

Allowing spirituality into the healing process

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Practice recommendations

- Research indicates spirituality and religion are a core aspect of life, and patients want physicians to address issues of spirituality in the context of medical care (C).
- Studies of the effect of patients' faith on disease outcomes have shown reduced hypertension, better lipid profiles and lower cholesterol levels, and improved immune function (C).
- An appropriate model for addressing patients' spiritual concerns should include active-listening skills, identification of spiritual/emotional issues, effective referrals to "spiritual specialists," and ongoing communication about this aspect of the healing process (C).
- Remember, it is all about the patient's spirituality, not the caregiver's, and about supporting the patient's spiritual beliefs (unless clearly pathologic) (C).

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Most people have a strong awareness of themselves as spiritual beings. For many, their spirituality profoundly impacts, and is impacted by, illness. A review of studies in which spiritual factors are included suggests spirituality influences the process of healing significantly, either positively or negatively. A healthy spirituality can aid in prevention, improve outcomes, and facilitate coping, and should be supported and encouraged. A negative spirituality can hinder the process of healing and should be addressed.

This article considers means by which physicians may enable patients to express their spiritual concerns and find support for them, without stepping over professional boundaries or imposing personal views on those of patients.

■ PATIENTS' REGARD OF SPIRITUALITY AND MEDICAL CARE

According to a myriad surveys, most Americans consider spirituality and religion a significant part of who they are.^{1,2} Although definitions and expressions vary, in general *spirituality* is defined as a search for what is sacred or holy in life, coupled with a transcendent (greater than self) relationship with God or a higher power or universal energy.³ *Religion* is seen as focusing more on prescribed beliefs, rituals, and practices as well as social institutional features,⁴ and on the undertaking of a spiritual search using specific means or methods (ie, rituals or behaviors) within an identifiable group.

Research in the field indicates that spirituality

and religion are seen as a core aspect of life, and patients want physicians to address issues of spirituality in the context of medical care.^{5,6} A public survey done in 1996 by *USA Weekend* showed that 63% of patients believe doctors should ask about spirituality issues, but only 10% have actually been asked.² In another study, 77% of patients surveyed said physicians should consider patients' spiritual needs, and 37% wanted physicians to discuss religious beliefs with them more frequently.⁷

■ INTERTWINING OF MEDICINE AND SPIRITUALITY

The relationship of the discipline of medicine with the world of spirituality has been long and varied. The beginning of medicine was deeply imbedded in spirituality with spiritual leaders being some of the earliest "healers."

A chasm forms

With the advent of the scientific revolution and the emergence of the scientific method in the late 1500s, the relationship between spirituality and science changed dramatically. Since this new experimental method could not be readily or confidently applied to God, or to one's experiences with God, religion/spirituality was excluded from the realm of science and a chasm emerged between the 2 realms.

The chasm widened given the religious community's tendency to reject many of the discoveries generated by the scientific method. Distrust, even dislike, of the spiritual by the medical community became widespread. Mandel, in *The Psychobiology of Consciousness*, calls spirituality a "temporal lobe dysfunction."⁸ Perhaps more telling was the use of spirituality in the glossary of technical terms in *Diagnostic and Statistical Manual of Mental Disorders*, revised 3rd edition (DSM-III-R).⁹ In that document, all allusions to spirituality were illustrations of psychopathology; 22.2% of all the negative illustrations in the glossary had religious content, while none had sexual, ethnic, racial, or cultural content.

This negativity was exacerbated by an ever-

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increasing emphasis on the science of medicine, reflecting the exponential growth of scientific knowledge relevant to medical practice, the public's demand for technologically sophisticated medical care, and an increased emphasis on tools such as evidence-based medicine. Medical practice became centered on the task of choosing treatments proven effective through rigorous study. Aspects of the "art of medicine" that had not undergone rigid empirical evaluation were considered suspect and deemed unworthy of inclusion in medical practice.

Spanning the chasm

However, a new interest in the integration of medicine and spirituality has emerged. One reflection of this interest is the discussion of the topic in both popular and professional journals. A search by Oregon Health and Science University faculty in 1999 of a large public library database of popular magazines using the key words "spirituality and health" revealed only 25 articles from 1990 to 1994, but over 100 articles from 1995 to 1999.

A similar movement can be seen in the medical literature. A search of MedLine using the keyword "spirituality" produced 52 articles from 1960 to 1990, 90 from 1991 to 1995, and almost 200 from 1996 to 1999. A more recent search produced 554 citations from January 2000 to April 2003.

■ WHAT OUTCOMES RESEARCH HAS SHOWN ABOUT SPIRITUALITY

Much of the focus in this area has been on what research can reveal regarding the impact of spirituality on health. The late David Larson, MD, MSPH, of the International Center for the Integration of Health and Spirituality (ICIHS) and his collaborators extensively reviewed journals and identified large numbers of studies that included spiritual indicators. They found a

TABLE 1

Areas of spirituality research to date

Major focus	Subtopics	Earliest publication	Number of publications
Mental health	Religious coping, hope and optimism, purpose/meaning in life, self-esteem, bereavement, social support, depression, suicide, assisted suicide/euthanasia, anxiety, schizophrenia/psychosis, alcohol use/abuse, drug use/abuse, delinquency/crime, marital instability, personality, general mental health	1932	1075
Physical health	Heart disease, hypertension, cerebrovascular disease, immune system, cancer risk, mortality, functional disability, pain and somatic symptoms, health behaviors, miscellaneous	1902	455
Use of health services	General medical services, mental health services, disease prevention, health responsibility, compliance	1960	53
Clinical implications and applications	Health professionals, religious professionals	1973	131
Research	Measurement	1967	40
Miscellaneous	Religious beliefs/behaviors, religious/faith development, religious conversion, spiritual/faith healing, prayer, death and dying, religious harm	1902	171

strong trend toward identifying spirituality as a positive factor for coping with illness, preventing illness, and aiding treatment.^{3,10}

Harold G. Koenig of Duke University continued the effort and recently published a *Handbook of Religion and Health*.¹¹ This work systematically reviewed and rated around 1600 studies related to the relationships between religion and a variety of mental and physical health conditions, starting with the earliest identified studies through 2000. The research can be broken down into 3 major categories: religion and mental health, religion and physical disorders, and religion and the use of health services. A smaller number of studies focus on research issues, spiritual development,

and implications for health and religious professionals (**Table 1**).

Although most studies in English have focused on “Western faiths” such as Roman Catholicism, Orthodoxy, mainline and fundamentalist Protestantism, Pentecostalism, Jehovah’s Witnesses, Judaism, and Mormonism, studies have also looked at such faiths as Baha’i, Hare Krishna, Islam, Sikhism, and Hinduism.^{12,13} In some cases, especially in the area of mental health (depression and psychoses), the type of religious affiliation did seem to be a factor in outcomes, both positive and negative.¹¹

Studies have also included a variety of cultures and nations. Thirty-nine different countries are

TABLE 2

Propositions regarding the effect of spirituality on physical outcomes

Proposition Studies	Rating* #-Letter
<p>Religious coping aids stress management Ellison, CG, Taylor RJ. Turning to prayer: Social and situational antecedents of religious coping among African Americans. <i>Rev Religious Research</i> 1996; 38:111–131.</p>	8/NA
<p>Pargament KI, Smith BW, Koenig HG, et al. Patterns of positive and negative religious coping with major life stressors. <i>J Scientific Study Religion</i> 1998; 37(4):710–724.</p>	8/NA
<p>Spirituality/religious affiliation prevents substance abuse Bell R, Wechsler H, Johnston LD. Correlates of college student marijuana use: Results of a US national survey. <i>Addiction</i> 1997; 92:571–581.</p>	9/NA
<p>Religious practices/spirituality decreases the incidence of depression Idler EL, Kasl S. Religion, disability, depression, and the timing of death. <i>Am J Sociology</i> 1992; 97:1052–1079.</p> <p>Kennedy GJ, Kelman HR, Thomas C, et al. The relation of religious preference and practice to depressive symptoms among 1,855 older adults. <i>J Gerontol</i> 1996; 51B:301–308.</p>	10/NA 10/NA
<p>Religious practice/spirituality lowers suicide rates Neeleman J, Halpern D, Leon D. Tolerance of suicide, religion, and suicide rates: An ecological and individual study in 19 Western countries. <i>Psychol Med</i> 1997; 27(5):1165–1171.</p>	10/NA
<p>Religious practice/spirituality prevents hypertension/lowers blood pressure Steffen PR, Hinderliter AL, Blumenthal JA, et al. Religious coping, ethnicity, and ambulatory blood pressure. <i>Psychosomatic Med</i> 2001; 63:523–530.</p> <p>Koenig, HG, George LK, Hays, JC, et al. The relationships between religious activities and blood pressure in older adults. <i>International J Psych Med</i> 1998; 28:189–213.</p>	7–A/B 9 A/B
<p>Religious practice/spirituality is related to better lipid profiles Friedlander Y, Kark JD, Stein Y. Religious observance and plasma lipids and lipoproteins among 17 year old Jewish residents of Jerusalem. <i>Prevent Med</i> 1987; 16:70–79.</p>	8-B
<p>Religious practice/spirituality is associated with better immune function Woods TE, Antoni MH, Ironson GH, et al. Religiosity is associated with affective and immune status in symptomatic HIV-infected gay men. <i>J Psychosomatic Research</i> 1999; 46:165–176.</p> <p>Koenig HG, Cohen JH, George LK, et al. Attendance at religious services, interleukin-6, and other biological parameters of immune function in older adults, <i>International J Psych Med</i> 1997; 27:233–250.</p>	7-B 8-A/B
<p>Religious practice/spirituality is related to lower cholesterol Patel, C, Marmot MG, Terry DJ, et al. Trial of relaxation in reducing coronary risk: Four year follow up. <i>Brit Med J</i> 1985; 290:1103–1106</p>	NA/A
<p>Attendance at church services leads to longer life Koenig JG, Hays JC, Larson DB, et al. Does religious attendance prolong survival? A six-year follow-up study of 3,968 older adults. <i>J Gerontology Series A: Biologic Sci Med Sci</i> 1999; 54A:M370–M376.</p>	9-A
<p>*Ratings Systems: Koenig/Miller Number = Rating system from Koenig et al., <i>Handbook of Religion and Health</i>. Scale of 1–10 (1=poor, 10=excellent). Based on overall study design, sampling method, quality of religious measure, quality of statistical analysis, interpretation of results, and discussion in the context of existing literature). Methodology validated by outside reviewers. Letter = Rating system from Miller WR, Thoresen CE, <i>Spirituality, Religion and Health: An Emerging Research Field</i>. A = Methodologically Sound B= Methodologically Sound with at least one methodological limitation. NA = not rated by this system</p>	

Studies show spirituality and religion benefit patients by helping prevent illness and increasing ability to cope

specifically listed as study locals, with many other studies listing the “world” as the local. Many studies contrast nations, cultures, or faith systems. In some cases these differences were significant, with one study focused on suicide showing opposite results depending on culture.¹⁴

Religion and mental health. Studies have looked at the impact of religion or spirituality on well-being, self-esteem, depression and suicide, as well as alcohol and drug use and abuse. Religious or spiritual people, especially those who are regularly involved with a community of faith, experience depression less often than others, are less likely to abuse drugs or alcohol, cope with life-issues and illness more effectively, and are less likely to commit suicide.¹¹

Religion and physical disorders. Studies have focused specifically on the effect of faith on heart disease, hypertension, cerebrovascular disease, immune system dysfunctions, and cancer. Other studies have looked at broader issues such as pain and mortality.¹¹ Results have shown reduced hypertension,^{15,16} better lipid profiles,^{17,18} improved immune function,^{19,20} and lower cholesterol levels²¹ (**Table 2**).

A recent article in *American Psychologist* notes there is more evidence that religion or spirituality impedes recovery than it improves recovery.²¹ However, the evidence cited by the article was connected to religious struggle or to negative coping (eg, “I feel God has abandoned me”). This is not surprising, and it underscores the need to support positive religious coping and to help patients move beyond negative religious coping.

Religion and use of health services. Studies looking at the use of health services focus on such matters as screening services²² and compliance.²³ One of the interesting factors here is the role of religion in noncompliance. The refusal of Jehovah’s Witnesses to receive blood products has

been a highly visible example. But other issues—more subtle, but nevertheless critical—emerge when one examines the literature; these include noncompliance due to a belief that a higher power “caused” the illness, or that illness is the result of “sinful” behavior.²⁴

In general, research shows the impact of religion and spirituality is positive. Although a person’s spirituality sometimes is pathological, and spiritual beliefs can create health issues, an overwhelming number of studies show a positive benefit. Of those studies reviewed by Koenig et al,¹¹ where the impact of spirituality could be classified as positive, negative, no association, complex, or mixed, 70% showed a positive impact (68% a strong positive with $P < .05$) while only 5% showed a negative impact. The studies show spirituality and religion benefit patients by helping prevent illness, increasing the ability to cope, and improving outcomes.

■ BARRIERS AND ISSUES

In spite of the evidence showing religion and spirituality to be positive health factors, there are still reasons to be cautious. Many obvious concerns have been expressed by physicians in recent surveys.^{25,26} More than 50% of physicians surveyed by Ellis and colleagues²⁶ listed such factors as time, lack of training in taking a spiritual history, and a concern about projecting their own beliefs onto patients as barriers to discussing spiritual issues.

Recently a group of articles strongly challenged the entire premise of integration. Richard P. Sloan and his associates, in the “Sounding Board” section of the *New England Journal of Medicine*, said they are “troubled by the uncritical embrace of this trend...”²⁷ They cite a number of reasons to be wary of this integration:

1. Studies suggesting a relationship between spirituality and health are flawed.
2. The unique nature of the patient/physician relationship causes physician assumptions and beliefs to have undue influence.
3. Physicians have no expertise in spiritual matters.

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4. Most patients do not truly want to discuss spiritual issues, and interest does not necessarily justify the incorporation of religious matters.

5. The integration of spirituality into practice is an attempt to use religion that trivializes a deep and complex reality.

A similar article in the *Lancet* echoed these concerns.²⁸ Again, the empirical evidence is challenged. Added to that concern is a variety of ethical issues. The first ethical issue relates to boundaries. The authors insist “when doctors depart from areas of established expertise to promote a nonmedical agenda, they abuse their status as professionals.” The second issue involves the ethics of “taking into account” spiritual issues versus “taking them on” as the objects of interventions.” A third ethical problem focuses on the possibility that physicians might actually do harm to patients by linking health status and spirituality.²⁸

It is fair to say these cautions are worthy of serious consideration and need to be addressed by any responsible model of integration. Certainly there is a need for added research on this subject. Koenig et al,¹¹ for example, in rating the research done on the subject, rate only 18.5% of the studies a 10, 9, or 8 on a scale of 1 to 10 (10=excellent) and assert “we have only scratched the surface in acquiring knowledge about the influences of religion on health, the influences of health on religion, and the mechanisms by which these effects occur.” A review of studies attempting to link religiosity to physiological processes notes that the results are “suggestive,” but that additional research is needed that combines both stronger research methodology with more representative populations.²⁹ Even proponents of integration are aware of the difficulties related to boundaries.³⁰

Providers with an interest in the integration of medicine and spirituality are thus left with a dilemma. On the one hand there appear to be some very good reasons for integration: patient need and desire, the respect such an approach illustrates for the whole person, and strong clues that it does aid with coping, prevention, and recovery. On the other hand, there appear to be

Good active-listening skills and other tools encourage the patient to share safely and freely about spirituality

very real dangers with integration: a potential violation of boundaries, lack of training, lack of time, and potential misuse of the spiritual.

A model for integration

An appropriate response seems to be finding a model that encourages physicians to treat the patient as a whole person, addressing not only physical, but also social, emotional, and spiritual issues. This model should provide the physician with the ability to identify patients who are struggling with such issues, and the tools for addressing them in an appropriate manner. But this model should take into account the serious issues of time, boundaries, and respect for the deep and complex nature of spiritual and emotional issues.

In general the model should have the following components:

1. Good active-listening skills and other tools that encourage the patient to share safely and freely about such issues, providing new self-awareness on the part of the patient, and in some cases spiritual relief.

2. Identification of spiritual/emotional issues.

3. Appropriate and effective referral of the patient to a “spiritual specialist,” one trained to deal with spiritual issues in a longer term, deeper manner.

4. Ongoing communication with the patient and their specialist about this aspect of the person’s healing process.

The first step involves simply asking specific questions to develop a basic understanding of the patients’ spiritual culture. Various sets of questions have been developed to aid practitioners with this task.³¹⁻³³ It is also a matter of practicing what many have called the “art of medicine.” It is being patient centered and entering into a true dialogue with patients that involves active-listening skills. Active listening is important, because

TABLE 3

Emotional continuums used in spiritual assessment

Curse	←————→	Blessing
Dread	←————→	Courage
Alone	←————→	Connected
Abandoned	←————→	Supported
Anger	←————→	Acceptance
Despair	←————→	Hope
Meaninglessness	←————→	Purpose
Helplessness	←————→	Empowerment

most patients will not make direct statements regarding their feelings or issues. Usually their deep spiritual turmoil is expressed indirectly through body language, tone of voice, stories, and other subtle expressions. True dialogue allows physicians to pick up the clues patients are sending regarding spiritual issues, and to help their patients come to a clear awareness of those issues for themselves.

Once the discussion has begun, it is important to include some element of assessment. A hospital chaplain has developed an assessment tool that he uses to think about the spiritual health of those he visits and to structure his interventions with those patients.³⁴ At Oregon Health and Science University we have adapted his approach by encouraging physicians to develop a set of 5 to 8 paired terms, such as anger and acceptance, which they believe reflect important spiritual issues (**Table 3**). Using these terms, a continuum is developed that can be used to help assess patients from a spiritual perspective.

A physician can use this continuum to think about the patient and to develop ideas for intervention. *First*, the physician places an “X” on each continuum of the chart, noting his or her perception of how the patient is functioning.

Second, the physician evaluates that position. Is

this a logical place for the patient to be at this place, in this time? Severe anger might be appropriate when one first receives news of a terminal illness. It may not be as appropriate 6 months later.

Third, the physician picks the issue(s) they believe should be addressed through intervention. If a person is feeling helpless, what might be done to help them feel more empowered? The physician can ask what he or she can do. This is likely to be somewhat limited due to training, time, and other issues. The physician can also seek collaboration. Who can be brought into the healing mix, who might become a partner in helping healing happen?

In some cases it will be clear that the patient is spiritual, and that spirituality is a very positive factor in the effort to find wholeness. What these patients need is support, an affirmation that what they are doing is working. They need permission to bring their spirituality into the exam and treatment space as a powerful resource for wellness.^{35,36} If, for example, a patient is coping well and is maintaining a sense of purpose in the face of a debilitating illness, they should be commended for that, and the coping mechanisms that support that stance should be reinforced.

■ COLLABORATIVE INTERVENTION

Collaboration begins with the patient. The physician must be clear that this is all about the patient’s spirituality (not their own) and support the spiritual beliefs of the patient, working within the framework of those beliefs (unless clearly pathological). But there are many others who can be brought into the therapeutic process. Providers can collaborate with “spiritual specialists,” such as the patient’s spiritual leader or the hospital chaplains. Other collaborators may include social workers, mental health specialists, or even a group of some sort. Research suggests social support is a key factor that leads to improved outcomes.¹¹

Many options are available for intervention. Connecting the patient with a religious leader or “spiritual specialist” is often very appropriate. In hospital settings, chaplains are a good place to begin. In a community-based setting, the patient’s

own spiritual leader or, if the patient is not affiliated with any specific group, a spiritual specialist who is willing to work from the patient's perspective is often the most viable option. Support groups, study groups, worship experiences all can be a part of this strategy. The use of literature and tapes, prayer (best done with a religious professional if possible) are relatively easy responses to spiritual distress. Appointments with various professional "healers" such as social workers and psychologists may also be helpful, and in some cases necessary.

Follow-up is also critical in working with patients. To bring up such sensitive issues as spiritual matters, and then not show a continued interest in them would be detrimental. The physician should return to the issue(s) in following visits, until it is clear that the patient is moving toward resolution, or until the patient indicates they would like to drop the issue. Communication should continue to take place, if possible, between the physician and others working with the patient. Ongoing dialogue with chaplains, religious leaders, therapists, and others should take place.

Pursuing, not avoiding, integration

We are still early in the process of studying and understanding the complex relationship between spirituality and health. Much more research needs to be done to clarify the benefits and dispel the myths. What is it about spirituality and religious practice that benefits patients? Is it, as some have suggested, merely a matter of lifestyle or compliance? Or is there something deeper and more profound involved? When is religious or spiritual coping positive, and when is it negative?

A continued research agenda focusing on the impact of spirituality on health is needed. There is also a need to look at viable assessment tools, as well as appropriate interventions. Perhaps the issue of intervention is the most difficult challenge. What is appropriate? What can be done given time constraints, the need for boundaries, and limited training? Most research to date has focused on the existing spirituality of patients.

Follow-up is critical: to bring up such sensitive issues and not show further interest in them would be detrimental

Research that looks at the impact of practical spiritual interventions, such as spiritual listening, referral to a spiritual specialist, or prayer is needed to move integration to a new stage.

Careful attention to such issues can move us forward in the task of providing effective and humane care to patients. This task is increasingly important in today's medical environment. As theologian Martin E. Marty notes, "The modern biomedical enterprise—with its threefold work of knowledge acquisition, technology development, and care delivery—urgently needs the guiding visions and values embodied in the faith traditions. When technological momentum or economic necessity alone guides the health care enterprise, the sustaining impulses of respect, meaning and purpose often fall aside."³⁷

The process of learning how to integrate medicine and spirituality is not an easy one, nor will it be accomplished without struggle. But it is a process vitally important for modern medicine. The issue truly is one of caring, both when cure is possible, and when it is not. It is a matter of focusing on part of what makes us truly human, and supporting a healing process that often transcends the biomedical agenda.

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