Religion and health: the more we know the more we need to know

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In the last few decades, largely due to a growing body of robust empirical evidence, there has been an increasing recognition of the interconnections between religiousness and health. These data have challenged previous views, mostly based on theoretical perspectives, that religiousness is a vestige of a primitive psychological development, usually associated with immature defenses and psychiatric symptoms. Most data from epidemiologic studies indicate that religious involvement is associated with better health outcomes at a population level (1). However, there has been little discussion on the implications these findings might have for routine clinical practice, and little research on the negative side of the connection. Pargament and Lomax's paper highlights these two shortcomings.

The authors mention the "troubled history between psychiatry and religion". Undoubtedly, there have been conflicts between religion and psychiatry, and more generally between religion and science. However, it is important to be aware that, from a wider historical perspective, the relationship between science and religion has been more of synergy than antagonism. It seems that the conflict was predominantly confined to the period from mid-19th century to the end of the 20th century (2). Indeed, from ancient times spiritual issues and care for the sick have been interconnected, and it would be worthwhile to conduct new and in-depth studies of the historical connections between spirituality and the care of mentally disturbed people. This historical understanding would be very

important to put recent developments in perspective.

While the interaction between religiousness and health has been well established, the understanding of its mechanisms has been a challenge. The recognition of the "active ingredients" of religiousness is of special interest for the clinician, since they may help in the development of new treatment and preventive approaches. A review of four proposed psychosocial mediators (health practices, social support, psychosocial resources, and belief structures) has found that the empirical evidence is "mixed and inconsistent" (3). Pargament and Lomax discuss some promising mechanisms. In order to advance knowledge on this issue, it could be fruitful to investigate how spirituality may promote the development of "salutogenic" factors more than the decrease of "pathogenic" factors. It might also be useful to focus on the mechanisms that may be specific to spirituality, not being present in secular contexts. Qualitative studies are an important but still largely neglected source of new hypotheses for mediators.

The understanding of religion's dark side needs much more investigation. This applies in particular to religious violence. It seems that religion, more than a cause of violence between groups, may often be a marker, a proxy for a wider network of sociocultural characteristics. Several conflicts that have been hastily presented as religious might be better understood as having economic, ethnic, or other more mundane sources (4). Religion, as any other powerful idea like science, health, social justice, and freedom, may be and has been used as a justification for violence and intolerance.

In addition to the important issue of when a religious problem is primary or secondary to a mental disorder, it is also imperative to improve

the differentiation between healthy spiritual experiences that resemble psychiatric symptoms and mental disorders with religious content (5). This is an essential but still largely unexplored area.

Further to the exploration of spiritually integrated treatment, as emphasized by the authors, a better understanding of the mechanism and impact of spiritual treatments is needed. Millions of people suffering from mental disorders around the globe seek help from spiritual treatments alone or in conjunction with psychiatric treatments (6). One important example that deserves further in-depth investigation is religious/spiritual treatment for substance abuse. This kind of investigation may help us to clarify which practices are harmful (and should be avoided) and which may be effective (and should be better studied and used).

In addition to the studies on spiritually integrated treatment showing better outcomes compared to regular treatments, reviewed by Pargament and Lomax, there are other investigations that found a similar level of efficacy of the two treatments (7). Nevertheless, spiritually integrated treatment may foster a better acceptance of psychological/psychiatric treatments among religious patients. Some specific profiles of patients may especially benefit from these integrated approaches. It is also worth noting that, according to some evidence, spiritually integrated treatment may be adequately delivered by nonreligious clinicians (8).

In summary, Pargament and Lomax's review has the merit of bringing to the attention of a wide psychiatric audience some important aspects of religion that are relevant to clinical practice. It is possible to reach some conclusions on the basis of the available evidence: a) there is a frequent and significant connection between

religiousness and mental health; b) this relationship is usually positive, but there are also harmful ties; and c) there is a need of taking into consideration patients' spirituality in order to provide an adequate and culturally competent clinical care.

On the basis of this, the psychiatric community has some educational and research challenges. From the educational viewpoint, it is appropriate to make clinicians aware of the body of knowledge available in the field. From a research perspective, there is a need to: a) expand studies to a more diverse geographical and cultural base; b) conduct more studies in psychiatric populations; c) explore the impact of spiritual and spiritually integrated treatments; d) investigate the mechanisms through which religious involvement and spiritual-related treatments may affect health; e) study spiritual experiences, their roots and differentiation from mental disorders; and f) develop clinical applications of the currently available epidemiologic

data about the interconnection between religion and health.

In order to address these challenges, the WPA has a Section on Religion, Spirituality and Psychiatry, that includes and welcomes members from any religious/philosophical background from all over the world (www.religionandpsychiatry.com). This section has promoted several initiatives such as symposia in international congresses, published the newsletter *Psyche and Spirit: connecting psychiatry and spirituality*, and edited a comprehensive book (9).

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Religion and psychiatry: from conflict to consensus

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Pargament and Lomax present religion as a "double-edged sword", serving both as a resource and a challenge to psychiatry. This analogy may be useful in guiding further research and moving to a position of consensus a field that has been sometimes conflict-laden. Not only psychiatry has had difficulty with religion, but also religion – with its focus on mind, body and spirit – has had difficulty with psychiatry. Optimal restoration of mental health in a patient requires an ability by the psychiatrist to assemble evidence for treatment at levels ranging from cells

to communities. This evidence is best informed by credible research.

Factors to be considered in research aimed at understanding religion as a resource or challenge to psychiatric treatment include the following:

- *Operationalization of the definition of spirituality*. Typical measures of spirituality tend to use "common denominators", such as "I feel a connection to all life" (1), which may not accurately capture its essence. Such measures have informed research to date, but have been "impure", in that they measure psychological wellbeing and existential or social constructs as much as they measure spirituality (2). Accordingly, conclusions based on these studies may be mis-

leading. Furthermore, spirituality is generally measured by self-report assessment, a process that requires a level of insight in the respondents to assess some aspects about themselves against an unknown standard. Attempts to find objective validators, such as behaviors, related to spirituality are much more challenging. Here, the risk is in measuring the outcome of a spiritual life (i.e., peace or joy) rather than the spiritual essence itself, which leads to faulty conclusions.

- *Measuring religiosity in a multifaitth context*. Each religion claims exclusivity in certain domains. Thus, using all-encompassing or generic measures while ignoring the individual tenets of specific religions serves