Authors' Response

Michael Parker, D.S.W.
School of Social Work and The Center for Mental Health and Aging
The University of Alabama
Division of Gerontology and Geriatric Medicine
The University of Alabama at Birmingham

Walter L. Larimore, M.D.
Department of Family Medicine
The University of South Florida

Martha Crowther, Ph.D., M.P.H.
Department of Psychology
The University of Alabama

The primary purpose of our article (1) was not to provide a review of the literature but to challenge heuristically the reoccurring clinical propensity for marginalizing the faith factor in assessment, despite the preponderance of evidence that suggests that positive spirituality is a clinically relevant variable. Except for the past 2 centuries, religion and medicine have been closely linked for most of written history; however, it was nearly the end of the 20th century before science began to study the relation among measures of religion, spirituality, health and aging (2). In this regard, the American Psychiatric Association recently awarded posthumously the Oskar Pfister Award to David Larson, M.D., M.S.P.H., in acknowledgment of his lifetime work that called attention to the general neglect by the research community of religion and spirituality on a variety of physical and mental health outcomes.

Although much progress has been made since Larson's initial work in the late 1980s (3), much remains to be accomplished. Given this historical context, and the relative newness of this area of inquiry, we are confident that Dr. Hebert does not prefer a return to the thinking of a few years ago when religious people were viewed by some in the medical and behavioral science communities as pathological or to a time when religion and science were viewed as mutually prohibitive viewpoints (4).

In response to Dr. Hebert's concerns about the methodological weaknesses of some of our cited studies, we would add this: A major methodical review of research published in the 20th century (5) identified 724 quantitative studies, of which 478 (66%) found a statistically significant relation between religious involvement and many variables, including, but not limited to, better mental health, improved well-being, greater social support, and less substance abuse. In addition, several excellent prospective studies have found that more religious people have a lower incidence of cardiac events (6), a reduction in hypertension (7), better surgical outcomes (8), and longer survival (9,10).

We acknowledge concerns regarding the general lack of sophistication among the available measures of religious beliefs and practices that are often used clinically. We agree with those pointing out the clear need for prospective studies and clinical trials to assess the order of effects of multiple dimensions of religion and spirituality and their interactions on a variety of physical and mental health outcomes. However, we would point out the growing number of publications and research projects that are available or that have been initiated that reflect a growing scientific rigor and creativity in this area (11–16).

Nevertheless, as we discussed in our article, the weight of evidence suggests that people in the United States often turn to religion or their spirituality when coping with life events (i.e., the terrorist attacks of September 11, 2001) (17). A number of recent works (18–20) represent investigations that have demonstrated the benefits of spirituality in living with a variety of health conditions. Similarly, studies of mental health and substance abuse have shown that religious activity buffers against the negative effects of physical illness or stressful life events (21).

We would agree partially with Dr. Hebert's second issue regarding the evidence we cited supporting our contention that patients desire physicians to address religious issues in the context of clinical visits as "less than conclusive." However, we refer Dr. Hebert to a growing body of evidence that describes medical–religious partnerships. These results are not based on Likert-style survey work but report efficacious, faith-based interdisciplinary interventions that reach people in need. This research offers an important bridge to underserved and privileged populations when a variety of professionals acknowledge the faith of clients (22). Further, the critics of such intervention carry the burden of producing evidence of harm if they wish to censor the intervention in an evidence-based fashion. Clients may not prefer physicians when discussing spirituality because professionals are only now beginning to be trained systematically in how to approach this subject.

The clinical community must remain current in its application and understanding of what we do know about spirituality and religiosity and their impact on health and evidence-based clinical care. Koenig (23); Astrow, Puchalski, and Sulmasy (24); and Larimore (25) viewed the taking of a spiritual history or a spiritual assessment as a matter of matter of kindness and clinical competence in addressing patients' medical concerns. The Joint Commission on Accreditation of Healthcare Organizations seemed to agree and now requires a spiritual assessment in its regulations (26). Further, more than half of U.S. medical schools provide related training in this regard (27), and a number of professional organizations provide practice guidelines on

assessing spirituality and incorporating it into clinical care (28–30).

We emphasize that religious forms of expression and spirituality represent a major source of coping for the vast majority of people in the United States and therefore represent an area worthy of assessment and acknowledgment. It should never be used as a mechanism for undermining those to whom religiousness or spirituality is not important. We maintain that all patient interactions and interventions should be sensitive to the diversity of Americans' religious and spiritual beliefs, attitudes, and practices, and spiritual or religious interventions should be offered only with permission, respect, and sensitivity. Any intervention utilizing positive spirituality should be patient and not caregiver centered (1,18,31).

In regard to Dr. Hebert's concerns about prayer, we acknowledge that a patient's willingness to pray or to discuss spiritual matters is related to the client/health care provider relationship. The context for prayer must first be an adequate spiritual assessment and the verification that the patient is religious and shares a similar belief system with the clinician. Second, the situation must call for prayer (e.g., life-threatening or chronic illnesses). Third, clinicians should remain open to consultation and/or referral to a chaplain, member of the clergy, or other pastoral professionals in matters beyond their competence. Fourth, if a client expresses a desire not to discuss spiritual matters, the clinician should redirect the conversation to the patient's preferred coping mechanisms with the added assurance that the clinician remains open to discuss spiritual concerns in the future.

Regarding Dr. Hebert's concerns about the negative health effects of religion, as the title of our article implied, our intent was to emphasize positive spirituality. As we wrote elsewhere,

> There is general agreement that certain religious beliefs and activities can adversely affect both mental and physical health. Spirituality may be restraining rather than freeing and life enhancing. Further, religious beliefs have been used to justify hypocrisy, self-righteousness, hatred, and prejudice. The aspects of spirituality or religiousness (e.g., hypocrisy, self-righteousness) that separate people from the community and family or that encourage *unquestioning* devotion and obedience to a single charismatic leader, or promote religion or spiritual traditions as a healing practice to the total exclusion of traditional medical care, are likely to adversely affect health over time. (31)

We look forward to a continued dialogue on the important issue of appropriating evidence-based, positive spirituality into clinical care.

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