

# 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 August 2015) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

## LATEST RESEARCH OUTSIDE DUKE

### Religion and the Resiliency Campaign in U.S. Army

*Military Review* is publishing an article this month (Sept-Oct) written by Major Bryan Koyn from the 7<sup>th</sup> Infantry Division that examines the role of religion in the U.S. Army, particularly in light of the recent Ready and Resilient Campaign that has emerged in response to increasing rates of suicide and PTSD in soldiers. In fiscal year 2014, a survey of 1,053,840 Army National Guard, Army Reserve, and Army Active Duty soldiers found that 70.6% indicated a religious affiliation, 28.8% indicated no religious preference, and 0.6% were atheist. Of those with a religious affiliation, 96.6% were Christian, 0.4% Buddhist, 0.1% Hindu, 0.3% Jewish, 0.3% Muslim, and 1.3% indicated other religion. After reviewing the challenges that soldiers face in the military, and the relationship between religious involvement and resiliency, Major Koyn recommended: (1) more research to inform Army leaders, facilitate policy decisions, and refine programs; (2) reinforce existing religious support efforts; (3) medical providers implement procedures to address religious issues (if relevant to the soldier) in both individual treatment plans and various programs managed by the U.S. Army Medical Command; and (4) educate the soldiers about the research on religion and health that exists.

*Citation:* Koyn B (2015). Religious participation: The missing link in the ready and resilient campaign. *Military Review* 95(5):2-12

*Comment:* We'll see in the future how many of these recommendations the Army carries out. Our military is a dominant force that both preserves the freedom of people here in the U.S. and of people in many countries around the world as aggressive neighbors (ISIS, Boko Haram, Russia, North Korea, etc.) seek to dominate and control their lives. Having resilient U.S. soldiers, then, is crucial to the peace and freedom of people everywhere. To ignore a critical psychosocial factor that lies at the core of resilience would not be a good strategy.

### Religiosity and Cardiovascular Risk Factors in Japan

Researchers at Harvard's Beth Israel Deaconess Hospital in the division of general medicine, along with Japanese colleagues, analyzed data collected from a retrospective cohort study on 36,965 individuals who had in-person annual health checkups at St. Luke's International Hospital in Japan between 2005 and 2010. The purpose was to examine cross-sectional and longitudinal relationships between

religiosity and a range of cardiovascular (CV) risk factors. Religiosity was assessed at baseline with a single question: "Are you religious?" Response options were "religious," "somewhat religious," "slightly religious," and "not religious at all religious." CV risk factors examined were cigarette smoking, excessive alcohol consumption, regular exercise, and body mass index (BMI). CV biomarkers examined were systolic blood pressure (SBP), diastolic blood pressure (DBP), fasting blood sugar (FBS), HgbA1C, lipid levels, and presence of hypertension, diabetes, and dyslipidemia. Controlled for in all analyses were age, gender, marital status, occupation, BMI, and other health habits except for the outcome being examined as the dependent variable. **Results:** Average age of participants was 47 years, 51% were male, 72% were married, and 15% worked on jobs involving physical labor. Of the entire sample, 62.2% were slightly or not at all religious and 37.8% were at least somewhat religious (24% were not religious at all and 10% were religious). Those who were older, female, and married were more likely to be religious. Cross-sectional multivariate analyses in 2005 showed that those who were religious were less likely than non-religious to smoke cigarettes (OR=0.60, 95% CI=0.53-0.67), less likely to consume excessive alcohol (OR=0.78, 95% CI=0.70-0.85), more likely to regularly exercise (OR=1.25, 95% CI 1.14-1.37), but were more likely to be overweight/obese (OR=1.33, 95% CI=1.20-1.47); furthermore, a "gradient in effect" was found for smoking, regular exercise, and obesity. When stratified by gender, differences were similar in males and females. No differences were found for rates of hypertension, diabetes, or dyslipidemia. In longitudinal analyses (using GEE adjusted for time), being religious at baseline predicted a lower likelihood of smoking, a lower likelihood of drinking excessively, a greater likelihood of regular exercise, and a lower likelihood of developing diabetes mellitus over time; no effect was found on development of hypertension, dyslipidemia, or becoming overweight/obese. No longitudinal relationships were found with CV biomarkers. Researchers concluded that: "Individuals who were more religious were significantly more likely to have favorable health habits and fewer cardiovascular risk factors, except for higher prevalence of overweight/obesity at baseline. Religiosity was also associated with better health habits over time and less likely to be associated with future diabetes but not with blood pressure or lipid levels."

*Citation:* Kobayashi D, Shimbo T, Takahashi O, Davis RB, Wee CC (2015). The relationship between religiosity and cardiovascular risk factors in Japan: A large-scale cohort study. *Journal of the American Society of Hypertension* 9(7):553-562

*Comment:* Although only 10% of the sample was religious in this secular country, compared to those not religious at all, the former were 40% less likely to smoke, 22% less likely to drink excessive alcohol, and 25% more likely to exercise (although were also 33% more likely to be obese/overweight). Over time, baseline religiosity predicted a lower likelihood of smoking, excessive alcohol intake, and development of diabetes, and a greater likelihood of regular exercise. Given the large sample size, presence of gradients in effect for several analyses, and the fact that longitudinal findings largely replicated baseline associations, these findings are impressive. A lower likelihood of developing diabetes over time (despite being more obese at baseline) is also noteworthy. The findings were largely the same in both men and women.

### Religious Involvement and Cigarette Smoking in U.S.

Investigators from the department of social and behavioral sciences in the School of Public Health at Harvard analyzed data collected on a random national sample of 7,112 adults assessed in 1994-1995

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(MIDUS-I) and in 2004-2005 (MIDUS-II) to examine relationships between religious involvement and cigarette smoking. Of the baseline sample, 4,496 answered the cigarette smoking question at both baseline and follow-up 10 years later, allowing for longitudinal analyses. Cigarette smoking was assessed at baseline and follow-up by the question: "Do you smoke regularly now?" Four categories of smokers were created from responses: persistent smokers (12.8%), ex-smokers (6.6%), relapsed smokers (2.0%), and non-smokers (78.7%). Religious involvement was assessed at baseline and follow-up by frequency of religious attendance (RA), importance of religion (RI), importance of spirituality (SI), seeking religious/spiritual comfort (CS), and religious/spiritual decision-making (DM). Four categories of religious involvement were created for each religious variable: high at baseline and follow-up (51% RA, 67% RI, 73% SI, 55% CS, 48% DM), high at baseline and low at follow-up (17% RA, 8% RI, 5% SI, 10% CS, 10% DM), low at baseline and high at follow-up (7% RA, 6% RI, 10% SI, 9% CS, 11% DM), and low at baseline and follow-up (25% RA, 19% RI, 12% SI, 26% CS, 30% DM). Also assessed and controlled for in analyses were age, gender, education, race, income, and parental status. Multinomial logistic regression was used to examine relationships. **Results:** Compared to those with low-low attendance, those with high-high religious attendance were 70% less likely to be a persistent smoker (OR=0.30, 95% CI=0.22-0.41) and 49% less likely to be an ex-smoker (OR=0.51, 95% CI=0.34-0.76); no difference was found for relapsed smoker. Those with high-high religious importance were 39% less likely to be a persistent smoker (OR=0.61, 95% CI=0.47-0.79) and 34% less likely to be an ex-smoker (OR=0.66, 95% CI=0.47-0.93); again, no difference for relapsed smoker. Those with high-high spiritual importance were 39% less likely to be a persistent smoker (OR=0.61, 95% CI=0.45-0.82); no difference for ex-smoker or relapsed smoker. Those with high-high religious/spiritual comfort seeking were 42% less likely to be a persistent smoker (OR=0.58, 95% CI=0.45-0.74) and 33% less likely to be an ex-smoker (OR=0.67, 95% CI=0.47-0.92); no difference for relapsed smoker. Those with high-high religious/spiritual decision making were 43% less likely to be a persistent smoker (OR=0.57, 95% CI=0.45-0.72) and 30% less likely to be an ex-smoker (OR=0.70, 95% CI=0.51-0.97); no difference for relapsed smoker. High-high religious attendees were 75% more likely to unsuccessfully attempt to quit than low-low attendees between MIDUS-I and MIDUS-II (OR=1.75, 95% CI=1.01-3.03); however, high-high religious status was not different from low-low religious status on any other smoking characteristic. Researchers concluded: "Interventions to increase smoking abstinence may be more effective if they draw on ties to religious and spiritual organizations and beliefs. Meanwhile, religious involvement is unlikely to affect smoking cessation effectiveness."

*Citation:* Bailey ZD, Slopen N, Albert M, Williams DR (2015).

Multidimensional religious involvement and tobacco smoking patterns over 9-10 years: A prospective study of middle-aged adults in the United States. *Social Science & Medicine* 138:128-135

*Comment:* While religious involvement, especially religious attendance, appears to prevent the **initiation** of cigarette smoking (which, of course, is important because of the effect this has on a person's lifetime health status), it does not appear to be very helpful for stopping it (i.e., smoking cessation). Religious involvement is associated with frequent attempts to quit smoking (though being religious doesn't help much in terms of successfully quitting).

### Religious Involvement and Sense of Control

Researchers at four universities joined together to survey a random sample of 444 community-dwelling adults in Miami-Dade County (Florida) (60% response rate), collecting detailed information on the neighborhood environment, psychosocial and demographic characteristics, religious involvement, immigration status, health behaviors, and both physical and mental health. Mean age of was 57; 70% were female; 42% were Hispanic; and 48% were immigrants. Of particular interest was the relationship between religious involvement and control. Control was assessed in terms of sense of control over good conditions in life, self-control in terms of impulsivity and risk-taking, and health locus of control, all assessed using established measures. Religious involvement was measured by a 6-item scale that assessed private and public religious involvement, religious

coping, spirituality, and religious salience ( $\alpha=0.85$ ); participants were divided into high, moderate, and low levels of religious involvement based on their scores. **Results:** Regression analyses (controlling for age, gender, race, immigrant status, language, education, and income) indicated that high religious involvement (vs. low) was significantly associated with greater sense of control ( $B=0.132, p<0.05$ ), greater self control ( $B=0.146, <0.05$ ), and a greater health locus of control ( $B=0.180, p<0.01$ ). Researchers concluded that, "...people who exhibit high levels of religious involvement tend to report higher levels of the sense of control, self-control, and the health locus of control than respondents who exhibit low levels of religious involvement." This was not true, however, for only moderate levels of religiosity that were similar to low levels of religiosity, suggesting that there is a "threshold effect" with regard to the relationship between religious involvement and control.

*Citation:* Pascoe, A. E., Hill, T. D., Mossakowski, K. N., & Johnson, R. J. (2015). Religious involvement and perceptions of control: Evidence from the Miami-Dade Health Survey. *Journal of Religion and Health*, June 29 [E-pub ahead of print]

*Comment:* Sense of control over one's life has been associated with both mental and physical health in a wide range of studies. Enhancing a sense of control may be one mechanism that explains why religious involvement is linked to better health.

### Does Religiosity Predict Quality of Life in Canadian Nursing Home Patients?

Researchers from the School of Public Health at the University of Waterloo in Ontario, Canada, analyzed cross-sectional data from a survey of 928 residents of 48 long-term care facilities in six Canadian provinces (51% response rate, 66% women, 43% age 85 or older), examining predictors of quality of life. The Quality of Life (QOL) Survey assessed 10 domains including privacy, food/meal, safety/security, comfort, autonomy, respect, responsive staff, staff-resident bonding, activity level, and personal relationships. Resident characteristics were assessed with the Resident Assessment Instrument-Minimum Data Set (RAI-MDS 2.0) that measures cognitive performance, changes in health, existence of end-stage disease, signs and symptoms, physical functioning, social engagement, aggressive behaviors, and pain. Also assessed were a variety of LTC facility attributes (size, staffing, etc.). Religiosity was assessed with two questions: religious attendance and finds strength in religious faith; participants were divided into (1) those who usually attend religious services or find strength in faith (15%), (2) those who usually attend religious services and find strength in faith (25%), and (3) those who neither attend services nor find strength in faith (60%). **Results:** Regression analyses indicated that significant predictors of better QOL among resident characteristics were a positive global disposition, less education (not having post-secondary education), less impairment in activities of daily living, and religiosity. Attending a place of worship and finding strength in faith was significantly and independently related to greater QOL ( $B=7.12, SE=2.06, p=0.0006$ ).

*Citation:* Kehyayan V, Hirdes JP, Tyas SL, Stolle P (2015). Predictors of long-term care facility residents' self-reported quality of life with individual and facility characteristics in Canada. *Journal of Aging and Health*, E-pub ahead of print.

*Comment:* Many, many resident characteristics were measured in this study using the RAI-MDS. Of those characteristics, religiosity was one of the few that predicted higher QOL in these cross-sectional analyses. Remarkably, 60% of these older nursing home patients neither attended religious services nor found comfort or strength in religious faith.

### Religious Involvement and Onset of Marijuana and Other Drug Use in Switzerland

In this 15-month prospective study of 2,774 young men (average age 19) visiting Army recruitment centers in 21 of 26 Swiss cantons in 2010-2011, researchers at Zurich University examined predictors of onset of marijuana and other drug use during follow-up in those not using these substances at baseline. Predictors included age, education, housing situation, means of subsistence, living in partnership, and number of siblings. Physical and mental health were

assessed with the SF-12 Health Survey, the Major Depression Inventory, and the International Physical Activity Questionnaire. Several questions about participants' parents were also asked including financial situation, quality of parenting, and parents' history of mental disorder; in addition, questions were asked about their peers' use of alcohol or drugs. Sensation seeking and personality was also assessed using established scales. Religious denomination was inquired about with one question that divided respondents into Christians, Muslims, other religion, and no religion. Religiosity was measured with a single question with 5 response options: (1) "I believe in God and practice religion", (2) "I believe in God but do not practice religion," (3) "I do not know what to believe about God," (4) "I believe we cannot really know about God" (agnostic), and (5) "I do not believe in God" (atheist). Use of 15 different drugs in the past 12 months was assessed, in addition to lifetime alcohol, tobacco, marijuana, and other drug use. **Results:** Predictors of onset of marijuana use during the 15-month follow-up were (1) means of subsistence from other persons or institutions, (2) having one or two siblings, (3) depression, (4) poor mental health, (5) anti-social personality, (6) growing up with one parent or parent and step-parent, (7) parental divorce before age 18, (8) higher level of education than father or mother, (9) lower parental knowledge about peers and whereabouts at age 15, (10) psychiatric problem of mother age age 15, (11) higher peer pressure, (12) use of alcohol, (13) cigarette smoking, (14) use of drugs other than marijuana, (15) greater sensation-seeking, (16) greater sociability, (17) greater anxiety, **AND** (18) lower belief in God and practicing religion (OR=0.44, 95% CI=0.25-0.75). Controlling for all other variables in a multivariate regression, belief in God and practicing religion continued to predict a lower likelihood (46%) of starting to use marijuana during the 15-month follow-up (OR=0.54, 95% CI=0.31-0.96, p<0.05).

*Citation:* Haug S, Nunez CL, Becker J, Gmel G, Schaub MP (2014). Predictors of onset of cannabis and other drug use in male young adults: Results from a longitudinal study. BMC Public Health 12:1202  
*Comment:* This study assessed a wide range of characteristics likely to be associated with the onset of marijuana use in a relatively large sample of young men in Switzerland, carefully examining predictors of the onset of marijuana use in those not using it at baseline. Even though religiosity was measured in a quite superficial manner (a single question asking about believing in God and practicing religion), the fact that this variable was one of only nine significant predictors of marijuana use onset is notable.

### Intrinsic Religiosity as a Buffer of Peer Victimization in Adolescents

Investigators in the department of psychology at UNC Chapel Hill assessed 313 adolescents (mean age 17.1 years) in the 11<sup>th</sup> grade and then again in the 12<sup>th</sup> grade, examining the longitudinal relationship between peer victimization and depressive symptoms, and exploring factors that might buffer that relationship. Participants were recruited from rural low-income high schools in the southeastern U.S. (54% female; 49% Caucasian, 24% African American, 19% Latino, 8% mixed race; 40% living in single parent household or with parent and step parent or grandparent). Religious affiliation of most adolescents was Christian (80%). Religious involvement at Time 1 was assessed by frequency of religious attendance and the 3-item intrinsic religiosity subscale of the Duke Religion Index. Physical and relational victimization were assessed at Time 1 using a standard approach (Crick & Grotpeter, 1996). Physical victimization involved being threatened or physically hurt by others; relational victimization involved being left out of activities, ignored by others, being gossiped about, or having mean things said behind one's back. Depressive symptoms at Time 2, the primary outcome, was assessed by the Mood and Feelings Questionnaire (Costello & Angold, 1988). **Results:** While religious attendance and intrinsic religiosity were unrelated to either type of victimization or depressive symptoms, there was a significant interaction between intrinsic religiosity and relational victimization predicting Time 2 depressive symptoms (controlling for T1 depressive symptoms) (B=-0.05, SE=0.02, p=0.02). In other words, at high levels of intrinsic religiosity, increased relational victimization was not associated with higher levels of depressive symptoms over time (B=-0.04, p=0.11), whereas at low levels of intrinsic religiosity, that relationship was significant (B=0.07, p=0.01). Researchers concluded

that: "Results suggest that relational victimization is associated prospectively with depressive symptoms only under conditions of adolescents' low intrinsic religiosity."

*Citation:* Helms SW, Gallagher M, Calhoun CD, Choukas-Bradley S, Dawson GC, Prinstein MJ (2015). Intrinsic religiosity buffers the longitudinal effects of peer victimization on adolescent depressive symptoms. Journal of Clinical Child & Adolescent Psychology 44(3):471-479

*Comment:* Peer victimization is an unfortunate but common experience that adolescents must deal with. Cases of adolescent suicide as a result of peer victimization have appeared regularly in the popular media of late. This study suggests that greater intrinsic religiosity may protect adolescents from the negative effects of relational victimization.

### Protective Factors Against Peer Influence during Adolescence (Italy)

Investigators at universities in Italy and Belgium analyzed data from a 12-month prospective study of 908 adolescents ages 14-16 years during their first year of high school (students randomly sampled from five high schools in northern Italy). The goal was to identify protective factors that prevented adolescents from engaging in high risk behaviors as a result of peer pressure. Individual risk and peer risk were assessed separately by measures that asked about cigarette smoking, alcohol abuse, marijuana use, drug use, and nonuse of seatbelts. Protective factors examined were positive orientation to school, intolerant attitudes about deviance, regulatory self-efficacy, peer models of conventional behaviors, and religiosity. Religiosity was assessed using a 4-item scale (Jessor) that measured importance of relying on religion to cope with problems, belief in God, reliance on religious belief as a guide for day-to-day living, and turning to praying when facing personal problems. Hierarchical regression was used to predict the effect of Time 1 protective factors on Time 2 risk behaviors after controlling for Time 1 risk behaviors and demographic factors.

**Results:** Of all protective factors measured, only Time 1 religiosity was a significant independent protective factor against individual risk (B=-0.134, p<0.05) at Time 2.

*Citation:* Cattelino E, Glowacz F, Born M, Testa S, Bina M, Calandri E (2014). Adolescent risk behaviors and protective factors against peer influence. Journal of Adolescence 37:1353-1362

*Comment:* While positive relationships between religious involvement and health in secular Europe have been few and far between in recent years, that is apparently not true with regard to high risk health behaviors among youth in northern Italy.

### Religion and Health Insurance Status Among Black Americans

Researchers from University of Alabama and Birmingham VA Medical Center analyzed data from a 2010 national dataset to identify factors related to having health insurance among Black Americans.

Information about the study is limited since only the abstract was available. **Results** indicated that frequency of church attendance was positively related to continuously having health insurance for women ages 51-64, and a spiritual/religious identity was marginally associated with having health insurance in men ages 36-50. Researchers suggested that implementation programs for the Affordable Care Act be conducted in churches.

*Citation:* Williams BR, Wang MQ, Holt CL, Schulz E, Clark EM (2015). Social integration and health insurance status among African-American men and women. Journal of Women & Aging 27(3):195-215

*Comment:* Women ages 51-64 are at a relatively high risk of having health problems prior to going onto Medicare at age 65, underscoring the importance of these findings. Given the central role that the church plays in the lives of many Black women, this may be a place of "information flow" where women encourage each other to obtain and maintain health insurance. As the authors suggest, using the Black church as a vehicle for obtaining and maintaining health insurance (especially for women) seems reasonable.

### Religiosity and Suicidal Ideation in Black Americans

Shervin Assari in the department of psychiatry at the University of Michigan analyzed cross-sectional data involving 5,191 Black

Americans participating in the 2001-2003 National Survey of American Life (44% male, mean age 42, 31% Caribbean Blacks). Measures of subjective religiosity and suicidal ideation were collected. Subjective religiosity was assessed with two questions: "How religious are you?" and "How spiritual are you?" Responses to these questions were combined to form a scale ranging from 0 to 6. Suicidal ideation was assessed with a single question: "Have you ever seriously thought about suicide?" Analyses were stratified by gender and ethnicity (African vs. Caribbean). **Results:** 12% had seriously thought about suicide at some time in their lives. After controlling for demographics and DSM-IV psychiatric disorders (diagnosed using the CIDI), the likelihood of having seriously thought about suicide at some time in life was significantly lower among Black men with high religiosity (OR=0.85, 95% CI 0.72-0.99), although no relationship was found in Black women, in African-Americans only, or in Caribbean-Americans only.

*Citation:* Assari S (2015). Ethnic and gender differences in additive effects of socio-economics, psychiatric disorders, and subjective religiosity on suicidal ideation among Blacks. *International Journal of Preventative Medicine* [E-pub ahead of print, DOI 10.4103/2008-7802.158913]

*Comment:* Interesting how the inverse relationship between subjective religiosity and suicidal ideation was present only in Black males, since Black females tend to be more religious in general. The relatively weak relationships may also be due to the fact that suicidal ideation was assessed retrospectively ("ever seriously thought") and was not necessarily current (when religiosity was measured).

## Religiosity and Participation in Clinical Trials by Female Hispanic Americans

Investigators at the University of California, San Diego, surveyed 503 Hispanic American women over age 18 in Southern California examining the relationship between religiosity and attitudes toward participation in clinical trials. The majority of participants (average age 38) were Catholic (70%), had low education (42% had not graduated from high school), were employed outside the home (54%), and were married (53%). Religiosity was assessed with the 5-item Duke Religion Index that measures organizational, non-organizational, and intrinsic religiosity. Attitudes toward clinical trial participation were assessed using the 19-item Barriers to Clinical Trial Participation scale, which assesses four major barriers: lack of perceived personal benefits (e.g., "There's nothing in clinical trials for me"), lack of community support (e.g., "People I know have told me not to be in clinical trials"), mistrust (e.g., "I worry that they are not telling me everything I need to know"), and lack of familiarity with clinical trials (e.g., "It costs too much money to be in a clinical trial"). **Results:** Organizational religiosity (frequency of religious attendance) was positively associated with *lack of community support* for participating in clinical trials ( $r=0.12$ ,  $p<0.01$ ), especially among Catholics ( $r=0.15$ ,  $p<0.05$ ). Among Protestant Christians, organizational religiosity was associated with *lack of familiarity* with clinical trials ( $r=0.22$ ,  $p<0.05$ ). Non-organizational religiosity (frequency of prayer, meditation, or Bible study) was not related to any of the four barriers to clinical trial participation. Greater intrinsic religiosity (IR) was also positively related to *lack of community support* for clinical trial participation ( $r=0.10$ ,  $p<0.05$ ). Among women who spoke only Spanish, IR was significantly and positively related to *mistrust of clinical trials* ( $r=0.13$ ,  $p<0.05$ ), and among Protestant Christian women, IR was related to *lack of familiarity* with clinical trials ( $r=0.20$ ,  $p<0.05$ ). Investigators concluded that: "religious institutions that serve Latinas may be an effective venue for disseminating clinical trial education programs to improve attitudes toward clinical trials participation."

*Citation:* Daverio-Zanetti S, Schultz K, Martin del Campo MA, Malcarne V, Riley N, Sadler GR (2015). Is religiosity related to attitudes toward clinical trials participation? *Journal of Cancer Education* 30:220-224  
*Comment:* This is one of the few studies (if not only one) that has examined the effects of religiosity on attitudes of ethnic minorities (particularly Hispanic females) towards participation in clinical trials. These results suggest that religiosity may reduce the likelihood of participation in clinical trials by Hispanic women. Research like this is needed in Hispanic men and Blacks of both genders, given the health disparities so common in these ethnic minorities.

## In Polls We Trust

Robert Wuthnow, the Gerhard R. Andlinger Professor of Sociology at Princeton University, chair of Princeton's Department of Sociology, and Director of the University's Center for the Study of Religion, has written an informative article in the August edition of the magazine *First Things*. He discusses the benefits and downsides of polls (public opinion surveys involving national random samples). Most notable are the downsides. He indicates that public opinion polls are used for many reasons other than for political purposes, and are often used by religious groups to identify the demographic characteristics of regions to help churches address the needs of the population. Wuthnow provides a nice history of polling that extends from polls conducted by the Gallup Polls beginning in 1935 to polls conducted by Louis Harris, Elmo Roper, University of Chicago's National Opinion Research Center (NORC), and University of Michigan's Institute for Social Research (ISR), up through more recent polls conducted by the Pew Research Center. All polls to some extent surveyed the religious characteristics of Americans (and Gallup conducted some international polls as well). Of particular interest are the downsides of polling. Because of the sheer number of organizations now conducting polls (a billion dollar industry), pollsters are having a harder and harder time getting people to respond. While the response rate in the 1980's was typically in the 65-75% range, in the late 1990's it had dropped to 30-35% and is now about 9-10%. In an independent study of 140 polls, only three disclosed their current response rates (despite claims of accuracy within  $\pm 3-5%$ ). While news organizations present the results of polls as facts, Wuthnow writes that "A more honest report would explain that 90 percent of those who should have been included in the poll were not included."

*Citation:* Wuthnow R (2015, August). In polls we trust. *First Things*. See website: <https://www.firstthings.com/article/2015/08/in-polls-we-trust>

*Comment:* This is an eye-opening account of what "lies" behind national opinion polls. Few researchers today would try to generalize to the entire population results obtain from a sample with only a 9-10% response rate. Wuthnow has a new book soon to be published titled *Inventing American Religion: Polls, Surveys, and the Tenuous Quest for a Nation's Faith* (Oxford University Press).

## Religious Understanding as Cultural Competence in Psychiatry

In the online edition of *Psychiatric Times*, Rob Whitley and G. Eric Jarvis discuss the important role that religion plays in American society and describe what "religious competence" refers to in terms of providing culturally competent psychiatric care. According to these authors, "Religious competence involves learning and deployment of generic competencies, including active listening and nonjudgmental stance. It is also an overarching orientation, providing a safe place for discussion of religious issues and identities received in a humble, respectful, and empathetic manner." Psychiatrists are encouraged to take a spiritual history, and a case is provided that illustrates the important role that mental health professionals can play in linking patients with faith-based resources (even employment in religious settings). Caution, however, is stressed so that boundaries are not inappropriately crossed. Psychiatrists are encouraged to allow the patient to guide these sensitive and delicate discussions.

*Citation:* Whitley R, Jarvis GE (2015). Religious understanding as cultural competence: Issues for clinicians *Psychiatric Times* 32(6):000-000. See website: <http://www.psychiatristimes.com/special-reports/religious-understanding-cultural-competence-issues-clinicians/page/0/1>

*Comment:* This is a succinct discussion of the key issues involved in addressing religious issues in psychiatric care. It is encouraging that such articles are now being published in mainstream psychiatric periodicals that are now widely distributed (this monthly periodical goes out to 40,000 psychiatrists free of charge and its website has about 400,000 monthly page views).

## The American Medical Association and Religion

Kim and colleagues from the University of Chicago track the history of organized medicine's engagement with religion over the past century.

While interest in the intersection between religion and medicine appears to be increasing in the past 10 years, this is apparently not the first time. Based on primary source documents, the authors discovered that a Committee on Medicine and Religion (CMR) existed within the American Medical Association between 1961 and 1974 with state level committees in 49 states and county-level committees in 800 county medical societies. Physician-clergy conferences were the norm during those days, as American medicine reached out to clergy to help them grapple with growing ethical uncertainties, medical moral dilemmas, and patient dissatisfaction with medical care. In 1961, Rev. Granger Westberg -- a founding member of CMR -- wrote the book *Minister and Doctor Meet*. CMR at that time was made up of 10 nationally known physicians and 10 nationally known ministers, including the vice speaker of the house of the AMA who the first CMR chair. In 1967, CMR-sponsored conferences attracted over 3,000 attendees. Speakers included the eminent Rabbi Abraham Heschel and renowned physicians Edward Rynearson, Howard Rusk, and William Menninger, who spoke about "the power of religion in their own lives as caregivers." In 1972, however, CMR was abruptly abolished by the AMA Board of Trustees under puzzling circumstances thought to be due to the raging debate on abortion at that time. The authors end the article with a discussion of how that period in American medicine relates to what is happening today, as efforts to integrate spirituality into patient care increase and interest in the medicine-religion relationship grows.

*Citation:* Kim DT, Curlin FA, Wolenberg KM, Sulmasy DP (2014). Back to the future: The AMA and religion, 1961-1974. *Academic Medicine* 89(12): 1603-1609.

*Comment:* This is an amazing story completely buried within American medical history until discovered and retold by the authors of this article. The relationship between what clergy do and what physicians do cannot be separated for very long. Then it naturally surfaces again. This is a must read for anyone interested in the religion-medicine connection.

## LATEST RESEARCH FROM DUKE

### Review of Religion-Health Research

Readers should be aware of the latest review of religion-health research published in the journal *Advances*. This review succinctly summarizes the research systematically reviewed through 2010 in the *Handbook of Religion and Health* (2012). It also highlights some of the most recent research published since 2010 and describes research currently being conducted at Duke University in this area.

*Citation:* Koenig HG (2015). Religion, spirituality, and health: A review and update. *Advances in Mind-Body Medicine* 29(3):19-26.

*Comment:* This is a recent summary and update that will be useful to those who wish to become familiar with past and current research in this area.

## NEWS

### Clergy Survey Released

The General Board of Pension and Health Benefits/Center for Health has just released results from a 2015 survey of United Methodist clergy. The survey was sent to 4,000 clergy, of whom 1,501 completed the 100-item questionnaire. Physical and mental health conditions were assessed by self-report in this online survey. The findings (not surprisingly) indicate that healthy clergy are linked to healthy, vital congregations, and that healthy pastoral leaders are a key factor for vital congregations. For a summary of the full report, go to: <http://www.qbophb.org/assets/1/7/4785.pdf>. For questions, contact Anne Borish at [aborish@qbophb.org](mailto:aborish@qbophb.org).

## SPECIAL EVENTS

### 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](http://www.medicineandreligion.com).

### 2016 Annual Meeting of the Southern Association for the History of Medicine and Science

(Las Vegas, NV, March 17-19, 2016)

SAHMS is having their 16th annual meeting at the University of Nevada, Las Vegas School of Law. SAHMS is composed of a mixture of physicians, nurses, Ph.D.'s, and students, both graduate and undergraduate, who work in the medical humanities. The Southern in the name only relates to holding their annual meeting south of the Mason-Dixon Line and does not in any way limit paper topics. The organization is international in scope. SAHMS particularly welcomes papers from graduate students and advanced undergraduate students who would like the experience of presenting in this friendly type of forum. For more information, go to: <http://www.sahms.net/>.

## RESOURCES

### CME/CE Videos

Five professionally produced 45-minute videos on **why and how** to "integrate spirituality into patient care" are now available for viewing on our website (*for free*, unless CME/CE is desired) due to the generous support of the Templeton Foundation and Adventist Health System. These videos are specifically targeted at physicians, nurses, chaplains, and social workers to help them form spiritual care teams that will enable them 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>.

### Health and Well-being in Islamic Societies

(Springer International, 2014)

As ISIS marches across the Middle East, conducting ethnic cleansing, beheading Westerners, and rewarding their soldiers with women they've captured along the way—justifying these activities by pointing to the Qur'an—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 Qur'an 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. Much of this information will be a real eye-opener to readers. The core of the book, though, 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 by identifying and addressing the spiritual needs of patients. Chapters are targeted to the needs of physicians, nurses, chaplains and pastoral counselors, mental health professionals, social workers, and occupational and physical therapists. 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.researchliteratchaplaincy.org](http://www.researchliteratchaplaincy.org).

## FUNDING OPPORTUNITIES

### Templeton Foundation Online Funding Inquiry (OFI)

The fall funding cycle is being skipped, and next submission of OFI will likely 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...

### September

- 24 **Religion, Spirituality and Health**  
Southport Congregational Church  
Southport, CT, and Fairfield, CT  
Speaker: Harold G. Koenig  
Contact: Rev Paul Whitmore ([pwhitmore@southportucc.org](mailto:pwhitmore@southportucc.org))
- 30 **Religion and Medical Ethics: Empirical and Theoretical Relationships**  
Speaker: Farr Curlin, M.D.  
Josiah C Trent Professor of Medical Humanities, Duke U.  
Co-Director, Theology, Medicine, & Culture Initiative, Duke U  
Center for Aging, 3rd floor, Duke South, 3:30-4:30  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))

### 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](mailto:dyarbrough@admin.rochester.edu))
- 19 **Integrating Spirituality into Healthcare**  
Merchab Institute Spiritual Care Symposium  
Springdale, Arkansas (northwest Arkansas)  
Speaker: Harold G. Koenig  
Contact: CJ Malone, Executive Director, Merchab Institute  
([CMalone@NW-Health.com](mailto: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](mailto: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](mailto:Harold.Koenig@duke.edu))

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