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Should My Provider Pray with Me? Perspectives of Urban Adolescents with Asthma on Addressing Religious and Spiritual Issues in Hypothetical Clinical Settings

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Abstract

This qualitative study examined the preferences of urban adolescents with asthma for including religious/spiritual (R/S) inquiry in a variety of hypothetical clinical encounters. Twenty-one urban adolescents ($M_{\text{age}} = 15.6$ years, 52 % female, 81 % African American) with asthma participated in a semi-structured interview. Interviews were transcribed and underwent a thematic analysis. R/S preferences were contextual rather than personal, driven by: (1) acuity of the hypothetical clinical context; (2) nature of the patient-provider relationship; and (3) level of R/S intervention/inquiry. Most adolescents welcomed prayer if near death, but did not see the relevance of R/S in a routine office visit.

Keywords

Religion; Spirituality; Patient preferences; Adolescents; Prayer

Introduction

Religious and spiritual (R/S) issues are clearly important to adolescents (Smith and Denton 2005) and related to both physical and psychosocial health outcomes (Cotton et al. 2006; Pargament 1997; Pargament et al. 2000). Some 95 % believe in God, 85–95 % state that religion is important in their life, and over 50 % attend religious services at least monthly and participate in religious youth groups (Gallup and Bezilla 1992; Smith and Denton 2005). Overall, adolescents who describe themselves as more spiritual and/or religious have lower rates of risky health behavior and fewer mental health problems as compared with their less spiritual or religious peers (Cochran 1992; Cotton et al. 2006; Donahue and Benson 1995; Miller and Gur 2002; Pearce et al. 2003). What remains unclear is whether and how adolescents want R/S to be addressed in the medical setting—and whether addressing R/S with adolescents impacts their health outcomes or their relationship with their providers. To date, most research on patient preferences regarding R/S issues in the clinical context has been done with adults. For example, in 3,141 adult inpatients, patients who had R/S discussions were more likely to rate their care at the highest level on four measures of patient satisfaction (OR 1.4–2.2; Williams et al. 2011). Many adult patients want their physician to at least be aware of their R/S beliefs (Ehman et al. 1999; MacLean et al. 2003; Taylor et al. 2011), and some want their physicians to directly inquire about their R/S beliefs—particularly in a death or dying situation (McCord et al. 2004).

While issues of R/S in clinical care have been assessed in adults, only two studies were identified that have examined patient preferences regarding R/S issues in adolescents. Bernstein et al. (2013) published data from 19 HIV-positive ($M_{\text{age}} = 17.8$) and 26 HIV-negative adolescents ($M_{\text{age}} = 16.7$) in which four out of the 45 (9 %) had ever been asked by their doctor about their religious/spiritual beliefs, and only eight (18 %) had ever shared these beliefs with their healthcare provider. Most adolescents (67 %) wanted their provider to ask them about their R/S beliefs during some visits, especially when dealing with death/dying or chronic illness. Moreover, adolescents with HIV were more likely to endorse wanting their doctors to pray with them, having felt “God’s presence,” being “part of a larger force,” and having felt that “God had abandoned them,” as compared to those without HIV (Bernstein et al. 2013). In our previous study of 151 urban adolescents with asthma (Cotton et al. 2012), many adolescents felt that their provider should be aware of and even address their R/S beliefs. Most of the adolescents (81 %) described themselves as being R/S, 75 % of the adolescents reported that their relationship with God/a Higher Power contributed to their well-being, and 58 % had attended a religious service in the past month. Forty-five percent of the adolescents indicated that their R/S beliefs helped them cope with their asthma. Most notably, as the severity of the hypothetical clinical encounter increased (e.g., primary care visit versus dying), more adolescents wanted their R/S needs addressed ($p < .05$) (Cotton et al. 2012).

While authors have suggested addressing R/S with adolescent patients in certain contexts (Bernstein et al. 2013) and, in fact, accrediting agencies like The Joint Commission require attention to R/S issues in particular clinical settings (Association of American Medical Colleges 2001; American Psychological Association 2002), we know very little about child/adolescent patients’ (and families’) preferences in this area of health care. In an era of

translating evidence into practice, it behooves us to consider the growing evidence on the potential protective factors of R/S and health outcomes in adolescents, along with actual patient preferences regarding R/S issues. Knowledge of adolescent patient preferences might then inform ideas about developing best practice guidelines on whether and how to address R/S issues with adolescents across a variety of clinical settings. This is especially warranted in an era of healthcare reform and the movement toward increased attention on pay for performance and patient satisfaction, particularly as studies support that attending to patients' spiritual concerns is associated with higher levels of patient satisfaction (Clark et al. 2003; Williams et al. 2011). Therefore, the purpose of this qualitative study was to extend our previous findings on adolescent preferences for R/S care in hypothetical clinical encounters (Cotton et al. 2012), with a qualitative in-depth assessment of R/S preferences utilizing semi-structured interviews. A qualitative methodology was specifically chosen to allow for detailed in-depth questioning (Denzin and Lincoln 2000) about adolescents' preferences that are not as easily obtained via traditional quantitative methods. In particular, our aims were to: (1) describe adolescents' preferences for different levels of R/S involvement (e.g., Why is silent prayer more acceptable than asking about R/S beliefs?) by a provider; (2) describe adolescents' preferences for addressing R/S across a variety of clinical contexts (e.g., primary care versus dying situation); (3) examine whether these preferences differed by key demographic characteristics (e.g., gender or level of religiosity or spirituality); and (4) understand whether R/S contextual factors (e.g., religious symbols worn by the provider or similar/differing religious backgrounds of provider) were related to preferences.

The primary questions driving this study were: (1) What do urban adolescent patients think about clinicians' addressing R/S in their clinical interactions? (2) How might clinicians think about incorporating urban adolescent patient preferences when considering addressing R/S across a variety of clinical contexts?

Methods

Participants

Twenty-one adolescents aged 13–18 were recruited from a teen health center in a 475-bed Midwestern pediatric academic medical center between February and September 2010. Eligibility criteria included a current diagnosis of asthma, 11–19 years of age, and the ability to read English. Data on the religious and spiritual characteristics of this study population have been previously reported in our earlier quantitative study (Cotton et al. 2012).

Procedure

Participants were recruited in the teen health primary care clinic either by their provider or by a research assistant. After providing written informed consent and/or assent, participants were scheduled for a 30–45-min semi-structured qualitative interview with a member of the research team trained in clinical interviewing. This study was approved by the hospital's Institutional Review Board, and participants received \$25 for their time and effort.

Measures

Demographics—Demographic variables such as age, gender, race, and highest level of education were obtained via self-report. Insurance status, a proxy for socioeconomic status, was obtained via chart review. Interviews also included information regarding the participants' own R/S beliefs and practices (e.g., frequency of R/S attendance, religious preference). Asthma severity was rated by each adolescent's medical provider based on asthma impairment (frequency and intensity of symptoms) and risk (likelihood of exacerbation or decline in lung functioning) at the time of their baseline visit. Ratings were made according to National Heart Lung and Blood Institute guidelines (National Heart Lung and Blood Institute 2007), which outlines the multiple factors assessed by providers to determine asthma severity.

Semi-structured Interview—Questions on the interview were partially adapted from previous quantitative studies assessing patient preferences for integrating R/S into the clinical encounter (MacLean et al. 2003; McCord et al. 2004) and clinical input from co-authors. Both level of interventions (provider knowing or asking about R/S; silent versus out loud prayer) and hypothetical clinical settings (routine office visit versus hospitalized versus dying) were addressed. Sample questions included: "Is it important that [your doctor] has strong spiritual or religious beliefs?" and "Do you think that there are situations in which [your doctor] should pray out loud with you?" Interviews were audio recorded and transcribed by research staff for the purposes of data organization and analysis.

Data Analysis

Interviews were coded, organized, and analyzed using an iterative template organizational style of analysis as described by Crabtree and Miller (1999). This style of interpretation involves: (1) creating a code manual or coding scheme, (2) hand or computer coding text, (3) sorting segments to group similar texts in one place, and (4) making connections within and between segments that are then corroborated and legitimized. Consistent with these procedures, interview transcriptions were first imported into standard qualitative software package NVivo9.0 for data organization, coding, and analysis. Second, the first two authors independently reviewed transcripts to identify major themes (termed "codes" in qualitative methodology). Initial themes were discussed, and consensus was reached on what major themes would be coded in the transcripts. After this code manual was agreed upon, the first two authors coded all transcripts together and resolved any differences of opinion on codes through discussion, negotiation, and consensus (Crabtree and Miller 1999). This step resulted in sorting many segments of text into more similar groupings. Any similar or overlapping nodes were then collapsed or condensed in order to limit redundancy in the final representation of the data.

Results

The mean (SD) age of the participants was 15.6 (1.6) years; 11 (52 %) were female, and 17 (81 %) were African American. Approximately half (48 %) of the sample had moderate persistent asthma. The most common religious affiliation was Protestant (48 %; Table 1).

Key Factors to Consider When Addressing R/S with Adolescents

Overall, R/S preferences for these adolescents were contingent on contextual rather than personal factors and mostly driven by: (1) the acuity of the hypothetical clinical context; (2) patient–provider relationship; and (3) the level of R/S intervention or inquiry. Less important were adolescent personal-level factors such as gender, age, religious affiliation, or a perceived religious affiliation match between provider and patient. Less prominent themes including provider R/S beliefs and practices and R/S issues as related to healthcare decision-making are also presented.

Context of the Visit (Routine vs. Acute Care)

For these adolescents, the acuity of the hypothetical clinical context was central to whether or not they wanted their provider to address R/S issues with them. In general, R/S was not a high priority in a primary care visit. However, adolescents reported that they would be comfortable discussing R/S issues if the provider was “getting to know me” or if R/S issues could be potentially relevant to presenting concerns, “like if I was sad or upset about something” (19-year-old African American female). For example, “If your provider was to ask you just out of conversation, then it’s fine. But, to, you know, take notes, or what not, I don’t think that it’s okay to do that” (17-year-old African American female).

Preferences for including R/S differed if the patient were to imagine being in a more acute clinical situation. For example, one adolescent noted that if there was a potential that her physician would play a role in future, more invasive medical procedures, R/S would be important to have discussed upfront. “Like during surgical procedures and things like that, if like someone were to die and you know organ transplanting and things like that. It’s against some people’s religions and things like that so I think if they are going to be your primary caregiver and you want to build up some sort of relationship with them, they have the right to ask, because especially if it plays a big role in your medical care” (17-year-old African American female).

In severe situations when facing the possibility of death, the majority of these adolescents welcomed not only R/S inquiry but also actual prayer by a provider. For example, this 15-year-old biracial male was not interested in being asked about R/S during a primary care visit, but said “If I’m dying, yes, please (provide silent prayer). If I’m very sick ... Maybe even having surgery.”

Still for other adolescents, their preferences were not related to the clinical acuity at all. When asked “Do you think there’s any situation in which Dr. [X] should actually ask you about your religious beliefs?” a 16-year-old White female said, “Neutral. Cause, if they do, then I’ll tell them. And if they don’t, then it doesn’t really matter.” Or, “Maybe if she asked then I would tell her but, if she don’t ask, then I aint just going to come out of nowhere and say like I’m religious” (18-year-old African American female).

Nature of the Patient–Provider Relationship

Purpose of R/S Discussion—Adolescents often described their provider asking about R/S as a possible way to strengthen their patient–provider relationship, as a way to “get to

know me better as a person” or connect as people. “I feel like, if you want your doctor, especially if it’s your main doctor, y’all should at least talk over things that you care about and if your religion is what you care about, y’all should at least talk about it. Maybe y’all have something in common” (18-year-old African American male). Another adolescent had a different perspective saying that, “I think I need to build a relationship first with the provider. I mean it really don’t matter if they know about my religion, but I think I need to build a relationship first and see how that person is or how the doctor is” (15-year-old African American female).

Comfort with R/S Discussion—Of note, while some adolescents said that they would be surprised if a provider asked them their R/S beliefs during a clinic visit, none would be offended; instead, they would just wonder why R/S issues were being raised. “I would be like what? I wouldn’t be offended, I wouldn’t be mad. I just I’d be shocked, like, did she just ask me that? I’d be confused” (14-year-old African American female).

Trust was an important factor for many of these adolescents. The longer they knew their provider, the more they trusted them, and thus the more that personal issues such as R/S would be alright to talk about. For example, “I would just feel comfortable for the simple fact that I’ve been knowing Dr. [X] for ... I don’t know how long...and I feel comfortable talking about him with things like that” (15-year-old multiracial male).

Level of R/S Intervention or Inquiry

Response to Discussing R/S—There was a range of responses to simply being asked about R/S in a variety of hypothetical settings, ranging from, “It’s alright for him or her to know my religious beliefs. I don’t mind it” (17-year-old American male) to “It’s not her place to play a part in my spiritual life, she is just my doctor” (19-year-old African American female). Adolescents’ responses varied depending on what level of R/S intervention or inquiry (e.g., prayer versus simply asking about importance of R/S in one’s life) was being considered. For example, when asked “So you said that she [the provider] shouldn’t ask about your religious beliefs during a routine office visit, but you said it’s ok if she said a silent prayer for you. Why is that a different answer than asking about your religious beliefs?” this adolescent responded: “I mean you could pray any time about anything. But I’m just saying like I don’t mind her asking me about it but I’d still wonder like why she asked me that” (18-year-old African American female).

For many adolescents, directly asking about R/S beliefs was more tenuous than saying a silent prayer, presumably because of the “interactive” nature of asking R/S beliefs out loud versus saying a silent prayer internally. For example, when asked “What about during a routine office visit? If she (the provider) were to say a silent prayer for you?” one adolescent responded: “That’d be so fine with me. I don’t disagree on nobody wantin’ to do no type of prayers, anywhere, anytime” (19-year-old African American female).

Provider R/S Beliefs

Interestingly, alignment of religious belief between adolescent and provider was not important to these adolescents, although some did feel it was important to them that their

provider has strong R/S beliefs. For example, “I think if Dr. [X] came into the room and she had like a negative spirit, it’d kinda, affect her job a little. Maybe change the patient attitude too” (17-year-old African American female). Another adolescent said, “If she ain’t spiritual then I feel she will try to hurt me....” When asked “In what way? What do you mean?” this adolescent said: “Like not hurt me but, like you know, like spiritual people be kind and stuff like that” (18-year-old African American female).

When asked whether their provider should be allowed by the hospital to wear a religious symbol such as a cross or a Star of David, all adolescents reported that providers should be allowed to wear these symbols as expressions of their own personal beliefs. However, they were mixed on whether the religious symbol mattered to them as a patient. When asked, “Does it make you any more or less comfortable during your medical visit if your provider is wearing a cross or anything like that?” this adolescent responded, “It would make me more comfortable” (18-year-old African American female).

Interestingly, when asked about religious diversity of providers, adolescents responded openly albeit with some negative preconceptions or misconceptions about others’ religions and the delivery of health care. “Yeah because some people are Jews, the Jewish hospital would be the one they want to go to, so the provider should know that they are a Jew, so that they could put them in that hospital instead of a regular hospital where everybody’s religion is different because Jews are way different than we are. Way different, or like Muslims are way different from the way we are ... if I was in a hospital I would want her to know what my religion is so she can better me, like I would be better off in a hospital where everybody is the same instead of being in a Jewish hospital or a hospital where Muslims go to and not feel comfortable, I wouldn’t feel comfortable if I am being hospitalized” (19-year-old African American female).

Decision-Making

We also asked questions about how an adolescent’s R/S beliefs might influence their healthcare decision-making. We specifically did not give them examples (such as birth control) as we wanted to see what their spontaneous answers would be to that question. Interviewer: “Can you think of a situation where your spiritual or religious beliefs influenced how you dealt with a health care decision in the past? Any health care decision, so not just about your asthma.” One 15-year-old African American male answered, “Probably, because I’m a male but if I was a girl and like I was to get pregnant and she was talking about getting an abortion, then I’d be like I don’t want an abortion because my religion don’t believe in it.” Another adolescent said: “Because if I wanted to have sex unprotected without getting married first, that would be against my spiritual beliefs ... So it’d be a sin.” When asked, “Ok so what about like taking medication or taking birth control?” this adolescent responded, “Abortion, you know, but I would never think of it.” When asked, “So definitely it would impact your decision to have an abortion?” the adolescent said, “Mm hmm” (positive endorsement) (17-year-old African American female).

Discussion

The rich religious and spiritual lives of adolescents have been shown previously (Smith and Denton 2005), including associations between R/S and health outcomes (Cotton et al. 2006). This study is the first to report actual preferences of a sample of urban adolescents with asthma for having R/S addressed by their healthcare providers. For these urban adolescents, having these issues addressed depended greatly on contextual factors: the hypothetical acuity of the clinical setting, the nature of the provider–patient relationship, and the level of R/S intervention or inquiry being considered. Personal factors, including the perceived alignment of religious affiliation or content of R/S beliefs between the provider and patient, were largely unimportant. While not all adolescents endorsed strong R/S beliefs, nor wanted R/S to be included in a clinical encounter, it is noteworthy that none would have been offended by a providers' inquiry into the importance or relevance of R/S to the adolescent.

Adolescent health providers considering whether and how to take R/S into account should consider the following factors. First, how well do I know this adolescent? Increasing depth of relationships is consistent with greater adolescent openness to inquiry and possible R/S intervention. In early-stage relationships, it may be helpful to limit one's self to the use of simple mnemonic devices to conduct a simple screening for the relevance of R/S to the adolescent. A number of such screening tools have been proposed and have efficacy (Anandarajah and Hight 2001; Borneman et al. 2010; Maugans 1996). These tools are relatively noninvasive and can be used to identify adolescents for whom R/S beliefs or practices may play a significant role in their health care. Second, what is the acuity of the clinical encounter? These adolescents verbalized less openness to inquiry or intervention during routine primary care encounters (unless in the context of “getting to know me”), but were more open to it as the hypothetical clinical acuity increased. Similar to adult patient preferences in this area (MacLean et al. 2003; McCord et al. 2004), the greatest openness was before invasive procedures and end-stage disease. Adolescents did not believe that the provider needed to share similar beliefs in order to offer or provide any R/S intervention. Third, what level of R/S intervention or inquiry is appropriate? Inquiring whether or not there were R/S beliefs or practices that the provider should know about was more likely to be positively received by adolescents as compared to praying out loud with them. Selecting the appropriate level of R/S intervention is an art that draws on the provider's assessment of their relationship, the clinical acuity, and the providers' comfort level (Fitchett 2001; Koenig 2007). Previous studies have shown that those providers who rate themselves as personally more religious or spiritual are more comfortable raising these issues as compared to their less religious or spiritual peers (Grossoehme et al. 2007).

These findings support common themes from previous studies, though now further supported with data from urban adolescents. For example, the more serious the illness, the more patients believe it is appropriate for a clinician to inquire about R/S (MacLean et al. 2003), including urban adolescents interviewed for this study. In addition, while patients are not necessarily interested in R/S being addressed outright, very few would be offended by inquiries regarding R/S (Ehman et al. 1999; Koenig 2007), including these adolescents. Furthermore, discussing R/S is often seen as a practice that builds connection or relationship between the clinician and the patient, both in adults (Koenig 2007) and in adolescents.

This study certainly has the limitations inherent in single-site, cross-sectional, qualitative designs. In addition, the sample was a small urban mostly African American group of adolescents that likely reflect perspectives of a specific sociocultural perspective that may not be representative of other subgroups of adolescents. Nevertheless, the findings provide meaningful information to help guide providers' practices. The number of participants and the breadth of their responses provided sufficient data to achieve interpretive sufficiency for the identified themes. Future studies should examine adolescent patient preferences in actual clinical settings, across a variety of patient and sociocultural populations, and test the effectiveness of improved provider training for addressing R/S in health care.

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Table 1

Demographic and clinical characteristics of sample

Variables	
Mean (SD) age, years	15.6 (1.7)
Gender, <i>N</i> (%) female	11 (52 %)
Race/ethnicity, <i>N</i> (%)	
African American	17 (81 %)
White	3 (14 %)
Other	1 (5 %)
Asthma severity, <i>N</i> (%)	
Mild persistent	9 (43 %)
Moderate persistent	10 (48 %)
Severe persistent	2 (9 %)
Religious preference, <i>N</i> (%)	
Protestant	10 (48 %)
None	6 (29 %)
Other	5 (24 %)
Attended religious services in last 30 days, <i>N</i> (%)	
Yes	12 (57 %)

N = 21