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

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Focus on the Family

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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.

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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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