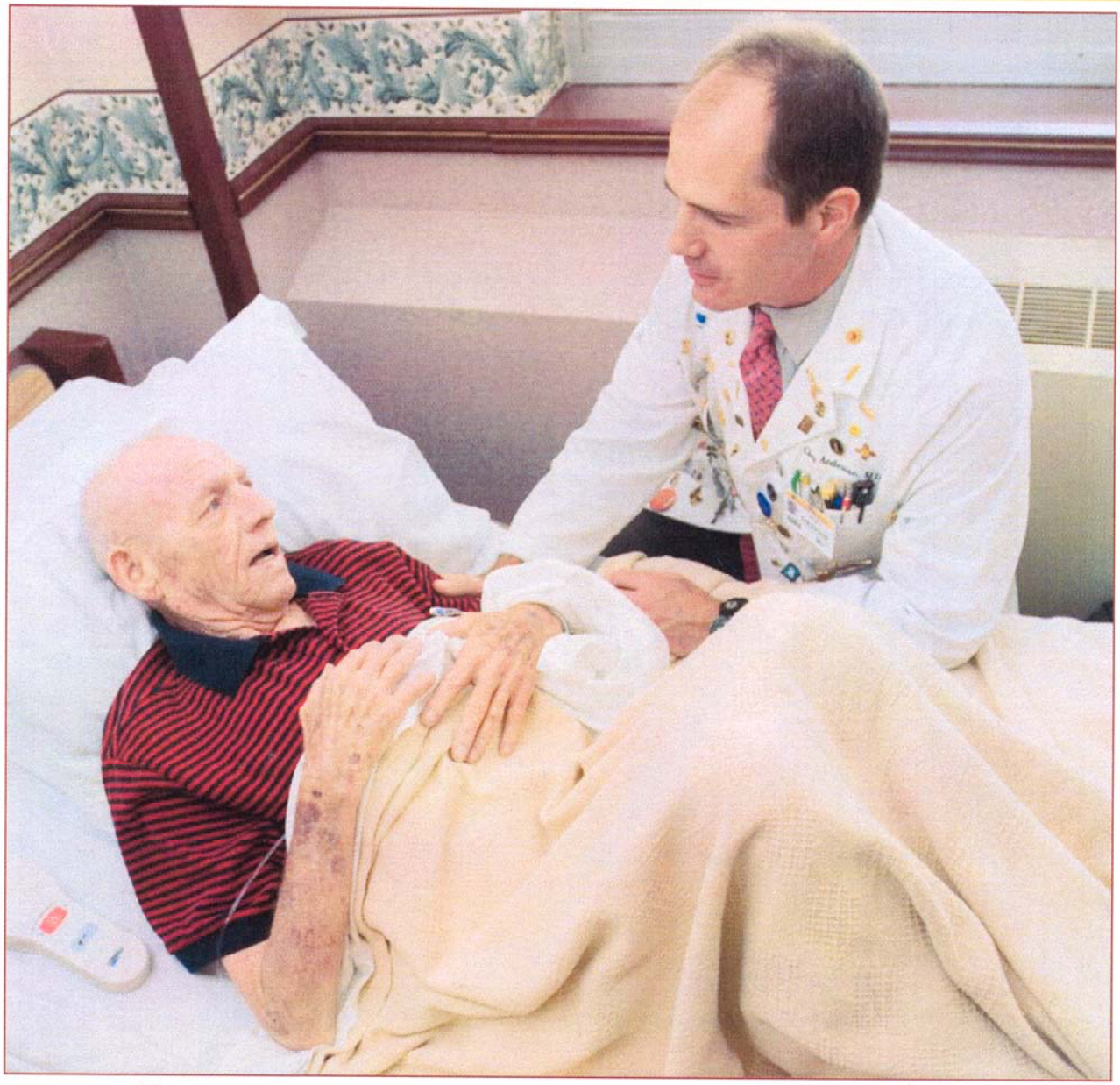
Interdisciplinary Center on Aging

CHRONICLES *in* AGING

Donald W. Reynolds Programs in Geriatrics

Discovery and Learning in Gerontology at the University of Missouri



enhancing the end of life

SPECIAL THEME ISSUE

SUMMER 2007

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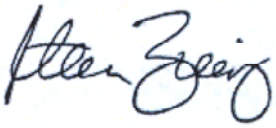
Editor's Note

End-of-life care is the theme of this issue of *Chronicles in Aging*. As much as we dislike thinking about it, death is an inevitable stage of life. In the United States, death usually follows a long life; more than 80 percent of the deaths in our country occur in people over 65 years old. Learning about death is truly an interdisciplinary function. In this issue there are articles by scholars in social work, nursing, medicine, sociology and ethics. Something so important, with so many implications, deserves a broad and introspective look.

Dr. Debra Parker Oliver and colleagues explore the implications of videophone technology on communication and caregiving in older adults. Dr. Kevin Craig reviews strategies for balancing the delivery of bad news with preserving hope for dying patients. We can't hope to live forever, but we can be helped in reducing pain and other symptoms, expressing our thoughts and feelings, and in being enabled to complete the "work" of our life. Finally there are two very personal stories from Dr. David Oliver, a sociologist and gerontologist, and Dr. David Fleming, a physician and ethicist. Both authors describe loved ones whose decline was not simple, one in the nursing home and one predominantly at home. Both older persons were affected by dementia, so common as more of us live to be very old. Both were cared for by family members and others — caregiving and dying are shared experiences. In the end, the people who loved them were with the dying persons, something each of us would ask for ourselves.

As death is increasingly the experience of the very old who often have multiple chronic diseases, we should not be surprised when it approaches. As a physician, I was taught to diagnose and treat disease, and the advances of biomedicine have made that increasingly possible. But while the culture of medicine supports this process, it may neglect the broader patient-centered approach so important in helping older patients and their loved ones decide what to do in the presence of life-limiting disease. Beyond diagnosis, we must better understand prognosis — what is likely to happen, and how good are our treatments? What are the patient's preferences — or those of their surrogates if they are unable to decide? Based on these factors, what are the goals of care? How should we prioritize goals of care relating to length of life, physical and cognitive function, and comfort? Finally, rather than relying only on diagnosis, let's create a management plan for the patient based on goals informed by prognosis and patient preferences. Learning from each other and working together, we can value the experience of dying as an important and inevitable part of life.



Chronicles in Aging is published quarterly by the Donald W. Reynolds Programs in Geriatrics at the University of Missouri-Columbia School of Medicine and the MU Interdisciplinary Center on Aging.

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Do religion and spirituality affect your health?

—*Jacob L. Jones, BA; James D. Campbell, PhD*

INTRODUCTION

More and more physicians and medical educators are recognizing the importance of religion and spirituality in medical practice. New research is linking patients' religion and spirituality (R&S) with valuable insights from psychology, immunology and sociology. Increasingly it is believed that R&S can help patients cope and can influence health for the better. Providers can help their patients reap these benefits. Although raising R&S topics may have been frowned upon in the past, it is becoming part of the current approach to patients' health and well being, and a new clinical aid (FICA, described below) is helping physicians get important information quickly from their patients.

PSYCHONEUROIMMUNOLOGICAL MODEL

"There is increasing interest in adding spiritual and religious variables to psychoneuroimmunological models of health, given the significant importance of spiritual beliefs and religious activities to individuals with health disorders," says Brick Johnstone, PhD, Professor and Chair of MU Department of Health Psychology. "In fact, research has indicated that increased positive spiritual beliefs (i.e. a loving, supportive God) are related to better physical and mental health, whereas negative spiritual beliefs (i.e. illness is reflective of God's punishment) have been shown to be related to poorer health outcomes. The specific mechanism of how religious and spiritual factors impact psychoneuroimmunological functions needs clarification."

In recent studies of the psychoneuroimmunological (PNI) model, health and illness come about as psychological, social and cultural factors interact with biochemistry and physiology.[1] PNI looks at the effects of behavioral aspects, such as stress, on the immune system. Researchers think these effects are moderated through the neuroendocrine system.[2] In Glaser et al's PNI study of older adults, the authors tested whether stress can significantly inhibit IgG antibody response to a pneumococcal bacterial vaccine.[3] Glaser gave a pneumococcal vaccine to current caregivers, former caregivers and controls. In addition, they measured antibody levels as well as stress levels using the Perceived Stress Scale (PSS).[3] Stress levels were correlated with immune deficiency; current caregivers had higher stress levels and a blunted immune response to the vaccine compared with the other two groups.

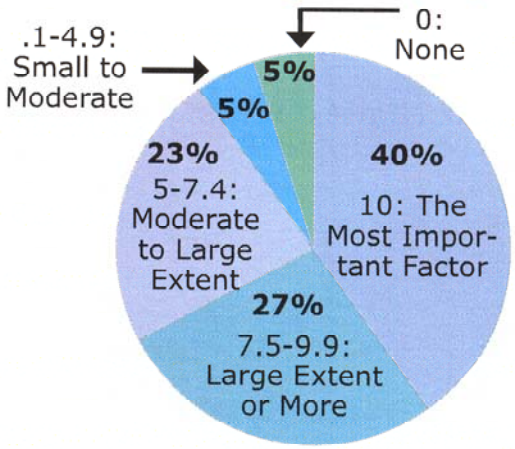
Table 1: Hospitalized Patients' Self-Defined Religious-Spiritual Categories[4]

Hospitalized medical patients (n=838)	
Religious and spiritual	88%
Spiritual, not religious	7%
Religious, not spiritual	3%
Neither	3%

AGING, RELIGION, AND SPIRITUALITY

It is important for health-care providers to be aware of the prevalence and importance of patients' beliefs and their potential influence on health outcomes. Most hospitalized patients, especially those over age 60, are religious or spiritual or both (see Table 1).[4] In fact, 40 percent of the hospitalized subjects in one study rate religious beliefs as the most important factor in coping (see Figure 1). The rest of this article reviews studies that characterize the relationship between religion/spirituality and health.

Figure 1: Self-Rated Religious Coping[4] (On a 0-10 scale, how much do you use religion to cope?)



BELIEFS, HEALTH AND MORTALITY

A fascinating 18-year study by Phillips and King[5] looked at patterns of death in Jewish men around the Passover holiday. Passover, a holiday during which friends and family gather in homes, has tremendous social importance, especially for older men, who are often heads of the households and lead holiday rituals. Passover celebrations that begin on a weekend result in an especially heightened potential for social importance because more family and friends may attend. The researchers found that, on these occasions, the death rate of Jewish men dropped by 24 percent the week before Passover and then increased 24 percent the following week. This study offers a compelling example of how R&S beliefs and social expectations may affect an individual's health.

Another study by Phillips et al[6] shows how the PNI model can help investigate whether beliefs can hasten death. The authors looked at Chinese Americans with varying levels of conviction concerning traditional Chinese culture and astrology. In the traditional belief system, a person's astrological birth year strongly influences his or her fate, and each astrological year is associated with a body organ, type of illness or symptom. Those who strongly engaged in this belief system had a greater chance of dying earlier than those who did not. Therefore, one's belief system may have a profound impact

Continued on next page

upon one's health and mortality, to such a degree that patients' R&S beliefs should be considered important to their health outcomes.

RELIGIOUS SERVICE ATTENDANCE AND HEALTH

Attending religious services is another area in which R&S influence health status. Three separate studies[7-9] show an inverse relationship between religious attendance and cognitive decline. The authors claim that religious and spiritual engagement, in the forms of social networking and spiritual inquiry, respectively, are factors important in slowing decline. Reinforcing and supporting religious engagement or other social supports may be a helpful strategy for many patients.

DISCUSSING RELIGION AND SPIRITUALITY

Health care providers and patients alike may be uncomfortable discussing R&S. According to one physician in a research study,[10] "It's sort of like at a junior high school dance with short boys wanting to dance with taller girls, and neither side of the gym wants to cross that vast space and approach some member of the opposite sex and ask them to dance. Physicians and patients, I think, both think that spiritual issues are important, at least some of the time, but neither side wants to bring it up for fear of alienating or making the other side uncomfortable, or appearing awkward, or embarrassing themselves or the other person." One way to get past the awkwardness is to cover the topic in an orderly fashion. The acronym FICA can help structure questions in taking a spiritual history (see Box). Answers to these questions will begin to describe the patient's spiritual resources and how the patient would like to work with the health care provider on spiritual issues.

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FICA CONVERSATION STARTERS

F **Faith and Belief**
"Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds, "No," the physician might ask, "What gives your life meaning?" Patients may respond with answers such as family, career or nature.

I **Importance**
"What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

C **Community**
"Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A **Address in Care**
"How would you like me to address these issues in your health care?"

Adapted with permission from Puchalski CM, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. J Pall Med 2000;3:129-37.