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Spirituality in the care of patients with cancer: What is the psychiatrist's role?

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Introduction

Although difficult to define, spirituality is generally recognized as connectedness with a larger reality that gives life meaning, experienced through a religious tradition, meditation, nature, or art. In the care of patients with cancer, considerations for spirituality are essential for myriad reasons: as a resource for coping with the stress of a cancer diagnosis and treatment, as a source of distress itself, and as an obstacle to recommended treatment. Hence, spirituality has a number of implications for all clinicians working with patients with cancer. Despite the well-established impact of spirituality on health outcomes in patients with cancer and the desire of most patients to have spirituality incorporated into their treatment, clinical oncologists often underestimate the importance of spirituality to patients. Furthermore, they have limited training in addressing spiritual concerns and, hence, provide relatively little spiritual care (Phelps et al., 2012; Balboni et al., 2013). The most recent guidelines from the National Comprehensive Cancer Network echo our observations on the impact of spiritual care in oncology and underscore that addressing spiritual needs in cancer patients is central to comprehensive psychosocial care (Riba et al., 2019).

The role of spirituality in patient care

Spirituality is relevant for the majority of patients with advanced cancer — in their coping, practices, beliefs, experiences of transformation and/or of community. Furthermore, religion and spirituality contribute to patients' positive psychological well-being factors (e.g., gratitude, hope, optimism), shown to be associated with several clinical outcomes in patients with serious illnesses (Peteet, 2018; Amonoo et al., 2020). Patients with cancer report spiritual concerns in the course of their cancer trajectory, such as seeking to find peace, to live life more fully, or to improve their spiritual practices (Alcorn et al., 2010). At the end of their lives or when imminently facing death, patients with cancer also rank being at peace with God among their highest priorities and distressing spiritual concerns such as feeling abandoned or punished by God are associated with reduced quality of life (Winkelman et al., 2011). Religion can also be central to medical decision making in patients with cancer, and greater use of religious coping is associated with more aggressive care at the end of life (Phelps et al., 2009). Moreover, spiritual care has been associated with greater use of hospice care (Balboni et al., 2010).

Addressing patients' spirituality: whose role is it?

We suggest that psychiatrists are uniquely positioned to collaborate with oncologists to bridge the gap in spiritual care provided to patients with cancer. Optimal psychiatric care of the oncology population entails understanding the existential and/or spiritual dimensions of despair, anxiety, and distress to comprehensively manage and help patients deal more effectively with an illness. The first step in this process is screening from a stance of curiosity about spirituality.

Although several validated spirituality screening instruments exist, most clinicians are not familiar with these and administering them can be cumbersome (Anandarajah and Hight, 2001; LaRocca-Pitts, 2015). Thus, simply asking a patient "have you been a spiritual or religious person?" can signal that one is open to hearing about this dimension of their life. If the answer is "yes," ask if he or she has a connection to a faith community and whether that has been helpful.

Beyond screening, one can actively listen for how the illness has affected the patient spiritually, or conversely whether religion or spirituality has been part of how they have responded to their illness. Does the patient make references to faith? Are there religious objects in the room? What seems to be most valued or sacred, or deeply troubling about their situation? Words like courage, despair, comfort, suffering, peace, and feeling blessed often provide clues.

Having actively listened, one can ask general questions about suffering caused by cancer and sources of resilience, such as: "What are the deepest questions your cancer diagnosis

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and treatment have raised for you?" "What causes you the greatest despair and suffering?" "Where do you find peace?" "From what sources do you draw strength and courage to go on?" Direct questions about personal experiences with religion/spirituality can be fruitful, with questions such as: "How do you envision God (if they speak of God)?" "In what ways, if any, has your practice of religion or spirituality helped you feel better mentally or emotionally?" "Where have you gone to replenish yourself spiritually?" "In what ways, if any, has your religion or spirituality been a source of struggle or pain for you?"

Spiritual sources of struggle or strength uncovered in the assessment can be incorporated into the psychiatric formulation and treatment plan. These can then become a focus of the work depending on the clinical context, the availability of other resources such as a hospital chaplain, and the skills and orientation of the clinician.

Clinical scenarios

The following case scenarios highlight the psychiatrist's role when religion/spirituality presents problems in the form of reluctance to accept care, spiritual struggle, and the loss of available religious/spiritual support.

Reluctance to accept care

An energy healing practitioner, describing herself as spiritual but not religious, felt drained and dehumanized by entering the world of medical treatments for her metastatic cancer. Her colleagues also raised questions about her pursuit of conventional treatment. The psychiatrist's openness to her experience, beliefs, and the nature of her work helped the team maintain an alliance with her despite her ambivalence about pursuing treatment.

A woman in her mid-30s with ductal carcinoma *in situ* (DCIS) refused care and lumpectomy stating that she would rather fast and pray for a miracle for complete healing. She was lost to follow-up but returned 2 years later with metastatic breast cancer in both breasts and lymph nodes requiring a bilateral mastectomy, chemotherapy, radiation, and reconstructive surgery. Her continued refusal of care frustrated her oncology team, who requested psychiatric help to unveil the source of her resistance to treatment and her capacity to refuse care. The consulting psychiatrist explored her beliefs about miracles and proposed the idea of considering her clinical team's treatment recommendations as a form of *miracle*, something the patient had not considered previously.

Spiritual struggle

An elderly man hospitalized with end-stage prostate cancer and pain was anxious and concerned about whether God was punishing him. The consulting psychiatrist asked how he pictured God. When he described envisioning a loving God, the psychiatrist encouraged the patient to imagine being in his presence. This simple bedside exercise helped the patient to relax and require less anxiolytic medication.

A patient with incurable breast cancer struggled to maintain her belief that God would heal her despite evidence of progressive disease, and encouragement from her team to revise her goals of care. A hospital chaplain prayed with her both for healing and for strength to bear the burden of her illness, which helped her to accept a consultation with the palliative care team.

Loss of available religious/spiritual support

A married gay man became more spiritual after receiving a diagnosis of prostate cancer. He felt unable to return to the Catholic church of his childhood because of its stance on same sex relationships. With the assistance of the psychiatrist, he was able to find a local welcoming parish in which to worship.

A hospitalized Muslim patient was reluctant to eat during Ramadan. An Imam and member of the spiritual care team was recommended by the psychiatric service to help clarify her religious obligation to care for herself and other ways of observing Ramadan than through fasting.

A hospitalized Buddhist patient was withdrawn and discouraged about being unable to meditate. In collaboration with the psychiatric team, a Buddhist chaplain offered practices he could manage in the setting of serious illness and deconditioning.

Most of the spiritual interventions highlighted in our clinical scenarios were not provided directly by psychiatrists; instead, psychiatrists used their understanding of the patient to enhance and facilitate collaboration with members of the spiritual and palliative care teams. Including hospital chaplains in regular psychosocial oncology rounds is another way to help ensure that patients' spiritual needs are always being carefully considered and addressed (Kao et al., 2017).

In conclusion, in addition to shaping the responses of patients to existential challenges in domains such as identity, hope, meaning/purpose, morality and connection, spirituality can contribute to the resilience of clinicians caring for patients with life-threatening illness (Peteet and Balboni, 2013). During uncertain times, as in the current COVID-19 pandemic, psychiatrists can remind their colleagues of ways to deal with existential distress through nurturing of their own inner lives, beginning with simple mindfulness (Pies, 2020).

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All authors were involved in drafting the article or revising it critically for important intellectual content. All provided final approval of the manuscript and agree to be accountable for all aspects of the work.

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