Link Between Religion & Health: Psychoneuroimmunology & the Faith Factor (Oxford University Press, 2002)
6. Handbook of Religion and Mental Health (Academic Press, 1998)
7. In the Wake of Disaster: Religious Responses to Terrorism and Catastrophe (Templeton Press, 2006)
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 2008

Durham, North Carolina

1-day clinical workshops and 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 21-25, Aug 11-15, Aug 30) 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

Application to Clinical Practice

Why Address Spirituality: Clinical Rationale

1. Many patients are religious, would like it addressed in their health care
2. Many patients have spiritual needs related to illness that could affect mental health, but go unmet
3. Patients, particularly when hospitalized, are often isolated from their religious communities
4. Religious beliefs affect medical decisions, may conflict with treatments
5. Religion influences health care in the community
6. JCAHO requirements

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 (CSI-MEMO)
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. All hospitalized patients need a spiritual history (and any patient with chronic or serious medical or psychiatric illness)

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

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

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

A Brief Explanation Should Precede the Spiritual History

1. Patients may become alarmed or anxious if a health professionals begins talking about religious or spiritual issues

2. The health professional should be careful not to send an unintended message to the patient that may be misinterpreted

3. Make it clear that such inquiry has nothing to do with the patient's diagnosis or the severity of their medical condition

4. Indicate that such inquiry is routine, required, and an attempt to be sensitive to the spiritual needs that some patients may have

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

Information Should Be Documented

1. A special part of the chart should be designated for relevant information learned from the Spiritual History
2. Everything should be documented in one place that is easily locatable
3. Pastoral care assessments and any follow-up should also go here
4. On discharge, for those with spiritual needs identified, a follow-up plan should conclude this section of the chart

Refer to Professional Chaplains

1. Get to know your chaplains. Are they competent? If yes, then…
2. If any but the most simple of spiritual needs come up, always refer
3. Need to know the local pastoral care resources that are available, and the degree to which they can be relied on
4. Before referral, explain to patients what a chaplain is and does (they won't know)
5. Explain why you think they should see a chaplain
6. (?) obtain patient's consent prior to referral

Key Roles of the Medical Social Worker

1. Be familiar with the patient's religious background and experiences, and if spiritual history not done, then do it and document it

2. Sensible spiritual interventions include supporting the patient's beliefs, praying w patients if requested, ensuring spiritual needs are met

3. On discharge, ask question such as: "Were your spiritual needs met to your satisfaction during your hospital stay, are there still some issues that you need some help with?"

4. For patients with unmet spiritual needs, work with chaplain to develop a spiritual care plan to be carried out in the community after discharge

5. For the religious patient, after permission obtained, SW or chaplain should contact patient's clergy to ensure smooth transition home or to nursing home, and to ensure follow-up on unmet spiritual needs

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)
6. Do not do any activity that is not patient-centered and patient-directed

Summary

1. There is a great deal of systematic research indicating that religion is related to better coping, better mental health, better physical health, and may impact medical outcomes

2. There are good clinical reasons for assessing and addressing the spiritual needs of patients

3. A spiritual history should be taken and documented on all patients, and care adapted to address those needs

4. Social workers play a key role in assessing spiritual needs and ensuring they are met, particularly after discharge

5. There are boundaries and limitations, however, and it is important to work with chaplains and pastoral counselors in addressing the spiritual needs of patients