

CROSSROADS...

Exploring research on religion, spirituality and health

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This newsletter provides updates on research, news and events related to spirituality and health, including educational resources and funding opportunities. **Please forward to colleagues or students who might benefit.** Our goal is to create a community of researchers, clinicians, clergy, and laypersons interested in spirituality and health and keep them informed and updated. An EVENTS CALENDAR concludes the newsletter and describes spirituality and health related presentations happening at Duke and around the world. This is your newsletter and we depend on you to let us know about research, news, and events in this area.

All e-newsletters are archived on our website. To view previous editions (July 2007 through Sept 2015) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

LATEST RESEARCH OUTSIDE DUKE

Religious Participation and Depression in Europe

Studies from United Kingdom and Europe during the past 5 years have reported mixed results concerning on the relationship between religious involvement and depression. The present study is one of the largest and longest prospective studies of religious participation and depressive symptoms from continental Europe. Researchers from the department of public health at Erasmus MC, University Medical Center in the Netherlands, report the results from a 4-year study of 9,068 persons aged 50 or older participating in the Survey of Health, Ageing and Retirement in Europe (SHARE). Ten countries participated from Northern Europe (Sweden and Denmark), Southern Europe (Italy and Spain), and Western Europe (Austria, Belgium, France, Germany, Switzerland, the Netherlands). Participants were asked if they engaged in: (1) voluntary or charity work, 2) educational or training courses, 3) sports, social club, or other kinds of club activities, 4) participation in religious organizations, and (5) participation in political or community organizations (response options ranged from 'almost daily' to 'less often than monthly'). Depressive symptoms were assessed with the 12-item EURO-D that asked about the usually symptoms associated with depressive disorder. Analyses controlled for education, region, marital status, household size, employment status, financial status, self-rated health, long-term health problems, activities of daily living, and physician-diagnosed illnesses. Fixed-effects models were used to assess whether changes in social participation predicted changes in depressive symptoms during a 4-year follow-up from 2006/2007 to 2010/2011. **Results:** Only participation in religious activities (which had a prevalence of only about 10%) predicted a decrease in depressive symptoms over time ($B=-0.190$, 95% CI= -0.365 to -0.016). In fact, participation in political or community organizations predicted an *increase* in depressive symptoms ($B=0.222$, 95% CI= 0.018 to 0.428). Researchers concluded that "Participation in religious organizations may offer mental health benefits beyond those offered by other forms of social participation."

Citation: Croezen S, Avendano M, Burdorf A, van Lenthe FJ (2015). Social participation and depression in old age: A fixed-effects analysis in 10 European countries. *American Journal of Epidemiology* 182 (2):168-176.

Comment: Remarkable findings from secular Europe. This study prompted the following headlines on August 14th in the *Washington Post*: "Want 'sustained happiness'? Get religion, study suggests." Unfortunately, the study did not measure happiness.

Why Not-Believing in God (With Others) is Good for You

Luke Galen from the department of psychology at Grand Valley State University in Allendale (U.S.) argues that the mechanisms of the association between religiosity and health derives largely from factors other than belief. Instead, the benefits of religious involvement come primarily from social engagement and embeddedness in supportive in-groups. Non-belief and secular worldviews can also be practiced in social groups such as atheist, humanist, and freethought organizations. He cites literature indicating that socially engaged nonbelievers have similar outcomes as socially engaged believers, and notes that nonbelievers have an advantage over believers in that they are more likely to have outgroup tolerance and advocate for moral universalism. Galen concludes that "there is no compelling evidence that lacking a belief in God itself is detrimental."

Citation: Galen L (2015). Atheism, wellbeing, and the wager: Why not believing in God (with others) is good for you. *Science, Religion & Culture* 2(3):54-69.

Comment: This is a good presentation of the argument that religious belief itself does not have substantial benefits beyond those obtained from social interaction and group membership. There are weaknesses, however, in the logic and the research cited. In particular, the evidence base for socially engaged nonbelievers having similar outcomes as socially engaged believers is poor. The argument is grounded largely on research suggesting that religious persons volunteer more for religious organizations, and that volunteering for secular organizations is similar between believers and non-believers. It is not surprising that religiosity is associated with volunteering for religious groups since that is what is important to religious people and such volunteering opportunities easily accessible and encouraged. Nor is it surprising that non-believers are more likely to volunteer for secular groups, since that is their preference and they don't really have other options (like religious individuals have). Furthermore, there is growing evidence that involvement in religious social activity has health benefits above and beyond those from involvement in non-religious social activity, even in Europe (see Croezen et al study above). The claim that the health benefits of religion derive primarily from social involvement is also overstated. While one of mechanism by which religiosity affects health is through social engagement, it is not the only mechanism or necessarily the primary one. We and others have found that social factors explain only about 15-25% of the effect that religiosity has on mental and physical health (with health behaviors and cognitive factors making up the balance).

EXPLORE...in this issue

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5-7 SPECIAL EVENTS & RESOURCES

7 FUNDING Opportunities & CALENDAR

Religion, Spirituality and Social Health in Cancer Patients: A Meta-Analysis

Investigators at the Rockefeller Cancer Institute at the University of Arkansas (Little Rock) analyzed data from 78 independent samples involving 14,277 patients to determine if there is a relationship between religion/spirituality (R/S) and social health in cancer patients. Social health was defined as involvement in social roles, relationships or activities, and the perceived quality of that involvement. Three domains of social health were examined: social well-being (favorable social interactions), low social distress (few conflicting or unsatisfying social relationships), and social support (perceived quality of emotional or instrumental assistance received). The dimensions of R/S examined were affective (spiritual well-being or connection to the sacred), behavioral (religious service attendance, prayer, meditation, religious coping), and cognitive (importance of R/S, religious motivation, specific R/S beliefs, images of God, etc.). **Results:** Social health was positively associated with R/S, with effect sizes (z) being 0.20 for overall R/S ($p < 0.001$), 0.31 for affective R/S ($p < 0.001$), 0.10 for cognitive R/S ($p < 0.01$), and 0.08 for behavioral R/S ($p < 0.05$). Sociodemographic and clinical variables (i.e., gender, age, race, geographical region, type of malignancy, stage, or phase of treatment/recovery) did not moderate these relationships. Researchers concluded that their findings "...suggest that several R/S dimensions are modestly associated with patients' capacity to maintain satisfying social roles and relationships."

Citation: Sherman AC, Merluzzi TV, Pustejovsky JE, Park CL, George L, Fitchett G, Jim HS, Munoz AR, Danhauer SC, Snyder MA, Salsman JM (2015). A meta-analytic review of religious or spiritual involvement and social health among cancer patients. *Cancer*, Aug 10 [Epub ahead of print]

Comment: Not surprising, but it is important to have these relationships systematically documented for cancer patients.

Religion, Spirituality and Physical Health in Cancer: A Meta-Analysis

Researchers at Moffitt Cancer Center in Tampa, Florida, together with co-investigators from multiple U.S. universities, conducted a meta-analysis involving studies that examined the relationship between religion/spirituality (R/S) and physical health outcomes in cancer patients. The meta-analysis involved 497 effect sizes from 101 unique samples involving more than 32,000 adult cancer patients. Data were analysed using generalized estimating equations with robust variance estimation. **Results:** Overall R/S was associated with better physical health ($z = 0.153$, $p < 0.001$). Affective R/S (spiritual well-being, absence of spiritual distress) was associated with physical well-being ($z = 0.167$, $p < 0.001$), functional well-being ($z = 0.343$, $p < 0.001$), and physical symptoms ($z = 0.282$, $p < 0.001$). Cognitive R/S (religious beliefs, spiritual growth) was associated with physical well-being ($z = 0.079$, $p < 0.05$) and functional well-being ($z = 0.090$, $p < 0.01$). Other R/S aspects (composite R/S, other religious measures) were associated with functional well-being ($z = 0.100$, $p < 0.05$). Sociodemographic or clinical variables did not moderate these relationships.

Researchers concluded that, "greater R/S is associated with better patient-reported physical health. These results underscore the importance of attending to patients' religious and spiritual needs as part of comprehensive cancer care."

Citation: Jim HS, Pustejovsky JE, Park CL, Danhauer SC, Sherman AC, Fitchett G, Merluzzi TV, Munoz AR, George L, Snyder MA, Salsman JM (2015). Religion, spirituality, and physical health in cancer patients: A meta-analysis. *Cancer*, Aug 10 [Epub ahead of print]

Comment: The authors indicate that this is the first meta-analysis of R/S and patient-reported physical health in cancer patients. The

results confirm what many clinicians have suspected for a long time.

Does Religion Deserve a Place in Medicine?

The "pro" view

Writing in the *Journal of Medical Ethics* (British), Nigel Biggar from the theological faculty at Oxford University argues that 'secular medicine' should not exist, at least in the way that the term 'secular' is often used today. Secularity does not necessarily mean a religion-free space (as often interpreted within mainstream medicine), but rather a 'forum for the negotiation of rival reasonings.' Biggar explains that religion is not simply 'irrational.' As an example, he argues that Christianity offers reasonable views of human beings that bear upon medicine and that such views should be tolerated and heard. These views provide considerable support for a humanist view of human dignity, the importance of social obligation, and a special concern for the weak and vulnerable.

Citation: Biggar N (2015). Why religion deserves a place in secular medicine. *Journal of Medical Ethics* (British Medical Journal) 41:229-233

Comment: An articulate and logical presentation of why religion should not be excluded from medicine.

Does Religion Deserve a Place in Medicine?

The "con" view

Brian Earp, from the Center for Practical Ethics at Oxford University, responds to Nigel Biggar's opinion piece above. Earp stresses that religion should not play a role in shaping secular health policy, and provides examples of dangers that may arise when it does so, particularly when it involves abortion, contraception, end-of-life decisions, and over-reaches a bit by including discrimination against gays and lesbians. He claims that Biggar's argument is based more on moral philosophy than on religion.

Citation: Earp BD (2015). Does religion deserve a place in secular medicine? *Journal of Medical Ethics* (British Medical Journal), June [E-pub ahead of print]

Comment: This is a marvelous exchange over a complex topic between two very scholarly individuals in a British setting.

Sense of "Calling" in Medicine

Sense of calling has received increasing interest as a motivating factor among physicians to help sustain meaning and purpose during demanding work that involves long hours and intense focus. Investigators from the department of medicine at the University of Chicago analyzed data from a stratified national random sample of 1,208 primary care physicians (PCPs, $n = 896$) and psychiatrists ($n = 312$) to determine the extent to which these physicians felt their practice of medicine was a calling. Participants were asked to rate their agreement or disagreement with the statement: "For me, the practice of medicine is a calling" (with response options being 'strongly agree,' 'agree somewhat,' 'disagree somewhat,' and 'disagree strongly'). PCPs and psychiatrists were compared in this regard, and predictors in each group were examined. **Results:** Among PCPs, 40% 'strongly agreed' that their practice of medicine was a calling, compared to 42% of psychiatrists who strongly agreed. In addition, similar percentages indicated they 'somewhat agreed' (43% of PCPs and 39% of psychiatrists). Thus, only 17% of PCPs and 20% of psychiatrists disagreed (5% 'strongly disagreed' in both groups). Predictors of 'strong agreement' among PCPs were religious affiliation (evangelical Protestant and Muslim, in particular), frequent religious attendance, importance of religion, high intrinsic religiosity, and moderate or high spirituality (analyses were controlled for age, gender, region, race, and immigration history). Among

psychiatrists, a strong sense of calling was predicted by similar religious/spiritual characteristics.

Citation: Yoon JD, shin JH, Nian AL, Curlin FA (2015). Religion, sense of calling, and the practice of medicine: Findings from a national survey of primary care physicians and psychiatrists. *Southern Medical Journal* 108:189-195

Comment: This is the first study, to our knowledge, to examine a sense of calling among a relatively large random sample of US physicians. Over 80% of both primary care physicians and psychiatrists indicated that they were motivated by this to at least some degree. While psychiatrists have been reported to be less religious/spiritual than other physicians, such a pattern did not emerge in the present study. The proportion of PCPs and psychiatrists who indicated their practice of medicine resulted from a sense of calling was almost identical.

Religion, Spirituality and Medicine: The Hidden Curriculum

Investigators at the Dana Farber Cancer Institute in Boston conducted qualitative interviews with 33 medical students and faculty (76% students) at Harvard Medical School “to explore the role of religion and spirituality as they intersect with aspects of medicine’s hidden curriculum.” By ‘hidden curriculum’ they mean the process by which medical training socializes the trainee through habitualization, institutional practices, knowledge, and viewpoints that make physicians act with little reflection. Semi-structured, one-on-one interviews and focus groups were conducted in the latter half of 2013 to assess student and faculty experiences regarding religion/spirituality (R/S) and the process of forming students into health professionals during their medical training. Recruited were students and faculty from a range of spiritual backgrounds, races, gender, and specialty interests; chain-referral sampling was also used to identify study participants. **Results:** R/S emerged within three domains of medical training: (1) challenges and benefits related to R/S in relationship to the hidden curriculum (non-religious/non-spiritual participants indicated more emotional stress, diminished compassion, difficulty finding work-life balance, and difficulty dealing with relationship strife; religious/spiritual participants were more likely to experience challenges to their personal identity); (2) ways that medical students coped in response to patient suffering (non-religious/non-spiritual participants were more likely to indicate less mature repressive coping and compartmentalization strategies to deal with powerful experiences/emotions); and (3) the fluctuation of the student’s R/S during medical training (many students [n=10] experienced an increase in R/S, fewer students [n=5] experienced a decrease, and the remaining [n=7] indicated no change). Researchers concluded that R/S might play an important role in medical student socialization, and there was need for further systematic study of this issue.

Citation: Balboni MJ, Bandini J, Mitchell C, Epstein-Peterson ZD, Amobi A, Cahill J, Enzinger AC, Peteet J, Balboni T (2015). Religion, spirituality, and the hidden curriculum: Medical student and faculty reflections. *Journal of Pain & Symptom Management*, May 27 [Epub ahead of print]

Comment: While there were only a few participants (n=11) who indicated that they were not religious or spiritual, these individuals appeared to have the hardest time in medical school compared to those who were more religious/spiritual (n=22). Surprisingly, more participants experienced an increase than a decrease in religiosity/spirituality during their medical school training. Further research will be needed to determine if these findings are true for students and faculty at other medical schools (or at Harvard Medical School more generally, given the way that participants were recruited).

Why Religion Needs a Seat at the Psychotherapy Table

In the June issue of the *Bulletin of the Society for the Advancement of Psychotherapy*, psychologist Michelle J. Pearce writes about integrating religion into psychotherapy. She addresses questions such as “Does religion belong in psychotherapy?”; “What challenges do therapists face in clinical practice, where therapists are a lot less religious than clients?” “How does the therapist address this challenge?” “Why does the therapist need to know about religion?” “Does talking about religious beliefs and practices in therapy actually help to alleviate mental health problems?” and “What exactly is religiously-integrated CBT for depression?”

Citation: Pearce, M. J. (2015, June). Why religion needs a seat at psychotherapy’s table. [Web article]. Retrieved from <http://www.societyforpsychotherapy.org/why-religion-needs-a-seat-at-psychotherapys-table>

Comment: Dr. Pearce led the development of the religiously-integrated CBT manuals used in the Duke Center’s recent randomized clinical trial that pitted religiously-integrated CBT against conventional CBT in the treatment of major depression in persons with chronic medical illness (<http://www.spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals>).

Are Psychiatric Patients Interested in a Spiritual Approach to Treatment?

David Rosmarin and colleagues at McLean Hospital (Harvard) in Boston surveyed 253 acutely hospitalized psychiatric patients (95-99% response rate) to assess their interest level in spiritually-oriented psychotherapy, religious affiliation, and general spiritual or religious involvement. Average age of participants was 34; 58% were female; 85% were White; and 46% had a college degree. The most common psychiatric condition was a mood disorder (82%) or anxiety disorder (55%); 37% were considered high risk for suicide; and 55% had been previously hospitalized for psychiatric reasons. General spirituality or religion was assessed with 5 questions: belief in God (‘not at all’ to ‘very much’ on 5-point scale), importance of religion, importance of spirituality, religious attendance, and private religious activity. **Results:** Religious affiliations were 22% Catholic, 20% Protestant, 7% Jewish, 5% Buddhist, 7% other, and 40% none. Belief in God (at least ‘fairly’) was present in 71%; 66% said spirituality was important (at least ‘fairly’); 46% said religion was important (at least ‘fairly’); 48% attended religious services at least weekly; and 82% engaged in private religious activity at least weekly. The primary question was “To what extent would you like to include your spirituality in your mental health treatment?” Among participants, 23% said not at all, 19% indicated slightly, 21% said fairly, 20% indicated moderately, and 17% said very much. Thus, more than half (58%) indicated fair or greater interest in the integration of spirituality into their treatment, and only about a quarter (23%) were definitely opposed. Interest in spiritual integration was particularly strong in those with major depressive disorder and in those who were more religious/spiritual. However, even among the 40% with no religious affiliation, more than one-third (37%) indicated they were at least fairly interested in having their spiritual beliefs integrated into therapy (SIP) and nearly 10% indicated they were very interested. Researchers concluded that their results “...suggest that many patients desire SIP, and it is thus incumbent upon our field to identify evidence-based approaches to facilitate the integration of patient spirituality into psychotherapy.”

Citation: Rosmarin DH, Forester BP, Shassian DM, Webb CA, Bjorgvinsson T (2015). Interest in spiritually integrated psychotherapy among acute psychiatric patients. *Journal of Consulting & Clinical Psychology*, E-pub ahead of print.

Comment: The findings above are probably a “worst case scenario” in terms of interest in spiritually-integrated therapy since this study took place in the northeastern U.S. (which tends to be less religious than other parts of the U.S.) and since only a few of the participants (<15%) were from ethnic minority groups (the most religious segment of the population).

Image of God, Gratitude, and Physical Health

Researchers in the department of health behavior and health education at the University of Michigan School of Public Health analyzed data from a nationwide survey of 3,010 US adults ages 18 or older collected by the National Opinion Research Center (response rate 50%). Persons who never attended religious services or attended them only once or twice per year (n=1,215) were excluded, leaving 1,774 cases for the analysis. Physical symptoms were measured using a 10-item checklist; self-rated health was measured using two items (overall self-rated health and self-rated health compared to others of similar age). Image of God was assessed using a three-item scale assessing the degree to which the participant viewed God as benevolent. Gratitude to God was assessed using a 3-item measure. Spiritual support was assessed with a 3-item measure that assessed degree to which the participant received support from fellow church members. Hope was assessed by a 4-item scale with items taken from other measures. Analyses controlled for age, education, gender, and marital status. The data were analyzed using structural equation modeling (LISREL). **Results:** Findings indicated that (1) those who attend religious services more often and those who receive more spiritual support from other church members experience more benevolent images of God (B=0.08, p<0.01, and B=0.362, p<0.001, respectively); (2) those with more benevolent images of God feel more grateful to God (B=0.578, p<0.001); (3) those who feel more grateful to God have more hope about the future (B=0.214, p<0.001); and (4) greater hope is associated with better physical health (B=0.330, p<0.001, for self-rated health and B=-0.255, p<0.001, for physical symptoms).

Citation: Krause N, Emmons RA, Ironson G (2015). Benevolent images of God, gratitude, and physical health status. *Journal of Religion & Health* 54(4):1503-1519

Comment: The associations make sense. It is unfortunate that 40% of the sample had to be dropped because they didn't attend religious services or only attended once or twice per year. Although this was necessary because one of the measures depended on the participant being a church member (spiritual support), the elimination of nearly half of the sample who were less religious reduces the variability of religiosity. This would result in a lower likelihood of finding significant relationships. Thus, the findings reported here might have been even stronger if all individuals (including those who did not attend religious services) were analyzed.

Religion and Trust Among Young Women in Iran

Investigators from the Population and Social Health Research Program at Griffith University in Australia analyzed data collected on young women living in the city of Shiraz, Iran. Participants were recruited from five sampling locations: public and private universities, workplaces, religious centers, health centers, and public places. Of the 420 women ages 18 to 35 identified, 383 completed the questionnaire (93% response). Trust was assessed using a 20-item subscale of the British General Household Survey Social Capital Scale (which has subscales assessing trust in the media, trust in institutions, and trust in the neighborhood). Level of religiosity was measured using a single question, with responses ranging from 'not religious at all' to 'very religious.' **Results:** Although this report did not focus on religion and trust (the focus was on trust and quality of life), information on the former relationship was provided. The religious affiliation of women was 96% Shia Muslim. Only 5% of women were 'very religious'

(following religious practices very often or often) and 40% were 'moderately religious' (following religious practices occasionally). The majority of these young women (53%) never or rarely followed religious practices. However, those who were 'very religious' were significantly more likely to report trust in the media, trust in institutions, and trust in general (p<0.001 for all comparisons). Furthermore, a gradient-of-effect was found, i.e., trust progressively declined as religiosity lessened.

Citation: Salehi A, Harris N, Coyne E, Sebar B (2015). Trust and quality of life: A cross-sectional study of young women.

International Journal of Social Psychiatry 61(5):506-514

Comment: The relatively low religiosity of these young Iranian women is notable, and appears linked to declining trust in the media, institutions, and trust in general. Since analyses were cross-sectional, direction of effect here is unknown, i.e., low religiosity could cause a lack of trust, or lack of trust could cause a decline in religiosity.

New Measures of Buddhism and Sikhism

Phra Thanissaro from the Warwick Religions and Education Research Unit at the University of Warwick in the United Kingdom has developed two new 24-item scales, one measuring attitude towards Buddhism and the other measuring attitude towards Sikhism. The two scales were tested in a multi-religious sample of 369 students ages 13 to 15 years attending 9th and 10th grade classes in three different schools in London. The religious composition of the sample was 41% Christian, 12% Muslim, 5% Hindu, 4% Buddhist (n=15), 1% Sikh (n=5), 1% Jewish, 4% other religions and 33% no religion. Of the participants, 49% had studied Buddhism and 43% Sikhism in their Religious Education lessons during the past year. The content of the questions making up the two scales was based on Buddhist and Sikh values derived from previous qualitative and quantitative research on adolescents in the United Kingdom. **Results:** The internal reliability of the 24-item Buddhist scale was 0.938; individual item-to-total correlations ranged from 0.405 to 0.785. Similarly, the reliability of the 24-item Sikhism scale was 0.944; individual item-to-total correlations ranged from 0.502 to 0.750. These are the only psychometrics for the scales provided. Both scales are contained in the article.

Citation: Thanissaro PN (2011). Measuring attitude towards Buddhism and Sikhism: Internal consistency reliability for two new instruments. *Mental Health, Religion & Culture* 14 (8):797-803

Comment: There are many problems with this presentation. First, the psychometric properties of these two scales are undeveloped (only internal reliability is provided; no information about test-retest reliability or validity is provided). However, since both scales are contained in the article, this allows the reader to assess their “content validity” (which on the surface appears reasonable). Second, the scale was tested in a sample that contained only 15 Buddhists and 5 Sikhs, who at the age of 13-15 probably had not lived long enough to develop a mature understanding of their religious beliefs. Note that the author refers to a 16-item Sikhism scale for adolescents developed by other authors (Smith & Kay, 2000), from which many of the questions for these 24-item scales were obtained from. We review these scales here because there are few quantitative measures of religiosity in these faith traditions. This two scales are readily available in the paper and have reasonable content validity.

New Native American Spirituality Scale

Researchers from the University of New Mexico, working together with members of a Southwest Indian tribe, adapted the Daily Spiritual Experiences Scale to form the Native American Spirituality Scale (NASS). The 12-item NASS was developed as part of a randomized trial involving the treatment of Native Americans with substance use disorder (SUD). The sample consisted of 83 participants (average age 34, 70% male). Most participants believed in God, a Higher Power, or Creator (86%).

The NASS was completed at baseline, 4, 8 and 12 months. Other measures included the Addiction Severity Index, the Scale of Ethnic Experience, and Brief Symptom Inventory (BSI-18).

Results: Factor analysis of the NASS produced two factors that were largely invariant over time (Factor 1=behavioral practices, $\alpha=0.86$; Factor 2=global beliefs, $\alpha=0.79$). Both factors increased in value over the 12-month follow-up period. Factor 1 was inversely related to substance use at baseline (alcohol and cannabis use), and was positively related to tribal identification; Factor 2 was unrelated to either outcome. Neither factor was related to BSI Global Severity, depression, anxiety, or somatization scores. The full 12-item NASS scale is included in the Appendix of the paper, and includes items such as: "I believe life is sacred"; "I wake up early and pray to Creator/ancestors"; "I find strength in my faith and spirituality"; "I participate in cultural/faith related activities"; "I believe everything is alive with a spirit," etc. (with responses ranging from 0 [never or almost never] to 5 [many times a day]).

Citation: Greenfield BL, Hallgren KA, Venner KL, Hagler KJ, Simmons JD, Sheche JN, Homer E, Lupee D (2015). Cultural adaptation, psychometric properties, and outcomes of the Native American Spirituality Scale. *Psychological Services* 12(2):123-133.

Comment: The authors indicate this is the first published questionnaire that uniquely taps tribal-specific spiritual beliefs and practices. There are approximately 562 Native American tribes in the U.S. (approximately 40% in Alaska), and each tribe is ethnically, culturally, linguistically, and spiritually diverse. These results, then, will have to be cautiously generalized beyond the single Southwest tribe in which the measure was developed and tested. Nevertheless, since there are so few spirituality measures specifically for Native Americans, the NASS is a good place to start.

LATEST RESEARCH FROM DUKE

Review of the "Belief into Action Scale"

This month's edition of the academic open access journal *Religions* has a review of two studies using the 10-item Belief into Action (BIAC) scale: a highly religious population of female family caregivers of severely disabled persons and a highly non-religious population of Chinese college students from Mainland China. The psychometric properties of the BIAC in each of these populations are solid. Although twice as long as the 5-item DUREL, the BIAC appears to be more sensitive and has virtually no ceiling effect. Correlations with mental and social health outcomes indicate that the incremental validity of the BIAC exceeds the DUREL by 75% to 300% (i.e., associations with psychosocial outcomes are 75% to 300% stronger than those with the DUREL). The DUREL is one of the most commonly used measures of religious involvement today, with over 1100 "hits" on Google Scholar, most of those within the past 3 years. The 10-item BIAC is more comprehensive and sensitive than the DUREL, and will likely surpass it in use during the years to come.

Citation: Koenig HG, Wang Z, Al Zaben F, Adi A (2015). Belief into Action Scale: A comprehensive and sensitive measure of religious involvement (Review). *Religions* 6(3):1006-1016

Comment: As the reader might guess, the BIAC is our favorite and most highly recommended measure of religious involvement today (in monotheistic populations especially, although useful in pantheistic populations as well). This measure is now available in Arabic, Spanish, and Chinese. No permission is necessary, although contacting the author prior to use is recommended (Harold.Koenig@duke.edu).

NEWS

Patients' Unmet Spiritual Needs Emphasized in *The New York Times*

Robert Klitzman, M.D., professor of psychiatry at Columbia University, wrote an article titled "Doctors fail to address patients' spiritual needs" for the Aug 13 issue of *The New York Times*. In this short NYT piece, he articulately describes the situation of one of his patients, a woman in her 20's dying of cancer, and the interaction he had with the resident who was taking caring of her. The bottom line: doctors are often insensitive to the spiritual needs of patients and need training in this area (see Resources below, which include three 45-min CME videos for physicians designed specifically to do that). Read Klitzman's article at: <http://well.blogs.nytimes.com/2015/08/13/doctors-fail-to-address-patients-spiritual-needs/>. Dr. Klitzman is also author of the recently released book *The Ethics Police: The Struggle to Make Human Research Safe* (Oxford University Press, 2015).

Stanford Psychiatrist Rania Awaad in the News

Rania Awaad, M.D., a psychiatrist and Muslim theologian (in the Qur'an and Islamic Law), was recently highlighted in the American Psychiatric Association's *Psychiatric News* (vol 50, no. 15, Aug 5) for her work in the mental health care of Muslim women in the U.S. She is a clinical instructor of psychiatry at Stanford University and director of its recently launched Muslims and Mental Health Research Lab. Dr. Awaad grew up in Damascus, Syria, and in 2013, attended our summer research workshop at Duke, which helped to form her future career direction and the work she is now doing at Stanford. **Congratulations to Rania!** Read the full interview with her at:

<http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.5b22#.VdQCGLDOFOI.gmail>.

2015 Spirituality & Health Research Workshop

This year 50 persons attended the Aug 10-14 Duke research workshop (beyond the projected capacity of 20-30). Participants included those from Kenya (two), South America (Columbia), Saudi Arabia, and other countries. A wide diversity of religions were represented, including Eastern, Middle-Eastern, and Western faith traditions. Physicians, nurses, social workers, chaplains, pastors, psychologists, undergraduate students, graduate students, and university professors were among the attendees. Many relationships were formed, both personal and professional. The 2016 workshop is scheduled for Aug 15-19, so mark your calendar now if you haven't attended one of these workshops before (and if you've attended, come for a second or third time!). For more info, see website:

<http://www.spiritualityhealthworkshops.org/>.

SPECIAL EVENTS

6th International Conference on Ageing and Spirituality (Los Angeles, CA, Oct 4-7, 2015)

As described by conference conveners: "Previously held in Australia, New Zealand, Great Britain and Scotland, the CLH Center for Spirituality and Aging is proud to host the inaugural US session of the International Conference on Ageing and Spirituality with the theme 'Paradox and Promise in the Spiritual Pilgrimage of Aging.' We invite those who see this journey as inherently spiritual to join us in Los Angeles to consider together what the realm of spirituality and religion brings to the current, world-wide discussion on and reality of aging. Let's discover together ways to access the wisdom of those who have taken this pilgrimage before us, and begin to journey together on this 21st century pilgrimage, making

music, finding meaning, and being full of hope in spite of losses and limitations.” Plenary speakers include Keith Albans (Great Britain), Jane Thibault (U.S.), Elizabeth MacKinlay (Australia), Ralph Kunz (Switzerland), Dayle Friedman (U.S.), and Mary Bateson (U.S.). Special events will include Dr. MacKinlay giving a talk in honor of legendary gerontologist Mel Kimble, along with brief video of Mel speaking to the conference. For more information, go to: <http://www.6thinternationalconference.org/>.

2016 Conference on Medicine and Religion

(Houston, TX, March 4-6)

The theme of this year's conference is “Approaching the Sacred: Science, Health and Practices of Care.” The Institute for Spirituality and Health in Houston is sponsoring the event this year. The keynote speaker will be Elaine Ecklund, the Herbert S. Autrey Chair Professor of Sociology and Director of The Religion and Public Life Program at Rice University, where she is also a Rice Scholar at the Baker Institute for Public Policy. An expert on institutional change, Ecklund is a sociologist who examines how individuals bring changes to religious, scientific and medical institutions. A more detailed bio can be found on the Conference website, where updates on additional speakers and presenters will be provided. The deadline for Abstracts has been extended to September 15, 2015. See website:

www.medicineandreligion.com.

8th Annual Muslim Mental Health Conference

(Dearborn, Michigan, March 17-20, 2016)

The theme of the 2016 conference is “Peace & Justice: Building Harmony between Psyche & Law”. The call for abstracts deadline was Sept 18, although they will likely continue to accept abstracts even if submitted a bit late. The topics this year include community violence, family violence, domestic violence, juvenile violence, impact of poverty, Muslim mental health, spirituality and therapy, cultural competence for Muslims, Islamic law and forensic psychiatry,

Family therapy for Muslims, Trauma informed care for Muslims, substance abuse, Islamic history of mental health, interventions, help seeking and stigma of mental health, role of Imam/Islamic Center in mental health services. Submit abstracts to:

MSUMMHConference@gmail.com. For more information, go to Michigan State University's website:

[http://www.psychiatry.msu.edu/](http://www.psychiatry.msu.edu)

4th International Conference of the British Association for the Study of Spirituality (BASS)

(Manchester, UK, May 23-26, 2016)

The theme of the 2016 conference is: “Can spirituality transform our world? New frontiers in understanding and exploring contemporary spiritualities.” As described by the conference conveners: “Three day conference bringing together researchers and scholars from a range of academic disciplines and the creative arts with policy-makers and practitioners from the caring professions, education sector and business communities, to consider the state of play in spirituality studies as well as the dynamic relationship between spirituality and contemporary society.” Keynote speakers include Prof. Emeritus David Aldridge (Nordoff/Robbins Zentrum, Witten, Germany), Dr Fiona Gardner (La Trobe University, Melbourne, Australia), Prof. Mel Gray (University of Newcastle, New South Wales, Australia), Prof. Graham Harvey (Open University, Milton Keynes, UK), Dr Mike King (freelance scholar), and Prof. Philip J. Larkin (University College Dublin, Dublin, Ireland). The conference will be held at the Chancellors Hotel and Conference Centre, Manchester, UK (www.chancellorshotel.co.uk). For further information and

bookings visit: www.bassspirituality.org.uk. For any enquiries, contact Prof. Emeritus Margaret Holloway (m.l.holloway@hull.ac.uk).

RESOURCES

CME/CE Videos

Due to the generous support of the Templeton Foundation and Adventist Health System, five professionally produced 45-minute videos on **why and how** to “integrate spirituality into patient care” are now available on our website (*for free*, unless CME/CE is desired). Videos are targeted at physicians, nurses, chaplains, and social workers in an effort to help them form spiritual care teams to provide “whole person” medical care that includes the identifying and addressing of spiritual needs. No other resource like this currently exists. Go to:

<http://www.spiritualityandhealth.duke.edu/index.php/cme-videos>.

Morals and Medicine: The Moral Problems of the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia

(Princeton University Press, 2015)

As part of the Princeton Legacy Library, this book originally published in 1954 has important information relevant to today. In the words of the publisher, “In *Morals and Medicine* a leading Protestant theologian comes to grips with the problems of conscience raised by new advances in medical science and technology. They arise as issues at the start or making of a life, in preserving its health, and in facing its death. They are the problems of Everyman: some are new problems of conscience, such as artificial insemination; some are old problems in new dimensions, such as euthanasia. Modern medicine provides such a high degree of control over health and vital processes that men must inevitably shoulder the burden of intelligent decision, and shoulder it as rationally as possible. Thus far, only Roman Catholic moralists have worked out a coherent ethics of medical care. *Morals and Medicine* is a new and independent analysis of the morals of life and death, striking out along the line of the values of personality rather than of mere physiological life itself. It offers a modern and at the same time Christian concept of right and wrong for all who are involved: the patient, the doctor and nurse, the pastor, and the family and friends.” Available in paperback for \$42.00 at <http://press.princeton.edu/titles/549.html>.

Health and Well-being in Islamic Societies

(Springer International, 2014)

What exactly do Muslims believe? What is contained in and emphasized in the Qur'an? In this volume, Muslim beliefs and practices based on the Qu'ran and Hadith are outlined in detail, as are health-related Islamic practices and moral standards. Differences and similarities between Christian and Muslim beliefs and practices are examined. The core of the book focuses on research on religiosity and health in Muslim populations and compares the health of Muslims with that of other religious groups. Available for \$53.15 at: <http://www.amazon.com/Health-Well-Being-Islamic-Societies-Applications/dp/331905872X>

Spirituality in Patient Care, 3rd Ed

(Templeton Press, 2013)

The 3rd edition provides the latest information on how health professionals can integrate spirituality into patient care. Chapters target physicians, nurses, chaplains and pastoral counselors, mental health professionals, social workers, and OT/PT. Available for \$21.23 (used) at: <http://www.amazon.com/Spirituality-Patient-Care-When-What/dp/1599474255/>.

Handbook of Religion and Health (2nd Ed)

(Oxford University Press, 2012)

This Second Edition covers the latest original quantitative research on religion, spirituality and health. Spirituality and health researchers, educators, health professionals, and religious professionals will find this resource invaluable. Available for \$132.51 (used) at: <http://www.amazon.com/Handbook-Religion-Health-Harold-Koenig/dp/0195335953>

Spirituality & Health Research: Methods, Measurement, Statistics, & Resources

(Templeton Press, 2011)

This book summarizes and expands the content presented in the Duke University's Summer Research Workshop on Spirituality and Health (see above), and is packed full of information helpful in performing and publishing research on this topic. Available for \$38.20 (used) at: <http://www.amazon.com/Spirituality-Health-Research-Measurements-Statistics/dp/1599473496/>

EDUCATION

Chaplain Research Training Program

The "Transforming Chaplaincy: Promoting Research Literacy for Improved Patient Outcomes" project will better equip hospital chaplains to use research to guide, evaluate and advocate for the spiritual care they provide. The project seeks to close the gap between hospital chaplains' current limited research literacy and the importance of evidence-based care for all members of the health care team. The project is co-led by George Fitchett and Wendy Cadge. The project's key training opportunities will include a fellowship program that will pay for 16 board-certified chaplains to complete a two-year, research-focused Master of Science or Master of Public Health degree in epidemiology, biostatistics or public health at an accredited school of public health. In addition, curriculum development grants will be awarded to 70 ACPE-accredited clinical pastoral education (CPE) residency programs to support incorporation of research literacy education in their curricula. Finally, with the support of the professional chaplaincy and pastoral education organizations (APC, ACPE, NACC, AJC) an online continuing education course, "Religion, Spirituality and Health: An Introduction to Research," will be made available at no cost to members of these organizations. Further information is available at the project website www.researchliteratechaplaincy.org.

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry (OFI)

The fall funding cycle is being skipped, and next submission of OFI will be in February 2016. The three main areas in religion, spirituality and health that the Foundation funds are: (1) research on causal mechanisms (basic psychosocial, behavioral, and physiological pathways), (2) increasing competencies of health care professionals in working with religious patients (physicians, but also psychologists and experts in public health), and (3) research involving the development of religious-integrated interventions that lead to improved health. More information: <http://www.templeton.org/what-we-fund/our-grantmaking-process>.

2015 CSTH CALENDAR OF EVENTS...

October

- 10 **Religion, Spirituality and Health**
Meliora Weekend, University of Rochester
Rochester, New York
Speaker: Harold G. Koenig
Cont: Dr. Denise Yarbrough (dyarbrough@admin.rochester.edu)
- 19 **Integrating Spirituality into Healthcare**
Merchab Institute Spiritual Care Symposium
Springdale, Arkansas (northwest Arkansas)
Speaker: Harold G. Koenig and others
Contact: CJ Malone, Executive Director, Merchab Institute
(CMalone@NW-Health.com)
- 23 **Religion, Spirituality and Health in Later Life**
Well-Spring Retirement Community
Greensboro, North Carolina
Speaker: Harold G. Koenig
Contact: Garrett Saake (gsaake@well-spring.org)
- 28 **Clinical Pastoral Education and the Provision of Spiritual Care: Research Needs**
Speaker: Dr. Jim Rawlings, Jr., Director of Pastoral Care, Duke University Medical Center
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

November

- 4 **Religion, Spirituality and Health**
Adventist HealthCare Behavioral Health Services, Maryland
Washington DC
Speaker: Harold G. Koenig and others
Contact: Clarenca Stephen
(CStephen@adventisthealthcare.com)
- 18 **In dialogue with the Qur'an**
Speaker: David Marshall, Ph.D.
Associate Professor of the Practice of Theology, Duke Divinity
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)
- 19 **Religion, Spirituality and Medicine**
Liberty University College of Osteopathic Medicine
Lynchburg, Virginia
Speaker: Harold G. Koenig
Contact: Joseph Brewer (jwbrewer1@liberty.edu)

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<http://www.spiritualityandhealth.duke.edu/about/giving.html>