HHS Public Access

Author manuscript

J Relig Health. Author manuscript; available in PMC 2017 June 01.

Published in final edited form as:

J Relig Health. 2016 June ; 55(3): 1065–1077. doi:10.1007/s10943-016-0190-2.

Incorporating Spirituality in Primary Care

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Introduction

Cultural competency in health care involves the recognition of differences in cultural knowledge and identity, including language and religion, and can be addressed at multiple levels (i.e. health systems and institutions, training, models of care and patient intervention) (Kirmayer, 2012). According to the National Institutes of Health (2015), awareness and attention to issues of cultural competency reduces health disparities and enhances clinical care as it "enables providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients" (National Institutes of Health, 2015). Spirituality, an aspect of cultural identity, has become increasingly recognized as a factor that may impact patients' health care decisions. The growing interest in this area is evidenced by an increase in its scholarly activity as well as in the number of medical school programs that now offer courses on religion and spirituality (Lucchetti & Lucchetti, 2014; Williams et al 2011; Koenig et al 2010; Puchalski, 2001; Puchalski et al 2001).

Religion and spirituality are often conflated and this has led to difficulty in defining each construct accurately. For example, Reinert and Koenig (2013) highlight that there is no "gold standard" when it comes to defining spirituality, pointing to the increase in concept analyses of spirituality in the nursing literature. Lindeman and colleagues (2012) argue that in order to obtain reliable results about spirituality and its outcomes, a parsimonious and unambiguous theoretical definition and assessment method is needed. Koenig (2012) has offered definitions of each term, defining religion as involving "beliefs, practices and rituals related to the transcendent…an organized system of beliefs, practices and symbols designed to facilitate closeness to the transcendent and foster an understanding of one's relationship and responsibility to others in living together as a community." Spirituality is defined as a "connection to that which is sacred, the transcendent… intimately connected to the

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supernatural, the mystical and to organized religion." With this definition, it appears that spirituality captures much of the complexity of a belief in a higher power, and may also include religious practices. According to the APA Handbook of Psychology, Religion and Spirituality (Pargament et al 2013), religion and spirituality may both be used when considering the full range of beliefs and practices that may include both secular and institutional practices, which facilitate the search for the sacred. Reinert and Koenig (2013) suggest that using spirituality as a broader term may lend itself to spiritual care in a clinical setting. As such, spirituality will be used in this paper to refer to the religiosity/spirituality connection.

A growing awareness of patients' spiritual practices has led to more consideration of the ways in which spirituality may impact patient care. A 2012 Gallup Poll found that 69% of American adults consider themselves to be very or moderately religious (Newport, 2012). Studies indicate patients want their physicians to have knowledge of their spiritual beliefs to facilitate better understanding of them as individuals, as well as help physicians understand patients' decision-making (McCord et al 2004). In a survey of family practice patients, McCord et al (2004) found that 83% of respondents indicated a desire for their physicians to ask about spiritual beliefs, particularly in instances of life threatening illness, serious medical conditions and loss of loved ones, with the majority of those respondents citing the importance of the physician's ability to encourage hope, give medical advice and change medical treatment.

Although the literature on incorporating spirituality into clinical care has focused primarily on serious illnesses and palliative care (Singh & Ajinkya, 2012; Stewart et al. 2013), spirituality may play a role in primary care. Specifically, it may be useful to consider the role that spirituality plays across the life course, considering the importance of spirituality for some individuals and the ways in which spirituality may be used to improve quality of life. Additionally, considering spirituality as part of a patient's cultural identity would allow practitioners to provide holistic, patient-centered care (D'Souza, 2007). Spirituality has been shown to have both negative and positive influences on health (Underwood & Powell, 2005; Holt et al 2003, Debnam et al, 2012). This complex relationship between spirituality and health suggests that health care providers may benefit from gaining a clearer understanding of the effects of spirituality on health and health behavior (Lesniak et al 2006). The present paper aims to shift the focus from spirituality in palliative care to the exploration of the role of spirituality in health promotion and primary care, considering its inclusion in the Health Belief Model. We also discuss the feasibility of incorporating spirituality into clinical practice, offering suggestions for primary care providers.

Spirituality and Perspectives of Illness

Spirituality and the role of a higher power can become salient in all aspects of a person's life, including health cognitions, behaviors and outcomes as well as explanations/ interpretations of why a person gets sick or stays healthy (e.g., clean living or having sinned) (Debnam et al 2012). According to the Common Sense Model of Illness Representation (Diefenbach & Leventhal, 1996), religious/spiritual identity may inform how individuals understand illness. For example, church participation provides access to a social network as

well as exposure to information and individuals suffering from various diseases, which may influence how members come to understand illness (Diefenbach & Leventhal, 1996). Spiritual explanations of health, including attributions to deities, devils or demons, may praise Gods for good health or attribute disease or accidents to evil forces (Burgoon & Hall, 1994). Illness and treatment may also play a role in patients' narratives about their lives and the way that an illness may be impacting their spiritual journey (Rumbold, 2007). Spiritual beliefs have been shown to affect patients' medical decisions, conflicting with medical treatment and/or influencing compliance with those treatments (Koenig, 2012; Sulmasy, 2009; Stewart et al. 2013; Kretchy et al. 2013). In their review of spirituality and patient care, Stewart and colleagues (Stewart et al., 2013) found that religious practices, including prayer, provide positive results in patients' lives through various measurable factors, including knowledge about their disease, adherence to treatment, coping with disease, quality of life, and overall health outcomes.

Spirituality in Health Promotion and Intervention

Health promotion efforts aim to engage health care consumers at the individual and community level in order to change disease risk and health behavior (Allicock et al 2013; Pender, Murdock & Parsons, 2002; Mason & McGinnis, 1990). In order to effectively engage consumers at the individual and community level, interventionists are encouraged to focus on more patient-centered strategies, which include shared decision-making (Glanz, Rimer & Viswanath, 2008). This type of engagement is made possible by considering cultural characteristics, such as spirituality, that make an impact on both an individual and community level. The evidence of the impact of spiritual involvement on health behaviors is mixed, with spirituality serving as a promoter as well as a barrier to health and health behavior (Powell, Shahabi & Thoresen, 2003; Underwood & Powell, 2005; Holt et al 2013; 2014). As cultural variables, spirituality and religious participation influence health attitudes, behaviors and choices (i.e. alcohol consumption, dietary choices, organ donation, notions of guilt and caring), communication with providers, promotion of wellbeing and healthy practices (Kirn, 1991; Ellison & Levin, 1998; George et al 2000; Seybold & Hill, 2001; Peterson, Atwood & Yates, 2002; Powell, Shahabi & Thoresen, 2003; Underwood & Powell, 2005; Davis & Radhawa, 2006; Loewenthal, 2013; Holt et al 2013, Holt et al 2014). In recent years, health promotion efforts at the community level have increasingly involved faith-based institutions, as there has been evidence for the efficacy of using religious institutions for promoting health behavior change (Allicock et al 2013).

Spirituality and Mechanisms of Health Behavior

Spirituality is multidimensional and may influence health behavior in a number of ways (Seybold & Hill, 2001). Thoresen and Harris (2002) highlighted the importance of efforts to move away from large macro-level concepts such as religious affiliation, toward more specific factors (e.g. coping, daily spiritual experiences and spiritual efficacy) that can help illustrate the connection between spirituality and health. The authors also emphasized the challenges in conceptualizing models connecting spirituality to health outcomes, stating that several factors may be involved in mediating or moderating the pathways connecting religious/spiritual factors with health, which may make associations with one factor or a

small number of factors too simplistic. Spirituality's multivalent impact on beliefs and behavior may pose a challenge to conceptualizing theoretical models (Pargament et al 2013; Thoresen and Harrison, 2002).

While the literature has examined the impact that spirituality has on health outcomes and health promotion, there is less information on the link between spirituality and direct patient care as well as the specific mechanisms by which spirituality affects health cognitions and behaviors. In examining health-related phenomena, existing theoretical frameworks may provide a way to organize information about the various factors that influence cognitions, emotions and behavior (Diefenbach & Leventhal, 1996). Existing models of health behavior focus on the mechanisms through which general health beliefs and other factors influence health behavior, but none explicitly incorporate religion/spirituality. Piedmont & Wilkins (2013) argue that in order for models of human functioning to be comprehensive, they must include spiritual and religious constructs. Below we discuss theory-driven mechanisms for the role of religiosity in promoting, as well as diminishing the adoption of health behavior. While a number of theoretical models could be used, such as The Theory of Reasoned Action/Theory of Planned Behavior, we have decided to focus on the Health Belief Model, which is a clearer, more well-defined theoretical model of mechanisms that influence health behavior. The HBM lends itself to discussing various issues related to health behavior and the role of spirituality.

Health Belief Model

One of the earliest and most widely used conceptual models is the Health Belief Model (Rosenstock, 1974). This model was developed to identify what mechanisms influenced persons who were faced with deciding to seek health services before the appearance of symptoms and was later extended to study how people respond to symptoms (Sayegh & Knight, 2013; Champion & Skinner, 2008). The model considers what factors influence the desire to avoid illness (i.e. screening) or, if ill, to get well, and examines the belief that a specific health action will prevent or ameliorate illness (Janz & Becker, 1984). The model comprises four factors: perceived susceptibility (subjective risk of contracting a condition); perceived severity (feelings concerning the seriousness of contracting an illness or leaving it untreated); perceived benefits (is treatment feasible/efficacious?); and perceived barriers (the negative aspects of a health action that can impede seeking treatment, including cost-benefit analysis and practical concerns) (Rosenstock, 1974; Champion & Skinner, 2008). Self-efficacy (how successfully can I execute the behavior needed to produce a particular outcome) and cues to action (i.e. action triggers) have been incorporated into some adaptations of the HBM as well as the consideration of other modifying variables, including demographic, psychosocial and structural variables (Janz et al 2002; Sayegh & Knight, 2013; Champion & Skinner, 2008). The HBM has been used to predict health related behaviors and to frame interventions to change behaviors, but a lack of rigorous testing of the relationships between constructs, a lack of consideration of the emotional components of behavior (i.e. fear) and the need for more research on the cues to action component have been cited as limitations of this well- recognized and well-used model (Janz & Becker, 1984; Champion & Skinner, 2008).

Although cultural factors have been included as moderating variables within the HBM, there has been little consideration with regard to the role that spirituality may play as a moderating variable. Kirn (1991) looked at religion and the HBM and suggested that spirituality may influence individual perceptions of susceptibility and severity of the disease, focusing on the ways in which different religious coping styles may influence health behavior. For example, a collaborative coping style may influence perceived barriers while a more deferential coping style in which power is ceded to God or to a religious leader might influence ideas about illness severity (Kirn, 1991). No other study has looked at the specific ways in which spirituality may relate to the variables in the HBM, but a focus on the ways in which spirituality may influence beliefs and coping and behavior may be an important inclusion in this model. In addition, it is important to consider other theoretical constructs that address this limitation of the HBM, which would facilitate a better understanding of how spirituality is related to health behavior. Focusing on the influence of spirituality on notions of control seems like the most useful addition.

Spiritual Health Locus of Control

Janz and Becker (1984) noted that locus of control could be applied to the Health Belief Model in terms of understanding outcome expectations of health behavior. Locus of control is a theoretical construct that refers to the extent to which individuals believe that they have control over the events that affect them (Lefcourt, 1991). Health has been considered as an area of interest within this theory. Health Locus of Control (HLOC) considers attributions about the factors that individuals believe control their health outcomes (Wallston et al, 1999, Debnam et al 2012). HLOC has been associated with health behavior and treatment adherence and the adjustment to health problems (e.g. knowledge about disease, smoking cessation, weight loss and birth control) (Lau, 1982). Belief in external sources of health has been associated with negative health behaviors and poor psychological adjustment (Debnam et al 2012). God Locus of Health control (GLHC), which refers to the belief in a higher power that controls an individual's health outcomes, was added as a subscale of the Multidimensional Health Locus scale developed by Wallston et al (1999). GLHC has been suggested to be relevant for populations who endorse high degrees of spirituality (Wallston et al 1999). The few studies that have explored the predictive role of GLHC on health behaviors have focused on African American samples, finding that high GLHC is associated with low adherence to mammography, low physical activity and less alcohol use (Karvinen & Carr, 2014; Franklin et al 2008; Kinney et al, 2002; Willis et al, 2001). A recent study of GLHC in the general population found that GLHC was correlated with less alcohol use, less physical activity, perceived risk of chronic disease, and beliefs that poor health behaviors contribute to chronic disease (Karvinen & Carr, 2014).

Spiritual Health Locus of Control (SHLOC) is a construct developed by Holt and her colleagues (2003) to include the role of religion and spirituality in determining health outcomes in the African American community. SHLOC reflects the belief that a higher power has control over one's health and has an active (higher being empowers one to be proactive about health behaviors/works with him to stay in good health) and a passive (because only a higher power is in control, there is no real reason to engage in health behaviors) dimension (Wallston et al 1999; Holt et al 2003; Holt, Clark & Klem 2007;

Debnam et al. 2012). Positive correlations have been found between Spiritual HLOC and preventive health behaviors (Debnam et al 2012). In a cross-sectional study examining mammography-screening behavior, Holt et al (2003) found that active Spiritual HLOC beliefs were associated with more perceived barriers to mammography and fewer perceived benefits.

Spiritual HLOC as a construct provides us with important context in understanding how spirituality may impact health behavior. Specifically, individuals with a more passive stance may become more passive, relying on God's will, while, for others, spiritual commitment may facilitate a more active stance in which self-protective behaviors are activated (Seybold & Hill, 2001; Diefenbach et al 1996). Although the outcome is bidirectional in nature (i.e. positive and negative) incorporating spirituality into our understanding of the factors within the Health Belief Model may be useful for patient care. We can use our understanding of the mechanisms of health behavior that are informed by spirituality to inform our interventions in the primary care setting (See Table 1).

Incorporating Spirituality into Primary Care: Considerations for Implementation

The spirituality of healthy primary care patients tends to be ignored, but the growing interest in having doctors understand this cultural aspect in patients requires us to consider incorporating spirituality into clinical care (McCord et al 2004). In primary care, the importance of spirituality in the lives of patients has raised the question of whether physicians should ever incorporate spirituality in their clinical encounters (Curlin et al, 2006; 2007). Recommendations for the inclusion of spirituality in clinical care are grounded in the assertion that issues of spirituality deserve a place in the health care system and should be considered a part of routine clinical care (Puchalski, 2009).

As primary care is often central in connecting patients to continued care in the health care system, it is an important setting to engage patients by promoting wellness. Based on an understanding of spirituality, culturally relevant interventions can be constructed that can engage patients by emphasizing wellness and prevention among patients. Providers may engage patients in dialogue that allows them to consider the ways in which their spiritual beliefs facilitate or inhibit health behavior. For example, fatalistic beliefs (an individual's health outcome is predetermined or purposed by a higher power and not within the individual's control) may facilitate a passive, non-active stance towards disease prevention, although studies indicate that it may be less inhibitive and more related to coping with illness (Franklin et al 2008; Roncancio, Ward & Berenson, 2011). Practitioners who are aware of the ways in which positive spiritual coping strategies serve as facilitators to health care (i.e. increased self-efficacy) (Holt et al 2014) may encourage patients to take a more active role in their overall health and wellness and frame messages to increase patient adherence to health promoting behaviors. Positive messages about wellness could be combined with spiritual tenets (i.e. the body is a temple) (Karvinen & Carr, 2014) to promote healthy behaviors such as diet change and screening and medication adherence.

Investigators have also endorsed having practitioners take a spiritual history of their patients (Koenig, 2012; Saguil & Phelps, 2012; Sulmasy, 2009; D'Souza, 2007; George et al, 2000). A number of spiritual history tools exist, including the FICA (Puchalski, 2014; Puchalski & Romer, 2000) the HOPE (Anandarajah, 2005) and the SPIRIT (Maugans, 1996), which are designed to be used in a primary care setting. Taking a spiritual history can communicate to patients that the physician is interested in their whole experience and the act of taking a history in itself may serve as an intervention (D'Souza, 2007). Koenig (2012) suggests that physicians take a spiritual history of all new patients in order to learn about various aspects of the patients' spiritual experience, including their religious background, the role their beliefs play in coping with illness and beliefs that may conflict with medical decisions (Koenig, 2012). Taking a spiritual history provides a context for conversations about patients' experience of their illness and provides the opportunity to discuss and potentially intervene on beliefs that can serve as barriers or promoters to taking certain health actions. Because the physician's role is not to provide spiritual guidance, experts have suggested that physicians refer patients to appropriate pastoral care in order to address any spiritual needs that arise (Koenig, 2012; Shin et al. 2013; Rumbold, 2007; Robinson & Nussbaum, 2004). Chaplains may be able to provide information to patients about health risks and the importance of taking a more active interest in their health. Hospital chaplains may also be used as a source of information and advocacy within hospitals through the creation of programs geared towards certain religious communities. While hospital chaplains may be a useful resource for patients' spiritual concerns, outpatient primary care settings are less likely to have this resource and may benefit from other resources in providing collaborative, integrated care.

Challenges to Incorporating Spirituality in Primary Care

Incorporating spirituality into clinical care is a challenging enterprise for health care providers. Discussion of spiritual concerns as they relate to health issues is controversial (Larimore, 2002), given that it is not a formal part of clinical training and physicians may feel ill equipped to have such discussions with patients. Practitioners may also feel uncomfortable bringing up spiritual matters with their patients because of their own spiritual backgrounds. For providers who may have different spiritual beliefs than their patients or are not spiritual at all, there may be a fear of engaging in charged, divisive discussions that may impact patient alliance. Furthermore, physicians have cited lack of time, difficulty identifying patients who want to talk about spiritual issues, concerns about offending patients and the belief that addressing spiritual concerns is not the physician's role as additional barriers (Balboni, Puchalski & Peteet, 2014; Saguil & Phelps, 2012; Curlin et al, 2006, 2007; D'Souza, 2007). These concerns are relevant as the potential for boundary violations increases with regard to implementing certain practices, such as prayer with patients. Despite these concerns, evidence suggests that patients want to discuss spiritual concerns relating to health (e.g. existential concerns, coping with illness, decision-making) with their physicians (D'Souza, 2007; Ellis & Campbell, 2004; Larimore, 2002) and, in order to provide comprehensive, holistic care to patients, physicians should not neglect this aspect of the patient experience (Sulmasy, 2009; Curlin et al, 2006; Milstein & Manierre, 2012).

Physicians acknowledge the positive role that spirituality plays in patients' lives (Shin et al, 2013) but express concern about the appropriateness of initiating conversations regarding spiritual matters with their patients. Independent of their religious affiliation, the majority of physicians stated that spiritual issues were appropriate to discuss with patients only if the topic was initiated by patients, with only a small number of physicians praying with or talking about their own experiences with patients (Curlin et al. 2007; Shin et al. 2013; Saguil, Fitzpatrick & Clark, 2011). In a survey of medical residents, Saguil, Fitzpatrick & Clark (2011) found that on average, only about 50% received instruction about spirituality in medical school and residency. The authors noted that despite their willingness, providers rarely address spiritual beliefs and practices that impact health during the medical encounter and suggested that family medicine continue to be reinvented to meet the spiritual needs of patients (Saguil, Fitzpatrick & Clark, 2011).

Educating Primary Care Practitioners about Spirituality

Primary care training should focus on increasing competencies in knowledge, skills and attitudes (see Anandarajah et al (2010). Given that lack of knowledge is one of the barriers to addressing spirituality among providers, Curlin and his colleagues (2006) suggest that health educators encourage students and practitioners to become more conscious of their own religious and spiritual identities, considering the ways in which their beliefs shape their approach to the presence of spiritual issues in the clinical encounter and the ways in which spiritual beliefs may serve as facilitators or barriers to patient care. Efforts to introduce spirituality as a special topic in seminars and grand rounds focused on patient care and cultural competence may be a way to engage providers in clinical settings and facilitate dialogue about spiritual issues. Curricula on spirituality may teach students how to clinically integrate spiritual themes into patient concerns and include discussions of how spiritual factors influence physical and psychosocial development throughout the life cycle (Puchalski et al (2001). Opportunities for dialogue and critical thinking about spirituality in the patient's biopsychosocial context allows practitioners to practice active listening, have a compassionate presence and provide spiritually integrated care (Ledford et al 2010).

A Collaborative Approach for Spirituality in Primary Care

The Patient Centered Medical Home (PCMH), focuses on treating the whole person, communities and families using a team-based approach to providing quality care for patients at all stages of life (Rosenthal, 2008; Stange et al 2010). The collaborative team of providers (i.e. physicians, nurses, social workers and community partners (i.e. faith-based organizations) may be referred to as a "medical neighborhood" (Taylor et al 2011). Collaboration between primary care providers and faith based institutions may allow us to address spiritual concerns as they relate to patient care. Religious institutions may be used as a venue for health programs or serve as active partners in developing programs to promote wellness. Churches and faith-based organizations may have committees or ministries that are dedicated to health-related issues (i.e. provide information to church members to promote awareness of conditions such as HIV, Diabetes, Heart Disease, sponsor walks and other fund-raisers). Providers may collaborate with these organizations to provide information to community members through health promotion events, such as health fairs that may be sponsored by faith-based organizations.

Conclusion

Spirituality may play a complex role in clinical care settings. Efforts to engage patients requires considering the ways in which cultural variables such as spirituality impact health behavior. From health promotion interventions to day-to-day interactions with health care providers, spirituality can be a useful means of connecting with patients for whom this is an important aspect of life. Although there has been increased recognition of the importance of spirituality, its incorporation in primary care practice remains difficult to implement. Nevertheless, recognition of spirituality and its potential for influencing health beliefs and behavior is essential for providers who wish to deliver holistic care. There is a continued need for a unifying theoretical framework to guide discussions of spirituality and health (Larimore et al 2002). Including spirituality into existing frameworks such as the Health Belief Model provides the opportunity to create more culturally relevant and engaging interventions individual level with the use of providers and chaplains to promote healthy behavior.

Providing culturally competent care involves open dialogue and effective provider-patient communication (Perloff et al 2006). Effective communication increases patient satisfaction, recall and understanding of information, adherence, and the potential for social support for patients (Ha & Longnecker, 2010; Ong, 1995). Issues of spirituality may pose a challenge to provider-patient communication, but the literature suggests that an openness to discussing these issues may facilitate better communication (Ledford et al 2014: Saguil & Phelps, 2012). Saguil & Phelps (2012) suggest that physicians keep an open ear for any mention of faith and spiritual practices, as they may potentially be invitational cues for the discussion of spirituality.

The relationship between physicians and their patients is important as providers are in a unique position to support and promote health and intervene on behalf of their patients. Providers should work to provide a safe environment for patients where they feel understood, respected and are able to trust their provider. As providers work to acknowledge the various aspects of identity and social location as they relate to patient care, it is essential that we consider all aspects of culture, including spirituality. To consider spirituality as it relates to the health of health consumers is to provide culturally competent care and, ultimately, good clinical care.

Biography

Author Autobiography: I am a doctoral student in the clinical psychology subprogram at the Graduate Center and City College of the City University of New York. I received my Bachelor’s degree from the University of Pennsylvania and currently hold an MPhil in anticipation of receiving my PhD upon completion of my doctoral program. My research interests include spirituality, health disparities in cancer and the role of spirituality in mental health.

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Table 1
Targeting Spiritual Beliefs in Primary Care

Incorporating spirituality into the Health Belief Model: Primary care providers can use understanding of the spiritual beliefs, which facilitate or hinder health behavior, to frame targeted interventions.

HBM Factor	Spiritual Belief(s)	Interventions
Perceived Severity: How serious is this illness?	■ I'll pray that it gets better ■ Use of spiritual remedies (e.g. salves, fasting) may delay seeking medical attention.	Providers may engage patients in dialogue about their beliefs while providing information about treatment and alternatives.
Perceived Susceptibility: What is the risk of contracting illness?	■ God is in control. ■ Fatalism/Everything happens for a reason.	Providers may provide information about health risk in community and faith based organizations as well as to individual patients.
Perceived Benefits: Is treatment feasible? Efficacious?	■ My body is a temple ■ I want to live longer ■ God helps those who help themselves ■ My church values Health	Use of Faith Based promotional materials (i.e. The Body is a Temple). Referrals to chaplains/ faith based orgs to promote healthy practices.
Perceived Barriers: Cost-benefit, practical concerns.	■ My beliefs prevent me from engaging in certain health behaviors or practices (i.e. contraception, organ donation)	Engage in dialogue and allow patients to express concerns. If needed, make referrals to chaplains/faith based orgs to help patient arrive at decisions that take their beliefs into consideration.
Self –Efficacy: Ability to execute desired behavior	■ Higher Power (i.e. God) gives me the power/courage to do anything ■ God is in control ■ Do my spiritual beliefs support what I want to do?	Partnerships between clinics and community/ faith organizations may promote healthy behaviors and engagement with primary care facilities. Providers may provide workshops in the community/churches to increase health awareness.
Cues to action: Triggers to taking action	■ Announcements about other church members who have fallen ill. ■ Pre-existing health conditions	
Sociopsychological Variables	■ Social Support in church	