CROSSROADS...

exploring the intersection of health, spirituality and faith

Newsletter of the Society for Spirituality, Theology & Health Volume 1 Issue 2 October 2007

Coping with Chronic Illness

Diminished health causes many challenges, particularly when that illness is chronic. These challenges may include a loss of vigor; the loss of restful sleep; the loss of independence; the loss of position and roles played in family and society; the loss of the ability to maintain social relationships and make new friends; the loss of the ability to work and generate income; and perhaps most challenging of all, the loss of purpose and meaning. The usual coping resources are often challenged by the chronic nature of an illness; thus, chronically ill persons search for new options or seek to tap into those that have served them in the past. Religion and spirituality, expressed within a wide variety of faith traditions and cultural contexts frequently become means of coping and survival for the chronically ill.

It is particularly true for people with chronic physical illnesses from which they cannot escape that religion is a source of meaning and purpose. People suffering from illnesses seek to find, within the context of the illness, renewed meaning and purpose in order to survive emotionally, care for themselves, and make the necessary efforts to recover and rehabilitate. Despite their health problems and the efforts focused on recovery and rehabilitation, persons disabled by illness need to know that they can contribute and are still valuable. Religion and spirituality often serve as the source of purpose and meaning within these efforts.

One of the most powerful ways that religion helps people cope is by providing a supportive community. Chronic illnesses cause people to feel isolated, lonely, and disconnected from others. The pain and disability from illness can alienate an individual from friends and family or force the person to live among strangers (long-term care settings). Most studies have found that religious persons have more social contacts and indicate that they experience a higher quality of social support than do those who are not religiously involved. Family and marital bonds also tend to be stronger among those who are more active in faith communities. Understanding of others and an interdependent sense of flourishing formed both by long-term relationships and by common faith commitments frequently encourage care for one another.

Perhaps most importantly, religion and spiritual formation direct the chronically ill person's attention outside of the self. Most major world religions have emphasized the care of others as being an important part of spiritual formation and flourishing for both the healthy and the sick. Such formation nurtures gratitude and hospitality and promotes forgiveness, mercy, kindness, and compassion. Focusing attention outside the self, while honoring the importance of sustaining a healthy sense of self in the context of relationships, helps avoid the seduction of entitlement and the presumption of privilege so common within our culture. Providing support and help to others frequently gives the chronically ill person a sense of purpose and well-being to reframe their own frailty in the context of their neighbor's vulnerability and suffering. Participating in the suffering of others gives meaning and purpose to one's own life by providing a constructive, interpretive lens for narrating an individual's own suffering within a story of shared hope and transformation.

Harold G. Koenig, M.D. Keith G. Meador, M.D.

Co-editors, ***CROSSROADS***

EXPLORE...in this issue

CONVERSATION…

Dr. Kenneth Pargament, Ph.D. has been a professor of psychology at Bowling Green State University for 28 years. In 2000, he won the Virginia Staudt Sexton Mentoring Award from the American Psychological Association for his encouragement of faculty, undergraduate, and graduate research in the psychology of religion. We spoke about how he became interested in the field of spirituality, coping, and health, and what inspires his work.

Tell me about your research.
I have three streams of research. The area I have been researching the longest is religion, stress, and coping. More recently, my colleague, Annette Mahoney, and I have been conducting a Templeton-funded longitudinal study of spirituality among pregnant couples and how this predicts individual, marital and family functioning over the first year of family life. Finally, my students and I have been developing and evaluating spiritually-integrated interventions. In fact, I have just published a book on this subject entitled, Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred (Guilford Press, 2007).

What got you interested in the area of the psychology of religion and coping?
I've always been personally interested in spirituality. In the mid 1970's I started researching spirituality at a correlational level. I examined the relationships between various measures of religiousness and mental health. Although these studies uncovered some significant correlations, the findings were not practically helpful to my patients, who were dealing with concrete problems in concrete contexts. I realized I had to get closer to religious life if my research was to be more practically useful. So I began visiting churches and talking to people from different traditions. I decided to focus on religious coping, because "coping" offered a valuable metaphor for understanding religion and spirituality, since it incorporates both the potential for growth and the potential for problems.

When did you first realize that you could connect spirituality with your professional career and how did you start doing that?
It was a gradual process. As I developed as a researcher and clinician, I began to learn that spiritual constructs could, in fact, be measured and some spiritual questions could, in fact, be answered. Of course, science will never be able to answer questions about God's existence, but we can study the "footprints left by faith." I have found that most people are happy to talk about their spirituality and what it means to them if we are willing to start a spiritual conversation and learn from what they have to teach us.

What has been most surprising to you about your career path or accomplishments?
When I first started this line of research in the 1970's I used to joke with my friends that this was a great field to be in if you liked working in obscurity. The greatest surprise for me was the explosion of interest in religion and health in the 1990's.

Where do you get your inspiration?
Many people ask me if my work with patients is depressing because it exposes me to disasters, illnesses, and tragedies. Actually, I've experienced just the opposite reaction. I am amazed by the spiritual strength and courage of the people I have come to know through my research and practice. Many are remarkably inspirational, and they have increased my faith in the human spirit.

Was there a point in your life when your research came alive for you? In other words, have you ever had to rely on your faith to cope with a difficult life event? Did that experience change how you conducted your research?
I think there is an autobiographical element to all research. We develop certain theories and test them with certain methodologies because at some level they speak to who we are and who we want to be. My research embodies my own values and the commitments I've developed over the years, such as my belief that trauma can be an opportunity for growth, not just decline. I also feel strongly that spirituality is interwoven in the events of everyday life, from the smile of a stranger to the experience of a beautiful sunset. Part of our challenge as scientists is to make the spiritual nature of daily experience more explicit.

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Effects on Physical Health Outcomes

Kaufman Y, Anaki D, Binns M, Freedman M (2007). Cognitive decline in Alzheimer's disease: Impact of spirituality, religiosity, and QOL. Neurology 2007; 68:1509–1514

Summary: Examined the effects of spirituality, religiosity and quality of life (QOL) on rate of cognitive decline in Alzheimer's disease (AD). Subjects were 70 patients (ages 49 to 94 years, mean age 78) with probable AD, and cognitive function was assessed over 12 months using the Mini-Mental State Exam (MMSE). All subjects met standard neurological criteria for probable AD or AD with cerebrovascular disease, and had MMSE scores of 10 or higher. Religious variables were religious attendance, private religious activity, intrinsic religiosity (based on Duke Religion Index), and self-ratings of religiosity and spirituality. Controlling for baseline cognitive function, age, gender, and education, subjects scoring higher on self-rated spirituality (p=0.01) and private religious practices (p=0.003) had a significantly slower rate of cognitive decline; 17% of the variance in cognitive decline was explained by these variables. Religious attendance, self-rated religiosity, intrinsic religiosity, and QOL were unrelated to cognitive decline.

Blumenthal JA, Babyak MA, Ironson G, Thoresen C, Powell L, Czajkowski S, Burg M, Keefe FJ, Steffen P, Catellier D (2007). Spirituality, religion and clinical outcomes in patients recovering from an acute myocardial infarction. Psychosomatic Medicine 69:501-508

Summary: Investigators followed 503 patients recruited within 28 days of an acute myocardial infarction (AMI) for 1½ years to determine the effects of religion/spirituality on likelihood of dying or having another AMI ("event"). Patients were recruited into the sample if they had major or minor depression or if they had low social support. Of the 503 patients, 61 had "events" during the 18-month period. They also examined the relationship between religion/spirituality, depression, and social support. No significant relationship was found between physical health outcomes ("events") and spirituality (measured using the 16-item Daily Spiritual Experiences Scale (DSE), frequency of religious attendance, or frequency of prayer/meditation. Religious attendance was significantly inversely related to depression and significantly related to social support, and total DES score was significantly and inversely related to depression. The authors concluded that there was no relationship between religious/spiritual measures and cardiac outcomes in this sample.

Associations with Mental Health

Koenig HG (2007). Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. Journal of Nervous and Mental Disease 195: 389-395

Summary. This research examined the impact of religious involvement on time to remission of depression in older hospitalized medical patients with heart failure and/or chronic pulmonary disease (CHF/CPD). One thousand (1000) medical inpatients over age 50 with CHF/CPD were systematically diagnosed with depressive disorder using a structured psychiatric interview (Structured Clinical Interview for Depression). Detailed information was obtained on depression, psychiatric and social characteristics, physical health, and religious involvement. Cox proportional hazards regression was used to examine the independent effects of religious involvement on time to remission, controlling for covariates (remission was determined by the Longitudinal Interview and Follow-up Evaluation). Of the 1000 depressed patients identified at baseline, follow-up data on depression course was obtained on 87%. Results indicated that patients who attended religious services and participated in other group-related religious activities experienced a shorter time to remission. This effect persisted after controlling for other baseline characteristics ($p \leq 0.01$) and could not be explained by social support. Although numerous religious measures were unrelated by themselves to depression outcome, the *combination* of frequent religious attendance, prayer, Bible study and high intrinsic religiosity, predicted a 53% increase in speed of remission (HR 1.53, 95% CI 1.20-1.94, p=0.0005, n=839) after controls. Social support explained only 15% of this effect. In summary, patients who are highly religious by multiple indicators, particularly those involved in organized religious activities, remit faster from depression.

Save the Date…
1st Annual Meeting of The Society
June 25-27, 2008
Durham, NC

CONVERSATION continued from page 2

What are the next important steps in the field of religious coping?

I think the most important next step is to move from research to practice. The findings on religion and health are consistent and robust.

We know that spirituality can help people cope with the greatest of life challenges, and we also know some people encounter potentially damaging spiritual struggles; either way, spirituality can impact physical and emotional health and well-being. I think we need to be developing interventions that deal with people's spiritual resources and struggles. A second important step is expanding the field to encompass other traditions and cultures. For the most part, current research is dominated by a Western perspective, but there, are many other perspectives out there and we need to be learning about them, too.

What do you say to people who criticize this field by saying that "using" religion to cope diminishes the sacredness of religion and turns it into an economic or "Genie in the sky" model?

I think there are two important points to keep in mind. First, there is nothing inconsistent about facilitating physical and psychological goals and facilitating spiritual goals. When you help someone relationally, physically, or emotionally there is a natural impact on them spiritually, and vice versa. Second, ultimately, religion and spirituality is about fostering a relationship with the sacred. Scientists who work in this area need to keep in mind that they are dealing with sacred matters. In the research I conduct with my colleagues we always include measures of spiritual health as criteria of health and well-being. This is one way we build a sensitivity to the spiritual domain into our research, and avoid the danger of treating spirituality as merely a tool for achieving nonspiritual goals.

What do you see yourself doing in ten years?

More of the same, I hope. I want to continue to study how spirituality impacts health and well-being, learn more about the ways spirituality expresses itself in marriage, family, and other religious traditions, develop and evaluate spiritually-integrated interventions, and focus on disseminating accurate information about our findings to scientists, practitioners, and the general public.

What advice would you give to up and coming researchers in this field?

First, I would advise new researchers to create a support network of others who share their interests. There is synergy in working in a research group. Not only is it more fun, but you also learn more. And, second, because the field is not yet mainstream, I would advise those interested in researching spirituality to choose another well-developed area of research to which they can link their interest in spirituality.

Interview by Michelle Pearce

CALENDAR OF EVENTS…

November 2007

1	Spirituality, Theology and Health Seminar.* Speaker: Neal Krause, PhD, Professor, Health Behavior and Health Education, University of Michigan
8, 15, 29	Spirituality, Theology and Health Literature Reading Group*

December 2007

6	Spirituality, Theology and Health Seminar.* Speaker: Rev. Professor John Swinton, PhD, Professor in Practical Theology and Pastoral Care, University of Aberdeen
13, 20	Spirituality, Theology and Health Literature Reading Group*

★ **Seminars**: Lunch is provided, registration requested. To register contact: elizabeth.alford@duke.edu

★ **Reading Group**: For additional information please contact Kari Lauderback at kari.lauderback@notes.duke.edu

All events are held in Durham, North Carolina unless otherwise noted

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http://www.dukespiritualityandhealth.org/sth/

FUNDING OPPORTUNITY…

Research on Interventions for Child Abuse and Neglect

National Institutes of Health (NIH), Administration for Children and Families (ACF), Centers for Disease Control and Prevention (CDC), and Substance Abuse and Mental Health Services Administration (SAMHSA) are soliciting research applications focused on conducting efficacy and effectiveness trials of child abuse and neglect interventions. This solicitation also supports research on understanding effective strategies to prevent child abuse and neglect (CAN) and on the amelioration of the biological and behavioral effects of CAN on its victims. Only projects proposing rigorous scientific research designs will be considered. For purposes of this solicitation, an intervention is broadly defined as any action that assists in changing the biological and behavioral negative health effects of child abuse and neglect. Interventions may target individuals or group of individuals (e.g., dyad, family, community, or service systems). **Opening Date**: December 7, 2007 (Earliest date an application may be submitted to Grants.gov). **More Information**: http://grants.nih.gov/grants/guide/pa-files/PA-07-437.html