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TRANSCULT PSYCHIATRY 2006; 43: 634
DOI: 10.1177/1363461506070788

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Religion and Spirituality in Psychiatric Care: 
Looking Back, Looking Ahead

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Abstract Cultural psychiatry has been an important contributor to the enhanced dialogue between psychiatry and religion in the past couple of decades. During this time, religion and spirituality have become more prominent in mainstream psychiatry in a number of areas of study and clinical care, including refugee and immigrant health, trauma and loss, psychotherapy, collaboration with clergy, bioethics, and psychiatric research. In looking towards the future, there is a great deal of promise for future enhancement of the study of religion and spirituality in psychiatric education, research, and clinical care.

Key words psychiatry • religion • religious studies • spirituality

For most of the 20th century there was a great deal of tension between psychiatry and religion, but during the past couple of decades in psychiatry there has been a greater understanding of the relevance of religious thought and practice in psychiatric assessment and treatment. Cultural psychiatry has been a major contributor to this enhanced dialogue between psychiatry and religion because it is an area of psychiatry that requires the integration of the biological and social sciences, and the humanities, including religion and spirituality. In its attempts to explain the full range of human behavior, including behavior associated with mental illness, psychiatry has often needed to go well beyond the world of natural science into the philosophical realm.

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All religions offer some type of explanation of how the universe was created, how life is maintained, and what happens when life ceases to exist. Moreover, all religions attempt to give their followers explanations for life’s meaning, including rationales for the reality of human suffering (Boehnlein, 2000). Religious symbols, beliefs, myths, and rites enable individuals and groups to deal with the ultimate conditions of existence that are experienced by members of every society (DeCraemer, Vansina, & Fox, 1976). From the standpoint of the individual as part of a social unit, religion serves as a source of conceptions of the world, the self, and the relations between them (Geertz, 1973). Both religion and cultural psychiatry are concerned with how identity is defined and how this definition is affected by interpersonal, social, and cultural processes. For much of history, the separate functions of religious practice and healing were performed by a single individual in most world cultures. Only with the explosive growth of scientific knowledge in the 20th century have the roles of religious and medical healers become separate.

Psychiatry and religion can be parallel and complementary frames of reference for understanding and describing the human experience and human behavior. Although placing different degrees of emphasis on the relative importance of mind, body, and spirit in defining human nature, the objective and subjective perspectives of psychiatry and religion can be integrated in comprehensive patient care in cultural psychiatry.

In the last 25 years religion and spirituality have become more prominent in mainstream psychiatry in a number of different areas:

1. As the world’s population has become more migratory over this time, there has been more exposure to diverse cultural and religious traditions in western cosmopolitan societies. This has required psychiatrists to be more knowledgeable about the backgrounds and traditions of immigrants and refugees resettling in these countries;
2. Trauma and loss among these migrant populations, war veterans, and survivors of civilian trauma and natural disasters have received much more attention during the last several decades. Religious and spiritual beliefs and practices have relevance for trauma recovery;
3. Also in the past several decades, various new approaches to psychotherapy have been developed that actually have their roots in religious and spiritual traditions. Moreover, the processes and goals of some psychotherapies and spiritual practices are remarkably similar;
4. After a long history of antagonism among mental health professionals and clergy, there has been a rapprochement that has focused on the overlapping goals of each profession to foster growth, resiliency, hope and meaning for individuals and groups;
5. Medicine and psychiatry have faced many ethical challenges as the frontiers of science have outpaced society’s ability to grasp change or adequately debate the ethical implications of the rapid evolution of knowledge. Consequently, in debates on a number of complex issues in bioethics, medicine has needed to draw upon philosophical traditions that often have their roots in religion and spirituality;  
6. Psychiatric research in recent decades has increasingly focused on the role of religion and spirituality in mental health and illness. This research has implications for future psychiatric care and for psychiatric training.

All of these issues will be explored in more detail in this article as I review the past few decades of cultural psychiatry and look towards the future.

International Mental Health

A discussion of psychiatry and religion has particularly become more timely now because of a resurgence of interest in religious belief and practice in many parts of the world, and because of the increased movement of the world’s population, with the subsequent assimilation of a variety of belief systems and practices throughout the world (Boehnlein, 2000). Mental health providers in developed countries increasingly are treating immigrants and refugees whose backgrounds are much different from their own, so it is important for them to understand cultural belief systems, including religious thought and practice, that relate to mental health and illness. Acculturation can also bring about change in religious traditions, just as it can influence dynamic changes in other areas of life for individuals and groups.

An increased awareness of religion in contemporary societies in recent years has both positive and negative aspects (Boehnlein, 2000). From a positive point of view, religious belief systems may provide meaning for individuals or groups. This includes survivors of various types of trauma such as war, civil violence, torture and natural disasters. Historically, a broad spectrum of religious organizations also have funded and operated mental health services in various countries, so it is important for organized psychiatry and clinicians to be knowledgeable about the historical belief systems and political structures of these organized religions so that the effectiveness of services can be enhanced.

From a negative point of view, any religious fundamentalism, regardless of belief system, can be damaging not only to individual mental health and social adjustment but also to peaceful coexistence among cultures. Unfortunately, many areas of the globe in recent decades, such as Northern Ireland, the Balkans, Africa, and the Middle East have seen
the politicalization of religious beliefs resulting in the destruction of lives and cultures. This is a very important realm for psychiatry because survivors of regional war trauma and violence frequently emigrate to other countries, where they subsequently attempt not only to acculturate but also to place their traumatic experiences into a meaningful context.

Another source of tension in the current era is the tension between religious resurgence in many parts of the world and the increase in secularization in developing societies. This tension frequently leads to a polarization of beliefs and perspectives, and the hardening of attitudes and opinions when, in fact, religious and secular perspectives may be complementary in understanding the human condition and human behavior.

**Trauma and Loss**

The complex existential and spiritual issues associated with trauma and loss are central to both religious faith and the process of posttraumatic recovery. During and after traumatic events, individuals frequently report great cognitive dissonance between what they observe and experience in reality and what they previously believed were stable, secure, and predictable relationships, not only with other individuals but also with the supernatural or the metaphysical (Boehnlein, 1987a). The person recovering from the trauma does not have to be religious in a formal sense to experience this dissonance; how the person was socialized to reconcile the pain of loss is what is important (Eisenbruch, 1984). Incorporating religious and spiritual perspectives in the clinical assessment of patients takes into account the effects of philosophical viewpoints, cultural values, and social attitudes on disease (Fabrega, 1975). Religious teachings recognize the transcendental meaning of suffering and the fact that suffering, such as agony, despair, pain and conflict, belongs to the totality of life (Rhi, 2001).

All the major world religions have belief systems, values and practices that allow survivors to adjust to and create meaning from severe loss and trauma. Buddhism, Hinduism, Islam, Judaism and Christianity all have oral traditions that facilitate the creation of meaning and hope for the future. It is now being recognized that patients bring these traditions with them to psychiatric treatment and psychotherapy, and they form an integral part of identity. The nature of the relationship between religious faith and negative life events can be complex: For some individuals, religious faith may enhance the ability to cope with negative life events, while for others, negative life events may result in greater religious faith (Connor, Davidson, & Lee, 2003).

Yet, experiencing massive trauma can also result in a collapse of faith. The human experience of useless cruelty, such as in the Holocaust, where the goal of the perpetrators is the suffering of others solely for the sake of
suffering rather than for a military or political aim (Langer, 1998), is an apt example. It illustrates well the problem of theodicy, the difficulty of defending divine justice in the face of great evil and suffering; if God is all-loving he would not be able to tolerate the appalling suffering that is evident in the created order and, if he is almighty, he would be able to do something about it (Bowker, 1970).

In the context of specific religious traditions, Judaism holds open the possibility of being restored to a right relationship with God through atonement; Christianity teaches that repentance for sin, accompanied by turning to God and asking to be united with Christ’s sacrifice, brings forgiveness and the gift of a new life (Christian trauma survivors often mention the loss of God as one of their greatest losses); Buddhism incorporates the acceptance of life as it comes, including traumatic events (reincarnation is a major tenet of Buddhism, along with Karma, the belief that a person’s actions in this life will affect one’s existence in the next) (Sparr & Ferguson, 2000). In Islam, given that death to an individual is divinely ordained, the survivor need not bear the guilt of a loss (Elbedour, Baker, Shalhoub-Kevorkian, Irwin, & Belmaker, 1999). In most of the religions of the world, pain, suffering, atonement and forgiveness are interrelated in theology and in everyday life. The relative importance of each, and their interaction, may vary among the major religions, but they are central issues that affect recovery from great trauma and loss (Boehnlein, 2006).

Religious traditions in the West generally include a more active approach to suffering and trauma, whereas eastern traditions prescribe a somewhat more reflective position. Both of these traditions can be seen in psychotherapeutic approaches to trauma recovery. In PTSD recovery, spiritual awakening can play a role in relieving survivor guilt (Khouzam & Kissmeyer, 1997). And there are a number of similarities between the spiritual process of repentance and the process of psychotherapy as, in both processes, the individual undertakes a journey of transformation that includes painful introspection; the working through of rage, guilt, or shame related to the experience of evil optimally involves seeking a proper balance of justice, repentance and forgiveness (Schimmel, 2002). This is not an easy task, however, for the survivor and there can be tension also between religious traditions and the process of psychotherapy or psychiatric treatment. Normal and expected human interactions such as anger, hate and the urge for revenge can be overwhelming, thus preventing resolution of the intense mix of emotions that occur after trauma. And, religious traditions that place healing in the hands of God may conflict with western psychotherapies that place a premium on individual power, control, and responsibility.

Greater levels of personal resilience have been associated with more favorable outcomes in PTSD (Connor et al., 2003). Religion and
spirituality may contribute to this resilience by providing guidance for the survivor on complicated moral questions, along with a social network of individuals with shared values and beliefs who can provide support and guidance. Also, success in psychotherapy in the treatment of PTSD requires overt questioning, on the part of the patient and the clinician, of the congruence of their respective models of illness causation, and ideas for treatment (Boehnlein, 1987b). It also allows for discussion that focuses on beliefs and values, which are central concerns for trauma survivors.

**Psychotherapy**

Spiritual and religious traditions also have had a significant influence on the development of some contemporary schools of psychotherapy in general psychiatry and addictions. Exploring subjective experience of belief as a motivating force (Sims, 1994) is an important area of study and practice. One conceptual viewpoint that arises from recent findings in cognitive science (interactive realism) asserts that each of us in our interaction with others, if the interaction is characterized by mutual acceptance, brings forth a shared domain that is value laden; for psychotherapy this process can be described as a process of coconstruction whereby the therapist and patient jointly bring forth a change in the being of each participant (Bathgate, 2003). Yet, in the realm of psychotherapy and spirituality, the therapist needs to be cautious and aware because there is a significant potential for the abuse of the therapeutic relationship if the therapist communicates a personal agenda that abandons the principle of psychotherapeutic neutrality (Lomax, Karff, & McKenny, 2002).

Johnson and Westermeyer (2000) note that Marsha Linehan (1993a, 1993b) developed a therapeutic modality – Dialectical Behavioral Therapy (DBT) – that is an integration of two areas: Her work in suicide prevention and behavior therapy, and her experience as a student of a Zen master and Benedictine monk. They point out that the main goals of Linehan’s therapy are to enhance dialectical patterns of cognitive functioning and to change extreme behaviors to more balanced and integrated responses to the moment. DBT does not function on maintaining a stable, consistent environment, but instead aims to help the patient become comfortable with change. According to Linehan, the three main polarities of DBT are: (1) The need for patients to accept themselves as they are and the need to change; (2) the tension between patients’ getting what they need and losing what they need if they become more competent; and (3) patients’ maintaining personal integrity versus learning new skills that will help them emerge from their suffering.

Johnson and Westermeyer (2000) also point out DBT’s partial roots in eastern religions by noting that Linehan described dialectical thinking as
the ‘middle path’ between universalistic thinking and relativistic thinking, which interestingly, also form similar poles in an ongoing debate in anthropology and cultural psychiatry. Dialectical thinking assumes that truth and order evolve and develop over time. Goals of this process consist of integrating contradictory points of view, learning to be comfortable with inconsistency, and avoiding simplistic explanations. This method is applied to patients with borderline personality disorder, who often have difficulty receiving new information and who tend to search unsuccessfully for absolute truths. Extremes and rigid behavior patterns are signals that a ‘middle way’ has not been achieved.

Psychoanalysis offers another example of the importance of religion and spirituality in the history of psychotherapy, although there has been a great deal of tension in this relationship dating back to Freud. However, over the past 20 years the relationship between psychoanalysis and religion has been changing as Freud’s reductionist understanding of religion and his evaluation of it as an expression of infantile needs has been rejected by numerous psychoanalytic writers (Blass, 2004). William Meissner (2000), an analyst and Jesuit priest, notes that one of the most significant contributors to the redirection of psychoanalytic thinking about religion was Erik Erikson (1962, 1969), not only in his ingenious broadening of the scope of analytic concepts regarding personality development and the formation of identity, but particularly in his interpretations of Luther and Gandhi. Meissner points out that Erikson was able to connect the most profoundly spiritual aspects of human experience with fundamental infantile roots and dynamics without entertaining the reductionistic fallacy that had plagued earlier efforts (Meissner, 1987; Zock, 1990). Erikson (1962) wrote,

Must we call it regression if man thus seeks again the earliest encounters of his trustful past in his efforts to reach a hoped-for and eternal future? Or do religions partake of man’s ability, even as he regresses, to recover creatively? At their creative best, religions retrace our earliest inner experiences, giving tangible form to vague evils and reaching back to the earliest individual sources of trust; at the same time, they keep alive the common symbols of integrity distilled by the generations. If this is partial regression, it is a regression which, in retracing firmly established pathways, returns to the present amplified and clarified. (p. 264)

A third example that illustrates the significant convergence of religion and psychotherapy is the development of existential psychotherapy in the mid and late 20th century, following the horrors of the Second World War. Although this school of psychotherapy does not have a religious base, it has a foundation in European philosophical traditions which deal intimately with profound questions that religion also confronts, such as the concept of evil (Prins, 1994), and the meaning of loss and death. The
problem of evil can be expressed in theological or secular terms, but it is fundamentally a problem about the intelligibility of the world as a whole; the problem of evil belongs essentially neither to ethics nor to metaphysics, but forms a link between the two (Neiman, 2002).

Yalom (2002), a key figure in the development of the school of existential psychotherapy, defines it as a dynamic therapeutic approach that focuses on four ultimate concerns pertaining to existence, specifically death, isolation, meaning, and freedom. He notes that existential psychotherapy and religious consolation also share common methods—the one-to-one relationship, the mode of confession, inner scrutiny, and forgiveness of self and others. And, in a further parallel that has great relevance to the creation of meaning, he notes that religion and psychotherapy have each developed methods of quelling the dysphoria of isolation and loneliness. This emphasis on isolation and loneliness has contributed to the growth over the past several decades of the importance of group and family psychotherapies, which are based on strengthening social relationships and connections.

**Clergy**

There are a number of issues central to the relationships between psychiatrists and clergy that are important for patient care, and which have appropriately received more attention in recent years (Larson, Milano, Weaver, & McCullough, 2000; Weaver, Koenig, & Larson, 1997). For example, given a better understanding of the interface between religion and psychiatry in our culture, psychiatrists in the future will need to become increasingly sensitive to their patients' religious backgrounds and expressions during evaluation and treatment. Moreover, psychiatrists will need to seek special knowledge about religious traditions that are unfamiliar to them. Such knowledge will help them to better identify the fine line between healthy religious expression and psychopathology. And mental health professionals will need to seek input from clergy familiar with the religious beliefs, practices, and experiences of their patients. Clinicians and clergy share a number of qualities that have been universally identified as central to the efficacy of healers, including communicating the expectation that suffering will be relieved, conveying a knowledgeable manner, drawing together key individuals in the person's life, and generating hope for an improved existence (Frank, 1961). In addition, one of the functions of a healer in psychiatric or religious practice is to help reestablish an equilibrium between a person and his or her environment, whether that environment is the natural world, interpersonal relationships, or the person's struggle with meaning, beliefs, or values (Boehnlein, 1987b). Therefore, mental health practitioners and
clergy have separate yet complementary roles in restoring patients to health.

Larson et al. (2000) also note that milder forms of depression, mild to moderate anxiety, and minor adjustment and coping difficulties that plague a portion of the population can be handled quite well in the pastoral care setting. They point out that initial screening for more severe psychiatric disorders can occur at the religious-community level to ensure early recognition and timely referral to psychiatric professionals; after diagnosis and treatment have been initiated by mental health professionals, clergy can assist in the follow-up of such patients by supporting the treatment plan, monitoring treatment compliance, and observing for deterioration.

Bioethics

Contemporary multicultural societies face immense challenges in developing appropriate ethical guidelines in biomedicine. The biological sciences have needed to turn to the perspectives offered by the great religious traditions that are grounded in philosophy and the social sciences to develop guidelines in how to approach many complex moral and ethical issues. Many of these dilemmas center around questions of when life begins and ends, and who has the power to influence the course of life and death.

At the beginning of life, controversies such as embryonic stem cell research and abortion deal with the question of when life begins, intertwined with cultural debates about individual and group rights and responsibilities. At the end of life, the societal debate about physician-assisted suicide and euthanasia deals with similar issues.

These issues are difficult and complex because they involve thought, discussion and debate about the most personal and central aspects of human existence, including individual identity and integrity. Consideration of these issues also includes debate about the relative value of human autonomy and social imperatives, along with the appropriate role of religious beliefs in a multicultural society.

Social attitudes toward illness and death are highly influenced by each culture’s values that have their roots in philosophical, religious, social, and political structures, all of which influence each other. Unfortunately, historical and legal traditions tend to rigidly compartmentalize these elements that form the core of social values and policy. But, on a practical level, physicians’ personal concepts of ethical practice cannot be judged apart from society’s broader ethical traditions, as professional ethics derive from general social and moral principles in a specific historical era, and within a predominant culture (Boehnlein, Parker, Arnold, Bosk, & Sparr,
In addition, an individual physician's views of issues in medical ethics cannot be judged totally apart from his or her personal, social, and religious background.

Physician-assisted suicide (PAS) is an excellent example of a contemporary medical issue in which social and religious paradigms can conflict although, in reality, there are areas of common ground. Physicians who hold opinions on either side of the PAS debate, and in between, all view their beliefs and actions as compassionate, and in the best interests of the patient. For those supporting physician-assisted suicide, the importance of patient autonomy in end-of-life decisions outweighs social or professional reservations that would forbid the practice. Proponents believe they are showing their professional care and compassion by valuing the patient's autonomy, and they believe that there is a professional ethical obligation to relieve patient suffering, including the option of physician-assisted suicide. For those who oppose physician-assisted suicide, patient autonomy, although important, is outweighed by the social nature of the issue (the patient's interpersonal relationship with family members and the physician; financial hardships that could favor physician-assisted suicide as an option other than one of last resort), and by a belief in the absolute value of life itself, regardless of how quality of life is judged at any specific stage of life. These competing paradigms continue to be debated in contemporary medicine and politics (Hamilton & Hamilton, 2005), with input from both secular and religious perspectives.

Therefore, in order to deal with these contemporary ethical issues, such as PAS, psychiatrists and other physicians must be able to draw upon a broadly based intellectual tradition in the social sciences and humanities, including the comparative study of religion. This ideally should begin in medical education and residency training when physicians' medical values are being formed. Education and training should introduce young physicians to the influence of religious cultures on the patient's worldview, the meaning of suffering, and the creative influence of spirituality on the maturation of personality (Rhi, 2001).

Scientific and religious perspectives do not need to be mutually exclusive. Since the mid 1990s, a large number of medical schools have begun to include topics related to spirituality and medicine in their curricula, including spiritual assessment as part of a routine history; clinical and ethical boundaries during discussions of spiritual and religious issues; research in spirituality and healthcare; and, spiritual issues in palliative care (Puchalski & Larson, 1998). Including these topics in medical education serves to enhance general communication skills, particularly when discussing sensitive topics in a compassionate and nonjudgmental manner (Lo et al., 2002). Yet, at the same time, the psychiatrist's own spirituality or religiousness may be the strongest predictor of inquiry.
into a patient’s spirituality or religiousness (Baetz, Griffin, Bowen, & Marcoux, 2004).

Fortunately, in the past decade the importance of these topics in organized psychiatry and psychiatry training programs has begun to increase (Larson, Lu, & Swyers, 1997; Lukoff, Lu, & Turner, 1995; Turner, Lukoff, Barnhouse, & Lu, 1995). Knowledge, skills and attitudes related to training in religion and spirituality include: Understanding the unique impact of religious/spiritual experiences in physical and psychological development; differential diagnosis of religious/spiritual experiences and their effect on the course and treatment of psychiatric disorders; transference and countertransference; providing appropriate psychotherapeutic interventions that reflect an understanding of patients’ religious/spiritual experiences; and, awareness of the psychiatrist’s own religious/spiritual experience and the impact on identity and worldview (Lu, 2000).

**Research in Religion and Spirituality: Present and Future**

Current research in religion, spirituality, and psychiatry is structured along enduring paradigms that originated centuries ago. Augustianism, named after St. Augustine (354–430 AD) conceptualizes religious belief as transcending objective reality, whereas Thomism, named after St. Thomas Aquinas (1224–1274 AD) describes religious faith as dependent upon reason and as accessible to empirical methods (Neeleman & Persaud, 1995). Despite its unknown nature, several features of spirituality can be measured and, given suitable statistical methods to control for confounding, its effect on people’s lives can be assessed (King & Dein, 1998). But this systematic quantitative study of religion and mental health was traditionally quite rare, it most often used a single static measure of religion rather than multiple dynamic measures, and has started to slowly increase only over the past decade (Larson et al., 1993; Larson, Pattison, Blazer, Omran, & Kaplan, 1986; Weaver et al., 1998).

Recent studies have shown that many, if not most, Americans use religion to help them cope, particularly during times of acute stress (Koenig, 1995; Koenig, McCullough, & Larson, 2001). In a recent national survey conducted by the Centers for Disease Control and Prevention’s National Center for Health Statistics on the use of alternative medicine in the U.S., 43% of respondents had prayed for their own health (Barnes, Powell-Griner, McFann, & Nahin, 2004). Among clinical populations, studies that have used measures based on psychiatric nosology have found religious commitment to be beneficial (Baetz, Larson, Marcoux, Bowen, & Griffin, 2002; Larson et al., 1992). For example, it has been shown in
numerous studies that high levels of religious involvement predict a reduced risk for substance misuse, and that the relationship between social religiosity and the risk of illness is consistent with the hypothesis that religious activity can be a potent form of social integration (Kendler et al., 2003).

Koenig (2000) notes that further studies are necessary to compare the effects of religious coping with those of nonreligious coping behaviors (e.g., distracting activities, support from family) on mental health and emotional wellbeing. He further points out that, although recent research has emphasized the health-promoting effects of devout religiousness, relatively few investigations have attempted to identify the specific elements of religious coping that are beneficial, or to isolate types of religious coping that are detrimental to health.

Koenig also notes that, with a few exceptions (Blazer & Palmore, 1976; Idler & Kasl, 1992; Koenig et al., 1992), most research examining the relationship between religiousness and mental health has been cross-sectional; although cross-sectional studies provide information about association, they do not elucidate causality or direction of effect. In the future, longitudinal, prospective studies or clinical trials will be necessary to yield information about the time sequence of events. Religiosity may alter the risk of illness, the experience of illness may have an effect on religiosity, or a third factor may influence both (Kendler et al., 2003).

However, some studies have begun to show associations between cultural and spiritual orientation and specific psychiatric outcomes. For example, a recent study by Garroutte, Goldberg, Beals, Herrell, and Manson (2003) suggests that American Indians with strong levels of cultural spiritual orientations have relatively lower rates of self-reported attempted suicide. In the published literature overall, results of studies of the interrelationship between religion and mental health tend to show that religiosity seems to exert a salutary effect on health, and that there is a trend toward better health and less morbidity in the presence of higher levels of religiosity (Levin, 1994). A wide range of research findings in the field, and even contradictory findings, likely are related to the fact that religion is a multifaceted construct and different aspects of religiosity are differentially related to mental health; using institutional religiosity as the defining characteristic produces the weakest (and the only negative) correlations across the board, ideology produces stronger effects, and personal devotion produces the greatest correlations (Hackney & Sanders, 2003).

One of the most promising areas for future research in spirituality and medicine is in palliative and end-of-life care. The impact of afterlife beliefs on health, particularly the influence of those beliefs on survival, terminal illness, and hopefulness, has been virtually ignored. In a study of spiritual wellbeing and psychological functioning in terminally ill cancer patients,
spiritual wellbeing offered some protection against end-of-life despair; in study participants low in spiritual wellbeing, depression was highly correlated with a desire for hastened death (McClain, Rosenfeld, & Breitbart, 2003). In another study with terminally ill cancer patients some of the same authors found that spirituality had a more powerful effect on psychological functioning than beliefs held about an afterlife (McClain-Jacobson et al., 2004). At the end of life, the beneficial aspects of religion may be primarily those that relate to general spiritual wellbeing rather than to specific religious practices.

Another promising area for research that is only exploratory at this point is the relationship among specific physiological health measures, mortality, and religion/spirituality. As an example, recent research has suggested that regulation of the proinflammatory cytokine interleukin-6 (IL-6) may be abnormal in patients with major depression (Alesci et al., 2005; Penninx et al., 2003). A study that prospectively examined the relationship between religious attendance, IL-6 levels, and mortality rates in a community-based sample of older adults found that religious attendance was significantly related to lower IL-6 levels and lower mortality rates, and that IL-6 levels mediated the prospective relationship between religious attendance and mortality (Lutgendorf, Russell, Ullrich, Harris, & Wallace, 2004).

**Conclusion**

There is certainly a great deal of promise for the future relationship between psychiatry and religion in research, as well as in patient care and education. With the continuing growing importance of cultural psychiatry in all areas of psychiatric work, there is great potential in the future for an exciting synergy of efforts that will positively influence cross-cultural psychiatric treatment, and the understanding of religion and spirituality.

At the same time, as described in this article, there are a number of challenges to the field in attempting to objectively study the variables that influence the relationships among religious and spiritual beliefs, societal values, conceptions of mental health and illness, and psychiatric nosology and treatment. But, it is an ideal field for the convergence of the biological sciences, the social sciences, and the humanities, in an attempt to more completely understand identity and meaning, social relationships, and the complexity of the human condition across all cultures and faiths.

**References**

Alesci, S., Martinez, P. E., Kelkar, S., Ilia, I., Ronsaville, D. S., Listwak, S. J., et al. (2005). Major depression is associated with significant diurnal elevations in


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Levin, J. S. (1994). Religion and health: Is there an association, is it valid, and is it causal? Social Science and Medicine, 38, 1475–1482.


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