Spirituality in Patient Care
To the next generation—
my son, Jordan Taylor Koenig,
and my daughter,
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Contents

Introduction 3

ONE. Why Include Spirituality? 23

TWO. How to Include Spirituality 51

THREE. When to Include Spirituality 78

FOUR. What Might Result? 96

FIVE. Boundaries and Barriers 115

SIX. When Religion (or Spirituality) Is Harmful 135

SEVEN. Chaplains and Pastoral Care 151

EIGHT. Spirituality in Nursing Care 173

NINE. Spirituality in Social Work 191

TEN. Spirituality in Rehabilitation 200

ELEVEN. Spirituality in Mental Health Care 213
TWELVE. A Model Course Curriculum 230

THIRTEEN. Information on Specific Religions 244

FOURTEEN. Summary of Key Points 281

Notes 287

Index 329
Spirituality in Patient Care
Introduction

Similar to the first two editions, this third edition provides a short course for health professionals (HPs) interested in identifying and addressing the spiritual needs of patients. Since the first edition was published in 2002 and the second edition in 2007, the research on religion, spirituality, and health has dramatically expanded, and further discussions have occurred on sensible ways of translating that research into caring for patients. In studying the research literature and interacting with literally hundreds of groups of HPs (physicians, nurses, chaplains, pastoral counselors, social workers, psychologists, counselors, physical and occupational therapists, administrators) and community clergy over the past six years, I have continued to learn new applications of this research. I’ve also learned a lot about the barriers to application and what may happen when research on spirituality and health is misapplied (or even when applied correctly, with negative consequences). As a result, I have rewritten and updated all sections of the second edition to provide the most recent research and current views on how to utilize this information in clinical practice.

Since the first edition of the Handbook of Religion and Health\(^1\) was published in 2001, literally thousands of discussions, reviews, and research studies have been published,
contributing new information to advance our understanding. To get a sense of the rapid increase in research and discussions on religion, spirituality, and health, I did a MEDLINE search using the keywords “religion” or “religiousness” or “religiosity” or “spirituality” and “health,” “medicine,” and “patient care” for six-year periods beginning in 1982, compared to all published articles during the eighty years between 1902 and 1981. Here are the results: 1902–1981: 3,369 articles; 1982–1987: 1,367 articles; 1988–1993: 1,976 articles; 1994–1999: 2,782 articles; 2000–2005: 4,108 articles; and 2006–2011: 5,155 articles. This means that in each of the last six-year periods since the year 2000, more peer-reviewed journal articles on religion, spirituality, and health have appeared than during the entire eighty-year period from 1902 to 1981. Furthermore, the number of articles published in the latest six-year period (2006–2011) increased by over 25 percent compared to the previous six-year period (2000–2005). Much of this new research has now been summarized in the second edition of the Handbook of Religion and Health published in 2012.

There is an urgent need to translate the findings from this rapidly expanding research base to practical applications at the bedside by a wide range of health professionals, and this book addresses that need. In addition to updating the information presented in the first and second editions, this third edition of Spirituality in Patient Care includes case histories and clinical examples on how to integrate spirituality into patient care depending on the particular circumstances the clinician is faced with. I have retained and revised the sections of the book relevant to physicians in primary care and the medical and surgical specialties, as well as those chapters for nurses, chaplains and other clergy, mental health professionals, social workers, and occupational and physical therapists. This new edition also retains and updates important health care information related to specific religious traditions that HPs need to know about to provide culturally and spiritually sensitive care.
Is there still a need for such a guide today to assist HPs to assess and address the spiritual needs of patients? Consider the following.

**PHYSICIANS**

The American Association of Medical Colleges (AAMC) has endorsed the need to train medical students to “incorporate awareness of spirituality, and culture beliefs and practices, into the care of patients in a variety of clinical contexts . . . [and to] recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients.”

Palliative care physicians recognize the importance of spirituality, spiritual assessment, and spiritual interventions, especially when caring for terminally ill children and their families. Himelstein and colleagues at the Medical College of Wisconsin and Cleveland Clinic write the following in the *New England Journal of Medicine*:

Primary care providers should be taught to recognize a child’s need for palliative care, to assess the emotional and spiritual needs of the child and family, to facilitate advanced care planning, to assess and manage the child’s pain and symptoms, to provide bereavement care to the child’s family, and to recognize the indications for a referral to a specialist. . . . Spiritual assessment centers on understanding the things that are important to the child, as well as the meaning of the child’s life to both the child and his or her family and the child’s hopes and dreams for the future, realistic or not in the context of disease. Transcendent relationships exist between infants and very young children and their parents and siblings—as exemplified by the connection between a nursing infant and mother. As children develop, transcendent matters such as relationships with God or other higher powers may become important. . . . To foster a child’s spiritual growth, the physician can be cognizant of and respect the way spirituality changes with age; provide opportunities for the ill child to participate in religious observances at an age-appropriate level; support the growth and maintenance of trusting, secure, and
loving relationships; provide support in times of crisis and despair; and allow time for reflection and questioning as part of a child’s normal spiritual development.5

The American Psychiatric Association indicates in its Practice Guidelines for the Psychiatric Evaluation of Adults the following:

“Important cultural and religious influences on the patient’s life” should be collected as part of the initial evaluation of the psychiatric patient. . . . Evaluation ought to be performed in a manner that is sensitive to the patient’s individuality, identifying issues of development, culture, ethnicity, gender, sexual orientation, familial/genetic patterns, religious/spiritual beliefs, social class, and physical and social environment influencing the patient’s symptoms and behavior. . . . [Assessment must include] information specific to the individual patient that goes beyond what is conveyed by the diagnosis . . . [including] issues related to culture, ethnicity, gender, sexual orientation, and religious/spiritual beliefs.6

NURSES

The American Nurses Association (ANA) Code of Ethics states, “The measures nurses take for the patient enable the patient to live with as much physical, emotional, social, and spiritual well-being as possible.”7 The International Code of Ethics for Nurses (ICN) indicates, “In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.”8 In the latest edition of Kozier & Erb’s Fundamentals of Nursing, there is an entire chapter devoted to spirituality (chapter 41).9 Likewise, Nursing Intervention Classification includes two standard nursing interventions related to spiritual care: Spiritual Support (5420) and Spiritual Growth Facilitation (5426).10 Nursing Outcome Classification has two spiritual outcomes, Spiritual Health (2001) and Personal Health Status (2006) (the latter described as “overall physical, social, and spiritual functioning of an adult of
Finally, the International North American Nursing Diagnosis Association (NANDA), which publishes *Nursing Diagnoses*, notes that its purpose is to “develop, refine and promote terminology that accurately reflects nurses’ clinical judgments. This unique, evidence-based perspective includes social, psychological and spiritual dimensions that ultimately contribute to improved patient safety and outcomes through the provision of holistic, quality nursing care.” NANDA provides three standard nursing diagnoses: “spiritual distress,” “spiritual distress, risk for,” and “spiritual well-being, readiness for enhanced.”

The American Association of Colleges of Nursing (AACN) publishes guidelines for professional nursing education. In those guidelines it mentions “spiritual” or “spirituality” eighteen times. Statements include:

Successful integration of liberal education and nursing education provides graduates with knowledge of human cultures, including spiritual beliefs, and the physical and natural worlds supporting an inclusive approach to practice. (p. 11)

Collaborate with other health care professionals and patients to provide spiritually and culturally appropriate health promotion and disease and injury prevention interventions. (p. 24, Essential VII)

The baccalaureate program prepares the graduate to: 1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. (p. 31)

Historically, nurses have provided care for patients within a context of privileged intimacy; a space into which a nurse is allowed and in partnership with the patient creates a unique, healing relationship. Through this connection, the nurse and patient work toward an understanding of a wide variety of physical, psychosocial, cultural, and spiritual needs, health illness decisions, and life challenges. (p. 25)
This emphasis on spirituality in nursing codes of ethics, the basic nursing textbooks, the standards of nursing diagnosis/classification, and the AACN’s guidelines for professional nursing education underscores the importance of considering patients’ spiritual beliefs and integrating those into patient care. This is not optional for nurses.

**SOCIAL WORKERS**

The *NASW Standards for Social Work Practice in Health Care Settings*, published by the National Association of Social Workers, also emphasizes that assessing and addressing spiritual issues is a core responsibility of social work practice.\(^{15}\) Consider the following statements documented in the *Standards*:

The biopsychosocial-spiritual perspective recognizes that health care services must take into account the physical or medical aspects of ourselves (bio); the emotional or psychological aspects (psycho); the sociocultural, sociopolitical, and socioeconomic issues in our lives (social); and how people find meaning in their lives (spiritual). (p. 9)

Case management addresses both the individual client’s biopsychosocial-spiritual status (micro level) as well as the state of the social systems in which the services operate (macro level). (p. 10)

Health care settings are practice areas in which assessment, care, and treatment address the physical, mental, emotional, and social well-being of the person; and address prevention, detection, and treatment of physical and mental disorders with the goal of enhancing the person’s biopsychosocial and spiritual well-being. (p. 12)

Social workers recognize that ethnic, cultural, spiritual, and religious factors can have an impact on health care choices and adherence to regimens of care. (p. 18)

Essential areas of knowledge and understanding about health care include: . . . the psychological and spiritual needs of clients and families and how to ensure that they can be addressed. (p. 19)
Social work assessments in health care settings include considering relevant biomedical, psychosocial, and spiritual factors and the needs of the individual client and the family (as defined by the client). (p. 20)

Thus, as for physicians and nurses, the professional standards of social workers emphasize that assessing and addressing patients’ spiritual needs is part of the job description.

**STANDARDS FOR ACCREDITATION AND PAYMENT**

Organizations that monitor health care institutions also stress the need to address patients’ spiritual needs in the guidelines they publish. For example, the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) requires that hospitals, nursing homes, and home health care agencies respect the patient’s cultural and personal values, beliefs, and preferences (including religious or spiritual beliefs). JCAHO allows hospital organizations themselves to decide on what information should be collected during assessment to accomplish this. Although the Joint Commission does not require specific content for a spiritual assessment, it provides examples of what could be included in such an assessment. These might be questions such as: Does the patient use prayer in his or her life? How does the patient express his or her spirituality? What type of spiritual/religious support does the patient desire? What are the patient’s spiritual goals? Is there a role for the church/synagogue in the patient’s life? How does faith help the patient cope with illness? See chapter 1 for greater details on JCAHO standards and Medicare/Medicaid payment requirements.
**MEDICAL EDUCATION**

While many medical schools address spirituality and health in their curricula, the extent to which this is done varies tremendously. In the most recent and most systematic study to date on what medical schools are teaching, we surveyed the deans at 115 of 122 AAMC accredited medical schools in the United States. No fewer than 90 percent indicated that they have “courses” or “content in an existing course” on spirituality and health in their curriculum. Only 7 percent, however, had a dedicated required course on spirituality and health. Most (73 percent) said that they did not have a dedicated course but rather addressed spirituality and health in required courses focusing on other subjects. Qualitative interviews with a subsample of medical school deans revealed that the curricular content varied widely, that no standard curriculum was being used, and that addressing spirituality and health could mean a dedicated course, a single lecture on the topic, or part of a lecture focused on another topic. In addition, what the deans meant by “spirituality” also varied widely, and could include anything from ethics to palliative care to human values. Thus there was no common consensus on what should be taught or even agreement on what the word “spirituality” means. Based on this survey, and other systematic surveys of medical schools in the United Kingdom and Brazil, there is a pressing need for a guide to increase the uniformity of what is being taught.

**NURSING EDUCATION**

The exposure to spirituality and health in the curricula of nursing schools is somewhat greater than that in medical schools. In addition to surveying medical school deans, we collected the same information from deans at a sample of 104 American Association of Nursing College–affiliated nursing schools. Of the 64 schools that responded (62 percent), 14 percent had a required course dedicated to spirituality
and health (vs. 7 percent for medical schools); 31 percent had a dedicated elective course; 80 percent had a required course dedicated to another subject that had spirituality and health content (although again, the content varied widely); and 44 percent had spirituality and health content in an elective course dedicated to another subject. Only 6 percent of schools had no course or content (vs. 10 percent for medical schools). The nursing school deans were significantly more likely than medical school deans to say that spirituality and health content in the school curriculum was important (72 percent vs. 39 percent). Nursing deans were also more likely than medical school deans to say that more spirituality and health content was needed in their curriculum (66 percent vs. 43 percent), and that their faculty would welcome training opportunities in spirituality and health (45 percent vs. 24 percent). Thus, although the exposure in nurses’ training to spirituality and health is only slightly greater than for medical students, nursing school deans place more value on this content and are more receptive to further training.

Inclusion of content on spirituality and health in the medical curriculum is improving (56 percent of medical deans said that compared to ten years ago, spirituality and health education is a more developed part of the curriculum today). Nevertheless, the situation today in medical training still remains rather bleak, and is reflected in the practice of physicians after they leave medical school. Few physicians in practice inquire about the spiritual needs of patients. In the United States (based on 2005 data), only about 10 percent of physicians “often or always” take a spiritual history, and nearly 50 percent never take one.21 The situation isn’t much better in seriously ill or dying patients. Consider that a study conducted in the Bible Belt of the United States found that only about 7 percent of patients with serious or terminal illnesses had a spiritual history documented in their medical records by a physician.22

Many nurses do not address these issues either. This is despite the
fact that nursing has its historical roots in the religious professions. Until the turn of the twentieth century, virtually all nursing care was done by religious orders, and in the United Kingdom, competency in assessing the spiritual needs of patients remains a requirement for registration. Unfortunately, we know very little about the spiritual practices of nurses in the United States currently, and not much more than we did when the second edition was published in 2007 or even the first edition in 2002. After an extensive review of the literature, I could not find any research documenting the percentage of nurses who take a spiritual history (a task that often falls on nurses because of the JCAHO emphasis), and by “spiritual history” I don’t mean recording the patient’s denomination or asking if the patient wants to see a chaplain (although no systematic research documents that percentage either). It is safe to say that nurses today often do not take the kind of spiritual history that would fulfill even the minimum requirement specified by JCAHO prior to November 2008 (see chapter 8 for research related to nurses’ attitudes and behaviors toward addressing spirituality in patient care).

Exposure to spirituality and health in nursing schools appears to be improving, though. In our survey of nursing school deans in 2008, more than one-half (52 percent) said that spirituality and health education is a more developed part of the nursing curricula today compared to ten years ago (unpublished data). Because this is a “natural” area for nurses, especially given the increasing volume of research by nurses documenting its importance, I expect that nurses in the future will be addressing spiritual issues more and more.

SOCIAL WORK EDUCATION

Based on data I gathered from experts in this area, the latest information on spirituality and health curricula at schools of social work comes from a 1995 study. Russel surveyed the 118 graduate programs
in the United States that awarded an MSW and were accredited by the Council on Social Work Education. Of those schools, 114 responded. Of responding programs, 17 (15 percent) had courses on spirituality and/or religion. All but 4 of those courses were developed within the previous five years, and 8 courses had been developed within the previous two years. In 1990, then, only 4 of 114 schools had courses on spirituality and health, but by 1995, 13 additional schools had such courses. By 2005, according to a report by Canda, about 75 schools of social work had such courses, including 25 graduate education programs that involved cooperation between social work and theology, ministry, pastoral care, Jewish studies, or religious studies. Again, however, these courses varied widely in content with no uniform curriculum. According to David Hodge (personal communication), most social work scholars have documented the curricular content on spirituality/religion in social work programs by using retrospective data from former students. For example, consider a 2009 review by Sheridan, who reported that across 15 studies conducted between 1992 and 2007, between 66 percent and 89 percent of social work practitioners said they received little or no instruction on spirituality and health during their social work education. Canda and Furman reported similar findings. Therefore, while spirituality and health is beginning to be taught in U.S. graduate schools of social work, there is plenty of room for improvement.

ADDRESSING SPIRITUAL NEEDS

Consider these three facts: (1) between three-quarters and 90 percent of seriously ill patients report spiritual or religious needs during hospitalization; (2) over 70 percent of those spiritual needs are addressed minimally or not at all by the health care system (including chaplains); and (3) patient satisfaction surveys indicate that the addressing of emotional and spiritual needs during hospitalization
is among the lowest ranked of all clinical care indicators and highest in need of quality improvement. Who, then, in the hospital is (or should be) responsible for identifying and addressing spiritual needs? Despite the lip service given to the importance of meeting spiritual needs by physicians, nurses, and social workers in their ethical codes, professional standards, and training programs, it doesn't sound like this is happening.

When HPs are asked about the barriers to communicating with patients about these issues, a common response is that there are others both within and outside the health care system available to do this (i.e., chaplains and community clergy), so nonclergy health care professionals don’t need to. Is that true? Although community clergy often go to heroic efforts to see members of their congregation when those members are acutely hospitalized, living in nursing homes, or homebound, most clergy are not trained to deal with the complex spiritual needs that occur during serious medical illness. Furthermore, they often don’t have time to. There are many other priorities that pull on the sleeves of today’s pastors, rabbis, imams, and priests, and the time pressures they face are not that different from those that physicians and nurses deal with. Furthermore, many patients may not be regular churchgoers and won’t have clergy to visit them, and patients with serious medical illness will often be hospitalized at a location far from their local church. These are just some of the reasons why chaplains are needed.

Chaplains receive extensive training to address the spiritual needs of medical patients. However, under intense scrutiny to reduce the costs of care, hospitals have been reducing their pastoral care services or combining them with social services. In a study of 370 randomly sampled pastoral care departments, now over thirteen years old, 27 percent of department directors reported budgetary cutbacks. Over twenty years ago, all full-time chaplain positions in Georgia’s state psychiatric hospitals were eliminated to help make up for the state’s budget deficit, and the situation remained the same as of January