

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 November 2020) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

NOTE: The Csth website is being moved to a different platform, so may not be accessible for periods during December.

LATEST RESEARCH

Impact of Religiosity on Remission from Active Crohn's Disease

In a 2-year prospective study, investigators at the Inflammatory Bowel Disease Center, University Hospital, Federal University of Juiz de Fora in Brazil, followed 90 patients with active Crohn's disease, examining the effects of baseline religiosity/spirituality on remission of the disease over time. Crohn's disease activity was assessed by the Harvey Bradshaw Index. Religion/spirituality (R/S) was assessed by the Duke Religion Index (DUREL), the Spirituality Self-Rating Scale (SSRS), and the Spiritual/Religious Coping Scale (SRCOPE). Logistic regression was used to examine the effects of baseline R/S on symptom remission at 2-year follow-up. **Results:** Baseline levels of spirituality and intrinsic religiosity predicted a 31% and 68% faster remission from disease, respectively (OR=1.31, 95% CI =1.10-1.55, for spirituality; OR=1.68, 95% CI=1.22-2.32, for intrinsic religiosity). R/S in this study did not predict quality of life, anxiety, or depression. The authors concluded: "Health professionals who treat CD [Crohn's disease] should be aware of the religious and spiritual beliefs of their patients, given these beliefs may impact on the disease course."

Citation: Jacob Daniel Salomão de Campos, R., Lucchetti, G., Lucchetti, A. L. G., Chebli, L. A., Schettino Pereira, L., & Chebli, J. M. F. (2020). Influence of religiousness and spirituality on remission rate, mental health and quality of life of patients with active Crohn's disease: a longitudinal 2-year follow-up study. *Journal of Crohn's and Colitis*, EPUB ahead of press (<https://doi.org/10.1093/ecco-jcc/ijaa130>).

Comment: Unfortunately, only the abstract of the study was available for review. Nevertheless, this is one of the first prospective studies examining the effects of religion/spirituality on speed of symptom remission in this painful and disabling gastrointestinal disease.

Impact on Cardiovascular Functions: Devotional Prayer vs. Secular Meditation

Researchers at the University of Colorado and Syracuse University compared the effects of Christian devotional prayer (DP) with secular meditation (SM) and a habituation control condition (HC) on cardiovascular reactivity in this randomized controlled trial. Participants were 85 Christian undergraduate psychology students at a secular northeastern university (Syracuse University, New York); none of the participants had any cardiovascular health problems. Cardiovascular responses that were examined included activity-stressor differences in systolic blood pressure, diastolic blood pressure, and heart rate. Intrinsic religiosity was assessed by the 32-item Religious Life Inventory. In the DP group, participants were asked to reflect on one of five New Testament scriptures that emphasized prosocial values and conduct, with a set of questions designed to facilitate deep processing of the material. Those assigned to the SM group were asked to perform the same activities as the DP group except that all passages and instructions were nonreligious. Finally, participants in the HC group were asked to relax while looking at non-interpersonally relevant pleasant natural landscapes. The activity for all three groups lasted 15 minutes. All three groups then underwent a Religious Views Interview (RVI; based on Richard Dawkins' *The God Delusion*) intended to be mildly confrontational and illicit psychophysiological arousal. In the recovery phase, a 15-minute period after the RVI, participants were asked to remain seated and wait for the interviewer to return. **Results:** Statistical analysis of the results revealed significantly reduced cardiovascular reactivity for those in the DP group compared to both SM and HC groups. The RVI was shown to be a strong stressor and a good indicator of a stressful event. Intrinsic religiosity at baseline predicted reduced cardiovascular reactivity across all three groups. Researchers concluded: "Among Christians, DP may be an effective method of dampening response to a potent, religiously-based, interpersonal stress."

Citation: Masters, K. S., Emerson IV, R. W., & Hooker, S. A. (2020). Effects of devotional prayer and secular meditation on cardiovascular response to a faith challenge among Christians. *Psychology of Religion and Spirituality*, EPUB ahead of press (<https://doi.org/10.1037/rel0000369>).

Comment: This experimental study found that among Christian college students, Christian devotional prayer may reduce the cardiovascular effects of a religious stressor, compared to secular meditation or a control group. Given that increased cardiovascular responses are known to negatively impact the cardiovascular system over the long-term, this may help to explain why those who are more religious tend to experience lower blood pressure and less cardiovascular disease in later life (after a lifetime of daily stressors).

Does Religiosity/Spirituality Modify the Relationship between a History of Childhood/Adolescent Abuse and Telomere Length in Adulthood

Researchers from Harvard's Center on Genomics at Massachusetts General Hospital analyzed cross-sectional data on 3,232 participants participating in five different cohort studies to

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examine the relationship between childhood/adolescent physical and sexual abuse on telomere length during adulthood. The cohorts consisted of convenience samples of participants in the U.S. Black Women's Health Study (BWHS; n=787-814), Brazilian Baependi Heart Study (BHS; n=356-386), U.S. Nurses' Health Study (NHS-II; n=1097), American Indian Strong Heart Study (SHS, n=279), and Mediators of Atherosclerosis in South Asians Living in America study (MASALA; n=505) on whom telomere length analyses were available. Religiosity/spirituality (R/S) was assessed by a single question asking about the participant's self-rated religiosity or spirituality the participant was (very vs. moderately, slightly, or not at all) and a 7-item religious coping scale that measured positive and negative religious coping. History of physical abuse before the age of 18 was assessed using the Revised Conflict Tactics Scale (obtained in all groups), whereas a history of sexual abuse was assessed using questions from a 1995 Gallup Poll (obtained in all groups except MASALA). Controlled in linear regression analyses with generalized estimating equations (GEE) were age, race, gender, parental education, parental home ownership, parental loss, childhood financial hardship, and receipt of public assistance in childhood; during adulthood, control variables included body mass index, household income, smoking status, physical activity, alternative healthy eating index, and depressive symptoms. **Results:** Physical abuse was not associated with telomere length (TL). Severe sexual abuse in childhood, however, was associated with an average 15.6% shorter TLs (95% CI = 4.9%-25.9%, p=0.04), and sexual abuse in both childhood and adolescence was associated with an 11.3% shorter TLs (95% CI= 2.0%-20.5%, p=0.03). Neither self-reported R/S nor religious coping moderated the relationship between sexual abuse in childhood and/or adolescence and adult telomere length.

Citation: Warner, E. T., Zhang, Y., Gu, Y., Taporoski, T. P., Pereira, A., DeVivo, I., ... & Shields, A. (2020). Physical and sexual abuse in childhood and adolescence and leukocyte telomere length: A pooled analysis of the study on psychosocial stress, spirituality, and health. *PLoS One*, 15(10), e0241363.

Comment: Although cross-sectional, this is likely to be the first study to examine the moderating effects of self-rated R/S and religious coping on the relationship between childhood/adolescence sexual/physical abuse and telomere length during adulthood.

Religion/Spirituality and Posterior EEG Alpha in Predicting Future Depressive Symptoms

Researchers in the department of psychiatry at Columbia University in New York City examined the effects of R/S importance on severity of depressive symptoms 5-8 years later in a prospective study involving 94 participants at high and low risk for depression based on family history. Importance of religion/spirituality was assessed by the question: "How important is religion or spirituality to you?" with possible responses being highly important, moderately important, somewhat important, or not important at all. The estimated R/S scored age 21 was based on assessments at T10, T20, T25, T30, and T40 in this overall 40-year follow-up study. Resting EEG was obtained at T30, which provided estimates of posterior EEG alpha rates. Depression severity was assessed by two measures (PHQ-9 at T35 and T40, and IDAS-II-GD at T40 only). Multiple linear regression analyses controlled for EEG alpha, MDD risk, and age in predicting future depression severity; the interaction between R/S importance and EEG alpha in predicting depression severity was also examined. **Results:** Overall, higher R/S estimates at age 21 predicted lower future depression severity (F=7.28, p<0.01), as did greater EEG alpha with eyes closed (F=5.24, p=0.02). Both higher R/S and greater EEG alpha, then, independently predicted lower depression severity over time. The interaction was also significant (F=5.84, p=0.018). Decomposing the interaction revealed that R/S

was only related to lower depression severity in those with low alpha levels; in those with high alpha levels, higher R/S importance predicted greater depression severity. Researchers concluded: "Findings revealed a complementarity role of R/S and alpha in that either variable exerted protective effects only if the other was present at low levels."

Citation: Panier, L. Y., Bruder, G. E., Svob, C., Wickramaratne, P., Gameroff, M. J., Weissman, M. M., ... & Kayser, J. (2020).

Predicting depression symptoms in families at risk for depression: Interrelations of posterior EEG alpha and religion/spirituality.

Journal of Affective Disorders 274 (9), 969-976.

Comment: Another important study showing that R/S predicts lower depression severity over time independent of other risk factors. The interactive effect with EEG alpha is a new finding, helping to provide a neurobiological mechanism underlying the protective effects of R/S importance, as the authors note.

Religiosity/Spirituality, Suicide Risk and Remission of Depressive Symptoms

Researchers from the Federal University of Rio Grande do Sul in Porto Alegre, Brazil, conducted a 6-month prospective study of 192 Brazilian outpatients with depressive disorder, examining the effects of religiosity/spirituality (R/S) on remission of depressive symptoms. Diagnoses of depression were made using the MINI International Neuropsychiatric Interview (MINI-Plus). Depressive symptoms were measured by the 17-item observer-rated HAM-D. Suicidal symptoms were assessed using 6 items from the MINI-Plus that were summed to create an index with a score range from 0 to 33. Religiosity was measured by the Duke University Religion Index (DUREL), and spirituality by an 8-item version of the WHOQOL-SRPB. Also assessed were childhood traumatic experiences and social support. Multivariate logistic regression was used to predict the likelihood of remission of depressive symptoms among 111 patients at 6-month follow-up, controlling for age, gender, childhood abuse, childhood neglect, social support, depression duration, depression severity, depression treatment failures, and treatment augmentation. **Results:** At baseline, both intrinsic religiosity and spirituality were inversely correlated with suicide risk scores. When followed up over time, those attending religious services more frequently were 82% more likely to experience a remission of depressive symptoms during follow-up compared to those attending religious services less frequently (OR=1.82, 95% CI = 1.08-3.07, p=0.02). All R/S variables were included in a single model, where frequency of religious attendance was the strongest predictor; after controlling for attendance, no other R/S variables were significant predictors. Researchers concluded: "Findings reinforce the importance of attending to religiosity/spirituality in order to improve outcomes and promote the recovery especially among severely depressed patients with increased suicide risk."

Citation: Mosqueiro, B. P., Caldieraro, M. A., Messinger, M., da Costa, F. B. P., Peteet, J. R., & de Almeida Fleck, M. P. (2020). Religiosity, spirituality, suicide risk and remission of depressive symptoms: a 6-month prospective study of tertiary care Brazilian patients. *Journal of Affective Disorders*, EPUB ahead of press (<https://doi.org/10.1016/j.jad.2020.10.028>)

Comment: This study adds to the growing evidence that religious involvement, particularly involvement in the religious community, helps to speed remission from depressive symptoms among those with depressive disorder when followed over time.

Religious/Spiritual Curriculum for Psychiatric Residency Programs

Researchers from Brazil and the United States report here the development of a flexible 12-hour core curriculum (six 2-hour sessions) to educate psychiatry residents on the role that religion/spirituality (R/S) plays in the mental health of psychiatric

patients. The content of the curriculum includes (a) reviewing the research on R/S and mental health, (b) taking a spiritual history and developing a case formulation, (c) learning about the religious beliefs and practices of local religious traditions, (d) differentiating between R/S experiences and symptoms of mental disorder (psychosis, OCD), and (e) learning how to integrate R/S into treatment. Teaching methods proposed in the curriculum include didactic lectures, group discussions, review of practice guidelines, taking spiritual histories, case presentations, and clinical supervision. They also present other options for providing such training, including a single 4-hour session that involves a brief introductory session with group discussion, review of the World Psychiatric Association position statement on R/S, residents taking each other's spiritual history, developing a bio-psycho-socio-spiritual case formulation, and obtaining feedback from residents. After the proposed curriculum is described in detail, the authors explore what should be taught and what competencies should be developed, how the curriculum should be taught, when the curriculum should be taught, who should teach the curriculum, how the curriculum is to be evaluated, how to overcome challenges, barriers and limitations, and what modifications might be made to the curriculum in order to fit it into existing psychiatric residency curriculums.

Citation: de Oliveira, E. O. F., Peteet, J. R., & Moreira-Almeida, A. (2020). Religiosity and spirituality in psychiatry residency programs: Why, what, and how to teach? *Revista Brasileira de Psiquiatria (Brazilian Journal of Psychiatry)*, EPUB ahead of press (<https://doi.org/10.1590/1516-4446-2020-1106>).

Comment: This paper describes a very well-developed structured curriculum that is comprehensive and succinct, which every psychiatric residency program should consider adopting. The *Brazilian Journal of Psychiatry* is the top academic psychiatry journal in the country.

Religion and Mental Health of Older Adults in Malaysia

Investigators at Southeast Asia Community Observatory, Monash University at Selangor and other universities in Malaysia analyzed cross-sectional data on 7,068 participants age 55 or older in a community health survey conducted in 2013. Participants were 62.5% Malays (all Muslims), 29.4% Chinese (mostly Buddhist), and 8.1% Indian (mostly Hindu). More specifically, religious affiliations of the sample were 62.8% Islam, 27.8% Buddhist, 7.1% Hindu, and less than 2% Christian, Taoist, or other. Religiosity was assessed by (1) importance of having an enriched religious/spiritual life and (2) belief in a Higher Power that determines the course of a person's life. Mental health was assessed by the 21-item Depression, Anxiety, and Stress scale (DASS). Multivariate regression analyses were conducted in Malays, Chinese, and Indian groups separately, while controlling for age, ethnicity, religion, gender, marital status, education, occupation, income, and chronic physical illness. **Results:** Among Malay Muslims (n=4418), importance of religion was positively associated with depressive symptoms ($b=0.32$, $p<0.05$), but was unrelated to anxiety or stress symptoms. Among Chinese (n=2080), importance of religion was again positively related to depressive symptoms ($b=1.19$, $p<0.001$), but also to anxiety ($b=1.26$, $p<0.001$) and stress level ($b=0.97$, $p<0.001$). Among Indians (n=570), religious importance was unrelated to depression, anxiety, or stress symptoms. In contrast, belief in a Higher Power was negatively related to depressive, anxiety, and stress symptoms in Malay Muslims (all $p<0.001$); negatively related to depressive symptoms and stress symptoms in Chinese (both $p<0.01$); and negatively related to depression, anxiety, and stress symptoms among Indians (all $p<0.001$). Researchers concluded: "The current study showed that there were ethnic variations in the associations between religion and mental health, and the associations depended on the religious variable included in the

analysis. The findings of this study showed that religion could be another potential channel to improve mental health among older adults by accommodating and understanding their religious beliefs."

Citation: Tan, M. M., Su, T. T., Ting, R. S. K., Allotey, P., & Reidpath, D. (2020). Religion and mental health among older adults: ethnic differences in Malaysia. *Ageing & Mental Health*, EPUB ahead of press (<https://doi.org/10.1080/13607863.2020.1799939>)

Comment: Although cross-sectional in nature, these findings demonstrate dramatic differences between two different religious indicators and mental health symptoms in each of the three ethnic groups, with belief in a Higher Power (but not importance of religion) being inversely related to all three types of emotional distress symptoms (depression, anxiety, and stress) among these older adults.

Religiosity/Spirituality and Suicide Risk in US Veterans

VA researchers analyzed cross-sectional data involving 1,002 Iraq and Afghanistan era veterans to examine the relationship between R/S, suicidal thoughts, and past suicide attempts. Participants were a convenience sample from across the U.S. recruited through targeted mailings, advertisements, and clinician referrals. Major depressive disorder and PTSD were identified using the SCID-IV-TR. Suicidal ideation was assessed by the Beck Scale for Suicidal Ideation. A history of suicide attempts was determined by a single item (0=no, 1=yes). Single items from the Brief Multidimensional Measure of Religiosity/Spirituality (BMMRS) were used to assess R/S (self-rated overall religiosity, self-rated spirituality, R/S attendance, R/S activities, forgiveness by God [and other R/S-driven indicators of forgiveness of self and others], strength from God, punished by God, and Divine abandonment). Other clinical and demographic variables included degree of combat exposure, alcohol misuse, drug misuse, social support, meaning and purpose in life, gender, ethnicity, family history of suicide, and traumatic brain injury. Logistic regression analyses were used to examine correlates of suicidal ideation and prior attempt. **Results:** Bivariate analyses indicated significant inverse relationships between multiple R/S characteristics (religiosity, spirituality, R/S attendance, R/S activities, R/S-driven forgiveness, strength from God) and suicidal ideation, as well as a positive relationship between negative religious coping and suicidal ideation. Frequency of R/S attendance and being forgiven by God also tended to be inversely related to prior suicide attempts. Logistic regression models, however, indicated no effect of any R/S variables on suicidal ideation after controlling for feeling in control of life, forgiveness, PTSD, and depression. Likewise, no R/S variables except feeling punished by God (in a positive direction) was associated with past suicide attempts, after controlling for PTSD, meaning and purpose in life, age, drug misuse, and feeling punished by God. Researchers concluded: "Clinical screening for spiritual difficulties may improve detection of suicidality risk factors and refine treatment planning. Collaboration with spiritual care provider such as chaplains, may enhance suicide prevention efforts."

Citation: Smigelsky, M. A., Jardin, C., Nieuwsma, J. A., Brancu, M., Meador, K. G., Mollo, K. G., ... & Elbogen, E. B. (2020). Religion, spirituality, and suicide risk in Iraq and Afghanistan era veterans. *Depression and Anxiety*, 37(8), 728-737

Comment: Unfortunately, researchers did not examine indirect effects of R/S through possible mediating variables (e.g., feeling in control of life, R/S-driven forgiveness, meaning/purpose in life, drug misuse, or indicators of mental health) in regression models. The likelihood that indirect effects were indeed present was suggested by the bivariate inverse correlations between multiple indicators of R/S and suicidal ideation. There is little doubt, however, about the last sentence in authors' conclusion above.

Religion/Spirituality and Postpartum Mental Health in Women with Histories of Childhood Maltreatment

In this prospective study, investigators from the department of psychiatry, obstetrics & gynecology at University of Michigan examined the effects of R/S on depression/quality of life in 108 women with a history of childhood maltreatment. Participants were assessed at 6 months postpartum and then again at 12 and 15 months postpartum. The 28-item Childhood Trauma Questionnaire was used to assess childhood appearances at 4 months postpartum. R/S was assessed by the BMMRS at the 6-month postpartum visit with the following six subscales: 6-item daily spiritual experiences subscale, a 2-item meaning subscale, a 3-item R/S-driven forgiveness subscale, 5-item religious practices subscale, 7-item R/S coping subscale, and 2 item attendance at religious services (organizational religiousness) subscale. Mental health outcomes included the 35-item Postpartum Depression Screening Scale and the 9-item Maternal Quality of Life (QOL) index, which were administered at the 12 and 15-month postpartum visits (but not the 6-month postpartum visit, i.e., baseline). Demographic variables controlled for in analyses were current living situation, race, work, relationship status, education, income, age, education, and marital status; however, baseline depression and QOL scores were not controlled for. **Results:** Bivariate analyses indicated no relationship between any R/S subscales and either depressive symptoms or QOL. Regression analyses indicated that only the forgiveness subscale (which included self-forgiveness, other forgiveness, and forgiveness by God based on R/S motivations) was inversely related to depression and positively related to QOL at both 12 and 15-month follow-ups (n=76-82 with attrition). The only exception was the organizational religiousness subscale, which was significantly and inversely related to QOL at 12 months (b=-0.28, p<0.05), after controlling for R/S-based forgiveness.

Citation: Handelzalts, J. E., Stringer, M. K., Menke, R. A., & Muzik, M. (2020). The association of religion and spirituality with postpartum mental health in women with childhood maltreatment histories. *Journal of Child and Family Studies*, 29(2), 502-513.

Comment: Failure to control for baseline depression and QOL made this largely a cross-sectional analysis. The inverse relationship between organizational religious activity (ORA) and QOL at 12 (but not 15 months) is likely the result of controlling for R/S based forgiveness, which was a powerful predictor. Regardless, little if any relationship was found between R/S variables and either depression or QOL in this relatively small study with low statistical power. The reason we include the study here is because of the relatively limited research on R/S and postpartum depression.

Gravestone Analysis of the Relationship between Religiosity and Longevity

Researchers from departments of psychology and social research from central and northern Europe analyzed data obtained from gravestones on 6,400 deceased persons. "Participants" were identified from religious and nonreligious counties in the United States. Religiosity was determined by "gravestone inscriptions and imagery," purportedly reflecting the religiosity of the deceased. A gravestone religiosity index was created based on symbols representing the Bible or Book of Life (10%), hands folded in prayer (7%), and angels (2%) (titled BPA) that were etched on tombstones. To confirm the validity of this method, biographies found on Findagrave.com (available for 7% of the sample) were examined. County religiosity was determined based on publicly available regional information from the US religion census. BPA scores were found to distinguish those buried in 32 religious counties from those buried in 32 secular counties. The relationship between the BPA index and longevity was then analyzed using

mixed-effects models with 14 "robustness checks" based on individual-level confounds and county and state-level confounds. **Results:** Among those buried in religious counties, BPA scores indicated that religious individuals assessed by this index live 2.2 years longer than did the non-religious deceased; in nonreligious counties, in contrast, religiosity measured in this manner conferred no longevity benefits. Researchers concluded: "Evidently, religiosity's longevity benefits are not due to some inherent feature of religiosity. Instead, they may be due to the more general phenomenon that people enjoy health benefits if they receive social valuation from their ambient cultural context... Religiosity does not delay death everywhere, and rising secularization will probably not curb collective life expectancy in the future." *Citation:* Ebert, T., Gebauer, J. E., Talman, J. R., & Rentfrow, P. J. (2020). Religious people only live longer in religious cultural contexts: A gravestone analysis. *Journal of Personality and Social Psychology*, 19(1), 1–6, EPUB ahead of press (<https://doi.org/10.1037/pspa0000187>)

Comment: We might question the authors' sweeping conclusions above, given the cross-sectional nature of their findings and the multiple limitations of the study itself. As the authors acknowledge, religious symbols on tombstones may not have been placed there by the deceased, but rather by family members (or even funeral directors). Individual characteristics of the deceased individual were also limited to gender, age, and marital status (information available from gravestones and from a limited number of obituaries). The remaining covariates in analyses were all community level (county or state) characteristics. There was no control for individual health factors that may have affected both religiosity and longevity, which could confound this cross-sectional relationship. Also, the authors failed to point out that perhaps religious individuals living in secular areas of the country may themselves have experienced psychological and social pressures because of their religious faith that adversely affected health outcomes (just as the authors claim for secular individuals in religious areas). In secular contexts, the health benefits of religiosity may have been offset by the adverse effects of cultural and social pressures they faced over their religion, reducing religiosity's effect on longevity. Finally, the results of this study contrast with many high-quality longitudinal studies reporting a positive effect of religious involvement on longevity across geographical location and independent of many psychological, social, behavioral, and physical health factors assessed at the individual level.

Does Social Support Explain the Health Benefits of Religiosity in Canada?

Canadian researchers examined whether the question of whether social support mediates the cross-sectional relationship between religiosity/spirituality (R/S) and health outcomes in Canada. Participants included 8,623 adults in the 2012 Canadian Community Health Survey. R/S was assessed by two questions: (Q1) "How important or religious or spiritual values in your daily life?" and (Q2) "To what extent do religious and spiritual values provide strength to face every day?" Based on responses to these questions, participants were categorized into a "maximal R/S" group (coded 1) or a "minimal R/S" group (coded 0). The maximal R/S group responded "very important" to Q1 and "a lot" to Q2 (n=5,471), whereas the "minimal R/S" responded "not at all important" to Q1 and "not at all" to Q2 (n=3,152), with sample sizes derived after excluding participants under age 20 and those with missing values on key predictor and outcome variables. Social support was assessed by the 10-item version of the Social Provision Scale. Examples of items included on this scale are "There are people who enjoy the same social activities I do" and "I feel part of a group of people who share my attitudes and beliefs." A total of 11 health outcomes were examined including emotional well-being (3-item EWB scale), psychological well-being (6-item

PWB scale), social well-being (5-item SWB scale), self-rated health (single item), satisfaction with life (single item), distress (10-item K10), diagnosis of generalized anxiety disorder (GAD=1 or 0), bipolar disorder (BPD=1 or 0), major depressive episode (MDD=1 or 0), alcohol use disorder (AUD=1 or 0), and drug use disorder (DUD=1 or 0). Linear and logistic regression models were used to examine the relationship between the dichotomized R/S variable and health outcomes, controlling for gender, age, minority status, marital status, education, income, and region of Canada. Meaningful differences between high and low R/S participants were defined as an effect size >0.20 (Cohen's d). **Results:** High R/S was significantly associated with healthier outcomes on nine of the 11 outcomes assessed. The relationships in seven of these health outcomes were attenuated when social support was controlled for, explaining 39.8% of the relationship with EWB, 25.0% of that with PWB, 13.8% of that with SWB, 33.4% of that with self-rated health, and 50.5% of that with life satisfaction. There was no attenuation of the relationship with alcohol abuse/dependence or drug abuse/dependence when social support was controlled for. Researchers concluded: "Social support plays a mediating role in many R/S-health relationships for Canadians. Although R/S appear to have a statistical relationship with many health outcomes, several of these lack practical significance."

Citation: Speed, D., Barry, C., & Cragun, R. (2020). With a little help from my (Canadian) friends: Health differences between minimal and maximal religiosity/spirituality are partially mediated by social support. *Social Science & Medicine*, 265, 113387.
Comment: Note the way that R/S is measured above, which focuses on "religious or spiritual values," not religiosity or religious involvement per se. Also, Q2 is a measure of R/S coping (strength provided by R/S to face every day life), which is likely to increase during periods of psychological and emotional distress. Such reverse-causation is likely to attenuate any inverse cross-sectional relationships between R/S and the mental health outcomes assessed here. Furthermore, dichotomizing the R/S variable – rather than using a continuous measure – is likely to reduce effects, since information is lost by collapsing response options. Finally, the measure of social support – particularly the specific items noted above – is likely to be strongly related to and overlap with the R/S predictor simply by the way the questions were asked (actually referring to beliefs), leading to further attenuation of R/S effects on mental health outcomes. Thus, considerable caution is necessary before concluding that the effects of R/S on health outcomes are primarily due to social support, and not to anything intrinsic about religiosity itself, which the researchers suggest.

The Psychology of Nonbelievers

In this commentary and review article, researchers from Croatia and the United Kingdom discuss the psychological characteristics of nonbelievers. Nonbelievers in God, the authors claim, makeup around 26% of the US population when "social desirability" is taken into account¹ (see comments below). The authors note that

¹ The estimate of 26% nonbelievers in the U.S. is based on an article published in *Social Psychological and Personality Science* (2018; 9:3-10), which uses a complex statistical model constructed from online responses obtained from two samples of 2000 pre-registered Americans (whose demographic characteristics were not described, although likely involved young, technology savvy respondents in need of cash). The way that questions were posed and the order in which they were asked may have influenced responses (i.e., "order response" bias). Likewise, some of the questions were rather complex, increasing the likelihood that paid preregistered responders (as is the case with YouGov, where the data was obtained from) may not have carefully read through the questions in order to save time. Regardless, in the first 2000 member sample, the indirect estimate of American atheists was 32% (range 11% to 54%), and in the second 2000 member sample it was 20% (range 6% to 35%). Really? The overall indirect

nonbelievers are characterized by analytic, flexible, and open-minded social-cognitive attitudes [indeed, as long as they don't involve religion, when attitudes and beliefs appear quite fixed and inflexible]. The authors question theories about how non-belief develops, emphasizing rather that general intelligence is related to non-religiosity, and that nonbelievers demonstrate higher analytic thinking, greater reasoning skills, are more open to new experiences, less dogmatic, and more likely to think flexibly [again, except when it comes to religion]. The authors also emphasize that nonbelievers are more likely to endorse humanistic beliefs related to egalitarian (e.g., marriage equality, women's rights, gay rights, racial equality) and liberal worldviews (e.g., acceptance of abortion, casual sex), are more likely to be members of the Democratic Party, and are more likely to value the moral foundations of care and fairness, placing these above values such as purity, loyalty, and authority. The authors also emphasize that nonbelievers find meaning and purpose in "here and now" resources, such as finances, creative activities, traveling, and hobbies. Interest in politics and community activities of nonbelievers appear similar to those of religious believers. The authors challenge the research finding that nonbelievers have worse psychological well-being and poorer health, emphasizing instead a U-shaped relationship between non-religiosity/religiosity and health [although fail to note that such U-shaped relationships are usually found in cross-sectional not longitudinal research]. Finally, the authors acknowledge that most of what they report in this article is based on nonbelievers in Western cultures, and therefore may or may not apply East-Asian non-believers [where restrictions on religious freedoms in some countries like China may influence the psychological characteristics of atheists in this region].

Citation: Uzarevic, F., & Coleman III, T. J. (2020). The psychology of nonbelievers. *Current Opinion in Psychology* 40, 131-138
Comment: Although somewhat one-sided, this is a fascinating commentary that looks into the psychology of non-believers and the relationship between nonbelief and health. One might challenge the benefits that non-belief has on mental, social, behavioral, and physical health, although more research is certainly needed in this area. The low percentage of non-believers in random samples of community adults in Western countries such as the U.S., however, has hampered research in this area.

The Psychology of Religion in East Asian Cultures

In this commentary, the author -- from the department of psychology at the University of Louvain, Belgium -- examines the impact of religion on health outcomes in East Asian cultural and religious contexts (health outcomes such as general health, personality, cognition and emotion, morality and values, intergroup attitudes and behaviors). The author argues that associations between religion and mental health may be weaker or nonexistent in these contexts, especially the moral domain, emphasizing that "Religion, as a guardian of morality, self-control, and collective interests may indeed be less meaningful in collectivistic societies where cultural norms already fulfill these roles." Concerning health and well-being, the author states that the protective role of religiosity seems to be valid in both Western and East-Asian contexts. With regard to personality and individual differences, the author stresses that studies in Western contexts find that religiosity is related to higher scores on agreeableness, conscientiousness, and honesty/humility, but are unrelated to neuroticism, openness

estimate of 26% sharply contrasts to Pew Research Foundation and Gallup Poll results from random national phone samples that indicate the prevalence of nonbelievers in the United States ranges from 3% to 11%. Atheists tend to be well-educated, rational, and are often quite outspoken about their lack of belief, rather than being shy and wanting to cover up what they believe. Therefore, the role that social desirability plays in the low percentages reported by Pew and Gallup -- as argued in this article -- seems questionable.

to experience, or extraversion. In contrast, studies in East Asian cultures find that religiosity is less related to conscientiousness and more strongly related to openness to experience. With regard to cognition and emotion, East Asian religiosity is more strongly associated with a higher tolerance for contradictions, a greater ability to infer others' mental states, and demonstrate a decreased self-serving bias [although such claims are often based on reports from single studies]. Finally, with regard to intergroup attitudes and behaviors, religiosity appears to promote prosocial attitudes and behaviors in East Asian and Buddhist contexts, including prosocial traits, attitudes and behaviors such as compassion, helping and generosity. They also emphasize that studies in these groups show less prejudice towards others (admitting, though, that such tolerance does not completely extend to moral out groups such as homosexuals and atheists). The author concludes with the statement: "In collectivistic societies, where individuals are encouraged to adapt to others' needs, to cultivate strong in-group ties, and to follow binding moral obligations, there is no need for religion to be a warrant of morality or control. Although the individualism-collectivism dimension is not unequivocal, they may provide some interesting future avenues to understand the interplay between religion and culture."

Citation: Clobert, M. (2020). East vs. West: Psychology of religion in East Asian cultures. *Current Opinion in Psychology* 40, 61-66

Comment: This is an important article that helps provide a good background for understanding the role that religion plays in the mental and social health of individuals living in East Asian contexts. Although many of the statements made by the author in this article are based on single studies, further research -- particularly longitudinal studies -- are needed to confirm many of the assertions made here. Culture no doubt plays an enormous role in the relationship between religion and health outcomes, and this article provides at least a glimpse of what role that may be.

NEWS

Duke University's Monthly Spirituality and Health Webinars via Zoom

Our Center's monthly spirituality and health research seminars are now being held by Zoom, and should be available to participants wherever they live in the world that supports a Zoom platform. All persons who receive this E-newsletter will be sent a link to join the seminar approximately one week before the seminar is held. When you receive this link, please save the link and forward it to your colleagues and students. This month's seminar on Tuesday, December 15th, will be delivered by UCLA and Veterans Administration psychiatrist Donna Ames, M.D., titled **Diagnosis and Treatment of Moral Injury in Veterans with PTSD Symptoms**. The PDFs of the Power Point slides for download and full recordings of all past webinars since July 2020 are now available at <https://spiritualityandhealth.duke.edu/index.php/education/seminars>.

Impact of Covid 19 on Burnout in Healthcare Professionals

COVID-19 has changed the way we interact with our patients and each other. We are looking to understand the impact of the pandemic on health care worker burnout, moral injury, fears, and hopes. Click the on the following link to fill out a brief (5-10 min) survey about your experiences; your responses will be identified prior to analysis:

https://duke.qualtrics.com/jfe/form/SV_b2T9YDeI4JuxVQN. This study has been approved by the Institutional Review Board at Duke University Health System [Protocol 00105516]

Prayer and Pain Scale Project

This notice is to announce the launch of a new research study involving the collaboration between the Episcopal Church in Delaware and academic researchers in the area of pain and prayer. The study goals are the development of a validated prayer-based clinical instrument and the design of a bedside-prayer-tool serving anyone with pain-related chronic conditions. Participation is easy via online questionnaires, less than 30 minutes long and confidentiality will be maintained. For interested participants, go to: <https://rally.partners.org/study/prayerandpainstudy>. If questions, contact Dr. Marta Illueca, Clergy-Medical Liaison at prayerpain@gmail.com or via phone at 1-302-803-6818 or Dr. Samantha Meints, Principal Investigator at Brigham and Women's Hospital in Boston, at 1-617-732-9014.

SPECIAL EVENTS

Medicine and Religion Conference

(March 22, 2021, via Zoom)

The 2021 Conference on Medicine and Religion invites clinicians, scholars, clergy, students and others to take up these and other questions related to the intersection of medicine and religion. In light of the seismic events of 2020, we also encourage submissions that address either the COVID-19 pandemic or racial inequities in health and health care. We encourage participants to address these questions and issues in light of religious traditions and practices, particularly, though not exclusively, those of Judaism, Christianity and Islam. The conference is a forum for exchanging ideas from an array of disciplinary perspectives, from accounts of clinical practices to empirical research to scholarship in the humanities. The theme for this conference is True to Tradition? Religion, the Secular, and the Future of Medicine.

Deadline for abstracts for paper presentations, posters, panel and workshop sessions, that address issues at the intersection of medicine and religion, including but not limited to the conference theme. All proposals must be submitted online by 11:59:59 p.m. CST, Tuesday, December 1, 2020. For more information go to: <http://www.medicineandreligion.com/>.

7th European Conference on Religion, Spirituality and Health

(Lisbon, Portugal, May 27-29, 2021)

The 2021 European Conference will focus on "Aging, Spirituality and Health" and will be held at the Catholic University of Portugal in Lisbon, one of the most beautiful cities in Europe. For more information go to <https://ecrsh.eu/ecrsh-2021>. **Note:** depending on the coronavirus situation, the conference may occur remotely via Zoom.

Research Workshop on Religion, Spirituality and Health in Lisbon, Portugal

(Lisbon, Portugal, May 23-26, 2021)

The 7th European Conference will also host a 4-day pre-conference spirituality and health research workshop on May 23-26 with Prof. Koenig from the U.S., along with Dr. Rene Hefti, Prof. Arndt Buessing, Prof. Niels Hvidt, Prof. Constantin Klein, and a number of other European presenters. For more information, go to: <https://ecrsh.eu/ecrsh-2021> or contact Dr. Rene Hefti at info@rish.ch. **Note:** depending on the coronavirus situation, the workshop may occur remotely via Zoom.

17th Annual Duke University Summer Research Workshop

(Durham, North Carolina, August 9-13, 2021, **to be held in-person with precautions**)

Register to attend this one-of-a-kind 5-day training session on how to design research, obtain funding support, carry out the research, analyze and publish the findings, with an emphasis on developing an academic career in the area of religion, spirituality and health.

Pass this information on to colleagues, junior faculty, graduate students, and anyone you think might be interested. The workshop compresses training material that was previously taught during our 2-year post-doctoral fellowship, so the curriculum is packed. Leading religion-health researchers from Duke, Yale and Emory serve as workshop faculty. Participants will have the option of a 30-minute one-on-one with Dr. Koenig or another faculty mentor of their choice, although these mentorship slots are limited, so early registration will be necessary to ensure that the mentor requested will be available. Nearly 900 academic researchers, clinical researchers, physicians, nurses, chaplains, community clergy, and students at every level in medicine, nursing, social work, chaplaincy, public health, psychology, counseling, sociology, theology, and rehabilitation (as well as interested members of the general public) have attended this workshop since 2004.

Participants from every faith tradition and region of the world have come to this workshop, and this year should be no different.

Partial tuition reduction scholarships are available, as are **full tuition and travel scholarships for academic faculty in underdeveloped countries** (see end of newsletter). For more information, go to:

<https://spiritualityandhealth.duke.edu/index.php/5-day-summer-research-course>

RESOURCES

Books

Religion and Health Care in East Africa: Lessons from Uganda, Mozambique, and Ethiopia

(Policy Press, 2019)

From the publisher: "What social factors contribute to the tragic state of health care in Africa? Focusing on East African societies, this book is the first to investigate what role religion plays in health care in African cultures. Taking into account the geopolitical and economic environments of the region, the authors examine the roles played by individual and group beliefs, government policies, and pressure from the Millennium Development Goals in affecting health outcomes. Informed by existing related studies, and on-the-ground interviews with individuals and organizations in Uganda, Mozambique and Ethiopia, this interdisciplinary book will form an invaluable resource for scholars seeking to better understand the links between society, multi-level state instruments, and health care in East Africa." Available for \$80.32 (hardcover) at <https://www.amazon.com/Religion-Health-Care-East-Africa/dp/1447337875/>.

Handbook of Spirituality, Religion, and Mental Health

(Academic Press, 2020)

From the publisher: "The *Handbook of Religion and Mental Health, Second Edition*, identifies not only whether religion and spirituality influence mental health and vice versa, but also how and for whom. The contents have been re-organized to speak specifically to categories of disorders in the first part of the book and then more broadly to life satisfaction issues in the latter sections. This updated edition is now revised with new chapters and new contributors." Available for \$84.95 (paperback) at <https://www.amazon.com/Handbook-Religion-Mental-Health-Rosmarin/dp/0128167661>.

Religion and Recovery from PTSD

(Jessica Kingsley publishers, December 19, 2019)

From the publisher: "This volume focuses on the role that religion and spirituality can play in recovery from post-traumatic stress disorder (PTSD) and other forms of trauma, including moral injury. Religious texts, from the Bible to Buddhist scriptures, have always contained passages that focus on helping those who have experienced the trauma of war. Many religions have developed psychological, social, behavioral, and spiritual ways of coping and healing that can work in tandem with clinical treatments today in assisting recovery from PTSD and moral injury.

In this book the authors review and discuss systematic research into how religion helps people cope with severe trauma, including trauma caused by natural disasters, intentional interpersonal violence, or combat experiences during war." Available for \$29.95 at <https://www.amazon.com/Religion-Recovery-PTSD-Harold-Koenig/dp/1785928228/>.

Religion and Mental Health: Research and Clinical Applications

(Academic Press, 2018) (Elsevier)

This 384 page volume summarizes the latest research on how religion helps people cope with stress, covering its relationship to depression, anxiety, suicide, substance abuse, well-being, happiness, life satisfaction, optimism, generosity, gratitude and meaning and purpose in life. It integrates research findings with best practices for treating mental health disorders in religious clients with depression, anxiety, posttraumatic stress disorder, and other emotional (and neuropsychiatric) problems. Available for \$69.96 (paperback) at <https://www.amazon.com/Religion-Mental-Health-Research-Applications-dp-0128112824/dp/0128112824/>

Hope & Healing for Those with PTSD: Psychological, Medical, and Spiritual Treatments.

(Amazon: CreateSpace Publishing Platform, 2018)

From the author: "If you or a family member has PTSD or are experiencing the aftermath of severe trauma, you will know a lot more about this disabling condition and how to deal with it after reading this book." Available for \$5.38 at <https://www.amazon.com/dp/172445210X>.

Protestant Christianity and Mental Health: Beliefs, Research and Applications

(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religious involvement and mental health in Protestant Christians. Available for \$7.50 at: <https://www.amazon.com/dp/1544642105/>

Catholic Christianity and Mental Health: Beliefs, Research and Applications

(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Catholics. Available for \$7.50 at: <https://www.amazon.com/Catholic-Christianity-Mental-Health-Applications/dp/1544207646>

Islam and Mental Health: Beliefs, Research and Applications

(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion,

spirituality and mental health in Muslims. Available for \$7.50 at: <https://www.amazon.com/Islam-Mental-Health-Research-Applications/dp/1544730330>.

Hinduism and Mental Health: Beliefs, Research and Applications

(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Hindus. Includes original research on current religious beliefs/practices in Hindus from India and throughout the world. Available for \$7.50 at: <https://www.amazon.com/dp/1544642105/>

Judaism and Mental Health: Beliefs, Research and Applications

(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

For mental health professionals, clergy, and researchers interested in the relationship between religion, spirituality and health in Judaism. Available for \$7.50 at: <https://www.amazon.com/Judaism-Mental-Health-Research-Applications/dp/154405145X/>

Buddhism and Mental Health: Beliefs, Research and Applications

(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Buddhists. Available for \$7.50 at <https://www.amazon.com/dp/1545234728/>

You are My Beloved. Really?

(Amazon: CreateSpace Publishing Platform, 2016)

From the author: "Simple and easy to read, this book is intended for Christians and non-Christians, those who are religious or spiritual or neither, and is especially written for those experiencing trauma in life (everyone). The book examines the evidence for God's love from Christian, Jewish, Muslim, Buddhist and Hindu perspectives based largely on the sacred scriptures from these traditions. Those of any age with an open mind will find this book enlightening, if not inspiring. Available for \$8.78 from <https://www.amazon.com/You-are-My-Beloved-Really/dp/1530747902/>.

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

(Templeton Press, 2011)

This book summarizes and expands the content presented in the Duke University's Annual Summer Research Workshop on Spirituality and Health. Available for \$29.15 (used) at: <http://www.amazon.com/Spirituality-Health-Research-Measurements-Statistics/dp/1599473496/>

Other Resources

CME/CE Videos (Integrating Spirituality into Patient Care)

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" healthcare that includes the identifying and addressing of spiritual needs. Go to: <http://www.spiritualityandhealth.duke.edu/index.php/cme-videos>.



In support of improving patient care, the Duke University Health System Department of Clinical Education and Professional Development is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the health care team.



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

Category 1: Duke University Health System Department of Clinical Education and Professional Development designates this CME activity for a maximum of 3.75 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Nurse CE: Duke University Health System Department of Clinical Education and Professional Development designates this activity for up to 3.75 credit hours for nurses. Nurses should claim only credit commensurate with the extent of their participation in this activity.

TRAINING OPPORTUNITIES

Full Scholarships to Attend Research Training on Religion, Spirituality and Health

With support from the John Templeton Foundation, Duke University's Center for Spirituality, Theology and Health is offering eleven \$3,600 scholarships to attend the university's 5-day Workshop on conducting research on religion, spirituality, and health. The workshop will be held on **Aug 9-13, 2021** (rescheduled due to coronavirus). These scholarships will cover the \$1200 tuition, up to \$1500 in international travel costs, and up to \$900 in living expenses. They are available only to academic faculty and graduate students living in third-world underdeveloped countries in Africa, Central and South America (including Mexico), Eastern Europe and North Asia (Russia and China), and portions of the Middle East, Central and East Asia. The scholarships will be competitive and awarded to talented well-positioned faculty and graduate students with the potential to conduct research on religion, spirituality, and health, and serve as research leaders in their part of the world. If you want to know more about this program, contact Harold.Koenig@duke.edu or go to our website for a description of the workshop:

<https://spiritualityandhealth.duke.edu/index.php/5-day-summer-research-course>. **Please let your academic colleagues in developing countries know about this unusual and time-limited opportunity.**

Unfortunately, but not surprisingly, the demand for such scholarships has far exceeded availability. Now that we are set up to evaluate potential scholarship recipients, we are hoping to identify individuals or foundations willing to support highly qualified third-world applicants we are unable to provide scholarships to in 2021-2023 and the years ahead. A donation of \$3,500 to our Center will sponsor a faculty member or graduate student from a disadvantaged region of the world to attend the workshop in 2021 or future years. If you are interested in sponsoring one or more such applicants and want to know more about this program, or have ideas about other sources of support, please contact Harold.Koenig@duke.edu.

Certificate in Theology and Healthcare

The Duke University Divinity School is now accepting applications for a new graduate certificate, the Certificate in Theology and Health Care. This one-year residential program provides robust theological and practical engagement with contemporary practices in medicine and health care for those individuals with vocations in health-related fields (e.g., trainees or practitioners of medicine, nursing, and other health care professions). The Certificate aims to equip Christian health care practitioners with the training to embrace that calling and live into it with theological clarity and spiritual joy. This fully accredited course of study focuses on combining foundational courses in Christian theology, scripture, and church history with courses engaging the practical issues that health care practitioners encounter in contemporary culture. If you, or some you know, seek theological formation and further confidence engaging questions of suffering, illness, and the place of health care in a faithful life, go to the following website: <https://tmc.divinity.duke.edu/programs/certificate-in-theology-and-health-care/>

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry

The John Templeton Foundation has postponed all Online Funding Inquiries (OFIs) for 2020 in the area of religion, spirituality and health to their 2021 funding cycle. The next deadline for Small Grant requests (\$234,800 or less) and Large Grant requests (more than \$234,800) is **August 20, 2021**. The Foundation will

communicate their decision (rejection or invitation to submit a full proposal) for all OFIs by October 15, 2021. Therefore, researchers need to think "long-term," perhaps collecting pilot data in the meantime, with or without funding support. JTF's current interests on the interface of religion, spirituality, and health include: (1) investigating the causal relationships between health, religion, and spirituality (determining direction of causation in associations reported; identifying the underlying causal mechanisms responsible), with a specific focus on longitudinal studies, and (2) engaging religious and spiritual resources in the practice of health care (increasing the religious and spiritual competencies of health care practitioners; testing the impact of religiously integrated therapies; and increasing the scientific literacy of health care chaplains). More information:

<https://www.templeton.org/project/health-religion-spirituality>.

2020-2021 CSTH CALENDAR OF EVENTS...

December

- 12/7 Spirituality/Spirituality & Health Symposium**
9:00-10:00AM EST; 10:00-11:00A Brazil (via Zoom)
UNASP-SP Liberdade University, Sao Paulo, Brazil
Title: **Religiosity and Health during COVID-19**
Speaker: Koenig (recorded presentation with Portuguese subtitles, followed by live questions and discussion)
Contact: Prof. Gina Abdala (ginabdala@gmail.com)
- 12/15 Spirituality & Health Research Seminar**
12:00-1:00 EST (via Zoom)
Title: **Diagnosis and Treatment of Moral Injury in Veterans with PTSD Symptoms**
Speaker: Donna Ames, M.D., Professor of Psychiatry, UCLA, & LA Veterans Administration Health System
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)
- 12/21 Population Sciences Program Grand Rounds**
11:30-12:30 EST, Roswell Park Comprehensive Cancer Center, Buffalo, New York (via Zoom)
Title: **Religion, Spirituality and Health: Is There a Relationship and What Does it Mean for Public Health?**
Speaker: Koenig
Contact: Rose Dever (Rose.Dever@RoswellPark.org)

January

- 1/14 Duke University Psychiatry Grand Rounds**
12:00-1:00 EST (via Zoom)
Title: **Religion, Spirituality and Mental Health: Research and Clinical Applications**
Speaker: Koenig
Contact: Lynn Labuda, Ed.D. (lynn.labuda@duke.edu)
- 1/26 Spirituality & Health Research Seminar**
12:00-1:00 EST (via Zoom)
Title: **Chronic Pain, the Brain, and Treatment Approaches**
Speaker: Koenig
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)