DIRECTIONS IN PSYCHIATRY
Vol 21 Lesson 21 November 2001

The Patient's Spiritual/Religious Dimension: A Forgotten Factor in Mental Health

David B. Larson, MD, MSPH, Susan S. Larson, MAT,
and Harold G. Koenig, MD, MHSc

David B. Larson is President, International Center for the Integration of Health and Spirituality, Rockville, MD, and Adjunct Professor, Departments of Psychiatry and the Behavioral Sciences, Duke University Medical Center, Durham, NC, and Northwestern University Medical School, Chicago, IL.
Susan S. Larson is Research Reports Editor, International Center for the Integration of Health and Spirituality, Rockville, MD.
Harold G. Koenig is Associate Professor, Departments of Psychiatry and Medicine, Duke University Medical Center, Geriatric Research Education and Clinical Center, and Veterans Administration Medical Center, Durham, NC.

Support for the writing of this paper was provided by Monarch Pharmaceuticals, a wholly owned subsidiary of King Pharmaceuticals, Inc., Bristol, Tennessee, and the John Templeton Foundation, Radnor, PA.

Learning Objective

Psychiatrists will (1) become more aware of the complexity and importance of religious / spiritual commitment in patients' lives, recognizing that this dimension may at times serve as a strength, and, at others, as a source of conflict, (2) recognize the new focus to improve sensitivity to religious / spiritual issues in guidelines by the American Psychiatric Association and in psychiatric residency training, (3) review quantitative research findings regarding potential mental health benefits of religious / spiritual commitment
and examining research findings on potential clinical harm, and (4) identify important elements of religious / spiritual assessment in taking patient histories.

Editors Note

Faith in God has always been an important factor in my life. So it was no surprise that the Chief of Psychiatry at the Payne Whitney Clinic in 1953, while interviewing me for a place in the residency program, asked whether I anticipated a conflict between my religious convictions and the study and practice of psychiatry. Without hesitation, I replied "no"… a response that was both insightful and naïve. In the nearly fifty years since then, I have not had a problem being a psychiatrist with faith. But it could have happened, since, in the 1950s, Freudian psychology was at its zenith and its founder had always

been outspokenly atheistic. As Dr. Larson and his colleagues point out in this lesson, as many as 40% of psychoanalysts and 26% of non-psychoanalytic psychiatrists who had been raised with theistic beliefs subsequently became atheistic or agnostic.

Until the past decade, official psychiatry largely ignored the relevance of religion in patients' lives. Only quite recently has this climate begun to change. Clinicians are now urged to assess patients' religious beliefs and practices with the same care that they use to assess other aspects of personality strengths and limitations. They are cautioned to respond to each patient's spiritual attitudes with due respect and take care lest countertransference factors intrude, however subtly, at the risk of injuring the therapeutic alliance or overlooking vital psychopathology.

The authors cite increasing research that point toward a meaningful connection between faith, especially intrinsic faith, recovery from illness, and overall health. People of faith appear to experience less depression. When depressed, they appear to recover much more quickly. They have lower suicide rates and are less vulnerable to drug and alcohol abuse disorders. Even recovery from surgical procedures seems to benefit significantly by the presence of genuine faith. And attending religious services once a week may add years or more to the average life span.

Introduction

During the past decade, psychiatry has taken a more comprehensive look at the patient's religious/spiritual outlook as a complex dimension of the patient's well being, and as a potentially important component in the therapeutic process and doctor-patient relationship. From a historical perspective, there is no doubt that religious activities, especially when taken to extremes, can adversely affect both physical and mental health. Religion has been misused to justify anger, hatred, aggression, violence, and prejudice, and at times encouraged unquestioning devotion to single, despotic religious leaders. In contrast, religious beliefs centering on forgiveness and caring can be life enhancing and provide an optimistic worldview. Religious beliefs and activities that promote generosity, thankfulness, kindness, understanding, compassion, and hope are more likely to be associated with mental health benefits.[1] These beliefs may also promote the development of strong social supports and encourage reaching out to others in both giving and receiving emotional and instrumental help. They can also promote a sense of personal worth. Feeling loved and valued by God or a Higher Power can bring comfort, especially when coping with the distress of emotional or physical illness.[2]

In accordance with the changing outlook on religion and spirituality, the American Psychiatric Association (APA) has provided guidelines to aid clinicians in developing sensitivity to a patient's spiritual/religious worldview. The APA's 1995 Practice Guidelines for the Psychiatric Evaluation of Adults stated that "the process of psychiatric evaluation must take into consideration and respect the diversity of American subcultures and must be sensitive to the patient's ethnicity and place of birth, gender, social class, sexual orientation and religious/spiritual beliefs."[3] These recommendations followed the 1990 Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitment and Psychiatric Practice.[4]

Though historically some theorists have dismissed religion/spirituality as an inherently harmful clinical factor, quantitative research in the last 15 years has discovered elements of religion linked with beneficial mental health outcomes.[5] An increase in peer-reviewed research examining spiritual/religious factors has continued to clarify aspects of spiritual/religious commitment, which might benefit, as well as harm, patient's mental and physical health.[6] Research is finding that religion/spirituality may potentially provide strength in coping with the stress of mental illness and serious physical illnesses, aid in prevention and recovery from addictions and depression, as well as reduce the risk of suicide and potentially increase longevity.[7,8] However, research has found emotional and mental health status to be at risk when spiritual "principles" have been used to condemn or manipulate, or used to advocate refusal of appropriate medical interventions for treatable diseases.

To date, the preponderance of quantitative studies have been conducted in the United States. Consequently, the religious demographics of the United States are important to keep in mind when considering the research presented. According to Gallup Poll data, 95% of those in the United States believe in God or a Universal Spirit, with 5% atheist or agnostic. Among those who believe in a higher power, 64% are Protestant, 28% Roman Catholic, 2% Jewish, 1% Eastern Orthodox, 1% Mormon, and 4% another faith tradition, such as Muslim, Buddhist, or Hindu.[9] Furthermore, a substantial 85% of Americans consider religion "very important" or "fairly important" in their lives. About 40% weekly attend one of the 500,000 places of worship in the United States, including churches, synagogues, and mosques. Another 20% attend monthly for a total of 60% attending monthly or more .[10]

Recognizing Complexity

Recognizing complexities in the spiritual/religious dimension parallels the understanding of complexity in human relationships. For example, sometimes a significant personal relationship, such as with a parent or spouse, can be abusive and characterized by rejection, manipulation, and contempt. Yet significant relationships are often healthy and life giving, with emphasis on caring, devotion, and empathy. One does not dismiss all relationships as pathological because pathological relationships can exist.

As in personal relationships, the dynamics of religion/spirituality can be highly complex. Religious/spiritual beliefs and practices can be misused to manipulate, control, or dominate. Yet, when serving as a source of acceptance, love, and caring, these beliefs and practices can supply strength, increase self-esteem, and provide meaning and hope.[11] Rather than skirt the discussion of religion/spirituality, clinicians can inquire what role, if any, religious/spiritual beliefs and practices have played in a patient's life to better understand the patient's background, culture, and worldview, and discover past or current helps or harms in this dimension.[12]

This review will examine:

- Past theoretical assumptions in light of recent research
- Potential divergences in patient-psychiatrist world views with risk of counter-transference or misinterpretation of religious language or culture
- Increased training in spiritual/religious issues in psychiatry residency programs
- APA guidelines for increasing clinician sensitivity
- Understanding the patient's perspective and assessing desire for acknowledgement of spiritual/religious issues in psychiatric care
- Quantitative research findings on religious/spiritual commitment and mental health status
- Elements of a sensitive "Spiritual Assessment"
- Case examples of patient dynamics with religious content

Quantitative Research Finds Benefits of Religious Belief and Practice

Psychiatrists and psychologists have sometimes taken a less than neutral stance in assessing the role of religious/spiritual beliefs in a person's life. Freud[13] and Ellis[14] both theorized about religion and spirituality in terms of psychopathology. In the mid-1970s the Group for the Advancement of Psychiatry echoed their assumptions, presenting religion as a "borderline psychosis."[15] Perhaps such statements made decades ago by field leaders are partially responsible for the lack of recognition of religion/spirituality's potential positive role in mental and physical health. To inquire objectively about these theoretical assumptions, researchers decided to statistically analyze how often and to what degree these assertions of religion/spirituality as psychopathology found support in quantitative research.

A systematic review[16] of psychiatric research, which was published in the *American Journal of Psychiatry,* surveyed all articles published in the top four general psychiatry journals from 1978–1982; these included the *American Journal of Psychiatry, British Journal of Psychiatry, Canadian Journal of Psychiatry, and the Archives of General Psychiatry.* The review found that only 3 of the 2,348 quantitative studies contained a religious variable as the central focus of the study, and only 1 used a state-of-the-art measure, a multi-dimensional religious commitment questionnaire previously tested for reliability.

Only 2.5% of the quantitative studies included any religious variable including denomination, with most using just a single item, inadequate in measuring the complexity of religious beliefs, attitudes, or frequency of practices.[16] Obviously, studies of spiritual/religious commitment fell far short of extensive research on which to build theoretical constructs.

In the studies that did include a religious variable, researchers investigated whether findings would confirm psychiatry's historical presupposition of harm. A systematic review of all quantitative articles published in 1978–1989 in the *American Journal of Psychiatry* and the *Archives of General Psychiatry* found that 72% f articles indicated a positive clinical association between religion and better mental health, 16% were negative, and 12% were nonsignificant.[17] This demonstrates potential benefits, previously overlooked.

Divergence Between Religious Worldviewsof Psychiatrists and the General US Population

When comparing surveys of the U.S. population with psychiatrists and other mental health professionals, a potential divergence in worldviews emerges between psychiatrists and the patients they treat. This divergence may indicate that some psychiatrists are unaware of the high relevance of religion/spirituality in many patients' lives. For example, during the past 50 years Gallup polls have found the percentage of the U.S. population who believe in God or a higher power to be remarkably constant: 96% in 1944 and 95% in1993.[9] More than 90% of Americans desire some form of religious education for their children.[18] As noted earlier, about 60% of the US population attends religious worship services monthly or more.[10]

Many psychiatrists' personal views are notably less religious than those of the general population. For example, Gallup surveys have found 5% of the US population are atheist or agnostic.[9] In contrast, surveys from 1990 found 21% of psychiatrists and 28% of clinical psychologists are atheists or agnostic.[18] Also, while Gallup Polls found 72% of the U.S. population agreed with the statement "My religious faith is the most important influence in my life,"[9] 1990 surveys of mental health professionals found only 39% of psychiatrists and 33% of clinical psychologists agreed with a similar statement: "My whole approach to life is based on my religion." [19] More recently, a random sample survey of APA members published in 2000 found 42% indicated religion was not very important in their lives, [20] compared with only 12% of the U.S. population,[9] suggesting a continuing important difference regarding the role religion might play in daily life. Consequently, many mental health professionals may be dealing with patients whose religious/spiritual views differ from their own.

COMPARISON BETWEEN VIEWS OF PSYCHIATRISTS AND ANOTHER MEDICAL SPECIALTY:

The same 2000 survey further compared psychiatrists' views of the personal importance of religion to those of physicians of another specialty.[20] **More than 75% of physicians specializing in rehabilitation medicine rated religion as personally important compared with 57% of the psychiatrists.** Given the similarity of religious upbringing of the two physician samples, the author suggested this divergence should raise questions about the influence of specialty training on personal belief orientation. **An earlier study had suggested that training may impact worldview. It found that as many as 40% of psychoanalysts and 26% of non-psychoanalyst psychiatrists who had been raised with theistic beliefs became atheistic or agnostic.[21]** The difference in the two specialties may point to the influence of psychiatric training, such as in embracing theories like Freud's that asserts that the pursuit of the religious/spiritual dimension in life is inherently pathological; however, changes in worldview or belief systems may have occurred before training. Noting the low ranking of the personal importance of religion among social scientists, including psychiatrists and psychologists,

researcher Rodney Stark said, “to put it plainly, many social scientists are inclined to regard conservative religious beliefs as abnormal. Because they reject the truth of such beliefs, they find it difficult to imagine that a truly normal person can believe them.”[22] In any case, residency training on the potential clinical relevance and possible positive aspects of spiritual/religious commitment, not only negative aspects, may help psychiatrists better understand religious patients who come to them for care.

IMPACT OF DIVERGING APPROACHES TO RELIGIOUS AND SPIRITUAL FAITH:

Bergin observed that for the 70% of the population for whom religious commitment is a central factor,“ secular approaches to psychotherapy may provide an alien values framework.” He states that “a majority of the population probably prefer an orientation to counseling and psychotherapy that is sympathetic, or at least sensitive, to a spiritual perspective.”[19] Surveys tend to support this observation. A 20-year study[23] on the patterns of emotional help-seeking in the United States found that about 40% of the U.S. population seeks out a member of the clergy when dealing with a personal problem. Among people who attend religious services at least once a week, more than 50% considered clergy to be their primary mental health care providers.[23] An analysis of data from the five-site Epidemiological Catchment Area (ECA) surveys of more than 18,000 adults found that individuals with serious mental illnesses such as major depression, schizophrenia, panic attacks, and bipolar disorder were just as likely to seek treatment from a clergy member as from a mental health professional.[24]

A psychiatrist’s sensitivity to a religious/spiritual worldview may influence who consults with them or comes to them for treatment; therapists who are religious may be sought by individuals with similar beliefs. For example, studies have shown that those who have no religious beliefs disproportionately seek out mental health professionals ,[25,26] while those with more conservative Protestant beliefs attempt to find a therapist with parallel beliefs who might better be able to understand their world view.[27]To work more effectively with the majority of potential patients, psychiatrists must be more aware of the importance of religion in many people’s lives. **Recognizing a potential divergence in world views may allow psychiatrists to become more sensitive to patients whose religious views differ from their own and acknowledge the central role religious/spiritual commitment may play in coping with the stress of mental illness.**

COUNTERTRANSFERENCE ISSUES:

The potential divergence in worldviews between clinician and patient presents a challenge for the therapist uneducated about spiritual factors and may lead to possibly overlooking or misunderstanding patient spiritual concerns.[28] Therapists may also be unaware of countertransference, especially if one has had little or no training in dealing with these issues. Lovinger notes:

"For the therapist who at one time had a religious affiliation, and now no longer has one, the problems posed by religion encountered in therapy are even more challenging. Pulls occur if the feelings are not walled off or well worked through via personal therapy or searching self-scrutiny. Guilt over desertion, apostasy or heresy are often experienced. There may be anger toward former beliefs and practices and toward those who hold these beliefs and practices."[29]

Consequently, religious issues may evoke deeply felt reactions for the clinician as well as for the patient.[30] **The therapist must observe his or her own reactions to the spiritual/religious views of the patient.** A consistently generally negative reaction to religious/spiritual matters in care could be due to therapist countertransference, with negative implications for treatment. Likewise, an overly positive reaction also due to countertransference could limit the clinician's ability to maintain a discerning perspective. "This self-assessment by the clinician is crucial for providing the context in which the religious or spiritual history can be credibly included within the psychiatric care of a patient," note Meador and Koenig .[31] For therapists uncomfortable with a patient's religious/spiritual world view, referrals or consultation remain options.

Despite a desire to remain neutral, a therapist may rate greater patient progress if the patient's values converge ore toward his or her own, according to one study assessing outcomes from four different perspectives.[32] In this study, patients undergoing time-limited dynamic psychotherapy had outcomes assessed four ways: (1) by pre- and post-assessment batteries of a standardized measure of interpersonal impairment, (2) by the therapist, (3) by the patient, and (4) by an independent clinician. Patient and therapist values were measured by the *Rokeach Value Surve*y. **Therapists rated higher improvement for those patients whose personal goals and values came to more closely resemble their own.** However, those same patients were not rated as more improved by the independent clinician, by the patient, or the by the standardized outcome measure. This indicates possible therapist biases in rating patients who have assimilated their values. Furthermore, the one religiously oriented value on the survey of 36 items was the one value on which patients and therapists differed most significantly. Overall, patient–therapist dyads whose values were moderately similar showed the most improvement when taking each of the four possible outcome ratings into account. The study concluded that values can play a part in the process, outcome, and even assessment of therapy. The authors recommended a values sensitization component in therapists' training curriculum that could enable trainees to both recognize their own values and become more sensitive to those of their patients, so that values-related issues are processed with increased sensitivity and skill.

Increasing Clinicians' Sensitivity

PSYCHIATRIC RESIDENCY TRAINING IN SPIRITUAL/RELIGIOUS ISSUES:

Misunderstanding the role religion plays in patients' lives could result in part from the lack of training concerning spiritual and religious issues for residents. The norm in psychiatric training had been to give scant attention, if

any, to methods for addressing a patient's religious/spiritual issues. A survey of psychiatric residency programs in 1988 showed that few included course work on any aspect of religion, and that residency supervision infrequently addressed religious issues.[33] In 2000, a random sample survey[20] of members of the APA found that 65% indicated that religious and spiritual issues were rarely or never addressed in their training. However, 92% of these graduate psychiatrists indicated that religious or spiritual issues came up in practice "at least sometimes," "often," or "a great deal." Furthermore, 44% reported that "loss of purpose or meaning in life," which can have spiritual or religious relevance, was a focus of treatment either often or a great deal of the time.[33]

To help close this gap in training, mandates of the Accreditation Council for Graduate Medical Education (ACGME) in 1994 required educating psychiatry residents about religious and spiritual factors as a potentially relevant dimension of patients' lives.[34] The ACGME designated that a curriculum should include a "presentation of the biological, psychological, socio-cultural, economic, ethnic, gender, religious/spiritual, sexual orientation and family factors that significantly influence physical and psychological development in infancy, childhood, adolescence, and adulthood." It added that the residency program should provide instruction about American culture and subcultures, and should include the issue of religion/spirituality as a relevant aspect of patient culture.

To meet the need for instruction in religious/spiritual issues, a group of psychiatrists from diverse religions - Buddhist, Hindu, Jewish, Christian, Moslem, and agnostic - formulated a model curriculum. The Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice: A Course Outline[12] released in May 1996 at the APA annual meeting, provides three core educational units, eight accessory units, and suggested learning formats for psychiatric residencies to use in developing their own programs. Also, in the years 1997–2000 the John Templeton Foundation awarded 16 outstanding programs in psychiatry and spirituality, including 13 adult psychiatry programs and 3 child psychiatry programs, with awardees such as Harvard, Baylor, Emory, and Georgetown. The programs cover a variety of topics and use a number of different teaching methods. In most programs residents learn how to perform an in-depth spiritual / religious values assessment and how to recognize patient spiritual strengths, distress, and supports. Patient interviews, live or videotaped, have been used to demonstrate instances of psychopathology involving religious content, as well as situations in which spiritual beliefs or practices provided support or strength during psychiatric illness[35] (please see case studies).

Some programs have panel discussions by members of the clergy or patients of various religious/spiritual backgrounds, others have clinical case conferences and group supervision to teach residents how to address and work with patients' spiritual issues. Aspects of the professional therapeutic relationship are discussed, including issues of transference, countertransference, and boundaries and ethical considerations. At the California Pacific Medical Center of the University of California at the San Francisco School of Medicine, for example, residents rotate through breast cancer spiritual focus groups to observe the roles spirituality can play in coping.

In addition to psychiatry, more than 70 US medical schools now have curricula focusing on spirituality and medicine.[36] The Association of American Medical Colleges (AAMC) has provided curriculum objectives that underscore the importance of addressing patients' spiritual issues as part of becoming a compassionate doctor; these are quite similar to the APA guide-lines, stating that physicians should seek to understand the patient "in the context of the patient's beliefs and family and cultural values." [37]

APA GUIDELINES AND DSM RECOGNITION:

In 1990 the APA issued the Guidelines Regarding Possible Conflict Between Psychiatrics' Religious Commitment and Psychiatric Practice.[4] **These guidelines indicated the usefulness for psychiatrists to obtain information on "the religious or ideological orientation and beliefs of their patients so that they may properly attend to them in the course of treatment," and that "no practitioner should force a specific religious, anti-religious, or ideological agenda on a particular patient."** In one example, the Guidelines described a psychiatrist whose views differed from those of a devoutly religious patient. The psychiatrist interpreted the patient's long-standing religious commitment as "foolishly neurotic." The Guidelines noted that "because of the intensity of the therapeutic relationship, the interpretations caused great distress and appeared related to a subsequent suicide attempt." The APA's "Practice Guidelines for the Psychiatric Evaluation of Adults" in 1995 also called for a respectful clinical assessment.[3]

The DSM-IV acknowledged a new non-psychopathological category entitled "Religious or Spiritual Problem" in the section labeled "Other Conditions that May Be a Focus of Clinical Attention."[38] This new category permitted clinicians to code a religious or spiritual adjustment separate from an Axis I or II disorder, rather than as merely an epiphenomenon that might be observed but not clinically addressed. This category could emphasize the importance of paying greater clinical attention to religion/spirituality, whether potentially harmful or beneficial. Furthermore, the DSM-IV included an "Out-line for Cultural Formulation," which can be used in assessing religious and spiritual issues when they are relevant to a patient.

Criticism of Relevance

Despite recognition from these defining bodies, some clinicians have objected to incorporating inquiry about a patient's spiritual/religious framework into therapeutic care, even when patients desire it, stating that patients often ask for things that are unrealistic or that may not be in their best interest .[39] Yet, religious/spiritual variables may be operating whether a therapist chooses to recognize this or not.[40] Critics have also implied that inquiring about such beliefs can be equivalent to, in essence "imposing" a religion on patients, suggesting that inquiring is the same as prescribing.[3 9] Yet, asking a question like "Do you have spiritual beliefs that help or hinder your coping with the stress of your illness?" shows openness regarding the patient's relevant religious or spiritual beliefs; it can easily be answered "n o" or can prompt explanation by the patient if they wish to clarify the nature of their beliefs. Doctors who ignore a patient's religious/spiritual framework may imply that it's

irrelevant at best, even if patients hope for acknowledgement or discussion of these issues. **Clinicians can consider how best to respect patients' beliefs and clinically discern whether they are assisting them in coping with illness or giving rise to conflicts.** The therapist who is uncomfortable with spiritual/religious issues might seek consultation or refer patients to clinicians more experienced with this life dimension, or to chaplains or clergy, if appropriate, to discuss their spiritual concerns in greater depth, if the patient so desires.[41]

INCREASING SENSITIVITY TO RELIGIOUS LANGUAGE:

It can be difficult to properly interpret a language or an aspect of a patient's culture that is unfamiliar. Anyone who has tried to learn a foreign language realizes idioms can certainly remain a puzzle, if not sound outright ludicrous, if taken literally. If someone from another culture heard the idiom "it's raining cats and dogs," they might think this response somewhat delusional.

Differing worldviews and the language used to express them can cause some of the same misunderstandings. For instance, when trying to illustrate the concept of delusion, the authors of the *Diagnostic and Statistical Manual-III-R (DSM-III-R)* Glossary of Technical Terms, Appendix C stated, "Delusion: Example, if someone claims he or she is the worst sinner in the world, this would generally be considered a delusional conviction"[42] Using the same logic, almost any hyperbole expressing depth of feeling could be regarded as a delusion if taken as a concrete statement, such as "I am the happiest man alive." Language, particularly religious language, can express depth of feeling, rather than a concrete rating scale, but one unfamiliar with it might misinterpret it. To point to this religious phrase as a delusion suggests a cultural misunderstanding. In fact the glossary showed a marked insensitivity by employing religion to demonstrate psychopathology in 22% of the case examples - a disproportionate amount compared with any other cultural factor the glossary used to illustrate a technical term.[43] However, when these potential misunderstandings were pointed out, the *American Journal of Psychiatry* published these observations of DSM-III-R.[44] Furthermore, the next edition, the DSM-IV re moved the many examples that used religious content to illustrate pathology.[15]

If a patient uses religious language to describe emotions, the clinician should ask the patient questions to better discern the clinical meaning of his or her statement, rather than viewing it unquestionably as a delusion; the clinician can inquire about what events or beliefs lead the patient to make that statement and explore what feelings are attached it. Once again, a clinician who is unfamiliar with the language of the patient's faith tradition, can also consult or collaborate with a chaplain, clergy person, or therapist who is more familiar with the religious language and expression of that patient's particular religious background.[43]

Understanding Patients' Perspectives

According to national survey data,[7,8] religion plays a central role in many Americans' lives. The next question is whether patients want

religion/spirituality addressed in treatment. More research is needed in this area, yet two studies below particularly document mental health patients' desires for spiritual support. A1995 survey[45] of 30 psychiatric patients with diagnoses, including schizophrenia, bipolar disorder, unipolar depression, schizoaffective disorder, and personality disorder, found:

- 57% attended religious services and prayed at least daily
- A substantial 83% felt that spiritual belief had a positive impact on their illness by providing comfort and feelings of being cared for and not being alone
- However, a quite sizeable 38% expressed discomfort with mentioning their spiritual or religious concerns to their therapist[45]

A 1997 survey[46] compared the spiritual needs of 51psychiatric inpatients with those of 50 general medical inpatients matched for age and sex.

- Some 80% of the psychiatric inpatients and 86% of the medical inpatients considered themselves spiritual or religious persons, with a substantial 48% of psychiatric patients and 38% of medical inpatients reporting they were "deeply religious"

- When asked to what degree they relied on religion as a source of strength, 68% of psychiatric patients and 72% of medical patients indicated "a great deal"

- Only 10% of psychiatric patients and 2% of medical patients indicated "not at all"

Furthermore, the study found that 88% of the psychiatric patients and 76% of the medical patients reported having three or more specific religious needs while hospitalized. These included:

1. The need to know God's presence (84% of psychiatric patients, 82% of medical patients)
2. The need for prayer (80% of psychiatry patients, 88% of medical patients) and
3. The need for a visit from a chaplain to pray with them (65% of psychiatric patients and 66% of medical patients).[46]

With such surprisingly similar high rates among both psychiatric and medical or surgical patients, additional medical patient surveys indicating a desire for inclusion of religious/spiritual issues may also indicate the relevance of this factor for psychiatric patients. For instance, a study published in the *Journal of Family Practice* surveyed more than 200 medical inpatients and found that 77% felt that physicians should consider their patients' spiritual needs.[47] Similarly, a national poll conducted by *USA Weekend* found that 63% of individuals surveyed felt that physicians should ask patients about their religious/spiritual background, but only 10% of their doctors had done so.[48]

Many doctors have remained unaware of the potential significance of religious faith in helping patients deal with serious illness. For example, one study at Duke University Medical Center found that 44% of hospitalized medical patients indicated that their religious beliefs were the most important factor in coping with their illness, but only 9% of physicians agreed.[49] Frequently, religious issues remain neglected in clinical care. The new focus in psychiatric residency training and in primary care residencies as well should enable the next generation of physicians to be more aware of their patients' religious values and beliefs, which can lead to more comprehensive, responsive care.

Why might patients feel so strongly that spirituality is relevant to their medical care? A decline in physical or mental health often precipitates a spiritual crisis; when illness strikes, patients often start to question their purpose in life, the meaning of their work, their relationships, and their personal identity, as well as their ultimate destiny. Furthermore, patients may draw upon their spiritual/religious beliefs in dealing with anxiety about their diagnosis, pain from their ill-ness, a sense of isolation, and feelings of loss of control.[6,50] On the positive side, they may turn to their religious/spiritual community and to their relationship with God or a Higher Power for comfort and hope, for a sense of belonging, and the feeling of being loved and valued in the midst of difficulties. On the negative side, they may feel a sense of guilt, condemnation, or abandonment. When spirituality or religion becomes negative or conflictual, these issues in particular need to recognized and addressed.

Research on Spirituality, Health, and Recovery From Illness

Quantitative research has helped to identify salutary links with religious/spiritual vitality as well as negative religious coping patterns and potential harmful effects. A Consensus Report[8] culminated the collaboration of more than 70 researchers, clinicians, and ethicists in the fields of physical and mental health, addictions, and the neurosciences to review current research findings and to map out future research directions as well as barriers to overcome. The 1998 report concluded that the data from many of the studies conducted to date were sufficiently "robust and tantalizing" to warrant continued and expanded clinical investigations.[8]

Briefly summarized below are peer-reviewed, published studies in the areas of (1) prevention, coping, and recovery from depression, (2) suicide prevention, (3) substance abuse prevention and treatment, (4) adolescent and adult health risk reduction, (5) coping with surgery and severe medical illness, (6) potential harmful aspects of spiritual/religious problems, and (7) religious/spiritual links with longevity. (For an extensive review of the research, please consult the *Oxford University Press Handbook of Religion and Health*,[6] published in 2001, which reviews more than 1,200 studies.)

PREVENTION, COPING, AND RECOVERY FROM DEPRESSION:

Spiritual/ Religious Commitment as a Protective Factor

A review of more than 80 studies published over the last 100 years found religious/spiritual factors generally to be linked with lower rates of depression. [51] Persons who both participated in a religious group and highly valued their religious faith were at a substantially reduced risk of depressive disorder, while those with no religious link may raise their relative risk of major depression by as much as 60% (Table 1). Lack of organizational religious involvement was linked with a 20%–60% increase in the odds of experiencing a major depressive episode. The authors suggested that valuing one's religious faith as centrally important and actively belonging to a religious group may develop spiritual roots that provide meaning as well as support from others, creating anchors of hope and caring that might help protect against depression.

TABLE 1
DEPRESSION FINDINGS

- Between 10%–25% of women and 5%–12% of men will meet the medical criteria for major depressive disorder within their lifetime.[1]
- Visits to physicians for depression nearly doubled within 10 years - from 11 million in 1985 to 20.4 million by 1994, according to the *Journal of the American Medical Associatio*n.[2]
- Antidepressant medication more than doubled from 5.3 million to 12.4 million in the same time.[1]
- People who have no connection with a religious/spiritual group are at an increased risk of depression.[3]
- People who often attend religious services and highly value their religious faith are at a substantially reduced risk for depression.[3]
- People whose religious faith is a central motivating factor may recover faster from depression when it develops.4
- Some 45% of older hospitalized seriously ill patients experience some form of depression, compared with only1% of the elderly in the community.[4]
- Depression among the seriously physical ill can lengthen hospital stays and increase use of medical services.[4]
- People with major depression have a substantially increased risk for early death and suicide attempts.[5]

1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder*s. 4th ed. American Psychiatric Association:Washington, DC; 1994.
2 Pincus HA, et al. Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. *Journal of the American Medical Association.*1998; 7:526–531.
3 McCullough ME and Larson DB. Religion and depression: A review of the literature. *Twin Research.* 1999; 2:126–136.
4 Koenig HG, George LK, and Peterson BL. Religiosity and remission of depression in medically ill older patients. *American Journal of Psychiatry.* 1998;155(4): 536–542.
5 Koenig HG and George LK. Depression and physical health outcomes in depressed medically ill hospitalized older adults. *American Journal of Geriatric Psychiatr*y. 1998; 6:230–247.

RECOVERY FROM DEPRESSION AMONG THE MEDICALLY SERIOUSLY ILL:

Depression often strikes older patients hospitalized for medical illness. While major depression afflicts only 1% of older adults living in the community, the figure rises to 10% among medically ill hospitalized elderly, while 35% or more suffer with less severe types of depression. Often these depressions persist long after treatment of the medical illness and may be triggered by the suffering, physical disability, and loss of control the hospitalized elderly encounter with their physical illness. Besides impairing quality of life, depression appears to delay recovery from physical illness, lengthen hospital stays, potentially increase further clinical problems, and even increase risk of death (Table 1).[52]

Researchers at Duke University, in Durham, NC, investigated whether religious coping might help patients recover faster from their depression. **The research team used multidimensional measures, including questions about frequency of religious attendance and private religious activities like prayer or scripture study. They also employed the *Hoge Intrinsic Religiousness Scal*e, a 10-item validated scale to measure to what extent a person's religious beliefs act as major motivating factor in decisions and behavior** (Table 2). The study sample included 87 depressed older adults hospitalized with medical illness. The course of their depression was tracked for almost one year. **For every 10-point increase in their intrinsic religion score, there was a 70% increase in the speed of remission from their depression. This effect remained after controlling for multiple demographic, psychosocial, physical health, and treatment factors. [53]**

In another study of 850 elderly men admitted to the hospital, researchers found that patients who used their religious faith to cope were significantly less depressed.[54] In a subgroup of 201 patients, the extent of religious coping predicted lower depression scores on follow-up 6 months later, after controlling for multiple predictors of depression. In fact, the clinical effects of religious commitment were strongest among those with more severe disabilities.[55]

LOWERING COGNITIVE BUT NOT SOMATIC SYMPTOMS OF DEPRESSION:

However, religious coping was associated with lowering only certain types of depressive symptoms.[55] Loss of interest, feelings of worthlessness, withdrawal from social interaction, loss of hope, and other "cognitive" symptoms of depression were significantly less common among patients drawing upon their religious beliefs or practices to cope. Yet "somatic" symptoms such as weight loss, insomnia, loss of energy, and decreased concentration appeared unaffected by religious coping. The investigators concluded that religious coping may reduce the affective symptoms of depression, but appeared less effective for the biological symptoms that are more responsive to pharmacologic treatment.[55]

TREATMENT OUTCOMES OF DEPRESSION IN CLINICAL OUTCOME STUDIES:

In a study of moderate depression, an intervention drawing upon the patients' spiritual resources hastened recovery.[56] Among patients whose

religious beliefs and practices were of great personal importance to them, receiving religiously oriented cognitive behavioral therapy sensitive to their religious framework had better scores on measures of post-treatment depression and clinical adjustment than those whose therapy omitted religious content.

This study randomized religious Christian patients into four groups to receive one of two different types of therapy - religious or non-religious - from one of two different types of therapists - religious or non-religious. The religious content included use of religious imagery and recognizing the use of religious arguments to counter irrational thinking processes. Therapy with religious content resulted in significantly faster recovery from depression, whether the therapist was religious or not. In fact, the group treated by non-religious therapists utilizing religious-content therapy showed the most clinical benefits. This somewhat surprising finding illustrates the potential for nonreligious therapists to effectively conduct therapy with religious content for those patients for whom it might be relevant.

In a similar study,[62] Muslim patients with generalized anxiety disorder were randomized to receive either a traditional treatment of supportive psychotherapy with anxiolytic drugs, or treatment with anxiolytic drugs plus psychotherapy that incorporated patients' use of prayer and reading verses from the Holy Koran.[57]The study reported that patients receiving psychotherapy drawing upon their spiritual resources showed significantly more rapid improvement in anxiety symptoms than those receiving traditional therapy alone.

TABLE 2
HOGE'S VALIDATED INTRINSIC MOTIVATIONAL SCALE

Directions: Below are some statements about religion. We would like to know how you feel about each statement. Please circle the response that best describes how you feel about the statement:

A. My faith influences my life.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

B. One should seek God's guidance in making important decisions.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

C. It doesn't matter what I believe as long as I live a moral life.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

D. In my life, I experience the presence of the divine.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

E. My faith sometimes restricts my actions.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

F. I refuse to let religious considerations influence my daily affairs.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

G. Nothing is as important to me as serving God the best way that I know.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

H. I try to carry my religion into my dealings in life.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

I. I feel that there are many more important things in life than religion.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

J. My religious beliefs are what lie behind my approach to life.
1. Strongly Disagree 2. Disagree 3. Cannot Decide 4. Agree 5. Strongly Agree

(Source: Hoge, DR. A validated intrinsic motivation scale. *Journal for the Scientific Study of Religio*n.1972;11:369–376

SUICIDE PREVENTION:

Several studies have reported that religious commitment prevents suicide more effectively than general social contact or steady employment. A review of 12 studies reported a negative relationship between religious commitment and suicide.[5]

A study of causes of death among adults 50 years or older found that persons who never participated in religious activities were four times more likely to commit suicide and those who participated less than once a month were twice as likely, even after controlling for the frequency of social contact.[58] Researchers analyzed data from the 1993 National Mortality Followback Survey undertaken by the US National Center for Health Statistics, to examine causes of nearly 5,000 deaths.[58] They adjusted for sex, race, marital status, age, frequency of social contact, and frequency of participation in religious activities. The analysis showed that visiting or talking with friends or relatives did not reduce the likelihood of suicide relative to death by natural causes, but frequent participation in religious activities did. The researchers suggested that these findings showed it may not be the social contact inherent in some forms of religious participation that decreases suicide risk, but something more intrinsic to religiousness. They concluded, "participation in religious activities may act as a safeguard against suicide".

Similarly, an earlier large-scale study found that persons who did not attend religious services were also four times more likely to commit suicide than we re frequent worship attenders.[59] **In another study, the rate of worship attendance predicted suicide rates more effectively than any other evaluated factor, including unemployment.[60] The researchers proposed several ways in which religion might help pre vent suicide, including: (1) enhanced self-esteem, (2) improving personal accountability, or (3) a sense of responsibility to God. Religious commitment can provide a unique source of self-esteem through feeling loved and valued by God. Given that low self-esteem can contribute to suicide, the self-esteem derived from one's religious commitment could play an important role in deterring suicide.**

In examining potential protective factors in the face of growing numbers of teen suicides, one study of 525 adolescents found that religious commitment significantly reduced risk of suicide.[61] Adolescent suicide has also been linked to depression.[62] A study of adolescents found that frequent worship attenders with high spiritual support had the lowest scores on the Beck Depression inventory.[63] Those high school students of either gender who infrequently attended church and had low spiritual support had the highest rates of depression, often at clinically significant levels.

Despite this and related data, an evaluation of suicide assessment instruments observed that "although religion is noted as a highly relevant factor in suicide literature, the number of religious items included on assessment scales approaches zero." The review noted the need to begin to recognize and include religion/spirituality in suicide prevention, treatment, and care, as well as in measures assessing suicidal risk.[64]

Substance Abuse Prevention and Treatment

DRUG ABUSE PREVENTION:

In research findings, **a lack of religious commitment has been determined to be a risk factor for drug abuse. A review of nearly 40 studies found that people with higher levels of religious commitment were less likely to become involved in substanceabuse.[65]** These review findings supported an earlier review, which also found that lack of religious commitment stood out as a consistent predictor of drug abuse.[66] A survey of almost 14,000 youths found that analysis of six measures of religious commitment and eight measures of substance abuse revealed that religious/spiritual commitment was linked with less drug abuse. In this study, **among the religious measures, the "importance of religion" to the person was the best predictor of less substance abuse: the more important religion was to the youth, the less likely that he or she would be abusing drugs.[67]**

DRUG ABUSE TREATMENT:

Drawing upon spiritual resources can also make a significant difference in outcomes in effective drug treatment.[68] For instance, **45% of participants in a religious outpatient treatment program for opium addiction were still drug-free 1 year later compared with only 5% of participants in a nonreligious, public health service hospital inpatient treatment program** - a nine-fold difference.[69]

PREVENTION AND TREATMENT OF ALCOHOL ABUSE:

What are Research Findings Concerning Alcohol Abuse?

As well as reducing use of illicit drugs, **religious involvement similarly predicts fewer problems with alcohol .[70]** The risk for alcohol dependency was 60% higher among drinkers with no religious affiliation compared with members of conservative denominations .[68] Religious involvement tends to be low among people diagnosed for alcohol abuse.[71] Furthermore, a relationship between religious/spiritual commitment and the nonuse or moderate use of alcohol has been documented. One study found that whether or not a religious tradition specifically teaches that alcohol use is harmful, those who are active in a religious group consumed substantially less alcohol than those who were not active .[72] **A study of the religious lives of alcoholics found that 89% of alcoholics had lost interest in religion during their teenage years .[73] Alcoholics often report having had negative experiences with religion and are more apt to hold concepts of God that are punitive, rather than loving and forgiving.[74] Once alcohol addiction has taken hold, spirituality can be an important factor in achieving treatment success.** Alcoholics Anonymous (AA) invokes a Higher Power to help alcoholics recover from addiction. **Those who participate in AA are more likely to remain abstinent after inpatient or outpatient treatment .[75]**

SMOKING PREVENTION:

Most smokers begin as teenagers or young adults, and approximately one-third of smokers quit by the time they reach age 65. **An initial study of smoking and religious activity in older Americans found that the life-long, strongly religious are much more likely never to have smoked at all. Also, the elderly who actively participated in their religious faith were 90% less likely to smoke. Among older adults who did smoke, the number of cigarettes smoked per day sank significantly among the more religiously active. Frequently attending religious services stood out as the most important religious factor linked with less smoking in this study.** Private study of scripture and prayer didn't show nearly as strong a link. Watching religious TV or listening to religious radio had no connection to smoking reduction. [76] Religious involvement has also been found to be associated with higher success rates in smoking cessation treatment.[77]

Reducing Adolescent Health Risks

In the past, infectious diseases were the leading cause of sickness and premature death in the United States; now, however, social and lifestyle factors often precipitate premature death. Therefore, researchers have begun to study psychosocial factors like religious commitment that might play a role in protecting teen health. Also, many lifestyle patterns that take a health toll in adult years, such as drinking, smoking, and poor eating habits, begin in teenage years, marking adolescence as an important time in forming either healthy or unhealthy lifestyle practices.

A national survey of 5,000 high school seniors conducted by University of Michigan researchers found that **seniors who attended church weekly and reported that religion was important to them were less likely than other youth to engage in high-risk behaviors and more likely to engage in behaviors that promote long-term physical well-being.[78]** Levels of current cigarette use, binge drinking during the past 2 weeks, and annual marijuana use ranked lowest among youth for whom religion was "very important" and attended church once a week or more. Teens who never went to religious services and who felt religion was not important had the highest level of substance abuse, with rates shrinking as religious attendance and importance increased. Multivariate analyses suggest that these relationships persist even after controlling for demographic factors: sociodemographics controlled
for in this study include age, gender, race, socioeconomic status, parents' education level, one- or two-parent family structure, geographical region, and urban or rural residence.

Accidents account for 60% of all deaths among U.S. teenagers,[79] with most (78%) **of these fatalities the result of car accidents.[80]** Driving a car while under the influence of alcohol or other drugs greatly increases risk of injury or death. Religious commitment appears to be a protective health factor, as it reduces drinking and drug use rates. **The University of Michigan study also found that religious teens were more likely to wear seat belts,** further curtailing potential auto injuries. Furthermore, murder and suicide are the second- and third-leading causes of death among adolescents, with firearms accounting for most of these deaths. **This study showed religious teens were less likely to carry weapons or get into fights.** Additionally,

youth for whom religion was very important and who attend church weekly were found to be significantly more likely than their less religious peers to eat in a healthy fashion, to exercise regularly, and to get adequate sleep.[78] **Other studies have found that highly religious teens initiate sexual activity at a later age, engage in sex less often, and have fewer sexual partners than their less religious peers, which reduces risk of sexually transmitted diseases, including HIV and cancers of the cervix and uterus.[81–84]** Relative to their peers, religious youth are less likely to engage in behaviors that compromise their physical health, suggesting that religious resources are a potentially important, often over-looked, ally in reducing these behaviors. The researchers commented, "Religion is only one of many important variables that relate to adolescent health behaviors; nevertheless, its continued importance as a correlate of adolescent health behavior, even after other factors are controlled, suggests that it is a factor that future research should not ignore."[78]

Reducing Adult Health Risks

A study of 1,900 female twins published in the *American Journal of Psychiatry* found significantly lower rates of major depression, smoking, and alcohol abuse among those who were more religious.[85] Because twins have the same genetic make-up, effects of beliefs and behavior, such as religious/spiritual commitment, stand out more clearly.

COPING WITH SURGERY AND SERIOUS MEDICAL ILLNESS:

Patients who are seriously ill or undergoing surgery often experience anxiety and have potential mental health needs. Coping resources contribute to the patient's ability to deal with anxiety and depression in the face of medical illness. Studies investigating patient coping mechanisms identify spiritual/religious commitment as a significant resource.

RECOVERY FROM SURGERY:

A study at Dartmouth Medical School found that elderly patients undergoing elective heart surgery were less likely to die in the 6 months after surgery if they found strength and comfort in their religious faith and also were socially involved in some type of organization.[86] In this study of 232 patients, those who said they derived no strength or comfort from their religious faith had almost 3 times the risk of death at the 6-month follow-up as patients who found at least some strength. None of those who saw themselves as deeply religious before surgery had died 6 months later, compared with 12% of those who rarely or never went to religious services.

The researchers also assessed psychological factors that might influence mortality, including depressive symptoms, history of psychiatric disorder, or personality characteristics, to examine whether social support and religious characteristics were surrogate measures for these emotional and personality factors, or more truly independent. Patients met with a board certified research psychiatrist who conducted a diagnostic interview based on the Schedule for Affective Disorders and Schizophrenia (SADS) adapted for

an outpatient medical population and who also quantified depressive symptoms. To assess for levels of social support, the researchers used three different instruments to assess frequency of contact in different types of relationships including spouse, confidant, relative, friend, or group. Also assessed was the type and amount of support provided by social network, as well as whether the patient perceived support as enhancing their well-being.

After controlling for biomedical indices, patients' lack of participation in an organized, regular social activity was associated with a four times greater risk of death after surgery compared with those who had been actively participating in groups, whether the group was a historical society, local government, a church supper club, or senior center. None of the other social support variables, including presence of confidants, monthly network contacts, support received, or adequacy of support, showed a trend toward association with risk of death. No significant relationship occurred between past or current psychiatric disorder and death. Although people who are depressed or neurotic are often less likely to participate in regular social groups, the researchers noted, controlling for these psychological correlates did not affect the prospective, predictive relationship with mortality.

The effect of lack of group participation and the absence of strength and comfort from religion had independent effects as well, evidenced in patients with one risk factor and not the other. Additive effects also emerged. When adjusted for biomedical risk factors, patients who did not participate in an organized social group or find strength or comfort from their religious faith were 14 more times likely to die during the 6- month follow-up.

A study of elderly women recovering from hip fractures also found patients' religious commitment enhanced recovery. Women with the best surgical outcomes were those to whom God was a strong source of strength and comfort and who frequently attended religious services. Testing showed they were less depressed and could walk farther at discharge than patients who lacked a strong religious commitment; apparently their lowered risk of depressive symptoms aided them in better handling the stress of this traumatic medical event.[87]

COPING WITH CANCER:

To discover how to better meet the needs of cancer patients, University of Michigan researchers surveyed 108 women undergoing treatment for various stages of gynecological cancer. What helped these women cope? Some 93% of these cancer patients said their religious lives helped them sustain their hopes, 75% said religion had a significant place in their lives, and 41% noted their religious lives supported their sense of worth. Almost half (49%) felt they had become more religious after their cancer diagnosis; not one patient noted becoming less religious after being diagnosed with cancer.[88]

COPING WITH AIDS:

A study at Yale University School of Medicine surveyed 90 HIV-positive patients regarding their fear of death, end-of-life decisions, religious status, and guilt about HIV infection. They found that those who were

religiously/spiritually active had less fear of death and less guilt about their disease than those who were less religiously active. Fear of death was more likely among the 26% of patients who felt their disease was some form of punishment, 17% believing it was a punishment from God. Fear of death diminished among patients who read the Bible frequently, attended church regularly, or stated that God was a central part of their purpose in life. Those patients who believed in God's forgiveness were more likely to engage in discussions about resuscitation status, indicating that their religious beliefs played at least some role in helping them make end-of-life decisions. The researchers suggested that belief in a God who forgives and comforts may represent an ability to accept HIV infection and premature death. [89]

Spiritual/Religious Links with Longevity

A number of well-designed, long-term studies of large community samples have found a link between active religious involvement and longer lives (Table 3).[90 – 96] By controlling for numerous factors that could lengthen lives, these studies addressed the concern that the link between religious/spiritual commitment and health can be attributed to greater levels of social support, healthier lifestyles, or higher socioeconomic status.

A meta-analysis published in 2000 of 42 study samples totaling nearly 126,000 people found that active religious involvement increased the chance for living longer by 29%.[97] A lack of religious belief or practices stood out as a risk for earlier death to the same degree as heavy alcohol consumption, exposure to organic solvents in the workplace, and hostility. Other factors such as healthier lifestyles, better overall initial health, and a more extensive social support system might predict longer lives as well. Therefore, the review took a close look at the studies, which controlled for up to 15 mediating or explanatory variables that also might play a role in longevity to see if these factors might explain the lower odds of early death among the more religious. Although these factors accounted for part of the link, the connection between religious involvement and longevity remained substantial. The only factor that approached the protective effect of religious involvement was lack of obesity. One of the studies included in the meta-analytic review tracked a national sample of more than 21,000 U.S. adults for 9 years. This study found that attending religious services more than once a week increased life span an average of 7 years for whites and 14 years for African Americans when compared with non-attenders.[98] A factor that may potentially help add 7 to 14 years of life merits attention by physicians.

Potential Harmful Aspects of Spiritual/Religious Problems

More research needs to be done to differentiate between the clinically helpful or supportive use of religion/spirituality and, in contrast, the harmful abuse of spiritual/religious beliefs that may manipulate or condemn. One study identified rigid religious families whose harsh parenting practices border on abuse to be associated with potential clinical problems.[99] Children from these families harbored negative images of God. Another study described individual psychopathology linked with families whose enmeshment, rigidity, and emotional harshness were supported by enlisting "spiritual"precepts.[100]

An *American Journal of Psychiatry* study of 52 seriously mental ill hospitalized patients - diagnosed with major depression, schizophrenia, manic episode, personality disorder, and anxiety disorder - found that nearly one fourth believed that sinful thoughts or acts may have contributed to the development of their illness .[101] If psychiatrists had not inquired about such potential religious concerns, these beliefs would not be addressed, potentially hindering treatment outcomes. It is important that psychiatrists are aware of the potential harm of excessively religious zeal in patients and their families and ask about religious background and beliefs. It's also important that they be able to distinguish excessively religious zeal from normative religious commitment. If psychiatrists feel unprepared to make these spiritual assessments, then collaboration with skilled, mental-health-sensitive hospital chaplains or clergy may help in these instances of spiritual distress.

TAKING A SPIRITUAL ASSESSMENT:

When taking a spiritual assessment the therapist's attitude is key; an inquiring, respectful attitude allows the patient to become more open about an aspect of life that may be of central importance without fear of criticism or denigration. Therapists' nonverbal messages will communicate their feelings about religious faith more profoundly than what questions they might ask; a patient can pick up disinterest, uneasiness, or negativity, which can lead to fracture in the doctor - patient relationship. Actively listening and honoring the patient's perspective with respect can also increase the strength of the therapist - patient relationship.

Inquiring about religious/spiritual beliefs or activities allows patients to indicate whether this is an issue they would like to discuss. If a patient indicates a desire to talk about spiritual or religious life, the therapist can listen and incorporate the information into the patient's history. Inquiring respectfully does not imply a therapist is an authority on such issues, or that the patient should or should not have spiritual beliefs, but gives the patients the opportunity to discuss a potentially important, culturally relevant aspect of their lives.[95]

EVALUATING RELIGION/SPIRITUALITY AS A COPING RESOURCE:

For up to 40% of certain patient populations, religious beliefs and practices may serve as a primary method of coping with the stress of illness.[96] As noted above, research has indicated religious activities may be inversely related to depression,[54] and, when depression occurs, may reduce the time until remission.[53] Consequently, the therapist will want to know if the patient's spirituality serves as a primary coping resource. Whether this factor provides adaptive coping or whether it increases problems such as strengthening avoidant denial requires clinical discernment. Enhancing a patient's adaptive coping strategies by remaining sensitive and respectful of a patient's spiritual outlook may be central to a supportive therapeutic effort for more religious patients. A clinician's negative predisposition about spirituality/religion might limit ability to recognize that a patient finds strength in religious coping, while an overly positive predisposition may promote a defensive or avoidant use of

religious coping, limiting insight into the patient's personal or religious dynamics.[102]

The therapist can start with open-ended questions, then inquire more specifically based on the patient's response:

- "What do you find is helping you cope with this distress?"
- " Some people find that religion or spirituality are helpful for coping and others don't. What has been your experience? "

A list of other suggested questions was compiled by a group of psychiatrists from varying religious perspectives: see Model Curriculum for Psychiatric Residency Training Programs for more information (Table 4).[103]

Table 3

MORTALITY FINDINGS: SPIRITUAL/RELIGIOUS ACTIVITY LINKED WITH LIVING LONGER

1 A meta-analysis of all published and unpublished studies examining religious involvement and death by any cause summed 42 study samples totalling nearly 126,000 people and found active religious involvement increased the chance for living longer by 29%.[1]

- A study in the *American Journal of Public Health* in 1997 found persons who attended religious services weekly or more were 25% less likely to die in the 28-year study period than infrequent attenders. For women, the protective effect of attending services was stronger than choosing not to smoke, and stronger for men than exercise.

2 To consider whether these findings might be explained by the possibility that persons in better health are more likely to attend religious services than those who are sick or disabled and thus unable to attend, the *American Journal of Public Health* study, found persons with significant impairment in mobility were in fact more likely to be frequent attenders. Improved health practices, increased social contacts, and more stable marriages occurred more often when persons frequently attended religious services. This helped contribute to, but did not fully account, for lower mortality rates.

- Attending religious services more than once a week stretched lives an average of 7 years for whites and added a potential 14 more years for African Americans in a study in *Demography* which tracked a national sample of more than 21,000 US adults for 9 years.
-

The study examined numerous social, economic, and health and lifestyle factors, as well-religious attendance, to see who was most likely to avoid death by any cause. Religious attendance surfaced as a strong predictor for living longer, even when other relevant factors were statistically controlled for. Stronger social ties and better health behaviors did explain some of the link with living longer, but a strong religious attendance effect remained.

- In a study of nearly 2,000 elderly, living in California followed for 5 years for each sex, weekly attenders had the lowest mortality and non-attenders had the highest mortality. But would different activities or non-religious social support have the same effects? Although substituting other social organizations for church, synagogue, or mosque failed to help people live longer, a "complementary" effect appeared. Persons who engaged in volunteer work along with attending religious services were even more likely to live longer.

- The researchers analyzed an extensive range of factors that could affect health, which might explain why those attending religious services might live longer, yet religious attendance still protected against mortality. The authors noted these findings supported previous research that showed attending religious services was linked with lower blood pressure, fewer deaths from cardiovascular disease, less depression, and less earlier death from all causes.

- A 1999 study supported by the National Institute on Aging published in the *Journal of Gerontology* found chances to live longer expanded by 28% for older Americans when they attended religious meetings weekly. The researchers posited that religious attendance could be related to lower rates of depression, anxiety, and stress. A strong religious faith reinforced by active religious participation may help persons to also better cope with life stressors, particularly physical health problems later in life.

- A 16-year study in Israel found distinctly lower rates of early death in religious kibbutzim compared with secular kibbutzim, evident in both sexes, at all ages, and with remarkable consistency over all causes of death. The magnitude of the protective religious effect wiped out the usual gender advantage: secular women did not live longer than religious men.

- Elderly people who engaged in private spiritual/religious practices, such as prayer and scripture reading, before they faced the onset of impairment of activities of daily living appeared to have a survival advantage of those who did not pursue spiritual practices, found a 2000 study in the *Journal of Gerontology Medical Science.*

Strawbridge W J, et al. Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health.* 1997; 87(6):957–61.
Hummer R A, et al. Religious involvement and U.S. adult mortality. *Demography.* 1999;36(2): 1–13.
Oman D, and Reed D, Religion and mortality among the community-dwelling elderly. *American Journal of Public Health.* 1998; 88(10):1469–1475.
Koenig H G, et al. Does religious attendance prolong survival?: A six-year follow-up study of 3,968 older adults. *Journal of Gerontology.* 1999; 54A(7): M370–M76.
Kark J D, Shemi G, Friedlander Y, et al. Does religious observance promote health? Mortality in secular vs. religious kibbutzim in Israel. *American Journal of Public Health.* 1996; 86(3):341–346.
Helm H H, et al. Does private religious activity prolong survival? A six-year follow-up study of 3,851 older adults. *Journal of Gerontology Medical Science.* 2000; 53A(7); M400–405.

If the patient states a preference not to talk about the spiritual or religious dimension of life, the therapist can respectfully follow the patient's lead, remaining attentive to the patient's reluctance to discuss spiritual history. Patients may have no interest in these matters or may prefer not to discuss them with their clinician. The hesitancy may indicate some dynamic significance, but this can be gleaned over time through careful listening to the role this dimension plays or does not play in the course of therapy.

Receptivity to Interventions

Inquiring about a patient's spiritual and religious beliefs and practices may facilitate a more open discussion of religious patients' potential concerns regarding psychotherapy or medications. Religious patients may fear lack of acceptance or degradation of their beliefs. Also, for religious reasons, they may be hesitant to take medications. Acknowledging these issues and addressing potential barriers in the context of the patient's belief system, rather than avoiding discussion of religiously based concerns, eases the progression of the therapeutic process.

INTRINSIC AND/OR EXTRINSIC RELIGIOUSNESS:

For patients who express that their religion/spirituality is of some importance in their life, assessing the degree to which their faith is intrinsic or extrinsic may have bearings on potential mental health outcomes. For instance, persons with an intrinsic faith have been shown to be less anxious, but those with extrinsic faith, more anxious.[104] A study of depression among patients with serious illness found that the more intrinsic their religious faith, the more rapidly they recovered from depression. [53] This study used Hoge's validated scale of assessment of intrinsic/extrinsic religious/spiritual beliefs (Table 2).

Allport distinguished between intrinsic and extrinsic forms of religious commitment: [105]

- ***Extrinsic:*** The extrinsically religious person uses religion as a means of obtaining status or personal security, for self-justification and for sociability, thus making religion more utilitarian and self-oriented.

- ***Intrinsic:*** The intrinsically religious person internalizes beliefs and lives by them regardless of outside or extrinsic social pressure or other possible personal consequences.

INDICATIONS OF STRESS OR CONFLICT: CHANGES IN FREQUENCY OF RELIGIOUS/ SPIRITUAL PRACTICES:

A gap between what patients believe and what they practice can also serve as an indicator of conflict. When patients express that their religious/spiritual beliefs are important to them, yet do not engage in practices such as attending religious worship services, this divergence may reveal unresolved issues. For example, one study found that anxiety-derived somatic symptoms were lessened by public religious participation such as attending

religious services, but private religious/spiritual commitment that lacked the public worship component was associated with higher levels of anxiety.[106]

Just as changes in sleep or eating patterns may indicate that a person is experiencing anxiety, a recent increase or decrease in patients' religious/spiritual practice patterns, such as how often one prays, can indicate an area of concern. For instance, in an effort to cope, patients may increase frequency of prayer to help handle a stress that needs identification.[107]

Table 4
SPIRITUAL ASSESSMENT

1. Do you believe in God or a higher power?
2. What does your belief in God mean to you?
3. What religion do you practice/follow?
4. Do you presently practice your religion and, if so, how frequently?
5. How important is your religion or spirituality to you?
6. Which religion did your family practice when you were growing up?
7. How has your religion/spirituality shaped your life?
8. Have your religious spiritual/beliefs changed over time, and, if so, how?
9. Has your religion/spirituality helped you, and, if so, how?
10. Has your religion/spirituality hurt you in any way, and, if so, how?

Source: Larson D B, Lu F G, Swyers J P, eds. Appendix A: Questions for assessing patients' religious beliefs and their influences on patients. *Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice,* National Institute for Healthcare Research: Rockville, MD, 1997. (Further questions are mentioned in the curriculum.)

A recent change in attendance at religious services may also serve as an indicator of stress. In a study of community-dwelling persons, Lindenthal found that among the 753 subjects who had experienced any of 62 life crises, 20% of those who were very impaired (based on a 20-item measure of psychiatric functioning) reported decreased attendance at religious services in response to stress. This compared with an 11% drop in the moderately impaired group and 4% in the unimpaired. This drop in attendance among the most impaired was troubling because this group might particularly benefit from maintaining contact with their social supports.[108] Furthermore, among the very impaired, 58% used prayer during the crisis, compared with 46% of the moderately impaired and 31% of the unimpaired. The authors concluded that when dealing with life crises, persons with high degrees of psychiatric impairment prayed more and went to religious services less. Increasing one aspect of one's faith (prayer), while reducing another (attending worship services) could be a red flag for spiritual tension and conflict. Consequently, in taking the spiritual history, the clinician can inquire about recent changes in frequency of religious practices, and also inquire about the patient's perceived reasons for any changes.

NEGATIVE VERSUS POSITIVE RELIGIOUS COPING:

Finally, it must be remembered and underscored that religious coping may have positive as well as negative elements that should be identified. One recent study of 550 older hospitalized patients found that seeing crisis events like a hospital stay in light of a caring God, versus a condemning one, makes a difference in levels of emotional distress.[109] Patients showed less emotional distress when they invoked positive patterns of religious coping, such as (1) seeking control through a partnership with God, (2) searching for comfort and reassurance through God's love and care, (3) asking God's forgiveness, (4) trying to forgive others, as well as (5) trying to see how God might be providing strength through the crisis. Positive religious coping was also related to positive personal growth as a result of the stress, as well as positive spiritual changes, such as growing closer to God and one's religious congregation. In contrast, more depression, poorer quality of life, and callousness toward others were linked with negative religious coping, such as seeing the crisis as punishment from God or questioning God's power or love.

Recognizing spiritual distress is an important factor in efforts to improve health outcomes. A 2 year study of 600 elderly hospitalized patients in 2001 found that spiritual struggles, such as feeling abandoned by God, increased the risk of dying by as much as 28%.[110]

Higher religious struggle scores at the beginning of the longitudinal study predicted a mildly greater risk of mortality of 6%. However, three religious distress items pointed to a significantly higher risk: (1) "Wondered whether God had abandoned me" - a 28% increased risk of dying, (2) "Questioned God's love for me" - a 22% increased risk, (3) "Decided the devil made this happen" - a 19% increased risk. Also a fourth factor, a patient feeling "punished by God for the lack of their devotion" predicted a slightly increased risk of death after controlling for demographic factors, but not after controlling for physical and mental health status. Analyses also revealed that religious struggle predicted declines in independence in daily activities among the survivors in this study. Similarly, a different study of medical rehabilitation patients found anger at God predicted poorer physical recovery 4 months later.[111] Elderly ill men and women who experience a religious struggle with their illness appear to be at an increased risk of death, even after for controlling for baseline health, mental health status, and demographic factors.

The researchers commented that these findings suggest that patients who indicate religious struggle during a spiritual history may be at particularly high risk for poor medical outcomes. Collaboration with, or referral of these patients to, a chaplain or a pastoral counselor trained to address these issues may help improve clinical outcomes. Some studies on anxiety and fear of death show that persons who are extrinsically, rather than intrinsically religious, may have higher rates of anxiety than persons who have internalized their faith or who are not religious.[112] Yet many patients turn to religion/spirituality as they become more gravely ill, and a sense of rejection or disappointment with God, or feeling guilty that healing is not taking place, may indicate that collaboration with clergy or a pastoral counselor trained to address these issues is appropriate. The authors of the study on recovery of elderly patients [110] noted further research is needed to determine whether

interventions that reduce religious struggles might also improve medical prognosis.

Case Examples

Two case examples illustrate dynamics a clinician might encounter. Both take into account the patient's religious/spiritual beliefs and illustrate how to work within the religious culture of the patient. Case 1 illustrates positive religious coping, while case 2 describes a situation in which religion is used defensively to cover up a problem.

CASE 1:

Jane, a 52-year-old married white woman, had a diagnosis of diabetes mellitus for 10 years. Her primary care physician referred her to a psychiatrist because she was no longer administering her insulin injections on time. She was also deviating from her diet, overeating, and "felt down." Her overeating appeared related to depression regarding her condition. She was distressed at the difficulty of managing diabetes on the one hand, but also was highly anxious about the disease progression in the future - whether she would lose her foot or her eyesight.

In taking the social history, the psychiatrist asked whether Jane had religious or spiritual beliefs that were important to her. She said that she did, and that she felt that they helped her cope with her illness. She mentioned that she was a member of a church and that her religious faith was very important to her. She really appreciated that her psychiatrist had asked about her spiritual beliefs.

The psychiatrist prescribed 50 mg of sertraline (Zoloft) once or twice a day for her depression and anxiety related to her diabetes. As it turned out, she had tried seeing other mental health professionals before, but she had stopped seeing them because they had little interest in her religious beliefs, which were quite important to her. The trust inspired in her by the psychiatrist's inquiring about her faith made her more comfortable and willing to comply with the medicine as something that might help her.

In addition to seeing the psychiatrist, she also went to see her church pastor; he prayed with her about her condition and her fears about the future disease progression, helping her to "turn it over to God." This helped her feel more in control, which, in turn, helped her feel less anxious and less likely to ruminate on future potential consequences of her diabetes. The pastor suggested reading specific scripture passages intended to increase her hope and also relieve her fears about the future. She started thinking more positively, a cognitive change that seemed to help further the effect of the medication. As she started feeling less depressed, she got back on her diet and complied better with her insulin administration. Her pastor suggested she encourage others in their congregation with diabetes; this increased her social participation and her sense of purpose, and further helped alleviate her depression and anxiety.

CASE 2:

Jim, a 43-year-old white male with bipolar disorder, was on lithium and seeing a psychiatrist for management of his bipolar disorder. Jim attended

church regularly and had a fairly good relationship with his pastor. He went to a special healing service at the church and asked for prayer to heal his bipolar disorder. Afterwards, to “prove” that he was healed, he decided to stop taking his lithium. Jim never liked taking lithium anyway because he felt it dampened his manic highs; this supposed “healing” gave him a reason that looked religious in nature to stop his lithium. Jim used his own defenses supported by his religion to justify his decision to stop his medication that was based on his own desire not to comply.

When Jim went to see the psychiatrist and the psychiatrist asked about his lithium, Jim said he didn’t need it anymore because he had been healed supernaturally. Jim appeared resolved in his decision and it seemed that the psychiatrist’s arguments would not change his mind. If the psychiatrist does not show respect for the patient’s religious perspective, despite its obvious clinical impact, this could injure the patient - doctor relationship. At this point the clinician must decide how best to help Jim. He could tell Jim that if he didn’t take his lithium he wouldn’t see him any more, and attribute this to the negative effect religion has on people. Alternatively, the psychiatrist could ask more about what happened at the healing service and Jim’s response. The psychiatrist could carefully listen to Jim’s feelings about his healing experience, about taking lithium before he felt he was healed, and his intentions on whether he will take lithium in the future, should manic symptoms begin. The psychiatrist will want to explore Jim’s conviction that he does not need lithium. Some patients may have a mixture of feelings about this - they may not want to take the medicine very much, and they may feel strongly and sincerely about wanting to “test their faith” to see if they are healed. They may feel pressured to stop their lithium because of something they heard during the religious healing service. Jim may not be entirely conscious of using the healing ceremony as an excuse to stop his lithium; he may genuinely believe at some level that he is healed, but this belief is buoyed by Jim’s dislike for taking lithium.

Following this discussion, the psychiatrist could ask for Jim’s consent to talk with Jim’s pastor or a pastoral counselor who recognizes the importance of medicine and its role in the healing process. With Jim’s permission, the psychiatrist could invite the minister to attend a session with Jim and him to help clarify matters; or the psychiatrist could talk with the minister by phone, and request that the minister discuss medication issues with Jim. The minister could help address why it would not be a good idea to stop the lithium, explaining to Jim how healing involves a slower process and how religious faith can provide the strength to heal in time. The minister might point out that religious healing might involve a reduction in stress, helping to prevent another episode, which can occur even on medication. It might also help prevent negative coping behavior such as drug or alcohol abuse, reducing the high risk of comorbid substance abuse among those with bipolar disorder. It may help with self-control and with keeping the family and social supports more cohesively intact. The minister or pastoral counselor could persuade Jim that medication can be a “God-given gift” to help with the healing process and thus remove the “religious” justification for medication noncompliance.

Sometimes, however, the psychiatrist will simply have to accept the patient's decision to stop the medication, and follow that patient closely. As long as the patient feels that the psychiatrist respects his or her beliefs and

feelings, and dialogue on the subject is kept open, when the patient becomes ill he or she will be more likely to consider starting the medicine again. At least more so than if there was an argument and the patient had to defend himself or herself and his or her religious beliefs.

Summary

The complex life dimension of religion/spirituality may play a significant role for many patients, at times serving as a healthy source of strength or comfort while at other times a source of conflict, distress, or an excuse for treatment avoidance. Becoming aware of the potential value or harm of these practices and beliefs is important to more fully understanding the patient. Consequently, respectfully asking about spiritual/religious beliefs and practices is important in taking a patient's history and relevant for providing insightful, compassionate care. In the past decade, the field of psychiatry has provided guidelines and added requirements in residency training to enhance clinicians' skills in addressing the patient's culture and values and for becoming more aware and sensitive to a patient's religious/spiritual worldview. Psychiatric residents are now learning to take a spiritual assessment as a part of the patient history, to discern if religious/spiritual issues are important to the patient, and how religious dynamics may be helpful or harmful. Quantitative research findings on the relationship between spiritual/religious commitment and mental health indicate the significance of this life dimension and the relevance of addressing it as part of a complete social and clinical history.

References

1. McCullough ME, Snyder CR. Classical sources of human strength. *J Soc Clin Psycho*l. 2000; 19(1):1–159.
2. Koenig HG, Larson DB, Larson SS. Religion and coping with serious medical illness. *Ann Pharmacother.* 2001;35:352–359.
3. American Psychiatric Association. APA practice guidelines for the psychiatric evaluation of adults. *Am J Psychiatry.*1995;152(suppl):64–80.
4. American Psychiatric Association Committee on Religion and Board of Trustees. Guidelines regarding possible conflict between psychiatrists' religious commitment and clinical practice. *Am J Psychiatr*y. 1990;1474:542.
5. Gartner J, Larson DB, Allen G. Religious commitment and mental health: A review of the empirical literature. *J Psychol and Theol.* 1991;19(1):6–25.
6. Koenig HK, Mc Cullough ME, Larson DB. *Handbook of Religion and Health.* Oxford: Oxford University Press; 2001.
7. Larson DB, Larson SS. The Forgotten Factor in Physical and Mental Health: What Does the Research Show? Rockville, MD: National Institute for Healthcare Research; 1994.
8. Larson DB, Swyers JP, McCullough ME, eds. *Scientific Research on Spirituality and Health: A Consensus Report.* Rockville, MD: National Institute for Healthcare Research;1997.
9. Gallup GH. *Religion in America: 1992-1993.* Princeton, NJ: The Gallup Organization; 1993.
10. Gallup GH. Religion in America:1996. Princeton, NJ: The Gallup Organization, 1996.

11. Koenig HG. Use of religion by patients with severe medical illness. *Mind/Body Medicine.* 1997;2(1):31–43.
12. Larson DB, Lu FG, Swyers JO. Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice: A Course Outline. Rockville,MD: National Institute for Healthcare Research; 1997.
13. Freud, S. *The Future of an Illusion.* London: Hogarth Press; 1962.
14. Ellis, A. Psychotherapy and atheistic values. *J Consult Clin Psychol.* 1980;48:635–639.
15. Group for the Advancement of Psychiatry. Mysticism: Spiritual quest or mental disorder. In Lukoff D, Lu F, Turner R. Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems. *J Nerv Ment Dis.*1992;180:673–682.
16. Larson DB, Pattison EM, Blazer DG, Omran AR, Kaplan BH. Systematic analysis of research on religious variables in four major psychiatric journals, 1978–1982. *Am J Psychiatr*y.1986;149:329–334.
17. Larson DB, Sherrill KA, Lyons JS, et al. Dimensions and valences of measures of religious commitment found in the American Journal of Psychiatry and the Archives of General Psychiatry 1978 through 1989. *Am J Psychiatry.* 1992;149:557–559.
18. Hoge DR. Religion in America: The demographics of belief and affiliation. In: *Religion and the Clinical Practice of Psychology.*Washington, DC: American Psychological Association;1996:21–41.
19. Bergin AE, Jensen JP. Religiosity of psychotherapists: A national survey. *Psychotherapy.* 1990;27:3–7.
20. Shafranske EP. Religious involvement and professional practices of psychiatrists and other mental health professionals. *Psychiat Ann.* 2000;30(8):525–532.
21. Henry W, Sims J, Spray SL. *The Fifth Profession.* San Francisco: Jossey-Bass; 1971.
22. Stark R. Psychopathology and religious commitment. *Review of Religious Researc*h. 1971;12:172.
23. Verhoff J, Kulka RA, Douvan E. *Mental Health in America:Patterns of Help-Seeking from 1957 to 1976.* New York: Basic Books; 1981.
24. Larson DB, Hohmann AA, Kessler LG, et al. The couch and the cloth: The need for linkag*e. Hosp Community Psy-chiatry.*1988;39:1064–1069.
25. Tischler GL, Henisz JE, Myers JK, et al. Utilization of mental health services, I: Patienthood and the prevalence of symptomatology in the community. *Arch Gen Psychiatry.* 1975;32:411–415.
26. Greenley JR, Mechanic D. Social selection in seeking help for psychological problems. *J Health Soc Behav.* 1976;17:249–262.
27. King RR. Evangelical Christians and professional counseling: A conflict of values. *Journal of Psychol and Theol.* 1978; 6:276–281.
28. Rizzuto A. *The Birth of the Living God.* Chicago: University of Chicago Press; 1979:210.
29. Lovinger RL Working with Religious Issues in Therapy. New York: Jason Aronson; 1984:16-17.
30. Plante TG, Sherman AC, eds. Faith and Health: *Psychological Perspectives.* Guilford Press: New York, 2001.

31. Meador KG, Koenig HG. Spirituality and religion in psychiatric practice: Parameters and implications. *Psychiatric Ann.* 2000; 30(8):549–555.
32. Kelly TA, Strupp HH. Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *J Consult Clin Psychol.* 1992;60(1):34–40.
33. Sansome RA, Khatain K, Rodenhauser P. The role of religion in psychiatric education: A national survey. *Acad Med.* 1990;14:37.
34. Accreditation Council for Graduate Medical Education. Special Requirements for Residency Training in Psychiatry.Chicago: Accreditation Council for Graduate Medical Education; 1994.
35. Puchalski CM, Larson DB, Lu FG. Spirituality courses in psychiatry residency programs. *Psychiatric Ann.* 2000;30 (8):543–548.
36. Puchalski CM, Larson DB. Developing curricula in spirituality and medicine. *Acad Me*d. 1998;73(9):970–974.
37. Association of American Medical Colleges. *Report I: Medical Schools Objective Project.* Washington, DC: Author; 1998:2–4.
38. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 4th ed.* Washington, DC: Author; 1994:685.
39. Sloan RP, Bagiella E, VandeCreek L, et al. Sounding board: Should physicians prescribe religious activities. *N Engl J Med.* 2000;342(25):1913–1916.
40. Foglio JR, Brody H. Religion, faith, and medicine. *J Fam Pract.* 1988;27(5):473–474.
41. Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: Professional boundaries, competency, and ethics. *Ann Intern Med.* 2000;132(7):578–583.
42. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed. Rev. Washington, DC: Author; 1987:395.
43. Larson DB, Thielman SB, Greenwold M, et al. Religious content in the DSM-III-R glossary of technical terms. *Am J Psychiatry.* 1993;150:1884-1885.
44. Post SG. DSM-III-R and religion. *Am J Psychiatr*y. 1990; 147:813.
45. Lindgren KN, Coursey RD. Spirituality and serious mental illness: A two-part study. *Psychosoc Rehabil J.* 1995; 18(3), 93-111.
46. Fitchett G, Burton LA, Sivan AB. The religious needs and resources of psychiatric patients. *J Nerve Mint Dis.* 1997; 185: 320 – 326.
47. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith, healing, and praye*r. J Fam Pract.* 1994;39:349–352.
48. McNichol T. *The new faith in medicine.* USA Weekend. April 5–7,1997:4–5.
49. Koenig HG, Bearon LB, Hover M, et al. Religious perspectives of doctors, nurses, patients and families. *J Pastoral Car*e. 1991;45:254-267.
50. Koenig HG, Larson DB, Weaver AJ. Research on religion and serious mental illness. In: Fallott RD, ed. *Spirituality and Religion in Recovery From Mental Illness.* San Francisco: Jossey-Bass; 1998:80–95.
51. McCullough ME, Larson DB. Religion and depression: A review of the literature. *Twin Research or Acta Genet Med Gemellol (Roma).* 1999;2:126–136.

52. Koenig HG, Shelp F, Goli V, Cohen HJ, Blazer DG. Survival and healthcare utilization in elderly medical inpatients with major depression. *J Am Geriatr Soc.* 1989;37: 599–606.
53. Koenig HG, George LK, Peterson BL. Religiosity and remission from depression in medically ill older patients. *Am J Psychiatry.* 1998;155:536–542.
54. Koenig HG, Cohen HJ, Blazer DG, et al. Religious coping and depression in elderly, hospitalized medically ill men. *Am J Psychiatr*y. 1992;149:1693–1700.
55. Koenig HG, Cohen HJ, Blazer DG, et al. Cognitive symptoms of depression and religious coping in elderly medical patients. *Psychosomatic*s. 1995;36:369–375.
56. Propst LR, Ostrom R, Watkins P, Dean T, Mashburn D. Religious values in psychotherapy and mental health: Empirical findings and issues. *J Consul Clin Psychol.* 1992; 60:94–103.
57. Azhar MZ, Varma SL, Dharap AS. Religious psychotherapy in anxiety disorder patients. *Acta Psychiatr Scan*d. 1994; 90:1–3.
58. Nisbet PA, Duberstein PR, Yeates C, Seidlitz L. The effect of participation in religious activities on suicide versus natural death in adults 50 and older. *J Nerv and Ment Di*s.2000;188(8):543–546.
59. Comstock GW, Partridge KB. Church attendance and health. *J Chronic Dis* 1972; 25: 665–672.
60. Stack S. The effect of religious commitment on suicide: A cross-national analysis. *J Health Soc Behav*. 1983;24: 362–374.
61. Stein D, Witzum E, Brom D, DeNour AK. The association between adolescents' attitudes toward suicide and their psychosocial background and suicidal tendencies. *Adolescence.* 1992;27(108):949–959.
62. Bostwick JM, Pankratz VS. Affective Disorder and suicide risk: A re-examination. *Am J Psychiatry,* 2000;157(12): 1925–1932.
63. Wright LS, Frost CJ, Wisecarver SJ. Church attendance, meaningfulness of religion, and depression symptomatology among adolescents. *J Youth Adolescenc*e. 1993;22(5): 559–568.
64. Koehoe NC, Gutheil TG. Neglect of religious issues in scale-based assessment of suicidal patients. *Hosp and Comm Psychiatr*y. 1994;45(4):366–369.
65. Benson P. *Religion and substance use.* In: Schumaker JE, ed. Religion and Mental Health. New York: Oxford University Press, 1992:211–220.
66. Gorsuch RL, Butler MC. Initial drug abuse: A view of pre-disposing social psychological factors. *Psychol Bul*l. 1976;3: 120–137.
67. Loch BR, Hughes RH. Religion and youth substance use. *J* Rel*igion Health.* 1985; 24(3):197–208.
68. Miller WR. Researching the spiritual dimensions of alcohol and other drug problems. *Addictio*n. 1998;93(7):979–990.
69. Desmond DP, Maddox JF. Religious programs and careers of chronic heroin users. *Am J Drug Alcohol Abuse.* 1981;8 (1):71–83.
70. Hardesty PH, Kirby KM. Relation between family religiousness and drug use within adolescent peer groups. *J Soc Behav Pers.* 1995;10(2):137–142.
71. Brizer DA. Religiosity and drug abuse among psychiatric inpatients. *Am J Drug Alcohol Abus*e. 1993;19(3):337–345.
72. Amoateng AY, Bahr SJ. Religion, family, and adolescent drug use. *Psychol Perspec.* 1986;29:53–73.

73. Larson DB, Wilson WP. Religious life of alcoholics. *South Med* J. 1980;73(6):723–727.
74. Gorsuch RL. Assessing spiritual values in Alcoholics Anonymous. In: McCrady BS, Miller WR, eds. *Research on Alcoholics Anonymous: Opportunities and Alternatives.* New Brunswick, NJ: Rutgers Center for Alcoholic Studies; 1993:301–318.
75. Montgomery HA, Miller WR, Tonigan JS. Does Alcoholics Anonymous involvement predict treatment outcome? *J Sub Abuse Treat.* 1995;12(4):241–246.
76. Koenig HG, George LK, Cohen HJ, Hays JC, Blazer DC, Larson DB. The relationship between religious activities and cigarette smoking in older adults. *J Gerontol A Biol Sci Med Sci.* 1998;53A(6):M1–M9.
77. Voorhees CC, Stillman FA, Swank RT, et al. Heart, body, and soul: Impact of church-based smoking cessation interventions
on readiness to quit. *Prev Me*d. 1996;25(3): 277–285.
78. Wallace J, Forman T. Religion's role in promoting health and reducing risk among American youth. *Health, Education, and Behavior.* 1998;25(6):721–741.
79. Leschoier I, Gallagher SS. Unintentional injury, in Diclemente RJ, William BH, Ponton LE, eds. *Handbook of Adolescent Health Risk Behavio*r. New York: Plenum Press, 1996; 225–228.
80. Diclemente RJ, William BH, Ponton . Adolescents at risk: A generation in jeopardy, in Diclemente RJ, William BH,
Ponton LE, eds. *Handbook of Adolescent Health Risk Behavior.* New York: Plenum Press, 1996; 1–4.
81. Hayes, C. ed. *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing (Vol. 1*). Washington, DC, National Academy Press, 1987.
82. Miller BC, Moore, KA. Adolescent sexual behavior, pregnancy, and parenting; Research through the 1980s. *J Marriage Fam* 1990; 52:1025–1044.
83. Muray V. Balck adolescent females: A comparison of early versus late coital initiators. *Family Relations.* 1994;43: 342–348.
84. Thornton A, Camburn D: Religious participation and adolescent sexual behavior and attitudes, *J Marriage and Fam.* 1989; 51: 641–653.
85. Kendler KS, Gardner CO, Prescott CA. Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. *Am J Psychiatry.* 1997; 154:322–329.
86. Oxman TE, Freeman DH, Manheimer ED. Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosom Med.* 1995;57(1):5–15.
87. Pressman P, Lyons JS, Larson DB, Strain JJ. Religious belief, depression, and ambulation status in elderly women with broken hips. *Am J Psychiatry.* 1990;147(6): 758–760.
88. Roberts JA , Brown D, Elkins T, Larson DB. Factors influencing views of patients with gynecological cancer about end-of-life decisions. *Am J Obstet Gynecol .* 1997;176(1): 166–172.
89. Kaldijian LC,Jeckel JF, Friedland G. End-of-life decisions in HIV-positive patients: The role of spiritual beliefs. *AIDS.* 1998;12(1):103–107.

90. Strawbridge WJ, Shema SJ, Cohen RD, et al. Frequent attendance at religious services and mortality over 28 years. *Am J Public Health.* 1997; 87(6):957–61.
91. Oman D and Reed D. Religion and mortality among the community-dwelling elderly. *Am J Public Health.* 1988; 98(10):1469–1475.
92. Koenig HG, Hays JC, Larson DB, et al. Does religious attendance prolong survival?: A six-year follow-up study of 3,968 older adults. *J Gerontol* 1999. 54A(7): M370–M76.
93. Kark JD, Shemi G, Friedlander Y, et al. Does religious observance promote health? Mortality in secular vs religious kibbutzim in Israel. *Am J Public Health.* 1996; 86(3): 341–346.
94. Helm H, Hays JC, Flint E, et al. Does private religious activity prolong survival? A six-year follow-up study of 3,851 older adults. *J Gerontol Med Sci.* 2000;53A(7);M400–405.
95. Meador KG, Koening HG. Spirituality and religion in psychiatric practice: Parameters and implications. *Psychiatric Ann.* 2000;30(8):549–555.
96. Koenig HG. Religious beliefs and practices of hospitalized medically ill older adults. *Int J Geriatric Psychiatry.* 1998; 13:213–224.
97. McCullough ME, Larson DB, Hoyt WT, et al. Religious involvement and mortality: A meta-analytic review. *Health Psycho*l. 2000;19(3):211–222.
98. Hummer RA, Rogers RG, Nam CB, Ellison CG. Religious involvement and U.S. adult mortality. *Demography.* 1999; 36(2):1–13.
99. Bowman ES. Understanding and responding to religious material in the therapy of multiple personality disorder. *Dissociation.* 1989;2:231–238.
100. Josephson AM. The interactional problems of Christian families and their relationship to developmental psychopathology: Implications for treatment. *J Psychol and Christianity.* 1993; 12:112–328.
101. Sheehan W, Kroll J. Psychiatric patients' belief in general health factors and sin as causes of illness. *Am J Psychiatry.* 1990;147:112–113.
102. Spero MH. Countertransference in religious therapists of religious patients. *Am J Psychothe*r. 1981;35:565–575.
103. Larson DB, Lu FG, Swyers JP, eds. Appendix A: Questions for assessing patients' religious beliefs and their influences on patients. *Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice.* Rockville, MD: National Institute for Healthcare Research:1997.
104. Bergin AE, Masters KS, Richards PS. Religiousness and mental health reconsidered: A study of an intrinsically religious sample. *J Counsel Psycho*l. 1987;4:197–204.
105. Allport GW, Ross JM. Personal religious orientation and prejudice. *J Pers Soc Psychol.* 1967;5:432–443.
106. De Figueiredo JM, Lemkau PV. The prevalence of psychosomatic symptoms in a rapidly changing bilingual culture: An exploratory study. *Soc Psychiatry.* 1978;13:125–133.
107. Levin JS, Lyons, JS, and Larson, DB. Prayer and health during pregnancy: Findings from the Galveston low birth-weight survey. *South Med J.* 1993;86(9):1022–1027.
108. Lindenthal JJ, Myers JK, Pepper MP, Stern MS. Mental status and religious behavior. *Journal for the Scientific Study of Religion.* 1979;9:143–149.

109. Pargament KI, Smith BW, Koenig HG, Perez L. Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion.* 1998;37 (4):710–724.
110. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious struggle as a predictor of mortality among medically ill elderly patients: a two-year longitudinal study. *Arch Intern Med.* 2001;161: in press.
111. Fitchett G., Rybarczyk BD, DeMarco GA, Nichols JJ. The role of religion in medical rehabilitation outcomes: A longitudinal study. *Rehab Psychol.* 1999;44:1–22.
112. Baker M, Gorsuch R. Trait anxiety and intrinsic-extrinsic religiousness. *Journal for the Scientific Study of Religion.* 1982;21(2):119–122.

Questions Based On This Lesson

61. Which one of the following statements is correct?

A. In Gallup polls, there was a dramatic reduction in the percentage of Americans who believe in God between 1944 (96%) and 1996 (53%).
B. Surveys in 1990 found 21% of psychiatrists and 28% of clinical psychologists to be atheists or agnostic versus only 5% for the U.S. general population.
C. Less than 5% of the U.S. population seek out a member of the clergy when dealing with personal problems.
D. The vast majority of psychiatric patients (92%) feel quite comfortable mentioning spiritual and religious concerns to their therapists.

62. Which one of the following statements is *not correct*?

A. A review of more than 80 studies published over the last 100 years reported that religious/spiritual faith was linked to more severe and persistent depression because of the readiness with which such individuals experience guilt.
B. Studies at Duke University revealed a close connection between patients' intrinsic religion scores (intrinsic faith) and the speed of their recovery from depression.
C. A study of 525 teenagers indicated that religious commitment significantly reduced suicide rates in this age group.
D. A study at Dartmouth Medical School found elderly heart patients to be 14 times less likely to die after surgery if they found comfort and strength in their religious faith and were socially involved in organizations.

63. In approaching religious/spiritual issues with their patients, psychiatrists should:
A. Avoid these issues altogether if they (the therapists) do not feel comfortable dealing with them.
B. Insist that each patient discuss in detail his/her religious convictions even if he/she does not want to do so.
C. With the patient's collaboration, explain how religion fits into his/her way of coping with stress, noting how fluctuations in the intensity of religious activity may serve as barometers of psychological change.

D. Focus exclusively on extrinsic faith rather than intrinsic faith, since the former is much easier to quantify and relates more strongly to positive adaptive styles.

The editor wishes to record his indebtedness to Dr. Frederic Flach MD, KHS, and Hatherleigh (www.hatherleigh.com) for permission to reproduce this paper 'The Patient's Spiritual/Religious Dimension: A Forgotten Factor in Mental Health' by David Larson, Susan Larson and Harold Koenig, first published November 2001 in Directions in Psychiatry, Vol.21. Lesson 21. and for making the paper available in pdf format.