Religion/Spirituality and Depression

To the Editor: The editorial by Dan Blazer, M.D., Ph.D., in the January issue (1) deserves commendation for highlighting an important issue we tend to avoid. Depression is a leading cause of disability worldwide, and in light of high rates of insufficient response to antidepressants, nonpharmacological treatment approaches should be more fully explored and implemented.

Dr. Blazer's editorial raises the question of how a psychiatrist should incorporate an assessment of the patient's religion and spirituality into the overall clinical evaluation. Although reimbursement limitations and other practical considerations are typically blamed for the limited discussion of these issues, there may be other reasons as well. Studies have shown, for example, that psychiatrists are less religious and show less religious affiliation relative to their patients or to the population in general (2–4). Omitting an assessment of the patient's religious views and spirituality, however, can result in deeply misunderstanding the patient's values and preferences.

Today we acknowledge that faith, belief, and trust strengthen the backbone of psychological well-being. Religious and spiritual beliefs and values can influence the course of psychiatric disorders. Rapprochement may best be achieved by raising psychiatric awareness and knowledge of the basic concepts of religion and spirituality and by having a willingness to embrace intellectual, cultural, and religious pluralism (5). The need for understanding has never been greater than at present, when our world's very survival is threatened by conflicts associated with the clash of cultures and values.

This article highlights the importance of providing such knowledge to psychiatrists in training. Our patients, our profession, and ultimately our world stand only to gain from such increased understanding.

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The Flight From Primary Care in Psychiatry

To the Editor: I read with interest the article by Samuel F. Law, M.D., F.R.C.P.C., and colleagues in the December issue (1) and applaud the initiative. We would like to point out that primary mental health care is lacking in other Asian countries too, but for reasons other than political. In Singapore, an urban city-state in Southeast Asia with a population of 5.18 million, these reasons are rooted in a rapid development and expansion of health care services. A rapid shift to medical specialization and subspecialization and increasing health care consumerism for specialized care have drawn patients away from primary health care to readily available specialist care at tertiary centers. While initially not undesired, the shift has gradually taken a toll on primary care physicians. In psychiatry, the gradual erosion of expertise and clinical skills in dealing with mental health issues has left primary care physicians reluctant and sometimes unwilling to handle even minor psychiatric problems. The population also continued to seek help for mental health issues from faith healers and from the nonmedical community.

In Singapore, major efforts have been made to remedy the situation, with postgraduate training programs for primary care physicians and allied health professionals and the setup of general practitioner partnership programs that allow for a two-way flow of patients for more appropriate allocation of care. Additionally, public health efforts to reduce stigma associated with mental illness have also been expanded.

Beyond this, recent calls to review undergraduate training and the relevance of clinical training in psychiatry should be heeded. Much can be done during early medical training to provide necessary skills for lifelong learning and change the attitudes of our medical students for their future practice (2–4).

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Response to Mahendran Letter

To the Editor: We thank Dr. Mahendran's attention to this concerning topic, as one of our goals for the article was to point out how psychiatric training and competence are sorely missing in a growing number of primary care physicians around the world for a diverse range of reasons. In China, this has been largely because of historical, political, and resource-limitation reasons, most notably for singling out psychiatry as a nonpriority in the delivery of a shorter, less intensive rural physician training program. The attendant significant negative impact over the years on the mental health of the coun-