



Figure 1 A) Axial computed tomographic image (soft-tissue algorithm) showing a hypoattenuating lesion involving the genu of the corpus callosum. B-D) Brain magnetic resonance images: B) sagittal, T2-TSE; C) axial, diffusion-weighted imaging (DWI); D) axial, T2-FLAIR. Hyperintense lesions involving the entire corpus callosum were seen on T2-TSE and T2-FLAIR sequences. The same lesions were also hyperintense on DWI, with a low apparent diffusion coefficient reflecting restricted diffusion.

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Spirituality or religiosity: is there any difference?

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We read with interest the letter published by Dr. Abayomi¹ concerning our article entitled “Religious beliefs and alcohol control policies: a Brazilian nationwide study.”² We agree that cultural values, personality, and stressful

life events can have an important influence on alcohol use. In our study, the population was predominantly composed by Catholics (67.3%), followed by Evangelical Protestants (23.3%). These religious affiliations usually have stronger opinions regarding public policy than do other religious traditions, including advocating for more restrictive alcohol policies.² There are distinct differences in alcohol use between religious traditions, as we reported in a recent article.³ For instance, Afro-Brazilian religions (i.e., Umbanda) utilize alcohol in their rituals, whereas some Brazilian Protestant Evangelicals forbid its use entirely, whether for religious or non-religious purposes.

With regard to the concepts of spirituality and religiosity and their measurement, we agree that these are distinct constructs, sometimes difficult to distinguish. According to Koenig et al.,⁴ spirituality is “the personal quest for understanding answers to ultimate questions about life, about meaning and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.” Several authors have examined relationships between spirituality, religiosity, and mental health, with varying results. For example, King et al.⁵ investigated associations between a spiritual or religious understanding of life and psychiatric symptoms in 7,403 people in England. They found religious people were similar to those who were neither religious nor spiritual

with regard to the prevalence of mental disorders, except that those who were religious were less likely to have ever used drugs or to be a hazardous drinker. On the other hand, spiritual people were more likely than those who were neither religious nor spiritual to have ever used or to be dependent on drugs and to have abnormal eating attitudes, generalized anxiety disorder, any phobia, or any neurotic disorder. Furthermore, Laurent et al.⁶ found that those who indicated that they were spiritual but not religious in the UK were nearly three times more likely to develop an episode of major depressive disorder during a 12-month follow-up period compared to those who were neither religious nor spiritual (OR 2.73, 95%CI 1.59-4.68).

In contrast, in a much smaller study, Farias et al.⁷ compared modern spiritual individuals (n=114) with traditional religious believers (n=86) in England. The authors found anxiety, depression, and insecure attachment were not significant predictors of spirituality. The results of this study also revealed that spiritual believers reported high satisfaction with social support, with this variable predicting involvement in modern spirituality. Furthermore, spiritual practices correlated negatively with death anxiety scores. These conflicting results are not easy to reconcile. First, since all these studies were conducted in the United Kingdom, cultural context would not seem to play a significant role. Second, as only one study⁶ actually followed participants over time, the other two cross-sectional studies provide no information about the time sequence. Third, important psychiatric outcomes such as depression and anxiety were addressed in both studies. Some major differences between these three studies also warrant mention. The instruments used to assess religiosity/spirituality and mental health were different, which could help to explain the varying results; the enrollment of patients was diverse (two nationwide studies vs. one convenience sample); and the same psychiatric outcomes were not assessed in all three studies.

In view of these findings, more research needs to be done comparing those who are religious and spiritual with those who are spiritual but not religious in a variety of locations and cultural settings to elucidate the role that spiritual and religious beliefs play in mental health and substance use.

Giancarlo Lucchetti,^{1,2,3} Harold G. Koenig,^{4,5}
Ilana Pinsky,⁶ Ronaldo Laranjeira,⁶ Homero Vallada⁷

¹Department of Medicine, Universidade Federal de Juiz de Fora (UFJF), Juiz de Fora, MG, Brazil. ²Hospital João Evangelista (HOJE), São Paulo, SP, Brazil. ³Associação Médico-Espírita Internacional, São Paulo, SP, Brazil. ⁴Duke University Medical Center, Durham, North Carolina, USA. ⁵King Abdulaziz University, Jeddah, Saudi Arabia. ⁶Department of Psychiatry, Universidade Federal de São Paulo (UNIFESP), São Paulo, SP, Brazil. ⁷Department of Psychiatry, Universidade de São Paulo (USP), São Paulo, SP, Brazil

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Disclosure

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Edgar Allan Poe's psychic daguerreotype

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Recently made freely accessible by the J. Paul Getty Trust and Museum in Los Angeles, the famous “Annie” daguerreotype of Edgar Allan Poe (Figure 1) invites introspection about the author's personality and mental illnesses.

Poe was an author, poet, editor, and literary critic, part of the American Romantic movement. Known for his tales of mystery and the macabre, he is considered the inventor of detective fiction.^{1,2} However, he is also known for his troubled mind, beset by alcoholism and bipolar affective disorder.^{1,2}

A pioneering author who tried to earn a living through writing alone, Poe led a life of hardship and some professional unpleasantnesses.^{1,2} This suffering always influenced his work and is present throughout his masterpieces, as he wrote in *The Fall of the House of Usher*: “It was, he said, a constitutional and a family evil, and one for which he despaired to find a remedy.”

Bipolar affective disorder is characterized by high rates of morbidity and disability and may be misdiagnosed as major depressive disorder in some settings.^{3,4} Alcoholism is a chronic remitting and relapsing condition and remains a serious cause of morbidity and mortality, despite progress in identifying new pharmacological strategies for its treatment through neurobiological research.^{5,6}

The “Annie” daguerreotype was taken by Mrs. Anne Richmond, a friend of Poe, and shows him in plain, pedestrian attire, unkempt, with a vacant look, mixing surprise and untidiness, disclosing a depressive mood and suffering.

João R. de Oliveira,¹ Matheus F. Oliveira²
¹Neuropsychiatric Department, Universidade Federal de Pernambuco (UFPE), Recife, PE, Brazil. ²Neurosurgery Residency Program, Hospital do Servidor Público Estadual de São Paulo, São Paulo, SP, Brazil

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