
References to Religion in *The Journal of Family Practice*

Dimensions and Valence of Spirituality

Frederic C. Craigie, Jr., PhD, David B. Larson MD, MSPH, and Ingrid Y. Liu, MD, MPH
Augusta, Maine, Durham, North Carolina, and Bethesda, Maryland

Several avenues of literature¹ attest to the potential importance of religion and spirituality for health and health care. Research utilizing quantitative review strategies,^{1,2} however, reveals that religious variables have received relatively little attention and unsophisticated consideration in clinical health disciplines. In an editorial accompanying two recent articles on spirituality in *The Journal of Family Practice*,^{1,3} Foglio and Brody⁴ comment on the dearth of research about religious issues in family medicine, arguing strongly on behalf of working to better understand "how vague concepts such as faith, trust, and hope actually operate in a variety of clinical settings."

Part of the difficulty in incorporating religious and spiritual factors into health care practice and research probably derives precisely from this conceptual vagueness to which Foglio and Brody allude. Before one can meaningfully evaluate the role of spirituality in health care, one must come to grips with what "spirituality" is. The issue is more than one of measurement and methodology (How will we define spirituality?); it is a more basic philosophical or psychosocial question about the types of human experience that spirituality subsumes.

Recent conceptual articles in this area^{5,6} suggest that spirituality is multidimensional, encompassing meaning (ethics, values, and principles), ceremony and sacramental activities, and social support (clergy and supportive communities) as well as "encounters with Deity."⁷

Within any or all of these dimensions, moreover, there exists the possibility of destructive as well as constructive

effects of spirituality. Craigie et al¹ argue that the interpretation of or "valence" of spirituality influences should not be assumed to be positive or negative.

As part of a program for understanding the role of religious and spiritual factors in family medicine, it is important to establish the way in which both the nature and valence of those factors have been considered. The current study builds upon the data of Craigie et al¹ in an effort to answer two questions. First, what dimensions of spirituality are reflected in religious references in the family medicine literature? Second, do those references reflect assumptions about spirituality as a positive or negative influence?

METHODS

In parallel with the study by Craigie et al,¹ all references to religious affiliations, attitudes, beliefs, or practices in articles from volumes 3 (1976) through 22 (1986) of *The Journal of Family Practice* were noted. Each religious reference was assigned to one of four categories reflecting different dimensions of spirituality: ceremony, meaning, relationship with God, and social support or influence. In addition, dimensional categories were added for the unelaborated reference to denominational affiliation and for references that were unclear. Each religious reference was also evaluated with respect to whether a positive, negative, or neutral view of the influence of spirituality was implied.

Scoring decisions for dimensions and valence of spirituality for each reference were made by the first author. Scoring of each reference for reliability purposes was performed independently by a medical student.

Submitted, revised, September 19, 1989.

From the Maine-Dartmouth Family Practice Residency, Augusta, Maine, and the Department of Psychiatry, Duke University Medical Center, Durham, North Carolina. Requests for reprints may be addressed to Frederic C. Craigie Jr., PhD, Maine-Dartmouth Family Practice Residency, 12 East Chestnut St, Augusta, ME 04330.

TABLE 1. NUMBER OF RELIGIOUS REFERENCES IN THE JOURNAL OF FAMILY PRACTICE, 1976-1986, REFLECTING DIFFERENT DIMENSIONS AND VALENCE OF SPIRITUALITY

Dimension	Valence			Total
	Positive	Negative	Neutral	
Ceremony	2	—	—	2
Meaning	1	5	9	15
Relationship with God	4	—	—	4
Social support or influence	18	—	3	21
Denomination	—	—	16	16
Other, unclear	—	4	2	6
Total	25	9	30	64

RESULTS

A total of 1086 articles were reviewed. Fifty-two articles (4.8%) contained a total of 64 references to religion or religiosity. Interrater reliability averaged 0.95 for all scoring decisions for dimension and valence. A breakdown of the dimensions and valence of spirituality reflected in these 64 references is provided in Table 1.

DISCUSSION

Results reveal that each identified dimension of spirituality was reflected in references from *The Journal of Family Practice* articles, although to varying degrees. References to social support and influence were the most frequent, followed by references to denominational affiliation, with references to meaning and purpose a close third. These findings parallel those in the review of the psychology of religion literature by Capps et al,⁸ except that Capps et al found substantial representation of "experiential" and "ritual" dimensions of spirituality, which approximate the present sparsely represented categories of relationship with God and ceremony.

It should be noted, of course, that these dimensions are not necessarily mutually exclusive. Ceremonies, for instance, may have meaning for some people because they provide a context for the experience of relating to God, or because they provide an opportunity for reflecting on meaning and values. Similarly, physicians might refer patients to clergy to offer sacraments, to help patients think through issues of meaning and values, or to mediate patients' relationships with God.

References implying a positive valence of spirituality were almost three times as frequent as references implying a negative valence. This finding is consistent with data recently presented by Koenig et al,⁹ who found that over two thirds of physicians surveyed believed that religion

has a positive effect on the mental health of older people while over 40% believed that it has a positive effect on their physical health.

The ratio of positive to negative valence varied considerably among the various dimensions, however. Most noteworthy was the predominance of references implying potentially harmful effects of spirituality within the dimension subsuming meaning, purpose, values, and beliefs. Only a single article implied a beneficial role of spiritually based attitudes or beliefs, while five articles alluded to values and beliefs that were considered to interfere with appropriate health care.

Such disparities raise the general issue of the cells with low or zero frequencies in Table 1. In view of the literature cited earlier, some cells such as "meaning and positive valence" would seem to be more important in family medical practice than the present data would indicate. Future research may clarify whether the low frequency reported here represents an accurate picture of minimally helpful religious attitudes and beliefs or whether it represents underappreciation or underreporting of potentially helpful religious attitudes and beliefs.

It may be argued, moreover, that a full understanding of the role of spirituality in medicine requires an investigation and understanding of each of the cells in Table 1. One may question, for instance, whether religiously based social support or influence always plays a beneficial role in health status and health care. Similarly, it may be evaluated empirically whether denominational affiliation may sometimes have a beneficial or harmful impact on health status or health care.

Future research might pursue a number of other directions as well. Is there empirical support for this categorization of dimensions of spirituality? In what medical contexts (disease entities, psychosocial issues, health promotion, etc) is spirituality being considered? How much of the variance in measured health care outcomes is attributable to spiritual variables? What are the variables that affect the degree of influence of spiritual variables? Greater clarity and understanding in such areas would serve to move forward with Foglio and Brody's⁴ strong recommendation to better incorporate religious and faith considerations into the practice of family medicine.

References

1. Craigie FC, Liu IY, Larson DB, Lyons JS: A systematic analysis of religious variables in *The Journal of Family Practice*, 1976-1986. *J Fam Pract* 1988; 27:509-513
2. Larson DB, Patterson DM, Blazer DG, et al: Systematic analysis of research on religious variables in four major psychiatric journals, 1978-1982. *Am J Psychiatry* 1986; 143:329-334
3. King DE, Sobal J, DeForge BR: Family practice patients' experiences and beliefs in faith healing. *J Fam Pract* 1988; 27:505-508

continued on page 480

INDICATIONS AND USAGE: HALCION Tablets are indicated in the short-term management of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings. It is recommended that HALCION not be prescribed in quantities exceeding a one-month supply.

CONTRAINDICATIONS: Patients with known hypersensitivity to this drug or other benzodiazepines.

HALCION is contraindicated in pregnant women due to potential fetal damage. Patients likely to become pregnant while receiving HALCION should be warned of the potential risk to the fetus.

WARNINGS: Overdosage may occur at four times the maximum recommended therapeutic dose. Patients should be cautioned not to exceed prescribed dosage.

Because of its depressant CNS effects, patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and also about the simultaneous ingestion of alcohol and other CNS depressant drugs.

Anterograde amnesia and paradoxical reactions have been reported with HALCION and some other benzodiazepines.

PRECAUTIONS: General: In elderly and/or debilitated patients, treatment should be initiated at 0.125 mg to decrease the possibility of development of oversedation, dizziness, or impaired coordination. Some side effects, including drowsiness, dizziness, lightheadedness, and amnesia, appear to be dose related.

Some evidence suggests that confusion, bizarre or abnormal behavior, agitation, and hallucinations may also be dose related, but this evidence is inconclusive. It is recommended that therapy be initiated at the lowest effective dose. Caution should be exercised in patients with signs or symptoms of depression which could be intensified by hypnotic drugs. Suicidal tendencies and intentional overdosage is more common in these patients. The usual precautions should be observed in patients with impaired renal or hepatic function and chronic pulmonary insufficiency.

Information for Patients: Alert patients about: (a) consumption of alcohol and drugs, (b) possible fetal abnormalities, (c) operating machinery or driving, (d) not increasing prescribed dosage, (e) possible worsening of sleep after discontinuing HALCION.

Laboratory Tests: Not ordinarily required in otherwise healthy patients. **Drug Interactions:** Additive CNS depressant effects with other psychotropics, anticonvulsants, antihistaminics, ethanol, and other CNS depressants. Pharmacokinetic interactions of benzodiazepines with other drugs have been reported, e.g., coadministration with either cimetidine or erythromycin approximately doubled the elimination half-life and plasma levels of triazolam, hence increased clinical observation and consideration of dosage reduction may be appropriate.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of carcinogenic potential was observed in mice during a 24-month study with HALCION in doses up to 4000 times the human dose.

Pregnancy: Benzodiazepines may cause fetal damage if administered during pregnancy. The child born of a mother who is on benzodiazepines may be at some risk for withdrawal symptoms and neonatal flaccidity during the postnatal period.

Nursing Mothers: Administration to nursing mothers is not recommended. **Pediatric Use:** Safety and efficacy in children below the age of 18 have not been established.

ADVERSE REACTIONS: During placebo-controlled clinical studies in which 1003 patients received HALCION Tablets, the most troublesome side effects were extensions of the pharmacologic activity of HALCION, e.g., drowsiness, dizziness, or lightheadedness.

	HALCION	Placebo
Number of Patients	1003	997
% of Patients Reporting:		
Central Nervous System		
Drowsiness	14.0	6.4
Headache	9.7	8.4
Dizziness	7.8	3.1
Nervousness	5.2	4.5
Lightheadedness	4.9	0.9
Coordination Disorder/Ataxia	4.6	0.8
Gastrointestinal		
Nausea/Vomiting	4.6	3.7

In addition, the following adverse events have been reported less frequently (i.e., 0.9-0.5%): euphoria, tachycardia, tiredness, confusional states/memory impairment, cramps/pain, depression, visual disturbances.

Rare (i.e., less than 0.5%) adverse reactions included constipation, taste alterations, diarrhea, dry mouth, dermatitis/allergy, dreaming/nightmares, insomnia, paresthesia, tinnitus, dysesthesia, weakness, congestion, death from hepatic failure in a patient also receiving diuretic drugs.

The following adverse events have been reported in association with the use of HALCION and other benzodiazepines: Amnesic symptoms, confusional states, dystonia, anorexia, fatigue, sedation, slurred speech, jaundice, pruritus, dysarthria, changes in libido, menstrual irregularities, incontinence and urinary retention.

Other events reported include: Paradoxical reactions such as stimulation, agitation, increased muscle spasticity, sleep disturbances, hallucinations, aggressiveness, falling, somnambulism, inappropriate behavior, and other adverse behavioral effects. Should these occur, use of the drug should be discontinued.

No laboratory changes were considered to be of physiological significance. When treatment is protracted, periodic blood counts, urinalysis and blood chemistry analyses are advisable.

Minor changes in EEG patterns, usually low-voltage fast activity have been observed in patients during HALCION therapy and are of no known significance.

DRUG ABUSE AND DEPENDENCE: Controlled Substance: HALCION Tablets are a Controlled Substance in Schedule IV. **Abuse and Dependence:** Withdrawal symptoms have occurred following abrupt discontinuance of benzodiazepines. Patients with a history of seizures are at particular risk. Addiction-prone patients should be closely monitored. Repeat prescriptions should be limited to those under medical supervision.

OVERDOSAGE: Because of the potency of triazolam, overdosage may occur at 2 mg, four times the maximum recommended therapeutic dose (0.5 mg). Manifestations of overdosage include somnolence, confusion, impaired coordination, slurred speech, and ultimately, coma. Respiration, pulse, and blood pressure should be monitored and supported by general measure when necessary. Immediate gastric lavage should be performed. Multiple agents may have been ingested.

Store at controlled room temperature 15°-30°C (59°-86° F). **B-5-S**
Caution: Federal law prohibits dispensing without prescription.

J-9271
 September 1988
 Printed in USA

DIMENSIONS OF SPIRITUALITY

continued from page 478

- Foglio JP, Brody H: Religion, faith, and family medicine. *J Fam Pract* 1988; 27:473-474
- Sevensky RL: Religion and illness: An outline of their relationship. *South Med J* 1981; 74:745-750
- Levin JS, Schiller PL: Is there a religious factor in health? *J Relig Health* 1987; 26:9-36
- Garrett WR: Reference groups and role strain related to spiritual well-being. *Soc Anal* 1979; 40:43-58
- Capps D, Ransohoff P, Rambo L: Publication trends in the psychology of religion to 1974. *Sci Stud Relig* 1976; 15:15-28
- Koenig HG, Bearon LB, Dayringer R: Physician perspectives on the role of religion in the physician-older patient relationship. *J Fam Pract* 1989; 28:441-448