

COMMENTARY

Integrating spirituality into the care of older adults

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ABSTRACT

We examine how to sensibly integrate spirituality into the care of older adult medical and psychiatric patients from a multi-cultural perspective. First, definitions of spirituality and spiritual integration are provided. Second, we examine the logic that justifies spiritual integration, including research that demonstrates an association between religious/spiritual (R/S) involvement and health in older adults and research that indicates widespread spiritual needs in later life and the consequences of addressing or ignoring them. Third, we describe how and when to integrate spirituality into the care of older adults, i.e. taking a spiritual history to identify spiritual needs and then mobilizing resources to meet those needs. Fourth, we examine the consequences of integrating spirituality on the well-being of patients and on the doctor–patient relationship. Finally, we describe boundaries in addressing R/S issues that clinicians should be cautious about violating. Resources will be provided to assist with all of the above.

Key words: older adults, spirituality, religion, integration, mental healthcare, research, spiritual history, spiritual needs, multi-cultural

Introduction

Addressing spirituality in the medical and mental healthcare of older adults around the world, particularly those with chronic illness, disability, problems coping, or at the end-of-life is gaining increasing attention in the literature (Stanley *et al.*, 2011; Hodge *et al.*, 2012; Koenig and Al Shohaib, 2014; Harrington, 2016). This has been driven by the large and ever-growing evidence base showing a connection between religious/spiritual (R/S) involvement and many aspects of mental and physical health in later life (Koenig *et al.*, 2012; Koenig, 2018), by the documentation of spiritual needs that arise during later adulthood (in response to illness and loss) (Fitchett *et al.*, 1997; Balboni *et al.*, 2007; Pearce *et al.*, 2012), and by the expression of human compassion as the clinician seeks to provide comfort and hope when medical or psychiatric interventions have reached their limit (Engel, 1982; Gordon, 2005). We will elaborate here on the many reasons why clinicians should

consider identifying and addressing the spiritual needs of older patients, and in specifying exactly what those spiritual needs are and what to do about them. First, however, what do we mean by “spirituality” or “spiritual integration,” and how are these different from or similar to religion and religious integration?

Definitions

The term *spirituality* historically meant having to do with the transcendent – God, Allah, Hashem, Brahman, Ultimate Truth or Reality (Sheldrake, 2007). The “spiritual person” was considered the deeply religious individual whose life was centered on their religious faith, which guided their outlook and behavior. The definition of spirituality, then, was quite similar to that for religion, and in fact described a particular kind of religious person (the especially devout). In modern times (past 20–25 years), however, the definition of spirituality has changed, broadening from its original one to include those who are not religious. This has been accompanied by increasing attention paid to a secular form of spirituality that is distinct from religion, largely self-defined,

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and focused on feeling good and self-fulfilled. There is very little agreement today within the academic community on a common definition for spirituality. Consequently, spirituality is now a quite broad and diffuse term that differs from individual to individual. From a clinical standpoint, this presents a distinct *advantage*. Patients define whatever spirituality means to them, and clinicians address it in those terms. Of course, without a common definition, this makes research on the relationship between spirituality and health outcomes in late life quite challenging, especially given the increasing overlap between spirituality and mental health, where spirituality is equated with meaning, purpose, peacefulness, harmony, and social connectedness (Koenig, 2008).

Many older adults include religion as part of spirituality, or consider the terms to mean the same thing, but as noted above, not necessarily. Being spiritual but not religious is a growing category that many younger elders are now identifying with. Nevertheless, religion is a more distinct concept and therefore more easily defined than spirituality because of more agreement on exactly what religion is. A common definition for religion is that it involves public and private beliefs, practices, and rituals related to the transcendent, as understood by the individual. This may include beliefs about God (or other manifestations of the transcendent) and practices such as attending religious services, praying, meditating, reading religious scriptures (Bible, Qur'an, Bhagavad Gita, Torah, etc.), and engaging in rituals and sacrificial ceremonies such as the Eucharist (Holy Communion), confession, baptism, confirmation, and other holy sacraments of a faith tradition. Religion often arises out of a group of people with common beliefs and practices concerning the transcendent, and so includes rituals that are practiced as part of a community. However, religion also involves personal practices and commitments, and may not involve attending services with others or social religious activities. Because religion involves a discrete set of beliefs and practices, it is easier to measure and quantify for research purposes, enabling the examination of its relationship to mental, social, and physical health outcomes.

For the purposes of this paper, the historical definition of spirituality will be used. Spirituality here is distinguished from its consequences – human values, morals, meaning, purpose, peace, connectedness to others, feelings of awe and wonder – by its link to *the transcendent*. The transcendent is that which is believed to exist outside of the self, although may also exist alongside of or within the self. In Western traditions (as noted above), the transcendent is called God,

Allah, Hashem, or a Higher Power, and in Eastern traditions is called Ultimate Truth or Reality, Vishnu, Krishna, Buddha, or the Dhamma (teachings of the Buddha). Spirituality is intimately connected to religion, and as used here lies at its core. For clinical purposes, however, this definition is expanded so that it includes those who do not consider themselves religious, although would refer to themselves as spiritual in the broader sense.

Spiritual integration involves the clinician identifying and addressing the religious or more broadly spiritual needs of patients as they arise during healthcare. As noted above, “spiritual” in this context means whatever the patient decides it means. Spiritual needs often involve religious needs, but again not necessarily, and may often involve existential needs related to purpose and meaning. The “spiritual history” is essential in determining what the patient means by spiritual and identifying the type of language the clinician should use when discussing and addressing the patient’s spiritual needs related to healthcare.

Reasons for integrating spirituality

First, adults over age 65 years tend to be religious and in fact are the most religious of any age group in the USA (Lyons, 2003), in part because they grew up during a time when religion was a more influential force in the culture than it is today. This is especially true for many older adults in developing countries (Africa and Central and South America) and the Middle East, where religion remains a dominant force. Second, R/S beliefs and practices are often used to cope with loss and change in later life, particularly declining physical health and increasing dependency, which medical treatments may be less effective in reversing. These changes present existential challenges in relation to identity, hope, meaning, purpose in life, and autonomy or connectedness – issues that many view as spiritual in nature. For example, religion gives meaning to later life and hope for the future, a fact that has been demonstrated in both older medical and psychiatric patients (Koenig *et al.*, 1998; Goh *et al.*, 2014; Raffay *et al.*, 2016). Because religion gives meaning to life, it may also influence medical decisions, especially among those with serious illness or at the end of life (Ehman *et al.*, 1999; Balboni *et al.*, 2007).

Third, there is growing evidence that indicates religious involvement is related to better physical health and greater well-being in middle-age and older adults, as well as more social support and positive health behaviors (and better treatment compliance) (Li *et al.*, 2016a; 2016b; VanderWeele *et al.*, 2016; 2017; Koenig, 2017a). Fourth,

spiritual needs are common among older medical patients who may be struggling with issues such as forgiveness of past hurts (either inflicted by others or inflicted on others), questions about whether there is a next life after this one and what it will be like, whether there is a God and whether that God will welcome or condemn them. Such struggles may be particularly common among those in monotheistic religious traditions (Christians, Jews, Muslims, and to some extent Hindus and Buddhists, depending on their beliefs) (Koenig, 2017b; Koenig and Al Shohaib, 2017). Failure to address such needs toward the end of life has been shown to decrease patient satisfaction with care and increase healthcare costs (Balboni *et al.*, 2011).

Some older adults may be quite suspicious of psychiatrists and may not comply with some pharmacological or psychological treatments for this reason, a problem that may be particularly common in developing countries or the Middle East where clergy and religious healers have served as the “de facto” mental health system for centuries if not millennia. Respectfully inquiring about and acknowledging the elder’s religious belief system as a resource for healing may be a good way to establish and strengthen a therapeutic relationship, which will ultimately influence the patient’s compliance with whatever treatment is prescribed. Studies have shown that older patients are often quite receptive and appreciative of efforts made by clinicians to integrate their spiritual beliefs into therapeutic treatments (Stanley *et al.*, 2011; Wharton *et al.*, 2018). This may be true even for those with cognitive impairment. Spiritual beliefs, practices, prayers, and hymns are often a good way to connect with religious elders even into the late stages of dementia. Since implicit (primarily unconscious, diffused, symbolic, affective, and not language-based) memory is often better preserved, ritualized spiritual practices may remain accessible and meaningful despite an individual’s loss of cognitive capacity (Kevern, 2015; Daly *et al.*, 2016).

When to integrate spirituality

Usually, a long-term relationship should be in place with patients before integrating spirituality into medical or psychiatric care. For example, an emergency room visit for a psychiatric problem or single visit involving surgical, medical, or psychiatric consultation is probably not the time for taking a detailed spiritual history. However, if a patient is admitted to the hospital for serious or life-threatening illness, severe depression, a manic episode, exacerbation of psychosis, or a

suicide attempt, then the hospitalist or attending psychiatrist may need to do a brief spiritual history, even if an ongoing relationship is not planned. The clinician will be making medical or psychiatric decisions that could be influenced by the religious beliefs of patients or family members. Having a long-term relationship with the patient, however, provides the ideal setting in which care is often broadened to include social, psychological, and spiritual issues.

Ordinarily, spiritual integration begins during the initial evaluation of the patient (intake history) if an ongoing relationship is expected. This always starts by taking a spiritual history, which can be done as part of the social history, when asking about sources of support within and outside the family. The spiritual history may also be taken when exploring what coping resources are available. However, it may be best to take only a brief spiritual history during the initial visit to determine whether the older patient is R/S and how important this is in their life. Once a therapeutic relationship has been developed, after the third or fourth session, this may be a good time to conduct a more thorough spiritual history that could lead to the integration of the patient’s beliefs into therapy. Thus, the spiritual history need not be taken all at once but rather completed over several visits.

In medical settings, there may be more time to inquire about spiritual needs during well-visit exams, when family and social issues are more likely to come up. In psychiatric settings, one might argue that at least a brief spiritual history should be taken during the initial assessment of most (if not all) elderly psychiatric patients, since R/S is often one of the most commonly used coping resources and can be very useful for those dealing with less severe disorders such as mild depression and/or social isolation. There will be more time during follow-up visits after the older patient’s psychiatric condition has stabilized to conduct a more thorough spiritual history. There may also be occasions when a refresher spiritual history may be needed, such as when there is a significant change in the patient’s medical or psychiatric condition. As noted above, this may be when the patient is admitted to the hospital for serious medical or psychiatric illness, when a patient’s illness becomes chronic and is accompanied by extended mental or physical disability, or when end of life care is needed (Koenig *et al.*, 2017a).

How to integrate spirituality

As noted above, the first step is taking a spiritual history (Table 1). This may be all that the clinician

Table 1. The mental health spiritual history for older adults (adapted from Koenig, 2018)

1. "Do you consider yourself a religious or spiritual person, or neither?"
2. If religious or spiritual, ask: "Explain to me what you mean by that."
3. If neither religious nor spiritual, ask: "Was this always so?" If no, ask: "When did that change, and why?" [Then *end the spiritual history for now*, although may return to it after therapeutic relationship established]
4. "Do you have any religious or spiritual beliefs that provide comfort?"
5. If yes, ask: "Explain to me how your beliefs provide comfort." If no, ask: "Do you think there a reason why your beliefs provide no comfort whatsoever?"
6. "Do you have any religious or spiritual beliefs that cause you to feel stressed?"
7. If yes, ask: "Explain to me how your beliefs cause stress in your life."
8. "Do you have any spiritual or religious beliefs that might influence your willingness to take medication, receive psychotherapy, or receive other treatments that may be offered as part of your mental healthcare?"
9. "Are you an active member of a faith community, such as a church, synagogue, or mosque?"
10. If yes, ask: "How supportive has your faith community been?" If not, ask: "How has your faith community not been particularly supportive?"
11. "Tell me a bit about the spiritual or religious environment in which you were raised. Were either of your parents religious?"
12. "During this time as a child, were your experiences positive or negative in this environment?"
13. "Have you ever had a significant change in your spiritual or religious life, either an increase or a decrease?" If yes, ask: "Tell me about that change and why you think it occurred."
14. "Do you wish to incorporate your spiritual or religious beliefs in your treatment?" If yes, ask: "How would you like to do this?"
15. "Do you have any other spiritual needs or concerns you'd like addressed in your mental health care?"

does, although this first step is essential and must be done by the physician/attending psychiatrist (not delegated to the nurse or other staff). The purpose is to learn about the older patient's religious background, determine if a faith community is a source of support (or stress), find out if there are any religious beliefs that might influence or conflict with medical or psychiatric treatments, and identify spiritual needs related to illness that should be addressed. For example, an older Muslim patient may see a mental health professional for emotional problems that he or she is convinced are due to an "evil eye" (transmitted by a jealous person or enemy) or result from "jinn" (spirit) possession and believes a "sheik" (healer who recites Qur'anic verses) is needed, not a mental health professional. Opposing such beliefs is usually unsuccessful; however, showing respect for them and suggesting that both spiritual and conventional mental health treatments may often work best together is usually successful. In most instances, the clinician will likely refer patients to a chaplain, pastoral counselor, or healer in the patient's faith tradition to address needs identified during the spiritual history. Either the clinician or their staff may decide to address simple spiritual needs, but everything else should be referred to a trained spiritual caregiver or arrangements be made to collaborate with a spiritual healer.

One of the best ways to organize the integration of spirituality into the care of older patients is to form a small spiritual care team consisting of the physician/therapist, a spiritual care coordinator,

and clinic receptionist (Koenig, 2014). The job of the physician (or lead therapist/psychiatrist) is to conduct a spiritual history; the spiritual care coordinator (often a nurse or clinic manager) will take the results of the spiritual history and coordinate the meeting of spiritual needs; and the receptionist will collect basic spiritual information such as the patient's religious affiliation and make referrals to chaplains or pastoral counselors as needed.

In some cases, however, it may not be appropriate to restrict the psychiatrist's role to just taking a spiritual history and referring to someone else. Simple approaches could be performed by psychiatrists that might directly meet patients' spiritual and emotional needs, such as encouraging the use of positive religious coping strategies that the patient has found useful in the past. This is similar to the usual approach of stimulating patients to use other positive non-religious coping strategies.

Consequences of integration

Although only limited research has examined the consequences of assessing and addressing the spiritual needs of older medical or psychiatric patients, the research done thus far has been promising.

For example, the Oncologist Assisted Spiritual Intervention Study (OASIS) examined the impact of taking a spiritual history on cancer patients (Kristeller *et al.*, 2005). This study involved

118 consecutive outpatients with cancer seen by four oncologists (two were Christian, one was Hindu, and one was Sikh). To minimize burden on participating oncologists, patients were alternatively assigned (rather than randomly) to either the spiritual history intervention or a control group receiving usual care. Outcomes were assessed at baseline and three weeks later using the FACT-G (quality of life), the Brief Symptom Inventory (depression), and the Primary Care Assessment Survey Interpersonal and Communication Scales (doctor–patient relationship). The spiritual history took an average of 6 min to be administered and increased the length of outpatient visits by an average of 1.7 min (increasing from 13.1 to 14.8 min).

In most cases (85%), oncologists reported feeling comfortable administering the spiritual history, and when patients were asked their views, 76% said they thought the spiritual history was useful. At follow-up three weeks later, patients who received the OASIS spiritual history (compared to the control group) scored significantly lower on depressive symptoms ($p < 0.01$), significantly higher on functional well-being ($p < 0.001$), and significantly higher on a sense of interpersonal caring by their physician ($p < 0.05$). Thus, the spiritual history was acceptable to oncologists, felt useful by patients, and significantly improved depressive symptoms, quality of life, and the doctor–patient relationship (three weeks after a single clinic visit). As noted above, for religious elders, an effective spiritual history will not only gather important information relevant to patient care, but will also help patients accept their illness, give them hope, and emphasize they already have tools (religious resources) that can be utilized that contribute to their own healing.

Sometimes clinicians need to “step out in faith” and take a spiritual history to see for themselves the benefits of doing so and the receptiveness of many patients to such inquiry. For example, in a study that focused on 427 physicians, 86 mid-level practitioners, and 224 nurses/staff affiliated with the Adventist Health System (Faith in Practice [FIP] Study), when asked how patients responded to their taking a spiritual history, 72.8% indicated that patients typically responded with acceptance/appreciation (Koenig *et al.*, 2017a). After these health professionals received further training on how to take a spiritual history, 12-month follow-up revealed that physicians’ reports of patient acceptance/appreciation increased from 72.8% to 80.5% ($p = 0.001$) (Koenig *et al.*, 2017b). Approximately 70% of these clinicians indicated that taking a spiritual history was appropriate in the outpatient setting. These findings are consistent

with those from a nationwide study involving 1,144 physicians, where 55% of physicians indicated that it was usually or always appropriate for physicians to take a spiritual history (Curlin *et al.*, 2006). Thus, systematic research indicates that many physicians feel that taking a spiritual history is appropriate and that the majority of patients are quite receptive to such inquiries (older patients in particular). This is also the recommendation of many psychiatric associations such as the World Psychiatric Association (2016), the American Psychiatric Association (1990), and the Royal College of Psychiatrists (Cook, 2013).

In most cases, the physician’s role ends with taking the spiritual history and mobilizing team members to address the spiritual needs identified (usually by referral to trained spiritual caregivers), but as noted above there will also be cases where psychiatrists may need to directly address the spiritual needs of patients. It is important, however, that whatever is done is patient-centered and avoids imposing not only the psychiatrist’s religious views on patients but also the anti-religious ones (American Psychiatric Association, 1990).

While many physicians also believe in the appropriateness of more controversial practices such as sharing their own religious beliefs with patients and physician-led prayer (Curlin *et al.*, 2006; Koenig *et al.*, 2017c), we generally discourage such practices unless initiated by the patient (to avoid any sense of coercion or proselytizing) (Koenig, 2013; Koenig *et al.*, 2017c).

Barriers to integration

In the Curlin *et al.* (2006) study, the most common reason given for not taking a spiritual history was not having enough time (48%), followed by concern that doing so would offend patients (40%), lack of training on how to do so (26%), and general discomfort with the topic (23%). In that study, physician religiosity/spirituality was the strongest predictor of “ever” having taken a spiritual history; only 23% of physicians with low personal R/S had done so, compared to 76% of those with high R/S. In fact, discomfort with the topic in general (*not* lack of time) was the strongest predictor of not taking a spiritual history, which is consistent with findings from a more recent meta-analysis (Best *et al.*, 2016). Training on why and how to address spiritual issues is one way to address discomfort over dealing with the topic. In the FIP Study, over 90% of outpatient medical providers had little or no training in how to integrate spirituality into patient care, despite being affiliated with a faith-based health system (Koenig *et al.*, 2017c).

In the latter study, older age was a significant predictor among physicians of frequency of taking a spiritual history (suggesting that experience in practice may play a role). With regard to the characteristics of patients more receptive to discussing spirituality as part of a medical or psychiatric encounter, a recent meta-analysis found that patients often wanted more frequent R/S discussions than they were getting, especially African Americans, those with lower incomes, and those with less education (Best *et al.*, 2015). Although age was not mentioned as a factor influencing receptivity to such discussions, older adults have long been known to favor spiritual activities such as prayer with their physicians (Koenig *et al.*, 1998), and more recent studies suggest that patients with serious health problems (more frequent in later life) are particularly open to discussing spiritual issues with their providers (Phelps *et al.*, 2012; Park and Sacco, 2017).

Boundaries

While many physicians feel that it is appropriate to assess and address the spiritual needs of patients, and patients are likely to be receptive (particularly older patients with serious medical or psychiatric illness), spiritual integration should always be patient-centered and patient-directed (Josephson and Peteet, 2008; Koenig, 2013). This is a sensitive area that often has deep meaning for both the health professional and the patient, requiring that clinicians recognize that there are certain boundaries that frame interactions in this regard.

First, clinicians should seldom if ever force a spiritual history if they sense patient discomfort or reluctance to engage in such discussions. As noted earlier, sharing personal religious beliefs with patients is not indicated unless the patient explicitly requests such information, and even then, the medical or mental health professional is not obligated to reveal anything about their personal beliefs. Health professionals should probably not ask patients to pray with them, but rather allow the patient to initiate such requests.

Finally, most physicians and other health professionals such as nurses and social workers are not trained to address the complex spiritual needs that often arise during the course of illness, and so should probably not provide advice in this regard unless they have specific training on how to do so. For example, when treating an older religious Muslim client, the mental health professional may decide to encourage the reading or reciting of verses from the Qur'an that specifically address

the problem the elder is struggling with; however, unless trained as a spiritual caregiver in this faith tradition, he or she should probably not choose those verses or recite them over the patient, but rather refer the patient to clergy or a Muslim healer (sheik) with experience in this practice. As noted earlier, referral to pastoral care specialists or other knowledgeable religious professionals should be considered for all but the simplest of spiritual interventions, unless the practitioner has special training in this regard and has met the required spiritual competencies.

Resources

Many resources exist for medical and mental healthcare professionals to help guide attempts to integrate spirituality into the care of older adults. A CME series has been developed to provide such training to medical physicians, nurses, and chaplains, and much of this is relevant to psychiatrists and mental health professionals as well (CME Videos, 2017). There are also numerous books that describe the step-by-step process involved in taking a spiritual history and addressing spiritual needs (Cobb *et al.*, 2012; Koenig, 2013), including a recent volume written specifically for mental health professionals (Koenig, 2018).

Conclusions

Assessing and addressing the spiritual needs of older patients, particularly those with serious or disabling psychiatric or medical illness is squarely within the scope of practice for health professionals, particularly those who are responsible for developing the plan of care for these individuals. RS beliefs are common in later life, often used to cope with health problems, and may affect patients' and their families' decisions on therapies that are acceptable, requiring that health professionals be familiar with such beliefs. Spiritual needs are also widespread among older adults with medical or psychiatric problems, and failure to address them may lead to poorer quality of life, reduced satisfaction with care, and increased use of health services (Astrow *et al.*, 2007; Balboni *et al.*, 2011; 2013; Vallurupalli *et al.*, 2012).

Conflicts of interest

None.

Description of authors' roles

Dr. Peteet conceived of the paper and contributed to its content; Dr. Koenig wrote most of the paper; Dr. Zaben contributed additional perspective.

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