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Spirituality and Patient's Clinical Outcome

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ABSTRACT

This review explores how spirituality and religion influence healthcare at the patient, provider, and system levels, shaping decisions, processes, and outcomes. Evidence highlights two main strands: the impact of religious beliefs and practices on care trajectories, and the effects of structured spiritual interventions. At the provider level, clinicians' religious affiliation strongly influences end-of-life decisions. For example, Jewish, Greek Orthodox, and Muslim physicians are more inclined to withhold treatment, while Catholic, Protestant, and non-affiliated providers more often withdraw life-sustaining measures. These differences reflect divergent moral frameworks regarding death and permissible interventions. Patients' religiosity and affiliation also affect care, often leading to more aggressive treatment near the end of life. However, chaplain involvement tends to moderate this, fostering clearer communication and value-concordant care. In mental health, intrinsic religiosity, supportive communities, and positive religious coping; seeking spiritual support, benevolent reframing are linked to better adjustment and faster recovery, while negative coping predicts poorer outcomes. Structured interventions-such as chaplaincy, spiritual group therapy, meditation, and retreats-demonstrate benefits including reduced psychological distress, improved quality of life, and greater satisfaction for patients and families across diverse settings. Importantly, these effects depend on timing, cultural tailoring, and alignment between patients and providers. Methodological challenges remain, including heterogeneous measures and limited randomized studies. Future research should clarify mechanisms, assess early integration of spiritual care, and evaluate provider training. Overall, the evidence suggests that respectful, patient-centered attention to spiritual needs can enhance psychological adjustment, improve care alignment, and support well-being, particularly in serious illness and end-of-life contexts.

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Introduction

Observational studies on spirituality and mortality in Intensive Care Units motivate the interest for its association with clinical outcomes in many intervention processes focused on patients and attendants' participations [1].

This review examines how spirituality and religion operate at several levels of the healthcare encounter - patient, provider, and system - to influence decisions, processes, and outcomes. Two complementary strands of evidence guide the discussion. The first addresses how religious beliefs and practices, both among clinicians and patients, shape care trajectories and clinical endpoints. The second considers structured spiritual interventions and their association with psychological and clinical benefits across diverse settings. Taken together, these literatures suggest that spirituality and religion are neither peripheral nor uniformly beneficial; rather, they function through specific mechanisms-values, coping, social support, and meaning-making - whose effects depend on timing, context, and the alignment (or misalignment) of patient and provider perspectives [2-5].

In end-of-life care, provider religiosity and affiliation are consistently associated with treatment preferences and clinical decisions. Wenger and Carmel (2004) report that highly religious Jewish physicians are less inclined to support treatment withdrawal, euthanasia, or even the use of pain medications that might hasten death [6]. This pattern underscores how moral frameworks can calibrate clinicians' thresholds for deeming interventions proportionate, permissible, or obligatory. Sprung et al. (2007) refine this picture by distinguishing withholding from withdrawing life-sustaining treatment: withholding appears more common among Jewish, Greek Orthodox, and Muslim physicians, whereas withdrawing is more frequently endorsed by Catholic, Protestant, and non-affiliated providers. These contrasts point to deep normative distinctions - e.g., between allowing to die and causing to die - those different traditions construe in diverging ways, and that can surface in practice as preferences for particular courses of action when prognosis is poor [7].

Patient religiosity and religious affiliation also shape end-of-life trajectories. In trauma populations, Shinall and Guillamondegui (2015) associate patient religious affiliation with more aggressive end-of-life care, a finding that suggests patient values and community norms can translate into preferences for maximal intervention, even when benefits are uncertain [8]. Notably, the presence of chaplaincy seems to moderate these tendencies:

chaplain visits are linked to less aggressive care near the end of life, consistent with a role for spiritual care in facilitating communication, clarifying goals, and aligning treatments with articulated values. Importantly, none of these results imply that any single religious orientation uniformly produces more or less intervention; instead, they emphasize that where patient beliefs, family expectations, and provider convictions intersect, the character of medical decision-making can shift.

Across mental health and adjustment outcomes, intrinsic religiosity and religious coping emerge as central modifiers. Koenig et al. (1998) observe that greater intrinsic Christian religiosity predicts faster remission of depression among older, medically ill adults [9]. The mechanism plausibly involves meaning-making, behavioral activation (e.g., prayer routines, community participation), and social support. Yet religiosity's benefits are not automatic. Tarakeshwar et al. (2006) show that positive religious coping - seeking spiritual support, benevolent reframing - corresponds with improved quality of life among advanced cancer patients, whereas negative religious coping - spiritual struggle, perceived abandonment - tracks with poorer outcomes [10]. Tsai et al. (2016) add that perceived religious support, especially among cancer patients, is associated with greater optimism and reduced anxiety, underscoring the interpersonal dimension of spirituality as a psychosocial resource [11]. Complementing these findings, Yucel (2007) associates Islamic prayer with improved psychological well-being, suggesting that devotional practices can function as structured, culturally resonant forms of mindfulness and self-regulation [12].

Religious coping is heterogeneous across traditions and contexts. Tix and Frazier (1998) report that religious coping aids psychological adjustment after kidney transplant, but the magnitude and nature of benefits vary between Protestant and Catholic patients, pointing to denominational differences in doctrine, community structure, and customary practices [13]. Hollywell and Walker (2008) further associate private devotional prayer with lower depression and anxiety, aligning with evidence that personal spiritual disciplines can reduce ruminative thought, enhance perceived control, and provide symbolic resources for interpreting suffering [14]. The recurring pattern across these studies is not that religion uniformly improves outcomes, but that specific facets - intrinsic orientation, supportive communities, constructive coping - are reliably linked to better psychological adjustment, whereas spiritual struggle signals risk and invites targeted support.

Evidence on structured spiritual interventions complements these observational findings. Studies of group therapy with a spiritual component, chaplaincy services, meditation practices, and retreats report reductions in psychological distress, heightened spiritual well-being, and improved quality of life across patient groups as varied as women with eating disorders, cardiac patients, psychiatric inpatients, and neurosurgical patients (sample sizes ranging from 24 to 1,443). Various studies document enhanced spiritual well-being, four report reductions in psychological disturbance, and two note higher patient or family satisfaction. These results, which span inpatient, outpatient, and community settings, converge on a plausible pathway: when spiritual needs are identified and addressed, patients report improved internal coherence and affective regulation, which often parallels gains in social functioning and satisfaction with care [15-20].

Timing and tailoring matter. Several reports indicate that increases in spiritual well-being coincide with better psychological and social functioning, and that early integration of spiritual care is associated with stronger effects. Provider characteristics - religious affiliation, comfort discussing spiritual issues, and prior training - may facilitate or hinder effective delivery. Interventions tailored to patients' cultural beliefs appear better positioned to leverage familiar narratives and practices, avoiding inadvertent spiritual dissonance. Chaplains, in particular, can act as boundary spanners: they translate between clinical aims and spiritual concerns, helping clinicians appreciate non-biomedical goals (e.g., reconciliation, forgiveness, preparation for death) while assisting patients and families in understanding medical realities and probabilistic outcomes.

Synthesizing across these lines of evidence, a three-level framework is useful. At the patient level, spirituality functions through coping styles, community support, and meaning systems that can buffer distress or, when strained, exacerbate it. At the provider level, personal religiosity and moral intuitions shape perceptions of proportionality, futility, and risk, influencing recommendations at clinical inflection points such as code status, ventilation, or dialysis initiation and continuation. At the system level, structured spiritual assessment and referral pathways operationalize attention to spiritual needs, making it more likely that supportive interventions occur early rather than reactively. Outcomes then emerge from the alignment - or misalignment - across these levels: a highly religious patient who prefers maximal intervention may receive different care depending on whether their clinician shares, respects, or is trained to neutrally navigate those values, and whether chaplaincy is engaged to facilitate shared understanding.

Several practical implications follow. Routine, respectful spiritual history-taking can surface preferences and concerns that are otherwise latent, especially in serious illness and perioperative contexts. Early chaplain referral may prevent escalation pathways toward unwanted aggressive care by clarifying goals and addressing existential distress that sometimes masquerades as demand for "everything." Clinician training should include awareness of how personal convictions can color the interpretation of medical facts and prognostic thresholds; the aim is not to evacuate moral commitments, but to cultivate reflexivity and ensure patient-centeredness. Culturally and religiously tailored interventions - mindfulness analogs rooted in specific traditions, group sessions that integrate familiar narratives, and family-inclusive spiritual support - may amplify uptake and effectiveness. Communication strategies that explicitly acknowledge and validate spiritual concerns can enhance trust and reduce decisional conflict.

Methodological considerations temper the conclusions. Much of the literature is observational, with inherent selection and confounding challenges. "Religiosity" and "spiritual well-being" are measured heterogeneously, and denominational labels may mask substantial within-group variation in belief and practice intensity. Sample sizes vary widely, and outcomes range from self-reported distress to concrete utilization measures, complicating cross-study comparisons. Moreover, apparent benefits may, in part, reflect broader social support or personality traits correlated with religious involvement. These limitations do not negate the observed associations, but they highlight the need for rigorous designs, clearer operationalization of constructs (e.g., distinguishing positive from negative religious coping), and attention to effect modification by culture, illness stage, and care setting.

Future work should prioritize randomized or well-matched quasi-experimental designs for spiritual interventions; articulate mechanistic pathways linking specific practices (e.g., prayer, meditation, chaplain-mediated life review) to defined psychological and clinical endpoints; and examine how early, protocolized spiritual assessments alter downstream utilization and quality metrics in serious illness. It will also be important to evaluate how provider training changes communication patterns and whether those changes translate into measurable patient and family outcomes. Throughout, ethical guardrails must remain explicit: spiritual care is supportive, not coercive; it respects pluralism, honors autonomy, and avoids proselytization.

In summary, current evidence indicates that spirituality and religion are consequential in healthcare. At the bedside, clinician convictions and patient beliefs can shape end-of-life decisions in patterned ways, while intrinsic religiosity and positive religious coping are linked to better psychological outcomes across conditions [6-14]. At the system level, spiritual components - group therapies, chaplaincy, meditation, retreats - are associated with reduced distress, enhanced spiritual well-being, improved quality of life, and greater satisfaction among patients and families, particularly when integrated early and tailored to culture. The most coherent reading of these findings is not that "more religion" or "more spirituality" is uniformly better, but that attention to spiritual needs, delivered with skill and respect, can support better psychological adjustment and more aligned care - especially near life's end.

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Conflicts of interest
No conflict of interest.

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