

Religion, Spirituality and Public Health: Research, Applications, and Recommendations

Testimony by Harold G. Koenig, M.D., to Subcommittee on Research and Science Education of
the U.S. House of Representatives on September 18, 2008

Summary

This report reviews *original* research published in social, psychological, behavioral, nursing and medical journals since the 1800s that has examined relationships between religion/spirituality (R/S) and the health of individuals and populations. I describe (1) the prevalence of religious beliefs and practices in United States; (2) the increasing stress in America and negative effects on physical health; (3) the role R/S play in coping with stress and physical illness; (4) the relationships between religious involvement, stress, and depression; (5) the relationships between religion, substance abuse, and health behaviors; (6) the relationships between religion and physical health; (7) the impact on need for medical care and use of health services; and (8) the effects on community resiliency following natural disasters and acts of terrorism. This review suggests that as many as 3,000 quantitative studies have now examined relationships between R/S and health (mental and physical), the majority reporting positive findings. I examine the implications this research has for public health and patient care, and make recommendations that could lead to a better understanding of these relationships and to applications that may improve public health, promote community resiliency, enhance patient care, and lighten the ever-increasing economic burden of providing health care and protecting our population.

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Introduction

Until recently, scientists have largely avoided studying the relationship between religion and health. A young faculty member wishing to examine these relationships was often told that conducting such research amounted to an “anti-tenure” factor. Furthermore, there was little if any funding from NIH to support such research. Religious beliefs and behaviors were largely thought of as too subjective, not quantifiable, unscientific, and based in fantasy and infantile projections or illusion (Freud). As a result, health professionals today ignore their patients’ religious or spiritual needs, and have little appreciation for their relationship to health.

Times are changing. There has been a tremendous surge in research examining relationships between religion, spirituality, and health (95% conducted without funding). Research on this subject carried out prior to the year 2000 has been systematically reviewed in the *Handbook of Religion and Health* (Oxford University Press, 2001). That review uncovered over 1200 studies published in a wide array for psychological, behavioral, medical, nursing, sociological, and public health journals. During the time since publication of this book, the amount of research on the subject has increased dramatically. An online search using the keywords “spirituality” and “religion” between 2000 and 2008 in *PsychInfo* (the American Psychological Association’s online database of research in the psychological, social, and behavioral sciences) recently uncovered 7,145 scientific articles (about 20% reporting original research). Repeating the same search but restricting the years to 1806 to 1999, uncovered 6,282 articles. Thus, more research on religion, spirituality and health has been published in the past 7-8 years than was published in the nearly 200 years before that. Covering this massive research base, then, is a daunting task.

The present report reviews *original* research conducted in the social, psychological, behavioral, and medical sciences that has examined relationships between religion/spirituality (R/S), and health. Where individual studies are cited, these represent some of the best work on the topic in terms of research design. They often utilize large representative population-based or clinical samples, control for relevant confounders, and employ distinctive, uncontaminated measures of religion/spirituality (R/S). Most studies are observational in research design, although a small number of clinical trials are included. Some aspects of this review are systematic (for example, studies on depression, positive emotions, substance abuse, delinquency, health behaviors), while others are not. For example, studies reported on physical health outcomes have been chosen to illustrate the kinds of studies published, but the review is not systematic. A complete systematic review of this area is now underway (*Handbook of Religion and Health*, 2nd edition, Oxford University Press, 2011).

Below I examine (1) the prevalence of religious beliefs and practices in the United States; (2) the increasing stress in our population and the negative effects of stress/depression on physical health; (3) the role that R/S plays in coping with stress and physical illness; (4) the relationships between religious involvement, stress, and depression; (5) the relationships between religion, substance abuse, and health behaviors; (6) the relationships between religious involvement and physical health; (7) the impact on need for medical care and use of health services; and (8) the effects that religious involvement has on community resiliency following natural disasters and acts of terrorism. Next, I examine the implications of this research for public health and clinical practice. Finally, I make a series of recommendations for members of Congress to consider.

Facts to Ponder

- *The United States is a very religious nation:*

Fact #1: 93% of Americans believe in God or a higher power, according to a Gallup Poll conducted in May 2008, (see website: <http://www.gallup.com/poll/109108/Belief-God-Far-Lower-Western-US.aspx>).

Fact #2: 89% of Americans report affiliation with a religious organization (82% Christian, i.e., Protestant or Catholic), according to a representative national survey conducted by Baylor Institute for Studies of Religion in September 2006 (see website: <http://www.baylor.edu/content/services/document.php/33304.pdf>). Same figures reported by Gallup Poll in December 2007 (see website: <http://www.gallup.com/poll/103459/Questions-Answers-About-Americans-Religion.aspx>)

Fact #3: 83% of Americans say religion is fairly or very important to them, according to a September 2006 Gallup Poll (latest data available) (see website: <http://www.gallup.com/poll/25585/Religion-Most-Important-Blacks-Women-Older-Americans.aspx>)

Fact #4: 62% of Americans say that they are members of a church or synagogue, according to a December 2007 Gallup Poll (latest data available) (see website: <http://www.gallup.com/poll/103459/Questions-Answers-About-Americans-Religion.aspx>)

Fact #5: 58% of Americans pray every day (and 75% at least weekly), according to a 2008 U.S. Religious Landscape Survey (see website: <http://religions.pewforum.org/>)

Fact #6: 42% of Americans attend religious services weekly or almost weekly (and 55% attend at least monthly), according to aggregate Gallup Pools in 2007 (see website: <http://www.gallup.com/poll/105544/Easter-Season-Finds-Religious-Largely-Christian-Nation.aspx>).

- *Stress and depression are common in American society, especially due to the recent economic downturn. Both stress and depression worsen when people develop medical illness and health problems.*

Fact #1: Stress levels, and likely stress-related disorders, are increasing in the United States, based on Associated Press-AOL poll (see website: <http://www.aolhealth.com/healthy-living/debt-stress>; also see: http://www.usatoday.com/news/health/2007-10-23-stress_N.htm)

Fact #2: Rates of significant depression in the community are about 5-10%, and place a substantial burden on the economy due to cost of treating depression and time lost from work due to depression-related disability (*Journal of the American Medical Association* 2002,

287:203-209; *Journal of Clinical Psychiatry* 2003m 64:1465-1475; *Pharmacoeconomics* 2007, 25:7-24)

Fact #3: Nearly 50% of hospitalized medical patients develop depressive disorder, usually due to the prolonged stress and life changes caused by medical problems (*American Journal of Psychiatry* 1997; 154:1376-1383)

- *Stress and depression have effects on physical health and need for health services*

Fact #1: Psychological stress and depression adversely affect health. This applies to a wide range of medical outcomes (hypertension, myocardial infarction, stroke, speed of wound healing, etc.), and may even affect the aging process itself (based on changes at the DNA level) (*Lancet* 1996, 346:1194-1196 (wound healing); *New England Journal of Medicine* 1998, 338:171-179 (general review); *Lancet* 2003, 362:604-609 (prognosis after myocardial infarction); *Proceedings of the National Academy of Sciences* 2004,101:17312-5 (cellular aging))

Fact #2: Depression increases length of hospital stay and cost of medical services, in addition to adversely affecting the quality of life of the patient and their family (*American Journal of Psychiatry* 1998, 55:871-877; *Social Psychiatry and Psychiatric Epidemiology* 2004, 39:293-298; for more recent information, see the following NIH report: <http://www.nih.gov/news/pr/jan2007/nimh-19.htm>)

- *Many in the United States turn to religion for comfort when stressed or sick.*

Fact #1: Religion is often used to cope with stress. Following the terrorist attacks on September 11, 2001, research shows that 9 out of 10 Americans turned to religion to cope (*New England Journal of Medicine* 2001, 345:1507-1512)

Fact #2: Religion is often used to cope with mental/physical health problems. Research shows that in some areas of the United States, 9 out of 10 hospitalized patients say they use religion to cope with illness, and over 40% say that it is the most important factor that keeps them going. (*Handbook of Religion and Health*, 2001; Oxford University Press). Since the year 2000, over 130 separate *quantitative* studies have documented high rates of religious coping in a range of health conditions, especially in minority groups and in women. This number does not include hundreds of peer-reviewed published *qualitative* studies (in the words of patients) that support these findings.

- *Religious involvement may help to reduce stress, minimize depression, and enhance quality of life.*

Fact #1: Because of its effectiveness as a coping behavior, religious involvement may **reduce psychological stress, buffer against depression, and speed recovery from emotional disorders** (*American Journal of Psychiatry* 1992, 149:1693-1700; *American Journal of Psychiatry* 1998, 155:536-542; *Journal of Nervous and Mental Disease* 2007, 195: 389-395).

Of studies examining religion and depression prior to the year 2000, 64 of 101 studies (64%) reported less depression or faster recovery from depression among the more religious (*Handbook of Religion and Health*, *ibid*). Since the year 2000 (past 7-8 years), 140 of 223 studies (63%) reported less depression or faster recovery from depression in the more religious (unpublished review).

Fact #2: Religious involvement is associated with positive emotions (greater well-being, happiness, optimism, hope, meaning and purpose in life) and higher quality of life.

Well-being: Of research conducted prior to the year 2000, 106 of 131 studies (81%) reported that religious persons experienced more positive emotions (*Handbook of Religion and Health*, *ibid*). Since the year 2000 (past 7-8 years), 172 of 228 studies (75%) have reported this same finding (unpublished review). **Quality of Life:** Since the year 2000, 20 of 29 studies on R/S and quality of life reported that they were positively associated.

- *Religious involvement is related to lower rates of alcohol and drug abuse, less crime and delinquency, and better grades in school.*

Fact #1: Religious involvement predicts **lower rates of alcohol and drug use**, particularly in high school students, college students, and young adults (*Prevention Science* 2001, 2(1):29-43; *Social Science Research* 2003, 32:633-658; *Psychology of Addictive Behaviors* 2003, 17:24-31; *Social Science & Medicine* 2003, 57:2049-2054; *Journal of Adolescent Health* 2006, 39:374-380; *Journal of Adolescent Health* 2007, 40:448-455; *Alcoholism: Clinical and Experimental Research* 2008, 32:723-737).

Concerning research published prior to the year 2000, 124 of 138 studies (90%) reported less alcohol and drug use/abuse in those who were more religious (*Handbook of Religion and Health*, *ibid*). Since the year 2000 (past 7-8 years), an *incomplete review* indicates that 152 of 186 studies (82%) reported this same finding (unpublished review). Thus, 276 of 324 studies report significant inverse relationships between religious involvement and substance abuse.

Fact #2: Delinquency rates and crime are less frequent in those who are more religious (*Journal of Adolescent Research* 1989; 4:125-139; *Sociology of Religion* 1996; 57:163-173; *Social Forces* 2004; 82:1553-1572; *Journal of Family Issues* 2008; 29:780-805)

Prior to the year 2000, 28 of 36 studies (78%) reported that delinquency or crime rates were lower among the more religious (*Handbook of Religion and Health*, *ibid*). Since the year 2000 (past 8 years), an *incomplete review* indicates that 12 of 16 studies (75%) report similar findings.

- *Religious involvement is related to healthier life styles and fewer risky behaviors that could adversely affect health*

Fact #1: Religious involvement is associated with better health behaviors, including **less cigarette smoking and more exercise** (Cigarette smoking: *Journal of Gerontology, Medical Sciences* 1998, 53:M426-434; *Prevention Science* 2001, 2:29-43; *Social Science & Medicine* 2003, 57:2049-2054; *Families in Society* 2004, 85:495-510; *Nicotine & Tobacco Research* 2006, 8:123-133; *Journal of Adolescent Health* 2007, 40:506-513; Exercise: *American Journal of Public Health* 1997, 87: 957-961; *Activities, Adaptation & Aging* 2002, 26:17-26; *Family & Community Health* 2006, 29:103-117)

Smoking: Prior to the year 2000, 22 of 25 studies (88%) indicated that religious persons are less likely to smoke cigarettes (*Handbook of Religion and Health*, *ibid*). Since the year 2000, an *incomplete review* indicates that 28 of 33 studies (85%) reported this finding. **Exercise:** Four of six studies have reported that religious persons are more likely to exercise. **Weight,** however, is another issue; only 1 of 8 studies show that religious persons weigh less than those who are less religious (probably because of those potluck suppers!).

Fact #2: Religious involvement is related to **less extra-marital sex and safer sexual practices** (fewer partners) (*Social Psychology Quarterly* 1985; 48:381-387; *American Journal of Public Health* 1992; 82:1388-1394; *Journal of the American Medical Association* 1997, 278:823-832; *Social Science & Medicine* 2003, 57:2049-2054; *American Journal of Community Psychology* 2004, 33(3-4):151-161; *Pediatrics* 2006, 118:189-200)

Prior to the year 2000, 37 of 38 studies reported this finding. Since 2000, an *incomplete review* indicates that 8 of 8 studies (100%) report this.

Fact #3: Religious involvement is related to a **lower risk, healthier lifestyle, particularly among youth**. This includes greater likelihood of wearing seat belts, better sleep quality, regular vitamin use, regular physical and dental visits, etc. (*Psychological Reports* 1991; 68:819-826; *Health Education and Behavior* 1998; 25:721-741; *European Journal of Pediatrics* 2005; 164:371-376; *Preventive Medicine* 2006; 42:309-312; *Journal of the National Medical Association* 2006,98:1335-1341)

- *Religion is related to better physical health and faster recovery*

Fact #1: Religious involvement is associated with less cardiovascular disease, improved outcomes following cardiac surgery, lower rates of stroke, less cardiovascular reactivity and lower blood pressure, better immune/endocrine functioning, improved outcomes for patients with HIV/AIDS, lower risk of developing or better outcomes from cancer, and less susceptibility to infection:

Coronary artery disease: *International Journal of Cardiology* 1986, 10:33-41; *Cardiology* 1993, 82:100-121; *American Journal of Cardiology* 1996, 77:867-870; *Journal of Clinical Epidemiology* 1997, 50:203-209.

Cardiac surgery: *Psychosomatic Medicine* 1995, 57:5-15; *Health Psychology* 2004, 23:227-238.

Cardiovascular reactivity: *International Journal of Neuroscience* 1997, 89:15-28; *Annals of Behavioral Medicine* 2004, 28:171-178; *Journal of Health Psychology* 2005; 10:753-766.

Blood pressure: *Hypertension* 1988; 12:457-461; *Hypertension* 1995; 26:820-829; *International Journal of Psychiatry in Medicine* 1998, 28:189-213; *Behavioral Medicine* 1998, 24:122-130; *Psychosomatic Medicine* 2001, 63:523-530; *Journal of Gerontology* 2002, 57B: S96-S107; *Journal of Biosocial Science* 2003, 35:463-472; *Psychosomatic Medicine* 2006, 68:382-385.

Stroke: *American Journal of Epidemiology* 1992, 136:884-894; *Stroke* 2000, 31:568-573.

Metabolic problems: *Diabetes Care* 2002, 25(7):1172-1176; *Archives of Internal Medicine* 2006, 166:1218-1224; *Psychosomatic Medicine* 2007, 69:464-472

Immune/endocrine: *Psychology and Health* 1988, 2:31-52 *International Journal of Psychiatry in Medicine* 1997, 27:233-250; *Journal of Psychosomatic Research* 1999, 46:165-176; *Breast Journal* 2001, 7:345-353; *Annals of Behavioral Medicine* 2002; 24:34-48; *Journal of Biological Regulators & Homeostatic Agents* 2003, 17: 322-326; *Health Psychology* 2004, 23:465-475; *International Journal of Psychiatry in Medicine* 2004, 34:61-77; *Journal of General Internal Medicine* 2006, 21:S62-68; *Journal of Psychosomatic Research* 2006, 61:51-58.

Cancer: *Journal of the National Cancer Institute* 1989, 81:1807-1814 (misc. cancers); *Journal of the Royal Society of Medicine* 1993, 86:645-647(colorectal); *Social Indicators Research* 1996, 38:193-211 (misc. cancers); *International Journal of Psychiatry in Medicine* 2002, 32:69-89 (gastrointestinal); *International Journal of Psychiatry in Medicine* 2003, 33:357-376 (breast); *American Journal of Epidemiology* 2003; 158:1097-1107 (colon); *Oral Oncology* 2006, 42:893-906 (oral).

Infection susceptibility: *British Medical Journal* 2006, 332(7539):445-450.

For reviews of the research before 2000, see *Handbook of Religion and Health*, *ibid.* For a more recent review, see *Medicine, Religion and Health* (2008, Templeton Press). For a critique of this research, see *Lancet* 1999, 353(9153):664-667, and *Blind Faith* (2006, St. Martin's Press).

Fact #2: Religious involvement predicts **greater longevity** and lower mortality, with religious attendance being the strongest predictor (and associated with 7-14 years of additional life) (*American Journal of Public Health* 1996, 86:341-346; *American Journal of Public Health* 1997, 87:957-961; *Demography* 1999; 36:273-285; *Journal of Gerontology, Medical Sciences* 1999, 54:M370-M37; *Journal of Gerontology, Medical Sciences* 2000, 55:M400-405; *Archives of Internal Medicine* 2001, 161:1881-1885; *Annals of Behavioral Medicine* 2001, 23:68-74; *Research on Aging* 2002; 22:630-667; *American Journal of Epidemiology* 2002, 155:700-709; *Journal of Health and Social Behavior* 2004, 45:198-213; *Annals of Epidemiology* 2005, 15:804-810; *International Journal of Epidemiology* 2005, 34:443-451; *Journal of Clinical Epidemiology* 2005, 58:83-91; *Journal of Gerontology* 2005, 60:S102-S109; *Journals of Gerontology* 2006, 61:S140-S146)

Fact #3: Religious activity predicts **slower progression of cognitive impairment** with aging, and may be associated with a slower progression of Alzheimer's disease (*Journal of Gerontology* 2003, 58B:S21-S29; *Journal of Gerontology* 2006, 61:P3-P9; *Neurology* 2007, 68:1509-1514 (Alzheimer's); *Journal of Gerontology, Medical Sciences* 2008, 63:480-486)

Fact #4: Religious involvement predicts **less functional disability** with increasing age, and faster functional recovery following surgery (*American Journal of Psychiatry* 1990, 147:758-759;

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Journal of Gerontology 1997, 52B:S306-S316; *Journal of Aging and Health* 2004, 16:355-374; *Research on Aging* 2008, 30:279-298)

- *All things being equal, religious people need and use fewer health care services; this is because they are healthier, more likely to have intact families to care for them, and have greater social support*

Fact #1: Religious involvement is related to greater marital stability and social support, particularly in minority communities. This affects the kind of support and monitoring a person with chronic illness will have in the community (which may keep them out of the hospital or out of a nursing home). **Marital stability:** *Journal of Health and Social Behavior* 1989, 30:92-104; *Behavior Genetics* 1992, 22:43-62; *Journal for the Scientific Study of Religion* 1997, 36:382-392; *Addiction* 2007, 102:786-794. **Enhanced family relationships:** *Sociological Quarterly* 2006; 47:175-194. **Social support:** *Research on Aging* 1991, 13:144-170; *Journal of Gerontology* 1997, 52B:300-305; *American Journal of Geriatric Psychiatry* 1997, 5:131-143; *Health Care for Women International* 2001, 22:207-227; *Journal of Palliative Medicine* 2006, 9:646-657; *Journal of Health Psychology* 2007, 12:580-596). Prior to the year 2000, 19 of 20 studies found that religious persons had significantly more social support.

Fact #2: Religious involvement is associated with **lower rates of health services use** (medical), both acute hospitalization and long-term care (*Social Science & Medicine* 1988, 27:1369-1379; *Southern Medical Journal* 1998, 91:925-932; *International Journal of Psychiatry in Medicine* 2002, 32:179-199; *Archives of Internal Medicine* 2004, 164:1579-1585)

- *Communities with high percentage of religious involvement recover more quickly from natural disasters and acts of terrorism*

Fact #1: After the police, firefighters, and emergency medical technicians, religious communities are often the first responders and often the most enduring responders following disasters. The extensive literature (both research studies and popular articles) documenting this fact is described in two books, *In the Wake of Disaster: Religious Responses to Terrorism and Catastrophe* (Templeton Press, 2006), and *Tend my Flock: Emergency Planning for Faith Communities* (forthcoming, 2009).

Fact #2: Religious involvement is related to better mental health, greater community resilience, and higher social capital following disasters (*Journal of Community Psychology* 2000, 28:169-186; *Annals of the New York Academy of Sciences* 2006, 1094:303-307; *Journal of Health Care for the Poor & Underserved* 2007, 18:341-354; *Social Science & Medicine* 2008, 66:994-1007)

Implications for Public Health and Patient Care

So what? Should we try to make people more religious? There are numerous direct public health and clinical applications for all of the above that have nothing to do with prescribing religion, endorsing religion, or over-stepping the bounds of church-state separation that the 1st Amendment guarantees. I divide the implications of this research into two categories: implications for public health and implications for clinical care.

Implications for Public Health

(1) More research is needed. Although there is every reason based on existing research to suggest that religious involvement is related to better health, we don't really understand why this is the case. Religion can certainly have negative health effects as well, but certain aspects of religion (cognitive, behavioral, or social) appear have positive effects on health and well-being. Is this not relevant to the health of our population and resiliency of our communities? The problem is that we don't know what aspects of religion are particularly healthy, or how these health benefits occur in terms of behavioral and physiological mechanisms. We also don't fully know how religion impacts the health of communities, or their resiliency to crime, poverty, teenage pregnancy, school performance, venereal disease transmission, natural disasters, etc. Given the widespread prevalence of religious beliefs and activities (with nearly 200 million church members, and over 125 million weekly church attendees), even small effects on either individual or community health could have enormous public health impact.

(2) Although it is not ethical or desirable to change or increase religious involvement for health reasons, it is important for social and behavioral scientists to learn how R/S is affecting health and then inform the public about this. People, then, will need to make their own choices in this regard, free from coercion or manipulation. Furthermore, doesn't the majority of the U.S. population for whom religion is important deserve to know what effect their religious beliefs and practices are having on their health? This is particularly true since certain religious practices in some settings may actually worsen health (about 5-10% of studies find negative correlations between religion and health). For religious beliefs, practices, and rituals that are shown to improve health, knowing this may help to boost the health effects that these beliefs/practices have for religious people (since it may encourage them to continue these practices, or may help them to utilize their beliefs to help them change unhealthy lifestyles). Thus, education of the public and dissemination of research findings about factors that may affect health is an important role for both health professionals, as well as for government agencies interested in maintaining and enhancing the health of the population.

(3) There are many human characteristics that we study in the social and behavioral sciences that we cannot change, but need to understand what impact they are having on health for planning purposes (i.e., anticipating health care needs of the population). These include age, gender, race, ethnic background, sexual preference, political belief, etc. There are also characteristics that we may be difficult to change, and yet we need to know how these factors affect health and use of health services. These include the effects of poverty, personality, level of social involvement, health habits, obesity, and so forth. This doesn't prevent us from conducting research to better understand how these factors affect health. For some reason, however, religion seems to be

placed in a different and separate category. Currently, there is widespread bias in the mainstream scientific community against research on the health effects of traditional religious beliefs and practices [just take a look at the portfolio of NIH grants and see how many grants in the psychological, social, and behavioral sciences are focused this area of research].

(4) What about one-third of the U.S. population who are not religious? It may be that they too will benefit from research on religion, spirituality and health. By learning about how R/S affects health, we can apply this knowledge to non-religious settings and to non-religious people using secular techniques. For example, how does religious involvement convey meaning and purpose, hope, self-esteem, protection from depression, and buffer against stress (and perhaps consequently reduce blood pressure, heart attacks, and stroke, or slow the development of cognitive impairment and disability with age)? If we know the mechanisms, we could use them to enhance the way secular beliefs and behaviors provide these healthy effects. This would benefit everyone.

(5) There is even some research that suggests that communities where high proportions of the population are members of religious groups have better health in general, even the non-religious people who live in those communities (see *Annals of Epidemiology* 2005, 15(10):804-810; *American Journal of Sociology* 2005, 111:797-823). Shouldn't public health experts be interested in why and how this occurs? Would such research not provide clues on how to enhance the health of entire populations?

(6) There are few places where people of all ages (young, middle-aged, and elderly), all socioeconomic levels, and all ethnic backgrounds congregate on a regular basis as happens in religious communities. This makes religious organizations an ideal route by which to provide health screening, health education, and other disease detection and prevention services. A few studies have shown that health education programs in churches can affect diet, weight, exercise, and other health behaviors, and this is particularly true for minority communities who often do not have easy access to such information or to preventative healthcare services. Religious communities may also be an ideal place to provide alcohol and drug education, as well as inculcate moral values and character that could affect future decisions that impact health, prosocial behaviors, and even affect the ability to afford health insurance during adulthood. More research is needed and effective programs developed. Again, such efforts could have a direct impact on public and community health.

(7) Religious communities often have altruism as one of their basic values. Thus, members of churches, synagogues and mosques represent an army of potential volunteers to assist with social programs, mentoring, and direct service provision. This is perhaps most evident with regard to disaster preparation and response. Why are we not supporting and nourishing this role that many faith communities are already engaged in? Instead, faith groups often meet resistance from formal emergency management services when they try to help, since they are not integrated into these efforts. Without the volunteer help that faith communities provide, it is not hard to imagine what the additional cost to FEMA might be. The health of our communities, particularly when affected by natural disasters or acts of terrorism, may depend on whether religious communities are fully prepared and involved in response efforts.

Implications for Patient Care

(1) If future research confirms that religious involvement significantly affects mental and physical health, then health professionals need to be educated about this and need to consider this in their treatment of patients. In fact, one could argue that there is already sufficient research evidence to begin to do this. Furthermore, there are other reasons why health professionals should be integrating spirituality into patient care. Here are a few (see *Spirituality in Patient Care*, 2007, for a complete description):

- Many patients are religious or spiritual, and would like it addressed in their health care. Because religious beliefs are used to cope with illness (either mental or physical), religious patients would like their spiritual needs to be acknowledged and addressed by their physicians (and by nurses who provide more direct and personal care)
- Patients, particularly when hospitalized or imprisoned by chronic illness, are often isolated from their religious communities. Our country has recognized that when people are prevented from practicing their religious faith because of circumstances imposed on them, we have provided the resources necessary for them to practice their faith (based on the principle of religious freedom). This is why we have chaplains in the army, and in federal and state prisons and psychiatric facilities. Hospitalized patients with medical problems or the chronically ill are no different. Many people are hospitalized far away from their religious communities of support (this is especially true for nursing homes, where contact is minimal even when religious communities are nearby).
- Religious beliefs affect medical decisions, and may conflict with medical treatments. This is a very practical reason why health professionals need to communicate with patients about religious or spiritual beliefs. Studies find that 45% to 73% of seriously ill patients indicate that their religious affect their medical decisions (*Archives of Internal Medicine* 1999, 159:1803-1806; *Journal of Clinical Oncology* 2003, 21:1379-1382; *Family Medicine* 2006, 38:83-84). Yet 90% of physicians do not take a spiritual history or discuss these matters with patients, and 45% of physicians say that it is not appropriate to do so (*Medical Care* 2006, 44:446-453). How can physicians practice competent medicine if they don't have knowledge about factors that will affect compliance with the treatments they prescribe?
- Religious struggles or spiritual conflicts over medical issues have been shown to predict increased mortality and worse medical outcomes (see *Archives of Internal Medicine* 2001, 161: 1881-1885). If left undetected and not addressed, these struggles may adversely affect disease course despite the best of medical treatments.
- Religion influences health care in the community. Because of the rising costs of health care, most health care is now shifting out of the hospital and into the community. Hospital stays are becoming shorter and shorter (since hospitalization is the most expensive form of medical care), and people are being discharged sicker and sicker into the community. If patients are involved in a religious community, they will have a ready support system that can provide emotional support, monitor compliance, and provide practical services (meals, home-maker services, respite care, rides to physician office). If they are not, then they are dependent on family members for support, and if no family is available, then they are forced to rely on the government. This will become a real issue

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as our population ages and the medical needs escalate (*Faith in the Future: Healthcare, Aging, and the Role of Religion* -- see Further Readings).

(2) What are some sensible ways that clinicians can integrate spirituality into patient care, without prescribing religion or coercing patients to believe or practice? First of all, most of their patients are already religious to at least some degree (recall that up to 90% of seriously ill patients in some parts of the U.S. use religion to cope), so clinicians don't have to promote religion. It's already there. What they do need to do, however, is to recognize it, support it, and consider it when making medical decisions and developing treatment plans. Here are some ways to do that:

- For patients admitted to the hospital or those with serious or chronic medical illness, physicians should take a brief, screening spiritual history that identifies if spiritual beliefs are (1) important to the patient, (2) helping the patient to cope (or, alternatively, are causing spiritual struggles), (3) influence medical decisions or conflict with treatments prescribed, (4) membership in a supportive spiritual community, and (5) whether there are any spiritual needs that someone should address (see *Journal of the American Medical Association* 2002, 288:487-493). This takes about 2 minutes to conduct.
- Support (verbally and non-verbally) the religious or spiritual beliefs of patients if those beliefs are helping the patient to cope.
- If spiritual needs or conflicts are identified, refer patients to professional chaplains or trained pastoral counselors to address these needs.
- If patients are not religious, then the spiritual history should focus on what gives patients lives meaning and purpose in the setting of illness (grandchildren, hobbies, etc.), and then those activities supported. Religion should never be prescribed, forced, or even encouraged in patients who are not already religious, so as not to add guilt to the already heavy burden of illness. Inquiry and support in this area must always be patient-centered and patient-directed.

(3) Health professionals in hospital and outpatient settings should be willing to accommodate the religious or spiritual beliefs and traditions of patients. Examples: For the American Indian, this may involve altering the environment (or providing alternative environments) so that traditional spiritual ceremonies concerning sickness and death may be performed (if requested by the patient or family). For the Muslim patient, the environment should be altered so that the patient can perform his or her daily prayers, and care arranged so that only gender-matched health professionals give personal care. Religious and cultural sensitivity will help both the patient and the family to cope better with illness, will improve patient and family satisfaction with care, and thereby will likely enhance medical outcomes.

(4) Efforts should be made to ensure that there are adequate numbers of chaplains available so that patients' spiritual needs can be adequately addressed. A recent study conducted by Harvard investigators documented that three-quarters (72%) of patients dying of cancer said that their spiritual needs were minimally or not at all met by the medical system (i.e., doctors, nurses, or chaplains) (*Journal of Clinical Oncology* 2007, 25:555-560). Currently, there are only enough chaplains in U.S. hospitals to see about 20% of patients (1 in 5) (*International Journal of*

Psychiatry in Medicine 2005, 35:319-23). There are typically no chaplains in outpatient settings and no chaplains in nursing homes. Who meets these patients' spiritual needs?

Recommendations

Recommendations for members of Congress emphasize their providing support for research on R/S and health (support for both research training and research projects); public education of the role of religion in health and wellness; health professional education on why and how to integrate spirituality into patient care; and motivating healthcare systems to allow health professionals the time necessary to address the spiritual needs of patients. Finally, recommendations are provided for supporting and integrating efforts by religious organizations in disaster preparation and response.

I. Support Research

- (1). Because research on the effects of religious/spiritual beliefs and behaviors is a substantial need, **current barriers at NIH to funding research on the effects of traditional religious beliefs/behaviors need to be overcome**. This could be done by (1) assigning a specific branch at NIH to review such grants, (2) ear-marking funds to support such research, (3) establishing review sections at NIH with the specific expertise and sensitivity to this topic so as to give such grants a fair chance of being awarded.
- (2). Provide **NIH training grants** to support the development of young researchers on university faculty to conduct research in this area, or to help senior investigators to transition their research into this area. There are currently models at NIH of junior and senior investigator awards, but none focus on supporting the training of researchers to study the health effects of R/S.
- (3). Urge NIH to develop a “**request for proposals**” (RFP) in the area of the effects of traditional religious beliefs and behaviors on mental, physical, and social/community health. The John Templeton Foundation may be willing to partner with the NIH to provide support for such a competitive grants program.
- (4). Establish an **intramural research program at the NIH** to examine the impact of religious beliefs and practices on public health, the cost-savings that this might produce, and the effectiveness and acceptability of disease detection and prevention programs within (or in cooperation with) religious organizations, especially in minority congregations.

II. Support Congregational Health Programs

- (1). Consider partial government **support for parish nurse programs** within religious congregations that provide disease screening, health education, lifestyle change, and volunteer recruitment and training for service delivery. If that latter keeps members of religious communities in their homes and out of hospitals or nursing homes, then this could represent a substantial cost savings for Medicare and Medicaid.

(2). Along these same lines, encourage the **development of health care system–religious congregation partnerships**. This would involve closer working relationships between local hospitals or medical systems and religious communities for the purposes of providing early disease detection and referral for treatment, volunteer recruitment and training, and the teaching of health promotion activities that encourage self-care, keep people healthy, and reduce the need for expensive medical services (Florida Hospital is a good model to follow). Such efforts could also be expanded outside of congregations to persons in the general community who need services, but have fallen through the cracks of the current healthcare system.

III. Educate the Public

(1). Develop a public education campaign to help **disseminate research findings** (both past research and new research) on the role that R/S plays in maintaining health and well-being. There is already great public interest in this topic as exemplified by multiple cover stories on spirituality and health in popular magazines such as Reader’s Digest, Newsweek, Time, Prevention, and others.

(2). Support/encourage **adult education classes** at state and federally funded universities to teach the public about relationships between R/S and health, and how people can take advantage of these relationships to prevent disease, overcome addiction, and enhance their health and well-being. These classes should also emphasize the seeking of timely medical care, and the important role that allopathic medicine plays in health and wellness. Religion and medicine should complement each other, not compete or conflict.

(3). The public should be taught **how to talk with their doctors about R/S**. If religion is important to a patient, should this be a consideration in their selection of a physician? What are some ways that patients can communicate with their physicians about the important role that religion plays in their lives and how it could influence their medical decisions? A recent article by Elizabeth Cohen on CNN.com illustrates such an approach (see website: <http://www.cnn.com/2008/HEALTH/09/11/ep.faith.medicine/index.html?iref=newssearch>).

(4). The public should also be **taught how to talk with their clergy about initiating a health programs** within their local religious congregation. If the 500,000 religious congregations in America all had such programs, then two-thirds of the U.S. population would be exposed to disease detection, disease prevention, and health promotion efforts. Since persons of all ages participate regularly in religious congregations, this means that health education efforts would occur at all ages, from the young (focused on substance abuse prevention and character development) to the middle aged (focused on healthy eating, exercise, stress-reduction, etc.) to the elderly (focused on volunteering, mentoring and generative types of activities).

IV. Include Faith Communities in Disaster Preparation and Response

Part of maintaining public health involves protecting communities who may be in constantly threat of natural disasters and even terrorist attacks, and helping them to recover if those events occur. Religious organizations already play a big role in this regard, both at the individual level in helping persons cope with the stress of the event and on the community level in helping

communities minimize their losses in the short term and recover over the long term. What can the government do to support faith-based efforts? Here are some recommendations (see *In the Wake of Disaster* for more details):

(1). **Research and Education.** Research is needed to determine the prevalence of spiritual needs and the extent to which they are met (and by whom) during each phase of a disaster. Further research on the relationship between addressing spiritual needs and long-term mental health outcomes following disasters is critically needed. Systematic data are needed on the activities of clergy and non-clergy volunteers from the faith community following disasters. Although more research is clearly needed, much is already known that justifies a major educational initiative. Education is needed for Emergency Management Services (EMS) agencies/personnel, mental health authorities, and faith-based groups to help dispel myths and misconceptions about each other, to define the unique roles that each group serves, and to emphasize the consequences of not valuing and not including each other in the disaster response.

(2). **Leadership.** Government supported EMS agencies should take the lead in inviting Faith-Based Organizations (FBOs) to participate in disaster planning and response. Government agencies should encourage interested FBO's to identify the types of resources they wish to contribute to the disaster response effort. This may involve efforts to coordinate disaster response; mobilize and train clergy and congregational volunteers to provide psychological, social and spiritual support; raise funds or material necessities to assist victims during their recovery; or many other potential activities.

(3). **Organize and coordinate.** Government supported EMS agencies need to take the initiative to establish a body to coordinate FBO efforts. Once established, it could organize itself into national and local networks.

(4). **Include in Planning Phase.** On the local level, EMS agencies should include deployment of FBO resources as part of their response protocol. As noted above, this would require that the leaders of local FBOs are included in disaster response planning.

(5). **Encourage teamwork, partnership and collaboration.** Partnerships should be encouraged between mental health workers and local faith-based groups. Local mental health workers should be encouraged to visit or participate on local ministerial associations or church councils. In this way, the two groups could develop working relationships and establish referral patterns before a disaster strikes. Mental health counseling services could offer a spiritual component by developing a referral network with local pastoral counselors or clergy. Faith-based groups, in turn, could refer members who need specialized mental health care to mental health professionals. Furthermore, mental health professionals could provide education to faith-based communities on how to identify mental disorders, which kinds of interventions might be helpful, and when to refer.

(6). **Consider making trained clergy “first responders.”** Besides offering necessary spiritual support, local clergy are ideally positioned to serve as first responders in meeting the psychological needs of disaster survivors and triaging those with more complex needs to mental health professionals – enhancing the efficiency with which scarce specialized mental health

services can be delivered. In many communities, clergy serve this function anyway following disasters (by default). However, making this part of the formal EMS response would help to systematize and coordinate the effort.

(7). **Credential.** There needs to be a way of screening clergy before sending them out into the field to ensure that they are adequately trained. Basic national standards should be established for credentialing clergy, as well as methods of identifying clergy credentialed in disaster response prior to a disaster. This needs to be done as part of pre-disaster planning to ensure that it is part of a coordinated response.

(8). **Fund.** First, provide greater flexibility in support mechanisms by offering more grant options than SAMHSA currently offers. The options should address the pastoral care needs of disaster victims during long-term recovery extending beyond the first few months after the event. It is during recovery, as people begin to put their lives back together, that issues of meaning and purpose in life begin to surface and pastoral care services are most needed. Second, make it easier for FBO groups to apply for available funding to help support their preparation and response.

V. Educate Health Professionals

(1). Physicians, nurses, social workers, counselors, and hospital administrators need to be **informed of the existing research on R/S and health, and the rationale for integrating spirituality into patient care.** Most health professionals did not receive training on how to do this, and many are nervous about doing so and feel unprepared. They don't know how to take a spiritual history or what to do with the information they learn from it. They don't know what a chaplain does, the type of training a professional chaplain receives, or how the chaplain can be useful to them or their patients. They don't know what benefits might result from their addressing the spiritual needs of patients and ensuring that those needs are appropriately addressed. Many medical schools are now developing courses on religion, spirituality and medicine for medical students. In fact, nearly 100 of the 141 medical schools in the U.S. and Canada now have such courses (70% of which are a required part of the curriculum).

(2). These medical courses, however, are a relatively new development. In 1992, only three medical schools had such courses. As a result, most physicians in practice today have no training in this regard. The same is true for nurses and other health professionals. This means that **CE (continuing education) programs are needed** to train current health professionals about how to sensitively and sensibly address spiritual issues with patients. These CE programs could be held at regional medical centers or in local hospitals, with several institutions linked by video-conferencing or Internet-based methods.

VI. Initiate Healthcare System Changes

(1). Even with adequate education and training, **health professionals need time to address the spiritual needs of patients.** Administering a screening spiritual history, supporting patients' beliefs, and referral to pastoral care all take time, precious time that most health professionals don't have in the busy clinic or hospital setting. While freeing up such time will be modestly

expensive in the short-term, there is every reason to think that it will be cost-effective in the long-term. If patients have their spiritual needs addressed, this will likely influence their health over the long-term and reduce their need for future health services (as well as enhance satisfaction and help them move more smoothly through the health system). In the only clinical trial that has examined this possibility, researchers found that physicians taking a spiritual history (which added 2.1 minutes to the visit) resulted within 3 weeks in oncology patients experiencing less depression, greater functional well-being, and a strengthening of the doctor-patient relationship (see *International Journal of Psychiatry in Medicine* 2005, 35:329-347).

(2). Government-funded health programs should emphasize the importance of health professionals addressing the spiritual needs of patients and need to free them up from other responsibilities to do so (this is true for physicians, but perhaps even more true for nurses). This may require providing monetary or some other types of incentive for hospitals to free up time for physicians, nurses, social workers, and chaplains to address these issues. Perhaps tying this to **Medicare/Medicaid reimbursement** based on post-hospitalization patient satisfaction surveys might be one route to go. This would require that all hospitals include post-hospitalization surveys that assess patient satisfaction with spiritual care, which few such survey currently do.

[end of recommendations]

Suggested Readings

Medicine, Religion and Health. Templeton Press (September, 2008)

The latest review and discussion of research on religion, spirituality and health (including both mental and physical health), written in a reader-friendly, non-researcher format (updates the *Handbook of Religion and Health*, 2001). Length: 235 pages. To order, go to website: http://www.templetonpress.org/book.asp?book_id=124

Spirituality in Patient Care, 2nd Edition. Templeton Press (2007)

This book is for health professionals interested in identifying and addressing the spiritual needs of patients. It addresses the whys, hows, whens, and whats of patient-centered [integration of spirituality into patient care](#), including details on the health-related sacred traditions for each major religious group. This book provides healthcare professionals with the training necessary to screen patients sensitively and competently for spiritual needs, begin to communicate with patients about these issues, and learn when to refer patients to trained spiritual-care professionals who can competently address spiritual needs. Sections specifically address [mental-health professionals, nurses, chaplains and pastoral counselors, social workers, and occupational and physical therapists](#). A ten-session model course curriculum on spirituality and healthcare [for medical students](#) is provided, with suggestions on how to adapt it for the training of nurses, social workers, and other health professionals. Length: 264 pages. To order, go to website: http://www.templetonpress.org/book.asp?book_id=105

Deleted: medicine/spiritual issues

Deleted: physicians in primary care and medical and surgical specialties, as well as psychiatrists and other

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Deleted: in the medical field

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

This is a comprehensive review of history, research, and discussion of religion and health. Its 35 book chapters span mental and physical health, from well being to depression to immune function, cancer, heart disease, stroke, chronic pain, disability, and others. Appendix lists 1200 separate scientific studies on religion and health that are reviewed and rated on 0-10 scale, and followed by 2000 references and extensive index for rapid topic identification. This is the most cited of all references (books, book chapters, and peer review articles) on religion and health. Length: 714 pages.

The Link Between Religion and Health: Psychoneuroimmunology and the Faith Factor. Oxford University Press (2002)

Edited volume (15 chapters) examines the role of psychoneuroimmunology as an explanation for the link found between religion and physical health. Leaders in psychoneuroimmunology discuss their respective areas of research and how this research can help elucidate the relationship between religion and health. This volume reviews research on religious involvement, neuroendocrine and immune function, and explores further research needed to better understand these relationships. Length: 304 pages

Faith in the Future: Healthcare, Aging and the Role of Religion. Templeton Press (2004)

This book presents a compelling look at one of the most serious issues in today's society: healthcare in America. How will we provide quality healthcare to older adults who will need it during the next 30-50 years? Who will provide this care? How will it be funded? How can we establish effective, comprehensive, and cost-effective systems of care as demographic and

health-related economic pressures mount? Innovative programs created and maintained by volunteers and religious congregations are emerging as pivotal factors in meeting healthcare needs. Summarizing decades of scientific research and providing numerous inspirational examples and role models, the authors present practical steps that individuals and institutions may emulate for putting faith into action. Length: 200 pages. To order: http://www.templetonpress.org/book.asp?book_id=63.

In the Wake of Disaster: Religious Responses to Terrorism & Catastrophe. Templeton Press (2006)

Based on White Paper produced for the Center for Mental health Services (CMHS) of the U.S. Department of health and Human Services (DHHS). Examines psychological responses to natural disasters and acts of terrorism, outlines the emergency response system in the United States, and describes that role that individual religious faith plays in coping with disaster. However, the main focus of the book is describing the role that faith-based organizations play in responding to disasters, and discusses the many ways that they are involved at all stages whenever a disaster strikes. See pp 109-119 for recommendations to public policy makers. Length: 162 pages. To order: http://www.templetonpress.org/book.asp?book_id=84

Faith and Mental Health: Religious Resources for Healing (Templeton Press, 2005)

This book is also based on White Paper produced for the Center for Mental health Services (CMHS) of the U.S. Department of health and Human Services (DHHS). It provides an updated review of the history, research, and interventions related to religion and mental health. The focus is on examining faith-based delivery of mental health services. Five faith-based organizations are discussed: clergy and local religious congregations, networking and advocacy groups for the chronically mentally ill, national religious organizations that deliver mental health services, and groups that deliver faith-based mental health services but do not belong to a national religious group (religious counselors, chaplains, pastoral counselors). See pp 255-275 for recommendations to public policy makers. Length: 342 pages. To order: http://www.templetonpress.org/book.asp?book_id=80.

Handbook of Religion and Mental Health. Academic Press (1998)

Due to our religiously diverse society, *The Handbook of Religion and Mental Health* is a useful resource for mental health professionals, religious professionals, and counselors. The book describes how religious beliefs and practices relate to mental health and influence mental health care. It presents research on the association between religion and personality, coping behavior, anxiety, depression, psychoses, and successes in psychotherapy, and discusses specific religions and their perspectives on mental health. Chapters address clinical considerations when treating Protestants, Catholics, Mormons, Unitarians, Jews, Buddhists, Hindus, and Muslims. Length: 408 pages