Spirituality, Religiousness, and Health: From Research to Clinical Practice

Paul J. Mills, Ph.D.
University of California, San Diego

There are several high-profile and controversial topics in medicine today (cloning and stem cell research come to mind). A less well known yet controversial area receiving increasing federal and private funding is spirituality, religiousness, and health. Attention to topics of spirituality, religiousness, and health has increased substantially in medical and graduate school curricula, clinical practice, and research (1–3). Of the many interesting aspects of this phenomenon, perhaps the most remarkable is the observation that medical science, the field of inquiry that initially separated mind from body (e.g., the ghost from the machine) (4), now finds it compelling and perhaps even necessary to reexamine relationships among spirit, mind, and body.

The number of empirical studies on spirituality, religiousness, and health has proliferated in the scientific literature. Using the keywords *religion and health* and *spiritual/spirituality and health,* a Medline search from the year 1975 to the present reveals a striking trend, especially in the last 5 to 6 years (Figure 1). In recent years, every major medical, psychiatric, and behavioral medicine journal has published on the topic. In 1999, the National Institutes of Health Office of Behavioral and Social Sciences Research created an expert panel of scientists to critically examine this growing body of literature.

Usually, such an increase in interest and publications on a topic follows a new discovery, such as that of a novel gene; the development of a new medical instrument; or perhaps a more sensitive and reliable assay. This is obviously not the case in this instance because spirituality and religion have been relative constants of cultures. The word *spirituality* did not even appear in Medline until the 1980s. Reasons for this relatively dramatic increase likely include the growing field of complementary and alternative medicine as well as one of the more unpalatable characteristics of managed care: the impersonal nature of assessment and treatment. There have been efforts on numerous fronts, the impetus for a majority of which originated from patients themselves, to bring acknowledgment of the "whole person" back into medicine (5).

The impetus for this special issue of *Annals of Behavioral Medicine* arose from a panel presentation[1] on spirituality, religiousness, and health at the annual meeting of the Society of Behavioral Medicine, held in March 2000 in Nashville, Tennessee (6). Six of the eight articles are from members of the Society, and two were solicited from nonmembers. As indicated by the special issue title, the articles cover topics of relevance to research (including reviews of the existing literature and methodologies and an examination of new instruments) and to clinical practice.

Carl E. Thoresen and Alex H. S. Harris present an overview of the field, examine evidence, and address possible mechanisms that may underlie the potential effects of religious and spiritual factors on health outcomes. The authors also discuss implications for health care professionals. Richard P. Sloan and Emelia Bagiella present a critical review of the literature linking religious involvement and health outcomes. The authors call into question the methodological soundness of these studies and illuminate a tendency of review articles to rely on inappropriate secondary sources. These articles serve to advance the field by calling into question the prior tendency of "uncritical positivism" when reporting research findings (7).

Three articles address the critical issue of the development and testing of instruments. As in any field of research, true progress can only be built on the foundation of valid and reliable data. These instruments have been designed for topics of spirituality, religiousness, and health among healthy and chronically ill populations. They have had to address some rather basic and difficult questions as well. Exactly what spirituality is, for example, has been a vexing issue in the literature and somewhat of a stumbling block (8,9). Concepts such as sense of peace, faith, compassion, religious behavior, and belief in God have needed to be addressed and incorporated into definitions of spirituality and religiousness. Other challenges have included determination of the most appropriate way to assess religiousness and spirituality in respondents from different religious traditions and how to assess spirituality without the use of terms typically of a religious nature.

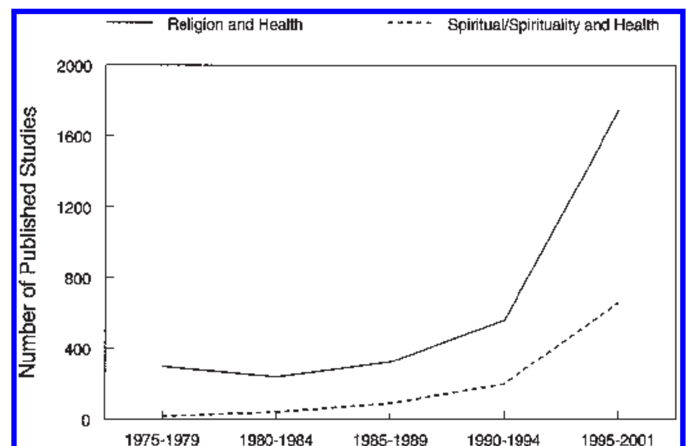

FIGURE 1 Number of published studies having the keywords *religion and health* and *spiritual/spirituality and health* appearing in the Medline database from 1975 to December 2001.

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Reprint Address: P. J. Mills, Ph.D., Department of Psychiatry, UCSD Medical Center, 200 West Arbor Drive, San Diego, CA 92103–0804. E-mail: pmills@ucsd.edu

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It is obvious from these articles that enormous efforts have gone into the development of meaningful, valid, and reliable instruments to assess attitudes toward religiousness and spirituality as well as spiritual experience. Lynn G. Underwood and Jeanne A. Teresi describe the development, testing, and health-related outcomes of the Daily Spiritual Experience Scale. This scale fills an important need because it provides assessment of everyday ordinary experience rather than assessment of particular religious beliefs or behaviors. Gail Ironson and colleagues examine relations among spirituality, religiousness, health outcomes, and survival in people living with HIV using the Ironson–Woods Spirituality/Religiousness Index, an instrument designed to assess private and public aspects of both spirituality and religiousness. Amy H. Peterman and colleagues report on the development and testing of a measure of spiritual well-being in people with chronic illness. The authors present findings from the Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale in two samples of cancer patients.

Leila Shahabi and colleagues used data from several instruments to determine the sociodemographic and behavioral correlates of self-perceptions of spirituality and religiousness in a large sample of American adults. They included in their questionnaires the Daily Spiritual Experience Scale (see Underwood and Teresi, this issue) and questions on religious denomination and public and private religious behavior. These investigators found that attitudes toward spirituality and religiousness were different across disease-risk relevant demographic characteristics (e.g., age, sex, education). These data have significant implications when the data linking religiousness or spirituality with morbidity and mortality outcomes are considered, and they lend support to prior calls for the need to more thoroughly consider potentially confounding variables in research design and interpretation (10–12).

Although most of the research has been devoted to the determination of whether spirituality or religious behavior actually has significant effects on health (positive or negative), it is in the other half of the endeavor, the examination of the potential for translation into clinical practice, where the more substantive controversies exist. *Archives of Internal Medicine* recently published an article that examined the effects of remote intercessory prayer on outcomes in patients admitted to a coronary care unit (13). A beefy 15 letters to the editor were subsequently published in response to that article (Vol. 160, June 26, 2000). The letters addressed a host of topics, including methodological and statistical concerns and questions regarding ethical issues, informed consent, and implications for medical practice. The final two articles of this issue address these latter, clinically oriented questions, including whether physicians should take a spiritual history (i.e., whether they should inquire about a patient's faith or religious commitment) and whether physicians should prescribe religious activities as adjunctive medical treatment (14–16). Walter L. Larimore and colleagues write in favor of these efforts, whereas Raymond J. Lawrence argues against them.

Together, these eight articles should provide the readers of *Annals of Behavioral Medicine* with an appreciation of the numerous research and clinical challenges in the field today and of the creative approaches being taken to address them. With time, the literature will undoubtedly provide a more conclusive answer to the question of whether and through what mechanisms spirituality and religiousness influence health. Resolving issues related to the clinical translation of such research findings will be more difficult. In the meantime, a more immediate and certainly welcome outcome is that the medical community has extended an invitation for the spirit, mind, and body to once again reside together when the physical health and well-being of the individual are considered.

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