Spirituality as a Source of Resiliency in African American Patients with Serious Illness

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OVERVIEW

- Background (2 mins)
- Current Work in Spirituality and AA Health (7 mins)
- Comments/Questions (3 mins)
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Nearly 7 in 10 African Americans (AA) Medicare beneficiaries have ≥2 chronic conditions (Centers for Medicare & Medicaid Services, 2021)

Early palliative care participation ↑ goals of care communication, ↑QOL, ↓symptom burden (Bakitas et al. 2020)

Only 8.2% AA Medicare beneficiaries use hospice (Rhodes et al., 2006)

Lack of culturally-responsive care practices = Disparity in AA palliative care use (Ejem et al., 2019)
Nearly 65% of hospitalized older adults experience spiritual distress.

Patients who endorse higher levels of spiritual distress are also more likely to report increased levels of pain, depression, anxiety, resting heart rate, and suicidal ideation.

Patients and families consistently express that spirituality is an important component of their health.

Hall, Hughes, and Handzo, 2019; Siddall et al. 2017; Hui et al., 2011; Abu-Raiya et al. 2015; Krause et al., 2016
DIVERSITY SUPPLEMENT: SPECIFIC AIMS

- Explore how reciprocal relationships may influence patient well-being and family caregiver (FCG) burden with a particular focus on the sociocultural aspects of AA race and spirituality

- Sub aim: Understand the religious and spiritual (R/S) beliefs and preferences of AA patients and FCGs in treatment discussions with clinicians
**Domain 1**

R/S Beliefs in Living with Illness

1a. R/S a source of strength (coping)

1b. R/S is separate from illness

**Domain 2**

Discussion of R/S in Clinical Encounters

2a. R/S not discussed in clinical encounters

**Domain 3**

Ideal Discussion of R/S in Clinical Encounters

**Patient-derived Themes**

Pt 3a. R/S should not be discussed

Pt 3b. R/S should only be discussed if patient initiates it

**FCG-derived Themes**

CG 3a. Provider R/S communication not a priority

CG 3b. Providers should be open to discuss R/S with patients

CG 3c. Providers should engage in R/S with patients
A wide spectrum of beliefs exists between patients and FCGs concerning ideal R/S discussion in clinical encounters. Differences should be considered in the design of palliative care interventions aimed at improving communication among patient, FCGs, and clinicians.
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Develop and conduct a small-scale feasibility trial of a culturally-responsive Spiritual Care and Assessment Intervention (SCAI) with African American (AA) patients with chronic illness at Cooper Green Mercy Health Services Authority (CGMHSA).
1) Elicit perspectives of chronically-ill older AA patients, FCGs, primary care key constituents (n=24) on patients’ illness-related spiritual concerns and distress, and potential desired spiritual support resources for outpatients at CGMHSA; and 2) the potential content, format, and delivery of a culturally responsive SCAI
1. Please describe for me your religious or spiritual beliefs.
2. What role, if any, does spirituality or religion play in your life as a whole?
3. What role does spirituality or religion play in your life as a [patient/caregiver/provider]?
4. What are your thoughts on clinicians including R/S in patient care? How should it be done?
5. So, when you hear the word “hope”, what comes to mind?
6. What gives you hope?
7. What are your personal goals outside of [your health/ your professional role]?
8. What are your goals related to [your health/ your professional role]?
PRELIMINARY RESULTS: PRACTITIONERS

It's like politics. You don't wanna talk about stuff like that.

We want to definitely make sure that they feel …open to discuss those beliefs with us, and then we pretty much partner with them in developing that plan of care.

I do think …patients that feel that they can't bring religious beliefs up in a care setting because that relationship can be perceived as very sterile…most of the time that wall gets broken down in really acute, serious illness.

I think [R/S] are aspects that are probably more patient-drive…if someone doesn’t have any religious beliefs or religiosity, I wouldn’t keep bringing it up.

It's a disservice…every part of a person should be an equal part of that person. … [S]pirituality, my healthcare, my mental health care, and my socioeconomic status—all of those should be equally considered in any kind of treatment that I receive.
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