Religion, Spirituality and Health in Older Adults

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Overview

- Definitions
- Religion in the U.S.
- Stress and depression: common and increasing
- Stress affects physical health & need for healthcare services
- Use of religion to cope with stress, sickness, and disability
- Religion, depression, and quality of life
- Religion, alcohol/drug abuse, and crime/delinquency
- Religion, health behaviors, and healthier lifestyles
- Religion, physical health, and faster recovery
- Religion, and need for healthcare services
- Particularly relevant in older persons
- Clinical and community applications
Definitions

Facing the most difficult and thorny issue first
Religion

Involves beliefs, practices, and rituals related to the ‘transcendent,’ where the *transcendent* is that which relates to the mystical, supernatural, or God in Western religious traditions, or to Divinities, ultimate truth/reality, or enlightenment in Eastern traditions. Religion may also involve beliefs about spirits, angels, or demons. Religions usually have specific beliefs about the life after death and rules about conduct that guide behaviors within a social group. Religion is often organized and practiced within a community, but it can also be practiced alone and in private, outside of an institution. Central to its definition, however, is that religion is rooted in an established tradition that arises out of a group of people with common beliefs and practices concerning the transcendent. Religion is a unique construct, whose definition is generally agreed upon. It can be measured and examined in relationship to mental and physical health outcomes.
Spirituality

Spirituality is a concept which today is viewed as broader and more inclusive than religion. It is a term more popular today, much more so than religion. Spirituality is more difficult to define than religion. It is considered personal, something individuals define for themselves that may be free of the rules, regulations, and responsibilities associated with religion.

The term “spirituality” is most useful in clinical settings, since the goal is to be welcoming and inclusive, and for patients to define the term for themselves so that conversation may begin. But because of its vague and nebulous nature, it is difficult to measure and quantify for research purposes – especially since the definition of spirituality has been changing and expanding.
Traditionally-Historical Understanding

**Source**
- Religion
- Spirituality

**Mental Health**
- Meaning
- Purpose
- Connectedness
- Ex. well-being
- Peace
- Hope

**Physical Health**
- Depression
- Suicide
- Anxiety
- Addiction

**Psychoneuroimmunology**
- Cardiovascular Disease
- Cancer
- Mortality
Modern Understanding

Source

Spirituality

Religion vs. Secular

Mental Health

Meaning

Purpose

Connectedness

Ex. well-being

Peace

Hope

Depression

Suicide

Anxiety

Addiction

Physical Health

Cardiovascular Disease

Psychoneuroimmunology

Cancer

Mortality

Meaningful

Purposeful

Connected

Ex. well-being

Peaceful

Hopeful

Depressed

Suicidal

Anxious

Addicted

Cardiovascular

Cancer

Mortality
Modern Understanding - Tautological Version

Source

Religion

Spirituality

Secular

Mental Health

Meaning

Purpose

Connectedness

Ex. well-being

Peace

Hope

Physical Health

Depression

Suicide

Anxiety

Addiction

Cardiovascular Disease

Cancer

Mortality

Psychoneuroimmunology
Modern Understanding - Clinical Application only

Source

- Religion
- Secular

Spirituality

Mental Health

- Meaning
- Purpose
- Connectedness
- Ex. well-being
- Peace
- Hope

- Depression
- Suicide
- Anxiety
- Addiction

Physical Health

- Cardiovascular Disease
- Cancer
- Mortality

Psychoneuroimmunology

Not a Researchable Model
In this talk, to keep things simple and clear, I will be addressing relationships with health in terms of “religion”.

First, let us examine how “religion” might influence health. This is a theoretical model involving causal pathways and intermediary variables. The example to be provided is based in the Judeo-Christian-Islamic tradition, which views God as separate from humans and creation, and as personal.

Models like this exist for Eastern religious traditions as well, but my lack of expertise in those traditions make it easier for me to illustrate effects using a Western religious model.
God belief, relation, attachment

Public prac, rit

Private prac, rit

R commit

R exp

R coping

Health Behaviors, Lifestyle Choices, Decisions

Forgiveness

Altruism

Gratefulness

Social sup & connections

Positive Emotions*

Negative Emotions*

Genetics, Personality, Developmental Experiences

SOURCE

God belief, relation, attachment

Physical Health and Longevity

Immune, Endocrine, Cardiovascular Functions

Pathway / Order of Effects

*Positive emotions: peace, harmony, existential well-being, happiness, hope/optimism, meaning, purpose

*Negative emotions: depression, anxiety, emotional distress, loneliness, low self-esteem
Let us now examine the circumstances we are facing and the role that religion may play in them, especially for older adults.
Stress & Depression Common, Increasing

- Increased stress due to recent economic downturn
- Increased depression due to losses (jobs, homes)
- Increasing debt, decreasing savings
- Youth facing many choices, with fewer absolutes to guide
- Population aging, facing increasing health problems
- Few saving for retirement (fear)
Stress & Depression Affect Physical Health, Need for Health Services

- Myocardial infarction
- Hypertension
- Stroke
- Susceptibility to infection
- Slow wound healing
- Increase aging process
- Increase length of hospital stay, need for medical services
Religion in widespread in the United States

- 93% of Americans believe in God or a higher power
- 89% report affiliation with a religious organization
- 83% say religion is fairly or very important
- 62% are members of a church, synagogue or mosque
- 58% pray every day (75% at least weekly)
- 42% attend religious services weekly or almost weekly
- 55% attend religious services at least monthly
Belief in God
Membership
Importance
Attendance

Percent

13-17
18-29
30-49
50-64
65-74
75+

Many in U.S. Turn to Religion to Cope with Stress and Illness

- 90% turned to religion to cope with September 11th (NEJM)
- 90% of hospitalized patients rely on religion to cope
- >40% say it’s most important factor that keeps them going
- Hundreds of quantitative and qualitative studies report similar findings in persons with health problems, especially in minorities, women, the poor
- Research on the effects of religion on coping and health is growing rapidly world-wide
Religion/Spirituality-Health Articles 1960-2008 Cumulative

Search words: religion or religiousness or religious or religiosity or spirituality (2/20/09)

Thousands of Articles

Year


PsychInfo

Medline
Religion/Spirituality-Health Articles per 5-Year Period (Non-Cumulative)

Search words: religion or religious or religiosity or religiousness or spirituality (2/20/09)
Religion/Spirituality-Health Articles per 5-Year Period (Non-Cumulative)

Search words: religion or religious or religiosity or religiousness or spirituality (2/20/09)
Search words: psychotherapy or psychoanalysis (for comparison)
Religious involvement can buffer stress, reduce depression, enhance quality of life

Religion is related to:

- Lower perceptions of stress

- Less depression, faster recovery from depression
  (204 of 324 studies show depression less among religious)

- Greater well-being, happiness, meaning, purpose, hope
  (278 of 359 studies show positive emotions higher in religious)

- Increased quality of life
  (20 of 29 recent studies show QOL higher among religious)
Religion is related to:

- Less alcohol/drug use, especially among the young, although true for all ages groups (276 of 324 studies show significantly lower rates)
Religious live healthier lifestyles, have better habits, fewer risky behaviors

Religion is related to:

- Less cigarette smoking, especially among the young  
  (102 of 117 studies show significantly lower rates)

- More exercise  
  (4 of 6 studies show significantly more likely to exercise)

- Diet and weight  
  (1 of 8 studies show religious persons weigh less)

- Less extra-marital sex, safer sexual practices (fewer partners)  
  (45 of 46 studies show significant relationships)
Religious persons need and use fewer health care services – due to better health and more support from family, community

- Marital stability greater - less divorce, greater satisfaction (36 of 39 studies prior to year 2000)
- Social support greater (19 of 20 studies prior to year 2000)

Thus:
- Shorter hospital stays, fewer hospital days per year
- Less time spent in nursing home after hospital discharge (particularly for women and African-Americans)
Model of Religion's Effects on Health

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

Religion → Mental Health → Stress Hormones

Religion → Social Support → Immune System

Religion → Health Behaviors → Autonomic Nervous System

Religion → Health Behaviors → Disease Detection & Treatment Compliance

Religion → Health Behaviors → Smoking

High Risk Behaviors

Alcohol & Drug Use

Infection → Cancer → Heart Disease → Hypertension → Stroke → Stomach & Bowel Dis. → Liver & Lung Disease → Accidents & STDs*

* Sexually Transmitted Diseases

Genetic susceptibility, Gender, Age, Race, Education, Income

Childhood Training → Adult Decisions → Values and Character → Adult Decisions
Religion related to better physical health, recovery from illness

- Fewer heart attacks, fewer deaths from CAD
- Better recovery following cardiac surgery, fewer complications
- Lower cardiovascular reactivity to laboratory induced stress
- Lower blood pressure
- Less stroke
- Fewer metabolic problems
- Better immune functioning
- Lower stress hormone levels
- Less cancer, longer survival with cancer
- Less susceptibility to infection
- Greater longevity
- Slower cognitive decline with aging, Alzheimer’s disease
- Less functional disability with increasing age
Recent Studies

• Religious attendance associated with slower progression of cognitive impairment with aging in older Mexican-Americans
  Hill et al. *Journal of Gerontology* 2006; 61B:P3-P9

• Religious behaviors associated with slower progression of Alzheimer’s dis.

[for depression-cognition relationship see *Arch Gen Psychiatry* 2006; AGP 63:530-538; 2008;65(5):542-550; AGP 2008; 65(10):1156-1165]

• Fewer surgical complications following cardiac surgery
  Contrada et al. *Health Psychology* 2004;23:227-38

• Greater longevity if live in a religiously affiliated neighborhood

• Religious attendance associated with >90% reduction in meningococcal disease in teenagers, equal to or greater than meningococcal vaccination
Recent Studies - Physical Health Outcomes

- HIV patients who show increases in spirituality/religion after diagnosis experience higher CD4 counts/lower viral load and slower disease progression during 4-year follow-up

- Religion and survival in a secular region. A twenty year follow-up of 734 Danish adults born in 1914.

- Nearly 2,000 Jews over age 70 living in Israel followed for 7 years. Those who attended synagogue regularly were more likely than non-attendees to be alive 7 years later (61% more likely to be alive vs. 41% more likely to be alive for infrequent attendees. Gradient of effect.
  European Journal of Ageing 2007; 4:71-82

- Experimental study shows that less pain is experienced when subjects view religious vs. secular paintings; functional MRI scans documents that pain circuits in brain are reduced (Journal of Pain 2008, forthcoming)

Over 70 recent studies with positive findings since 2004
http://www.dukespiritualityandhealth.org
Applications to Clinical Practice

Spirituality in Patient Care, Second Edition
Templeton Foundation Press, 2007

Reviewed in JAMA 2008; 299:1608-1609
Why Address Spirituality in Clinical Practice

1. Not dependent on research alone; even without research, integrating spirituality into patient care has value.

2. Many patients are religious, would like it addressed in health care.

3. Many patients have spiritual needs related to illness that could affect mental health, but go unmet; mental health affects physical.

4. Patients, particularly when hospitalized, are often isolated from religious communities (requiring others to meet spiritual needs).

5. Religious beliefs affect medical decisions, may conflict with treatments.

6. Religion influences support and care in the community.
Take a Spiritual History

1. The screening spiritual history is brief (2-4 minutes), and is not the same as a spiritual assessment (chaplain).

2. The purpose of the SH is to obtain information about religious background, beliefs, and rituals that are relevant to health care.

3. If patients indicate from the start that they are not religious or spiritual, then questions should be re-directed to asking about what gives life meaning & purpose and how this can be addressed in their health care.
Physician Should Take The Spiritual History

1. Physician directs the care of the patient

2. Patient needs to feel comfortable talking with physician about spiritual issues

3. Patients' medical decisions are influenced by their religious beliefs

4. Patients' compliance with treatments are influenced by religious beliefs

5. Taking spiritual history enhances doctor-patient relationship & may itself affect health outcomes

6. Spiritual struggles can adversely affect health outcomes
Religious Struggle
444 hospitalized medical patients followed for 2 years

Each of 7 items below rated on a 0 to 3 scale, based on agreement. For every 1 point increase on religious struggle scale (range 0-21), there was a 6% increase in mortality, independent of physical and mental health
(Arch Intern Med, 2001; 161: 1881-1885)

- Wondered whether God had abandoned me
- Felt punished by God for my lack of devotion
- Wondered what I did for God to punish me
- Questioned the God’s love for me
- Wondered whether my church had abandoned me
- Decided the Devil made this happen
- Questioned the power of God
Contents of the Spiritual History


1. What is patient’s religious or spiritual (R/S) background (if any)

2. R/S beliefs used to cope with illness, or alternatively, that may be a source of stress or distress

3. R/S beliefs that might conflict with medical (or psychiatric) care or might influence medical decisions

4. Involvement in a R/S community and whether that community is supportive

5. Spiritual needs that may be present and need to be addressed for health reasons
Besides Taking a Spiritual History…

1. Support the religious/spiritual beliefs of the patient (verbally, non-verbally)

2. Ensure patient has resources to support their spirituality – refer patients with spiritual needs to CHAPLAINS

3. Accommodate environment to meet spiritual needs of patient

4. Be willing to communicate with patients about spiritual issues

5. Pray with patients if requested (?)

6. Prescribe religion to improve health (?)
Limitations and Boundaries

1. Do not prescribe religion to non-religious patients
2. Do not force a spiritual history if patient not religious
3. Do not coerce patients in any way to believe or practice
4. Do not pray with a patient before taking a spiritual history and unless the patient asks
5. Do not spiritually counsel patients (always refer to trained professional chaplains or pastoral counselors)
6. Do not do any activity that is not patient-centered and patient-directed
Community Applications
Projected growth of the U.S. elderly population (> 65)

2000 US Census

 Millions of People


Middle Series Estimates
High Series Estimates
What do these aging and economic trends mean?

1. Need of health services outstripping ability to pay for health services

2. Older adults falling through the cracks in terms of medical services and long-term care

3. Older adults without family members to care for them living out their latter days on city streets and parks

4. Need to identify community resources to help alleviate the burden of care off the health care system and off of young families
Prevention and Management of Disease

Primary, Secondary, and Tertiary


Congregation
- Clergy

Healthcare System
- Acute Care Hospital
  - Nurses
  - MDs
- Outpatient Clinics/Offices
  - Chaplains
  - Social workers
- Nursing Homes
  - Provides education/training
  - Provides speakers
  - Government Incentives
  - Provides $$ support

Volunteers
- Parish Nurse or Lay Leader
  - Mobilizing, training
  - Communicating
  - Run health programs - take BP's, blood sugars
  - Coordinate services - respite, homemaker

Larger Community
- Individual members
- Lay ministers
- Small group leaders

Provide services
  - Patient advocate
  - Supporting, calling, visiting

Physician Advisor
  - Motivating

Supporting, calling, visiting
Further Reading

**Medicine, Religion and Health** (2008, Templeton Press)

**Handbook of Religion and Health** (2001, Oxford University Press)


**Aging and God** (1994, Haworth Press)


**Further Information**
Website: Duke Center for Spirituality, Theology and Health
Summer Research Workshop
July and August 2009
Durham, North Carolina

5-day intensive research workshops focus on what we know about the relationship between religion and health, applications, how to conduct research and develop an academic career in this area (July 20-24, Aug 17-21, 2009) Leading religion-health researchers at Duke, UNC, USC, and elsewhere will give presentations:

- Previous research on religion, spirituality and health
- Strengths and weaknesses of previous research
- Applying findings to clinical practice
- Theological considerations and concerns
- Highest priority studies for future research
- Strengths and weaknesses of religion/spirituality measures
- Designing different types of research projects
- Carrying out and managing a research project
- Writing a grant to NIH or private foundations
- Where to obtain funding for research in this area
- Writing a research paper for publication; getting it published
- Presenting research to professional and public audiences; working with the media

If interested, contact Harold G. Koenig: koenig@geri.duke.edu