Conference Overview

8:20-8:40

The Challenge and Opportunity

Center for Spirituality, Theology and Health

DukeMedicine

Conference Overview

8:20-8:40

- Focus on spiritual transformation
- What is "spiritual transformation"?
- How does one measure spiritual transformation?
- Challenges and opportunities
- Why the need to develop tools for applications
- Research driving the need for applications
- Structure of conference

What is "Spiritual Transformation"?

- Something that occurs during or after a crisis or traumatic event

- Sudden (or more gradual) change in:
  - world view
  - life values and goals
  - relationships
  - sense of self

- Change involves the Transcendent in some way (i.e., it is more than simply a psychological change or transformation)

Spiritual Transformation Scale

Spiritual Growth subscale (29-item)

1. Spirituality has become more important to me
2. My way of looking at life has changed to be more spiritual
3. Because of spiritual changes I've been through I've changed my priorities
4. I pay more attention to things that are spiritually important and forget about the little things
5. I pray or meditate more
6. I spend more time taking care of my spiritual needs
7. I more often experience life around me as spiritual
8. I have a stronger spiritual connection to other people
9. I have a stronger spiritual connection to nature
10. Spiritually I am like a new person
11. Taking care of my body has taken on spiritual meaning
12. My relationships with other people have taken on more spiritual meaning
13. I have a stronger sense of the Sacred (God, Higher Power, Allah, etc.) directing my life now
14. I more often express my spirituality
15. I spend more time thinking about spiritual questions
16. I more often think about how blessed I am
17. I have grown spiritually
18. I am more spiritually present in the moment
19. I take part in spiritual rituals more often
20. I more often pray for other people
21. My spirituality is now more deeply imbedded in my whole being
22. I am more receptive to spiritual care from others (ex: prayer, healing practices, etc.)
23. I more often look for a spiritual purpose for my life
24. I'm finding it more important to participate in a spiritual community

Spiritual Transformation Scale

Spiritual Decline subscale (11-item)

1. In some ways I am spiritually withdrawn from other people
2. My faith has been shaken and I am not sure what I believe
3. Spirituality seems less important to me now
4. In some ways I have shut down spiritually
5. In some ways I think I am spiritually lost
6. I feel I've lost some important spiritual meaning that I had before
7. My relationships with other people have lost spiritual meaning
8. I am more spiritually wounded
9. In some ways I am off my spiritual path
10. I more often think that I have failed in my faith
11. I am less interested in organized religion

Responses are on a to 7 scale from not at all true to true a great deal

Cole et al (2008). Assessing spiritual growth and spiritual decline following a diagnosis of cancer: reliability and validity of the Spiritual Transformation Scale. Psycho-Oncology 17:112-121

Challenges and Opportunities in Healthcare

- Aging population
- Caring for those with complex chronic illnesses
- HP has less time, more patients, decreased reimbursement, more difficulty getting reimbursed, increased documentation, increased hassle with insurance companies for medication approvals, etc.
- Spiritual needs arise during medical or psychiatric illness
- Resistance from providers and health institutions to take the time necessary to identify & address spiritual needs
- Increasing ethnic and religious diversity among patients, making it difficulty to address spiritual needs in person-centered way

Why Develop Spiritual Care Applications that Produce Spiritual Transformation?

- Spiritual transformation has potential to affect "health" in many ways
- Many patients are religious or spiritual, or at a minimum, are struggling with life's meaning and purpose when ill, and so have spiritual needs
- Patients often have acute needs that the health professional must address immediately – anxiety, panic, hopelessness, depression – with an activated autonomic nervous system indicating the stress response is present
- This setting represents fertile ground for a spiritual transformation that can ultimately affect ability to cope with illness, quality of life, and both mental & physical health outcomes, including physiological processes

Many Patients Have Spiritual Needs Related to Illness

In a multi-site study by Harvard investigators, 230 patients with advanced cancer were surveyed. Most (88%) considered religion to be at least somewhat important. However, 47% reported that their spiritual needs were minimally or not at all supported by their religious community and 72% said their spiritual needs were minimally or not at all supported by the medical system (doctors, nurses or chaplains). Furthermore, spiritual support provided by their medical team or religious communities was associated with significantly higher quality of life ($p=0.0003$) (Balboni et al, 2007).

Balboni et al. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. Journal of Clinical Oncology 25:555-560

Not Addressing Spiritual Needs is *Expensive*

Multi-site, prospective study of 345 patients with advanced cancer who were followed to their death. They found that intensive, expensive, futile life-prolonging care (mechanical ventilation or resuscitation in last week of life) was significantly more common among those with high levels of religious coping (Phelps et al, 2009).

Phelps et al. (2009). Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer JAMA 301 (11), 1140-1147

When these investigators examined who among those using religion to cope were using more expensive health services, they found that this was primarily among those whose spiritual needs were not being addressed by the medical team. Among high religious copers whose spiritual needs were to a large extent or completely supported (vs. not supported), the likelihood of receiving hospice increased 5-fold ($p<0.005$) and of receiving aggressive care towards the end of life decreased by 72% (range 21% to 96%) ($p=0.02$)

Balboni et al (2010). Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. Journal of Clinical Oncology 28:445-452

Very Expensive

Patients reporting that their religious/spiritual needs were inadequately supported by clinic staff were less likely to receive a week or more of hospice (54% vs 72.8%; P = .01) and more likely to die in an intensive care unit (ICU) (5.1% vs 1.0%, P = .03).

Among minorities and high religious coping patients, those reporting poorly supported religious/spiritual needs received more ICU care (11.3% vs 1.2%, P = .03 and 13.1% vs 1.6%, P = .02, respectively), received less hospice (43.% vs 75.3% ≥1 week of hospice, P = .01 and 45.3% vs 73.1%, P = .007, respectively), and had increased ICU deaths (11.2% vs 1.2%, P = .03 and 7.7% vs 0.6%, P = .009, respectively).

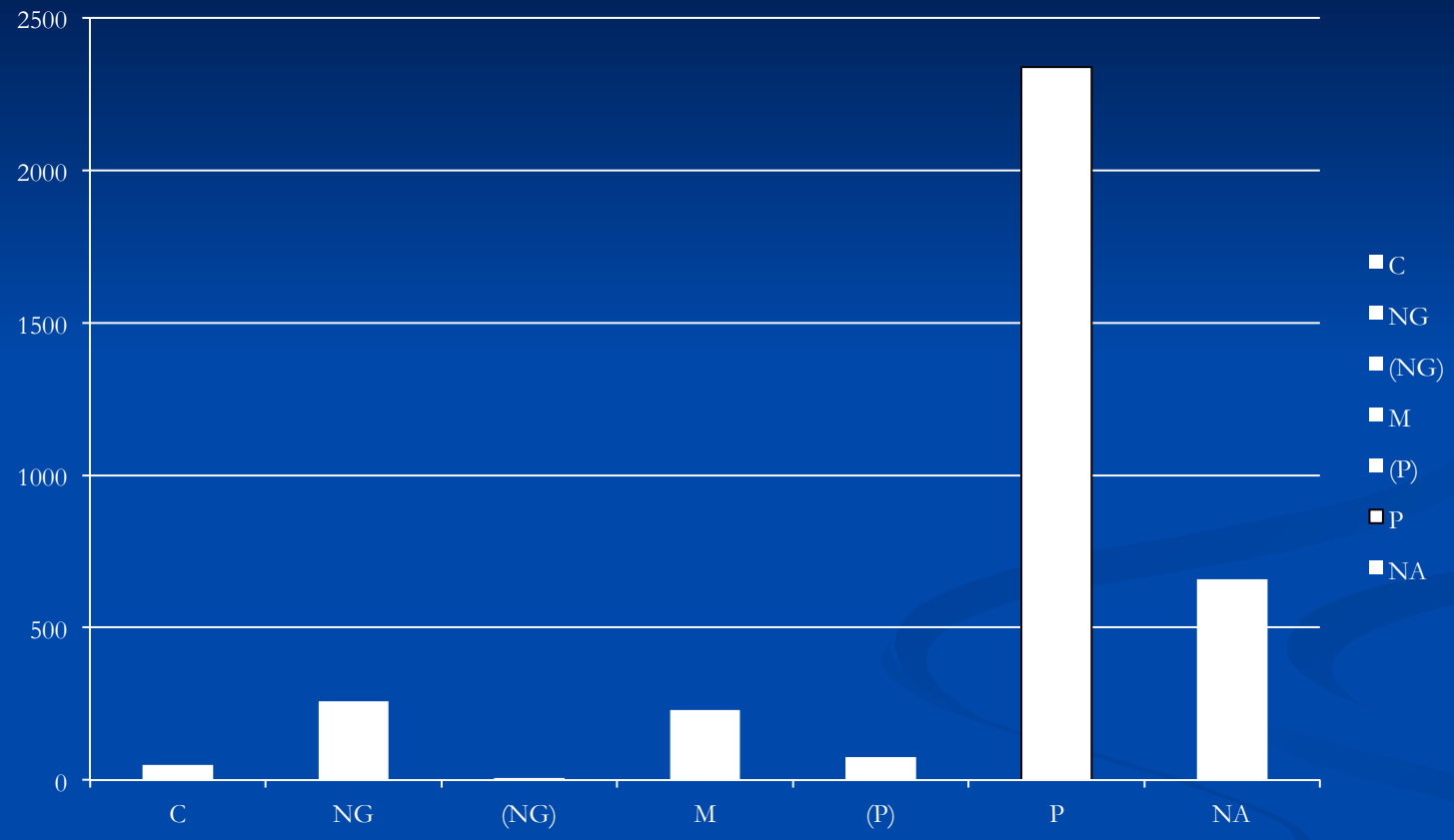
EOL costs were higher when patients reported that their spiritual needs were inadequately supported ($4947 vs. $2833), particularly among minorities ($6533 vs. $2276) and high religious copers ($6344 vs. $2431)

Balboni et al. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 117(23): 5383-5391

Research Driving the Applications

- There were 3,000 + quantitative studies as of 2010 examining religion/spirituality and mental health, social health, physical health, and medical outcomes, two-thirds showing better health among those who were more R/S
- Religious/spiritual interventions now being tested against usual care or conventional treatments
- Research provides clues for developing tools for application that may result in spiritual transformation

The Relationship between Religion and Health: All Studies



Number of studies includes some studies counted more than once (see Appendices of 1st and 2nd editions). Prepared by Dr. Wolfgang v. Ungern-Sternberg

It's time to do something with all this research!

Structure of Conference (unique)

- Focus on developing novel tools for assessing and addressing spiritual needs in clinical practice – "practice oriented"
- The "work groups" are the core around which conference has been developed (work groups to be formed at lunch TODAY)
- All presentations designed to feed work groups with information to help YOU develop tools for specific populations
- Aim is to produce interdisciplinary work groups (doctor, nurse, chaplain, counselor, social worker, psychologist, OT/PT, etc.)
- 4-8 work groups each focused on a different population (hospitalized patients, outpatients, mental health, addictions, palliative care, geriatrics, children, etc.)
- Friday presentations

Sessions Day by Day

Monday

- 8:40-11:45	Stephen Post (sp care interventions lead to ST)
- 11:45-1:30	Description & formation of Work Groups (all)
- 1:30-2:45	Post, Koenig, Group discussion
- 3:00-5:00	Mentors & Work Groups connect Work Groups develop spiritual care applications (with mentors)

Tuesday

- 8:00	Begins
- 8:30-11:30	Stephen W. Cole (physiology of transform exp)
- 11:30-12:00	Work Groups Discussion (all)
- 1:30-2:45	Peter Hill, Koenig, Group discussion
- 3:00-5:00	Work Groups develop spiritual care applications (with mentors)

Sessions Day by Day (cont)

Wednesday

- 8:00 Begins
- 8:20-10:30 Harold Koenig (spitual assess & interv to ST)
- 10:30-11:45 Doug C. Nies, PhD, medical actors
- 11:45-12:00 Work Groups Discussion (all)
- 1:00-4:15 Doug Nies, medical actors
- 4:15-5:00 Work Groups (with mentors)

Thursday

- 8:00 Beings
- 8:30-11:30 Robert A. Emmons, PhD (practical research)
- 11:30-12:00 Work Groups Discussion (all)
- 1:30-2:45 Harold Koenig (research designs & applications)
- 3:00-5:00 Work Groups (with mentors)

Sessions Day by Day (cont)

Friday

- 8:00	Begins
- 8:30-9:30	Emerging Vision (Abernethy, Berk, Koenig, Nelson, Nies, Tyson)
- 9:45-11:30	Work Group Presentations: Practical Solutions
- 1:00-2:10	Work Group Presentations: Practical Solutions
- 2:10-2:30	Next steps, networking, planning, evaluation (all)
- 2:30-3:30	Open discussion (all)
- 3:30	Goodbye!

And now, Dr. Stephen G. Post