Spiritual Care: Moving from Stress to Spiritual Transformation

8:20-10:30

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DukeMedicine

8:20-9:45

Overview

1. Definitions – spiritual vs. religious
2. The research base justifying Spiritual Care interventions
3. Understanding why is religion/spirituality is related to health
4. Clinical applications that address spiritual needs: The Duke - Adventist Health System Study
5. What is spiritual care?
6. Why aren't health professionals doing it?

From: **Spirituality in Patient Care (Templeton Foundation Press, 2013)**

Definitions


Spirituality
Religion

Sigmund Freud
Future of an Illusion, 1927

"Religion would thus be the universal obsessional neurosis of humanity... If this view is right, it is to be supposed that a *turning-away from religion is bound to occur with the fatal inevitability of a process of growth*… If, on the one hand, religion brings with it obsessional restrictions, exactly as an individual obsessional neurosis does, on the other hand *it comprises a system of wishful illusions together with a disavowal of reality, such as we find in an isolated form nowhere else but amentia, in a state of blissful hallucinatory confusion*…"

Definitions

Religion

Beliefs, practices, and rituals related to the Transcendent, where in Western traditions, the Transcendent is also called God, Allah, HaShem, or a Higher Power, and in Eastern traditions, the Transcendent is variously called Vishnu, Krishna, Buddha, or concepts such as Ultimate Truth or Reality. Religion may also involve beliefs about spirits, angels, demons, or other supernatural forces. Religions usually have doctrines about life after death and rules to guide behavior during the present life to prepare for the life to come. Religion is often organized as a community and maintained as an institution. Religion, however, can also exist outside of an institution, and may be practiced alone and involve private expressions of devotion to the Transcendent. At its core, religion involves an established tradition that arises out of a group of people with common beliefs about and rituals concerning the Transcendent.

Belief in God

	Believe	Absolutely Certain
National Total	92%	71%
Evangelical Protestant	99%	90%
Mormon	99%	90%
Mainline Protestant	97%	73%
Catholic	97%	72%
Muslim	92%	82%
Hindu	92%	57%
Jew	83%	41%
Buddhist	75%	39%

Source: Pew Religious Landscape Study (U.S.), 2007, n=35,000

Secular Humanism

Secular humanism is a way of viewing human existence and behavior that does not involve religion, i.e., God, the transcendent, a higher power, or ultimate truth. The focus is on the rational self as the ultimate source of power and meaning.

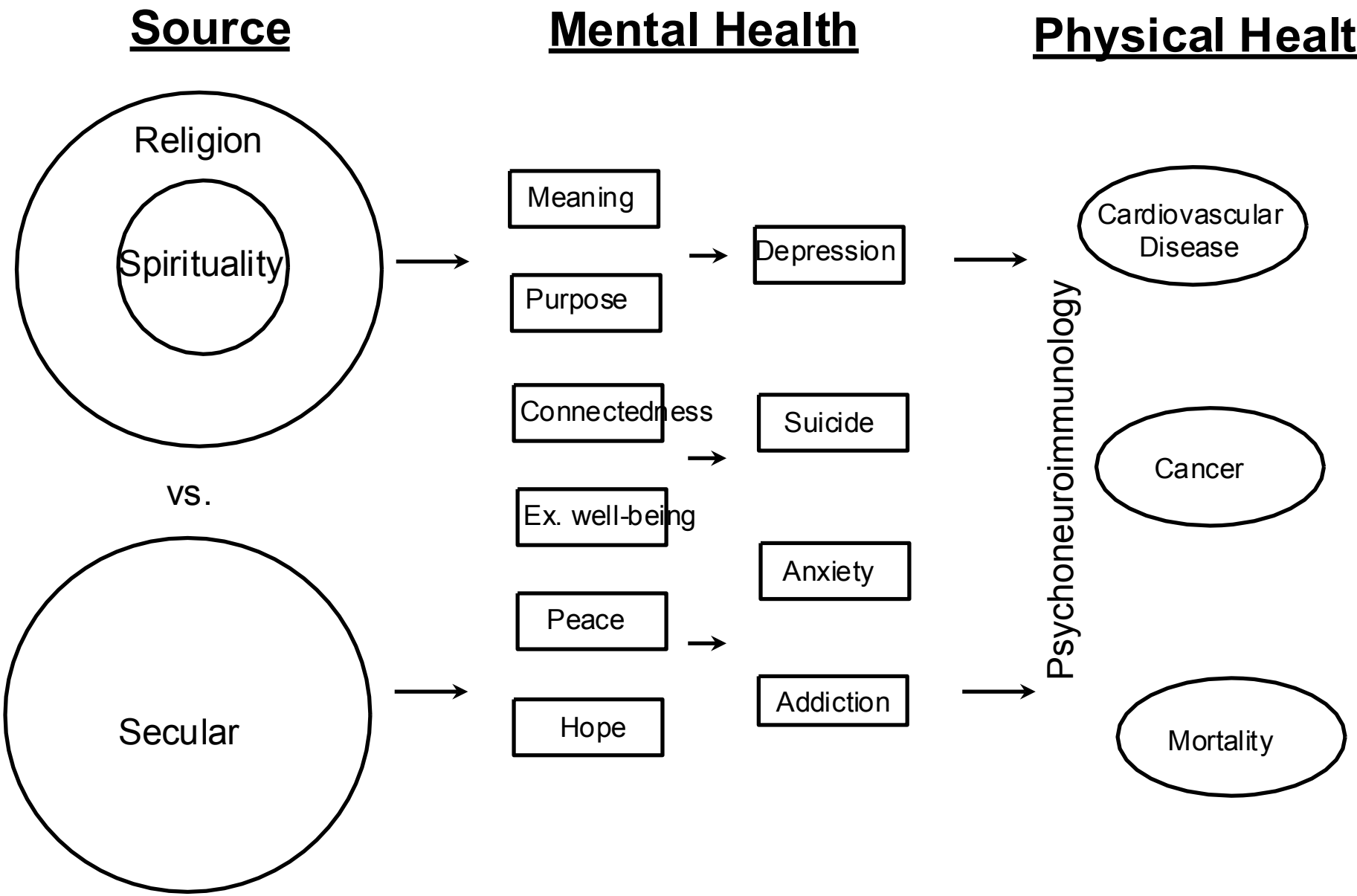
This definition is generally agreed upon, is clear, and does not overlap with other constructs.

Spirituality

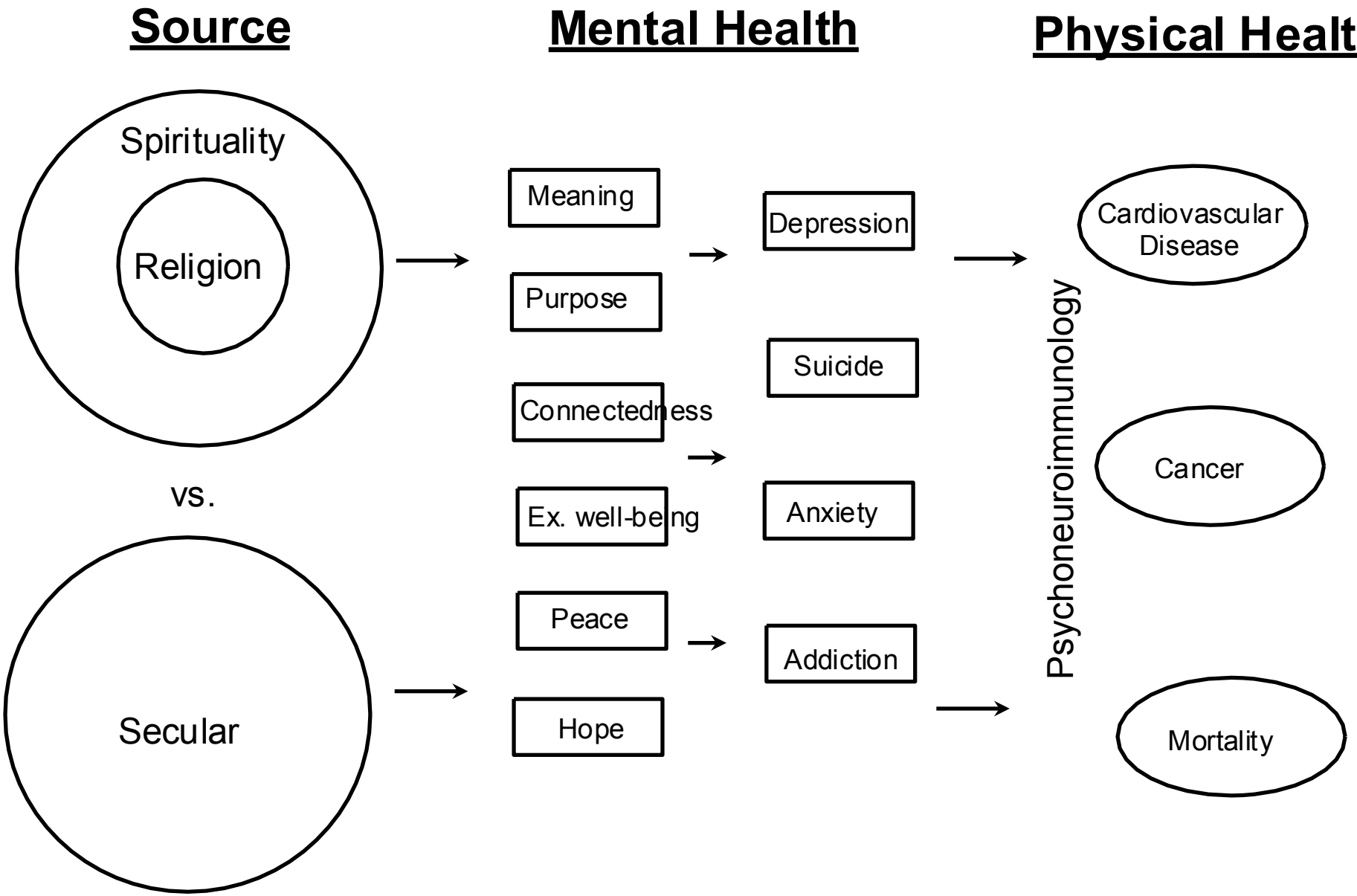
There are many definitions for spirituality, whose definition has been changing over time. According to the traditional definition, spirituality is the core of what it means to be religious, i.e., those who are deeply religious, whose lives are consistent with the devout beliefs professed, involving a dedication and surrender to the Divine as understood. The modern definition, however, has expanded the concept of spirituality to include not only those who are deeply religious, but also those who are superficially religious and those who are not religious at all (i.e., humanists, secular).

Spirituality: An Expanding Concept

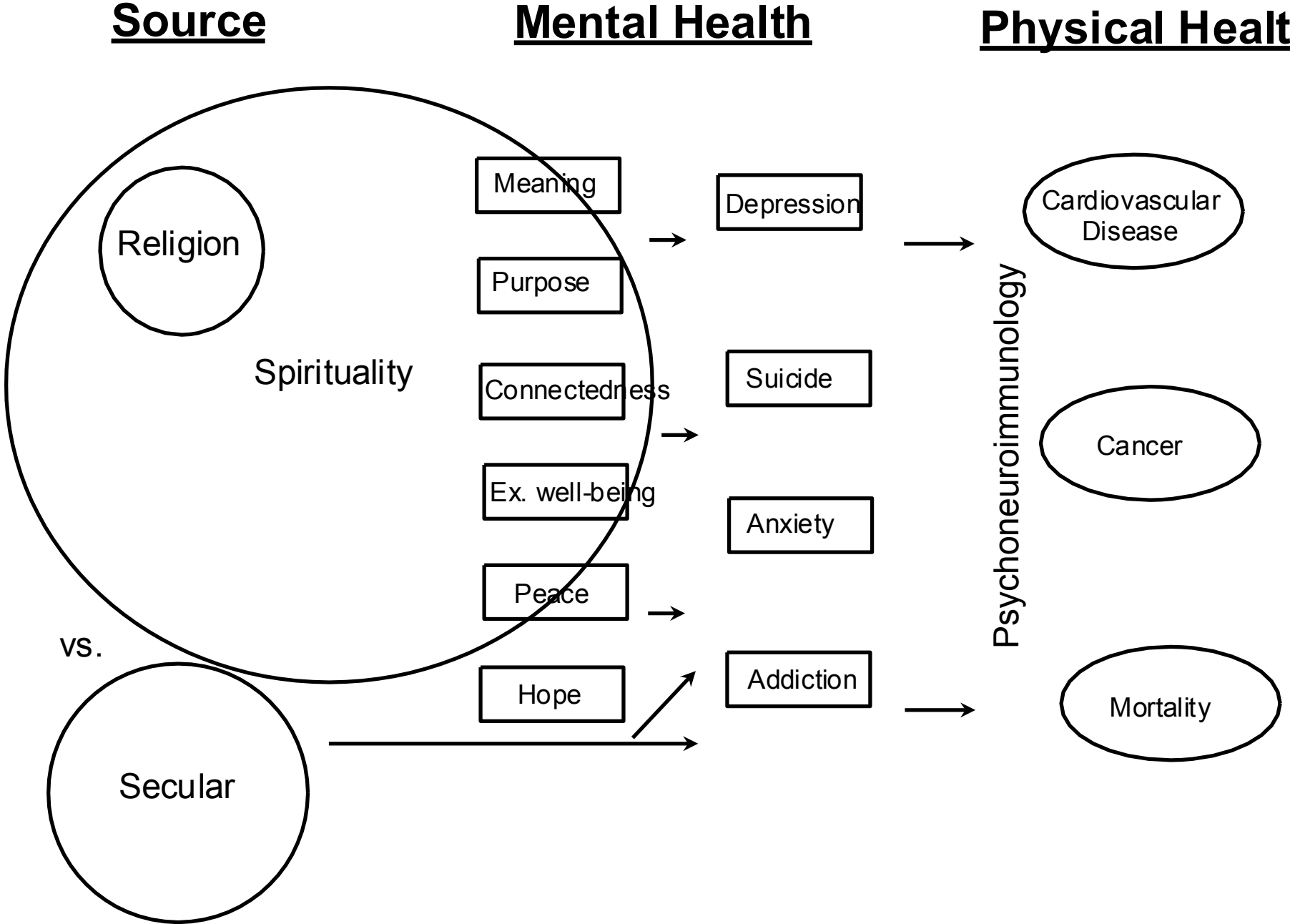
Traditional-Historical Understanding



Modern Understanding



Modern Understanding - Tautological Version



Main points

1. Spirituality is an ideal term to use in clinical settings when talking to and engaging with patients, where patients should be allowed to define this term for themselves.

2. Religion is more useful construct when conducting research that seeks to identify specific characteristics that prevent disease or alter disease course.

Research Justifying Spiritual Care Interventions

In this era of "evidence-based" medicine and "evidence-based" interventions, research is necessary and unavoidable

Research and the findings from research are highly influenced by those conducting the research (true for ALL areas of research)

Research is not as objective as we would hope it to be

Who conducts the research makes a difference

On Thursday, will talk more about research designs that spiritually sensitive clinicians and chaplains may implement. Thus far, though, most research on religion, spirituality and health has been done by social and behavioral scientists not always friendly to the topic

Research on Religion/Spirituality & Health

(systematic review 1940's-2010 of all quantitative research published in peer reviewed academic scientific journals in the English language listed in PsychInfo and Medline)

This research is documented in:

Handbook of Religion and Health , 1st ed (Oxford University Press, 2001)

Handbook of Religion and Health, 2nd ed (Oxford University Press, 2012)

Religion as a Coping Behavior

1. Many persons turn to religion for comfort when stressed

2. Religion used to cope with common problems in life, especially those involving loss

3. Religion often used to cope with challenges associated with medical illness
   - uncertainty
   - fear
   - pain and disability
   - loss of control
   - discouragement and loss of hope

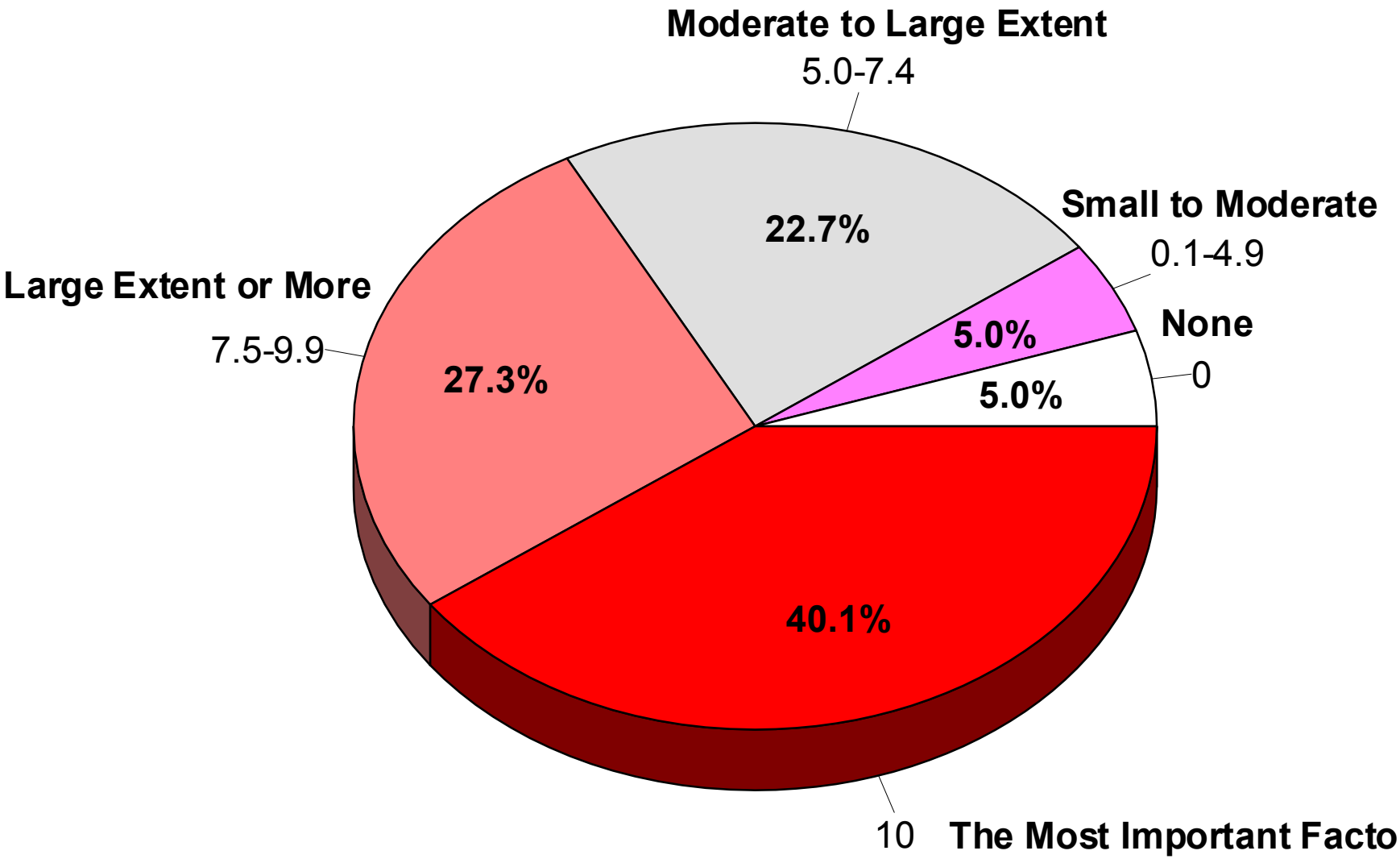
Religious Coping

The use of religious beliefs or practices to cope with and make sense of negative life experiences (and sometimes positive ones, too). For example, in Western religious traditions, behaviors such as praying to derive comfort and hope in emotionally trying times; reading religious writings for inspiration and guidance; attending religious services to be uplifted by singing and worshiping together as a group; seeking support from members of one's congregation, or giving support to others for religious reasons. RC may also involve cognitive processes, including beliefs about a better life after death when pain and suffering will be no more, or beliefs in a loving, caring God who is in control, has a purpose for the world and individuals in it, and has the power to transform difficult circumstances so that good outcomes are possible. Thus, both behaviors and beliefs are involved in RC.

How Common is Religious Coping?

Self-Rated Religious Coping

(On a 0-10 scale, how much do you use religion to cope?)



Responses by 337 consecutively admitted patients to Duke Hospital (Koenig 1998)

Stress-induced Religious Coping

America's Coping Response to Sept 11th:

1. Talking with others (98%)
2. **Turning to religion (90%)**
3. Checked safety of family/friends (75%)
4. Participating in group activities (60%)
5. Avoiding reminders (watching TV) (39%)
6. Making donations (36%)

Based on a random-digit dialing survey of the U.S. c

New England Journal of Medicine 2001; 345:1507-15

How Religion Influences Coping

1. Positive world view
2. Meaning and purpose
3. Psychological integration
4. Hope (and motivation)
5. Personal empowerment
6. Sense of control (prayer)
7. Role models for suffering (facilitates acceptance)
8. Guidance for decision-making (reduces stress)
9. Answers to ultimate questions
10. Social support (both human and Divine)

Not lost with physical illness or disability

Example of Religious Coping

(JAMA 2002; 288 (4): 487-493)

1. 83 years old
2. Multiple serious medical problems
3. Chronic, progressive, unrelenting pain
4. Traditional medical treatments ineffective
5. Alternative medical treatments ineffective
6. Limited material resources – lives alone
7. But, doing well psychologically
8. Positive, hopeful and optimistic
9. Functioning independently- without assist
10. Concerned with meeting others' needs
11. How does she do it? Religion, she says

Religion – How does it help to cope?

"I don't dwell on the pain. Some people are sick and have pain and it gets the best of them. Not me. I pray a lot…. I believe in God, and I give my whole heart, body, and soul over to him… Sometimes I pray and I'm in deep serious prayer and all of a sudden, my pain gets easy. It slackens up and I drop off to sleep, and wake up and I can do things for myself. So prayer helps me a lot – I give God my heart and soul – and you don't have to worry about nothing. He leads you and directs you, and he takes care of you. And I believe in that. That is my belief."

Religion and Mental Health Studies

1. Well-being
2. Depression
3. Suicide
4. Anxiety
5. Substance abuse

Well-being and Depression

(systematic review: 1872-2010)

Religious involvement is related to:

- Greater well-being and happiness
  (256 of 326 studies or 79%)

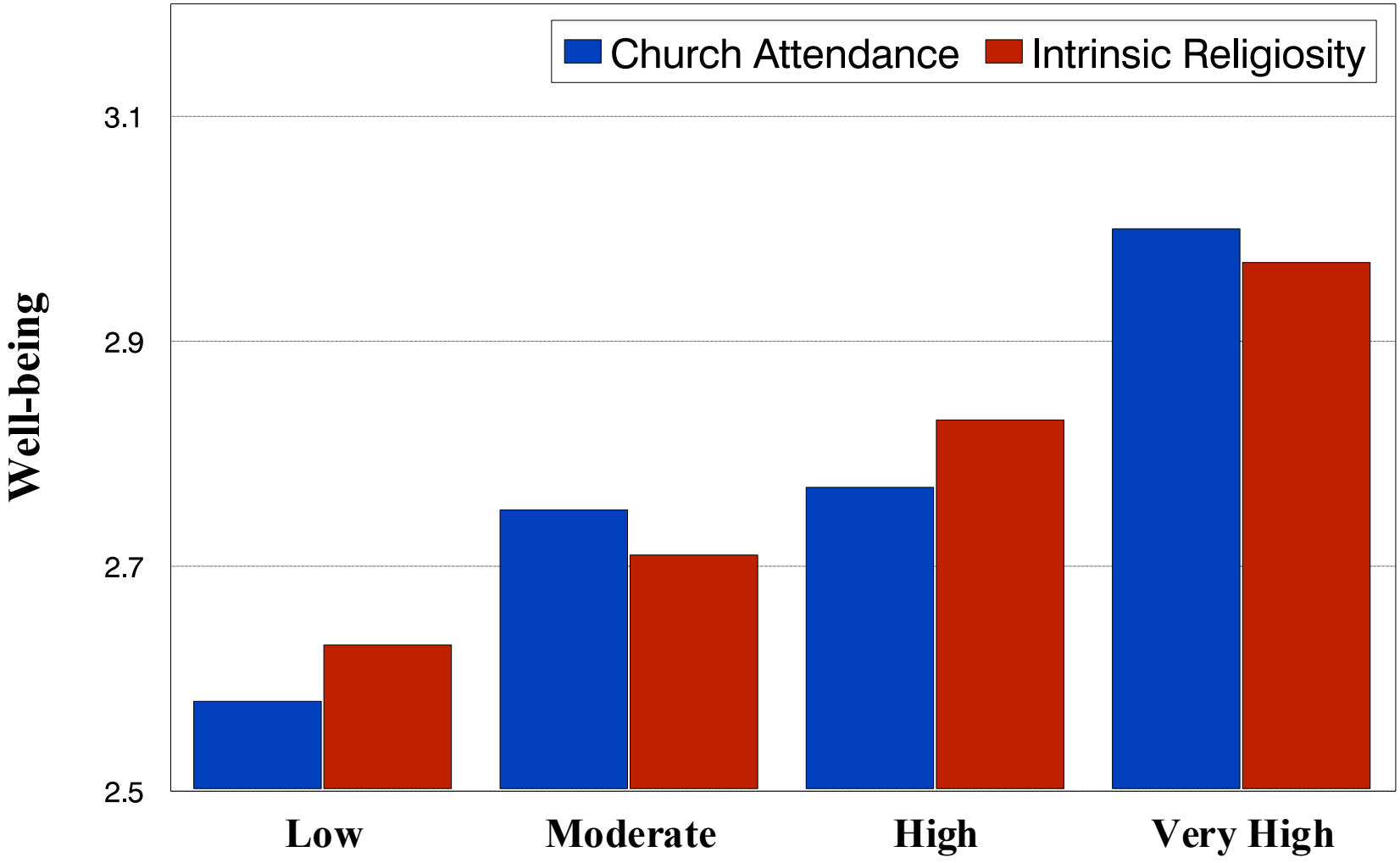
  (3 of 326 studies or 1% less happiness)

- Less depression, faster recovery from depression
  (272 of 444 studies or 61%)

  (28 of 444 studies or 6% more depression)

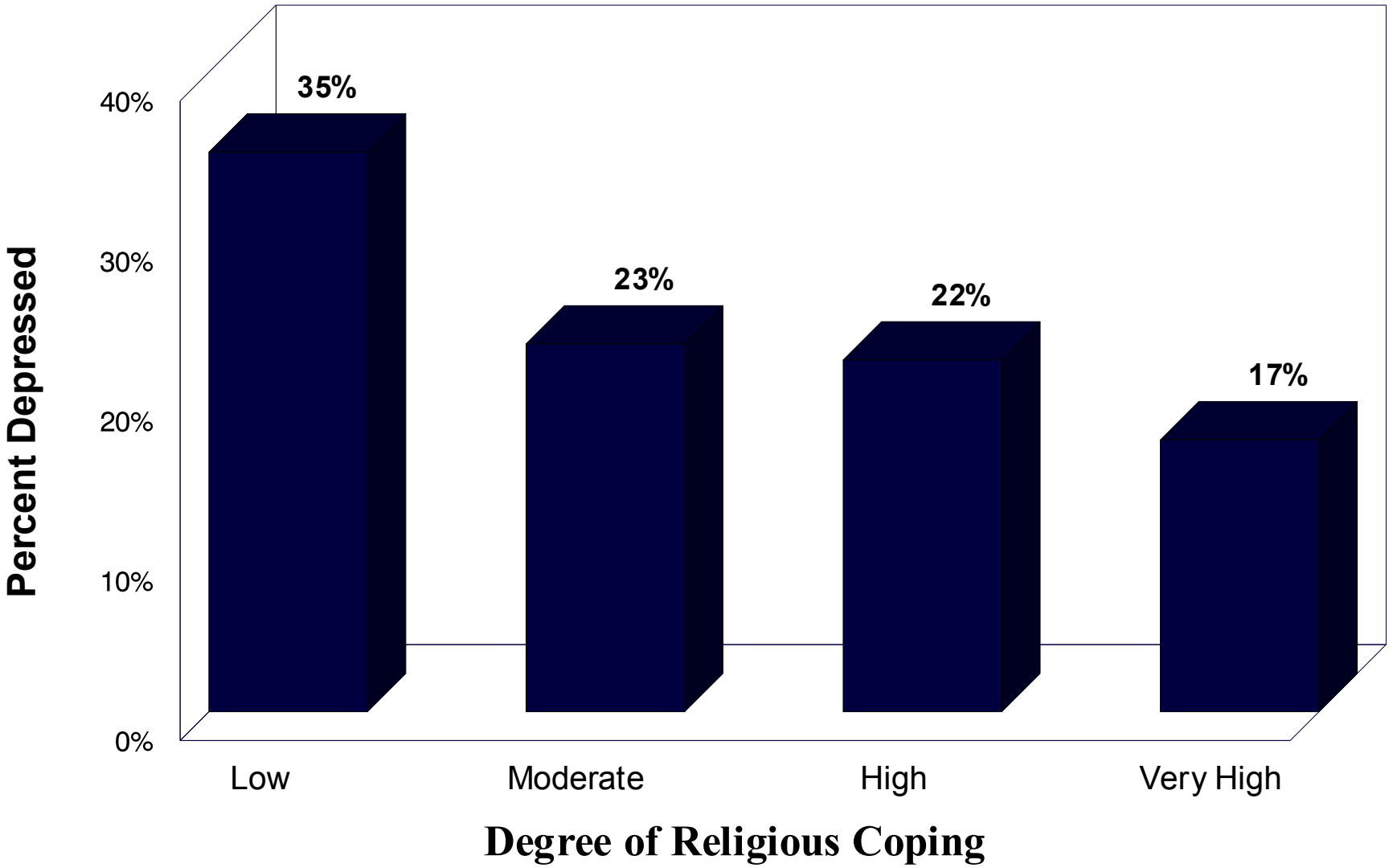
Religion and Well-being in Older Adults

The Gerontologist 1988; 28:18-28



Religious categories based on quartiles (i.e., low is 1st quartile, very high is 4th quartile)

Religion and Depression in Hospitalized Patients

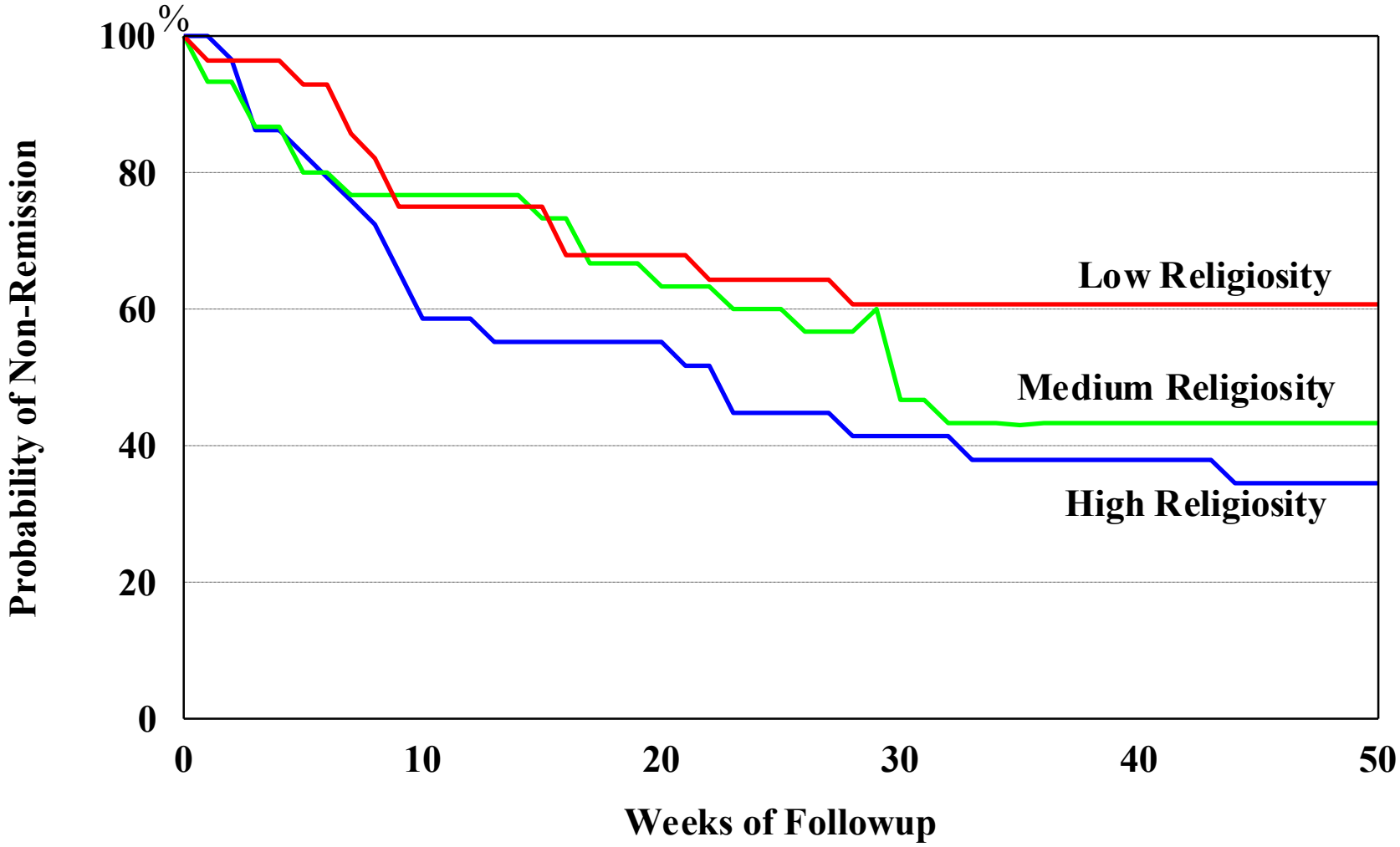


Geriatric Depression Scale

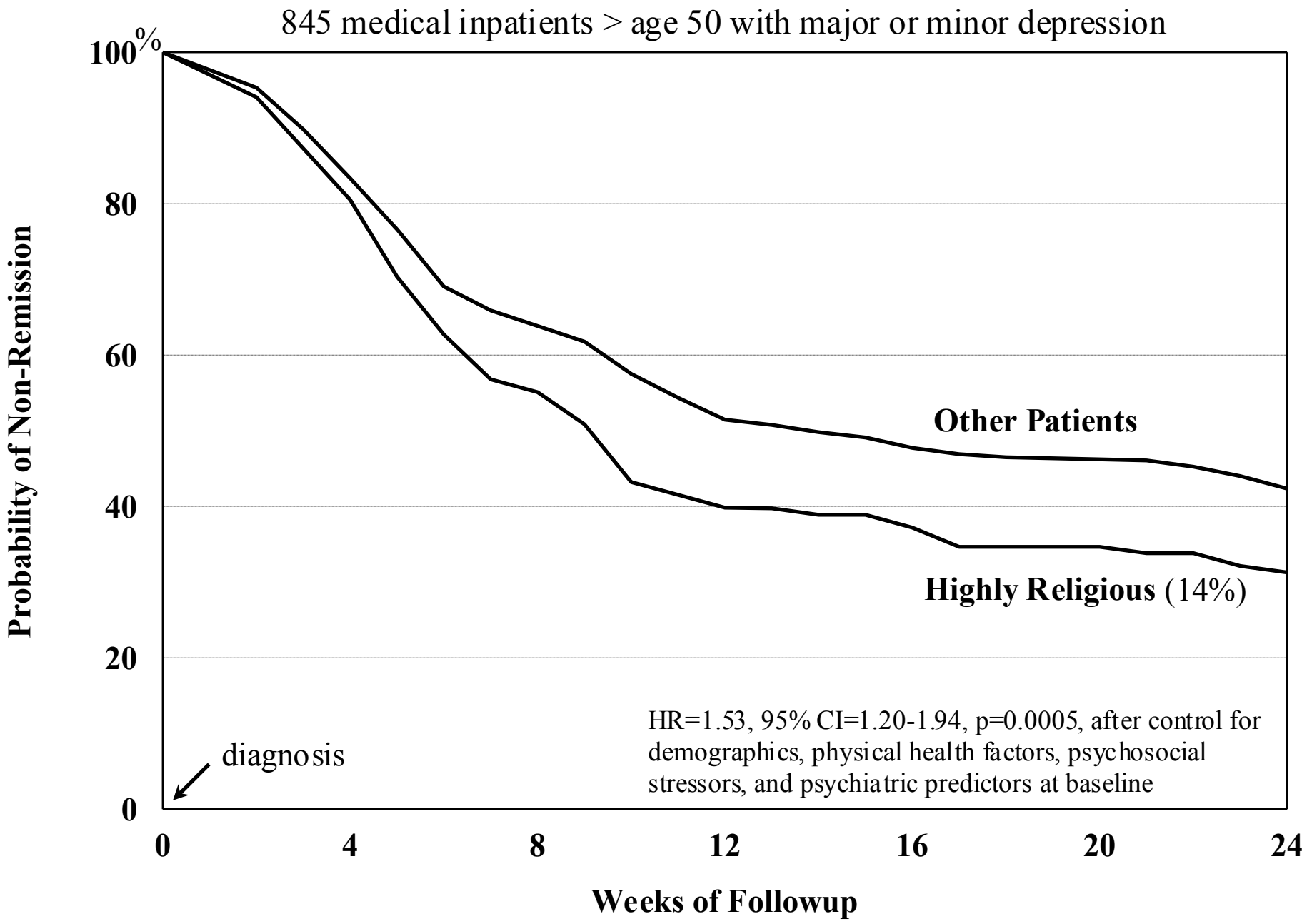
Information based on results from 991 consecutively admitted patients (differences significant at p<.0001)

Time to Remission by Intrinsic Religiosity

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



American Journal of Psychiatry 1998; 155:536-542


845 medical inpatients > age 50 with major or minor depression
100%
80
60
40
20
0
Probability of Non-Remission
Other Patients
Highly Religious (14%)
HR=1.53, 95% CI=1.20-1.94, p=0.0005, after control for demographics, physical health factors, psychosocial stressors, and psychiatric predictors at baseline
diagnosis
0
4
8
12
16
20
24
Weeks of Followup

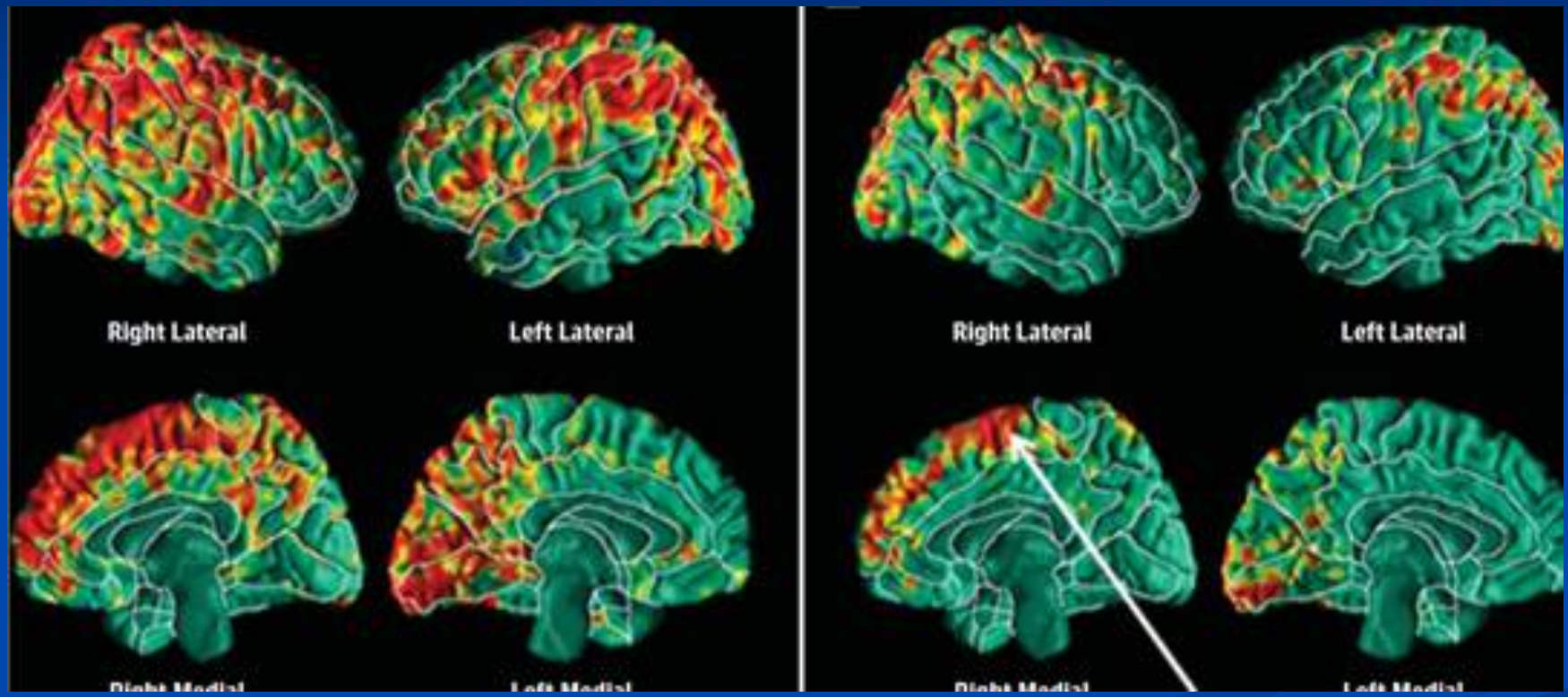
Religion/Spirituality (R/S) and Cortical Thickness: MRI Study

MPORTANCE We previously reported a 90% decreased risk in major depression, assessed prospectively, in adult offspring of depressed probands who reported that religion or spirituality was highly important to them. Frequency of church attendance was not significantly related to depression risk. Our previous brain imaging findings in adult offspring in these high-risk families also revealed large expanses of cortical thinning across the lateral surface of the right cerebral hemisphere. OBJECTIVE To determine whether high-risk adults who reported high importance of religion or spirituality had thicker cortices than those who reported moderate or low importance of religion or spirituality and whether this effect varied by family risk status. DESIGN, SETTING, AND PARTICIPANTS Longitudinal, retrospective cohort, familial study of 103 adults (aged 18-54 years) who were the second- or third-generation offspring of depressed (high familial risk) or non-depressed (low familiar risk) probands (first generation). Religious or spiritual importance and church attendance were assessed at 2 time points during 5 years, and cortical thickness was measured on anatomical images of the brain acquired with magnetic resonance imaging at the second time point. MAIN OUTCOMES AND MEASURES Cortical thickness in the parietal regions by risk status. RESULTS Importance of religion or spirituality, but not frequency of attendance, was associated with thicker cortices in the left and right parietal and occipital regions, the mesial frontal lobe of the right hemisphere, and the cuneus and precuneus in the left hemisphere, independent of familial risk. In addition, the effects of importance on cortical thickness were significantly stronger in the high-risk than in the low-risk group, particularly along the mesial wall of the left hemisphere, in the same region where we previously reported a significant thinner cortex associated with a familial risk of developing depressive illness. We note that these findings are correlational and therefore do not prove a causal association between importance and cortical thickness. CONCLUSIONS AND RELEVANCE A thicker cortex associated with a high importance of religion or spirituality may confer resilience to the development of depressive illness in individuals at high familial risk for major depression, possibly by expanding a cortical reserve that counters to some extent the vulnerability that cortical thinning poses for developing familial depressive illness.

Citation: Miller L et al (2014). Neuroanatomical correlates of religiosity and spirituality in adults at high and low familial risk for depression. JAMA Psychiatry 71(2):128-35

Religion/Spirituality and Cortical Thickness:
A functional *MRI Study*

Areas in red indicate reduced cortical thickness



Religion NOT very important

Religion very important

Citation: Miller L et al (2014). Neuroanatomical correlates of religiosity and spirituality in adults at high and low familial risk for depression. JAMA Psychiatry 71(2):128-35

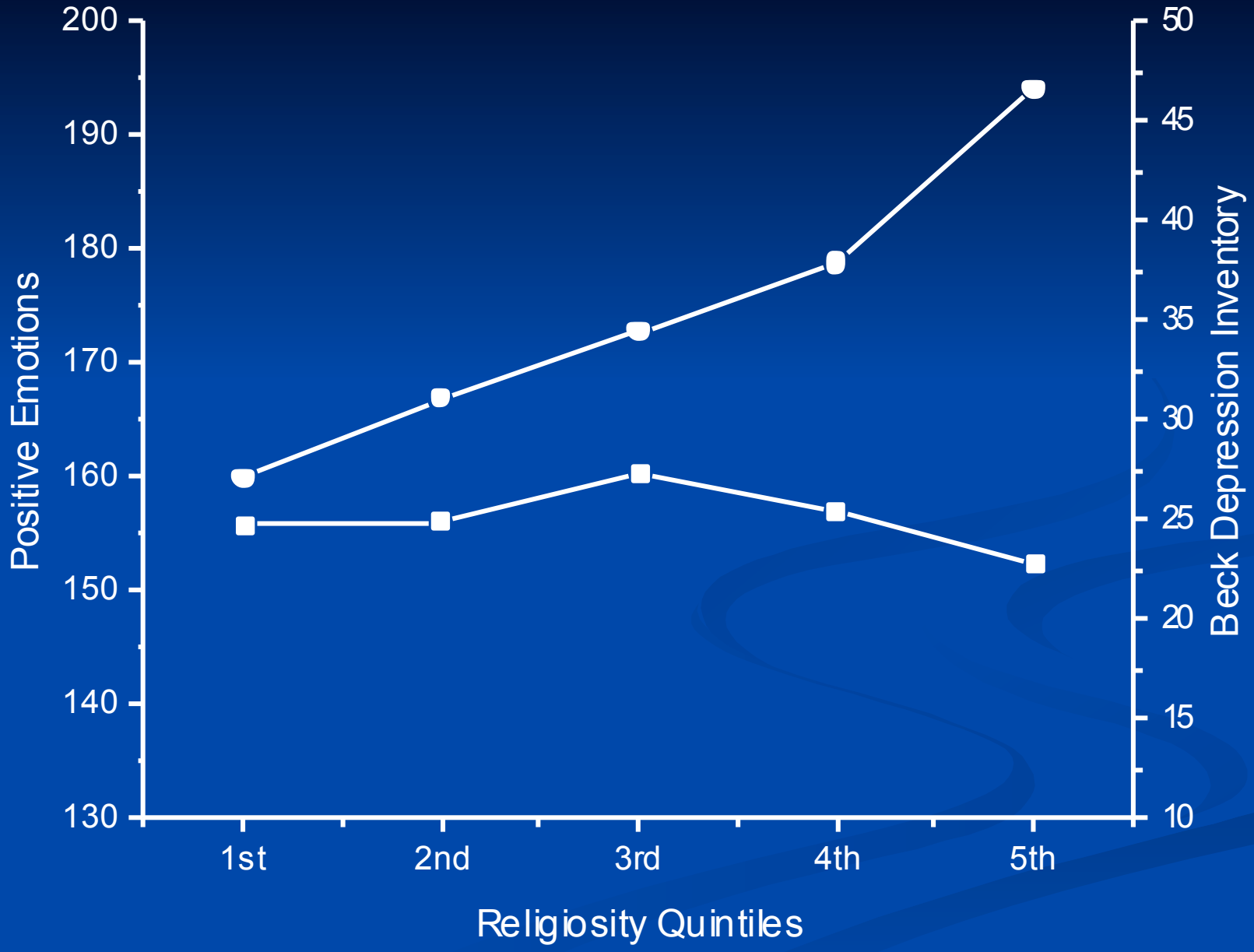
Is Emotional Disorder Different in the Religious?

Is depression the same in those with deep religious faith?

Even if depressed, research suggests that:

- greater purpose and meaning
- greater optimism and hope
- more gratitude and thankfulness
- more generosity

Koenig HG, Berk LS, Daher N, Pearce MJ, Belinger D, Robins CJ, Nelson B, Shaw SF, Cohen HJ, King MB (2014). Religious involvement, depressive symptoms, and positive emotions in the setting of chronic medical illness and major depression. Journal of Psychosomatic Research 77:135–143


200
190
180
170
160
150
140
130
Positive Emotions
50
45
40
35
30
25
20
15
10
Beck Depression Inventory
1st
2nd
3rd
4th
5th
Religiosity Quintiles

Benefits of Being Spiritual But Not Religious

Followed 8,318 medical outpatients in United Kingdom, Spain, Slovenia, Estonia, The Netherlands, Portugal and Chile. AIM: determine if baseline spiritual or religious (S/R) beliefs predict onset of MDD during 12-mo f/u. S/R beliefs measured by (1) whether understanding of life is primarily religious, spiritual, or neither, and (2) if S/R, how strongly held. CIDI used to make the diagnosis of MDD at 6 and 12 mo follow-ups. Controlled for: gender, age, education, marital status, employment status, ethnicity, and history of depression. SLE in past 6 mo and social support examined as mediators. **Results:** Of those with a religious view of life, 10.3% experienced MDD vs. 10.5% for spiritual view vs. 7.0% for neither. Adjusting for confounders and mediators, those with a spiritual view (but not religious) were more likely to experience MDD over the next 12 months vs. secular view (OR=1.32, 95% CI 1.02-1.70, but not statistically significant, $p>0.01$). When analyses stratified by country, effect significant only in UK (OR 2.68, 95% CI 1.52-4.71, $p<0.01$), not other countries. When examining change in S/R belief, those with a decrease in strength of belief at greater risk of depression on f/u.

Citation: Leurent B et al (2013). Spiritual and religious beliefs as risk factors for the onset of major depression: An international cohort study. Psychological Medicine, Jan 29 [E-pub ahead of print]

Benefits of being Spiritual But Not Religious

King et al. investigated associations between a spiritual or religious understanding of life and psychiatric symptoms in 7403 people in England. They found religious people were similar to those who were neither religious nor spiritual with regard to the prevalence of mental disorders, except that those who were religious were less likely to have ever used drugs or to be a hazardous drinker. On the other hand, spiritual people (spiritual but not religious0 were more likely than those who were neither religious nor spiritual to have ever used or to be dependent on drugs, and to have abnormal eating attitudes, generalized anxiety disorder, any phobia or any neurotic disorder.

King M, Marston L, McManus S, Brugha T, Meltzer H, Bebbington P. Religion, spirituality and mental health: results from a national study of English households. Br J Psychiatry. 2013; 202(1):68-73.

Suicide

(systematic review)

Religious involvement is related to:

Less suicide and more negative attitudes toward suicide (106 of 141 or 75% of studies)

Why?

A religious world-view gives people a reason for living – it gives life meaning.

Meaning, Purpose, and Hope
(systematic review)

Religious involvement is related to:

- Significantly greater meaning and purpose in life
  (42 of 45 studies) (93%)

- Significantly greater hope
  (29 of 40 studies) (73%)

Alcohol and Drug Abuse

(systematic review)

Religious involvement is related to:

Less alcohol use, especially among the young
(240 of 278 or 86% of studies show significantly lower rates)
(4 of 278 or 1% of studies with higher rates)

Less drug use, especially among the young
(155 of 185 or 84% of studies show significantly lower rates)
(2 of 185 or 1% of studies with higher rates)

Forgiveness, Altruism, and Gratitude
(systematic review)

Religious involvement is related to:

- Significantly more forgiveness
  (34 of 40 studies) (85%)

- Significantly more altruism / volunteering
  (33 of 47 studies) (70%)

- Significantly more gratitude
  (5 of 5 studies) (100%)

Social Support
(systematic review)

Religious involvement is related to:

- Great social support
  (61 of 74 studies) (82%)

Delinquency and Crime

(systematic review)

At least 104 quantitative peer-reviewed studies have now been published that have examined the spirituality-delinquency/crime relationship. Of those, 82 (79%) reported inverse relationships between spiritual involvement and delinquency or crime.

Of the 60 best studies, 82% found significant inverse relationships.

Of the studies published during the past 10 years that have examined relationships between spiritual involvement and school performance (GPA or persistence to graduation), all 11 (100%) indicated that spiritual students performed significantly better.

Divorce, domestic abuse, single-parent families

(systematic review)

Religious involvement is related to:

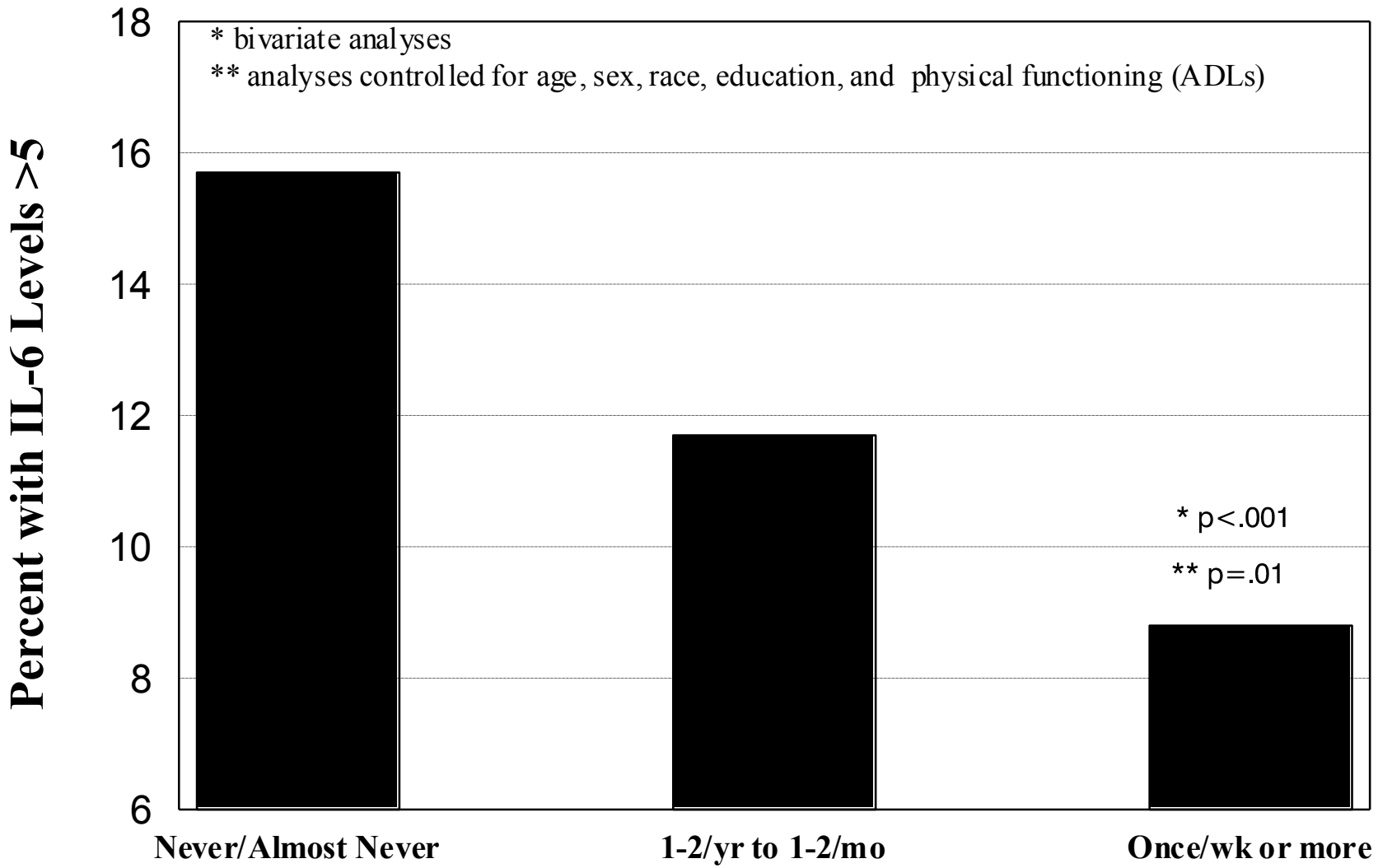
Great marital stability - less divorce, greater satisfaction, less spousal abuse, more likely to have intact family with two parents in home (68 of 79 studies or 86%)

Religion and Physical Health Research

1. Immune function (IL-6, lymphocytes, CD-4, NK cells)
2. Death rates from cancer by religious group
3. Predicting cancer mortality (Alameda County Study)
4. Diastolic blood pressure (Evans County Study)
5. Diastolic blood pressure (Duke EPESE Study)
6. Predicting stroke (Yale Health & Aging Study)
7. Coronary artery disease mortality (Israel)
8. Survival after open heart surgery (Dartmouth study)
9. Overall survival (Alameda County Study)
10. Overall survival (National Health Interview Survey)
11. Overall survival (Duke EPESE)
12. Summary of the research

Serum IL-6 and Attendance at Religious Services

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



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

Replication

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

Attending religious services more than once weekly was a significant predictor of lower subsequent 12-year mortality and elevated IL-6 levels (> 3.19 pg/mL). Mortality was lower by 68% (OR=0.32, 95% CI = 0.15-0.72; p <.01) and likelihood of having high IL-6 levels was reduced by 66% (OR=0.34, 95% CI = 0.16-0.73, p <.01) among weekly attendees, compared with those never attending religious services. Results were independent of covariates including age, sex, health behaviors, chronic illness, social support, and depression.

Immune and Endocrine Functions

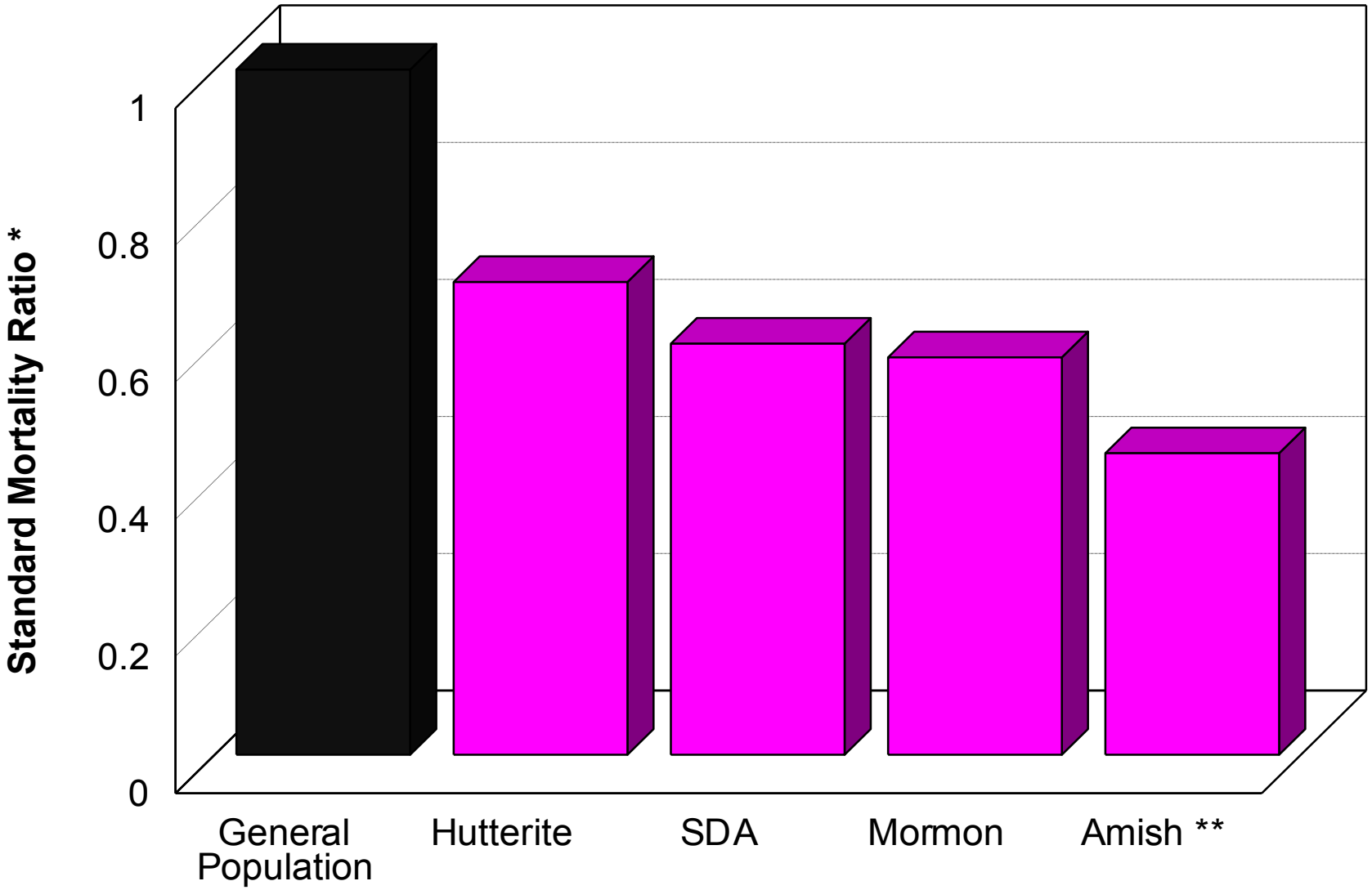
(systematic review)

Religious involvement is related to:

Better immune functions
(14 of 25 studies) (56%)

Better endocrine functions
(23 of 31 studies) (74%) (majority involving meditation)

Death Rates from Cancer
by Religious Group



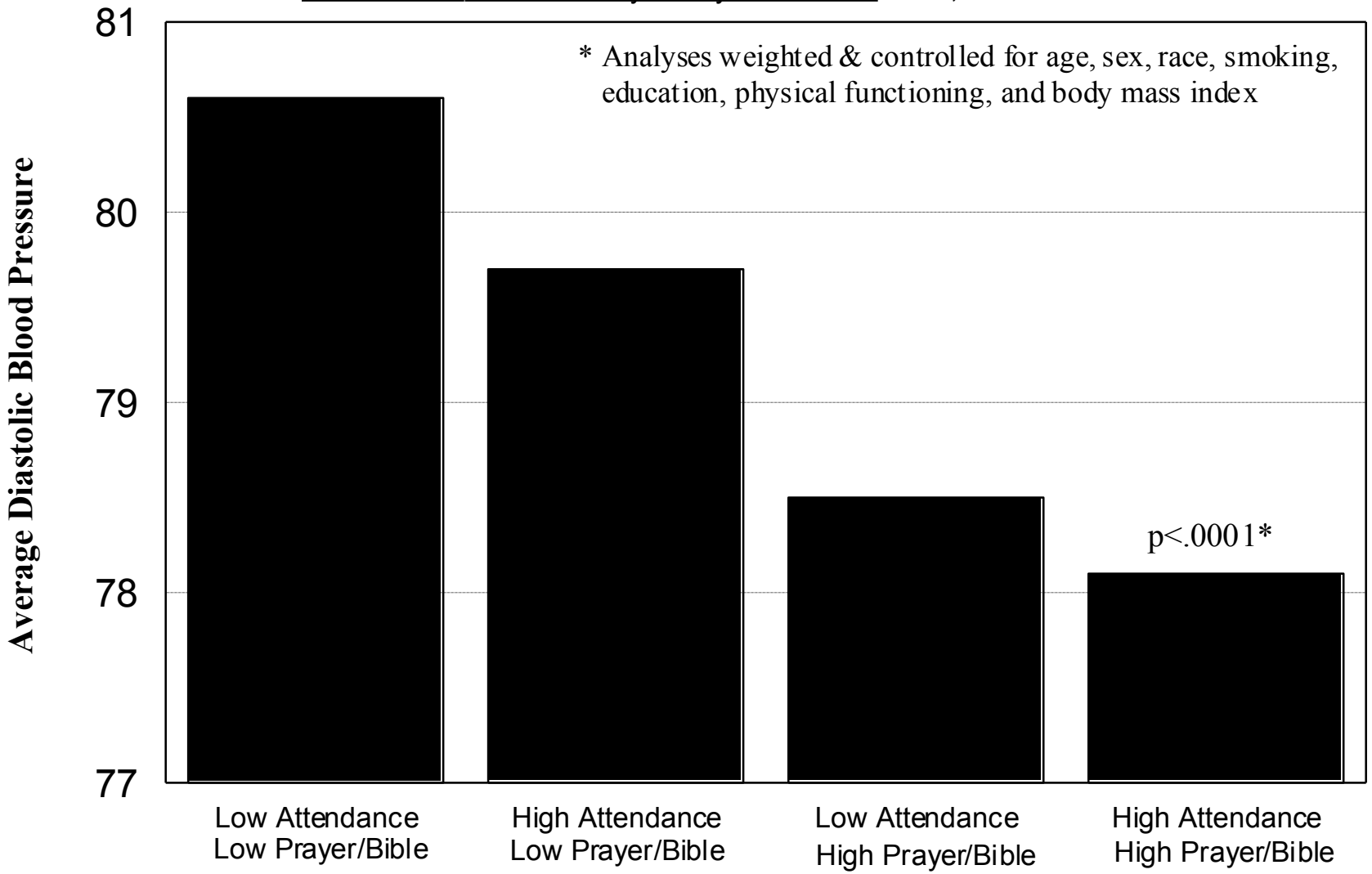
* 1.0=average risk of dying from cancer

** Males ages 40-69 only

Religious Activity and Diastolic Blood Pressure

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

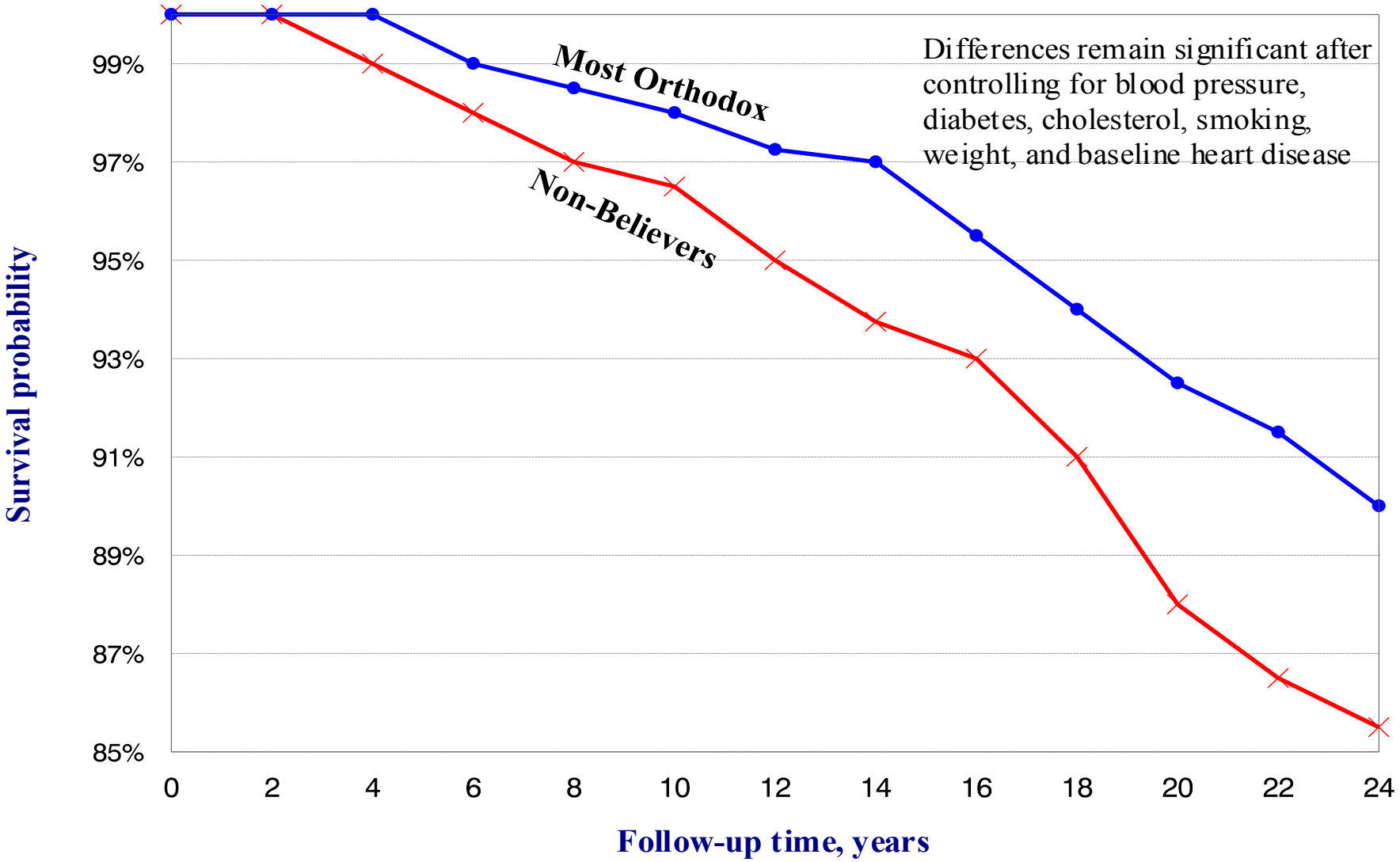
Citation: International Journal of Psychiatry in Medicine 1998; 28:189-213



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

Mortality From Heart Disease and Religious Orthodoxy

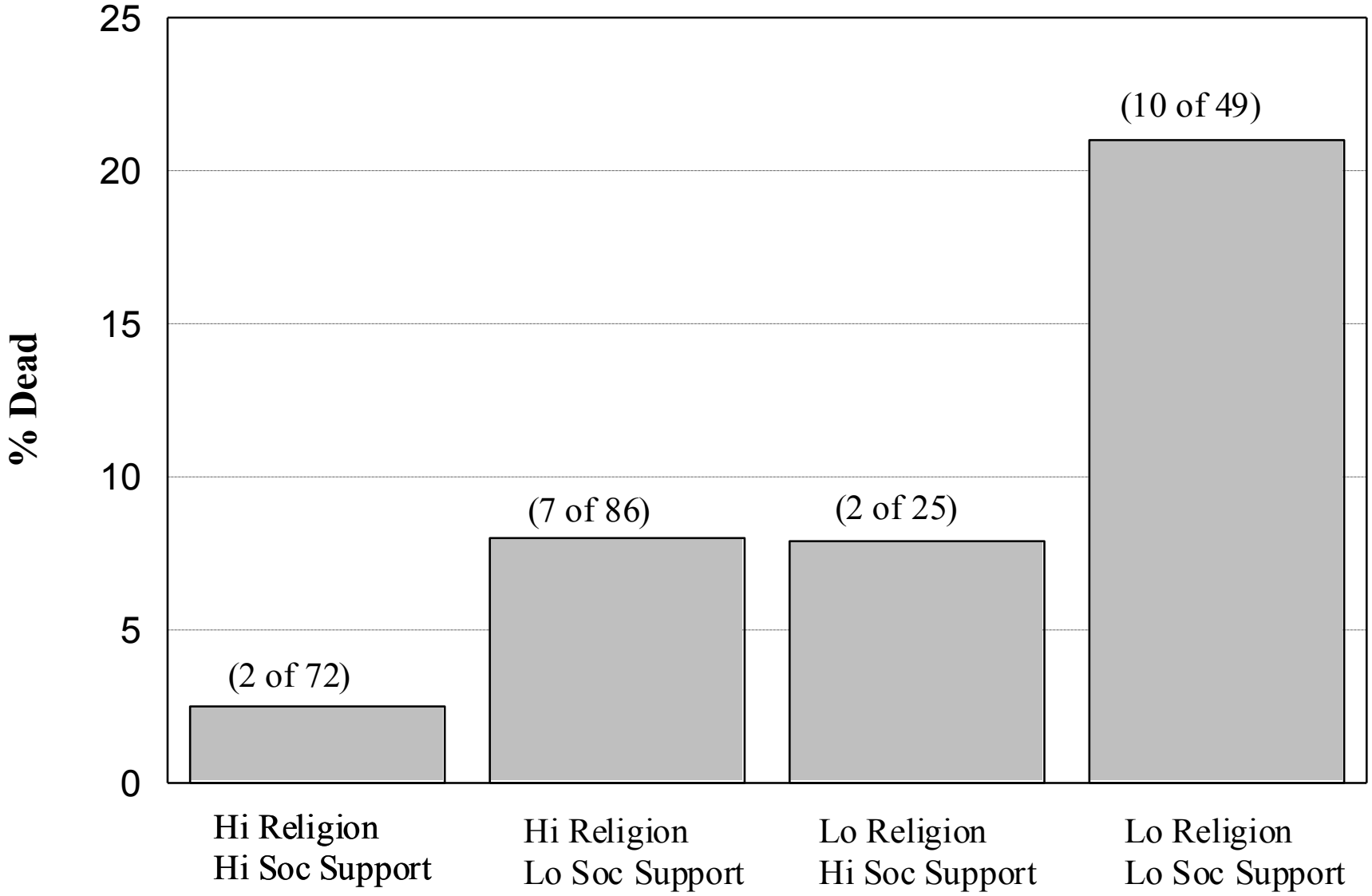
(based on 10,059 civil servants and municipal employees)



Kaplan-Meier life table curves (adapted from Goldbourt et a l 1993 Cardiology 82:100-121)

Six-Month Mortality After Open Heart Surgery

(232 patients at Dartmouth Medical Center, Lebanon, New Hampshire)



Citation: Psychosomatic Medicine 1995; 57:5-15

Cardiovascular Functions

(systematic review)

Religious involvement is related to:

Lower blood pressure
(36 of 63 studies) (57%)

Better cardiovascular functions (CVR, HRV, CRP)
(10 of 16 studies overall) (63%)

Less coronary artery disease
(12 of 19 studies overall) (63%)

Mortality (all-cause)
(systematic review)

Religious involvement related to:

- Greater longevity in 82 of 120 studies (68%)
- Shorter longevity in 7 of 120 studies (6%)

Religious Attendance and Survival in the Alameda County Study

28-year follow-up of 5,286 persons living in Alameda County, CA initially seen in 1965; comparing frequent church attenders to infrequent attenders:

I. Frequent attenders had lower mortality rates (RH=0.65) (35% lower)

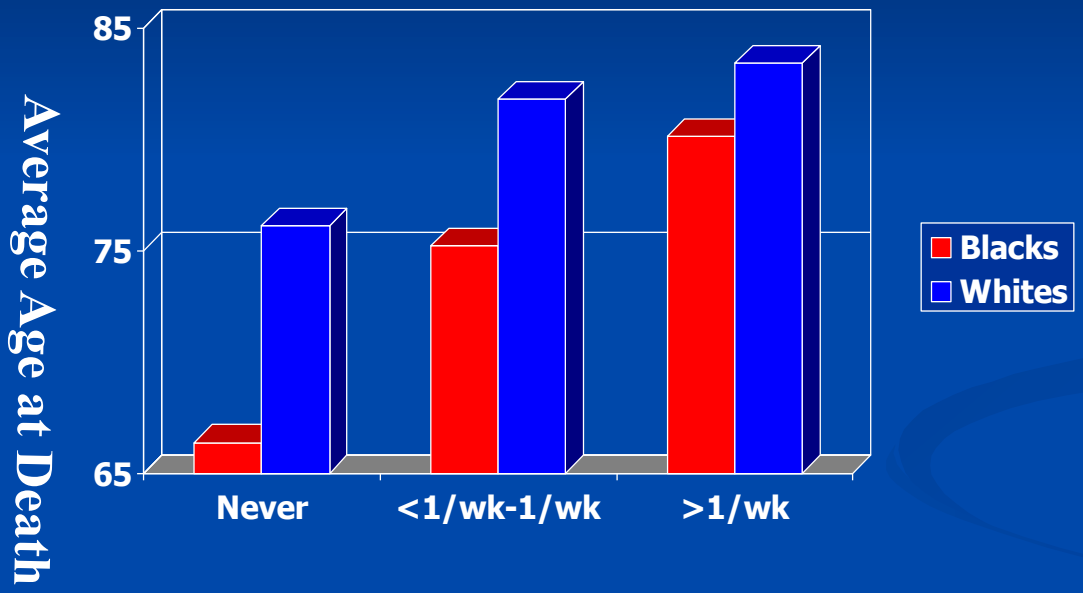
II. During follow-up frequent attenders were:
   a. more likely to stop smoking
   b. more likely to increase exercising
   c. more likely to increase social contacts
   d. more likely to stay married

III. Adjusting for the 4 health practices did not significantly change frequent attenders' mortality rates

Strawbridge et al. (1997). American Journal of Public Health, 87:957-961.

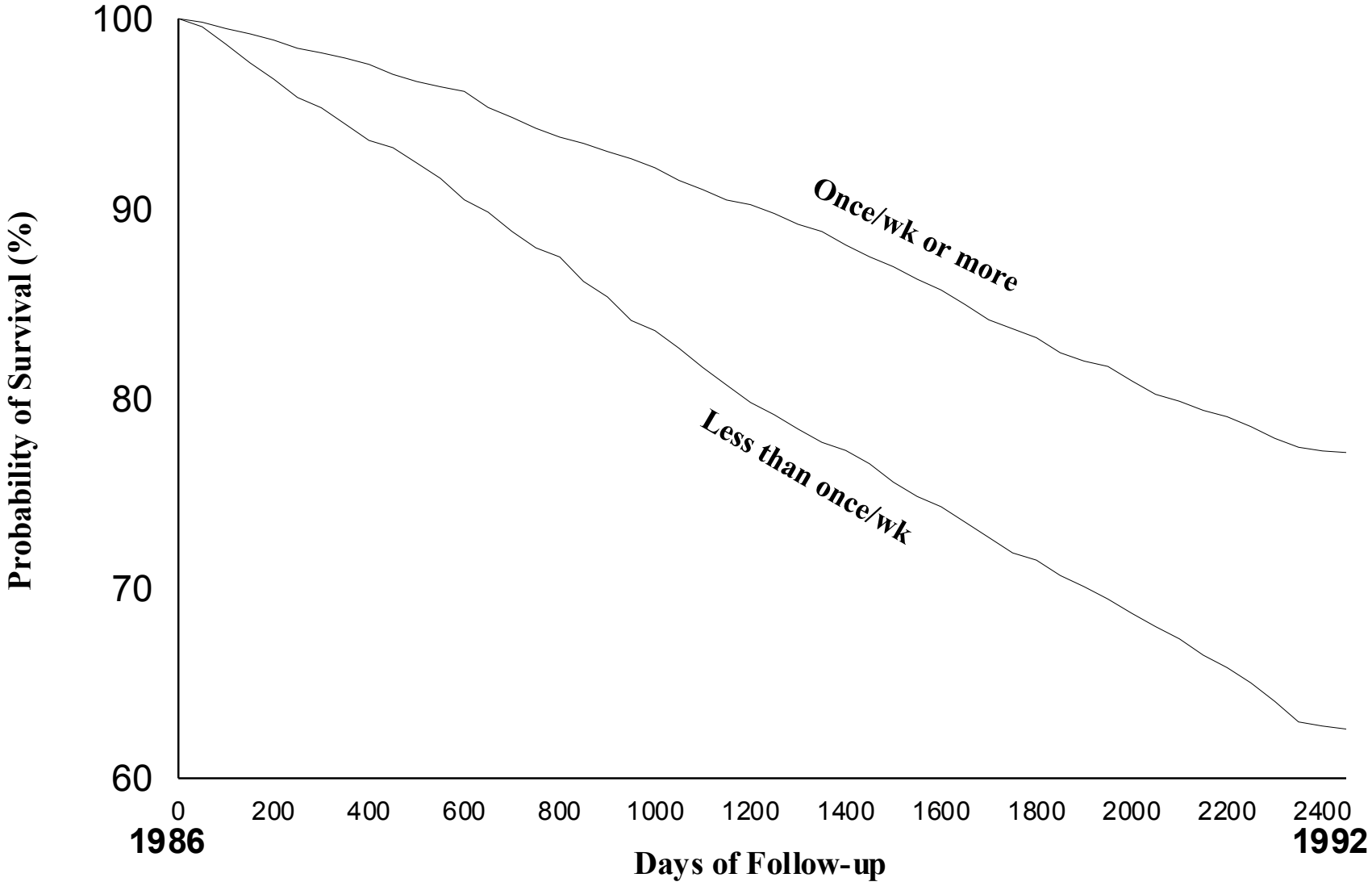
U.S. Life Expectancy at Age 20 by Religious Attendance

(n=21,204)



Hummer et al (1999). Demography 36:273-285

Church Attendance and Length of Survival (n=4000 adults)



Citation: Journal of Gerontology, Medical Sciences1999; 54A: M370-M377

Sometimes, though, things get mixed up

The following appeared in a manuscript submitted to Oxford University Press

Koenig et al. (1999) followed about 4,000 randomly selected older adults for six years and found that frequent religious attendance predicted a 28% reduction in morality

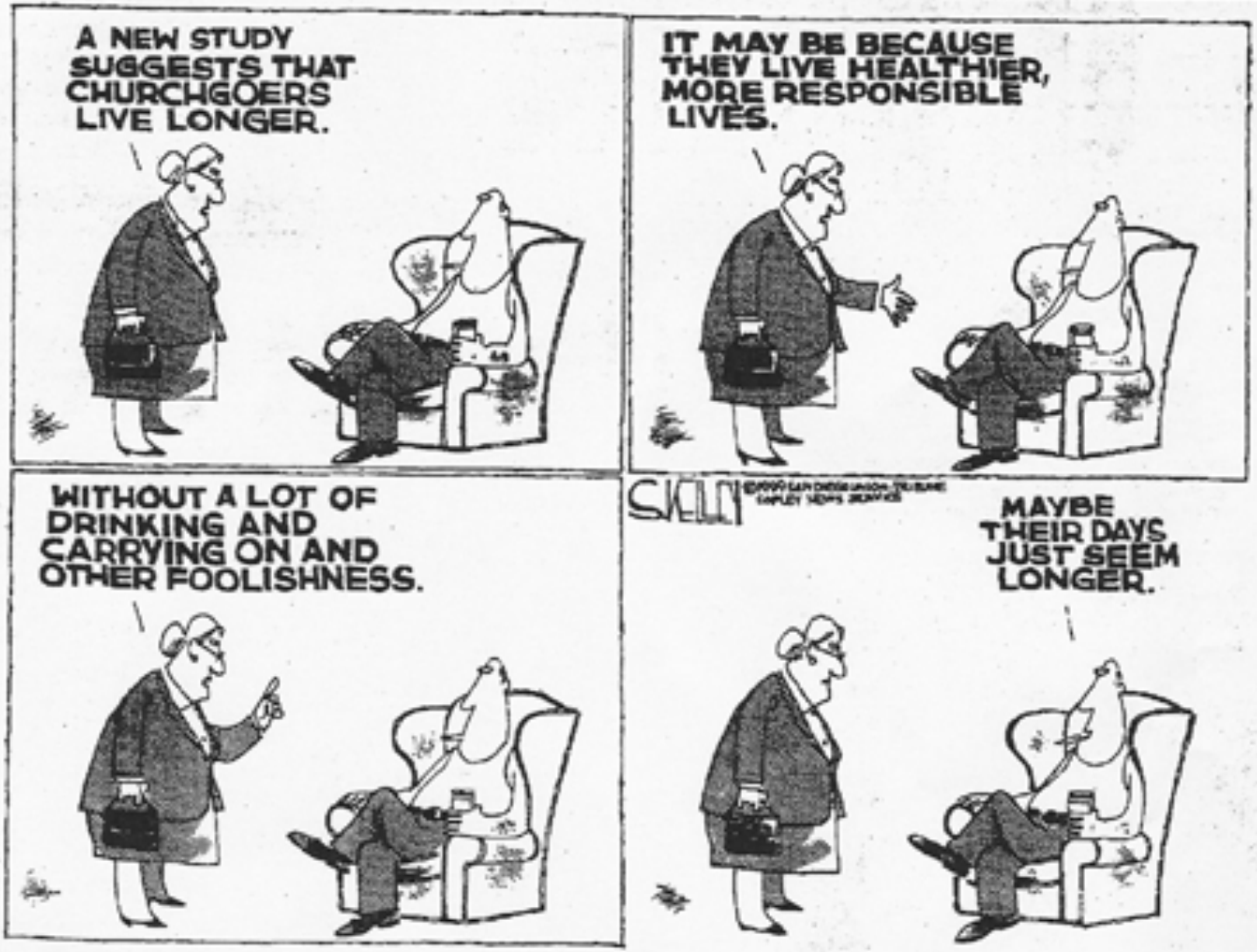
Standard Mortality Ratios (ages 25-99)

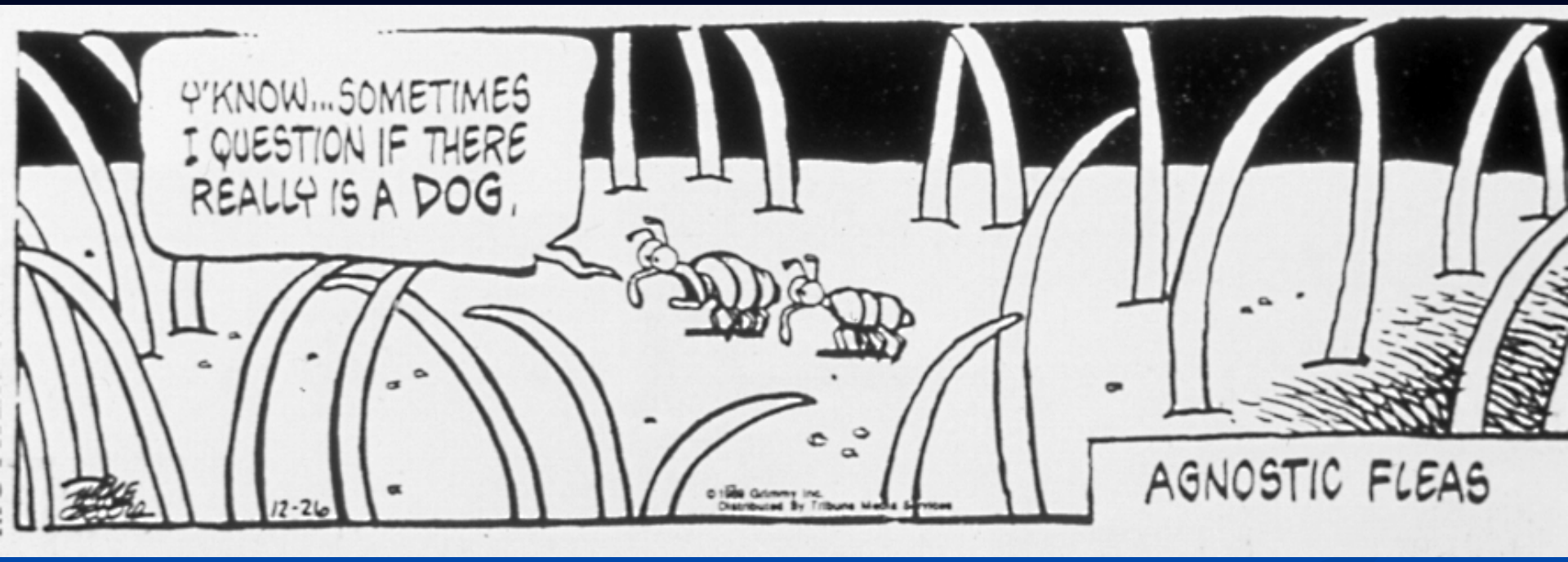
	Males	Females
California Mormons (n=9815)*	0.54 (0.51-0.57)	0.61 (0.57-0.65)
Attend church wkly (99% M / 99% F)		
+ never smoke+married+12 yr ed **	**0.45 (0.42-0.48)**	**0.55 (0.51-0.59)**
+ moderate BMI (57% M / 65% F)	0.43 (0.39-0.47)	0.52 (0.47-0.57)
** Life Expectancy age 25	84 years	86 years
US Whites (n=15,832)*	0.90 (0.85-0.96)	0.83 (0.79-0.88)
Attend church wkly (28% M / 39% F)	0.78 (0.68-0.88)	0.70 (0.62-0.79)
+ never smoke	0.60 (0.48-0.74)	0.63 (0.55-0.74)
+ married	0.51 (0.40-0.66)	0.52 (0.42-0.66)
+ 12 yr education **	**0.47 (0.33-0.64)**	**0.38 (0.28-0.52)**
+ moderate BMI (7% M / 10% F)	0.43 (0.30-0.61)	0.35 (0.24-0.50)
Life Expectancy age 25 (US Whites – all)	74 years	81 years
**Life Expectancy age 25 (extrapolated)	84 years	86 years+

*Based on a systematic sample of active Calif. Mormons followed 1980-2004, and random sample of white US adults followed 1988-1997. **Preventive Medicine 2008; 46:133-136**

Austin American-Statesman

STEVE KELLEY




Y'KNOW...SOMETIMES I QUESTION IF THERE REALLY IS A DOG.
12-26
AGNOSTIC FLEAS

Why is Religion Related to Greater Longevity?

On January 3, 2009, after the death of the Guinness 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 has lived so long.

Her reply: "God. Ask him. I took good care of myself, the way he wanted me to."


CNN

Summary

1. Religion is commonly used to cope with stress in general, and medical illness in particular
2. There are psychological and social mechanisms to help explain how religion affects coping
3. Religious involvement is associated with greater well-being, less emotional disorder, and less substance abuse
4. Consequently, religious involvement is related to less physical illness and better medical outcomes
5. Spiritual struggles, however, if left unaddressed can worsen health and shorten survival
6. This research forms the clinical rationale for assessment and provision of spiritual care

If religion/spirituality is good for health and well-being, then identifying spiritual needs and providing care that leads to Spiritual Transformation should be a real contribution to health care more generally, both the maintenance of health and the response of illness to medical interventions.

Spiritual Care, then, should be the kind of care that leads to Spiritual Transformation – right?

One View of Spiritual Care (by non-Chaplain HP)

In addition to identifying spiritual needs and addressing them, the way health care is provided – by physicians, nurses, social workers, counselors, physical therapists, occupational therapists, dieticians, etc. – can be Spiritual (recognizing the Sacred nature of the person and the Holy obligation and privilege that health professionals have)

What does this mean?
-providing care with respect for the individual patient
-inquiring about how patient wishes to be cared for
-providing care in a kind and gentle manner
-providing care in a competent manner
-taking extra time with patients who really need it

This is not easy to do

Spiritual Care requires a Team Approach
(Eastern-Midwestern U.S. AHS Study)

1. Physician as leader of the healthcare team (assess)
2. Spiritual care coordinator (coordinate)
3. Social worker (assist coordination)
4. Chaplain (address the spiritual needs)
5. Receptionist/ward clerk (record affiliation)

Requires Education and Training (and encouragement)

1. Five 45-min CE/CME educational videos (Duke)
2. Brief introductory & training videos (AHS)
3. Regular spiritual care team "huddles"
4. Regional Faith Coordinators to encourage/train
5. Network of chaplains available to address needs

Baseline, 3 month, 12 month assessments to document changes in attitudes and behaviors (research part)

Many Health Professionals Resistant
(even to take 1-2 minutes for spiritual assessment)

1. Too much to do
2. Overwhelmed with patient care tasks, documentation
3. Unable to find time to even watch a video
4. Operating on the "edge" of burnout
5. Lives are rushed, family problems common, withdrawal, substance abuse, health problems

To provide Whole Person spiritual care, though, the HP needs to be a whole person

HPs (including the health care chaplain) have needs too:

Physical
Emotional
Social
Spiritual

When these needs are not met, ability to provide spiritual/compassionate care will suffer. Thus, efforts by health systems must be made to ensure that HPs in those systems are whole persons.

Physical Needs of the HP

1. Regular exercise
2. Healthy diet and optimal weight
3. Regular check-ups
4. Limit alcohol use
5. Time for rest

Emotional Needs of HP

1. Able to comfortably handle the anxiety and stress involved in health care
2. Absence of depression and exhaustion
3. Able to cope with the loss of patients or inability to cure a patient's illness (without withdrawing)
4. Able to empathize and care about patients, rather than de-humanize them
5. Having a sense of purpose and meaning when caring for patients
6. Having the capacity to be caring, kind, and compassionate

Social Needs of HP

1. Need time with family – spouse and children
2. Need time with friends and colleagues outside of work
3. Need supportive interactions with colleagues during work

Spiritual Needs of HP (often the first to suffer)

1. For many, though not all, need to express and practice a religious faith

2. Need to develop spiritual resources through quiet time spent in prayer, meditation, scripture or inspirational reading, participation in faith community

3. Meditation, prayer, or "practicing the presence of God" will help HP achieve a relaxed, open state that fosters compassion and increases energy

Meditation

1) Meditation can help develop spirituality and increase compassion

2) Mindfulness meditation (Buddhist) and transcendental meditation (Hindu)

3) HP should have the freedom to choose what type of meditation they wish to practice, i.e., one that is consistent with their religious faith

4) The vast majority of HPs are likely to be Christian

5) There are many forms of Christian meditation, as there are many forms of Muslim and Jewish meditation

Muslim meditation

Salat (prayer, ritualistic form not supplication) can be considered a meditation. Any dhikr (short phrases or prayers are repeatedly recited silently or aloud, and simultaneously counted on a string of beads (سلسلة صلوات) or knotted cord) can be consider meditation because you are focusing on what you are saying such as SUBHANALLAH (glorious is God), etc. You concentrate on the meaning of this.

Sufi Meditations by Ibn 'Ata' Allah (Amazon Digital Services)

Sufi Meditation and Contemplation (Omega publications, 2013)

Jewish meditation

Jewish Meditation: A Practical Guide by Aryeh Kaplan
(Schocken publishers, 2011)

Meditation and Kabbalah by Aryeh Kaplan
(Jason Aronson publishers, 2012)

The Secret Art of Talking to God: A Creative Prayer Journal of Jewish Meditation for Beginners (A 30 Day Holy... by Rae Shagalov
(Holy Sparks Press, 2014)

Christian Meditation

1) Christian Meditation: Experiencing the Presence of God
   (by Finley, a former Trappist monk & student of Thomas Merton)

2) Centering Prayer (Fr. Thomas Keating)

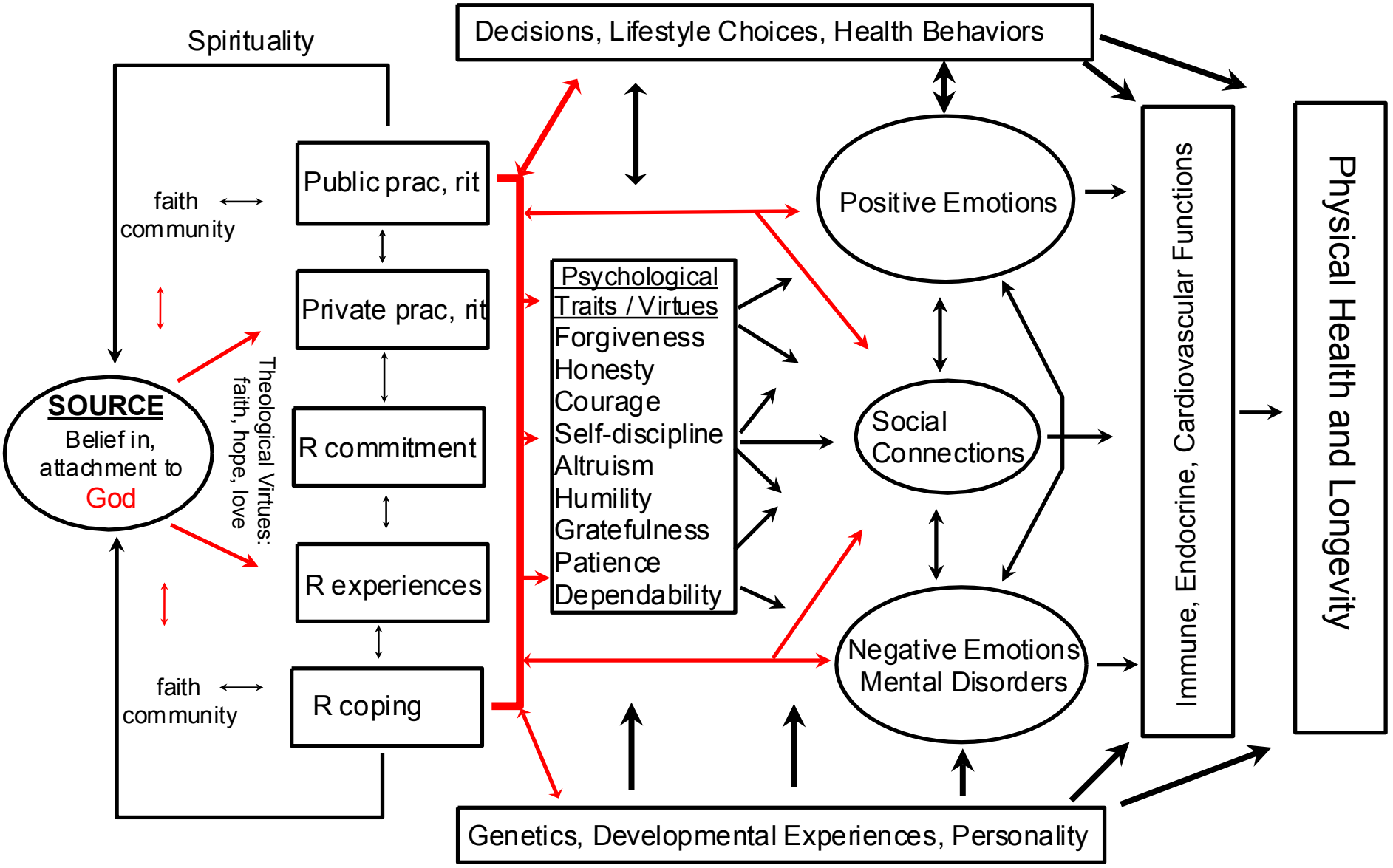
Meditating on readings

3) The Imitation of Christ (Bernard Bangley, 1983, Shaw Publishers)

4) My Utmost for His Highest (Oswald Chambers, Barbour publishers)

5) Closer than a Brother: Practicing the Presence of God (Winter, Shaw Publishers)

Theoretical Model of Causal Pathways



*Model for Western monotheistic religions (Christianity, Judaism, and Islam)

Developing a Relationship with God
(A Theory of One Path)

The Beginning

Something Bad Happens

Something Bad Happens

Shock, Pain, Anger

Despair

Despair

Search for Meaning…. and Relief

Openness

Openness

Consideration of God
(among other things)

Consideration of God

"I set out first to think through his divine existence – that he really and truly and objectively exits, as Someone quite other and apart from me his creature."

"That was first, and I thought of him and all I knew of him from the Scriptures and from my experience until I was totally convinced that God is."

Winter D (1971). Closer than a Brother. Wheaton, IL: Harold Shaw Publishers

God Exists

"Then I spent hours letting that tremendous truth impress itself deeply on my heart – my feelings, if you like."

The experience of <u>being</u>
in God's presence

The Experience of God

Relationship with God

Relationship with God

"Well, St. Paul said that there are three things that last forever: faith, hope and love. My experience is that those three are the permanent elements of any man's relationship with God… Through faith we believe his promises and have hope. Through faith and hope we come to love him and for love of him we want to please him in everything we do. So faith, hope and love combined unite us to the will of God….

We believe in him, and so we go where he leads. He is our only hope, and so we cling to him whatever comes. And we love him, and so set out to please him by what we think, what we say, and what we do."

Developing, Maintaining Relationship with God

"As often as I could, I expressed my thanks and worship to him, and I consciously kept my mind in his presence, and called it back whenever it wandered off after other things… This wasn't easy but I kept at it…I practiced this all the time – thinking of God, reminding myself of his goodness, love, and holiness"

Practicing the Presence of God

"Holiness doesn't depend on changing our jobs, but in doing for God's sake what we have been used to doing for our own…he's the God of the whole of life, but we need to give it to him, consciously turning it over into his hands. Then whatever we're doing – provided it is not against his will – becomes an act of… service…

[T]he very best way of coming closer to God that I have yet discovered…is to do my ordinary, everyday business without any view of pleasing men, but as far as I can, purely for the love of God."

Summary

- Scientific and financial reasons justify assessing & addressing the spiritual needs of patients
- But, there are many challenges to providing whole person care that includes the spiritual dimension
- HPs who are not whole themselves may have difficulty providing this type of care
- Spiritual resources exist that may help the HP become and maintaining their whole personhood

DISCUSSION

(till 9:45 then BREAK till 10:00)

Integrated Spiritual Assessment

10:00-10:30

Spiritual assessment is a spiritual care application with immediate impact that can lead to Spiritual Transformation

"Integrated spiritual assessment" involves two parts:

(1) Assessment of the emotional state of the patient

(2) Assessment of the spiritual state of the patient

These shouldn't be confused with one another

Integrated Spiritual Assessment
(emotional and spiritual)

1. By non-chaplain health professional (brief assessment)

2. By chaplain (comprehensive assessment)

Emotional Assessment
(identify Anxiety, Anger or Depression)

Anxiety

- symptoms of stress (feeling anxious, worried)
- physical signs of autonomic hyperactivity (looking anxious, sweating, trembling, rapid breathing, rapid heart rate)

Anger

- symptoms of anger (says "I'm angry" or is irritable, inpatient)
- physical signs of autonomic hyperactivity (same as above, but looking angry, upset)

Depression

- symptoms of depression (SIG E CAPS)
- physical signs (said looking, withdrawn, hopeless)

Spiritual Assessment

(focus on religious beliefs and concerns, or if patient not religious, on broader issues of purpose and meaning)

Examples of spiritual assessments to follow…

Spiritual Assessment by non-chaplain Health Professional

1. Do your beliefs provide comfort?

2. Are your beliefs a source of stress?

3. Do you have beliefs that might influence your medical decisions?

4. Are you a member of a faith community, such as a church, synagogue, or mosque? If yes, is it supportive?

5. Do you have any other spiritual concerns that you'd like someone to address?

[1]Adapted from Koenig HG (2002). JAMA 288 (4): 487-493

Spiritual Assessment by non-chaplain Health Professional

(abbreviated version used for physicians in AHS project)

What is your religious affiliation, if any? _____
(documented when register for visit or during admission process)

1. Do you have a faith-based 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?

Spiritual Assessment by Health Care Chaplain

(are there any chaplains in the audience?)

Bringing it All Together

Effective spiritual assessment leads to spiritual interventions that lead the patient towards Spiritual Transformation, part of which involves a parasympathetic response that counteracts the sympathetic activation (adrenaline) stimulated by the stressful medical event.

Anticipating this afternoon's session with the medical actors, conference participants should be able to visualize what's happening physiologically under the surface of the behavioral symptoms that are being manifested by the patient (e.g., person raped as child presenting as an adult to ER after a suicide attempt following a divorce)

Summary

Spiritual care interventions – beginning with spiritual assessment – may in an acute care environment have benefits that complement medical interventions and, in fact, make medical interventions more effective

The timing of interventions seems to be critical – when the patient is in a distressed state, searching for answers and open to suggestions or guidance. Assessment and brief intervention can be transformative in such situations. We often see the patient at such critical times.

Benefit down the road may also be gained by providing **tools** to the patient that address the long-term challenges and the ongoing stresses in the future that will re-activate the sympathetic nervous system (such as a spiritual practice consistent with their faith tradition)

Discussion

(till 10:30)