GRACE PRESCRIPTIONS

By WALT LARIMORE, MD, and WILLIAM C. PEEL, DMin

INCORPORATING SPIRITUAL CARE IN YOUR PRACTICE

DVD SERIES WORKBOOK

The Christian Medical & Dental Associations was founded in 1931 and currently serves more than 16,000 members; coordinates a network of Christian healthcare professionals for personal and professional growth; sponsors student ministries in medical and dental schools; conducts overseas healthcare projects for underserved populations; addresses policies on healthcare, medical ethics and bioethical and human rights issues; distributes educational and inspirational resources; provides missionary healthcare professionals with continuing education resources; and conducts international academic exchange programs.

For more information:
Christian Medical & Dental Associations
P.O. Box 7500
Bristol, TN 37621-7500
888-230-2637
www.cmda.org • main@cmda.org

ISBN 978-0-970-6631-5-3
2013944822

Printed in the United States of America

In Memory of
Wayne Sanders
who, like Andrew, was always bringing
people to meet his Savior.

Wayne was responsible for linking Walt and Bill, and
he made *The Saline Solution* possible by hosting the
first live conference to see if anyone would come.

To Gene Rudd, MD

Through his tireless efforts, ...

astonishing humility as a man,
persistent vision as a leader,
exemplary practice as a grace-prescribing physician,
and extraordinary commitment as a friend,

... *Grace Prescriptions* became a reality.

FOREWORD

by David Stevens, MD, MA (Ethics) Chief Executive Officer

Dr. David Stevens is the CEO of Christian Medical & Dental Associations.

Most people will never enter a church, turn on a Christian radio station, or pick up a religious magazine, but everyone will eventually get sick. When they do, they will be thinking about their mortality, their lifestyle, and where they will spend eternity. If our patients are seriously ill, they may be praying for the first time in years. They trust their doctors with their most intimate details. They seek advice and strive to follow it.

Okay, you agree that you *should* witness and that you are in an ideal profession to *do* it. Otherwise, you probably would not have picked this course. But I expect that you have felt guilty for years because you rarely or never witness through your work. You probably feel an internal conflict between the church's command to "share your faith" and your medical training that said "it's unethical to impose your personal views on patients because of your powerful position." Beyond that quandary, you may feel inadequate and question: What if my patient asks me a religious question I can't answer? And perhaps worst of all, you are pressured by time constraints, wondering: How can I start that topic when I only have a few minutes with each patient?

And the bottom line: you just don't know *how* to witness. The word "evangelism" scares you. You envision people waving Bibles and forcing tracts on strangers. You couldn't do that. It's unprofessional, and it's just not you!

But there is still that nagging problem—Jesus *COMMANDED* us to be a witness. So if you're like most Christian health professionals, you give mental assent to the idea, but fail to carry it out. You live a double life—at times wearing your "church face," but in your practice you just put on your "professional face." Your fractured life causes tension and mental conflict, but you have suppressed it. You're just focused on getting through the day.

I admit that I'm twisting the knife by now. That's because I am speaking to myself. I have been that multiple personality Christian health professional who desperately needed to be shaken out of my complacent routine. I have been the doctor who failed to find fulfillment in practice and had the nagging knowledge of an important missing element. I claimed that I wanted to be like the Great Physician, but deep inside I knew I was not. How could I be like Christ if I failed to address the spiritual needs of my patients?

I'm so glad I am no longer that kind of health professional, and you don't have to be either. The training you will receive in *Grace Pre-*

Witnessing to Christ's work in your life is not an option; it's an imperative. Christ's final command before He ascended into heaven was that His disciples be witnesses (Acts 1:8). Pointing people to Christ is a mandate, but also an incredible opportunity. Those of us who serve in the healthcare professions have the best opportunities to point individuals toward Christ.

If the average health professional sees one hundred patients a week, that translates into almost two hundred million opportunities to share the love of Christ every year.

scriptions builds on the strong foundation of CMDA's acclaimed *Saline Solution* curriculum used to train almost twenty thousand healthcare professionals around the world. Maybe you are coming to this for a refresher after attending *Saline Solution* or maybe you have never been exposed to a course that integrates addressing spiritual issues in a healthcare setting. Watch out. What you are about to experience will transform your life and practice. You will go to work with a whole new sense of purpose and God's presence.

You will learn that witnessing is not a formula or a tract; it is simply telling people what God is doing in your life. You will find that witnessing is not time-consuming. It is as easy as having a cup of coffee, and you can do it with each patient. Not only is it ethical, it is probably unethical not to provide for your patients' spiritual health as you care for their physical health. You will discover that a relationship with God can have a positive impact on your patients' health. And you will learn much more, until sharing the love of Christ becomes a natural and fulfilling part of your daily life whether you are in the operating room, emergency room, hospital, exam room, or lounge.

As a bonus, your calling to healthcare will be refreshed and you will find new purpose and fulfillment in practice. You will conform your routine day to the pattern of the Great Physician's, who not only healed but also dealt with the deepest longings of each individual He encountered.

The Christian Medical & Dental Associations' (CMDA) number one priority is training health professionals like you to integrate their faith into their practice of healthcare. We know that outreach is God's top priority—that is why He sent His Son—so it must be ours as well. Our goal is to revitalize the twenty thousand healthcare professionals we have trained and to educate that many more who have no spiritual ministry training to be salt in the healthcare world. If the average health professional sees one hundred patients a week, that will translate into almost two hundred million opportunities to share the love of Christ every year.

After you complete the course, train others in your practice or community using the small group video series materials. We want every Christian nurse, physician, physician assistant, nurse practitioner, dentist and other health professional to integrate their faith and have an effective ministry in their practices.

Though it is our priority, training health professionals to witness is not all we do. CMDA has more than forty ministries to transform healthcare professionals to transform the world. If you are not a CMDA member, I invite you to visit *www.cmda.org* and join this movement of Christian health professionals determined to change the world. If you join, we will not only change the world, through CMDA, God will change *you*.

Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything I have commanded you. And surely I am with you always, to the very end of the age.
—Matthew 28:19-20

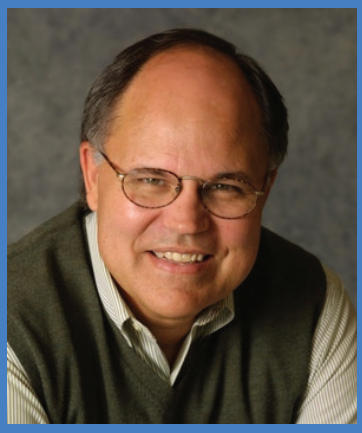
INTRODUCTION

About the Authors of Grace Prescriptions

Walt Larimore, MD, award-winning family physician, bestselling author, and educator, has been called "one of America's best-known family physicians." He serves as a visiting professor to the In His Image Family Medicine Residency in Tulsa, Oklahoma. Dr. Larimore is a prolific author, having published thirty-two books, thirty medical textbook chapters, and nearly eight hundred articles in a variety of medical journals and lay magazines. His books have garnered a number of national awards, including a Book of the Year Award from ECPA. Dr. Larimore and Barb, his sweetheart from childhood, have been married since 1973, and they live in Colorado Springs, Colorado. They have two adult children, two grandchildren, and a cat named Jack. Visit his website at *www.DrWalt.com*. His daily Bible devotional, *Morning Glory, Evening Grace*, is available at *www.Devotional.DrWalt.com*.

Walt Larimore, MD

William C. Peel, DMin, is the former director of CMDA's Paul Tournier Institute. For more than thirty years, he has helped people identify their calling and close the gap between Sunday faith and Monday work. Bill serves as founding Executive Director of the Center for Faith & Work at LeTourneau University and is an award-winning author of seven books including *Workplace Grace* and *What God Does When Men Pray*. He holds a master's degree from Dallas Theological Seminary and a doctoral degree from Gordon-Conwell Seminary. Bill and his wife Kathy have been married since 1971, and they live in Dallas, Texas. They have three grown sons, three daughters-in-law, six grandchildren, and a Border collie named Hank. For more information about Bill and the Center for Faith & Work, visit *www.centerforfaithandwork.com*.



William C. Peel, DMin

APPENDIX

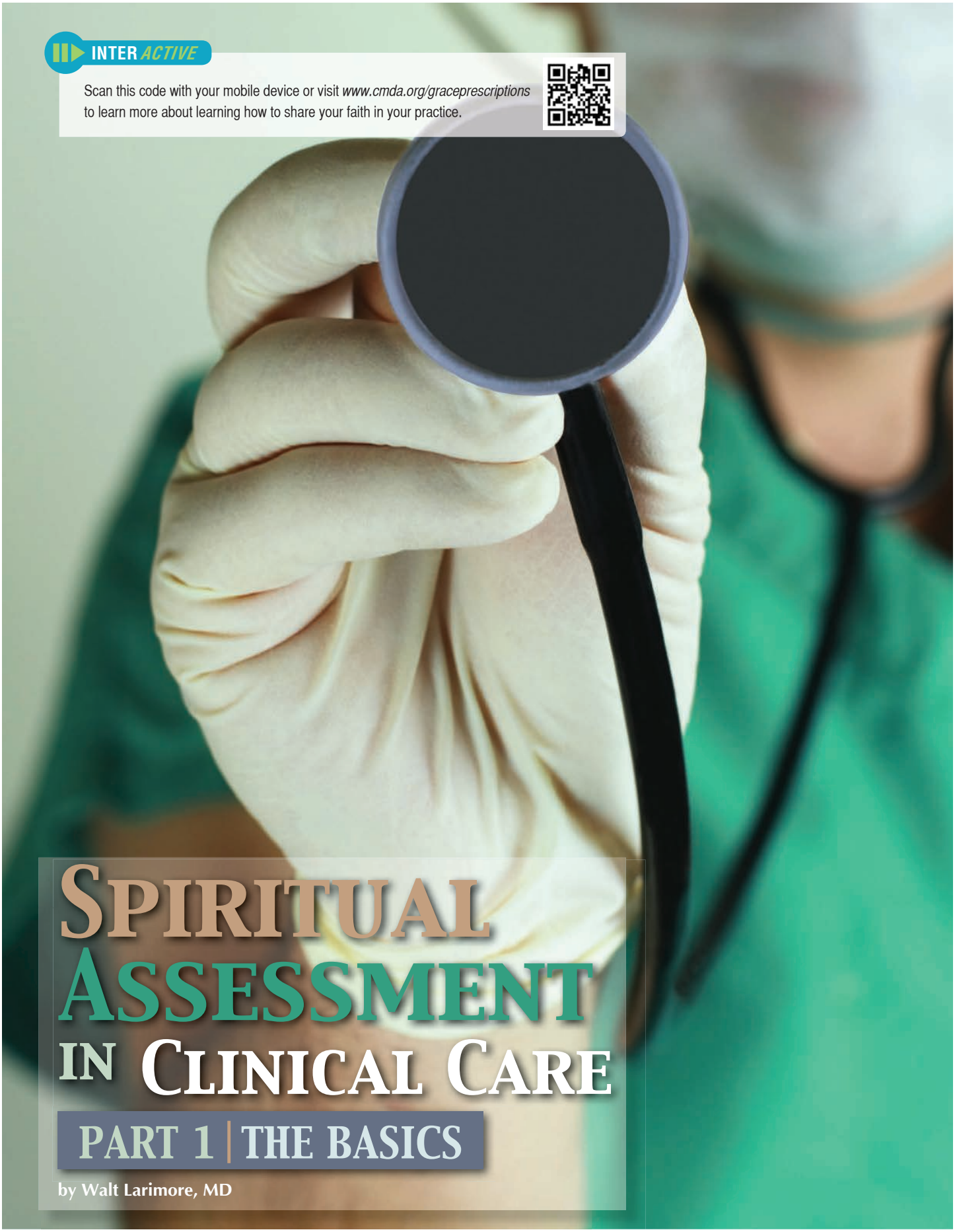
Relevant Articles and Additional Information

The following articles are included within the workbook for your use:

Additional *Grace Prescriptions* Resources

- Live Seminars
- DVD series
- Small group curriculum
- Online course

For more information on additional *Grace Prescriptions* resources and materials, please visit *www.cmda.org/graceprescriptions*.



INTER *ACTIVE*

Scan this code with your mobile device or visit *www.cmda.org/graceprescriptions* to learn more about learning how to share your faith in your practice.

Spiritual Assessment in Clinical Care

Part 1 | The Basics

by Walt Larimore, MD

About 25 years ago, while sharing an early morning cup of coffee with my dear friend and practice partner, family physician John Hartman, MD, he asked, "Walt, how come we don't bring our faith to work with us more often?"

It was a question the Lord used to convict me of the fact that although my personal relationship with God was the primary and most important relationship in my life, more often than not I tended to leave Him at the door when entering the hospital or medical office.

Over several years, John and I prayed about and explored ways in which we might incorporate a number of spiritual interventions into our practice. The fruit we experienced eventually led to my working with William C. Peel, ThM, and CMDA to develop the *Saline Solution* in the mid-1990s and, more recently, *Grace Prescriptions.* Feedback from tens of thousands of attendees from these conferences and small group curricula from around the world indicate that these interventions have revolutionized their witness for Christ and their satisfaction with practice. In the first part of this two-part article, we're going to explore the basics of spiritual assessment in clinical care.

Are spiritual assessments important?

The value of religiousness and/or spirituality (R/S) to patients and health professionals is underscored by lay polls, medical research, undergraduate curricula, recommendations of professional organizations, government regulations and clinical practice guidelines.

The most recent data from Gallup indicate 86 percent of adults in the United States believe in God and 78 percent consider religion either very important (56 percent) or important (22 percent).[1] An informal survey of physicians revealed that 99 percent believe religious beliefs can heal and 75 percent believe others' prayers can promote healing.[2] Studies demonstrate that up to 94 percent of hospitalized patients believe spiritual health is as important as physical health,[3] 40 percent of patients use faith to cope with illness[4] and 25 percent of patients use prayer for healing each year.[5]

According to Duke University psychiatrist Harold Koenig, MD, "Nearly 90% of medical schools (and many nursing schools) in the U.S. include something about R/S in their curricula and this is also true to a lesser extent in the UK and Brazil. Thus, spirituality and health is increasingly being addressed in medical and nursing training programs as part of quality patient care."[6]

Numerous health professional organizations call for greater sensitivity and training concerning the management of religious and spiritual issues in the assessment and treatment of patients.[7] For example, the Joint Commission, whose certification is a requirement for organizations receiving government payment (i.e., Medicare and Medicaid), now requires a spiritual assessment for patients cared for in hospitals or nursing homes or by a home health agency.[8,9]

Health professionals who don't take a spiritual history are often surprised to learn how frequently spirituality affects their patient encounters and how open their patients are to their inquiry. For example, one recent review found that "studies have shown that (up to) 90% of patients (depending on the setting) want physicians to address their spiritual needs" and emphasizes that "the ability to identify and address patient spiritual needs has become an important clinical competency."[10]

Another review concluded, "The majority of patients would not be offended by gentle, open inquiry about their spiritual beliefs by physicians. Many patients want their spiritual needs addressed by their physician directly or by referral to a pastoral professional."[11]

Why aren't more health professionals doing spiritual assessments?

Nevertheless, most ambulatory and hospitalized patients report that no health professional has ever discussed spiritual or religious beliefs with them,[12,13] even though 85 to 90 percent of physicians felt they should be aware of patient spiritual orientation.[14,15] In fact, our most recent national data (now about 10 years old) reveals that only 9 percent of patients have ever had a health professional inquire about their R/S beliefs.[16]

So why do health professionals ignore this "important clinical competency" of quality patient care? When asked to identify barriers to the spiritual assessment, family physicians in Missouri pointed to a lack of time (71 percent), lack of experience taking spiritual histories (59 percent) and difficulty identifying patients who wanted to discuss spiritual issues (56 percent).[17]

I have seen the same concerns expressed time and time again. In fact, *Saline Solution* and *Grace Prescriptions* were designed specifically to address these apprehensions.

Yet, one review on spiritual assessment concluded:

Assessing and integrating patient spirituality into the health care encounter can build trust and rapport, broadening the physician-patient relationship and increasing its effectiveness. Practical outcomes may include improved adherence to physician-recommended lifestyle changes or compliance with therapeutic recommendations. Additionally, the assessment may help patients recognize spiritual or emotional challenges that are affecting their physical and mental health. Addressing spiritual issues may let them tap into an effective source of healing or coping.[18]

From the perspective of the health professional, a spiritual assessment, included routinely in the patient's social history, provides "yet another way to understand and support patients in their experience of health and illness."[19]

How do I do a spiritual assessment?

Before you get started, I must share this caution from Stephen Post, PhD: "Professional problems can occur when well-meaning healthcare professionals 'faith-push' a patient opposed to discussing religion." However, on the other side of the coin, "rather than ignoring faith completely with all patients, most of whom want to discuss it, we can explore which of our patients are interested and who are not."[20]

Simply put, a spiritual assessment can help us do this with each patient we see. We can potentially gain the following from a spiritual assessment:

- The patient's religious background,
- The role that religious or spiritual beliefs or practices play in coping with illness (or causing distress),
- Beliefs that may influence or conflict with decisions about medical care,
- The patient's level of participation in a spiritual community and whether the community is supportive, and
- Any spiritual needs that might be present.[21]

Several fairly-easy-to-use mnemonics have been designed to help health professionals, such as the "GOD" spiritual assessment I developed for CMDA's *Saline Solution*:

- G = God:
  - May I ask your faith background? Do you have a spiritual or faith preference? Is God, spirituality, religion or spiritual faith important to you now, or has it been in the past?
- O = Others:
  - Do you now meet with others in religious or spiritual community, or have you in the past? If so, how often? How do you integrate with your faith community?
- D = Do:
  - What can I do to assist you in incorporating your spiritual or religious faith into your medical care? Or, is there anything I can do to encourage your faith? May I pray with or for you?

However, this and other spiritual assessment tools fail to inquire about a critical item involving spiritual health: any religious struggles the patient may be having. A robust literature shows religious struggles can predict mortality, as there is an inverse association between faith and morbidity and mortality of various types.[22] In Part 2 of this article, I'll review that literature with you and show you a new tool I'm using in my practice to address this factor.

Conclusion

Sir William Osler, one of the founding professors of Johns Hopkins Hospital and frequently described as the "Father of Modern Medicine,"[23] wrote, "Nothing in life is more wonderful than faith…the one great moving force which we can neither weigh in the balance nor test in the crucible—mysterious, indefinable, known only by its effects, faith pours out an unfailing stream of energy while abating neither jot nor tittle of its potence."[24]

You can experience that driving force of faith when you apply these principles of spiritual assessment in your practice of healthcare, thereby allowing you to minister

to your patients in ways you never imagined possible, while also increasing personal and professional satisfaction. One doctor recently shared with me, "Ministering in my practice has allowed God to bear fruit in and through me in new and wonderful ways. I can't wait to see what He's going to do in and through me each day. My practice and I have been transformed."

Are you ready to be transformed? Visit *www.cmda.org/graceprescriptions* to start learning how to share your faith in your practice.

For an expanded version of this article and a complete list of citations, please visit www.cmda.org/spiritualassessment. *Look for Part 2 of Dr. Larimore's article in the fall 2015 edition of* Today's Christian Doctor.

Upcoming Seminars

September 25-26, 2015 in Los Angeles, California
October 23-24, 2015 in Raleigh/Durham/Chapel Hill, North Carolina
November 13-14, 2015 in Indianapolis, Indiana

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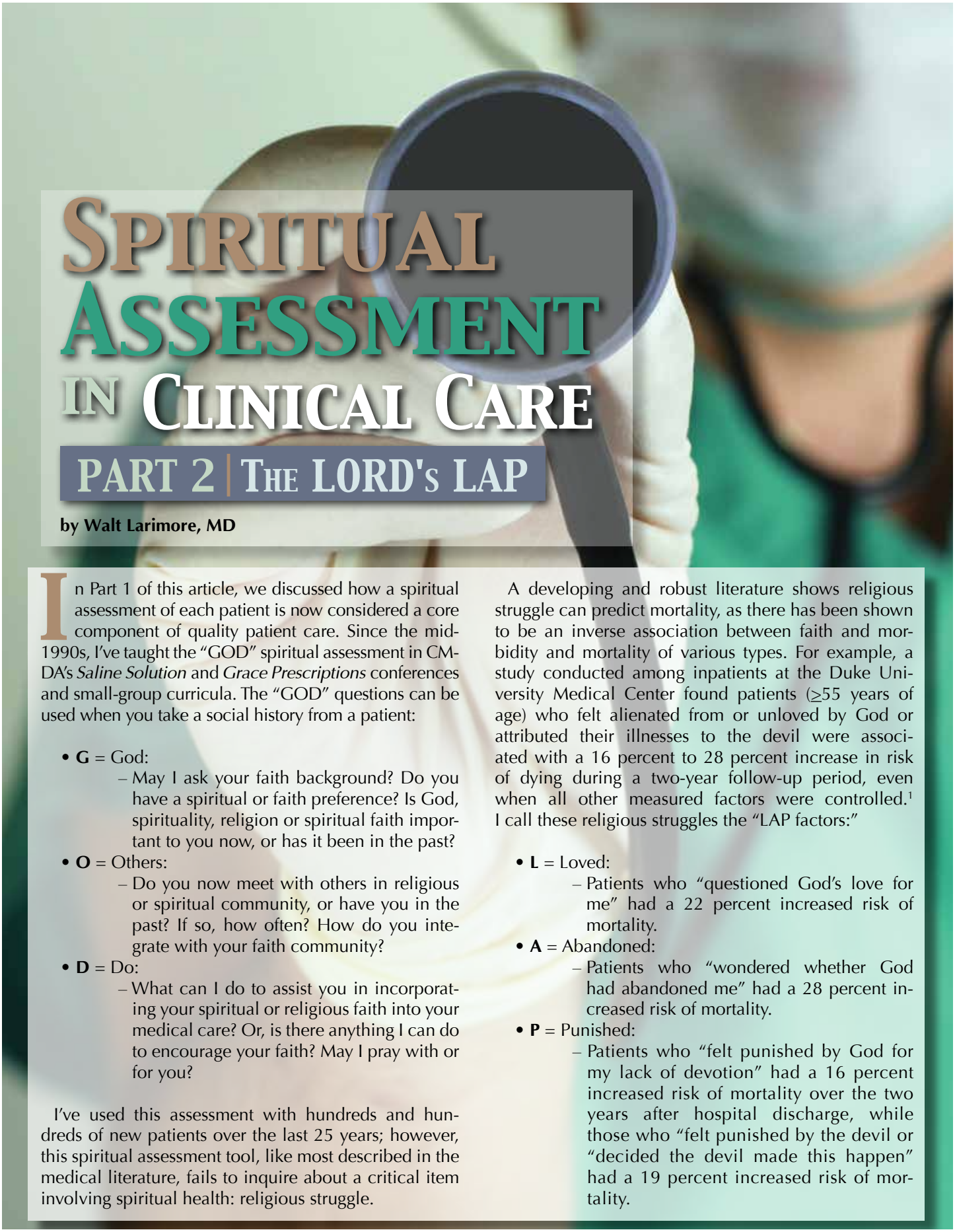
About The Author

WALT LARIMORE, MD, is a lifetime member of CMDA. He has been named in *Guide to America's Top Family Doctors*, *The Best Doctors in America*, *Who's Who in Medicine and Healthcare* and *Who's Who in America*. He and his wife of 40 years, Barb, reside in Colorado, have been named Educators of the Year by CMDA and are the parents of two adult children, the doting grandparents of two beautiful granddaughters and the adopted parents of Jack the Cat. Walt serves on the adjunct faculty of the In His Image Family Medicine Residency in Tulsa, Oklahoma and is the best-selling author of more than 30 books, 700 articles and 25 medical textbook chapters. You can find Walt's daily health blog and daily devotions at *www.DrWalt.com*.



Spiritual Assessment in Clinical Care

Part 2 | The LORD's LAP

by Walt Larimore, MD

In Part 1 of this article, we discussed how a spiritual assessment of each patient is now considered a core component of quality patient care. Since the mid-1990s, I've taught the "GOD" spiritual assessment in CMDA's *Saline Solution* and *Grace Prescriptions* conferences and small-group curricula. The "GOD" questions can be used when you take a social history from a patient:

- **G** = God:
  - May I ask your faith background? Do you have a spiritual or faith preference? Is God, spirituality, religion or spiritual faith important to you now, or has it been in the past?
- **O** = Others:
  - Do you now meet with others in religious or spiritual community, or have you in the past? If so, how often? How do you integrate with your faith community?
- **D** = Do:
  - What can I do to assist you in incorporating your spiritual or religious faith into your medical care? Or, is there anything I can do to encourage your faith? May I pray with or for you?

I've used this assessment with hundreds and hundreds of new patients over the last 25 years; however, this spiritual assessment tool, like most described in the medical literature, fails to inquire about a critical item involving spiritual health: religious struggle.

A developing and robust literature shows religious struggle can predict mortality, as there has been shown to be an inverse association between faith and morbidity and mortality of various types. For example, a study conducted among inpatients at the Duke University Medical Center found patients (≥55 years of age) who felt alienated from or unloved by God or attributed their illnesses to the devil were associated with a 16 percent to 28 percent increase in risk of dying during a two-year follow-up period, even when all other measured factors were controlled.[1] I call these religious struggles the "LAP factors:"

- **L** = Loved:
  - Patients who "questioned God's love for me" had a 22 percent increased risk of mortality.
- **A** = Abandoned:
  - Patients who "wondered whether God had abandoned me" had a 28 percent increased risk of mortality.
- **P** = Punished:
  - Patients who "felt punished by God for my lack of devotion" had a 16 percent increased risk of mortality over the two years after hospital discharge, while those who "felt punished by the devil or "decided the devil made this happen" had a 19 percent increased risk of mortality.

One study of outpatients with diabetes, congestive heart failure or cancer found that while 52 percent reported no religious struggle, 15 percent reported moderate or high levels of religious struggle. Even younger patients reported high levels of religious struggle, and religious struggle was associated with higher levels of depressive symptoms and emotional distress in all three patient groups.[2]

While further research is needed on religious struggle, what is clear is that "clinicians should be attentive to signs of religious struggle" and "where patient's responses indicate possible religious struggle, clinicians should consider referral to a trained, professional chaplain or pastoral counselor."[3]

A New Tool

When I began to realize the importance of these religious struggle factors and that I, as the health professional, needed to inquire about this, I developed and began using and teaching to my students and residents a new tool I call the "LORD's LAP" assessment:

- L = Lord
- O = Others
- R = Religious struggles or relationship
- D = Do

The "L," "O," and "D" questions of the "LORD's LAP" tool are identical to the "GOD" questions. It's the "R" part of this acrostic that's new for me. After completing the "L" and "O" questions, I usually have a pretty good idea if the patient is a religious believer or not. Now, I'm not referring to whether they are a Christian or not, just whether they are or have been a religious believer. If so, I need to ask about any religious struggles they may have. To do this, I use what I call the "LAP" questions," which are based upon the factors discussed above:

- Love: Has this illness caused you to question God's love for you?
- Abandon: Has this illness led you to believe God has abandoned you? Have you asked God to heal you and He hasn't?
- Punish: Do you believe God or the devil is punishing you for something?

If the patient answers positively to any of these questions, then the patient's risk of mortality may be significantly increased over similar patients not experiencing religious struggle. If the patient does indicate they are having a religious struggle, then I need to either consult with or refer them to a pastor or Christian psychological professional. Or, if I feel comfortable providing spiritual counsel, it certainly would be indicated.

Now, it's important to point out that I don't usually take such actions immediately, as the patient likely has more pressing health concerns. But I also no longer ignore religious struggle, which I did for so many years. Furthermore, for the patient with religious struggle, I need to record this on the patient's problem list. In fact, diagnostic coding systems have codes that can be applied to spiritual or religious struggles or problems.

If the "L" and "O" questions reveal my patient has no religious or spiritual interests or beliefs at all, then the religious struggle (LAP) questions would not be indicated. So, for these patients, I briefly indicate I am in the "LORD's LAP."

First of all, I thank the patient for their honesty, let them know I'm aware how difficult it can be to discuss religious or spiritual beliefs and tell them I appreciate their trust. Then I might share a brief testimony that may be something like, "Even though religion and spirituality are not important to you now, I often see patients who, when facing a health crisis or decision, will begin to have spiritual thoughts or questions. When I was younger, I had similar questions that resulted in my coming into a personal relationship with God. I just want you to know that if you ever want to discuss these things, just let me know."

Then, the final step of the "LORD" acrostic involves the "Do" questions. For believers, I might ask, "What can I do to assist you in incorporating your spiritual or religious faith into your medical care? Do you have any spiritual beliefs of which I need to be aware?" Or, "Is there anything I can do to encourage your faith? Do you need any spiritual resources or to see a chaplain?"

Or for a hospitalized patient I may add, "May I have the staff let your pastoral professional know you're here?" For believers and non-believers, I may ask, "May I pray with or for you?"

Putting It into Practice

I remember the first patient with whom I used the "LAP" questions. I was rounding on a middle-aged man who had been admitted in respiratory distress secondary to bilateral pulmonary effusions secondary to lung cancer. During my social history, he indicated he frequently attended church and had done so since childhood. He prayed and studied the Bible, even memorizing dozens of verses. In the past, I would have offered to pray with and for him. But this day I asked him the LAP questions.

I started with the "L" question: "Does this cause you to question God's love for you?" His response surprised me as his lips began to tremble and his eyes watered. He could only nod his head.

I then asked the "A" question: "Do you think God's abandoned you?" His head dropped into his hands and he wept for a few moments. When he composed himself, he whispered, "I've asked Him again and again to heal me, and He hasn't. Even went to a healing service. No luck there, either."

Taken aback a bit, I pressed on with the "P" question: "Do you believe God or the devil is punishing you for something?" Big tears continued to streak down his cheeks as he confessed, "I've sinned in so many ways. I'm sure this is God's punishment of me." I was grateful for his honesty, but even more grateful to the Lord for teaching me this new way to approach patients.

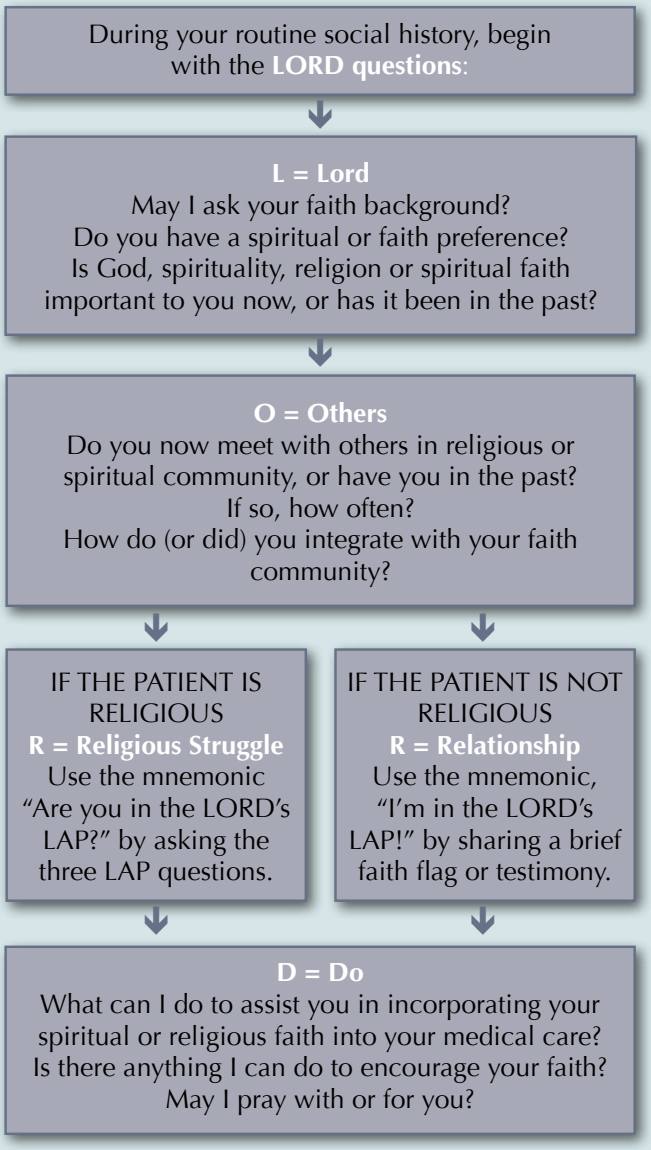
Another patient, a lifelong, devout Buddhist who immigrated to the U.S. from Myanmar, shared that she was sure her chronic dermatitis was punishment from God for her lack of devotion. A Muslim patient, when asked about divine punishment as a cause for his injuries from a traumatic fall, looked at me as if I had two heads, smiled and replied, "Of course God's punishing me. What other explanation could there be?"

With these, and many other patients who have openly shared with me about their religious struggles, I simply would not have known had I not asked. In fact, over the 25 years in which I took spiritual assessments from my patients, I can only remember a few who spontaneously shared their religious struggles with me when I didn't inquire. I can only wonder how many opportunities for significant spiritual impact passed by because I did not know how to ask.

Conclusion

In the last two years of systematically asking my religious or spiritual patients the "LAP" questions, my impression is that about one of five patients confesses to me one or more religious struggles. I'm thankful I've learned this new skill and pleased to see the many ways it helps me bear witness to God and His grace in my practice each day.

One large review concluded, "The available data suggest that practitioners who make several small



changes in how patients' religious commitments are broached in clinical practice may enhance healthcare outcomes."[4]

In a systematic review I published, my co-authors and I concluded, "Until there is evidence of harm from a clinician's provision of either basic spiritual care or a spiritually sensitive practice, interested clinicians and systems should learn to assess their patients' spiritual health and to provide indicated and desired spiritual intervention."[5]

Duke University psychiatrist Harold Koenig, MD, writes, "At stake is the health and wellbeing of our patients and the satisfaction that we as healthcare providers experience in delivering care that addresses the whole person—body, mind and spirit."[6]

Most of all, a spiritual assessment allows us, as followers of Jesus and Christian health professionals, to find out where our patients are in their spiritual journeys. It allows us to see if God is already at work in their lives and join Him there in His work of drawing men and women to Himself.

Are you ready to start using these techniques in your practice? Visit *www.cmda.org/graceprescriptions* to learn how to share your faith in your practice. For an expanded version of both parts of this article and a complete list of citations, please visit *www.cmda.org/spiritualassessment*. Part 1 of Dr. Larimore's article was published in the spring 2015 edition of *Today's Christian Doctor*.

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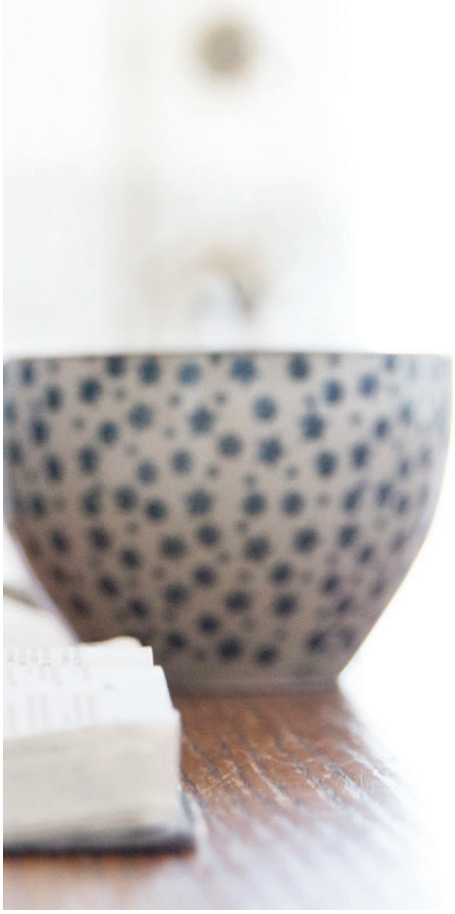
About The Author

WALT LARIMORE, MD, is a lifetime member of CMDA. He has been named in *Guide to America's Top Family Doctors*, *The Best Doctors in America*, *Who's Who in Medicine and Healthcare* and *Who's Who in America*. He and his wife of 40 years, Barb, reside in Colorado, have been named Educators of the Year by CMDA and are the parents of two adult children, the doting grandparents of two beautiful granddaughters and the adopted parents of Jack the Cat. Walt serves on the adjunct faculty of the In His Image Family Medicine Residency in Tulsa, Oklahoma and is the best-selling author of more than 30 books, 700 articles and 25 medical textbook chapters. You can find Walt's daily health blog and daily devotions at *www.DrWalt.com*.

Praying With Our Patients

by Walt Larimore, MD



> *"Not to employ prayer with my patients was the equivalent of deliberately withholding a potent drug or surgical procedure."*
>
> —Larry Dossey, MD

We had completed a full workup for chronic pain for Susan, a patient of mine, and I could not find a physical or emotional etiology. Though she initially resisted discussing her social and spiritual health, she eventually became willing to talk after I questioned her again. She admitted her marriage was on the rocks. And while she was active in her church, she did not know the peace her pastor often spoke about. I asked Susan if she ever prayed about these things. She had not, but she said she was willing to. When I asked if I could pray for her, tears filled her eyes. As I prayed, an emotional floodgate opened in Susan's heart.

More than two years later, Susan's chronic pain is now much improved. She points back to our time in prayer as the beginning of her healing. What do you think? Do you think it is appropriate for healthcare professionals to pray for or with their patients? Do you pray for or with your patients?

Spirituality in Practice

As we discuss in *Grace Prescriptions* and two previous articles published in *Today's Christian Doctor* on this topic, researchers increasingly report evidence linking positive spirituality with health, calling it the forgotten factor in health and insisting the spiritual care of our patients should not be the exclusive domain of pastoral professionals.[1,2,3,4]

In fact, significant evidence indicates *all* healthcare professionals should incorporate positive spirituality into their practices.[5] A spiritual history or assessment is now considered a core clinical competency for quality care for all of our patients, not just for palliative care or end-of-life care.[6,7,8,9] In fact, "the ability to identify and address patient spiritual needs has become an important clinical competency."[10]

For Christian healthcare professionals in particular, prayer is one of the most potent spiritual interventions we can utilize with our patients, not only because it has been shown by research to provide comfort for patients, but because we understand it is ultimately God who heals (Exodus 15:26).

The Biblical Case for Prayer

As we see in Genesis 20:7, the first time God calls on a man to pray it is for physical healing. Scripture also provides these biblical reasons for our praying with and for our patients:

- God prescribes prayer for Christians (1 Thessalonians 5:16-18).
- God prescribes prayer for the sick (James 5:14-15).
- God prescribes prayer for our time of need (Hebrews 4:16).
- God cares about the physical world and human bodies (Matthew 14:14; 3 John 1:2; 1 Thessalonians 5:23).
- God hears and answers prayer (1 John 5:14-15).
- Ultimate healing comes from a relationship with Christ (Isaiah 53:4-5; Revelation 21:3-5; John 6:44).

I Don't Have Time to Pray[1]

Charles Hummel's classic booklet, *Tyranny of the Urgent*, notes that the urgent and the important are seldom the same. What seems urgent seldom is. And we must refuse the urgent if we would do the important.

It is the same with prayer. The busier we are, the more we need God's strength. I can pick up a book by myself, but I need help to move a bookcase. The more you have to do, the more you need time with the One who can empower you to do it.

Martin Luther translated the entire Bible into German, wrote hymns we still sing today and sparked the Protestant Reformation. He once said, "I have so much to do that I shall have to spend the first three hours in prayer."

The Clinical Case for Prayer

Randomized controlled trials are no help

Along with these biblical admonitions, the research literature encourages us to pray with our patients. Several randomized controlled trials (RCTs) reported statistically significant effects with intercessory prayer, including a retrospective study completed 10 years after diagnosis.[11] However, several RCTs have been negative, including the largest and most rigorous trial.[12] (For a full list of these trials, please visit *www.cmda.org/graceprescriptions*.)

Why the mixed results? Simply put, the scientific study of prayer's efficacy in healing using RCTs is problematic. One group of researchers explained, "God may indeed exist and prayer may indeed heal; however, it appears that, for important theological and scientific reasons, randomized controlled studies cannot be applied to the study of the efficacy of prayer in healing." They added, "In fact, no form of scientific enquiry presently available can suitably address the subject."[13]

Why is this? According to a 2006 article published in *Perspectives in Biology and Medicine,* all of the published studies fail to meet RCT standards in several criti-

cal respects. Most importantly, each one of them fails "to measure and control exposure to prayer from others."[14]

It would be like doing a RCT in Mexico in which we were trying to determine if an antibiotic worked for a particular common bacterial infection. We randomly and in double-blinded fashion give half the patients the active drug and half the patients a placebo. So far, so good. But the problem arises when we realize that antibiotics in Mexico are over the counter. Almost everybody has a supply in their home medicine cabinet. And with no way of knowing which of the patients are taking or being given an over-the-counter antibiotic, our study would be useless.

Just like our antibiotic RCT would fail to measure and control for exposure from an over-the-counter antibiotic, the prayer RCTs "fail to measure and control exposure to prayer from others."[15]

In their study published in the *Indian Journal of Psychiatry*, authors Andrade and Radhakrishnan said two important questions remain unanswered. First, if a RCT "on intercessory prayer is positive, does it suggest to us ways and means by which we can manipulate God or make His behavior statistically predictable?" Secondly, "Why would any divine entity be willing to submit to experiments that attempt to validate His existence and constrain His responses?"[16]

Non-RCT Data Are Very Helpful

Even though the RCT data are not able to guide us as Christian healthcare professionals when it comes to whether we should or should not pray with patients, we can hang our hats on other significant data. Specifically, studies show that most of our patients draw on prayer and other religious resources to navigate and overcome the challenges that arise in their illnesses.[17]

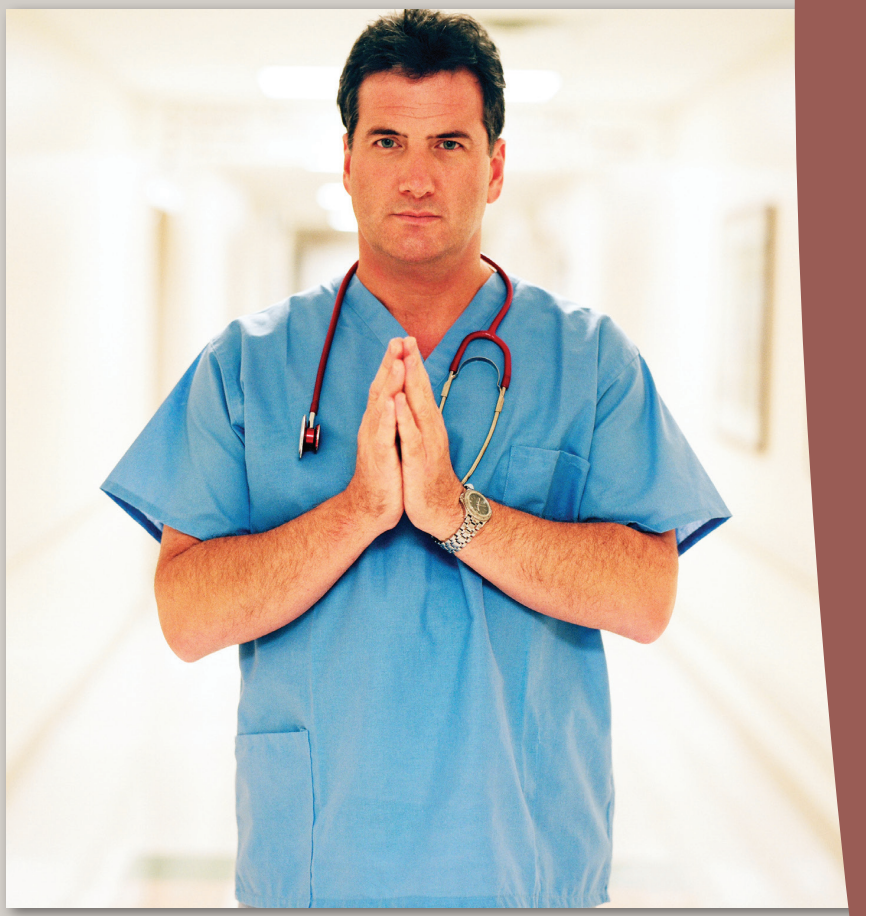
Furthermore, religious beliefs and prayer are commonly used to endure the distress caused by health problems, giving meaning to illness, promoting hope for recovery and providing rituals and behaviors that bring individuals together and settle anxiety.[18] In some areas of the country, 90 percent of hospitalized patients use religion, especially prayer, to enable them to cope with their illnesses, and more than 40 percent indicate it is their primary coping behavior.[19]

Health Professional's Prayer

Lord, Great Physician, I kneel before You. Since every good and perfect gift must come from You, I pray give skill to my hand, clear vision to my mind, kindness and sympathy to my heart. Give me singleness of purpose, strength to lift at least a part of the burden of my suffering fellow men, and a true realization of the rare privilege that is mine. Take from my heart all guile and worldliness, that with the simple faith of a child I may rely on You.

Patient agreement with a healthcare professional praying for them increases strongly with the severity of the illness setting: 19 percent agree with prayer during routine office visits, 29 percent in hospitalized settings and 50 percent in life-threatening scenarios.[20]

In addition, research indicates about 75 percent of physicians report that patients sometimes or often mention spiritual issues such as prayer. While two-thirds of U.S. physicians believe the experience of illness often or always increases patients' awareness of and focus on religious and spiritual issues, about 75 percent of these physicians be-



lieve prayer is positive in healthcare by helping patients cope and giving them a positive state of mind. In addition, 55 percent believe prayer provides emotional and practical support via the religious community.[21]

However, primary care physicians are divided about when and if it is appropriate. At least one-third of surveyed doctors sometimes engage in prayer with their patients; however, this number increased to more than 77 percent if the patient requested physician prayer.[22]

Cautions for Praying with Patients

When it comes to praying with patients, Duke University psychiatrist Harold Koenig, MD, suggests:

1. Contemplating a spiritual intervention (praying with patients) should always be patient centered and patient desired.
2. The healthcare professional should never do anything related to religion or spirituality that involves coercion.
3. The patient must feel in control and free to reveal or not reveal information about their spiritual lives or to engage or not engage in spiritual practices (i.e., prayer, etc.).
4. The healthcare professional, however, may inform religious or spiritual patients (based on the spiritual history) that they are open to praying with patients if that is what the patient wants.
5. The patient is then free to initiate the request for prayer at a later time or future visit, should they desire prayer with the healthcare professional.
6. In most cases, healthcare professionals should not ask patients if they would like to pray with them, but rather leave the initiative to the patient to request prayer. [23]

However, CMDA has found that most members are comfortable praying with their patients in at least some clinical situations. Furthermore, after going through CMDA's *Saline Solution* or *Grace Prescriptions* courses, Christian healthcare professionals seem even more willing and able to pray with patients. If you choose to offer to pray with patients, CMDA recommends considering the following prerequisites:

1. You should have taken a spiritual history.
2. The patient must either request or consent to prayer.
3. The situation calls for prayer.

Discuss with the patient any specific prayer requests and specific people you can share the prayer request with (i.e., colleagues, prayer ministers at your church, etc.). Finally, it is critical you record the patient's request or consent for prayer in the medical record and, of course, at all times, remember confidentiality.

The Lumberman[26]

A newly-hired lumberjack cut down more trees on his first day than anyone else in the camp. The next day, he fell behind the others. By the third day, his production was so low the foreman asked for an explanation.

"I don't understand," he said. "I'm working as hard as ever."

With a flash of insight, the foreman asked, "When last did you sharpen your axe?"

"Sharpen my axe?" the lumberjack replied. "I don't have time to sharpen my axe."

Opportunities for Prayer WITH Patients

- Critical care, critical counseling or giving a critical diagnosis
- After the return of test results
- During hospice or specialty referrals
- Preventive care visits

- Prenatal visits or after the birth of a baby
- Preoperative visits and hospital visits
- Consider asking a patient pray with or for you (i.e., before a surgery or a procedure you'll be performing on the patient)

Opportunities for Prayer FOR Patients

- During your daily quiet time
- While driving to and from work
- With other believers at work or at worship
- Via an electronic prayer memo

The Obligation

"…pray for each other so that you may be healed. The prayer of a righteous person is powerful and effective."

—James 5:16, NIV 2011

"To be a Christian without prayer is no more possible than to be alive without breathing."

—Martin Luther King, Jr.

"Prayer can never be in excess."

—Charles H. Spurgeon

"Men may spurn our appeals, reject our message, oppose our arguments, despise our persons, but they are helpless against our prayers."

— J. Sidlow Baxter

For Christian healthcare professionals, not praying for and with their patients is as much spiritual malpractice as for pastors failing to pray for their flock. Larry Dossey, MD, wrote, "Not to employ prayer with my patients was the equivalent of deliberately withholding a potent drug or surgical procedure."[24] And for a patient who desires prayer, a Christian healthcare professional's prayer may be as or more therapeutic than any other intervention we can offer.

In a weekly devotion to CMDA members, Al Weir, MD, writes about the power of prayer:

> Adam sat across from me, two years out from a very severe illness. "You know, I contribute my healing to four things: the grace of God, the miracle of modern medicine, the support of family and friends and the power of prayer."
>
> He then added after a pause, as if to avoid hurting my feelings, "And I sure thank you for what you've done."
>
> I answered him, "I just work for the Boss; He's the One who healed you."

What We Can Pray for Others (Our Patients and Colleagues)[27]

- The Father would draw them to Himself (John 6:44)
- They would seek to know God (Deuteronomy 4:29; Acts 17:27) and believe the Bible (Romans 10:17; 1 Thessalonians 2:13)
- Satan would be restrained from blinding them to the truth (Matthew 13:19; 2 Corinthians 4:4)
- The Holy Spirit would convict them of sin, righteousness and judgment (John 16:8-13)
- God would send other Christians into their lives to influence them toward Jesus (Matthew 9:37-38)
- They would believe in Jesus as their Savior (John 1:12; John 5:24)
- They would turn from sin (Acts 3:19; Acts 8:22; Acts 17:30-31) and would confess Jesus as Lord (Romans 10:9-10)
- They would yield their lives to follow Jesus (Mark 8:34-37; Romans 12:1-2; 2 Corinthians 5:15; Philippians 3:7-8)
- They would take root and grow in Jesus (Colossians 2:6-7)
- They would become a positive influence for Jesus in their realm (2 Timothy 2:2)

What We Can Pray for Ourselves

- We would do excellent work (Proverbs 22:29)
- We would bring glory to God (Matthew 5:16)
- We would treat people fairly (Colossians 4:1)
- We would clothe ourselves with compassion, kindness, humility, gentleness and patience (Colossians 3:12)
- We would have a good reputation with unbelievers (1 Thessalonians 4:12)
- Others would see Jesus in us (Philippians 2:12-16)
- Our lives would make our faith attractive (Titus 2:10)
- Our conversations would be wise, sensitive, grace-filled and enticing (Colossians 4:5-6)
- We would be bold and fearless (Ephesians 6:19)
- We would be alert to open doors (Colossians 4:3)
- We would be able to clearly explain the gospel (Colossians 4:4)
- God would expand our influence (1 Chronicles 4:10)

Not a bad quatrain for the wonder of healing. Those who follow the Christ should remember:

- The grace of God
- The miracle of modern medicine
- The support of family and friends
- The power of prayer

Summary

Eighteenth century pastor and theologian Samuel Chadwick wrote, "Satan dreads nothing but prayer. His one concern is to keep the saints from praying. He fears nothing from prayerless studies, prayerless work, prayerless religion. He laughs at our toil, he mocks our wisdom, but he trembles when we pray."

As Christian healthcare professionals, we have a powerful healing resource not all healthcare professionals know how to use—prayer. Use it! Intentionally, wisely and prayerfully.

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About The Author

WALT LARIMORE, MD, is a lifetime member of CMDA. He has been named in The Guide to America's Top Family Doctors, The Best Doctors in America, Who's Who in Medicine and Healthcare and Who's Who in America. He and his wife of 40 years, Barb, reside in Colorado and have been named Educators of the Year by CMDA. They are the parents of two adult children, the doting grandparents of two beautiful granddaughters and the adopted parents of Jack the Cat. Walt serves on the adjunct faculty of the In His Image Family Medicine Residency in Tulsa, Oklahoma, and he is the bestselling author of more than 30 books, 700 articles and 25 medical textbook chapters. You can find Walt's daily health blog and devotions at www.DrWalt.com.

Should Clinicians Incorporate Positive Spirituality Into Their Practices? What Does the Evidence Say?

Walter L. Larimore, M.D.
Focus on the Family

Michael Parker, D.S.W.
Department of Social Work
The University of Alabama

Martha Crowther, Ph.D., M.P.H.
Department of Psychology
The University of Alabama

ABSTRACT

Most of the rhetoric decrying the incorporation of basic and positive spiritual care into clinical practice is not based on reliable evidence. We briefly review the current evidence, which demonstrates that (a) there is frequently a positive association between positive spirituality and mental and physical health and well being, (b) most patients desire to be offered basic spiritual care by their clinicians, (c) most patients censure our professions for ignoring their spiritual needs, (d) most clinicians believe that spiritual interventions would help their patients but have little training in providing basic spiritual assessment or care, (e) professional associations and educational institutions are beginning to provide learners and clinicians information on how to incorporate spirituality and practice, and (f) anecdotal evidence indicates that clinicians having received such training find it immediately helpful and do apply it to their practice. We point out the reasons that much more research is needed, especially outcome-based, clinical research on the effects of these spiritual interventions by clinicians.

We conclude that the evidence to date demonstrates trained or experienced clinicians should encourage positive spirituality with their patients and that there is no evidence that such therapy is, in general, harmful. Further, unless or until there is evidence of harm from a clinician's provision of either basic spiritual care or a spiritually sensitive practice, interested clinicians and systems should learn to assess their patients' spiritual health and to provide indicated and desired spiritual intervention. Clinicians and health care systems should not, without compelling data to the contrary, deprive their patients of the spiritual support and comfort on which their hope, health, and well-being may hinge.

(**Ann Behav Med** 2002, *24*(1):69–73)

Although the views expressed in this article reflect our exclusive opinions, we gratefully acknowledge the assistance of the John A. Hartford Foundation's Geriatric Faculty Scholars Program.

Reprint Address: M. Crowther, Ph.D., M.P.H., The University of Alabama, Department of Psychology, Box 870348, Tuscaloosa, AL 35487–0348. E-mail: crowther@bama.ua.edu

Until the 20th century, religion and medicine were closely linked (1). The famous Johns Hopkins physician, Sir William Osler, wrote in 1910 in the first edition of the *British Medical Journal,* "Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible" (2).

The earliest practice linkages of social work were religious. Religious organizations were the first sponsors of social service programs in America, and most of the first social workers in the Charity Organization Society and settlement house movements shared a common spiritual mission. Despite these historical roots, the social work profession gradually went through secularization and professionalization processes that emulated psychiatry and the medical model (3).

During the 20th century, medicine, psychiatry, psychology, and social work replaced religion and spirituality with naturalism, empiricism, secular humanism, and libertarian morality as the primary sources of ethics and values (4). Yet until the last few decades of the 20th century, the medical sciences had not begun to study the relation between measures of religion and spirituality and mental and physical health.

During the 20th century, religion and science were considered by the academic, scientific, and medical communities to be separate realms of thought whose presentation in the same context leads to misunderstanding of both (5). Religiousness was labeled "equivalent to irrational thinking and emotional disturbance" (6, p. 637).

It has now been demonstrated that such notions were not based on any scientific evidence but rather on non-evidence-based clinical impressions. Research indicated that religious and spiritual beliefs and practices were widespread among the American population and that these beliefs and practices had clinical relevance. Therefore, toward the end of the 20th century, professional organizations increasingly called for greater sensitivity and better training of clinicians concerning the management of religious and spiritual issues in the assessment and treatment of patients; these organizations included the American Psychiatric Association in 1989, the American Psychological Association in 1992, the Accreditation Council for Graduate Medical Education in 1994, the Council on Social Work Education in 1995, the Joint Commission on the Accreditation of Healthcare Organizations in 1996, the Ameri-

can Academy of Family Physicians (AAFP) in 1997, the American College of Physicians in 1998, and the Association of American Medical Colleges in 1998.

A random survey of almost 300 physicians at the 1996 meeting of the AAFP revealed that 99% believed that spiritual well-being can promote health and healing. Seventy-five percent believed that others' prayers could promote healing (7). Another survey reported that the majority of family physicians believed spiritual well-being is an important component in health (8). Despite this belief, most of these physicians reported infrequent discussions of spiritual issues with patients and infrequent referrals of hospitalized patients to chaplains. Why? The physicians reported not that they lacked the interest, but they lacked appropriate training. For example, Ellis, Vinson, and Ewigman (8) reported that 59% of physicians feel uncomfortable taking a family history, whereas 56% reported uncertainty about how to determine which patients desired spiritual discussion, and 49% reported uncertainty about how to handle spiritual matters.

Medicine is not the only profession that has not prepared its clinicians to provide basic spiritual services to patients. Surveys of social work faculty have suggested that almost 90% report that religious or spiritual issues were never or rarely presented in their graduate social work studies, and yet over 80% of those being surveyed favored the development of specialized elective courses to address spirituality and practice (9). In parallel to other professions, calls for spiritually sensitive strategies for research and evaluation of practice are increasingly being made by social work researchers and educators (10).

For the past several years, Walter L. Larimore has taught a Continuing Medical Education course, sponsored by the Christian Medical Association, to more than 6,000 health care clinicians. The course emphasizes how clinicians could incorporate research-based positive spirituality into their clinical practices. Over 99% of the attendees, in precourse surveys, reported interest in the ethical and practical how-to's of incorporating basic spiritual skills (how to utilize a spiritual assessment, how and when to provide a spiritual consult or referral, and how and when to pray with a patient or family) into their practices.

In postcourse surveys, over 97% of attendees reported satisfaction with the training, and over 95% predicted that they could use one or more of these spiritual interventions in their practice. When attendees were surveyed 6 or 12 months after the course, over 90% reported that they were able to incorporate and had continued to incorporate this training into their practice.

However, there are those who question whether the use of such spiritual interventions is either wise or ethical. For example, two recent commentaries (11,12) attempted to minimize the ability of and to question the ethics of clinicians that desire to assess and address their patients' spiritual needs.

In the first commentary, two PhDs and several theologians and chaplains from New York City wrote, "It is not clear that physicians should engage in religious discussions with patients as a way of providing comfort" (11). Another group of academicians suggested that "it is a general mandate of modern developed societies to keep professional roles separate … [as] distinct spheres of activity … [to] ensure competence and boundaries" (12). They asserted that clinicians "might need to explain to patients why [spiritual] activities usually fall better under the purview of competent pastoral care" (12). Unfortunately, although these assertions may appear to be evidence based, they are unaccompanied by any outcome-based research.

Our view of the evidence is significantly different. We believe that there are sufficient, research-based reasons for clinicians to provide basic spiritual interventions, albeit cautiously, for example, with their patient's permission, and with respect and sensitivity to the multiple ethical issues such interventions entail. Over 35 systematic reviews have all concluded that in the vast majority of patients, the apparent benefits of intrinsic religious belief and practice outweigh the risks (13,14). Furthermore, surveys indicate that a sizeable majority of patients want their physician to address religious and spiritual issues in the context of a clinical visit (1,13). Fears of religious abuse and claims of possible negative effects of religion on health, although deserving of discussion, prevention, and investigation, are highly speculative and have no basis in population-based systematic reviews.

In fact, the vast majority of the cross-sectional and prospective cohort studies have shown that religious beliefs and practices are consistently associated with better mental and physical health outcomes (1,15). Some critics have asserted that the magnitude of these effects is weak and inconsistent; others have claimed these effects do not reflect risk. The reader should be aware that these criticisms are the distinct minority of opinions among the 1,600 publications in this area (1). We believe that objective observers will conclude that the apparent health benefits of positive spirituality are not established beyond doubt and that better research is needed.

Further, we would acknowledge the absence of a unifying theoretical framework that would foster interdisciplinary thinking about spiritual interventions by clinicians. We also join with our critics in recognizing that outcome-based, clinical research on the effects of spiritual interventions is almost nonexistent (16). However, to claim that there is no evidence to support either the training of clinicians in basic spiritual intervention or the practice of the same by experienced or interested clinicians is, in our view and in the view of others (1,15), uninformed.

One group wrote that "the absence of compelling empiric evidence and the substantial ethical concerns (we raise) suggest that, at the very least, it is premature to recommend making religious and spiritual activities adjunctive medical treatments" (17). We simply and strongly disagree. Furthermore, we believe the current evidence speaks against such admonitions.

First and foremost, if clinicians were to wait for controlled data to be available before utilizing interventions, many aspects of mental and physical health care would screech to a halt. That said, unwise would be the practitioner who would utilize therapy, without controlled data, that has a high probability of being harmful. However, therapies that are inexpensive, easy to apply, desired by the patient, and appear to be helpful (based on uncon-

trolled data) with minimal risk of harm not only seem reasonable to clinicians, who must after all, live and practice in an imperfect world.

Second, most who publish on the intersection of positive spirituality and patient care agree that clinicians should become comfortable addressing the basic spiritual and religious needs of their patients, including taking a religious history, supporting healthy religious beliefs, ensuring access to religious resources (e.g., religious reading materials, a chapel or prayer room, contact information for local clergy), providing spiritual referral or consultation, and viewing the clinical pastoral professional (clergy or chaplain) as an integral part of the health care team (1,18). One systematic review conducted by Matthews and colleagues concluded that practitioners who make some small changes in how patients' religious commitments are broached in clinical practice might improve health care outcomes (13).

Third, a growing number of clinical educators seem to disagree with our critics. In 2000, at least 65 of 126 U.S. medical schools and a growing number of residencies offered courses on the incorporation of religion or spirituality into clinical practice (1). In one allied field, survey research of accredited graduate schools of social work identified 17 schools in 1995 that offered courses with a spiritual or religious focus. By 2000, the number of schools offering courses related to spirituality had grown to over 50 (19). Studies have begun to describe the result of such courses. However, if such basic spiritual interventions were to be harmful, as claimed by some critics, one would expect such reports would be widespread. We are not aware of any published reports or systematic studies about clinicians having caused harm by addressing patients' religious or spiritual needs.

We concur that there is less agreement about some spiritual interventions, such as praying with patients or providing religious counsel. Those supporting these interventions are in nearly universal agreement that they should be patient centered, not practitioner centered (1,18). Furthermore, patients have a right to expect that religious counseling, like other forms of counseling, will be performed only by clinicians trained or experienced in such therapy. Medical ethicists are right in insisting the practitioner must honor the patient's autonomy, follow the patients' lead and needs, and utilize permission, respect, wisdom, and sensitivity (1,13,14,18).

Current data indicate that a practitioner's religious beliefs will influence whether and to what extent he or she addresses these issues (1). Nevertheless, almost 70% of primary care doctors agree that physicians should address at least some religious issues with patients. Between 46 and 78% of patients indicate that they would like their physician to pray with them. One third of primary-care physicians and two thirds of religiously devout physicians report doing so (1). So, why do some experts so vociferously argue that this patient-perceived need should not be met or that clinicians should discontinue their current practice of basic spiritual intervention until more research is available?

In our view, a major part of the problem with the incorporation of basic spiritual interventions into health care has been the confusion associated with the terms *faith, spirituality, religiosity,* and *religion.* Religious variables in most early research were limited to religious affiliation. The current science of spiritual assessment suggests that the measurement of religiousness and spirituality must be multidimensional. Because there is a multiplicity of definitions for each of these terms (*faith, spirituality, religiosity,* and *religion*), we prefer to use the term *positive spirituality.* Positive spirituality, a term attributed to Parker, Fuller, Koenig, Bellis, and Vaitkus (20) and Crowther, Parker, Koenig, Larimore, and Achenbaum (21), is distinctive from broader terms in that positive spirituality involves a developing and internalized personal relationship with the sacred or transcendent. This relationship is not bound by race, ethnicity, economics, or class and promotes the wellness and welfare of others and self.

We join those who assert that certain religious beliefs and activities can adversely affect both mental and physical health (1). Spirituality or religion can be restraining rather than freeing and life enhancing (22). Religion has been used to justify hypocrisy, self-righteousness, hatred, murder, torture, and prejudice. The aspects of spirituality or religiousness (e.g., hypocrisy, self-righteousness) that separate people from the community and family, that encourage unquestioning devotion and obedience to a single charismatic leader, or that promote religion or spiritual traditions as a healing practice to the total exclusion of research-based medical care are likely to adversely affect health over time.

We have theorized that religious or spiritual beliefs and activities that encourage honesty, self-control, love, joy, peace, hope, patience, generosity, forgiveness, thankfulness, kindness, gentleness, goodness, faithfulness, understanding, and compassion and that provide hope and foster creative problem solving under difficult circumstances are more likely to be associated with mental and physical health benefits.

The evidence to date seems to indicate that dependence on the transcendent helps an individual acknowledge his own self-limitations without despairing of his or her circumstances (23). Research has shown that when people become ill, many rely heavily on religious beliefs and practices to relieve stress, retain a sense of control, and maintain hope and a sense of meaning and purpose to life (24). To encourage clinicians to ignore such needs seems to us senseless and uncaring.

Western religious traditions emphasize an intimate relationship with a transcendent force, place high value on personal relationships, and stress respect and value for the self, while placing an emphasis on self-sacrificing service and humility. The resulting emphasis on relationship (relationships to a transcendent force, to others, and to self) may have important mental health consequences, especially in regard to coping with the difficult life circumstances that accompany poor health and chronic disability (24).

Positive spirituality may reduce the sense of loss of control and helplessness that accompany physical illness. Positive spiritual beliefs may also provide a cognitive framework that could reduce stress and increase purpose and meaning in the face of

illness (25). Spiritual activities such as prayer may reduce the sense of isolation and increase the patient's sense of control over the illness. Public religious behaviors that improve coping during times of physical illness include but are not limited to participating in worship services, praying with others (and having others pray for one's health), and visits from religious leaders such as a chaplain, pastor, priest, monk, or rabbi either at home or in the hospital.

For the reader desiring to learn more about including spiritual assessment into their practice, we would recommend the following:

1. The work of the Fetzer Institute, which in collaboration with the National Institute on Aging, compiled 12 reviews reflective of different domains of religiousness and spirituality and a series of brief multidimensional measures for clinical use (which may be obtained by calling 616–375–2000).
2. A self-study module by the National Institute of Healthcare Research (available by calling 301–984–7162).
3. For Christian clinicians, the Christian Medical Association has developed a small-group video series for study (available by calling 888–230–2637).

Each of these works point out the critical distinction between *religiousness* (specific behavioral, social, doctrinal, and denominational characteristics that involve a system of worship and doctrine shared within a group) and *spirituality* (individualistic, transcendent, ultimate meaning of life).

In summary, this evidence points overwhelmingly to a positive association between what we call positive spirituality and mental and physical health and well-being. Most patients desire basic spiritual interventions by their care providers and decry that the profession is ignoring their spiritual needs. Most clinicians believe that spiritual interventions would help their patients but have little training in providing basic spiritual assessment or care. Professional schools and associations are encouraging and, in many cases, providing such training. Anecdotal evidence indicates that learners or clinicians seeking such training find it immediately helpful and apply it to their practice. Nevertheless, much more research is needed, especially outcome-based, clinical research on the effects of these spiritual interventions by clinicians.

The evidence to date tells us that it is clear that clinicians should encourage positive spirituality with their patients. Until more evidence is available, we would encourage interested mental and behavioral health care providers and systems to learn to assess their patients' spiritual health and to provide indicated and desired spiritual intervention. Clinicians should not, without compelling data to the contrary, "deprive their patients of the spiritual support and comfort upon which their hope, health and well being may hinge" (1).

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OPEN ACCESS
religions
ISSN 2077-1444
www.mdpi.com/journal/religions

Article

The Spiritual Care Team: Enabling the Practice of Whole Person Medicine

Harold G. Koenig [1,2,3]

[1] Department of Psychiatry & Behavioral Sciences; Department of Medicine, Duke University Medical Center, Durham, NC 27710, USA; E-Mail: Harold.Koenig@duke.edu; Tel.: +1-919-681-6633
[2] Department of Medicine, King Abdulaziz University, Jeddah 21531, Saudi Arabia
[3] School of Public Health, Ningxia Medical University, Yinchuan 750004, China

External Editor: Arndt Büssing

Received: 13 October 2014; in revised form: 9 November 2014 / Accepted: 25 November 2014 / Published: 9 December 2014

Abstract: We will soon be piloting a project titled "Integrating Spirituality into Patient Care" that will form "spiritual care teams" to assess and address patients' spiritual needs in physician outpatient practices within Adventist Health System, the largest Protestant healthcare system in the United States. This paper describes the goals, the rationale, and the structure of the spiritual care teams that will soon be implemented, and discusses the barriers to providing spiritual care that health professionals are likely to encounter. Spiritual care teams may operate in an outpatient or an inpatient setting, and their purpose is to provide health professionals with resources necessary to practice whole person healthcare that includes spiritual care. We believe that this project will serve as a model for faith-based health systems seeking to visibly demonstrate their mission in a way that makes them unique and expresses their values. Not only does this model have the potential to be cost-effective, but also the capacity to increase the quality of patient care and the satisfaction that health professionals derive from providing care. If successful, this model could spread beyond faith-based systems to secular systems as well both in the U.S. and worldwide.

Keywords: spirituality; religion; spiritual history; spiritual care; spiritual care team

1. Introduction

Research is rapidly accumulating that demonstrates a link between religious involvement and health [1]. As a result, clinicians are searching for ways to apply the findings from these studies to patient care. Perhaps just in time. Healthcare systems and healthcare professionals are struggling. As public health measures improve and healthcare becomes more widely available, people are living longer. Consequently, healthcare systems around the world are beginning to feel the strain involved in caring for more and more patients with chronic health problems as people advance in years. This is especially true in countries such as China, India, the Middle East, and some of the African and South American countries as well [2–5]. The problem is becoming particularly acute in developed countries, such as the United States, where rising healthcare costs are threatening to bankrupt the nation [6], leaving little room for other government-sponsored programs (social security, Medicaid, *etc.*) and encroaching on budgets to preserve the environment, invest in education, infrastructure and research, public safety and security, and defense [7].

Healthcare systems have sought to adapt to increasing numbers of patients by increasing the volume of patients that providers see, creating stress on providers and resulting in an estimated 30%–40% of physicians in the U.S. experiencing burnout (figures which are now about five years old, and the situation has worsened since then) [8]. The stressful healthcare environment limits clinicians' ability to provide whole person care that considers the physical, psychological, social, and spiritual needs of those with chronic disabling illness. These needs are closely interconnected, as research in the field of psychoneuroimmunology is demonstrating [9]. The mind, the body, the social environment, and people's spiritual beliefs and practices all influence each other in complex ways that make focusing on the physical body alone—especially when illness is chronic—incomplete and less effective than might otherwise be. In the days when diseases were primarily acute and occurred in the young or middle-aged, treating the physical body was often enough. That is not the case today, however, with chronic illnesses that may last many years and not only increase medical costs, but cause functional disability, adversely affect quality of life (of both the afflicted person and their family), and often raise questions about the meaning and purpose of life [10].

2. The Spiritual Care Team and Its Goals

The "spiritual care team" (SCT), a phrase coined by Emmer and Brown [11], is made up of a group of health professionals and staff who seek to integrate spirituality into patient care in a way that enhances their ability to provide "whole-person" healthcare that includes "spiritual care". The model described here is being developed at Duke University's Center for Spirituality, Theology and Health for implementation in the Adventist Health System, the largest Protestant healthcare system in the United States [12]. The goals of the SCT are to: (1) identify the spiritual needs of patients related to medical illness; (2) competently address those spiritual needs; (3) create an atmosphere where patients feel comfortable talking about their spiritual needs with the physician and other team members; (4) address the whole-person needs of healthcare team members related to patient care; and (5) provide whole-person health care to all patients they serve. Spiritual needs are those related to the Transcendent (however that is understood by the patient). For example, a patient may feel that their medical

condition is a punishment from God or that God has deserted them or that their faith community has abandoned them. Alternatively, a patient may be struggling with where he or she is going after death, fearful perhaps of going to hell or concerned that there actually is a hereafter. A patient may have a need for prayer or a desire to be visited by members of their faith community. These are examples of spiritual needs.

3. The Rationale

Why should health professionals take the time to form SCTs to assess and address the spiritual needs of patients? The rationale is both theoretical and concrete, and relates to the interconnectedness of mind, body, and spirit. First, many patients have spiritual needs related to illness, and addressing those needs affects satisfaction with care, quality of life, and interestingly, healthcare costs [13–15]. Furthermore, clinical trials have reported that when physicians conduct a spiritual assessment, patient outcomes improve, including compliance with clinic visits, reduction of depressive symptoms, increased functional well-being, and improved the doctor-patient relationship (sense of personal caring from the physician) [16,17]. Second, religious beliefs influence coping with illness and may affect the patient's emotional state and motivation towards recovery, affecting their ability to provide self-care [18]. Third, religious beliefs affect important health-related behaviors and likely influence medical outcomes, as is increasingly being documented [19]. Fourth, religious beliefs influence medical decisions made by *both* patients [20,21] *and* physicians [22]; these decisions often involve the use of expensive, high tech treatments, especially towards the end of life [23].

Fifth, the "standard of care" put forth by the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) in the U.S. requires that providers respect patients' cultural and spiritual beliefs [24]. Specifically, the regulations for hospitals (for all patients) say: "The hospital respects the patient's cultural and personal values, beliefs and preferences" (RI.01.01.01 EP 6) and "The hospital accommodates the patient's right to religious and other spiritual services" (RI.01.01.01 EP 9). The regulations are even more specific about respecting the spiritual beliefs of patients in end-of-life care, those being treated for alcohol and substance use, and those receiving treatment for emotional or behavioral disorders (PC.01.02.01 EP 4, PC.01.02.11 EP 5, and PC 01.02.13 EP3, respectively). Assessment is the only way to know the nature of these beliefs.

Sixth, support from a religious community may increase patient monitoring and improve compliance with treatment, resulting in more timely healthcare that is always less expensive than acute emergency care. Finally, addressing spiritual issues may benefit the health professional as well by providing intrinsic rewards associated with delivering whole-person healthcare.

There is also scientific rationale for assessing and addressing patients' spiritual needs. I will briefly review some of that research here. However, for a more detailed examination of these studies, readers are referred to the *Handbook of Religion and Health*, which contains a systematic review of quantitative studies published in academic peer-reviewed journals through 2010 [1]. I begin with mental health, and then move on to social health, health behaviors, and physical health.

First, in some areas of the U.S. and elsewhere in the world, up to 90% of medical patients rely on religion to cope [18]. High levels of stress, such as those experienced after the September 11 terrorist attacks, often cause people to turn to religion for comfort and control during such events [25]. In the

overwhelming majority of over 400 studies that have now examined this (not including most qualitative studies), people say that religion helps them to cope better [1]. Religious beliefs are commonly used to endure the distress caused by health problems, giving meaning to illness, promoting hope for recovery, and providing rituals and behaviors that bring individuals together and settle anxiety (such as prayer). Similarly, beliefs of this kind have been repeatedly linked with better mental health in medical patients [26–28].

How is religious involvement related to mental health more generally and to social health? In brief, religiosity or spirituality is related to less depression in over 60% of 444 quantitative studies; greater well-being and happiness in nearly 80% of 326 studies; greater meaning and purpose in over 90% of 45 studies; greater hope and optimism in over 75% of 72 studies; and because they convey greater meaning, purpose and hope, religious beliefs and activities are related to less suicide, fewer suicide attempts, and more negative attitudes toward suicide in 75% of 141 studies. Religiosity was also found to be related to less alcohol or drug use/abuse in over 85% of nearly 300 studies, and greater social support, marital stability, and prosocial behavior in more than 80% of 257 studies.

What about health behaviors, such as exercise, diet, cigarette smoking, sexual activity, and weight control that are responsible for nearly 80% of all chronic medical illness? The research shows that religious persons were more likely to exercise or be physically active in nearly 70% of 37 studies; eat a better diet in over 60% of 21 studies; have lower cholesterol in over 50% of 23 studies; participate in less extra-marital sex in 86% of 95 studies, and were less likely to smoke cigarettes in 90% of 137 studies. Unfortunately, those who are more religious had lower weight in less than 20% of studies and were heavier than non-religious persons in nearly 40% of studies. Yes, those potluck suppers!

Despite this, however, religious persons have tended to have better physical health than non-religious persons in the majority of studies so far. This includes better immune function in over 50% of 25 studies; better endocrine function in nearly 75% of 31 studies; better cardiovascular functions in close to 70% of 16 studies; less coronary heart disease in nearly two-thirds of 19 studies; lower blood pressure in nearly 60% of 63 studies; less cancer or a better prognosis in more than half of 25 studies, and greater longevity overall in 68% of 121 studies, including over 75% of the most rigorously designed studies. Finally, research indicates that when spiritual needs have not been addressed by the medical team, this not only reduces the patient's quality of life and satisfaction with care, but may *double or triple healthcare costs*, at least towards the end of life [15].

In conclusion, based on this review of the available research, religion is often used to cope with stress in general and medical illness in particular; religious or spiritual involvement is associated with greater well-being, less emotional disorder, less substance abuse, greater social support, and better health behaviors; religiosity is related to less physical illness, better medical outcomes, and greater longevity; spiritual needs are widespread in medical settings, especially in those with serious, life-threatening disease; and assessing and addressing patients' spiritual needs is related to greater satisfaction with care, better QOL, less depression, fewer unnecessary health services, better functioning, and a better doctor-patient relationship. Much more research is needed to better understand relationships between religion and health; determine the underlying biological mechanisms involved; and develop new interventions that harness these effects. However, given the results of research already done, there is *every reason* for health professionals to assess and address the spiritual needs of patients.

4. Structure of the Spiritual Care Team

The members of the SCT and their roles will vary depending on whether the setting of care is outpatient or inpatient. For outpatient settings, the SCT will likely consist of a physician, a spiritual care coordinator (nurse or clinic manager), a chaplain or pastoral counselor, and a receptionist. In hospital settings, the SCT will include a social worker or case manager. The roles of each member of the team are distinct.

Physician. The physician's responsibility on the SCT is to conduct a brief "spiritual assessment" in order to identify spiritual needs. Once spiritual needs are identified, the physician will then arrange for someone to address those needs, follow up to ensure that spiritual needs are met, and be available to discuss this subject with patients as needed. The spiritual assessment done by the physician involves asking a few simple questions to identify spiritual needs related to medical illness. The purpose is to make the physician aware of the patient's religious background; determine if the patient has religious or spiritual support; identify beliefs that might influence medical decisions and affect compliance with the medical care plan; identify unmet spiritual needs related to medical illness; determine if engagement of the "spiritual care team" is necessary; and create an atmosphere where the patient feels comfortable talking with their physician about spiritual needs affecting medical care. The spiritual assessment consists of three questions:

1. Do you have a religious or spiritual support system to help you in times of need?
2. Do you have any religious beliefs that might influence your medical decisions?
3. Do you have any other spiritual concerns that you would like someone to address?

The physician will then document the patient's responses in the medical record, elaborating on any "yes" responses. If spiritual needs are identified, the physician will alert the Spiritual Care Coordinator (see below) so that arrangements can be made to address those needs. Finally, there should be follow-up down the road to determine if spiritual needs have been adequately addressed. The SCT will assist in this regard, although the physician is responsible for ensuring that such follow-up occurs. This is the minimum requirement that we are requesting of physicians. The spiritual assessment, however, is NOT a one-time event. Whenever there is a significant change in the patient's condition, the physician will want to check whether any new spiritual needs have arisen that the patient needs help with. Patients may not disclose a spiritual need or wish to discuss spiritual concerns, especially during a first visit. However, once the patient learns that the physician is receptive to discussing such issues, he or she may bring up the topic if needed during a future visit.

Do all patients need a spiritual assessment? No. There are five categories of patients where a spiritual assessment is indicated: patients with serious, life-threatening conditions; patients with chronic, disabling medical illness; patients with depression or significant anxiety; patients newly admitted to the hospital or to a nursing home; and patients being seen for a well-patient exam when time is available to address social issues. Those who do not need a spiritual assessment are patients seen for an acute problem without long-term implications, such as an upper respiratory infection, minor surgical procedure, routine pelvic exam, or some other specific, well-defined condition; patients seen for follow-up of a time-limited problem where there is no significant disability or challenges to coping; children, teenagers or young adults without chronic illness, life-threatening conditions, or disabling

serious medical problem; and patients who are not religious or spiritual and so this area is not relevant to them.

Spiritual Care Coordinator (SCC). The SCC is often a nurse or a clinic manager. If the physician is the leader of the spiritual care team, then the SCC could be considered the "coach" of the team. The SCC has multiple duties. The first duty is to review the results of the physician's spiritual assessment, and identify and prioritize the spiritual needs that require addressing. The SCC does not conduct the assessment. The physician's assessment cannot be deferred to the SCC, since the physician needs to collect this information first hand. Next, the SCC manages each step to ensure that the patients' spiritual needs are addressed, providing resources as needed (for example, information on local faith communities, spiritual reading materials, information on pastoral care services, and so forth).

If a chaplain or pastoral care referral is necessary, the SCC prepares the patient to see the chaplain, *i.e.*, explains the reasons for the referral, describes the training that a chaplain has, and discusses what the chaplain will do. The SCC also prepares the chaplain (or pastoral counselor) for the referral, informing him or her about the spiritual needs identified and why the physician or SCC is referring the patient. After the chaplain referral is completed, the SCC follows up to obtain feedback from chaplain on the results of the evaluation and information about spiritual care plan, and then communicates this to the physician. The SCC then helps the chaplain follow-up with patient to ensure that spiritual needs identified during the physician's assessment were adequately addressed by the spiritual care plan. Finally, together with the chaplain, the SCC provides spiritual support to the physician and other members of the team, helping them to provide whole-person care to their patients. If, on the other hand, a patient prefers to address spiritual concerns with their own clergy, other member of their faith community, or other member of the healthcare team, the SCC will make the arrangements for such a meeting to occur.

The Chaplain. The chaplain likewise plays many roles, but there is one that is completely unique. The chaplain is the only person on the SCT *trained* to comprehensively assess and address the spiritual needs of patients. After receiving a referral, the chaplain will do a spiritual assessment that is quite different from physician's brief "screening" assessment. The chaplain will clarify spiritual needs that are present and will then develop a "spiritual care plan" to address those needs. The chaplain will work with the social worker (if available) to implement the spiritual care plan after discharge from the hospital or from the clinic. He or she will also follow up to ensure that spiritual needs are met and provide feedback to the team. Finally, the chaplain will work with the Spiritual Care Coordinator to address the spiritual needs of team members that are related to patient care. More specifically, what is involved in the chaplain's assessment and what types of interventions are then implemented?

The chaplain's assessment will differ depending on her or his individual style. Generally, though, the chaplain will make contact with the patient and spend time forming a relationship. During this time, the chaplain learns the "spiritual language" of the patient, which may or may not be religious. Much of the assessment will be spent listening to the patient talk about his or her struggles. No advice or spiritual counsel is usually offered during this time, which is often called the "ministry of presence". After that, the chaplain may ask questions about the patient's religious or spiritual background, and inquire about positive and negative experiences with religion. When the assessment has been completed, the chaplain will develop a spiritual care plan to address the spiritual needs identified.

The spiritual care plan will involve one or more specific interventions by the chaplain. Note that the "ministry of presence", which involves simply sitting with the patient and listening, is a powerful intervention by itself. The chaplain, however, may do other things besides simply listen. The chaplain may or may not pray with the patient, depending on the patient's preference. The chaplain may or may not read a Holy Scripture related to the patient's illness, again depending on the patient's preference. The chaplain may or may not provide spiritual advice, depending on patient's request and on the patient's readiness for such advice. The chaplain may provide religious resources to the patient, by request, such as spiritual reading materials, prayer beads, a prayer rug, *etc.* The chaplain may contact the patient's clergy or mobilize the patient's faith community for support, after obtaining explicit consent from the patient. All of this activity is highly patient-centered and focused on the patient's particular religious tradition or humanistic worldview. Finally, the chaplain will re-contact the patient at some future time to get follow-up on how effective the interventions were in addressing the patient's spiritual needs.

The chaplain may also engage in other activities, such as listening to, counseling, praying with, or providing spiritual and emotional support to family members. The chaplain may do the same for other members of the SCT. In hospital settings, the chaplain may hold chapel services and administer sacraments or perform other rituals at the bedside. The chaplain may also serve on the ethics committees or the institutional review board at the hospital. Finally, the chaplain works with community clergy, who may be trained to fill in for the chaplain during emergencies or during situations where the chaplain is absent.

Whether in an outpatient or inpatient setting, the chaplain should be fully integrated into the healthcare team. As noted above, the chaplain or pastoral counselor is at the core of the spiritual care team because he or she is the only person fully trained to address spiritual needs. Consequently, the chaplain should be actively involved in hospital rounds and in discussions involving patients in the clinic. Unfortunately, many hospital and outpatient settings do not have enough healthcare chaplains to meet the need. In a survey of 1591 patients at the Mayo Clinic [29], researchers found that 70% of hospitalized patients wanted to see a chaplain, but only 43% were visited by a chaplain, which is over double the national rate in the U.S. (*i.e.*, 20%) [30]. The proportion of outpatients seen by a chaplain or pastoral counselor is probably in the single digits. Note that over 80% of patients visited by a chaplain in the Mayo Clinic study said that the visit was important to them.

If a chaplain is not available, as may be the case in some outpatient settings, the Spiritual Care Coordinator would arrange a visit with a pastoral counselor or other person trained to address the spiritual needs of medical patients. If spiritual needs are urgent and trained clergy are not immediately available, then the SCC or other spiritual care team member might have to do their best to address the spiritual needs of the patient (primarily by listening and providing resources) and then make arrangements for follow-up by a religious professional at a later date. For this reason, all members of the spiritual care team, including the physician, should receive some training on providing "spiritual first aid" in the event that such care is needed.

Social Worker. In hospital settings, chaplains often have a close relationship with the team social worker, and some hospitals have actually combined pastoral care and social services into a single department. The reason is that spiritual needs are often closely linked with social issues. As a result, the social worker may provide important input to the spiritual care plan.

In this regard, the social worker may contact members of the patient's faith community for support after hospital discharge; identify a local faith community for the patient, if desired; identify a pastoral counselor after discharge and set up appointments; or help the chaplain follow-up to determine whether spiritual needs were effectively addressed.

There are many other contributions that the social worker can make to the spiritual care team. These include identifying spiritual needs during routine social assessment (however, this would not replace the physician's assessment); arranging referral to the chaplain or pastoral counselor if the Spiritual Care Coordinator is not available (or may work with the SCC to arrange the referral); and addressing simple spiritual needs if a chaplain is unavailable or is refused by the patient (this applies only to "simple" spiritual needs, since most social workers are not trained to address such needs). The social worker may also connect the patient with a mental health professional trained to integrate spiritual and emotional needs, as might be the case for trauma survivors and others with serious mental health problems.

The Receptionist. The receptionist in the physician's clinic or ward clerk in the hospital plays an important role on the spiritual care team. The duty of the receptionist is to record the patient's religious affiliation (specific denomination or religious group) in the medical record so that the physician can access it easily. This will save the physician time in conducting the spiritual assessment.

5. Spiritual Care

A major goal of the spiritual care team is to provide "spiritual care" to all patients as part of whole-person medicine. What is spiritual care? Although assessing and addressing the spiritual needs of patients is an important part of it, spiritual care goes far beyond that. The way that *ordinary health care* is provided by the physician and other members of the healthcare can be "spiritual". By that, I mean recognizing the sacred nature of the person being cared for and the holy obligation and privilege that health professionals have. More specifically, this means providing care with respect for the individual patient, a person with a unique life story; inquiring about how the patient wishes to be cared for, rather than providing the same care in the same way to everyone; providing care in a kind and gentle manner; providing care in a "competent" manner; and taking extra time with patients who really need it.

Spiritual care is the heart of what whole-person healthcare is really about, and has the potential to bring vitality back into the patient and into the practice of healthcare. However, it is not easy to do. Research indicates that only about 10% of physicians regularly conduct a spiritual assessment (and nearly 50% never do one) [31]. Why is this so? The following are 10 barriers that stand in the way of spiritual care. These barriers are based on research by the Harvard oncology group at the Dana Farber Institute [32]. They asked oncologists and oncology nurses why they did not routinely assess and address the spiritual needs of patients. Here is how they responded. After each barrier, I will suggest how to overcome it:

(1) *Lack of Time*. Spiritual care is just one more thing that health professionals are now being asked to do. They barely have enough time to perform required duties and document the results. Many are concerned about opening Pandora's box and not having adequate time to address the issues uncovered. There is temptation, then, to eliminate this "optional" activity (or defer it to others).

How to overcome: Doing a brief spiritual assessment must be a priority for the physician and addressing those needs a priority for the spiritual care team. This is not an optional activity, but central to providing "whole-person" medical care. The spiritual assessment can actually save time, improve the relationship with the patient, improve compliance, and make the physician's work more rewarding. The physician, as the director of the spiritual care team, cannot defer the spiritual assessment to anyone else. The spiritual care team, though, must be ready to fully address the patient's spiritual needs as their part of whole-person care.

(2) *Discomfort*. Many health professionals are not comfortable addressing this topic, particularly if they are not religious or particularly spiritual. Few health professionals have training on how to assess or address the spiritual needs of patients in a sensible and timely manner, or what to do if spiritual needs are identified.

How to overcome: Comfort comes with training and practice. Sometimes health professionals must do things that are not comfortable with to improve the quality of care that patients receive.

(3) *Making Patient Uncomfortable*. Health professionals may fear that asking such questions will make the patient feel uncomfortable, or may not know how to respond if the patient says: "Why are you asking these questions?"

How to overcome: Research shows that most patients, especially when seriously ill, are not offended or made uncomfortable when the physician performs a spiritual assessment, and in fact, the majority would like health professionals to do so [21,33]. If a patient asks why these questions are being asked, an appropriate response would be: "We are doing this routinely as a show of respect for the beliefs and values of patients, which may influence their medical care".

(4) *Spirituality Not Important*. Because spirituality is not important to the health professional, there is fear that the patient will ask about his or her own beliefs.

How to overcome: First, patients seldom ask health professionals about their personal beliefs. If they do ask, then a brief or general response usually satisfies the patient. The reason why most patients ask is that they are worried about how the clinician will treat their beliefs. Reassuring the patient that their beliefs will always be respected and honored usually allays this concern.

(5) *Topic Too Personal*. Health professionals feel that this topic is too personal to ask about, or they are concerned that they don't have a private space to discuss it.

How to overcome: Clinicians deal with other sensitive areas related to health much more personal than asking about religious beliefs. Sensitive areas include sexual behavior or personal health habits, such as smoking, drinking, diet, or weight control. Fear that these areas are too personal does not prevent health professionals from thoroughly assessing them.

(6) *Done Better by Others*. The physician believes that the spiritual assessment is done better by others.

How to overcome: Recognize that the physician is the leader of the healthcare team and needs to know about factors that could affect the patient's health and their compliance with the medical care plan.

(7) *Patients Don't Want Spiritual Care from Doctors/Nurses*. Health professionals believe that patients don't want them to address these issues.

How to overcome: As noted above, patient surveys indicate that only a minority of patients show resistance to inquiry about spiritual needs, or wish to keep medicine and religion separate [21,33]. Furthermore, doctors are usually only responsible for *assessment* in this model. Once spiritual needs

are identified, the chaplain or pastoral counselor is the health professional who addresses them. One large study even found that when patients who did not want a visit from a chaplain and received one anyway, actually reported more satisfaction with their overall healthcare than did non-visited patients [34].

(8) *Power Inequality*. There is concern that the power inequality between patient and health professional might lead to coercion.

How to overcome: Realize that coercion in this area is unethical and a violation of civil rights. Thus, it is never appropriate to do so. I will discuss this boundary issue further in the next section.

(9) *Religious Beliefs Differ*. The religious beliefs of the healthcare provider differ from those of the patient.

How to overcome: Realize that in this era of patient-centered medicine, the focus should always be on respecting and supporting the spiritual beliefs of the patient, whether or not the health professional agrees with those beliefs.

(10) *Not Health Professional's Role*. Healthcare providers feel that assessing and addressing spiritual needs related to medical care is not part of their role.

How to overcome: Realize that providing whole-person care *is* part of the health professional's role and whole-person care includes addressing this area.

All of these barriers could be overcome through training and practice. Future research, however, will be needed to determine whether training, careful dividing up tasks among team members, and practice will make health professionals comfortable and fluent in spiritual care. In the Duke-Adventist Health collaborative study, we plan to systematically examine exactly this—whether the forming and training of spiritual care teams to assess and address patients' spiritual needs will affect health professionals' attitudes and behaviors (which will be measured at baseline and then 3 and 12 months afterwards).

6. Boundaries

There are, however, boundaries to providing spiritual care. Sometimes health professionals go beyond their expertise and perform actions that are neither sensible nor ethically justifiable. Here are five behaviors that healthcare providers should almost never do. First, don't prescribe religion to non-religious patients. Even though religious involvement may be good for health, non-believers should not be encouraged to become religious. Furthermore, the spiritual assessment should be conducted in such a way that patients who do not consider themselves spiritual do not feel devalued. As noted above, the spiritual assessment should be framed in such a way that the patient understands that such questions are being asked as a matter of routine in order to provide whole person care to those who do have spiritual needs. Second, and related to the latter, don't force a spiritual assessment if the patient is not religious. In that case, quickly switch to asking about what gives life meaning and purpose in the context of illness and how this can be supported. For these individuals, issues related to demoralization or death anxiety should be dealt with in a broad way using a holistic model grounded on humanistic beliefs and values. Third, don't pray with a patient before doing a spiritual assessment *and* unless the patient asks. While more than two-thirds to three-quarters of patients would like to pray with a health professional and deeply appreciate this [35,36], others might not. Fourth, in general, don't provide spiritual counsel to patients. Instead, always refer the patient to a trained professional

chaplain or a pastoral counselor. As noted earlier, the only exceptions might be if the health professional has pastoral care training, or if addressing spiritual issues is urgent and the patient refuses pastoral care or pastoral care is not available. Finally, don't do any activity that is not patient-centered and patient-directed. Remember, it's about the patient—not the health professional. Addressing spiritual issues is like a ballroom dance. The patient leads and the health professional tries not to step on his or her toes.

Finally, in order for the physician and other team members to deliver whole-person spiritual care to patients, they need to be whole-persons themselves. The difficult task of caring for sick patients day-in and day-out challenges the physical, emotional and spiritual resources of most providers. For that reason, one major task of the spiritual care team is to support each other's spiritual needs that arise during the course of providing healthcare. Part of the role of the spiritual care coordinator and the chaplain is to ensure that the spiritual needs of team members are met. There are numerous spiritual resources that may help in this regard, depending on the provider's faith tradition [37–40].

Models, such as the one proposed here, and similar ones proposed by others [41], will need to be adapted to the unique settings and cultural environments that health professionals find themselves in—particularly as these models begin to be applied in non-Western countries (and in hospital settings that may not reflect the religious values of the Adventist Health System).

7. Conclusions

The following are the main points that this paper has been trying to convey. First, there is every reason to assess and address spiritual needs related to medical care—based on common sense, good clinical practice, and a firm scientific rationale. Second, the *physician* is responsible for a brief spiritual assessment that is designed to identify spiritual needs and create an atmosphere where spiritual needs related to medical care can be discussed. Third, the rest of the spiritual care team, led by the spiritual care coordinator, supports the physician by ensuring that the spiritual needs identified are effectively addressed. Fourth, the chaplain or pastoral counselor is at the core of the spiritual care team, and is responsible for conducting a comprehensive spiritual assessment to clarify spiritual needs and develop a spiritual care plan to address them. Finally, in hospital settings, the social worker helps the chaplain to develop and implement the spiritual care plan, and to arrange for follow-up to ensure that spiritual needs are met. For a more comprehensive resource on assessing and addressing the spiritual needs of patients, readers are referred elsewhere [42,43].

Conflicts of Interest

The author declares no conflicts of interest.

A complete list of the 43 references cited by Dr. Koenig for this article can be found at http://tinyurl.com/kh42c2d.

International Scholarly Research Network
ISRN Psychiatry
Volume 2012, Article ID 278730, 33 pages
doi:10.5402/2012/278730

Review Article

Religion, Spirituality, and Health: The Research and Clinical Implications

Harold G. Koenig[1, 2]

[1] *Departments of Medicine and Psychiatry, Duke University Medical Center, P.O. Box 3400, Durham, NC 27705, USA*
[2] *Department of Medicine, King Abdulaziz University, Jeddah 21413, Saudi Arabia*

Correspondence should be addressed to Harold G. Koenig, harold.koenig@duke.edu

Received 25 September 2012; Accepted 15 October 2012

Academic Editors: S. M. Hyman and B. J. Mitterauer

This paper provides a concise but comprehensive review of research on religion/spirituality (R/S) and both mental health and physical health. It is based on a systematic review of original data-based quantitative research published in peer-reviewed journals between 1872 and 2010, including a few seminal articles published since 2010. First, I provide a brief historical background to set the stage. Then I review research on R/S and mental health, examining relationships with both positive and negative mental health outcomes, where positive outcomes include well-being, happiness, hope, optimism, and gratefulness, and negative outcomes involve depression, suicide, anxiety, psychosis, substance abuse, delinquency/crime, marital instability, and personality traits (positive and negative). I then explain how and why R/S might influence mental health. Next, I review research on R/S and health behaviors such as physical activity, cigarette smoking, diet, and sexual practices, followed by a review of relationships between R/S and heart disease, hypertension, cerebrovascular disease, Alzheimer's disease and dementia, immune functions, endocrine functions, cancer, overall mortality, physical disability, pain, and somatic symptoms. I then present a theoretical model explaining how R/S might influence physical health. Finally, I discuss what health professionals should do in light of these research findings and make recommendations in this regard.

1. Historical Background and Introduction

Religion, medicine, and healthcare have been related in one way or another in all population groups since the beginning of recorded history [1]. Only in recent times have these systems of healing been separated, and this separation has occurred largely in highly developed nations; in many developing countries, there is little or no such separation. The history of religion, medicine, and healthcare in developed countries of the West, though, is a fascinating one. The first hospitals in the West for the care of the sick in the general population were built by religious organizations and staffed by religious orders. Throughout the Middle Ages and up through the French Revolution, physicians were often clergy. For hundreds of years, in fact, religious institutions were responsible for licensing physicians to practice medicine. In the American colonies, in particular, many of the clergy were also physicians—often as a second job that helped to supplement their meager income from church work.

Care for those with *mental health* problems in the West also had its roots within monasteries and religious communities [2]. In 1247, the Priory of St. Mary of Bethlehem was built in London on the Thames River [3]. Originally designed to house "distracted people," this was Europe's (and perhaps the world's) first mental hospital. In 1547, however, St. Mary's was torn down and replaced by Bethlehem or Bethlem Hospital [4]. Over the years, as secular authorities took control over the institution, the hospital became famous for its inhumane treatment of the mentally ill, who were often chained [5], dunked in water, or beaten as necessary to control them. In later years, an admission fee (2 pence) was charged to the general public to observe the patients abusing themselves or other patients [4]. The hospital eventually became known as "bedlam" (from which comes the word used today to indicate a state of confusion and disarray).

In response to the abuses in mental hospitals, and precipitated by the death of a Quaker patient in New York asylum in England, an English merchant and devout Quaker

named William Tuke began to promote a new form of treatment of the mentally ill called "moral treatment." In 1796, he and the Quaker community in England established their own asylum known as the York Retreat [6]. Not long after this, the Quakers brought moral treatment to America, where it became the dominant form of psychiatric care in that country [6]. Established in Philadelphia by the Quakers in 1813, "Friends Hospital" (or Friends Asylum) became the first private institution in the United States dedicated solely to the care of those with mental illness [7]. Psychiatric hospitals that followed in the footsteps of Friends Asylum were the McLean Hospital (established in 1818 in Boston, and now associated with Harvard), the Bloomingdale Asylum (established in 1821 in New York), and the Hartford Retreat (established in 1824 in Connecticut)—all modeled after the York Retreat and implementing moral treatment as the dominant therapy.

It was not until modern times that religion and psychiatry began to part paths. This separation was encouraged by the psychiatrist Sigmund Freud. After being "introduced" to the neurotic and hysterical aspects of religion by the famous French neurologist Jean Charcot in the mid-1880s, Freud began to emphasize this in a widely read series of publications from 1907 through his death in 1939. Included among these were *Religious Acts and Obsessive Practices* [8], *Psychoanalysis and Religion* [9], *Future of an Illusion* [10], and *Moses and Monotheism* [11]. These writings left a legacy that would influence the practice of psychiatry—especially psychotherapy—for the rest of the century and lead to a true schism between religion and mental health care. That schism was illustrated in 1993 by a systematic review of the religious content of DSM-III-R, which found nearly one-quarter of all cases of mental illness being described using religious illustrations [12]. The conflict has continued to the present day. Consider recent e-letters in response to two articles published in *The Psychiatrist* about this topic [13, 14] and an even more recent debate about the role of prayer in psychiatric practice [15]. This conflict has manifested in the clinical work of many mental health professionals, who have generally ignored the religious resources of patients or viewed them as pathological. Consider that a recent national survey of US psychiatrists found that 56% said they never, rarely, or only sometimes inquire about religious/spiritual issues in patients with depression or anxiety [16]. Even more concerning, however, is that the conflict has caused psychiatrists to avoid conducting research on religion and mental health. This explains why so little is known about the relationship between religious involvement and severe mental disorders (see *Handbook of Religion and Health*) [17].

Despite the negative views and opinions held by many mental health professionals, research examining religion, spirituality, and health has been rapidly expanding—and most of it is occurring outside the field of psychiatry. This research is being published in journals from a wide range of disciplines, including those in medicine, nursing, physical and occupational therapy, social work, public health, sociology, psychology, religion, spirituality, pastoral care, chaplain, population studies, and even in economics and law journals. Most of these disciplines do not readily communicate with each another, and their journal audiences seldom overlap. The result is a massive research literature that is scattered throughout the medical, social, and behavioral sciences.

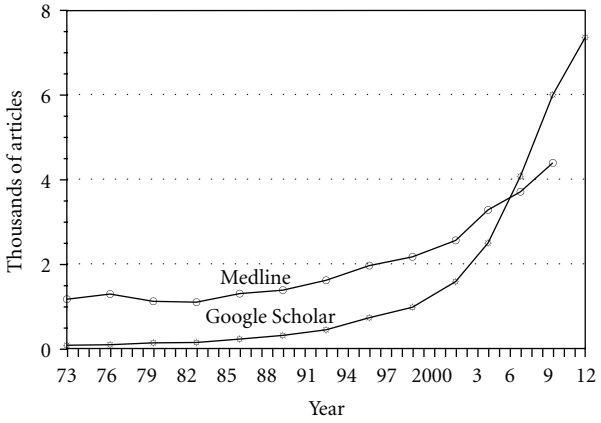

Figure 1: Religion spirituality and health articles published per 3-year period (noncumulative) Search terms: religion, religious, religiosity, religiousness, and spirituality (conducted on 8/11/12; projected to end of 2012).

To get a sense of how rapidly the research base is growing see Figure 1. The graphs plot the number of studies published in peer-reviewed journals during every noncumulative 3-year period from 1971 to 2012. Note that about 50% of these articles are reports of original research with quantitative data, whereas the other 50% are qualitative reports, opinion pieces, reviews, or commentaries. Google Scholar presents a more comprehensive picture since it includes studies published in both Medline and non-Medline journals. These graphs suggest that the volume of research on R/S and health has literally exploded since the mid-1990s.

2. Definitions

Before summarizing the research findings, it is first necessary to provide definitions of the words religion and spirituality that I am using. There is much controversy and disagreement concerning definitions in this field, particularly over the term "spirituality," and space here does not allow a full discussion of these complex issues. For an in depth discussion, including an exploration of contamination and confounding in the measurement of spirituality, I refer the reader to other sources [18–20]. Here are the definitions we provided in the *Handbook*.

"[Religion] Involves beliefs, practices, and rituals related to the *transcendent*, where the transcendent is God, Allah, HaShem, or a Higher Power in Western religious traditions, or to Brahman, manifestations of Brahman, Buddha, Dao, or ultimate truth/reality in Eastern traditions. This often involves the mystical or supernatural. Religions usually have specific beliefs about life after death and rules about conduct within a social group. Religion is a multidimensional construct that includes beliefs, behaviors, rituals, and ceremonies that may be held or practiced in private or

public settings, but are in some way derived from established traditions that developed over time within a community. Religion is also an organized system of beliefs, practices, and symbols designed (a) to facilitate closeness to the transcendent, and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community." [21].

"Spirituality is distinguished from all other things—humanism, values, morals, and mental health—by its connection to that which is sacred, the *transcendent*. The transcendent is that which is outside of the self, and yet also within the self—and in Western traditions is called God, Allah, HaShem, or a Higher Power, and in Eastern traditions may be called Brahman, manifestations of Brahman, Buddha, Dao, or ultimate truth/reality. Spirituality is intimately connected to the supernatural, the mystical, and to organized religion, although also extends beyond organized religion (and begins before it). Spirituality includes both a search for the transcendent and the discovery of the transcendent and so involves traveling along the path that leads from nonconsideration to questioning to either staunch nonbelief or belief, and if belief, then ultimately to devotion and finally, surrender. Thus, our definition of spirituality is very similar to religion and there is clearly overlap." [22].

For the research review presented here, given the similarity in my definition of these terms and the fact that spirituality in the research has either been measured using questions assessing religion or by items assessing mental health (thereby contaminating the construct and causing tautological results), I will be using religion and spirituality interchangeably (i.e., R/S).

3. Method of the Review

I summarize the research findings between R/S and health first in the area of mental health outcomes, then for health behaviors, and finally for physical health outcomes. The information presented here is based on a systematic review of peer-reviewed original data-based reports published though mid-2010 and summarized in two editions of the *Handbook of Religion and Health* [23, 24]. How these systematic reviews were conducted, however, needs brief explanation. This is particularly true for ratings of study methodology that are used to summarize the findings below.

The systematic review to identify the studies presented in the Handbooks and summarized in this paper was conducted as follows. We utilized a combination of strategies to identify the studies (excluding most reviews or qualitative research). First, we systematically searched online databases (PsycINFO, MEDLINE, etc.) using the search words "religion," "religiosity," "religiousness," and "spirituality" to identify studies on the R/S-health relationship. Second, we asked prominent researchers in the field to alert us to published research they knew about and to send us research that they themselves had conducted. Third, if there were studies cited in the reference lists of the studies located, we tracked down those as well. Using this method, we identified over 1,200 quantitative original data-based publications during the period 1872 to 2000 and 2,100 studies examining the R/S-health relationship from 2000 to 2010. All of these studies are described in the appendices of the two editions of the Handbook. Based on other reviews of the research conducted around this same time period (but more limited), we estimate that our review captured about 75% of the published research. Bear in mind that many, many more qualitative studies have been published on the topic that were not included in this review.

In order to assess the methodological quality of the studies, quality ratings were assigned as follows. Ratings of each of the more than 3,300 studies were made on a scale from 0 (low) to 10 (high) and were performed by a single examiner (HGK) to ensure rating consistency. Scores were determined according to the following eight criteria: study design (clinical trial, prospective cohort, cross-sectional, etc.), sampling method (random, systematic, or convenience), number of R/S measures, quality of measures, quality of mental health outcome measure, contamination between R/S measures and mental health outcomes, inclusion of control variables, and statistical method, based on a scheme adapted from Cooper [25]. Cooper emphasized the definition of variables, validity and reliability of measures, representativeness of the sample (sample size, sampling method, and response rates), research methods (quality of experimental manipulation and adequacy of control group for clinical trials), how well the execution of the study conformed to the design, appropriateness of statistical tests (power, control variables), and the interpretation of results.

To assess the reliability of the ratings, we compared HGK's ratings on 75 studies with the ratings made by an independent outside reviewer (Andrew Futterman, Ph.D., professor of psychology, College of the Holy Cross, a scientist familiar with the scoring criteria and active in the field of R/S-health research). When we examined correlations between HGK and Futterman's ratings, we found them moderately correlated (Pearson $r = 0.57$). Since scores of 7 or higher indicated higher quality studies, we also compared the scores between the two raters in terms of lower (0–6) versus higher (7–10) quality. This was done by dichotomizing scores into two categories (0–6 versus 7–10) and comparing the categories between the two examiners. The kappa of agreement (κ) between the two raters was 0.49 (where kappas of 0.40 to 0.75 indicate good agreement [26]). Overall, the raters agreed on whether quality was low or high in 56 of the 75 studies or 75%. I now summarize the results of the systematic review described above.

4. Religion, Spirituality, and Mental Health

Approximately 80% of research on R/S and health involves studies on mental health. One would expect stronger relationships between R/S and mental health since R/S involvement consists of psychological, social, and behavioral aspects that are more "proximally" related to mental health than to physical health. In fact, we would not expect any direct or immediate effects of R/S on physical health, other than indirectly through intermediary psychosocial

and behavioral pathways. With regard to mental health, we would expect R/S to boost positive emotions and help neutralize negative emotions, hypothesizing that it serves as both a life-enhancing factor and as a coping resource. With regard to the latter, there is both qualitative and quantitative research suggesting that R/S helps people to deal better with adversity, either external adversity (difficult environmental circumstances) or internal adversity (genetic predisposition or vulnerability to mental disorders).

In the present paper, I have chosen to cite original reports as examples of the most rigorous studies in each area based on ratings in the Handbooks (i.e., 7 or higher on 0–10 scale). Cited here are both positive and negative studies reporting significant relationships. For some topics, such as well-being and depression, there are too many high-quality studies to cite, so only a few examples of the best studies are provided.

4.1. Coping with Adversity. In the first edition of the Handbook [27], we identified 110 studies published prior to the year 2000 and 344 studies published between 2000 and 2010 for a total of 454 studies. Among these reports are descriptions of how R/S helped people to cope with a wide range of illnesses or in a variety of stressful situations. These include people dealing with general medical illness [28, 29], chronic pain [30], kidney disease [31], diabetes [32, 33], pulmonary disease [34], cancer [35, 36], blood disorders [37], heart/cardiovascular diseases [38, 39], dental [40] or vision [41] problems, neurological disorders [42], HIV/AIDS [43], systemic lupus erythematosus [44], irritable bowel syndrome [45], musculoskeletal disease [46], caregiver burden [47–49], psychiatric illness [50, 51], bereavement [52, 53], end-of-life issues [54, 55], overall stress [56–58], natural disasters [59, 60], war [61, 62] or acts of terrorism [63], and miscellaneous adverse life situations [64–66]. In the overwhelming majority of studies, people reported that R/S was helpful.

4.2. Positive Emotions. Positive emotions include well-being, happiness, hope, optimism, meaning and purpose, high self-esteem, and a sense of control over life. Related to positive emotions are positive psychological traits such as altruism, being kind or compassionate, forgiving, and grateful.

4.2.1. Well-Being/Happiness. By mid-2010, at least 326 quantitative, peer-reviewed studies had examined relationships with R/S. Of those, 256 (79%) found only significant positive associations between R/S and well-being (including eight studies at a statistical trend level, that is, $0.05 < P < 0.10$). Only three studies (<1%) reported a significant inverse relationship between R/S and well-being. Of the 120 studies with the highest methodological rigor (7 or higher in quality on the 0–10 scale), 98 (82%) reported positive relationships (including two at a trend level) [67–77] and one study reported a negative relationship (but only at a trend level) [78].

4.2.2. Hope. At least 40 studies have examined relationships with R/S, and of those, 29 (73%) reported only significant positive relationships with degree of hope; no studies found an inverse relationship. Of the six highest quality studies, half found a positive relationship [79–81].

4.2.3. Optimism. We located 32 studies examining relationships with R/S, and of those, 26 (81%) reported significant positive relationships. Of the 11 best studies, eight (73%) reported significant positive relationships [82–85]. Again, as with hope, no studies reported inverse relationships.

4.2.4. Meaning and Purpose. At least 45 studies have examined relationships with R/S, and 42 (93%) reported significant positive relationships. These studies were often in populations where there was a challenge to having meaning and purpose, such as in people with chronic disabling illness. Of the 10 studies with quality ratings of 7 or higher, all 10 reported significant positive associations [86–89].

4.2.5. Self-Esteem. Critics have claimed that R/S adversely affects self-esteem because it emphasizes humility rather than pride in the self [90]. Furthermore, R/S could exacerbate guilt in some for not living up to the high standards of conduct prescribed by religious traditions, resulting in low self-esteem. We found 69 studies that examined associations with R/S, and of those, 42 (61%) found *greater* self-esteem among those who were more R/S and two (3%) reported lower self-esteem. Of the 25 studies with the highest methodological rigor, 17 (68%) reported greater self-esteem [91–98] and two (8%) found worse self-esteem [99, 100]. Not surprisingly, these findings are parallel to those of depression below (in the opposite direction, of course).

4.2.6. Sense of Control. Although one might expect R/S to correlate positively with an external locus of control (i.e., the Transcendent controlling events), and some studies confirm this, the majority of research finds a positive correlation with an internal not an external sense of control. Of 21 studies that have examined these relationships, 13 (61%) found that R/S was related to a greater sense of personal control in challenging life circumstances. Of the nine best studies, four reported significant positive relationships (44%) [101–104] and three report significant negative relationships (33%) [105–107], whereas the two remaining studies reported complex or mixed results (significant positive and negative associations, depending on R/S characteristic). R/S beliefs may provide an indirect sense of control over stressful situations; by believing that God is in control and that prayer to God can change things, the person feels a greater sense of internal control (rather than having to depend on external agents of control, such as powerful other people).

4.2.7. Positive Character Traits. With regard to character traits, the findings are similar to those with positive emotions. With regard to altruism or frequency of volunteering, 47 studies have examined relationships with R/S. Of those, 33 (70%) reported significant associations, whereas five (11%) found less altruism among the more R/S; of the 20 best studies, 15 (75%) reported positive relationships [108–113]

and two (10%) found negative associations [114, 115] (both concerning organ donations, which some religions prohibit). With regard to forgiveness, 40 studies have examined correlations with R/S, and 34 (85%) reported significant positive relationships and no studies found negative associations. Among the 10 highest quality studies, seven (70%) reported greater forgiveness among the more R/S [116–119], a finding that recent research has supported [120]. Regarding gratefulness, five of five studies found positive associations with R/S [121, 122], and with regard to kindness/compassion, three of three studies reported significant positive relationship with R/S [123]. Admittedly, all of the studies measuring character traits above depend on self-report.

4.3. Depression. As with self-esteem, mental health professionals have argued that R/S might increase guilt by focusing on sin and could thus lead to depression. Again, however, this has not been found in the majority of studies. Given the importance of depression, its wide prevalence in the population, and the dysfunction that it causes (both mental and physical), I describe the research findings in a bit more detail. Overall, at least 444 studies have now examined relationships between R/S and depression, dating back to the early 1960s. Of those, 272 (61%) reported significant inverse relationships with depression (including nine studies at a trend level), and 28 (6%) found relationships between R/S and greater depression (including two studies at a trend level). Of the 178 studies with the highest methodological rigor, 119 (67%) reported inverse relationships [124–135] and 13 (7%) found positive relationships with depression [136–148].

Of 70 prospective cohort studies, 39 (56%) reported that greater R/S predicted lower levels of depression or faster remission of depression, whereas seven (10%) predicted worse future depression and seven (10%) reported mixed results (both significant positive and negative associations depending on R/S characteristic). Of 30 clinical trials, 19 (63%) found that R/S interventions produced better outcomes than either standard treatment or control groups. Two studies (7%) found standard treatments were superior to R/S interventions [149, 150] and one study reported mixed results.

Note that an independent review of this literature published in 2003 found that of 147 studies involving 98,975 subjects, the average correlation between R/S and depression was −0.10. Although this is a small correlation, it translates into the same effect size that gender has on depressive symptoms (with the rate of depression being nearly twice as common in women compared to men). Also, the average correlation reported in the 2003 review was 50% stronger in stressed versus nonstressed populations [151].

A widely renowned psychiatric epidemiology group at Columbia University, led by Lisa Miller and Myrna Weissman, has come out with a series of recent reports on R/S and depression studying a cohort of low- and high-risk children born to parents with and without depressive disorder. The findings from this cohort support an inverse link between R/S and depression, particularly in high-risk individuals [152–154].

4.4. Suicide. Correlations between R/S and suicide attempt, completed suicide, and attitudes toward suicide are consistent with those found for depression, self-esteem, and hope. Those who are depressed, without hope, and with low self-esteem are at greater risk for committing suicide. At least 141 studies have now examined relationships between R/S and the suicide variables above. Of those, 106 (75%) reported inverse relationships and four (3%) found positive relationships. With regard to the 49 studies with the highest methodological rigor, 39 (80%) reported less suicide, fewer suicide attempts, or more negative attitudes toward suicide among the more R/S [155–170] and two (4%) found positive relationships (one study in Delhi, India [171], and one in college students distressed over R/S concerns [172]).

4.5. Anxiety. Anxiety and fear often drive people toward religion as a way to cope with the anxiety. Alternatively, R/S may increase anxiety/fear by its threats of punishment for evil deeds and damnation in the next life. There is an old saying that emphasizes this dual role: religion comforts the afflicted and afflicts the comforted. Sorting out cause and effect here is particularly difficult given the few prospective cohort studies that have examined this relationship over time. However, a number of clinical trials have also examined the effects of R/S interventions on anxiety levels. Overall, at least 299 studies have examined this relationship, and of those, 147 (49%) reported inverse association with R/S (three at a trend level), whereas 33 (11%) reported greater anxiety in those who were more R/S. Of the latter, however, only one was a prospective study, one was a randomized clinical trial, and 31 (94%) were cross-sectional studies (where it was not clear whether R/S caused anxiety or whether anxiety increased R/S as a coping response to the anxiety). Of the 67 studies with quality ratings of seven or higher, 38 (55%) reported inverse relationships [173–182] and seven (10%) found positive relationships (greater anxiety among the more R/S) [183–189].

Among these 299 studies were 239 cross-sectional studies, 19 prospective cohort studies, 9 single-group experimental studies, and 32 randomized clinical trials. Of the 19 longitudinal studies, 9 (47%) reported that R/S predicted a lower level of anxiety over time; one study (5%) found an increase in anxiety (among women undergoing abortion for fetal anomaly) [189], seven reported no association, and two reported mixed or complex results. Of the nine experimental studies, seven (78%) found a reduction in anxiety following an R/S intervention (before versus after comparison). Of the 32 randomized clinical trials, 22 (69%) reported that an R/S intervention reduced anxiety more than a standard intervention or control condition, whereas one study (3%) found an increase in anxiety following an R/S intervention in persons with severe alcohol dependence [190].

4.6. Psychotic Disorder/Schizophrenia. We identified 43 studies that have examined relationships between R/S and

chronic psychotic disorders such as schizophrenia. Of the 43 studies examining psychosis, 14 (33%) reported inverse relationships between R/S and psychotic symptoms (one at a trend level), 10 (23%) found a positive relationship between R/S and psychotic symptoms (one at a trend level), eight reported mixed results (significant negative and positive associations, depending on the R/S characteristic measured), and one study reported complex results. Of these studies, seven had quality ratings of seven or higher; of those, two found inverse relationships, two found positive relationship, two reported mixed results (negative and positive), and one found no association. Note that the two studies finding inverse relationships between R/S and psychosis were both prospective studies [191–193], finding that R/S predicted better outcomes in subjects with psychotic disorders or symptoms. Of the two studies reporting positive relationships (both cross-sectional), one study found that importance of religion was significantly and positively associated with religious delusions [194] (not surprising), and the other study found that importance of religion was associated with "psychotic-like" symptoms in a national sample of Mexican Americans [195]; since the latter study involved participants who were not mentally ill, religion-related cultural factors may have influenced this finding. For a recent and more comprehensive discussion of R/S, schizophrenia, other chronic psychotic disorders, and the challenges distinguishing psychotic symptoms from religious beliefs, the reader is referred elsewhere [196].

4.7. Bipolar Disorder. Despite it's importance and wide prevalence, we could locate only four studies examining the relationship between R/S and bipolar (BP) disorder. Two found a positive association between R/S and bipolar disorder, and the remaining two reported mixed findings (both positive and negative correlations, depending on R/S characteristic). Of the two studies with high-quality ratings, one found a positive association and the other reported mixed findings. The first study of 334 US veterans with BP disorder found that a higher frequency of prayer or meditation was associated with mixed states and a lower likelihood of euthymia, although no association was found between any religious variable and depression or mania [197]. A second study examined a random national sample of 37,000 Canadians and found that those who attributed greater importance to higher spiritual values were more likely to have BP disorder, whereas higher frequency of religious attendance was associated with a lower risk of disorder [198]. In a qualitative study of 35 adults with bipolar disorder (not included in the review above), one of the six themes that participants emphasized when discussing their quality of life was the spiritual dimension. Over one-third of participants in that study talked about the relationship between BP disorder and R/S, emphasizing struggles to disentangle genuine spiritual experiences from the hyperreligiosity of the disorder. In another report, a case of mania precipitated by Eastern meditation was discussed; also included in this article was a review of nine other published cases of psychosis occurring in the setting of meditation [199].

4.8. Personality Traits. Personality traits most commonly measured today in psychology are the Big Five: extraversion, neuroticism, conscientiousness, agreeableness, and openness to experience. These are assessed by the NEO Personality Inventory [200]. Another personality inventory commonly used in the United Kingdom is the Eysenck Personality Questionnaire, which assesses extraversion, neuroticism, and psychoticism [201]. Relationships between personality traits and R/S using these measures have been examined in many studies [202]. With regard to psychoticism (a trait that assesses risk taking or lack of responsibility, rather than psychotic symptoms), 19 studies have examined its relationship to R/S, with 84% of those reporting significant inverse relationships (and no studies reporting a positive relationship). There have been at least 54 quantitative studies examined relationships between R/S and neuroticism, of which 24% found an inverse relationship and 9% reported a positive relationship (most of the remaining found no association). Concerning extraversion, there have been 50 studies, with 38% reporting a positive relationship with R/S and 6% reporting an inverse or negative relationship. With regard to conscientiousness, there have been 30 studies, of which the majority (63%) reported significant positive relationships with R/S and only 3% found significant inverse relationships. For agreeableness, 30 studies have examined relationships with R/S, and 87% of these studies reported positive relationships (no studies report inverse relationships). Finally, there have been 26 studies examining openness to experience, and of those, 42% found positive relationships with R/S and 12% reported negative relationships. Thus, R/S persons tend to score lower on psychoticism and neuroticism, and higher on extraversion, conscientiousness, agreeableness, and openness to experience. They score especially low on psychoticism and especially high on agreeableness and conscientiousness. These personality traits have physical health consequences that we are only beginning to recognize [203–205].

4.9. Substance Abuse. If R/S influences one domain of mental health, it is in the area of substance abuse. With regard to alcohol use, abuse, and dependence, at least 278 studies have now examined relationships with R/S. Of those, 240 (86%) reported inverse relationships and only 4 studies (1%) indicated a positive relationship. Of the 145 studies with the best methodology, 131 (90%) reported inverse relationships [206–221] and only one study found a positive relationship [222]. Findings are similar with regard to drug use or abuse. We located 185 studies, of which 84% reported inverse relationship with R/S and only two studies (1%) found positive relationships. Of the 112 best studies, 96 (86%) reported inverse relationships [223–238] and only one study found a positive relationship [239]. The vast majority of these studies are in young persons attending high school or college, a time when they are just starting to establish substance use habits (which for some will interfere with their education, future jobs, family life, and health). Thus, the protective effects of R/S on substance abuse may have influences on health across the lifespan.

4.10. Social Problems. Here I examine research in two areas of social instability (delinquency/crime and marital instability) and two areas of social stability (social support and social capital). Given the emphasis that most major world religions place on human relationships, love, and compassion, one might expect that some of the strongest relationships with R/S would be found here, and they are indeed.

4.10.1. Delinquency/Crime. At least 104 studies have examined relationships with R/S. Of those, 82 (79%) reported significant inverse relationships (five at a trend level), whereas three (3%) found positive relationships with more delinquency/crime. Of the 60 studies with quality ratings of 7 or higher, 49 (82%) reported inverse relationships [240–252] and only one study found a positive relationship [253]. Of particular interest are the 10 studies examining relationships between R/S and school grades/performance in adolescents and college students between 2000 and 2009, of which all 10 (100%) found that more R/S youth did better than less religious youth [254].

4.10.2. Marital Instability. We identified 79 studies that examined relationships with marital instability. Of those, 68 (86%) found R/S related to greater marital stability and no studies reported an association with greater marital instability. Of the 38 methodologically most rigorous studies, 35 (92%) reported significant relationships between R/S and greater marital stability [255–265]. An independent meta-analysis reviewing research conducted before the year 2000 likewise concluded that greater religiousness decreased the risk of divorce and facilitated marital functioning and parenting [266].

4.10.3. Social Support. There is substantial evidence indicating a relationship between R/S and social support. Of 74 quantitative peer-reviewed studies of R/S and social support, 61 (82%) found significant positive relationships, and none found inverse relationships. Of the 29 best studies, 27 (93%) reported significant positive relationships [82, 267–274]. For older adults in particular, the most common source of social support outside of family members comes from members of religious organizations [275, 276].

4.10.4. Social Capital. Social capital, an indirect measure of community health, is usually assessed by level of community participation, volunteerism, trust, reciprocity between people in the community, and membership in community-based, civic, political, or social justice organizations. Research has examined relationships between R/S and social capital. We located a total of 14 studies, with 11 (79%) finding significant positive relationships between R/S and level of social capital, and none reporting only inverse relationships. Almost all of these studies were of high quality, and of the 13 studies with ratings of seven or higher, 10 (77%) found that R/S was related to greater social capital [277–280].

5. Explaining the Relationship: R/S and Mental Health

R/S influences mental health through many different mechanisms, although the following are probably the predominant ones (see Figure 2). First, religion provides resources for coping with stress that may increase the frequency of positive emotions and reduce the likelihood that stress will result in emotional disorders such as depression, anxiety disorder, suicide, and substance abuse. Religious coping resources include powerful cognitions (strongly held beliefs) that give meaning to difficult life circumstances and provide a sense of purpose. Religions provide an optimistic worldview that may involve the existence of a personal transcendental force (God, Allah, Jehovah, etc.) that loves and cares about humans and is responsive to their needs. These cognitions also give a subjective sense of control over events (i.e., if God is in control, can influence circumstances, and be influenced by prayer, then prayer by the individual may positively influence the situation). Religious beliefs provide satisfying answers to existential questions, such as "where did we come from," "why are we here," and "where are we going," and the answers apply to both this life and the next life, thus reducing existential angst. These beliefs also help to normalize loss and change and provide role models of persons suffering with the same or similar problems (often illustrated in religious scriptures). Thus, religious beliefs have the potential to influence the cognitive appraisal of negative life events in a way that makes them less distressing. For people with medical illness, these beliefs are particularly useful because they are not lost or impaired with physical disability—unlike many other coping resources that are dependent on health (hobbies, relationships, and jobs/finances).

Second, most religions have rules and regulations (doctrines) about how to live life and how to treat others within a social group. When individuals abide by those rules and regulations, this reduces the likelihood of stressful life events that reduce positive emotions and increased negative ones. Examples of stressful life events that religion may help people avoid are divorce or separation, difficulties with children, financial stress resulting from unfair practices in the marketplace, incarceration for lawbreaking (cheating or crime), and venereal diseases from risky sexual practices. Religions also usually discourage the use of drugs and excessive amounts of alcohol that increases the risk of engaging in the behaviors above (crime, risky sex) that are associated with negative mental health consequences.

Third, most religions emphasize love of others, compassion, and altruistic acts as well as encourage meeting together during religious social events. These prosocial behaviors have many consequences that buffer stress and lead to human support when support is needed during difficult times. Because religion encourages the helping of others and emphasizes a focus outside of the self, engagement in other-helping activities may increase positive emotions and serve to distract from one's own problems. Religion also promotes human virtues such as honesty, forgiveness, gratefulness, patience, and dependability, which help to maintain and enhance social relationships. The practice of these human

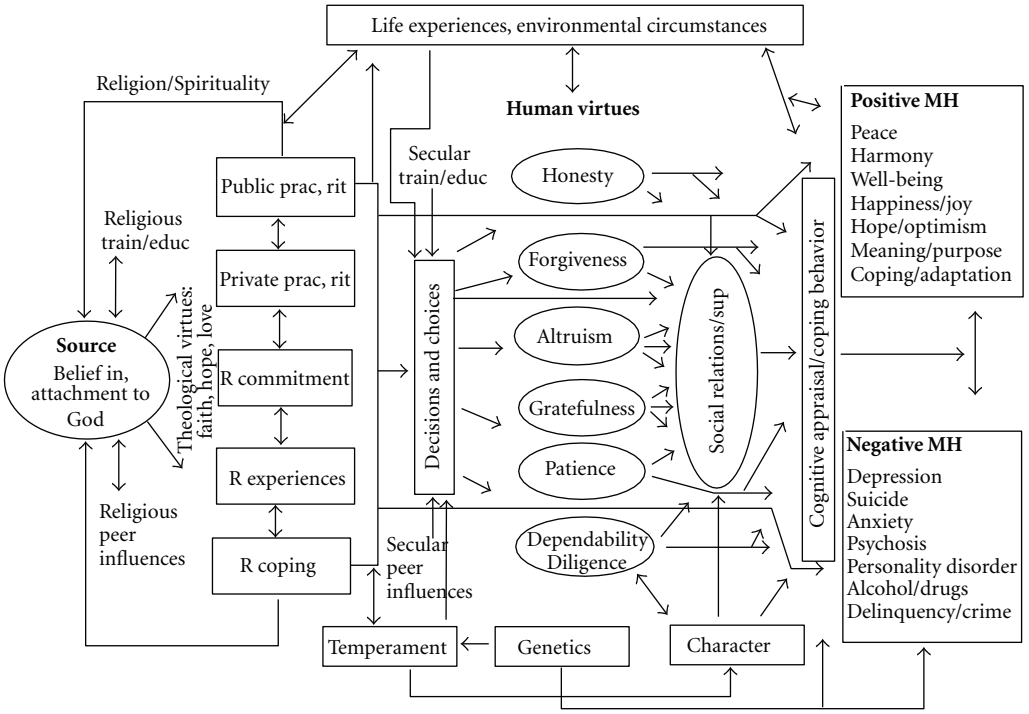

Figure 2: Theoretical model of causal pathways for mental health (MH), based on Western monotheistic religions (Christianity, Judaism, and Islam). (Permission to reprint obtained. Original source: Koenig et al. [17]). For models based on Eastern religious traditions and the Secular Humanist tradition, see elsewhere. (Koenig et al. [24]).

virtues may also directly increase positive emotions and neutralize negative ones.

Thus, there are many possible mechanisms by which R/S may enhance mental and social health. This is not to say that R/S always does so. Religion may also be used to justify hatred, aggression, prejudice, and the exclusion of others; gain power and control over vulnerable individuals (as seen in cults); foster rigid thinking and obsessive practices; lead to anxiety, fear, and excessive guilt over minor infractions (and even self-mutilation in some cases); produce psychosocial strains due to failure to live up to high religious standards; lead to escape from dealing with family problems (through excessive involvement in religious or spiritual activities); and delay diagnosis and effective mental health care (due to antagonistic relationships with mental health professionals). While R/S is not a panacea, on the balance, it is generally associated with greater well-being, improved coping with stress, and better mental health. This relationship with mental health has physical health consequences (see Section 7 below).

6. Religion, Spirituality, and Health Behaviors

Religious doctrines influence decisions about health and health behaviors. In the Judeo-Christian scriptures, for example, there is an emphasis on caring for the physical body as a "Temple of the Holy Spirit" (see 1 Corinthian 6:19-20) [281]. Religious scriptures in other faith traditions also emphasize the person's responsibility to care for and nourish their physical body [282–284]. Behaviors that have the potential to harm the body are usually discouraged. This is reflected in teachings from the pulpit and influences what is considered appropriate within religious social groups. In summarizing the research on R/S and health behaviors, I cite only a few of the studies with high-quality ratings since there are so many.

6.1. Cigarette Smoking. The influence of R/S is most evident in it's "effects" on cigarette smoking. At least 137 studies have examined relationship between R/S and smoking, and of those, 123 (90%) reported statistically significant inverse relationships (including three at a trend level) and no studies found either a significant or even a trend association in the other direction. Of the 83 methodologically most rigorous studies, 75 (90%) reported inverse relationships with R/S involvement [213, 285–294]. Not surprisingly, the physical health consequences of not smoking are enormous. Decreased cigarette smoking will mean a reduction in chronic lung disease, lung cancer, all cancers (30% being related to smoking), coronary artery disease, hypertension, stroke, and other cardiovascular diseases.

6.2. Exercise. Level of exercise and physical activity also appears linked to R/S. We located 37 studies that examined this relationship. Of those, 25 (68%) reported significant positive relationships (two at a trend level) between R/S involvement and greater exercise or physical activity, whereas

six (16%) found significant inverse relationships. Of 21 studies with the highest quality ratings, 16 (76%) reported positive associations [82, 295–300] and two (10%) found negative associations [296, 301].

Writers in the popular press have encouraged the combining of R/S activity and exercise through "prayer walking" [302, 303] and "walking meditation." [304].

6.3. Diet. At least 21 studies have examined relationships between R/S and a healthy diet. A healthy diet here involves increased intake of fiber, green vegetables, fruit, and fish; low intake of snacks, processed foods, and fat; regular vitamin intake; frequent eating of breakfast; overall better nutrition (following recommended nutritional guidelines). Of those studies, 13 (62%) found a significant positive association between R/S and a healthier diet (one at a trend level) and one found a worse diet [305]. Among the 10 studies with the highest quality ratings, seven (70%) reported a better diet among those who were more R/S [213, 306–310]. In addition, we identified 23 studies that examined relationships between R/S and blood cholesterol levels. Of those, more than half (12 studies) found significantly lower cholesterol among those who were more R/S, whereas three studies (13%) reported significantly higher cholesterol levels. Of the nine best studies, five (56%) reported lower cholesterol [311–313] or a lowering of cholesterol in response to a R/S intervention [314, 315], whereas one found higher cholesterol (but only in Mexican American men) [316].

6.4. Weight. Although R/S people tend to eat a healthier diet, they also eat more of it. This, then, is the one health behavior that places R/S individuals at greater risk for medical illness. At least 36 studies have examined the associations between weight (or body mass index) and R/S involvement. Of those, 14 (39%) found a positive relationship (R/S associated with greater weight), whereas only seven (19%) reported an inverse relationship. The situation does not improve when results from the most rigorously designed studies are examined. Among the 25 studies with the highest quality ratings, 11 (44%) reported greater weight among the more R/S [82, 317–322] and five (20%) found lower weight (or less underweight [323]). Lower weight among the more R/S appears only in a few religious groups (Amish [324], Jews [325], and Buddhists [326]), in those with certain demographic characteristics (white, older, and high education) [327], and in response to a specific R/S intervention [328] or practice [314, 329]. Faith-based weight-reduction programs in religious communities have been shown to be effective [328, 330, 331].

6.5. Sexual Behavior. We identified 95 studies that examined relationships between R/S and risky sexual activity (sex outside of marriage, multiple partners, etc.). Of those, 82 studies (86%) found significant inverse relationships with R/S (one at a trend level) and only one study (1%) found a significant relationship with more risky sexual activity [332]. Of the 50 highest quality studies, 42 (84%) reported inverse relationships [333–343] and none found a positive one. If those who are more R/S engage in less risky sexual behavior, this means they should have fewer venereal diseases, that is, less syphilis, gonorrhea, herpes, chancroid, chlamydia, viral hepatitis, and human papillomavirus and human immunodeficiency virus, many of which have serious physical health consequences.

7. Religion, Spirituality, and Physical Health

There is rapidly growing evidence that stress and negative emotions (depression, anxiety) have (1) adverse effects on physiological systems vital for maintenance of physical health and healing [344–346], (2) increase susceptibility to or worse outcomes from a wide range of physical illnesses [347–351], and (3) may shorten the lifespan prematurely [352, 353]. Social support, in turn, has long been known to protect against disease and increase longevity [354–356]. By reducing stress and negative emotions, increasing social support, and positively affecting health behaviors, R/S involvement should have a favorable impact on a host of physical diseases and the response of those diseases to treatment. As in the earlier sections, I cite high-quality studies as examples. Since there are fewer high-quality studies for physical health than for mental health or for health behaviors, I cite all of the studies with ratings of seven or higher.

7.1. Coronary Heart Disease (CHD). Given the strong connections between psychosocial stressors, health behaviors, and CHD, it is not surprising that there is a link with R/S. Our review uncovered 19 studies that examined associations between R/S and CHD. Of those, 12 (63%) reported a significant inverse relationship, and one study reported a positive relationship. Of the 13 studies with the most rigorous methodology, nine (69%) found inverse relationships with CHD [357–365] and one found a positive one [366]. In addition, there have been at least 16 studies examining relationships between R/S and cardiovascular reactivity, heart rate variability, outcomes following cardiac surgery, and other cardiovascular functions. Of those, 11 studies (69%) reported that R/S was significantly related to positive cardiovascular functions or outcomes [367–374] or to lower levels of inflammatory markers such as C-reactive protein [375–377] and fibrinogen [378] that place individuals at high risk for cardiovascular disease.

7.2. Hypertension. The word "hypertension" itself suggests a relationship with stress or tension, and high blood pressure has been linked to greater psychosocial stress [379–381]. At least 63 studies have examined the relationship between R/S and blood pressure (BP), of which 36 (57%) reported significantly lower BP in those who are more R/S (five at a trend level) and seven (11%) reported significantly higher BP (one at a trend level). Of the 39 highest quality studies, 24 (62%) report lower BP (including one at a trend level) among those who are more R/S [382–394] or in response to an R/S intervention [328, 395–404] (including a study whose

results were reported twice, once for the overall sample and once for the sample stratified by race).

Two lower quality studies [405, 406] and five well-done studies [407–411] (13%, including one at a trend level), however, reported higher BP in the more R/S or with religious fasting. The reason for an association between R/S and higher BP is not entirely clear. Perhaps, in certain population subgroups, intrapsychic religious conflict between psychosexual drives and religious standards creates unconscious stress that elevates BP. However, there is another possibility. This may be related to confounding by ethnicity. Three of the five studies reporting increased BP with increased R/S included in their samples a large proportion of ethnic minorities (samples from large urban settings such as Detroit and Chicago, made up of 36% to 100% African Americans). Since African Americans are more likely to have high BP (40% with hypertension) [412] and because African Americans are also the most religious ethnic group in society [413], it may be that controlling for race in these analyses is simply not sufficient to overcome this powerful confound.

7.3. Cerebrovascular Disease. Relationships between R/S, hypertension and other cardiovascular diseases or disease risk factors ought to translate into a lower risk of stroke. We located nine studies that examined this relationship, of which four reported a lower risk of stroke, all having quality ratings of seven or higher [414–417].

One study, however, reported significantly more carotid artery thickening, placing R/S individuals at higher risk for stroke [418]. Again, however, 30% of that sample was African American an ethnic group, known to be both highly religious and at high risk for stroke.

7.4. Alzheimer's Disease and Dementia. Physiological changes that occur with stress and depression (elevated blood cortisol, in particular) are known to adversely affect the parts of the brain responsible for memory [419–421]. The experience of negative emotions may be like pouring hydrochloric acid on the brain's memory cells [422]. By reducing stress and depression through more effective coping, R/S may produce a physiological environment that has favorable effects on cognitive functioning. Furthermore, R/S involvement may also engage higher cortical functions involved in abstract thinking (concerning moral values or ideas about the transcendent) that serve to "exercise" brain areas necessary for retention of memories. Regardless of the mechanism, at least 21 studies have examined relationships between R/S involvement and cognitive function in both healthy persons and individuals with dementia. Of those, 10 (48%) reported significant positive relationships between R/S and better cognitive functioning and three (14%) found significant negative relationships. Of the 14 studies with the highest quality ratings, eight (57%) reported positive relationships [423–430] and three (21%) reported negative relationships with cognitive function [431–433]. Studies finding negative relationships between R/S and cognitive function may be due to the fact that R/S persons have longer lifespans (see below), increasing the likelihood that they will live to older ages when cognition tends to decline. More recent research supports a positive link between R/S and better cognitive function in both dementia and in old age [434, 435].

7.5. Immune Function. Intact immune function is critical for health maintenance and disease prevention and is assessed by indicators of cellular immunity, humoral immunity, and levels of pro- and anti-inflammatory cytokines. We identified 27 studies on relationships between R/S and immune functions, of which 15 (56%) found positive relationships or positive effects in response to a R/S intervention, and one (4%) found a negative effect [436]. Of the 14 studies with the highest quality ratings, 10 (71%) reported significant positive associations [437–443] or increased immune functions in response to a R/S intervention [444–447]. No high-quality study found only an inverse association or negative effect, although one study reported mixed findings [448]. In that study, religious attendance was related to significantly poorer cutaneous response to antigens; however, it was also related (at a trend level) to higher total lymphocyte count, total T-cell count, and helper T-cell count. In addition, importance of religious or spiritual expression was related to significantly higher white blood cell count, total lymphocyte count, total T cells, and cytotoxic T cell activity.

There have also been a number of studies examining R/S and susceptibility to infection (or viral load in those with HIV), which could be considered an indirect measure of immune function. We identified 12 such studies, of which eight (67%) reported significantly lower infection rates or lower viral loads in those who were more R/S (including one at a trend level); none found greater susceptibility to infection or greater viral load. Ten of the 12 studies had quality ratings of 7 or higher; of those, seven (70%) reported significant inverse associations with infection/viral load [440, 441, 449–454].

7.6. Endocrine Function. Because stress hormones (cortisol, epinephrine, and norepinephrine) have a known influence on immune (and cardiovascular) functions, they are important factors on the pathway between R/S involvement and health [455, 456]. We identified 31 studies that examined R/S and associations with or effects on endocrine functions. Of those, 23 (74%) reported positive relationships or positive effects and no studies reported negative associations or negative effects. Of the 13 methodologically most rigorous studies, nine (69%) reported positive associations with R/S [457–461] or positive effects of an R/S intervention (all involving Eastern meditation) [462–465]. We (at Duke) are currently examining the effects of religious cognitive-behavioral therapy on a host of pro- and anti-inflammatory cytokines, cortisol, and catecholamines in patients with major depressive disorder, although results will not be available until 2014 [466].

7.7. Cancer. At least 29 studies have examined relationships between R/S and either the onset or the outcome of cancer (including cancer mortality). Of those, 16 (55%) found that those who are more R/S had a lower risk of

developing cancer or a better prognosis, although two (7%) reported a significantly worse prognosis [467, 468]. Of the 20 methodologically most rigorous studies, 12 (60%) found an association between R/S and lower risk or better outcomes [469–480], and none reported worse risk or outcomes. The results from some of these studies can be partially explained by better health behaviors (less cigarette smoking, alcohol abuse, etc.), but not all. Effects not explained by better health behaviors could be explained by lower stress levels and higher social support in those who are more R/S. Although cancer is not thought to be as sensitive as cardiovascular disorders to psychosocial stressors, psychosocial influences on cancer incidence and outcome are present (discussions over this are ongoing [481, 482]).

7.8. Physical Functioning. Ability to function physically, that is, performing basic and instrumental activities of daily living such as toileting, bathing, shopping, and using a telephone, is a necessary factor for independent living. Persons who are depressed, unmotivated, or without hope are less likely to make attempts to maintain their physical functioning, particularly after experiencing a stroke or a fall that forces them into a rehabilitation program to regain or compensate for their losses. Several studies have examined the role that R/S plays in helping people to maintain physical functioning as they grow older or regain functioning after an illness. We identified 61 quantitative studies that examined relationships between R/S and disability level or level of functioning. Of those, 22 (36%) reported better physical functioning among those who were more R/S, 14 (23%) found worse physical functioning, and six studies reported mixed findings. Considering the 33 highest quality studies, 13 (39%) reported significantly better physical functioning among those who were more R/S (including one study at a trend level) [483–495], six (18%) found worse functioning [496–501], and five studies (15%) reported mixed results [82, 124, 502–504] (significant positive and negative associations, depending on R/S characteristic). Almost all of these studies involve self-reported disability and many were cross-sectional, making it impossible to determine order of causation—that is, (1) does R/S prevent the development of disability, (2) does disability prevent R/S activity, (3) does R/S promote disability, or (4) does disability cause people to turn to religion to cope with disability.

7.9. Self-Rated Health. There is more agreement across studies regarding the relationship between R/S and self-rated health (SRH) than between R/S and physical functioning. While based on participants' subjective impression, self-rated health is strongly related to objective health, that is, future health, health services use, and mortality [505–507]. Might R/S, perhaps because it is related to greater optimism and hope, influence one's self-perceptions of health in a positive way? At least 50 studies have now examined the relationship between R/S and self-rated health. Of those, 29 (58%) reported that R/S was related to better SRH, while five (10%) found that it was related to worse SRH. Of the 37 methodologically most rigorous studies, 21 (57%) reported significant positive relationships between R/S and SRH [503, 508–527], whereas three (8%) found the opposite [528–530].

7.10. Pain and Somatic Symptoms. On the one hand, pain and other distressing somatic symptoms can motivate people to seek solace in religion through activities such as prayer or Scripture study. Thus, R/S is often turned to in order to cope with such symptoms. For example, in an early study of 382 adults with musculoskeletal complains, R/S coping was the most common strategy for dealing with pain and was considered the second most helpful in a long list of coping behaviors [531]. More recent research supports this earlier report [532]. On the other hand, R/S may somehow cause an increase in pain and somatic symptoms, perhaps by increasing concentration on negative symptoms or through the physical manifestations of hysteria, as claimed by Charcot in his copious writings around the turn of the 20th century [533].

We identified 56 studies that examined relationships between R/S and pain. Of those, 22 (39%) reported inverse relationships between R/S and pain or found benefits from an R/S intervention, whereas 14 (25%) indicated a positive relationship between R/S and greater pain levels (13 of 14 being cross-sectional). Of the 18 best studies, nine (50%) reported inverse relationships (less pain among the more R/S [534] or reduced pain in response to a R/S intervention [535–542]), while three (20%) reported positive relationships (worse pain in the more R/S) [543–545]. Research suggests that meditation is particularly effective in reducing pain, although the effects are magnified when a religious word is used to focus attention [546, 547]. No clinical trials, to my knowledge, have shown that meditation or other R/S interventions increase pain or somatic symptoms.

7.11. Mortality. The most impressive research on the relationship between R/S and physical health is in the area of mortality. The cumulative effect of R/S, if it has any benefits to physical health, ought to reveal itself in an effect on mortality. The research suggests it does. At least 121 studies have examined relationships between R/S and mortality. Most of these are prospective cohort studies, where baseline R/S is assessed as a predictor of mortality during the observation period, controlling for confounders. Of those studies, 82 (68%) found that greater R/S predicted significantly greater longevity (three at a trend level), whereas six studies (5%) reported shorter longevity. Considering the 63 methodologically most rigorous studies (quality ratings of 8 or higher), 47 (75%) found R/S predicting greater longevity (two at trend level) [548–566], whereas three (5%) reported shorter longevity [567–569]. Another systematic review [570] and two meta-analyses [571, 572] have confirmed this relationship between R/S and longer survival. The effects have been particularly strong for frequency of attendance at religious services in these three reviews. Survival among frequent attendees was increased on average by 37%, 43%, and 30% (mean effect being 37% across these reviews). An increased survival of 37% is highly significant and equivalent to the

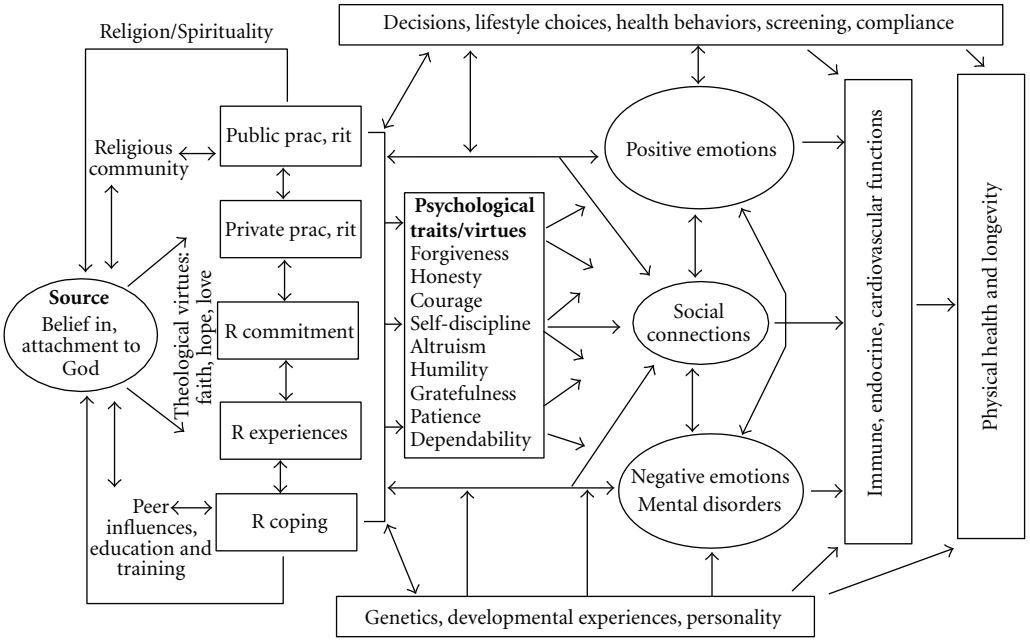

Figure 3: Theoretical model of causal pathways to physical health for Western monotheistic religions (Christianity, Islam, and Judaism). (Permission to reprint obtained. Original source: Koenig et al. [17]). For models based on Eastern religious traditions and the Secular Humanist tradition, see elsewhere (Koenig et al. [24]).

effects of cholesterol lowering drugs or exercise-based cardiac rehabilitation after myocardial infarction on survival [573].

8. Explaining the Relationship: R/S and Physical Health

How might R/S involvement influence physical health and longevity? There are at least three basic pathways: psychological, social, and behavioral (see Figure 3).

8.1. Psychological. As noted above, there is ample evidence that R/S—because it facilitates coping and imbues negative events with meaning and purpose—is related to better mental health (less depression, lower stress, less anxiety, greater well-being, and more positive emotions). Furthermore, several randomized clinical trials have shown that R/S interventions improve mental health (at least in those who are R/S). There is also much evidence that poor mental health has adverse physiological consequences that worsen physical health and shorten the lifespan (see earlier references). Thus, it stands to reason that R/S might influence physical health through psychological pathways.

8.2. Social. R/S involvement is associated with greater social support, greater marital stability, less crime/delinquency, and greater social capital. R/S beliefs and doctrines encourage the development of human virtues such as honesty, courage, dependability, altruism, generosity, forgiveness, self-discipline, patience, humility, and other characteristics that promote social relationships. Participation in a R/S community not only provides supportive social connections and opportunities for altruism (through volunteering or other faith-based altruistic activities), but also increases the flow of health information that may increase disease screening and promote health maintenance. Social factors, in turn, are known to influence both mental health and physical health and predict greater longevity [574–576]. Again, if R/S boosts supportive social interactions and increases community trust and involvement, then it should ultimately influence physical health as well.

8.3. Health Behaviors. Finally, R/S promotes better health behaviors, and is associated with less alcohol and drug use, less cigarette smoking, more physical activity and exercise, better diet, and safer sexual practices in the overwhelming majority of studies that have examined these relationships. Living a healthier lifestyle will result in better physical health and greater longevity. Consider the following report that appeared on CNN (Cable Network News). On January 3, 2009, after the death of the Guinness Book of World Records' oldest person, Maria de Jesus age 115, next in line was Gertrude Baines from Los Angeles. Born to slaves near Atlanta in 1894, she was described at 114 years old as "spry," "cheerful," and "talkative." When she was 112 years old, Ms. Baines was asked by a CNN correspondent to explain why she thought she had lived so long. Her reply: "God. Ask Him. I took good care of myself, the way he wanted me to." Brief and to the point.

8.4. Other Pathways. There are many ways by which R/S could have a positive influence on physical health, although the pathways above are probably the major ones. Genetic

and developmental factors could also play a role in explaining these associations. There is some evidence that personality or temperament (which has genetic roots) influences whether or not a person becomes R/S. To what extent R/S persons are simply born healthier, however, is quite controversial. Note that more R/S persons are typically those with the least resources (minority groups, the poor, and the uneducated), both in terms of finances and access to healthcare resources. Karl Marx said that religion is the "opiate of the masses." Rather than being born healthier, then, the opposite is more likely to be true for R/S persons. R/S could actually be viewed as acting counter to an evolutionary force that is trying to weed genetically vulnerable people from the population. R/S involvement is providing the weak with a powerful belief system and a supportive community that enables them to survive. For a more complete discussion of the role of genetic factors in the R/S-physical health relationship, see the *Handbook* [577].

Another important point needs to be made. Nowhere do I claim that supernatural mechanisms are responsible for the relationship between R/S and health. The pathways by which R/S influences physical health that researchers can study using the natural methods of science must be those that exist within nature—that is, psychological, social, behavioral, and genetic influences. Thus, this research says nothing about the existence of supernatural or transcendent forces (which is a matter of faith), but rather asks whether belief in such forces (and the behaviors that result from such beliefs) has an effect on health. There is every reason to think it does.

9. Clinical Implications

There are clinical implications from the research reviewed above that could influence the way health professionals treat patients in the hospital and clinic.

9.1. Rationale for Integrating Spirituality. There are many practical reasons why addressing spiritual issues in clinical practice is important. Here are eight reasons [578] (and these are not exhaustive).

First, many patients are R/S and have spiritual needs related to medical or psychiatric illness. Studies of medical and psychiatric patients and those with terminal illnesses report that the vast majority have such needs, and most of those needs currently go unmet [579, 580]. Unmet spiritual needs, especially if they involve R/S struggles, can adversely affect health and may increase mortality independent of mental, physical, or social health [581].

Second, R/S influences the patient's ability to cope with illness. In some areas of the country, 90% of hospitalized patients use religion to enable them to cope with their illnesses and over 40% indicate it is their primary coping behavior [582]. Poor coping has adverse effects on medical outcomes, both in terms of lengthening hospital stay and increasing mortality [583].

Third, R/S beliefs affect patients' medical decisions, may conflict with medical treatments, and can influence compliance with those treatments. Studies have shown that R/S beliefs influence medical decisions among those with serious medical illness [584, 585] and especially among those with advanced cancer [586] or HIV/AIDs [587].

Fourth, physicians' own R/S beliefs often influence medical decisions they make and affect the type of care they offer to patients, including decisions about use of pain medications [588], abortion [589], vaccinations [590], and contraception [591]. Physician views about such matters and how they influence the physician's decisions, however, are usually not discussed with a patient.

Fifth, as noted earlier, R/S is associated with both mental and physical health and likely affects medical outcomes. If so, then health professionals need to know about such influences, just as they need to know if a person smokes cigarettes or uses alcohol or drugs. Those who provide health care to the patient need to be aware of all factors that influence health and health care.

Sixth, R/S influences the kind of support and care that patients receive once they return home. A supportive faith community may ensure that patients receive medical followup (by providing rides to doctors' offices) and comply with their medications. It is important to know whether this is the case or whether the patient will return to an apartment to live alone with little social interaction or support.

Seventh, research shows that failure to address patients' spiritual needs increases health care costs, especially toward the end of life [592]. This is a time when patients and families may demand medical care (often very expensive medical care) even when continued treatment is futile. For example, patients or families may be praying for a miracle. "Giving up" by withdrawing life support or agreeing to hospice care may be viewed as a lack of faith or lack of belief in the healing power of God. If health professionals do not take a spiritual history so that patients/families feel comfortable discussing such issues openly, then situations may go on indefinitely and consume huge amounts of medical resources.

Finally, standards set by the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) and by Medicare (in the US) require that providers of health care show respect for patients' cultural and personal values, beliefs, and preferences (including religious or spiritual beliefs) [593]. This point was reinforced by a personal communication with Doreen Finn (dfinn@jointcommission.org), Senior Associate Director, who works under Mark Pelletier (mpelletier@jointcommission.org), Executive Director, JCAHO, Hospital Accreditation (January 6–12, 2012). If health professionals are unaware of those beliefs, they cannot show respect for them and adjust care accordingly.

9.2. How to Integrate Spirituality into Patient Care. What would I recommend in terms of addressing spiritual issues in clinical care?

First and foremost, health professionals should take a brief spiritual history. This should be done for all new patients on their first evaluation, especially if they have serious or chronic illnesses, and when a patient is admitted to a hospital, nursing home, home health agency, or other health care setting. The purpose is to learn about (1) the

patient's religious background, (2) the role that R/S beliefs or practices play in coping with illness (or causing distress), (3) beliefs that may influence or conflict with decisions about medical care, (4) the patient's level of participation in a spiritual community and whether the community is supportive, and (5) any spiritual needs that might be present [594]. It is the *health professional*, not the chaplain, who is responsible for doing this two-minute "screening" evaluation. If spiritual needs are discovered, then the health professional would make a referral to pastoral care services so that the needs can be addressed. The spiritual history (and any spiritual needs addressed by pastoral services) should be documented in the medical record so that other health professionals will know that this has been done. Although notes need not be detailed, enough information should be recorded to communicate essential issues to other hospital staff.

Ideally, the physician, as head of the medical care team, should take the spiritual history. However, since only about 10% of physicians in the US "often or always" do so [595], the task often falls to the nurse or to the social worker. Although systematic research is lacking in this area, most nurses and social workers do not take a spiritual history either. Simply recording the patient's religious denomination and whether they want to see a chaplain, the procedure in most hospitals today, is NOT taking a spiritual history.

Second, R/S beliefs of patients uncovered during the spiritual history should always be respected. Even if beliefs conflict with the medical treatment plan or seem bizarre or pathological, the health professional should not challenge those beliefs (at least not initially), but rather take a neutral posture and ask the patient questions to obtain a better understanding of the beliefs. Challenging patients' R/S beliefs is almost always followed by resistance from the patient, or quiet noncompliance with the medical plan. Instead, the health professional should consult a chaplain and either follow their advice or refer the patient to the chaplain to address the situation. If the health professional is knowledgeable about the patient's R/S beliefs and the beliefs appear generally healthy, however, it would be appropriate to actively support those beliefs and conform the healthcare being provided to accommodate the beliefs.

Third, most health professionals without clinical pastoral education do not have the skills or training to competently address patients' spiritual needs or provide advice about spiritual matters. Chaplains have extensive training on how to do this, which often involves years of education and experience addressing spiritual issues. They are the true experts in this area. For any but the most simple spiritual needs, then, patients should be referred to chaplains to address the problem.

Fourth, conducting a spiritual history or contemplating a spiritual intervention (supporting R/S beliefs, praying with patients) should always be patient centered and patient desired. The health professional should never do anything related to R/S that involves coercion. The patient must feel in control and free to reveal or not reveal information about their spiritual lives or to engage or not engage in spiritual practices (i.e., prayer, etc.). In most cases, health professionals should not ask patients if they would like to pray with them, but rather leave the initiative to the patient to request prayer. The health professional, however, may inform R/S patients (based on the spiritual history) that they are open to praying with patients if that is what the patient wants. The patient is then free to initiate a request for prayer at a later time or future visit, should they desire prayer with the health professional. If the patient requests, then a short supportive prayer may be said aloud, but quietly, with the patient in a private setting. Before praying, however, the health professional should ask the patient what he or she wishes prayer for, recognizing that every patient will be different in this regard. Alternatively, the clinician may simply ask the patient to say the prayer and then quietly confirm it with an "amen" at the end.

Fifth, R/S beliefs of health professionals (or lack of belief) should not influence the decision to take a spiritual history, respect and support the R/S beliefs of patients, or make a referral to pastoral services. These activities should always be patient centered, not centered on the health professional. One of the most common barriers to addressing spiritual issues is health professionals' discomfort over discussing such issues. This often results from lack of personal R/S involvement and therefore lack of appreciation for the importance and value of doing so. Lack of comfort and understanding should be overcome by training and practice. Today, nearly 90% of medical schools (and many nursing schools) in the US include something about R/S in their curricula [596] and this is also true to a lesser extent in the United Kingdom [597] and Brazil [598]. Thus, spirituality and health is increasingly being addressed in medical and nursing training programs.

Sixth, health professionals should learn about the R/S beliefs and practices of different religious traditions that relate to healthcare, especially the faith traditions of patients they are likely to encounter in their particular country or region of the country. There are many such beliefs and practices that will have a direct impact on the type of care being provided, especially when patients are hospitalized, seriously ill or near death. A brief description of beliefs and practices for health professionals related to birth, contraception, diet, death, and organ donation is provided elsewhere [599].

Finally, if spiritual needs are identified and a chaplain referral is initiated, then the health professional making the referral is responsible for following up to ensure that the spiritual needs were adequately addressed by the chaplain. This is especially true given the impact that unmet spiritual needs are likely to have on both medical outcomes and healthcare costs. Given the short lengths of stay in today's modern hospital (often only 2–4 days), spiritual needs identified on admission are unlikely to be resolved by discharge. Therefore, a spiritual care discharge plan will need to be developed by the hospital social worker in consultation with the chaplain, which may involve (with the patient's written consent) contact with the patient's faith community to ensure that spiritual needs are addressed when the patient returns home. In this way, continuity of pastoral care will be ensured between hospital and community.

10. Conclusions

Religious/spiritual beliefs and practices are commonly used by both medical and psychiatric patients to cope with illness and other stressful life changes. A large volume of research shows that people who are more R/S have better mental health and adapt more quickly to health problems compared to those who are less R/S. These possible benefits to mental health and well-being have physiological consequences that impact physical health, affect the risk of disease, and influence response to treatment. In this paper I have reviewed and summarized hundreds of quantitative original data-based research reports examining relationships between R/S and health. These reports have been published in peer-reviewed journals in medicine, nursing, social work, rehabilitation, social sciences, counseling, psychology, psychiatry, public health, demography, economics, and religion. The majority of studies report significant relationships between R/S and better health. For details on these and many other studies in this area, and for suggestions on future research that is needed, I again refer the reader to the *Handbook of Religion and Health* [600].

The research findings, a desire to provide high-quality care, and simply common sense, all underscore the need to integrate spirituality into patient care. I have briefly reviewed reasons for inquiring about and addressing spiritual needs in clinical practice, described how to do so, and indicated boundaries across which health professionals should not cross. For more information on how to integrate spirituality into patient care, the reader is referred to the book, *Spirituality in Patient Care* [601]. The field of religion, spirituality, and health is growing rapidly, and I dare to say, is moving from the periphery into the mainstream of healthcare. All health professionals should be familiar with the research base described in this paper, know the reasons for integrating spirituality into patient care, and be able to do so in a sensible and sensitive way. At stake is the health and well-being of our patients and satisfaction that we as health care providers experience in delivering care that addresses the whole person—body, mind, and spirit.

Conflict of Interests

The author declares that he has no conflict of interests.

Acknowledgment

The support to write this paper was provided in part by the John Templeton Foundation.

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