References to Religion in *The Journal of Family Practice*

Dimensions and Valence of Spirituality

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Several avenues of literature[1] 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 Brody[4] 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 al[1] 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 al[1] 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.

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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's[4] strong recommendation to better incorporate religious and faith considerations into the practice of family medicine.

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continued on page 480

continued from page 478

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