

## Religion, Spirituality, and Medicine

In this month's issue of the *Journal*, Curlin and colleagues provide us with a subset of data from their 2000 study of U.S. physicians regarding beliefs and practices salient to religion and spirituality in clinical practice (1). With a solid response rate for the self-report questionnaire, Curlin et al. report an apparent softening of what has been perceived as an anti-religious posture by psychiatry (2); one could even say this change in attitudes indicates an embrace of religion and spirituality in psychiatric care. The study affirms that psychiatrists, like the physician population as a whole, endorse the positive influences of religion and spirituality on health. However, the authors note that psychiatrists are less sanguine about globally positive effects, as 82% of psychiatrist respondents (compared with 44% of nonpsychiatrist respondents) believed that religion and spirituality sometimes cause increased patient suffering. More than 90% of psychiatric respondents affirmed an openness to encountering and addressing religious and spiritual issues with patients. However, this openness and encouragement of disclosure may be somewhat unilateral, as there appeared to be more psychiatrists than other physicians reporting that personal religious beliefs or experiences should not be shared with patients. Similarly, psychiatrists reported less actual praying or participation in a religious experience with patients.

---

*“Are we training our profession sufficiently in the language and concepts of religion and spirituality?”*

---

This study serves many different purposes. First, its presence highlights the extraordinary silence in the literature regarding religion and spirituality as both healing and pathologic elements in the lives of psychiatric patients. Second, it enticingly suggests that this human element is being more explored and encouraged in psychiatric practice.

Yet the article poses more questions than it answers about “what goes on behind closed doors” concerning the spirituality of patients in treatment. For example, the study affirms that psychiatrists explore spirituality with patients suffering from anxiety and depression, but the study fails to mention how this information is used or if it is used in the therapeutic process. As a clinician, I myself have utilized religious exploration in cognitive treatment, encouraging patients, when appropriate, to alter their faith and move from allegiance to a guilt-evoking faith and belief in an exclusively punitive God toward a less punitive belief system more fully embracing such elements as “forgiveness” and “grace.” Such a transmuting of beliefs may allow patients to retain elements of their childhood faith, while cognitively altering these beliefs enough so as to allow continued practice or emotional support. However, where are the controlled studies that affirm or discredit such personal treatment strategies? Curlin et al. cite the study by Propst et al. (3) on religious and nonreligious cognitive therapy for depression in religious individuals. This study supports the tenet that incorporation of religious elements into treatment may be efficacious, even if utilized by “nonreligious” therapists.

The respondents in the Curlin et al. study generally endorse an openness to exploring religion and spirituality with patients and afford religion and spirituality a potential positive valence in patients' health. It would be interesting to speculate whether this signifies a change for our profession. In the past, even Freud's contemporary Fenichel noted that “the importance of all the age-old instruments of impressive magic and of the ancient magical power of faith should not be underestimated” (4), so perhaps not much has really changed. Perhaps in subsequent studies, age stratification of respondents could shed more light upon this.

Curlin et al.'s article is silent about how our peers use religious or spiritual material. Is it only for diagnosis? Is it to mobilize social support? Could it be used for cognitive restructuring, as mentioned above? If we do obtain religious and spiritual information from patients, and if we use it in any of the aforementioned ways, will it enhance therapeutic outcome?

Furthermore, if we are listening to the religious and spiritual beliefs of our patients, are we training our profession sufficiently in the language and concepts of religion and spirituality to afford some utility to this process? Psychiatry has developed a fairly substantial curriculum on another previously taboo life process—human sexuality—but we have only recently ventured into prescribing religious or spiritual “awareness” in our training programs (5). We remain mute about whether trainees should be exposed to the literature of prayer and meditation, or whether they should understand critical elements in the faiths of their patients (e.g., sin, grace, forgiveness, atonement, mitzvah, or even jihad). If they did understand these elements, would it make a difference in the outcome of therapy? Curlin et al. cite George Engel's biopsychosocial model (6) and imply that psychiatrists must understand the ontogenesis of a patient's spirituality and incorporate this into the model of the “whole” patient. But should we do this with every patient? How? And most critically, will it make any difference?

Lastly, as a profession, we remain apathetic as to whether treatment by psychiatrists who overtly profess their faith (e.g., Christian psychiatrists) is, in reality, any different from the treatment of those practitioners who are agnostic, atheist, or of a different faith than the patient. Galanter et al. (7) suggest that treatment is different in relation to the issues of abortion, premarital sex, and homosexuality. However, we do not know whether patient outcomes, such as symptom relief and improved levels of social functioning, are different, better, or worse. To use the jargon of managed care, is a request for a therapist of similar or professed faith “medically necessary”?

In closing, it is my opinion that the articles truly worthy of reading and contemplation should answer one or more questions; however, value can also come from illuminating what we do not know, and what we still need to know if our profession is to mature and advance. In this regard, the article by Curlin et al. is of great value.

## References

1. Curlin FA, Lawrence RE, Odell S, Chin MH, Lantos JD, Koenig HG, Meador KG: Religion, spirituality, and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *Am J Psychiatry* 2007; 164:1825–1831
2. Freud S: The question of a *Weltanschauung*, in Standard Edition of the Complete Psychological Works, vol 22. London, Hogarth Press, 1964, 158–182
3. Propst LR, Ostrom R, Watkins P, Dean T, Mashburn D: Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *J Consult Clin Psychol* 1992; 60:94–103
4. Fenichel OM: *The Psychoanalytic Theory of Neurosis*. New York, WW Norton, 1945
5. American Medical Association: Program requirements for residency education in psychiatry, in Graduate Medical Education Directory, 1995–1996. Chicago, American Medical Association, 1995
6. Engel GL: The need for a new medical model: a challenge for biomedicine. *Science* 1977; 196:129–136
7. Galanter M, Larson D, Rubenstone E: Christian psychiatry: the impact of evangelical belief on clinical practice. *Am J Psychiatry* 1991; 148:90–95

**BURR EICHELMAN, M.D., PH.D.**

*Address correspondence and reprint requests to Dr. Eichelman, Department of Psychiatry, University of Wisconsin—Madison, B6/585 CSC, 600 Highland Ave., Madison, WI 53592; bseichelman@facstaff.wisc.edu (e-mail). Editorial accepted for publication September 2007 (doi 10.1176/appi.ajp.2007.07091483).*

*Dr. Eichelman is on the speaker's bureau for AstraZeneca. Dr. Freedman has reviewed this editorial and found no evidence of influence from this relationship.*