

Religion, Spirituality and Health Care

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DukeMedicine



Overview

1. History, definitions, and mental health (9:00-9:50)
Questions/Discussion (9:50-10:00)
2. Mind-body relationship and physical health (10:00-10:45)
Break (10:45-11:00)
3. Applications to clinical practice (11:00-11:45)
4. Questions and discussion (11:45-12:00)

Historical Background

1. Care of the sick originated from religious teachings
2. First hospitals built & staffed by religious orders (378 CE)
3. Many hospitals even today are religious-affiliated
4. Until recently, most healthcare delivered by religious orders
5. First nurses and many early physicians – religious
6. First therapy for psychiatric illness – moral treatment
7. U.S. mental hospitals modeled after “Friends Asylum”
8. Not until mid-20th century that true separation developed
9. Since then, religion portrayed as irrelevant, neurotic, or conflicting with care
10. Spiritual needs of patients are generally ignored
11. Relationship is improving, but remains controversial

Controversial Relationship

1. Resistance against integration remains strong among health professionals, especially physicians
2. Time and short-term costs involved; hospitals resistant
3. The majority of patients want health professionals to address spiritual issues, but a significant minority don't
4. There are challenges to sensitively addressing spiritual needs in pluralistic health care setting
5. Problems compounded by confusing definitions for religion and spirituality

Religion vs. Spirituality vs. Psychology

Religion – beliefs, practices, a creed with do's and don'ts, community-oriented, responsibility-oriented, divisive and unpopular, but easier to define and measure

Spirituality – quest for the sacred, related to the transcendent, personal, individual-focused, inclusive, popular, but difficult to define and quantify

Humanism – areas of human experience and behavior that lack a connection to the transcendent, to a higher power, or to ultimate truth; focus is on the human self as the ultimate source of power and meaning

Religion is a component of spirituality, and you can be spiritual but not religious. Care should be taken not to call purely psychological terms and constructs "spirituality." Most of research has been done on **religion**.

Spirituality

“The very idea and language of ‘spirituality,’ originally grounded in the self-disciplining faith practices of religious believers, including ascetics and monks, then becomes detached from its moorings in historical religious traditions and is redefined in terms of subjective self-fulfillment.”

- C. Smith and M.L. Denton, *Soul Searching: The Religious and Spiritual Lives of American Teenagers*, p.175

How Address Lack of Agreement?

- Just remember to be explicit about your definition and use of these terms
- When discussing the research, I will talk about religion (specific, exclusive)
- When discussing clinical applications, I will talk about spirituality (broad, inclusive)

Self-defined Religious-Spiritual Categories

838 hospitalized medical patients

Religious and Spiritual	88%
Spiritual, not Religious	7%
Religious, not Spiritual	3%
Neither	3%

**Journal of the American Geriatrics Society 2004;
52: 554–562**

**Consecutively admitted patients over age 60,
Duke University Hospital, Durham, North Carolina**

Religion and Mental Health



Sigmund Freud

Civilization and Its Discontents

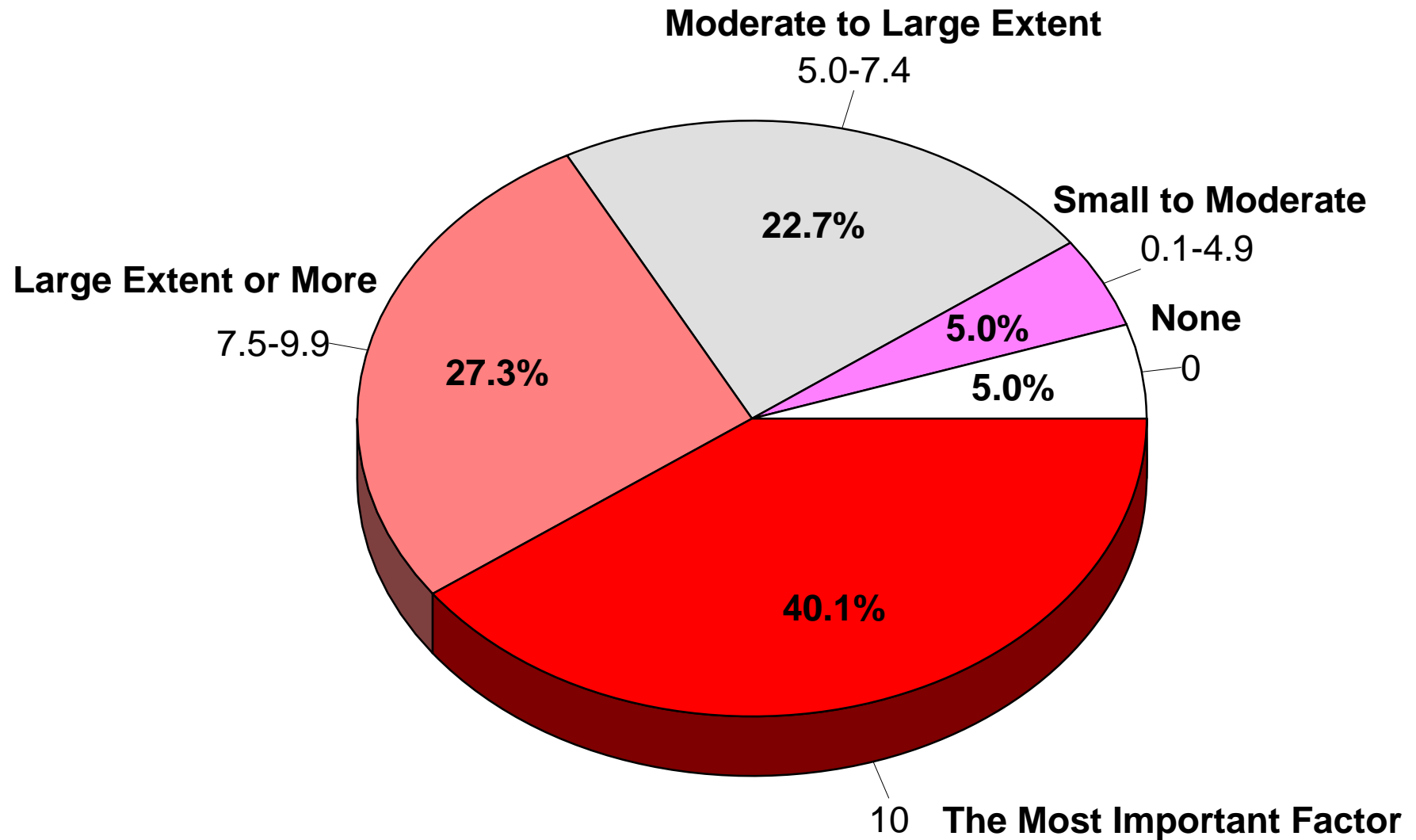
“The whole thing is so patently infantile, so incongruous with reality, that to one whose attitude to humanity is friendly it is painful to think that the great majority of mortals will never be able to rise above this view of life.”

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?)



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

Look. God, I have never before spoken to you,
But now I want to say, “How do you do?”
You see, God, they told me you didn’t exist.
Like a fool I believed all this.

Last night from a shell-hole I saw your sky.
I figured right then they had told me a lie.
Had I taken the time to see things you made.
I’d have known they weren’t calling a spade, a spade.

I wonder, God, if you’d take my hand.
Somehow I feel that you will understand.
Funny, I had to come to this hellish place
Before I had time to see your face.

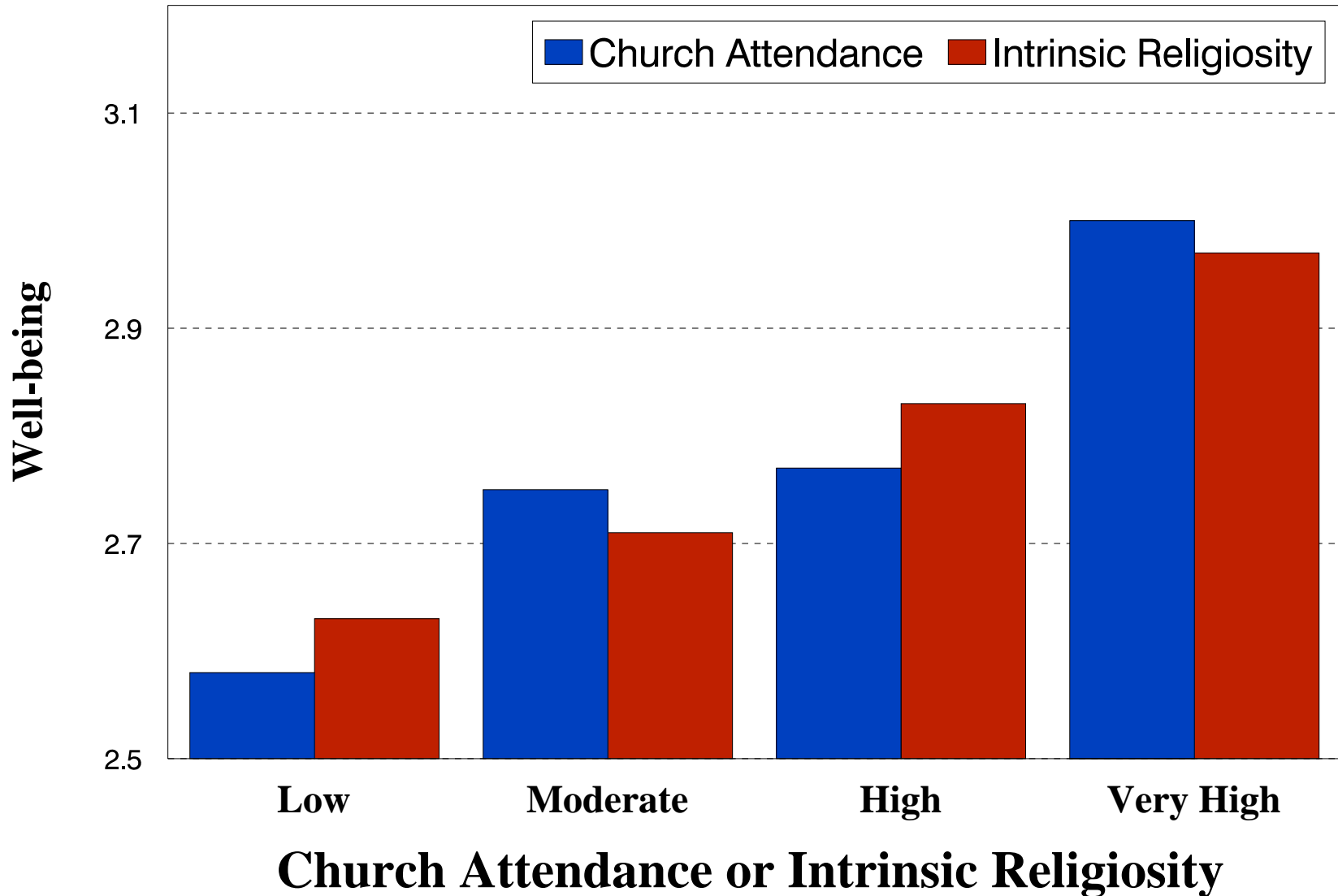
- a wounded soldier

Religion and Mental Health Studies



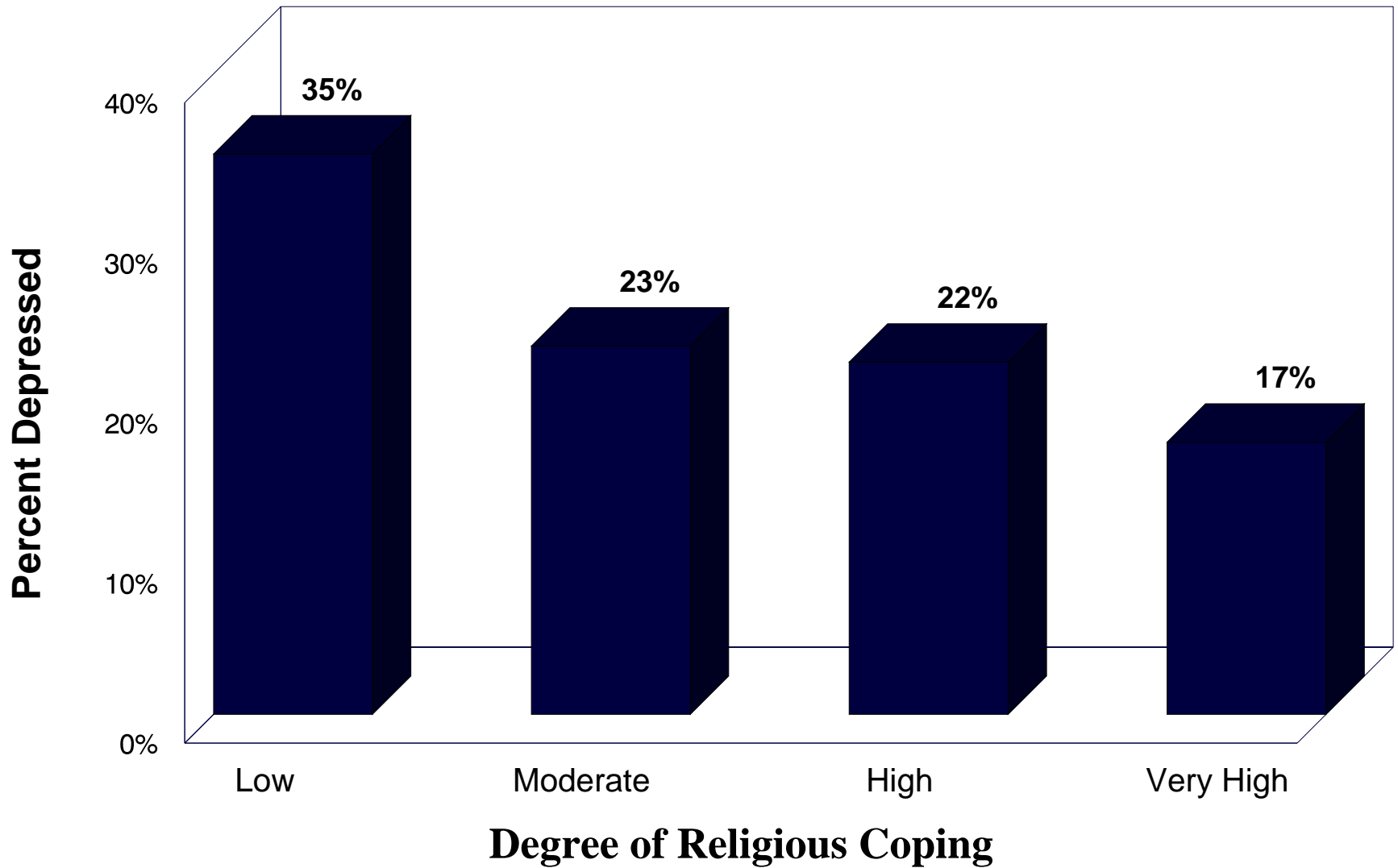
Religion and Well-being in Older Adults

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

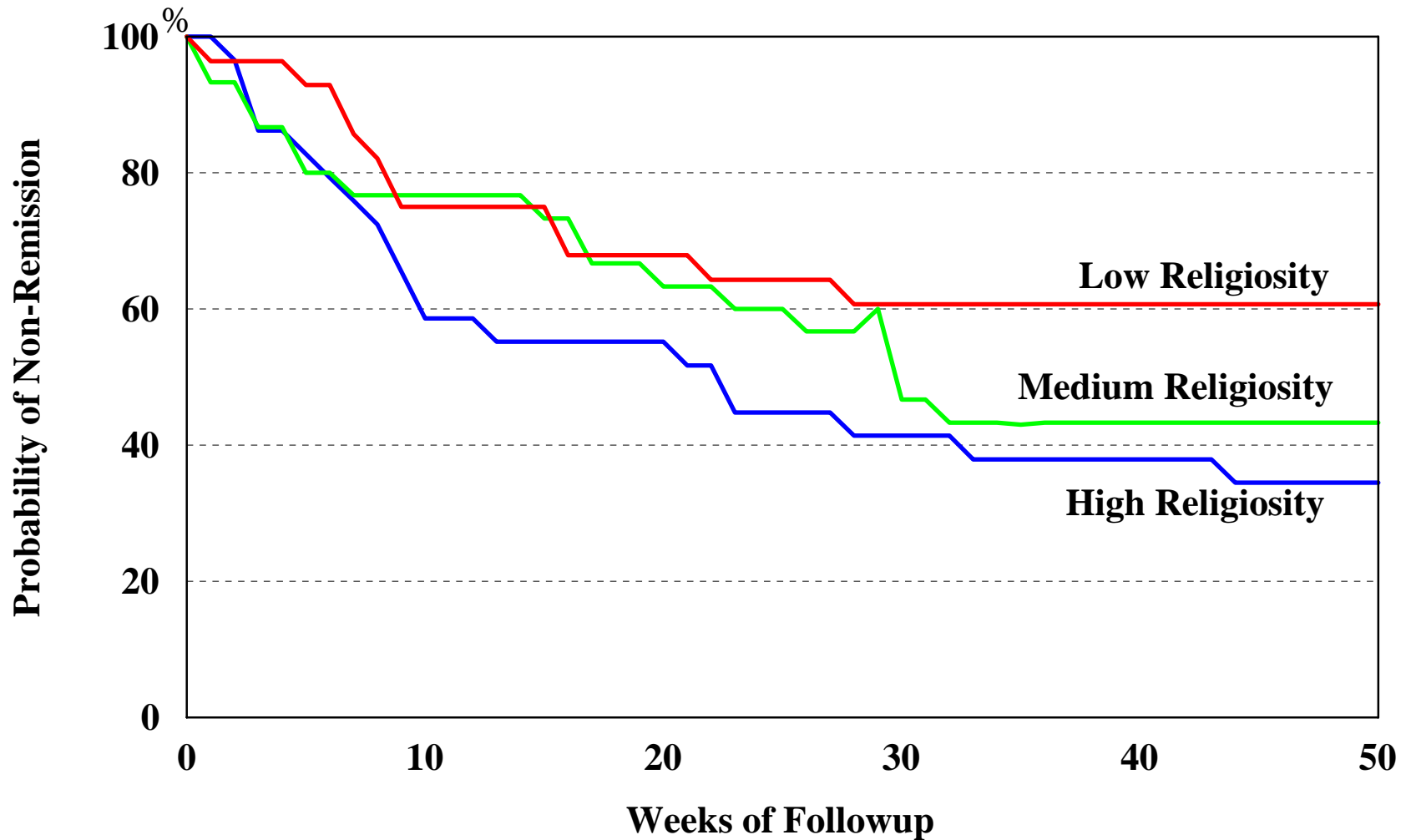


Geriatric Depression Scale

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

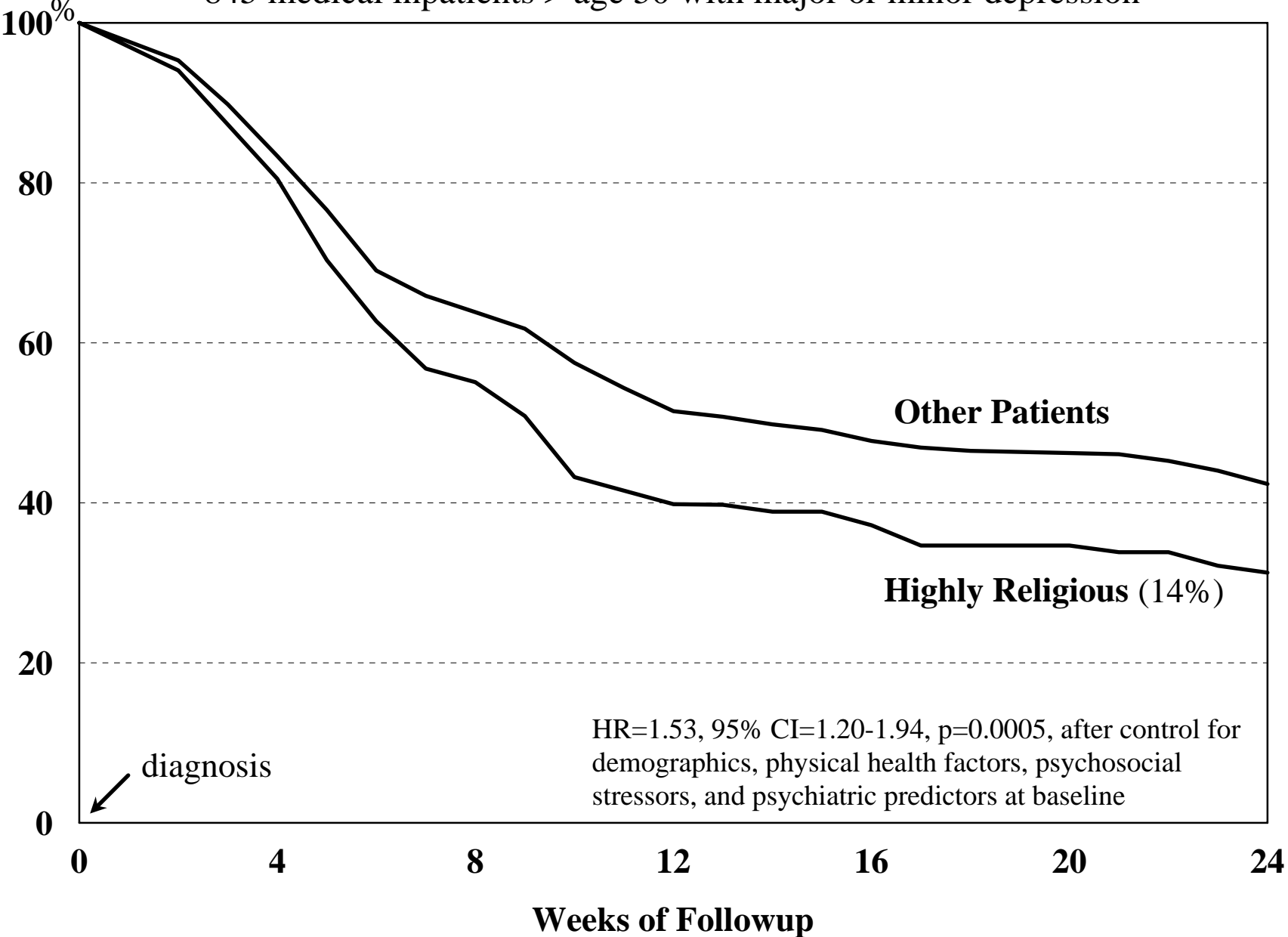
Time to Remission by Intrinsic Religiosity

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



845 medical inpatients > age 50 with major or minor depression

Probability of Non-Remission



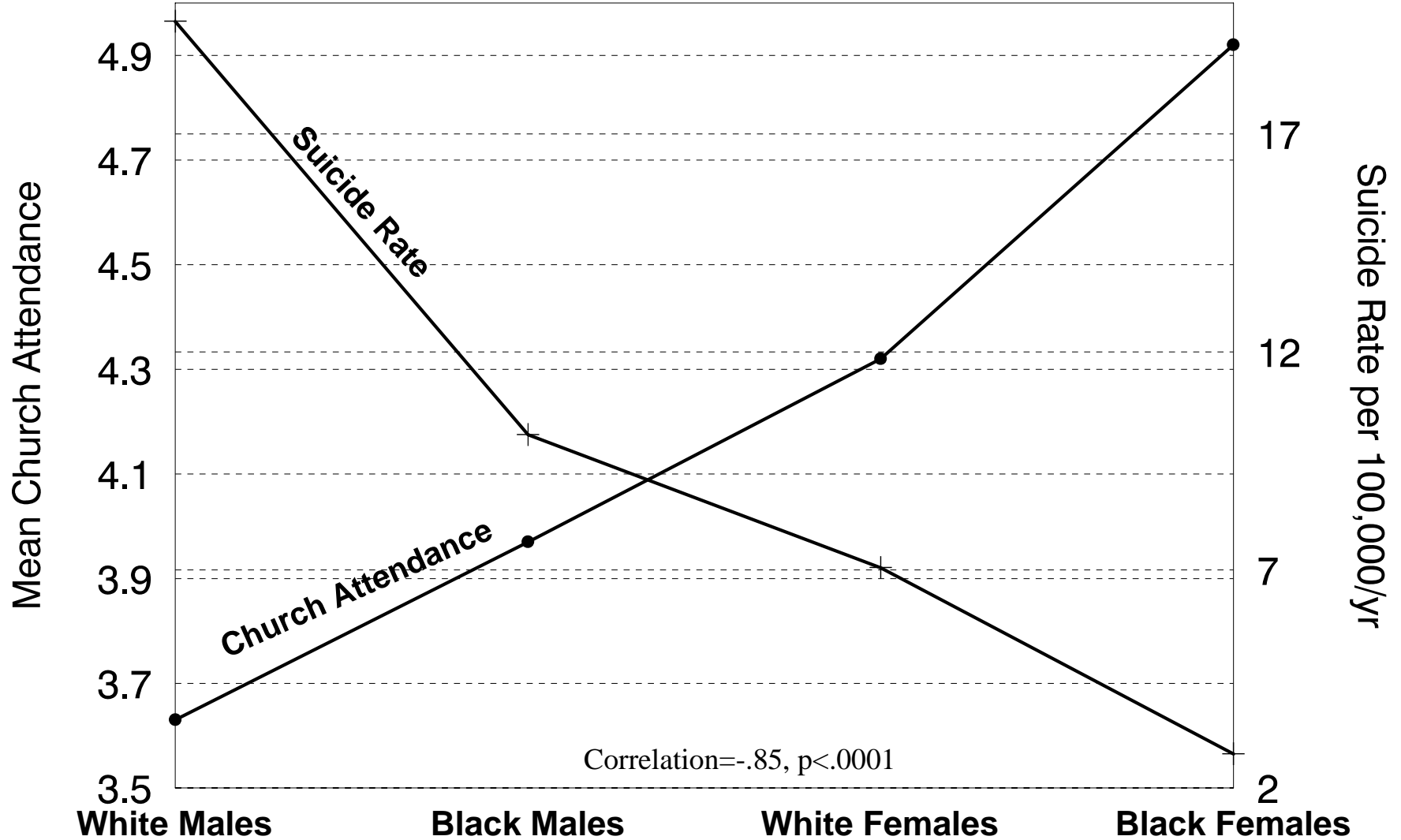
diagnosis

Other Patients

Highly Religious (14%)

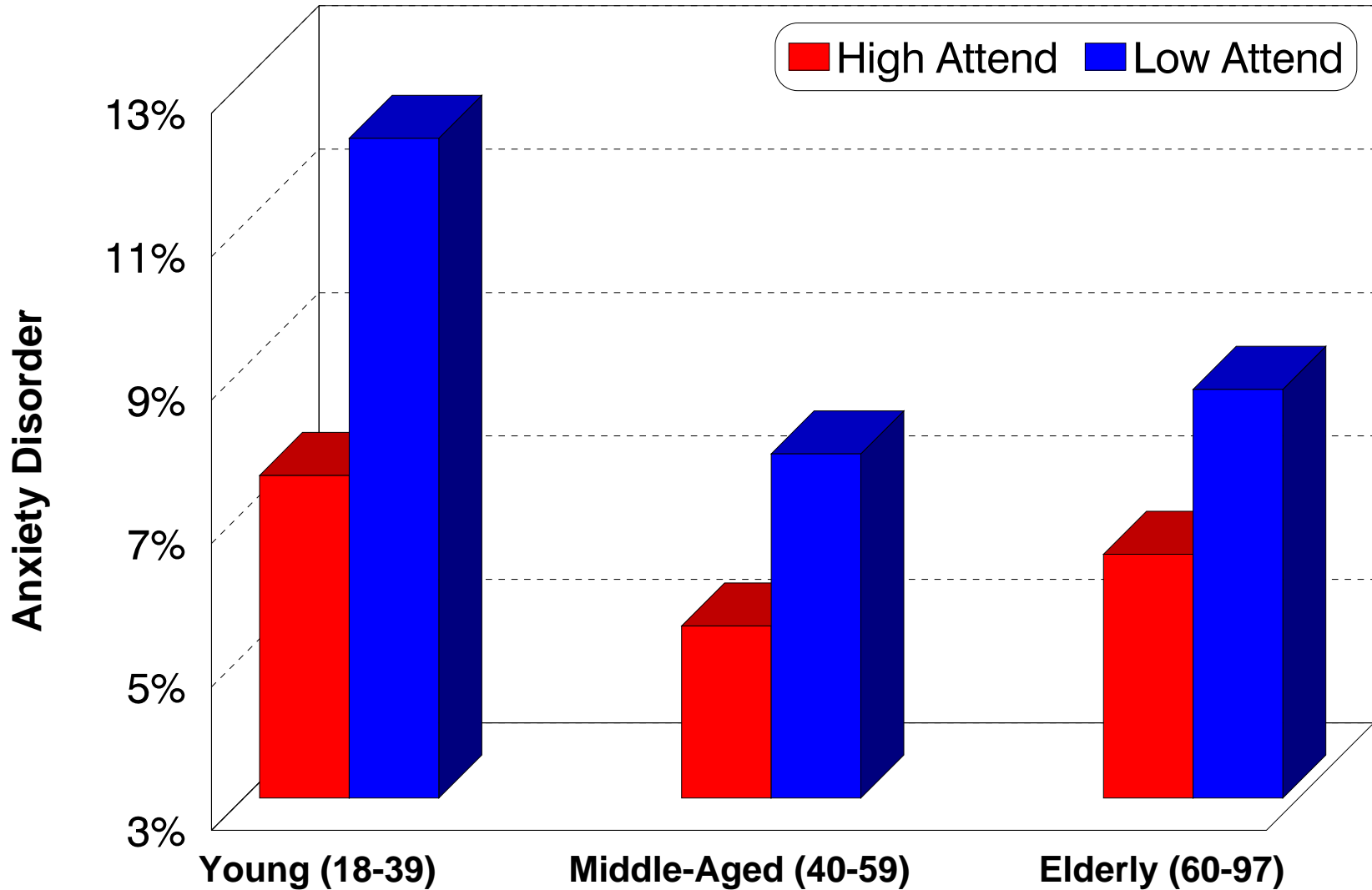
HR=1.53, 95% CI=1.20-1.94, p=0.0005, after control for demographics, physical health factors, psychosocial stressors, and psychiatric predictors at baseline

Church Attendance and Suicide Rates



Church Attendance and Anxiety Disorder

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



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

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%

Summary

1. Definitions are important, make them explicit
2. Long historical tradition linking religion with health care
3. Many patients are religious and use it to cope with illness
4. If they become depressed, religious patients recover more quickly from depression, especially those with greater disability
5. Religious involvement is related to better mental health, more social support, and less substance abuse
6. The research base is rapidly growing in this field

Questions/Discussion

9:45-10:00

The Mind-Body Relationship

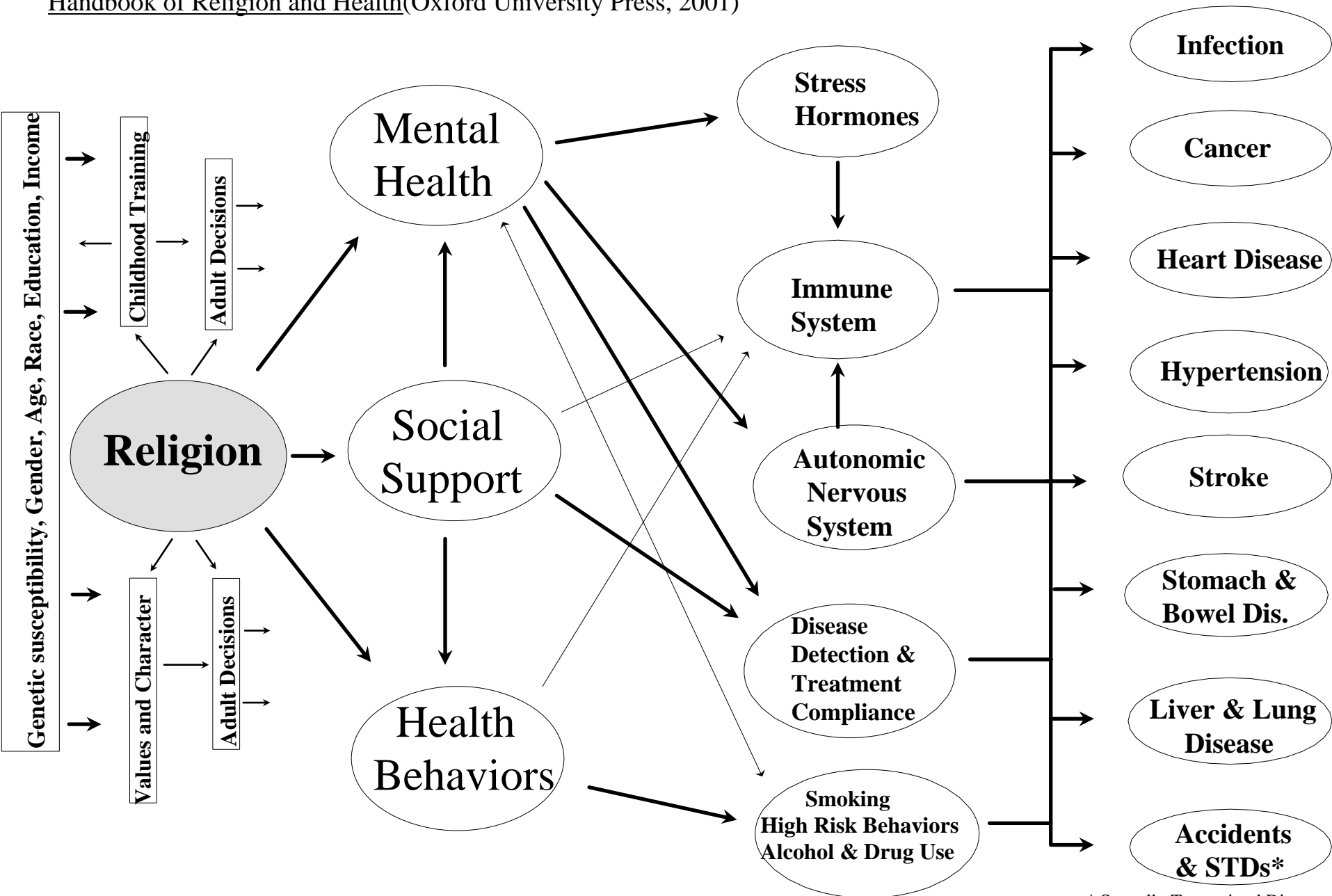
The background is a solid dark blue color. In the lower right quadrant, there are several overlapping, wavy white lines that create a sense of movement and depth, resembling ripples in water or stylized waves.

Effects of Negative Emotions on Health

- Rosenkranz et al. Proc Nat Acad Sci 2003; 100(19):11148-11152
[**experimental** evidence that **negative affect** influences **immune function**]
- Kiecolt-Glaser et al. Proc Nat Acad Sci 2003; 100(15): 9090-9095
[**stress of caregiving** affects **IL-6 levels** for as long as 2-3 yrs after death of patient]
- Blumenthal et al. Lancet 2003; 362:604-609
[817 undergoing CABG followed-up up for 12 years; controlling # grafts, diabetes, smoking, LVEF, previous MI, **depressed** pts had **double the mortality**]
- Brown KW et al. Psychosomatic Medicine 2003; 65:636–643
[**depressive symptoms** predicted **cancer survival** over 10 years]
- Epel et al. Proc Nat Acad Sci 2004; 101 :17312-17315
[psychological **stress** associated with shorter **telomere length**, a determinant of cell senescence/ longevity; women with highest stress level experienced telomere shortening suggesting they were aging at least 10 yrs faster than low stress women]

Model of Religion's Effects on Health

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



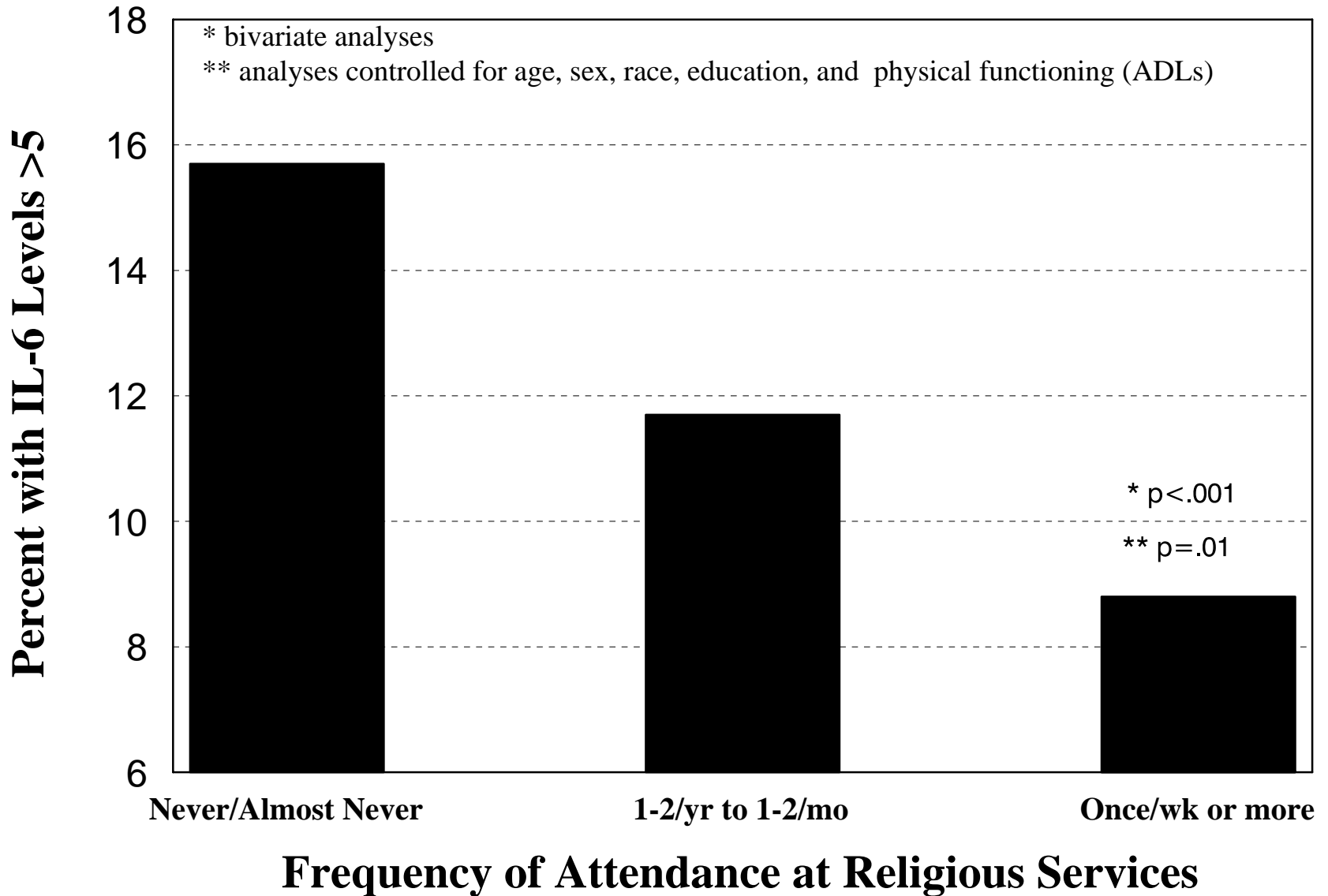
* Sexually Transmitted Diseases

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. Summary of the research
9. Latest research

Serum IL-6 and Attendance at Religious Services

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



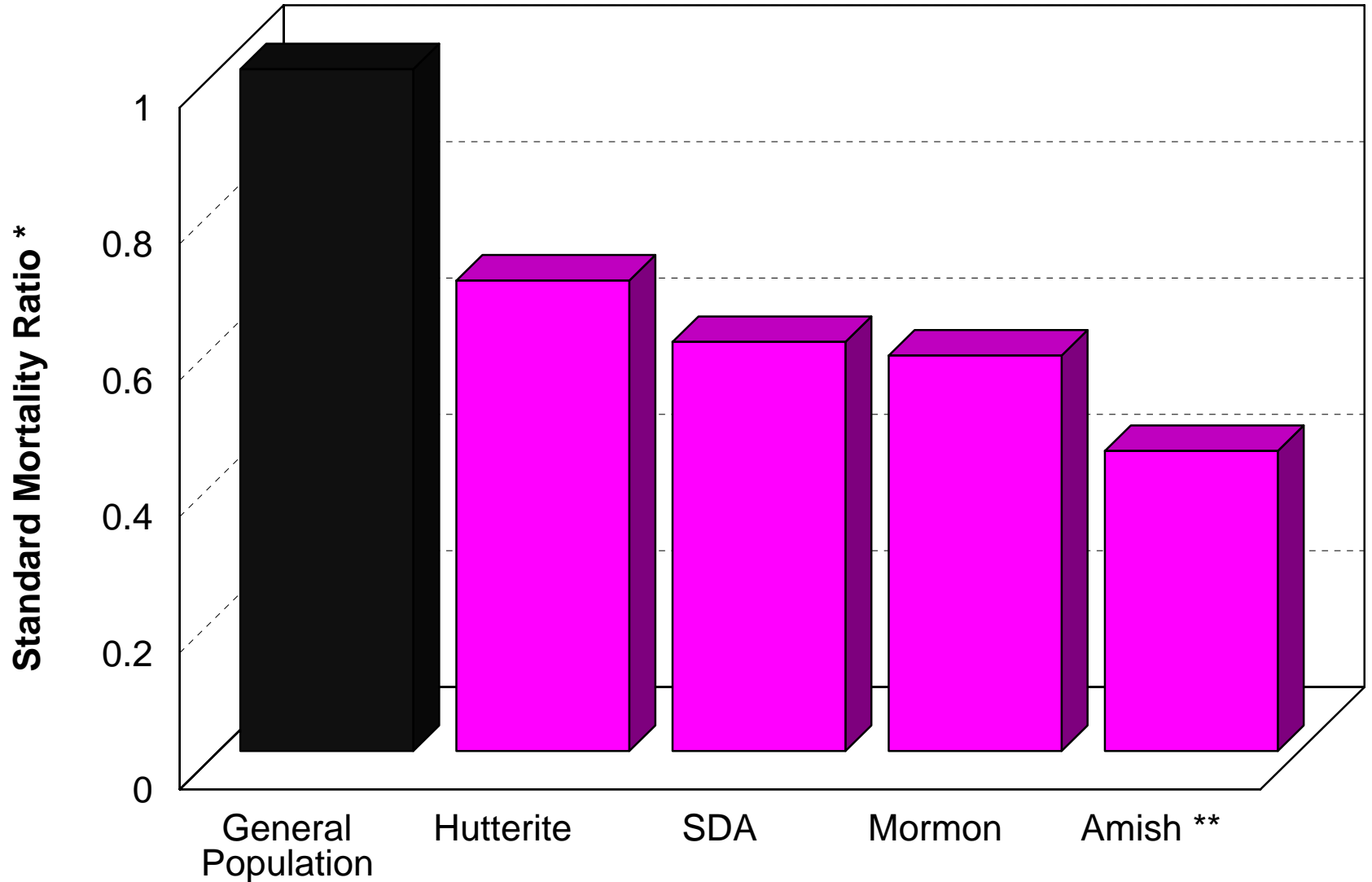
Citation: International Journal of Psychiatry in Medicine 1997; 27:233-250

Replication

Lutgendorf SK, et al. Religious participation, interleukin-6, and mortality in older adults. Health Psychology 2004; 23(5):465-475

Prospective study examines relationship between religious attendance, IL-6 levels, and mortality rates in a community-based sample of 557 older adults. Attending religious services more than once weekly was a significant predictor of lower subsequent 12-year mortality and elevated IL-6 levels (> 3.19 pg/mL), with a mortality ratio of .32 (95% CI = 0.15, 0.72; $p < .01$) and an odds ratio for elevated IL-6 of .34 (95% CI = 0.16, 0.73, $p < .01$), compared with never attending religious services. Structural equation modeling indicated religious attendance was significantly related to lower mortality rates and IL-6 levels, and IL-6 levels mediated the prospective relationship between religious attendance and mortality. Results were independent of covariates including age, sex, health behaviors, chronic illness, social support, and depression.

Death Rates from Cancer by Religious Group



* 1.0=average risk of dying from cancer

** Males ages 40-69 only

Predicting Cancer Mortality

Mortality data from Alameda County, California, 1974-1987

3 Lifestyle practices: smoking; exercise; 7-8 hours of sleep

n=2290 all white	All	<u>Attend Weekly</u>	<u>Attend Church Weekly+3 Practices</u>
SMR for all cancer mortality	89	52	13

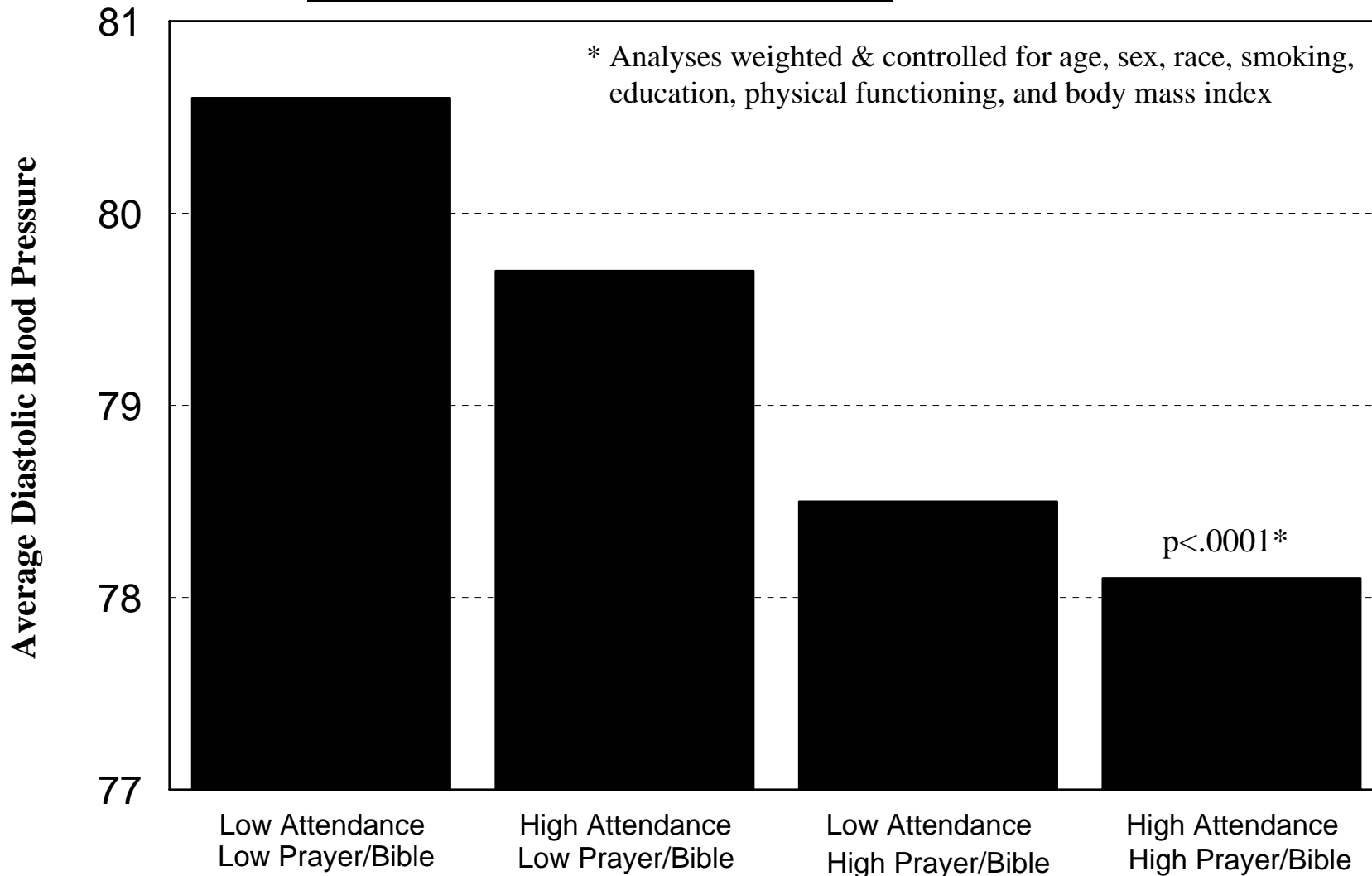
SMR = Standardized Mortality Ratio (compared to 100 in US population)

Enstrom (1989). Journal of the National Cancer Institute, 81:1807-1814.

Religious Activity and Diastolic Blood Pressure

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

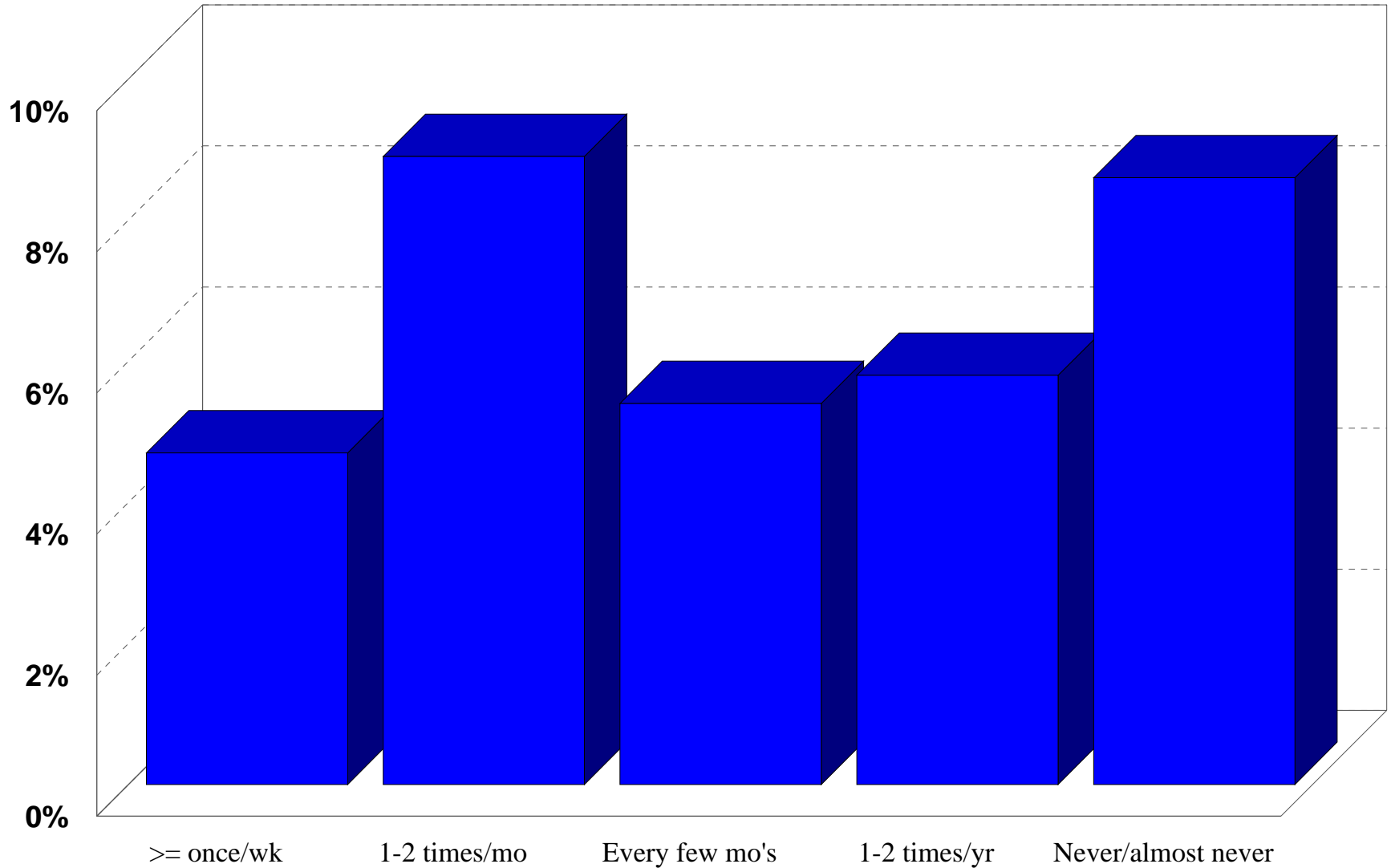
Citation: International Journal of Psychiatry in Medicine 1998; 28:189-213



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

Church Attendance and Stroke

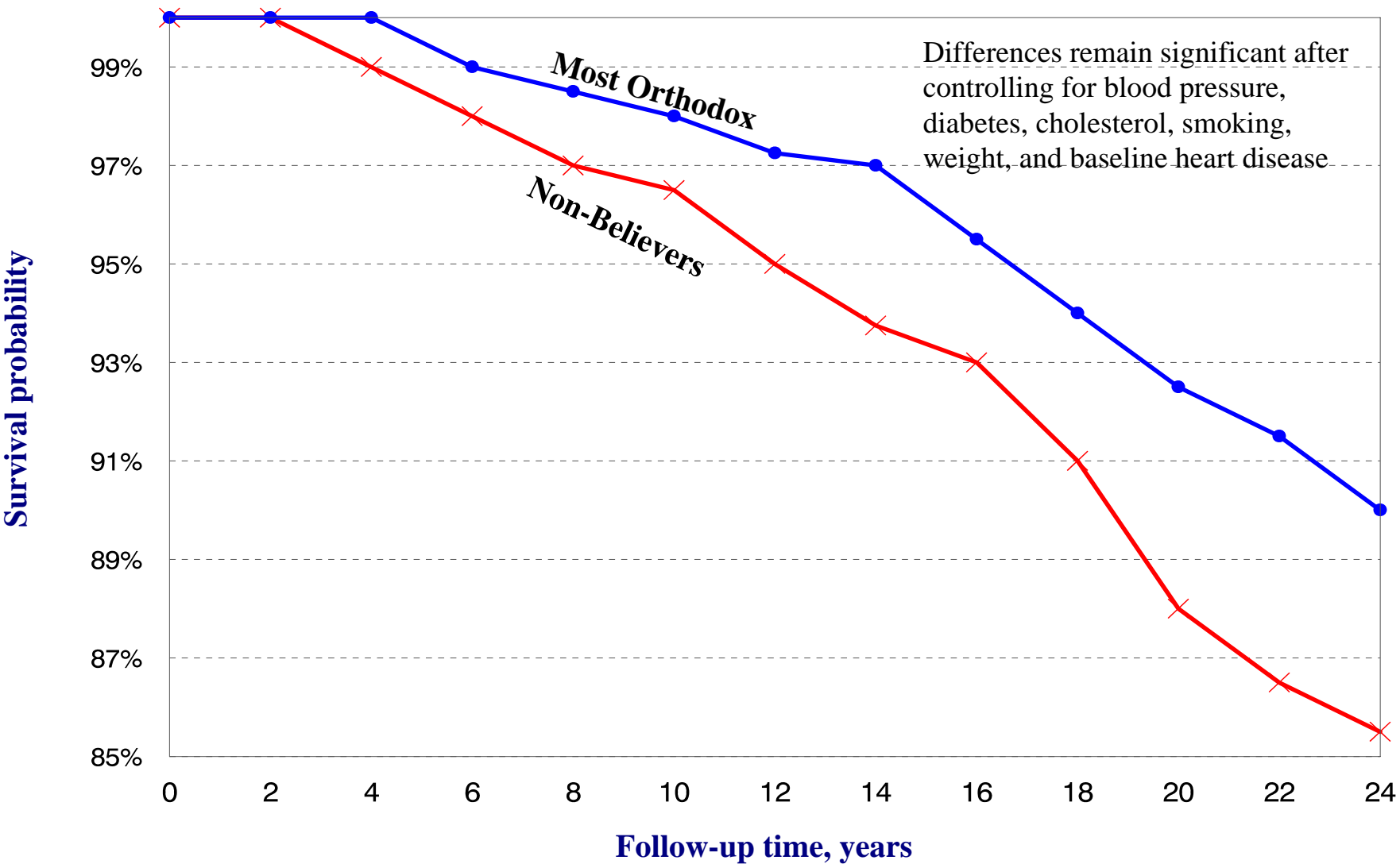
(likelihood of stroke over 6 years in approximately 3000 person over age 65)



Colantonio et al (1992). American Journal of Epidemiology 136:884-894

Mortality From Heart Disease and Religious Orthodoxy

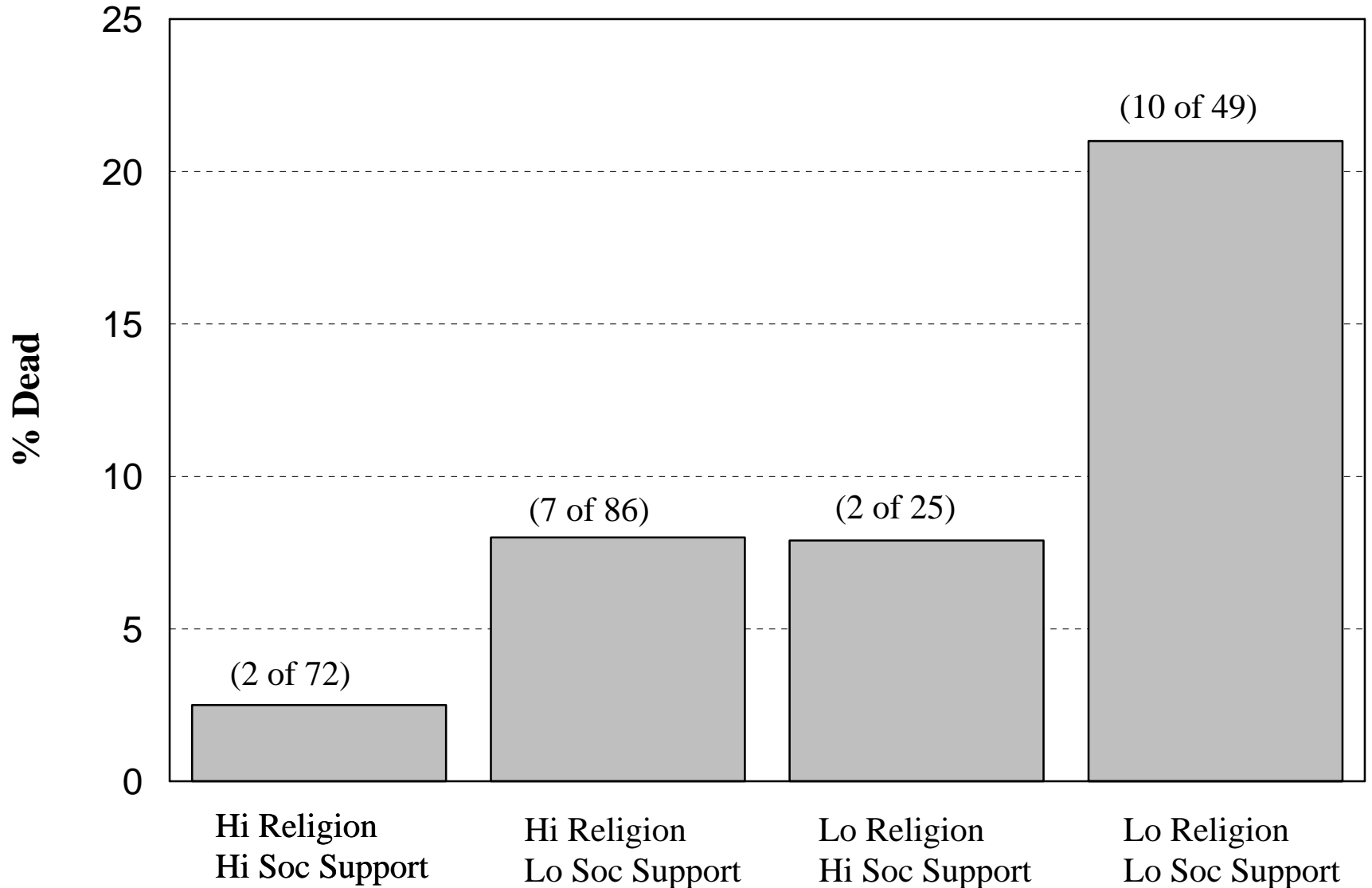
(based on 10,059 civil servants and municipal employees)



Kaplan-Meier life table curves (adapted from Goldbourt et al 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

Latest Research

- Religious behaviors associated with slower progression of Alzheimer's dis.
Kaufman et al. American Academic of Neurology, Miami, April 13, 2005
- Religious attendance and cognitive functioning among older Mexican Americans.
Hill TD et al. Journal of Gerontology 2006; 61(1):P3-9
- 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
- Church-based giving support related to lower mortality, not support received
Krause. Journal of Gerontology 2006; 61(3):S140-S146

Latest Research (continued)

- Higher church attendance predicts lower fear of falling in older Mexican-Americans

Reyes-Ortiz et al. Aging & Mental Health 2006; 10:13-18

- 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

- 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

Over 70 recent studies with positive findings since 2004

[http\\:www.dukespiritualityandhealth.org](http://www.dukespiritualityandhealth.org)

Summary

1. Negative emotions and stress adversely affect immune, endocrine, and cardiovascular functions
2. Social support helps to buffer stress, countering some of the above effects
3. Health behaviors are related to health outcomes
4. If religious involvement improves coping with illness, reduces negative emotions, increases social support, and fosters better health behaviors --- then it should affect physical health
5. Religious involvement is related to physical health and the research documenting this is increasing

Break

10:45-11:00

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

Many Patients Are Religious

1. Based on Gallup polls, 95% of Americans believe in God
2. Over 90% pray
3. Nearly two-thirds are members of a religious congregation
4. Over 40% attend religious services weekly or more often
5. 57% indicate religion “very important” (72%, if over age 65)
6. 88% of patients indicate they are BOTH religious & spiritual
7. 90% of patients indicate they use religion to cope

Patients' Attitudes Toward Spiritual Care

1. At least two-thirds of patients indicate that they would like spiritual needs addressed as part of their health care
2. 33% - 84% of patients believe that physicians should ask about their religious or spiritual beliefs, depending on (1) the setting and severity of illness, (2) the particular religion of the patient, and (3) how religious the patient is
3. 66% - 88 percent of patients say they would have greater trust in their physician if he or she asked about their religious/spiritual beliefs; less than 10% of physician do so
4. 19% - 78% are in favor of their physician praying with them, depending on the setting, severity of their illness, and religiousness of the patient; few physicians do this

Many Patients Have Spiritual Needs and they are often not met

1. At Rush-Presbyterian Hospital in Chicago, 88% of psychiatric patients and 76% of medical/surgical patients reported three or more religious needs during hospitalization
2. A survey of 1,732,562 patients representing 33% of all hospitals in the US & 44% of all hospitals with > 100 beds, patient satisfaction with emotional and spiritual care had one of the lowest ratings among all clinical care indicators and was one of highest areas in need of quality improvement

Patients Have Spiritual Needs

3. In a recent multi-site study of 230 advanced cancer patients, 88% of patients said that religion was at least somewhat important. However, just under half (47%) said that their spiritual needs were minimally or not at all met by their religious community; furthermore, nearly three-quarters (72%) said that their spiritual needs were minimally or not at all met by the medical system (i.e., doctors, nurses, or chaplains)
4. Only 1 out of 5 patients sees a chaplain in U.S. hospitals
5. 36% to 46% of U.S. hospitals have no salaried chaplains

Patients are Often Isolated from Sources of Religious Help

1. Persons in the military and those in prison are required to have access to chaplains, since they would otherwise have no way of obtaining religious help if needed
2. Many hospitalized patients may be in similar circumstances
3. Community clergy may not have time necessary to address the complex spiritual needs of medical patients, which may require several visits
4. Community clergy (and clergy extenders) may not have the training to do so; lack of CPE, lack of counseling skills; lack of regular contact with medical and nursing personnel; lack of access to pts medical records

Religious Beliefs can Affect Medical Decisions, or Conflict with Medical Treatments

1. Religious beliefs may influence medical decisions

- "faith in God" ranked 2nd out of 7 key factors likely to influence decision to accept chemotherapy
- 45%-73% of patients indicate that religious beliefs would influence their medical decisions if they became gravely ill

2. Religious beliefs may conflict with medical or psychiatric treatments

- Jehovah Witnesses may not accept blood products
- Christian Scientists may not believe in medical treatments
- Religious beliefs may affect end-of-life decisions, such as DNR orders or withdrawal of feeding tubes or ventilator support
- Certain fundamentalist groups may not believe in antidepressant medication or psychotherapy

Religious Involvement Influences Healthcare in the Community

1. Health care is moving out of the hospital and into the community

- Medicare and Medicaid budget constraints
- escalating costs of inpatient care
- limitations in housing of older adults in nursing homes
- more and more care taking place in people's homes

2. Religious organizations have a historical tradition of caring for the sick, the poor, and the elderly, which for many is a key doctrine of faith

- first hospitals built by religious organizations (and many still affiliated)
- first nurses from religious orders
- physicians often came from the priesthood
- health care systems in 3rd world countries still faith-based

Religious Involvement Influences Healthcare in the Community

3. Many disease detection, health promotion and disease prevention programs are ideally carried out within faith-community settings
 - screening for hypertension, diabetes, hypercholesterolemia, depression
 - health education on diet, exercise, other health habits
 - pre-marital, marital, and family counseling
 - counseling for individual emotional problems

4. Religious organizations have a tradition of caring for one another
 - checking up on the sick, calling and supporting
 - ensuring compliance with medical treatments
 - giving rides and providing companionship to doctor visits
 - providing respite care and home services

Religious Involvement Influences Healthcare in the Community

5. Many faith communities have health ministries, and may have a parish nurse on staff
 - parish nurse can help to interpret the medical treatment plan
 - parish nurse can help to ensure compliance and monitoring
 - parish nurse can train and mobilize volunteers to provide care

Thus, it is important to know whether a patient is a member of a faith community and how supportive that community is, since this may directly impact the care and monitoring that they receive after hospital discharge or after leaving doctor's office

JCAHO Requirements

Joint Commission for the Accreditation of Hospital Organizations (JCAHO)

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.

Examples of elements that could be but are not required in a spiritual assessment (JCAHO)

- Who or what provides the patient with strength and hope?
- Does the patient use prayer in their life?
- How does the patient express their spirituality?
- How would the patient describe their philosophy of life?
- What type of spiritual/religious support does the patient desire?
- What is name of patient's clergy, ministers, chaplains, pastor, rabbi?
- What does suffering mean to the patient?
- What does dying mean to the patient?
- What are the patient's spiritual goals?
- Is there a role of church/synagogue in the patient's life?
- How does your faith help the patient cope with illness?
- How does the patient keep going day after day?
- What helps the patient get through this health care experience?
- How has illness affected the patient and his/her family?

Thus,

1. Many patients are religious, would like it addressed in their health care
2. Many patients have spiritual needs that go unmet because they are not identified
3. Patients are often isolated from religious sources of help
4. Religious beliefs affect medical decisions, may conflict with treatments, and influences health care in the community
5. JCAHO requires that a spiritual history be taken so that culturally competent health care can be provided
6. Even if there were no evidence of a relationship between religion and health, these are clinical reasons why patients need to be assessed for religious or spiritual needs that might affect their health care

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

The **PHYSICIAN** Should Take the Spiritual History

1. As leader of the health care team who is making medical decisions for the patient, the physician needs the information from the SH
2. If the physician fails to take the spiritual history, then the nurse caring for the patient should do it
3. If the nurse fails to take the spiritual history, then the social worker involved in the care of the patient should take it
4. The SH should not be delegated to an admissions clerk or anyone not directly involved in the care of the patient

A Brief Explanation Should Precede the Spiritual History

1. Patients may become alarmed or anxious if a health professional 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

CSI-MEMO Spiritual History

1. Do your religious/spiritual beliefs provide **C**omfort, or are they a source of **S**tress?
2. Do you have spiritual beliefs that might **I**nfluence your medical decisions?
3. Are you a **M**EMber of a religious or spiritual community, and is it supportive to you?
4. Do you have any **O**ther spiritual needs that you'd like someone to address?

Koenig HG. Spirituality in Patient Care, 2nd Ed. Philadelphia: Templeton Press, 2007;
adapted from *Journal of the American Medical Association* 2002; 288 (4): 487-493

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. If any but the most simple of spiritual needs come up, always refer
2. Need to know the local pastoral care resources that are available, and the degree to which they can be relied on
3. Before referral, explain to patients what a chaplain is and does (they won't know)
4. Explain why you think they should see a chaplain
5. Always obtain patient's consent prior to referral, just like one would do before making a referral to any specialist

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

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 2007

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 16-20, Aug 4, Aug 13-17) 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