

# Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice

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**Abstract:** A growing body of scientific research suggests connections between religion, spirituality, and both mental and physical health. The findings are particularly strong in patients with severe or chronic illnesses who are having stressful psychologic and social changes, as well as existential struggles related to meaning and purpose. Recent studies indicate that religious beliefs influence medical decisions, such as the use of chemotherapy and other life-saving treatments, and at times may conflict with medical care. This article addresses the ways physicians can use such information. Spirituality is an area that makes many physicians uncomfortable, since training in medical schools and continuing medical education programs are limited. Not only do most physicians lack the necessary training, they worry about spending additional time with patients and overstepping ethical boundaries. While these concerns are valid, each can be addressed in a sensible way. Taking a spiritual history, supporting the patient's beliefs, and orchestrating the fulfillment of spiritual needs are among the topics this article will address. The goal is to help physicians provide medical care that is sensitive to the way many patients understand and cope with medical illness.

**Key Words:** mental and physical health, religion, spiritual needs

Religious beliefs and practices are common among patients seeking medical care, and even those who indicate that they are not religious often identify themselves as being spiritual in some way.<sup>1</sup> Spirituality is more individualistic and self-determined, whereas religion typically involves connections to a community with shared beliefs and rituals. Because of the heavy overlap between religiosity and spirituality (nearly 90% of medical patients consider themselves both religious and spiritual), these two terms will be used interchangeably in this article. When it comes to discussing such matters with patients, it is probably best to use the term spirituality because of its broad and inclusive nature, which

allows the patient to interpret the meaning for himself or herself. However, when discussing the research, it is necessary to be more precise. Most of the work done thus far has focused on religion because there is more agreement about its meaning, and it is associated with behaviors that can be quantified.

Why are many patients religious? One reason is because religion is so widespread in the United States, particularly in the South.<sup>2</sup> Religious belief, membership, importance, and attendance are prevalent and steadily increase with age. Since most patients with serious or chronic health problems are older, it is not surprising that many are religious. There is also a considerable gap between patients' and physicians' levels of religiosity.<sup>3,4</sup>

A second reason why religion is so common among medical patients is that as people become ill, they experience stress over the changes in life that illness causes. Many who were not religious previously may turn to religion for comfort. Whether it is as a new method of coping or a lifelong belief, religion becomes increasingly important as patients face the Goliath of illness. Those who seek comfort in religion approach it in many ways. In the United States, this often involves belief in a loving and caring God, private religious activities (such as prayer and meditation), reading religious scriptures for direction and encouragement, or looking for support from a pastor or members of a faith community.

Systematic studies of religious coping in medical settings document the high proportion of patients who depend on religious beliefs and practices to cope with health problems. In a study of 337 patients who were consecutively admitted to the general medicine, cardiology, and neurology services of Duke University Medical Center in North Carolina, nearly

## Key Points

- Research is increasingly demonstrating a relation between religion/spirituality and health.
- Physicians should be aware of this research and understand its clinical implications.
- It is recommended that a brief spiritual history be taken from all patients with serious or chronic illness.
- If spiritual issues are present, referral to chaplains or other spiritual care experts is recommended.

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90% reported using religion to some degree to cope, and more than 40% indicated that it was the most important factor that kept them going.<sup>5</sup> More than 60 studies have now examined the role that religion plays in helping patients cope with such diverse medical conditions as arthritis, diabetes, kidney disease, cancer, heart disease, lung disease, HIV/AIDS, cystic fibrosis, sickle cell anemia, amyotrophic lateral sclerosis, chronic pain, and severe or terminal illness as an adolescent.<sup>6</sup>

Patients in these studies commonly report that religious beliefs and practices are powerful sources of comfort, hope, and meaning, particularly in coping with a medical illness. As noted above, this is particularly true for patients with certain disorders that are characterized by their chronic nature, extent of disability, or poor prognosis. There are also special populations for whom religion appears particularly relevant, including the elderly, women, and ethnic minorities (for example, blacks and Hispanics).<sup>7</sup> The next question is whether religious beliefs and practices are actually effective in helping people to cope. During most of the 20th century, the answer given by prominent mental health professionals was "No." At best, religion was viewed as irrelevant to health; at worst, it was seen as emotionally unhealthy and a symptom or cause of neurosis.<sup>8,9</sup>

## Religion, Well-being, and Mental Health

However, when researchers began to systematically study the consequences of religious beliefs and practices, they found quite different results. Even before the year 2000, more than 700 studies examined the relation between religion, well-being, and mental health. Instead of documenting neurosis, nearly 500 of those studies demonstrated a significant positive association with better mental health, greater well-being, or lower substance abuse.<sup>10</sup> This included a number of randomized, clinical trials involving treatments for depression, anxiety, and bereavement, with the majority finding that religious therapies have faster results than secular therapies in religious patients.

Not only were religious beliefs and practices associated with significantly less depression and faster recovery from depression (60 of 93 studies), lower suicide rates (57 of 68), less anxiety (35 of 69), and less substance abuse (98 of 120), they were also associated with greater well-being, hope, and optimism (91 of 114), more purpose and meaning in life (15 of 16), greater marital satisfaction and stability (35 of 38),

and higher social support (19 of 20). This was particularly true for those who were more functionally disabled.<sup>11-13</sup> Between the years 2000 and 2002, more than 1,100 additional articles, studies, and reviews involving religion, spirituality, and mental health appeared in psychologic literature, compared with 101 articles between 1980 and 1982, suggesting a remarkable 11-fold increase in attention paid to this area by the scientific community.<sup>14</sup>

## Religion and Physical Health

Because religious beliefs and practices help patients to cope better with their illnesses, enhance their social support, and help them to avoid self-destructive behaviors such as substance abuse, it is important to understand how religion influences physical health through psychologic, social, and behavioral pathways. The effects of psychosocial stress on physiologic functioning and health-related quality of life

are increasingly well-documented.<sup>15,16</sup> If increased religiosity reduces stress levels and enhances social support, then it ought to also affect physical health. Although much research must be done to clarify this relation, there is growing evidence that religiosity may benefit patients' physical health through its positive effects on their mental health.

A summary of the research on physical health outcomes before the year 2000 (no systematic review has been done of the research after 2000) produces the following<sup>10</sup>: religious beliefs and activities have been associated with better immune func-

tion (5 of 5 studies); lower death rates from cancer (5 of 7); less heart disease or better cardiac outcomes (7 of 11); lower blood pressure (14 of 23); lower cholesterol (3 of 3); and better health behaviors (23 of 25, less cigarette smoking; 3 of 5, more exercise; 2 of 2, better sleep). In addition, in studies of mortality, 39 of 52 (75%) found that religious persons live significantly longer (including at least two prospective studies involving follow-ups of 23 and 31 years).<sup>17,18</sup> The effect for regular religious attendance on longevity approximates that of not smoking cigarettes (especially in women),<sup>19</sup> adding an additional 7 years to the lifespan (14 years for blacks).<sup>20</sup>

## Impact of Religion on Health Care

Besides the overall positive association between religiosity, mental health, and physical health, religion also influences factors that directly affect the delivery of health care.

### Religious beliefs and practices are associated with

- Lower suicide rates
- Less anxiety
- Less substance abuse
- Less depression and faster recovery from depression
- Greater well-being, hope, and optimism
- More purpose and meaning in life
- Higher social support
- Greater marital satisfaction and stability

These factors fall into four major categories: medical decision-making, beliefs that conflict with medical care, spiritual struggles that create stress and impair health outcomes, and disease detection and treatment compliance.

### Medical decision making

There is growing evidence that religious beliefs influence patients' medical decisions. A study of patients visiting the University of Pennsylvania's pulmonary disease clinic reported that 66% of patients indicated that religious beliefs would influence their medical decision-making should they become seriously ill; 80% of this sample said that they would be receptive to inquiries about their religious beliefs.<sup>21</sup> More recently, the *Journal of Clinical Oncology* published a survey of 100 patients with advanced lung cancer, their caregivers, and 257 medical oncologists attending the annual meeting of the American Society of Clinical Oncology.<sup>22</sup> In this study, investigators asked participants to rank the importance of the following 7 factors that might influence chemotherapy treatment decisions: oncologist's recommendation, faith in God, ability of treatment to cure the disease, side effects, family doctor's recommendation, spouse's recommendation, and children's recommendation. All three groups (patients, family, and physicians) ranked recommendation of patients' oncologist as No. 1. However, although patients and family members both ranked faith in God as No. 2, oncologists ranked faith in God last (7th). This study suggests that health professionals often underestimate the role that religious beliefs play in coping and the influence they have on patients' medical decisions. Decisions concerning withdrawal of life support or do-not-resuscitate orders are also made by patients and families on the basis of religious beliefs, although these beliefs are seldom discussed with doctors.

### Beliefs conflicting with medical care

Religious beliefs, particularly in deeply religious areas of the country, may conflict with treatments prescribed by the physician. The most commonly known conflict, and perhaps the simplest when it involves adults, is the conviction of Jehovah's Witnesses not to accept blood products.<sup>23</sup> Another example is belief by adult Christian Scientists or members of the Orthodox Reformed church against taking antibiotics or receiving immunizations.<sup>24</sup> These conflicts become more complex when they involve children.<sup>25</sup> Certain Christian groups may also have beliefs against taking drugs or receiving medical procedures, preferring rather to pray for healing or perform other religious rituals.

The most well-known case is that of Faith Assembly in Indiana. The members of this religious group practice out-of-hospital, nonphysician-attended birthing and do not seek prenatal care. Investigators compared maternal and perinatal mortality in the counties where members of Faith Assembly live with that of other Indiana counties during the same period.<sup>26</sup> They found that perinatal mortality among Faith Assembly children was 48 in 1,000 births compared with 18 in 1,000 live births for the state (3:1 ratio,  $P < 0.01$ ). The difference in maternal mortality rate was even higher: 872 in 100,000 births versus 9 in 100,000 births in rest of the state (100:1 ratio,  $P < 0.001$ ). After this study was published, the Indiana General Assembly passed a law requiring the reporting of withholding of medical care. Over the next 3 years, perinatal mortality rate declined by nearly one half, and maternal death was almost eliminated.<sup>27</sup>

The cases above are pretty straightforward. The situation gets more complicated when the individual patient has desires that conflict with the values of his or her faith community. For example, a depressed person may wish to take an anti-

depressant to bring them relief.

The pastor or other church members may feel strongly that the patient should pray, read the Bible, and lead a more wholesome Christian life, instead of taking medication. Beliefs concerning abortion, assisted suicide, or HIV infection may also conflict with the values of a patient's religious community, which may put pressure on the patient to behave in a certain way concerning medical treatment. These situations are difficult to deal with, since the patient and health care providers may become pitted against family and community supports.<sup>28</sup>

### Spiritual struggles

When patients are hospitalized with sudden medical illness or must endure chronic illness and disability, they often ask the question, "why me?" Then, as prayers for healing and relief go seemingly unanswered, they ask other questions. Is God punishing me for past sins? Does God even care about me? Does God even have the power to make a difference? Has my faith community deserted me? While such existential concerns are normal and to be expected in the short term, some patients get "stuck" in these spiritual struggles and without help are unable to resolve them on their own. The result is that they cannot rely on spiritual beliefs that might otherwise give them comfort and hope. Investigators followed a systematically identified sample of 444 medically ill, hospitalized patients for an average of 2 years after discharge.

#### Religion may

- Affect medical decision-making
- Generate beliefs that conflict with medical care
- Induce spiritual struggles that create stress and impair health outcomes
- Interfere with disease detection and treatment compliance

Those with spiritual struggles similar to the ones described above during their index hospital admission were significantly more likely to die during the follow-up period.<sup>29</sup> For every 1-point increase on a religious struggles scale (that ranged from 0 to 21), there was a 6% increase in mortality rate, an effect that was independent of physical health, social support, and psychologic status.

### Disease detection and treatment compliance

Since religiousness is associated with greater marital stability and more social support in general, the religious person has more persons around who are concerned about him or her. Having more social contacts results in greater monitoring and checking, including checking that the person is taking medication properly, seeking medical advice timely, and complying with whatever medical plan the doctor has ordered. Higher levels of social support resulting from contacts with relatives or friends have been associated with increased treatment compliance.<sup>30</sup> On the other hand, social isolation is a strong predictor of poor compliance due to lack of reminders and reduced motivation to comply.<sup>32</sup> Simply calling a patient on the telephone once a week to offer encouragement has been shown to predict better compliance.<sup>33</sup> Members of a faith community commonly make such contacts with those who are sick or having a difficult time.

Similarly, because religiousness is associated with greater hope, optimism, and meaning and purpose in life, religiously active persons are more likely to have a reason for living and getting better. In contrast, the depressed persons without hope may feel there is little reason to make an effort to comply with the treatment plan. It is not surprising, then, that depression is a strong predictor of poor self-care and treatment noncompliance.<sup>33</sup>

### What Do Physicians Need to Do?

Given the role religious beliefs play in successful coping and recovery, the negative impact that religious struggles can have on health outcomes, and the effects of religious belief on medical decisions, willingness to receive treatment, disease detection, and treatment compliance, there are plenty of reasons why doctors should know about their patients' religion and its effect on their health and medical care. So what should physicians do?

First and foremost, physicians should take a brief spiritual history and document this in the medical record.<sup>34</sup> Questions asked during a spiritual history include the following: (1) Are religious beliefs a source of comfort or a cause of

stress? (2) Are religious beliefs in conflict with medical care? (3) Are there religious beliefs that might influence medical decisions (and how)? (4) Is there a supportive faith community likely to check on and monitor the patients' recovery? (5) Are there any other spiritual needs that need to be addressed?<sup>6</sup>

This information may be collected over several visits or all at one time as part of the social history. The best times are at the time of hospital admission, during a new patient evaluation, or as part of a well-person check up. Studies have shown that a brief spiritual history adds only 1 or 2 minutes to the visit. The resulting information learned and the effect on the doctor-patient relationship, in terms of building trust, make this extra time well spent.<sup>28</sup>

What does the physician do with the information thus learned? If religious beliefs help the patient to cope, then it is appropriate to encourage and support the patient's beliefs and orchestrate the meeting of spiritual needs, including necessary referrals to chaplain services or pastoral care.<sup>35</sup> If patients are experiencing stress due to religious or spiritual conflict, referral to a chaplain or pastoral care professional is appropriate, since offering spiritual advice or trying to solve the patient's spiritual struggles is beyond the range of most physicians' expertise unless they have received special training to do so.<sup>36</sup>

Though controversial, a short prayer may provide comfort and relieve stress. Prayer between a physician and patient would seem appropriate if the patient is religious, if the patient requests prayer, if the physician and patient are from the same religious

background, and if the situation is serious and warrants prayer.<sup>28</sup> The doctor should also feel comfortable about praying. If not, then the physician should call for a chaplain or ask the patient or a family member to lead the prayer and then sit quietly while the prayer is being said, perhaps holding the patient's hand. The goal of this activity is to provide comfort and communicate caring.

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### Why Don't Physicians Do It?

Studies have shown that even in the southern United States, where religion is the most prevalent, less than 10% of physicians regularly address spiritual issues.<sup>37</sup> A number of barriers exist that prevent doctors from doing so: They don't know the reasons for doing this, they don't feel comfortable doing it, they don't feel they have the time to do it, and they are concerned about overstepping boundaries.

#### Don't know why

Already stressed by increasing clinical and administrative responsibilities, most doctors don't know why they should

#### Reasons physicians don't regularly address spiritual issues:

- They are unaware of the reasons time and energy should be expended to address spiritual issues.
- They don't feel comfortable doing it.
- They don't feel they have the time.
- They are concerned about overstepping boundaries.

expend energy and time to deal with these issues. Lacking training in medical school and rarely exposed to CME programs on the role of spirituality in patient care, most physicians are not familiar with the recent explosion of research in this area, the important role that religious and spiritual beliefs play in coping with illness, the ways that religion can affect health care, or the effect that addressing spiritual concerns may have on the doctor-patient relationship. They are also not aware of the role the faith community plays in providing support, care, encouragement, and practical help to patients recovering from illness, nor do they understand the key role that religious organizations can play in early disease detection and health maintenance, especially for ethnic communities plagued by huge health disparities.

### **Don't feel comfortable**

Most physicians feel uneasy about addressing spiritual issues. Not trained and lacking experience, unsure if patients would want this, and often feeling that religious or spiritual matters are the patient's own private business, they avoid the subject of spirituality all together. Being trained and educated in the scientific tradition, many physicians may not personally see much value in religion or spirituality, and talking about it with patients may stir up feelings of guilt or other conflicts related to their experiences with religion in the past. Some may be worried that patients might ask them about their own spirituality and they are not sure how to respond.

### **Don't have time**

Lack of time is a major factor in health care today. As reimbursement rates seem to be dropping, administrative and clinical responsibilities seem to be going up. As medical research advances, the amount of knowledge that physicians are responsible for is rapidly expanding. Because of increasing attention paid to medical errors and greater need to see more patients in less time, liability pressures are also escalating. On top of all this, completing paperwork as part of the business of medicine and haggling with insurance companies or Medicare over reimbursement seem to be taking more and more time. Where is there any room to take a spiritual history?

### **Don't want to go outside area of expertise**

Many physicians are concerned about overstepping their boundaries and delving into an area that they are not experts

in. Ministers and chaplains are seen as the spiritual care experts and therefore any spiritual issues are referred to them. Furthermore, physicians worry about imposing their own religious beliefs on patients and fear that making spiritual inquiries may be perceived as coercive.

## **Overcoming the Barriers**

While the above barriers might seem insurmountable, they are actually not as formidable as they might seem. Each of these concerns has a plausible solution.

### **Don't know why**

Lack of information can be corrected by education. Training in medical school (as more than 70 of 126 medical schools now have), attending CME courses (such as Harvard Medical School's Spirituality and Healing in Medicine course), and reading books<sup>28,38</sup> or articles in the medical literature<sup>35,39,40</sup> are

ways of becoming informed about the religion-health research, the role of religion in coping, the impact of religion on medical decisions, and the support that the religious community can provide to improve disease detection and compliance.

### **Don't feel comfortable**

Twenty years ago, most physicians felt uncomfortable taking a sexual history, and before that, asking about social relationships was seen as too personal. Now such questions are part of a standard medical history. Doctors overcame their discomfort by training and experience and by realizing how

important knowledge about a patient's social relationships and sexual activity was to providing adequate medical care. Similarly, the more often a spiritual history is taken, the easier and more natural it will feel.

### **Don't have time**

Time is a major factor, and as always, requires careful management to balance all responsibilities. Interestingly, however, lack of time is not the primary reason why doctors don't take a spiritual history or address spiritual issues. According to a physician survey in the St Louis, Missouri, area, lack of time was not a significant predictor of physicians addressing spiritual issues.<sup>37</sup> In fact, only 26% indicated that they did not have time to discuss religious issues with patients. In that survey, the only independent predictor of physician inquiry was interpersonal discomfort (eg, responding

### **Overcoming the barriers**

- Lack of information can be corrected by education.
- Doctors overcome their discomfort by training and experience and by realizing the importance of the spiritual history to providing adequate medical care.
- Time management may help to balance all priorities (lack of time, however, is not the primary reason doctors don't take a spiritual history or address spiritual issues).

“yes” to the statement, “I am uncomfortable addressing religious issues with patients”). Furthermore, a spiritual history doesn’t have to be taken on every patient at every visit. Part of a spiritual history may be taken on one occasion and completed on another visit. When time is short, a spiritual history may consist of a single question: “How are you doing spiritually? Any concerns or troubles in that area?”

### Don’t want to go outside area of expertise

Doctors are clearly not experts in addressing or resolving spiritual issues and should not attempt to do so. Taking a brief spiritual history to identify spiritual issues, however, doesn’t take much training or expertise—just as taking a sexual history doesn’t require that the physician be certified as a sex therapist. One study of 160 randomly selected primary care physicians in Illinois found that 69.4% disagreed with the statement, “Clergy only should address religious issues.”<sup>41</sup> The job of the physician is to identify problem areas that might affect medical care. If spiritual problems are identified, then trained experts (ie, chaplains) are brought in to address them, just as a cardiologist or neurologist would be consulted for complex cardiac or neurologic problems. The primary role of the physician is to ask the questions, become aware of the issues, and mobilize the resources necessary to address them. An encouraging word of support or a short prayer may also be helpful, depending on the circumstances and the religiousness of the patient. Again, none of these activities requires much expertise and most fall into the area of delivering compassionate, patient-centered care.

### Treating the Whole Person

The reason why physicians are being asked to inquire about and support patient spirituality is because doing so is part of whole person health care. Simply treating a medical diagnosis or a disease, without considering the person with the disease, is no longer acceptable. Patients are individuals with life stories, emotional reactions to illness, and social and family relationships that affect and are affected by illness. They are also people struggling with the meaning and purpose of their lives, confronting potentially dramatic changes in quality of life, independence, and well-being, changes that may bring them face to face with their own mortality. For many patients, these issues are mixed with existential and spiritual concerns, concerns that can have a direct impact on the acceptance of medical care and the recovery process.

Given the advances in this area over the past decade, physicians can no longer ignore the spiritual aspects of care. Nor are they able to ignore the spiritual aspects of delivering care. Constantly having to deal with life-and-death issues requires that the health care professional have a spiritual reserve to combat the enormous emotional drain that this can take. Without such spiritual resources, providers find that they have to distance themselves from patients to protect

themselves. That distance interferes with the doctor’s ability to be close to and care personally about the patient, which is one of the most important aspects of what it means to be a healer. Caring about the patient is also what gives joy and fulfillment to the practice of medicine and is why many of us chose this profession. Its absence, especially in this pressured health care environment, can rapidly lead to dissatisfaction, emotional exhaustion, and burnout. Practicing whole-person medicine is the best kind of care both for those who receive it and those who give it.

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In nothing do men more nearly approach the gods than in giving health to men.

—Cicero