Larson Explores Role of Faith in Health

Interview with David B. Larson of the National Institute for Healthcare Research

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By Stephen Goode

David Larson of the National Institute for Healthcare Research has pioneered investigation of the connection of spirituality to health, which long has been ignored by the medical community.

David Larson is president of the National Institute for Healthcare Research, or NIHR, a Washington-area think tank founded in 1991 to bridge "the gap between spirituality and health." The group acts both as a catalyst and as a clearinghouse for research on this important relationship.

It's an area of research that's growing rapidly, says Larson, a psychiatrist and epidemiologist. What fascinating is the number of professional studies now showing that religion is good for your health. What the numerous studies collected and sponsored by NIHR affirm is that patients overwhelmingly wish their physicians would consider their spiritual needs, something that many physicians have been reluctant to do.

NIHR studies also show that participation in religious worship can reduce stress, decrease the potential for addiction disorders, high blood pressure and cancer and reduce psychiatric symptoms in those suffering from mental disorders. Moreover, Larson tells Insight, NIHR has found that prayer and religious commitment can improve recovery rates and shorten the length of a patient's hospitalization.

Insight: What got you personally interested in the mind-body connection and the importance of religious faith?

David B. Larson: The spiritual side of it. When I was a medical student, "mind-body" wasn't even a term that was there. I was in my psychiatric training in North Carolina looking at environmental or cultural issues. I'd become a marriage-family therapist, very unusual for an M.D. But what had become a very obvious thing to me was that people's families, their marriages, sometimes even their neighborhoods -- their environments -- were very important factors -- factors I was interested in.

The thing I saw in my North Carolina patients- the state is part of the Bible Belt -- was that they would use religious language. I can't say it was always in the healthiest way -- a lot of times it wasn't -- but there was no place for that in psychiatry. I didn't know what to say. If they cursed, I understood that. But if they brought up the name of God or Christ, say in a prayer, I would ask myself, "What do I do with this?" When I raised it with my colleagues, they said, "Don't do anything -- that's off-limits."

I'll never forget this one patient. She had problems, but there was something different about her. There was something good about the role religion played in her life, and that surprised me. Sometimes she would be very guilty because of her religion, but it was also a resource, something that gave her strength and an identity.

Sometimes the effect of her faith was neutral but sometimes you could see it helping her. Sometimes you could see her religion enabling her to say, "I can see I have this problem." She hadn't grown up religious and had never had a faith until recently.

Insight: What surprised you was the positive, creative role religion played in her life?

DBL: That's the stow. In the seventies, among my colleagues, religion was a place where psychiatry didn't go. Religion was harmful. Religion was something that made for abusive males who had sex with their children. It made for hypocrisy.

I had come across an article from the 1950s by a prominent psychoanalyst who wrote about patients who had religious experiences while under his care and it helped speed up their therapy. But for my colleagues in the seventies the assumption was that religion was something people talked about while filled with animus and foaming at the mouth.

Insight: What does cutting-edge research say about how faith and spirituality help our mental and physical health?

DBL: In the Western tradition it does look like those people who are religious and have some type of regular involvement with their religious community can be contributing to better health outcomes.

You can't explain it totally, but there are important things going on. There's social support, for example, so if you're feeling stress and you need help, people in your community will reach out and help you.

Belief adds to your ability to handle coping. It also changes your lifestyle, and it may add other benefits as well, such as being more committed to your family and to your spouse. Belief gives you a worldview to handle stress. Catastrophic events can bring on so much stress in your life that you end up with illness, so the ability to handle that stress with a worldview that reinterprets it in a way that lets you say, "God is teaching me through this ..." is beneficial.

What I might view from one side as pain and suffering is from God's side an opportunity for us to be closer to Him. If the situation is reinterpreted as something where I get to know God in a better way, or as a situation which deepens my spiritual life, that's taking the cutting edge off the stress.

One study shows generally that people add seven years to their lives simply by regular attendance at church or synagogue or mosque. For African-Americans alone, the figure is 14 years. That's not small.

A Muslim neurosurgeon put it eloquently: He had heard we were a very religious nation, but then he saw that most American doctors, when their patients would bring up God, would change the subject or walk out in embarrassment. A neurosurgical event can be very traumatic and this Muslim doctor didn't think it was sensitive to ignore spiritual need, so he would say: "Let's get your spiritual adviser in on this" or "Would you be willing to see a chaplain?"

Insight: Traditional religious figures such as chaplains are an important part of the healthcare system?

DBL: The beauty about chaplains is that they know how to respond to death. Yet you now see chaplains being removed from hospitals. Why? Because they're "research deficient" in an age in which it is research that must be cited to confirm even the "obvious." These people know about comforting the frightened, sick, dying and grief-stricken. I never learned in school about how to handle death and dying. No one taught me about it. Research was needed.

Insight: So a person's attitude in times of stress such as a health crisis or family death should be that he's going to draw on his faith as a resource?

DBL: The attitude that makes things worse is a concrete, rigid belief that God is going to fix things. When a person says, "I have a problem, but I know God's going to fix me," look out. That's a type of coping that tends to create problems. The type of coping that seems to help is when a person sees himself in a collaborative venture with God: "I'm working on this together with God and I'm learning things through

this experience." Another type of coping that is helpful is the attitude, "God's will be done. I'm going to trust Him through all this."

Insight: You've written that there were only three medical schools in 1994 that offered courses on religious and spiritual issues affecting health care. Now half of them do. Were you surprised at the rapidity of the change?

DBL: I never expected this. I was told, "Good luck, the medical schools are jammed and there's no room for anything else." It's not that my generation was interested; it's that the next generation is. I think that's what's happening in medical school right now: They're not religious people, exactly; they're interested in spirituality more than religion.

Insight: NIHR's studies about religion and well-being are professional and scientific, which may be one reason the medical community now is more accepting of the importance of faith and spirituality to health.

DBL: We've always had a lot of people asking us, "Are you religious? It's an interesting question because the politically correct assumption is that if you're religious you're a bigot and you'll distort the research. I always point out that when we started to look at gender issues we didn't tell women that they couldn't be objective about this because they were women; we didn't tell them we need only men to look at these issues. The same with minorities and minority issues. So why exclude the religious when we're talking about religion? Indeed, it's the religious who can perhaps bring a true understanding of what religion does, not the atheist or the agnostic.

Insight: How do you handle religious faith when you realize it's important to a patient?

DBL: You ask, "Well how would you like me to address it?" when you see religion is important to them. They may say, "Doc, you don't have to address it again -- all I wanted to hear was a word from you that you understood the importance of my faith." We're not talking here about the doc giving a theological sermon! We're talking about respecting the importance of their religion and their culture when people are in crisis. When you realize that religion is high up on the list of things that give them hope, how can you do otherwise?

Personal Bio

David B. Larson: The mind-body analyst with his daughter Kristen.

Currently: Psychiatrist and president of the National Institute for Healthcare Research.

Born: March 13, 1947, Glen Ridge, N.J. Episcopalian.

Family: Wife, Susan; children, Kristen and Brad.

Education: B.S., Drexel University; M.S., Temple University Medical School; master of science in public health and epidemiology, University of North Carolina.

Career: Senior researcher, National Institutes of Health, for 10 years. Now, adjunct professor, psychiatry and behavioral sciences, at Duke University Medical Center and Northwestern University Medical School. Adjunct professor of preventative medicine and biometrics at the Uniformed Services University of the Health Sciences in Bethesda, Md.

Publications: More than 200 professional articles in leading journals. Coauthor with wife, Susan, of The Forgotten Factor in Physical and Mental Health, published by NIHR.