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Psychiatrists and Religious Belief

To the Editor: The article in the September issue by Curlin and colleagues (1) presents interesting data on the religious beliefs (or lack thereof) of U.S. psychiatrists. The authors appropriately note the historical antipathy to conventional religion expressed in some of Freud's writing.

I believe that part of psychiatry's difficulty in dealing with religious beliefs stems from a failure to distinguish pathological religiosity from what I would call the religious impulse. Consider, on the one hand, Mr. A, who is convinced not only that his religion is valid but that it is the only "true faith" and that everybody else is a "heretic." Mr. A is completely impervious to any attempts to challenge his beliefs, rituals, or religious practices. Any attempt to do so sends him into fits of rage and evokes fantasies of "avenging the slur against the One True Faith."

Now consider Ms. B. She describes herself as "not a religiously observant" person but one who does attend religious services "when I'm feeling a little lost or alone." Ms. B is not sure she believes in an "all-knowing, all-powerful God"; however, she says, "I feel like there is something out there greater than us—some kind of order or intelligence in the universe that I feel drawn to really strongly." Ms. B has undertaken psychotherapy to "help figure out who I am and where I'm headed—is there a purpose to life beyond just working and getting by?"

Ms. B's relationship to faith is clearly very different in tone and content from that of Mr. A. I believe Freud would have been quite wrong in regarding Ms. B's religious impulse as "neurotic" in any way. Not only should psychotherapy be tolerant of what in my view is a mature kind of religious impulse; psychotherapy's goals should be quite compatible with those of a "seeker" such as Ms. B. Of course, we must also be respectful of patients who espouse more conventional or "orthodox" religious beliefs and not reflexively see these as impediments to therapeutic progress.

Finally, with respect to the findings of Curlin and colleagues, there is much room for clarification of what the term "religious" means, both to patients and to psychiatrists. In 1929 during a dinner party in Berlin, someone asked Einstein whether he was religious, and his response has been widely repeated: "Try and penetrate with our limited means the secrets of nature, and you will find that, behind all the discernible concatenations, there remains something subtle, intangible and inexplicable. Veneration for this force beyond anything that we can comprehend is my religion. To that extent I am, in point of fact, religious."

Ronald Pies, M.D.

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To the Editor: The article by Curlin and colleagues in the September issue interested me for several reasons. First, it illuminates an area that has been largely neglected by the psychiatric profession, although I am sure that many of us have private conversations about the interface between psychiatry and religion.

One particular conversation comes to mind. A colleague whose office was across the hall came into my office appearing frustrated. He said that he was no longer going to take any patients referred to him by Roman Catholic sources. "The patients know I'm a Catholic and subtly coerce me into agreeing that we do not explore their religious beliefs. If I refuse, they drop out of treatment."

In my experience, the other side of that coin, however, is that many psychiatrists not only have little use for religion but an alarming lack of knowledge about it. I was raised a minister's son, and although I emerged from the experience with a lack of belief, I have no lack of knowledge of religion. This may be why church leaders and seminary officials have referred many patients to me. I would be able to understand where the patients were "coming from."

People often call upon religious feelings to deal with psychological conflicts. Guilt, if real, is often relieved by prayer or confession. Irrational guilt, however, is not, and this is the bulk of the guilt we deal with in psychiatry. Here, religious belief may function as a defense reaction and become antitherapeutic.

In summary, I would recommend that psychiatric residency curricula include didactic courses in comparative religion. In more than 50 years of practice, I have known too many colleagues with little or no understanding of religion and its varieties.

Philip S. Hicks, M.D.

Dr. Hicks, a psychiatrist who is retired from private practice, lives in San Rafael, California.

To the Editor: Research has indicated that religion can be a significant

source of support for some recipients of mental health services, although they typically have less access to religious resources (1–3). In their article in the September issue, Curlin and colleagues noted that psychiatrists are less likely than other physicians to be religious, which raises questions about whether they can accurately assess the importance of religion in their patients' lives. In light of our findings (presented below), psychiatrists need to keep in mind that some patients may need particular support in this area if they are to successfully join and remain part of faith communities.

We examined impediments to participation in faith communities by interviewing three groups of patients (N=40 each): patients with chronic psychiatric illness, patients with acute psychiatric illness, and a control group of medical-surgical patients. Participants in the control group were matched with participants in the chronic group on gender, race-ethnicity, and age. To partially control for socioeconomic status, all participants in the control group were recipients of Medicaid benefits or Medicare and Medicaid benefits. Participants in the chronic group were inpatients at a state psychiatric hospital in upstate New York. The acute care participants and the medical-surgical participants were patients at a large tertiary care hospital adjacent to the psychiatric hospital. Interviews were done in 1998.

Of the 120 participants, 66 (55%) were male, and 54 (45%) were female. A total of 79 patients (66%) were European American, 35 (29%) were African American, four (3%) were Hispanic, and two (2%) were in the "other" category. Forty-seven participants (39%) reported being Protestant, 41 (34%) were Roman Catholic, four (3%) were Jewish, three (3%) were Muslim, and 15 (13%) were in the "other" category. The individual interviews included open-ended questions, questions on specific impediments to participation in faith communities, and the Duke University Religion Index (4).

A one-way analysis of variance found no statistically significant differences in impediments among the groups, but the order of impediments differed. The most frequently endorsed item in the acute psychiatric and medical-surgical groups was lack of transportation, whereas for patients with chronic illness the most frequently endorsed item was "past experiences of being made to feel unwelcome." Other items endorsed by participants included not having the proper clothing to wear, fear of being made to feel unwelcome, not having money to put in the offering, being uncomfortable with groups of people, inconvenient time of the worship service, and difficulty sitting through the service.

Each of the 84 participants (70%) for whom faith was important reported that one or more of the impediments made it difficult to participate in a religious community at least some of the time. Thus it appears that being sick and poor makes it difficult to remain connected to a faith community. Recipients of mental health services, as well as people with low incomes who have chronic medical problems, may need assistance from caregivers if they are to be part of faith communities.

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In Reply: Dr. Pies' effort to distinguish pathological religiosity from the religious impulse reveals a tendency to evaluate "maturity" of faith commitments that may be most appropriately left to clergy and religious scholars rather than to therapists. As an example of pathological religiosity, Dr. Pies describes someone who believes that his religion is the only true faith. As an example of "mature" religious impulse, he describes someone who is not religiously observant and looks to psychotherapy to find answers to her existential questions.

This dichotomizing of pathological and mature religiosity is inherently problematic, particularly when characterized in this fashion. For many, being religious means observing the teachings and traditions of a particular religion precisely because one believes that religion most adequately answers the sorts of questions that Dr. Pies' "seeker" asks. In Freud's terms, such religious persons believe in an illusion, but they are hardly mentally ill otherwise, and the knowledge that other people disagree with their convictions leads few to "fits of rage" and fantasies about revenge.

Tensions between psychiatry and religion likely emerge when one of the two tries to explain and treat a human experience that the other believes it alone has proper authority and resources to address. For example, religious traditions might encourage the "seeker" in Dr. Pies' example to turn to her particular religion rather than to psychotherapy if she wants to "figure out who I am and where I'm headed—is there a purpose to life beyond just working and getting by?" With respect to Dr. Hicks' frustrated colleague, the close connection between existential questions and care of those with mental health concerns is demonstrated both by the fact that his patients did not want to talk with him about their Catholic faith and by the fact that their refusal seemingly limited his ability to care for them.

Although our study did not address the issue directly, we would hypothesize that physicians turn to psychiatry more consistently as patients' experi-

ences move along a gradient from milder to more severe psychiatric symptoms. As Dr. Hicks' noted, the normal yet painful consciousness of responsibility for doing wrong is not the same as the experience of oppressive feelings of guilt over actions for which one cannot reasonably be held responsible. We would expect religious physicians to show more preference for religious resources in responding to the former than they would in responding to the latter. Likewise with respect to the vignette in our survey, we think it likely that many physicians would classify the complicated grief of a widower as belonging to the category of human experiences better addressed by religious communities and practices than by behavioral sciences. Yet, had the vignette involved suicidality and vegetative symptoms of depression, we expect that physicians' preferences would have varied less with respect to their religious characteristics and would have been more consistently in favor of referral to a psychiatrist.

Finally, the study by Dr. Cutting and her colleagues gives a word of caution to those who might too sanguinely encourage individuals with mental illness to find help in religious communities. Such encouragement will be unhelpful to the extent that patients either do not have the means to participate in religious communities or have found such communities to be unwelcoming to those who suffer from mental illness.

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Mental Health Providers' Involvement in Diabetes Management

To the Editor: Recent policy recommendations and practice guidelines call for improved integration and coordination of psychiatric and medical care. The extent to which psychiatrists and other mental health providers should assume responsibility for mental health consumers' medical conditions requires further consideration, particularly for medical conditions that occur as a result of psychiatric interventions and perhaps also for preventive monitoring, screening, and education in regard to medical conditions that disproportionately affect psychiatric consumers.

Individuals with schizophrenia and other serious mental illnesses have rates of type 2 diabetes more than four times higher than the rate in the general population (1). The higher rates are likely attributable to a combination of lifestyle issues (including physical inactivity, poor nutrition, use of illicit substances, and smoking) and use of second-generation antipsychotic medications. We previously found that consumers with serious mental illness and diabetes had glycosylated hemoglobin (HbA1c) values that exceed those recommended by the American Diabetes Association; consumers for whom olanzapine was prescribed had higher HbA1c levels than those for whom other antipsychotic agents were prescribed (2). We also found that consumers in this cohort fell short of recommended goals for cholesterol levels and blood pressure control and evidenced lower quality of diabetes care as reflected by receipt of fewer recommended preventive and educational services (3,4). More effort may thus be required to provide optimal diabetes care to this vulnerable population.

To address this issue we examined involvement of community mental health providers in diabetes care in a cohort of 201 adults with type 2 diabetes and serious mental illness. Study participants were asked four questions that focused on the coordination of medical and psychiatric care during the past six months regarding whether or not their mental health providers asked about diabetes medications and behaviors, provided them with diabetes-related education, and asked to speak directly to their diabetes doctor.

Results indicate that mental health providers were engaged in some related care coordination. A total of 112 study participants (56%) reported at least one diabetes-related intervention by their mental health provider. Of these, 96 (48%) reported that mental health providers asked about diabetes behaviors and 78 (39%) reported being asked about diabetes medication. Given the poor diabetes outcomes related to HbA1C and the poor quality of care noted in this cohort, however, it is problematic that only 34 participants (17%) reported that their provider asked to speak with their diabetes doctor and 28 (14%) reported receiving any diabetes education.

Although these self-reported findings are limited by the absence of chart verification, they nonetheless suggest that mental health providers fall short of providing basic care coordination and counseling for consumers living with both serious mental illness and diabetes. Therefore, we strongly support efforts to increase mental health providers' involvement in the coordination of the medical and psychiatric care of consumers. Such efforts are squarely in line with recent calls to integrate health promotion services into the mental health system (5).

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Acknowledgments and disclosures

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Hospitalization for Medical Comorbidities Among Psychiatric Patients in Tokyo

The purpose of this prospective cohort study was to clarify the incidence and kinds of medical comorbidity for which psychiatric patients should be hospitalized. Gathering such epidemiological data in Tokyo, which has approximately 12 million inhabitants, might inform public policy not only in Japan but also in other countries.

The study was conducted throughout Tokyo from April 1 to May 31, 2007. Participating in the study were 21 of Tokyo's 28 general hospital psychiatric units (75%), all three general hospital psychiatric emergency units, and all 11 general hospital psychiatric units specializing in medical comorbidity. Because these three types of general hospital psychiatric units are responsible for treating severe medical illness among psychiatric patients in Tokyo, the study was designed to capture all psychiatric patients admitted for primary medical diagnoses. Information was collected about demographic and clinical characteristics of patients who were admitted and those who were not admitted because no beds were available. The study protocol was approved by an institutional review board.

In the two-month period 326 patients were admitted to one of these units for a primary medical diagnosis: 174 to general hospital psychiatric units, ten to general hospital psychiatric emergency units, and 142 to general hospital psychiatric units specializing in medical comorbidity. The mean±SD age of these patients was 61.7±16.2 years, and 150 patients (46%) were male. Of the 326 patients, 194 (60%) were medical cases and the remaining 132 patients (40%) were surgical. Respiratory diseases were the most frequent (61 patients, or 19%), followed by diseases requiring orthopedic surgery (42 patients, or 13%), diseases requiring abdominal surgery (32 patients, or 10%), and gastrointestinal and hepatic diseases (32 patients, or 10%). At discharge 130 patients (40%) had *ICD-10* psychiatric diagnoses in the F2 category (schizophrenia and schizotypal and delusional disorders), 91 patients (28%) had *ICD-10* F0 diagnoses (organic mental disorders, including symptomatic disorders), and 149 patients (15%) had *ICD-10* F3 diagnoses (mood disorders). Among the patients with F0 diagnoses were 59 patients (18%) with dementia and organic amnesic syndrome (F00–F04) and 32 patients (10%) with delirium and other disorders (F05–F07). A total of 88 patients could not be admitted to general hospital psychiatric units because there were no available beds.

On the basis of the number of patients who were admitted to general hospital psychiatric units (174 patients) and the participation rate for that type of unit in the study (75%), the estimated total number of patients admitted to that type of unit during the study is 232. Also, on the basis of the number of patients who weren't able to be admitted to that type of unit (88 patients) and the participation rate (75%), the estimated total number of patients who could not be admitted to that type of unit during the study is 117. The numbers of patients admitted to general hospital psychiatric emergency units and general hospital psychiatric units specializing in medical comorbidity were ten and 142, respectively. The participation rates for both of these types of unit were 100%, and there were no patients who were not able to be admitted.

Thus a total of 501 patients needed admission over the study period, which suggests an annual total of 3,006 patients. Thus with approximately 12 million inhabitants, the incidence of medical comorbidity for which psychiatric patients should be hospitalized appears to be at least 25 per 100,000 inhabitants in Tokyo.

Although previous studies have examined comorbid medical conditions among psychiatric inpatients (1,2), these studies looked at hospitals only and did not use population-based designs (1,2). One population-based study focused only on mortality among psychiatric outpatients (3). Thus few cohort studies about hospitalization for medical comorbidities among patients with severe mental illness have been conducted. One strength of our study is that it included all psychiatric patients who lived in a defined area during the study period. A limitation is that our findings may be representative only of patients in Tokyo.

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The authors report no competing interests.

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