

# 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 October 2017) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

## LATEST RESEARCH

### Religiousness and Health in Europe

Investigators at the University of Southern Denmark analyzed data from a longitudinal study of 14,255 persons ages 50+ who participated in Wave 1 and at least one more wave (Wave 2, 4, and/or 5) of the Survey of Health, Aging, and Retirement in Europe (SHARE). The study was conducted from 2004-2005 (Wave 1) to 2013 (Wave 5). European countries were categorized into three groups: Northern Europe (Denmark and Sweden), southern Europe (Italy and Spain), and Western Europe (Austria, Belgium, Germany, Switzerland, and the Netherlands). Also assessed were marital and employment status. Three measures of religiosity were administered in Wave 1 to the 71% who indicated they belonged to a religion (n=10,151): "Thinking about the present, about how often do you pray?" (with responses dichotomized into praying [65.4%] vs. not praying); "Have you been educated religiously by your parents?" (yes [74.0%] vs. no); and "Have you done any of these activities in the last month?" (of the 7 options presented, one was "Taken part in a religious organization (church, synagogue, mosque, etc.)" [13.3%]). Religiousness was defined as (1) **religious** (praying, taking part in a religious organization, and being religiously educated) (n=900, 8.9%), (2) **less religious** (praying, but without taking part in a religious organization or being religiously educated) (n=823, 8.1%), and (3) **non-religious** (neither praying nor taking part in a religious activities nor being religiously educated) (n=1,674, 16.5%). Health outcomes assessed were functional limitations in terms of activities of daily living (Global Activity Limitations Index) (present vs. absent), self rated health (SRH: excellent, very good, or good vs. fair or poor), long-term health problems (yes vs. no), and depressive symptoms (4 or more symptoms on the 12-item EURO-D scale vs. < 4 symptoms). Logistic regression and mixed effects logistic regression models were used to analyze the data, with health outcomes dichotomized as described above. Results were adjusted for baseline (Wave 1) health outcome, gender, region, age, education, marital and employment status, and study Wave. All analyses were adjusted for multiple comparisons using the

conservative Holm-Bonferroni correction. **Results:** Praying (Wave 1) was associated with fewer ADL limitations, better SRH, and fewer long-term health problems in Wave 4, but higher odds of depression in Wave 5. Participation in a religious organization was associated with fewer functional limitations, fewer depressive symptoms, and better SRH. Being religiously educated was associated with better SRH and fewer long-term health problems. Those who were **religious** (positive on all three religious measures) were less likely to have activity limitations (OR=0.76, 95% CI 0.48-0.99) and less likely to experience depressive symptoms (OR=0.77, 95% CI 0.64-0.92) compared with everyone else. When **religious** persons were compared to **less religious** individuals (praying only), the former had better SRH (OR=0.71, 95% CI=0.52-0.97) and fewer depressive symptoms (OR=0.66, 95% CI 0.50-0.87). When **less religious** individuals were compared to the **non-religious**, the former were *more likely* to have depressive symptoms (OR=1.46, 95% CI=1.15-1.86), but were less likely to have long-term health problems (OR=0.59, 95% CI=0.43-0.82). Those who dropped out of the study (i.e., did not participate in Waves 2, 4 or 5) were less likely to pray, take part in religious organization, or be religiously educated. Researchers concluded: "Our findings suggest two types of religiousness: 1. Restful religiousness (praying, taking part in a religious organization, and being religiously educated), which is associated with good health, and 2. Crisis religiousness (praying without other religious activities) which is associated with poor health." *Citation:* Ahrenfeldt, L. J., Möller, S., Andersen-Ranberg, K., Vitved, A. R., Lindahl-Jacobsen, R., & Hvidt, N. C. (2017). Religiousness and health in Europe. *European Journal of Epidemiology*, E-pub ahead of press. *Comment:* These are interesting findings coming from secular Europe. The size of the sample, longitudinal nature, and sophistication of the data analysis all add to the credibility of these findings. The fact that "crisis praying" was associated with more depressive symptoms is also an important finding, suggesting that prayer may actually be a marker for psychological distress not a cause for it (i.e., psychological distress leading to more prayer, not vice versa).

### Religious Beliefs of Veterans Administration Chaplains and Enjoyment of Work

Joe Currier and colleagues reported the results from a survey of 298 Veterans Health Administration (VHA) chaplains that asked about their beliefs about God and attempts to resolve existential issues related to evil and suffering from their work with Veterans. Views toward suffering were assessed using a standard scale (Hale-Smith et al.), and a measure of quality of life was administered to measure chaplains' enjoyment/purpose in their work. Since only the Abstract was accessible, few details are provided here. **Results:** 20-50% of chaplains endorsed strong belief in a compassionate God who suffers with those who are hurting, belief that God is ultimately responsible for suffering, and belief that suffering can produce opportunities for intimate encounters with God that lead to spiritual growth. Of particular interest was that chaplains beliefs about suffering were also associated with their enjoyment and sense of purpose when

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working with Veterans. Researchers concluded: "These results suggest that theodicies [beliefs about God] might serve as a pathway to resilience for individuals in spiritual communities and traditions in USA, particularly for clinicians and ministry professionals who are committed to serving the needs of traumatized persons."

*Citation:* Currier, J. M., Drescher, K. D., Nieuwsma, J. A., & McCormick, W. H. (2017). Theodicies and professional quality of life in a nationally representative sample of chaplains in the veterans' health administration. *Journal of Prevention & Intervention in the Community*, 45(4), 286-296.

*Comment:* This report is a must-read for chaplains, particularly VA and military chaplains, but also for all healthcare chaplains seeking to help those who suffer. It may also assist non-chaplain health professionals cope with the challenges that they face when caring for patients and families experiencing pain, loss, or having a hard time coping with illness. Beliefs about God's role in suffering may be key to enabling helping professionals to see meaning and purpose in their work, more effective in their calling, and on top of that, enjoy their work more.

### **The Role of Religion/Spirituality in Veteran Suicide: The Forgotten Factor**

In this review article, investigators from the Department of Veterans Affairs in Montrose, NY, and the Bronx, NY, discuss the protective role of religion/spirituality in Veteran suicide. They note that the Clay Hunt Suicide Prevention for American Veterans Act (2015) was designed to increase access to treatment for US military veterans; however, poor attendance at treatment programs and treatment refusal have been a major issue in reaching this population. The stigma of mental health problems is a particular problem in military culture where resilience plays such an important role (and where identification of mental health problems may affect future employment as well). In this article, the authors examined the question "What more might be done to engage and effectively treat veterans who are at high risk of suicide?" They note that research indicates that religious and/or spiritual beliefs, practices or affiliations may be protective against suicide, and should receive more attention than they currently do within the Veterans Administration. They describe ways to integrate religion and spirituality into suicide prevention through comprehensive risk assessment; safety planning; and implementation of evidence-based treatments for at risk veterans. The investigators conclude: "Attention to patients' religious and spiritual concerns may be critical to the prevention of veteran suicide. Faith, self-respect, and other ideals are sorely tested by violence, suffering and loss. Comfort that might otherwise come from a sense of belonging can be elusive. Emotional issues like these are often expressed in religious or spiritual terms."

*Citation:* Amato, J. J., Kayman, D. J., Lombardo, M., & Goldstein, M. F. (2017). Spirituality and religion: Neglected factors in preventing veteran suicide? *Pastoral Psychology*, 66(2), 191-199.

*Comment:* I suspect that anyone reading this E-newsletter would wholeheartedly agree with these authors. Now it's time to do something about it. Inquiry about and respect for Veterans' personal beliefs and values (that includes religious beliefs and values) in no way violates church-state separation, which many fear prevents any real progress in this area.

### **Religious Coping and Treatment Decisions in Prostate Cancer**

Investigators at Johns Hopkins University and George Washington University analyze data from 877 African-American and White men with prostate cancer (PC) to examine influences of religion on treatment decisions. The primary dependent variable was men's use of resources (number of information sources sought to learn about PC) or advisors (number of people from whom advice was

sought regarding PC) when making treatment decisions.

Participants were also asked to rate their agreement (on a 5-point scale) to statements such as "getting prostate cancer was punishment from God" (96% disagreed), "getting prostate cancer was a way to test my faith in God" (71% disagreed), "since being diagnosed with prostate cancer, my faith has grown stronger" (58% agreed), "my faith in God has helped me cope with my disease" (88% agreed), "whether I am cured will be decided by God only" (58% agreed), "if I pray enough I will be cured" (41% agreed [22% of Whites, 62% of Blacks]), and "since being diagnosed with prostate cancer, my faith in God has weakened" (97% disagreed). Religious coping was assessed by a 10-item Brief RCOPE (with negative religious items reverse scored so that higher scores indicated more positive religious coping). Controlled for were age, marital status, education, and insurance status.

**Results:** African-American men were more likely than White men to agree that cancer is a punishment from God, a test of faith, has strengthened (and weakened) their faith, is cured only by God, and is cured with enough prayer. African-Americans were less likely than Whites to use numerous information sources or seek help from many advisors. The relationship with sources of information was mediated by cancer as a punishment from God, cancer as a test of faith, cancer being cured with enough prayer, and higher RCOPE scores. The relationship with number of advisors was mediated by cancer as a punishment from God and cancer as a test of faith. Researchers concluded that "Religious views on prostate cancer may play an important role in explaining race differences in information used and in the number of advisors utilized for treatment decision making for prostate cancer."

*Citation:* Bowie, J. V., Bell, C. N., Ewing, A., Kinlock, B., Ezema, A., Thorpe Jr, R. J., & LaVeist, T. A. (2017). Religious coping and types and sources of information used in making prostate cancer treatment decisions. *American Journal of Men's Health*, 11(4):1237-1246.

*Comment:* Although the statistical analyses are a bit difficult to follow, this study underscores the influence that religious beliefs have on treatment decisions regarding prostate cancer, especially among African-Americans. These findings emphasize the importance of taking a thorough spiritual history in African Americans with prostate cancer, specifically exploring how their religious beliefs might influence their treatment decisions (as has been long advocated elsewhere: *JAMA* 2002; 288:487-493).

### **God imagery and Emotional Affect in Psychiatric Inpatients**

Researchers from the University of South Alabama, Fuller Theological Seminary, Hope College, and Azusa Pacific examined the effects of internalized images of God on treatment outcomes in a mixed-methods study involving 241 adult psychiatric inpatients completing a 7-day spiritually-integrated inpatient program at Pine Rest Christian Mental Health Service (Grand Rapids, MI). Participants were 74% Christian, 10% none, 15% spiritual but not religious; 56% had unipolar depression and 36% had bipolar depression. They were assessed within 48 hours of admission and again at discharge. Assessment involved asking the question "When God looks at you, how would God describe you?" Space (eight lines) was then provided to respond to this open-ended question. Responses were analyzed using the Linguistic Inquiry and Word Count program, which counts the number of words and places them in categories that provide a descriptive summary. Responses were categorized into "Positive God Imagery" and "Negative God Imagery" for analysis. Participants also completed the 24-item Religious Comforts and Strain Scale (Exline) and the 20-item Positive and Negative Affect Schedule (PANAS). Structural equation modeling (SEM) examined whether associations between God imagery (at baseline) and affect (at discharge) were mediated by religious comforts and strains (at discharge); gender, ethnicity, and religious affiliation were

controlled for (although it is not clear whether baseline affect was also controlled). **Results:** From baseline to discharge, participants experienced a decline in Negative God Imagery, although Positive God Imagery did not change significantly. There were also significant improvements in religious comforts/strains and positive/negative affect during the average 7-day treatment program. SEM revealed that God imagery at baseline predicted more positive affect and less negative affect at discharge, and this relationship was mediated by greater religious comforts and less religious strains. Researchers concluded that "...religious comforts and strains represent distinct pathways to positive and negative domains of affect for psychiatric patients with varying experiences of God."

*Citation:* Currier, J. M., Foster, J. D., Abernethy, A. D., Witvliet, C. V., Luna, L. M. R., Putman, K. M., ... & Carter, J. (2017). God imagery and affective outcomes in a spiritually integrative inpatient program. *Psychiatry Research*, 254:317-322.

*Comment:* This study adds to the existing sparse research on the effect of religious beliefs on treatment outcome among psychiatric inpatients. The sophisticated statistical modeling helps to add credibility to the findings, as does the relatively large sample size. It is interesting that positive God imagery did not increase significantly during this spiritually-integrated treatment program, while negative God imagery and religious strains did significantly improve during treatment.

### Religious Coping in Patients with Severe Substance Use Disorders

Medlock and colleagues in the Department of Psychiatry, Harvard Medical School, interviewed 331 patients receiving acute inpatient treatment for alcohol/drug detoxification at McLean Hospital in Belmont, MA. Participants were 69% male with a mean age of 38, and the most common substance use disorder (SUD) was alcohol (61%) followed by opioids (36%). Mean length of stay on this unit was four days. Measures included the 8-item Brief Addiction Monitor, 3-item Craving Scale, religious/spiritual involvement (How important is spirituality in your life? How important is religion in your life? To what extent do you believe in God? To what extent would you like to include your spirituality in your mental health treatment?). Religious attendance and private prayer/Bible reading were also assessed using a subscale of the Duke Religion Index, along with religious coping using the 14-item Brief RCOPE (which assesses positive religious coping [PRC] and negative religious coping [NRC]). Regression analyses were used to analyze the data. **Results:** Degree of belief in God was reported as moderate or higher in 51%, and 36% indicated that incorporating spirituality was important in their treatment. In bivariate analyses, PRC was inversely related to craving and days of primary drug use, and positively related to mutual-help meeting attendance and mutual-help meeting activities. Importance of religion in daily life was inversely related to craving, days of primary drug use, and number of substances used in past month, and was positively related to mutual-help meeting activities; similar relationships were found for importance of spirituality. Multivariate analyses indicated that NRC was associated with lower abstinence self-efficacy, and PRC was unrelated to abstinence self-efficacy. Greater PRC was associated with greater 12-step mutual-help participation; no relationship was found between NRC and mutual-help participation. A subset of participants indicated no engagement or importance of religion or spirituality and negligible levels of PRC or NRC in their lives. This group was younger and was significantly less involved in mutual-help group participation. Researchers concluded: "The findings of this study suggest that positive and negative religious coping are linked with several key SUD recovery variables."

*Citation:* Medlock, M. M., Rosmarin, D. H., Connery, H. S., Griffin, M. L., Weiss, R. D., Karakula, S. L., & McHugh, R. K. (2017). Religious coping in patients with severe substance use disorders

receiving acute inpatient detoxification. *American Journal on Addictions*, E-pub ahead of press

*Comment:* Although the relationship between religiosity and lower substance use is well-established, little research has examined religiosity in persons with severe substance use disorders during the detoxification process. The relatively large sample size and quality of the research team enhance the credibility of these results.

### Spiritual Health in the Czech Republic: Citizens vs. Physicians

Researchers from the department of recreation and leisure studies at Palacky University in Olomouc, Czech Republic, surveyed a random sample of 1,810 citizens age 15 or older and a representative sample of 1,210 physicians (general practitioners, pediatricians, and medical specialists) in the Czech Republic. The purpose was to determine the views of citizens and physicians toward "spiritual health" and compare them. The following open-ended question was asked to both groups: "Do you think that 'spiritual health' exists? If so, what do you think this term means? Briefly express your opinion." Participants were categorized into three groups: active believers (members of some church), believers (not members of any church), and nonbelievers (atheists). **Results:** Surprisingly, physicians were more likely to acknowledge the existence of spiritual health than citizens (47% vs. 26%, respectively); 13% of physicians and 28% of citizens had no clear opinion about the existence of spiritual health; and 31% of physicians and 32% of citizens indicated that spiritual health was an artificial construct that has no real basis. Among citizens, women were more likely than men to acknowledge the existence of spiritual health (30% vs. 22%), whereas men were more likely to deny the existence of spiritual health (35% vs. 29%). Age and marital status were unrelated to attitude toward spiritual health. University graduates were more likely to believe in spiritual health, as were citizens with more children. Among physicians, no relationship was found between attitude toward spiritual health and gender, age, medical specialization, or type of medical profession. With regard to the definition of spiritual health (of those who acknowledged the existence of spiritual health), nearly half of both citizens (46%) and physicians (44%) understood it in mental health terms (feelings of mental balance, zest for life, internal well-being, and peace). A second group of citizens (31%) and physicians (28%) understood spiritual health in terms of belief in God or a higher power. A third group of citizens (8%) and physicians (17%) understood spiritual health in terms of harmony of physical and mental health in body and spirit and harmonious relationships with other people and nature. Researchers concluded that "...in the Czech Republic, spiritual health is currently a more significant phenomenon for the professional medical community than for the ordinary population."

*Citation:* Jirásek, I., & Hurych, E. (2017). The perception of spiritual health differences between citizens and physicians in the Czech Republic. *Health Promotion International*, E-pub ahead of press.

*Comment:* This is likely the first study from the Czech Republic to compare beliefs about "spiritual health" between persons in the general population (citizens) and physicians. The finding of less belief in spiritual health among citizens compared to physicians (26% vs. 47%) is the opposite pattern found in the United States and other Western countries, where physicians tend to be less religious than the general population. Interestingly, only a relatively small proportion of either citizens or physicians understood spiritual health in religious terms, whereas nearly half of both groups understood it in mental health terms. Communist rule for many years in the Czech Republic may have influenced these findings.

## God Health Locus of Control among Medical Outpatients in India

Researchers from Wheaton College in Massachusetts surveyed 206 patients and visitors (53% men) at a public medical clinic in Faridabad, India, to examine their health locus of control and its role in understanding the cause for their illness. Participants were administered the Hindi version of the Multidimensional Health Locus of Control Scale that measures internal control and three sources of external control (chance, powerful others, and God). In addition, participants were assessed using the Traditional Value Scale and measures of health status and demographic information. **Results:** In terms of factors that controlled their health status, participants rated “control by God” as the most frequent. Investigators concluded: “For patients and visitors at the Faridabad clinic, religion played a significant role in their causal health beliefs.”

*Citation:* Berg, M. B., & Anshika, A. (2017). Health locus of control as manifested in individuals attending a state-run medical dispensary in northern India. *Ethnicity & Health*, 22(2), 145-155. *Comment:* These results suggest that religious belief (particularly belief in God) informs how medical patients in India understand the cause of their illness. Such beliefs will influence the kinds of treatments they seek for those illnesses. Medical professionals be aware.

## Effects of a “Spirituality & Health Course” on Student Health Professionals in Brazil: A Randomized Clinical Trial

Researchers at the Federal University of Mato Grosso de Sul and the Federal University of Juiz de Fora conducted a randomized clinical trial to examine the effects of a course on spirituality and health on the knowledge, attitudes, and skills of first and second year students in medicine, nursing, physiotherapy, and psychology. The course taught students how to conduct a spiritually-based approach to patients, where spirituality was defined as a “dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and to significant or sacred.” The course consisted of 14 hours of didactic classes and 10 hours of practical activities conducted over a period of four months. Seven themes were covered in the course: (1) why include spirituality in patient care; (2) research in the area of spirituality and health; (3) when and how to carry out this approach and what might result; (4) limits of and barriers to a spiritual approach (and when religion can be harmful); (5) points to be considered when treating terminal patients in light of their spirituality; (6) communication skills and health, and conveying bad news; and (7) taking a spiritual history (much of the course followed the book, *Spirituality in Patient Care*). A total of 86 students were recruited from medicine (n=43), nursing (n=34), physiotherapy (n=6), and psychology (n=3), and were randomized to either the spirituality course (n=43) or to a waitlist control group (n=43). Of those randomized, 25 in the intervention group and 24 in the waitlist control group completed pre- and post-course questionnaires. Outcomes of interest were student knowledge, attitude, and practical skills regarding integrating spirituality into patient care, as well as student religiosity (assessed by the Duke Religion Index). **Results:** At baseline, no significant differences were found between intervention and control groups on gender, age, undergraduate year, religiosity, knowledge, attitudes, or activities. Following the 4-month course, significant differences favoring the intervention group were found with regard to knowledge about integrating spirituality, comfort when conducting spiritual assessments, awareness that religious figures and chaplains were important for helping patients, belief that spirituality was an important to the doctor-patient relationship, ability to take a spiritual history from a simulated patient, and other

behaviors related to reading scientific articles, attending lectures, reading books and seeking knowledge about spirituality in patient care. Researchers concluded that “a structured course on ‘Spirituality and Health’ can lead to changes in knowledge, attitudes and skills for students in health-related areas when compared to students with the same profile who have not received that training.”

*Citation:* Osório, I. H. S., Gonçalves, L. M., Pozzobon, P. M., Gaspar Júnior, J. J., Miranda, F. M., Lucchetti, A. L., & Lucchetti, G. (2017). Effect of an educational intervention in “spirituality and health” on knowledge, attitudes, and skills of students in health-related areas: A controlled randomized trial. *Medical Teacher*, E-pub ahead of press.

*Comment:* This is one of the few randomized clinical trials that have examined the effectiveness of a spirituality and health course on the knowledge, attitudes, and skills of health professionals regarding integrating spirituality into patient care. This was a substantial training experience (24 hours of didactic and skills training over 4 months), one that all students in the health care professions should receive to prepare them to provide holistic care to patients.

## NEWS

### THEOS Thinktank Releases Report on Christianity and Mental Health in UK

THEOS, a Christian thinktank that works on issues of religion in public life in the United Kingdom (UK), recently released a report titled *Christianity and Mental Health: Theology, Activities, Potential*. According to the authors, this report speaks to a number of core Christian concerns pertaining to human wholeness and peace, and describes a growing number of Christian/church-based initiatives across the country. It helps to clarify, equip, guide and inspire serious Christian engagement with mental health problems in the UK today, including raising questions for future research. To obtain a copy of the report, go to:

<http://www.theosthinktank.co.uk/publications/2017/07/03/christianity-and-mental-health-theology-activities-potential>.

## SPECIAL EVENTS

### 6<sup>th</sup> European Conference on Religion, Spirituality and Health & the 5<sup>th</sup> International Conference of the British Association for the Study of Spirituality

(Coventry, England, May 17-19, 2018)

These two European conferences are meeting jointly in 2018, making for a particularly attractive program in a beautiful area of England. Although the **final date for submitting Abstracts is Oct 31, 2017**, the program may accept abstracts for a short period after that as well. The main theme of the conference will be “Forgiveness in Health, Medicine and Social Sciences.” The Coventry Lecture will be delivered by Everett Worthington on the dimensions of forgiveness. Keynote speakers include Anthony Bash (Durham University, England), Arndt Bussing (University of Witten/Herdecke, Germany), Robert Enright (University of Wisconsin-Madison), Deborah Lycett (Coventry University, England), and numerous other high quality speakers from Europe and around the world. For more information, go to:

<http://www.ecrsh.eu/ecrsh-2018>.

### 6<sup>th</sup> European Conference on Religion, Spirituality and Health PRE-CONFERENCE Workshop

Preceding the ECRSH18 will be 4-day Pre-Conference Research Workshop with Prof. Harold G. Koenig and other spirituality and

health experts. The workshop is open to all interested in doing research on religion, spirituality and health (accepting participants of any educational level or degree, including theologians, chaplains, physicians, nurses, psychologists, pastoral counselors, public health specialists, epidemiologists, or other). To register for the workshop, go to: <http://www.ecrsh.eu/ecrsh-2018/registration> (early registration is strongly encouraged since spaces are limited).

### **10<sup>th</sup> Annual Muslim Mental Health Conference**

(The United States Institute of Peace, Washington DC, March 15-17, 2018)

Sponsored by Michigan State University Department of Psychiatry in partnership with the Institute of Muslim Mental Health, and co-sponsored by the American Psychiatric Association's Division of Diversity and Health Equity, the theme of this year's conference is "Out of the Shackles: Pursuit of Civil Justice in the Face of Psychological Trauma." The deadline for Abstracts is October 1, 2017. The following is a description of the conference: "The number of hate crimes, bullying, and microaggressions American Muslims experience is drawing increasing attention. Scholarly research on the subject began long before the recent political rhetoric and even before 9/11. However, the mechanisms, scale, and impact of the treatment of American Muslims requires more rigorous study and better dissemination. Furthermore, the American Muslim experience is subject to American social and structural realities. The role of race, violence, policing, surveillance, educational policy, mental health care access and reform, immigration policy, and civil liberties in the U.S. all impact the American Muslim experience. Interventions, whether at a clinical, programmatic, or policy level have not been well described. This conference seeks scholars who will offer an analysis as well as intervention for American Muslims' challenges." For more information, go to:

<http://www.psychiatry.msu.edu/about/news/10th-mmh-conference.html>. Submit abstracts to: [MSUMMHConference@gmail.com](mailto:MSUMMHConference@gmail.com).

## **RESOURCES**

### **Beholden: Religion, Global Health, and Human Rights (Oxford University Press, 2015)**

From the publisher: "Global health efforts today are usually shaped by two very different ideological approaches: a human rights-based approach to health and equity—often associated with public health, medicine, or economic development activities; or a religious or humanitarian "aid" approach motivated by personal beliefs about charity, philanthropy, missional dynamics, and humanitarian "mercy." The underlying differences between these two approaches can create tensions and even outright hostility that undermines the best intentions of those involved..."

Susan R. Holman—a scholar in both religion and the history of medicine—challenges this traditional polarization by telling stories designed to help shape a new perspective on global health, one that involves a multidisciplinary integration of religion and culture with human rights and social justice. The book's six chapters range broadly, describing pilgrimage texts in the Christian, Hindu, Buddhist, and Islamic traditions; the effect of ministry and public policy on nineteenth-century health care for the poor; the story of the Universal Declaration of Human Rights as it shaped economic, social, and cultural rights; a "religious health assets" approach based in Southern Africa; and the complex dynamics of gift exchange in the modern faith-based focus on charity, community, and the common good. Holman's study serves as an insightful guide for students and practitioners interested in improving and broadening the scope of global health initiatives, with an eye towards having the greatest impact possible." Available for \$27.20

at <https://www.amazon.com/Beholden-Religion-Global-Health-Rights/dp/0199827761>.

### **Religious Beliefs, Evolutionary Psychiatry, and Mental Health in America: Evolutionary Threat Assessment Systems Theory (Springer, 2017)**

From the publisher: "This book provides a new perspective on the association between religious beliefs and mental health. The book is divided into five parts, the first of which traces the development of theories of organic evolution in the cultural and religious context before Charles Darwin. Part II describes the major evolutionary theories that Darwin proposed in his three books on evolution, and the religious, sociological, and scientific reactions to his theories. Part III introduces the reader to the concept of evolutionary psychiatry. It discusses how different regions of the brain evolved over time, and explains that certain brain regions evolved to protect us from danger by assessing threats of harm in the environment, including other humans. Specifically, this part describes: how psychiatric symptoms that are commonly experienced by normal individuals during their everyday lives are the product of brain mechanisms that evolved to protect us from harm; the prevalence rate of psychiatric symptoms in the U.S. general population; how religious and other beliefs influence the brain mechanisms that underlie psychiatric symptoms; and the brain regions that are involved in different psychiatric disorders. Part IV presents the findings of U.S. studies demonstrating that positive beliefs about God and life-after-death, and belief in meaning-in-life and divine forgiveness have salutary associations with mental health, whereas negative beliefs about God and life-after-death, belief in the Devil and human evil, and doubts about one's religious beliefs have pernicious associations with mental health." Available for \$91.58 at

<https://www.amazon.com/Religious-Beliefs-Evolutionary-Psychiatry-America/dp/3319524879>.

### **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>.

### **Hindusim 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/>

### **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/>

### **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/>

### **You Are My Beloved. Really?** (Amazon: CreateSpace Platform, 2016)

How does God feel about us? This 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 -- especially if going through hard times -- will find this book enlightening, inspiring, and possibly transforming. Written for Christians, non-Christians, those who are religious, those who are spiritual, and those who are neither. The author states: "Of the 50 books I have authored or co-authored, this is the most important one." Available for \$8.78: <https://www.amazon.com/You-are-My-Beloved-Really/dp/1530747902/>

### **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>.

### **Health and Well-being in Islamic Societies**

(Springer International, 2014)

The core of the book focuses on research exploring religiosity and health in Muslim populations. Available for \$57.89 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. Available for \$14.15 (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 (more than 3,300 studies prior to 2010). Available for \$139.99 (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 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/>

## **FUNDING OPPORTUNITIES**

### **Templeton Foundation Online Funding Inquiry**

The John Templeton Foundation is now accepting new funding requests through their Online Funding Inquiry (OFI) site. Small Grants are defined as requests for \$217,400 or less. The next OFI deadline for small grant requests is **August 31, 2018**, with decisions communicated no later than September 29, 2018. Large Grants are defined as requests for more than \$217,400. The deadline for OFIs related to large grant requests is **also August 31, 2018**. All decisions on large grant OFIs are communicated by September 29. 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:

<https://www.templeton.org/what-we-fund/grantmaking-calendar>

## 2017 CSTH CALENDAR OF EVENTS...

### November

- 29 **Research on Spirituality in the U.S. Military**  
**Speaker:** Patrick Sweeney, Ph.D.  
Director of Leadership, Character, and Business  
Ethics, Wake Forest University School of Business  
Former Deputy and Acting Head of the Department of  
Behavioral Sciences and Leadership at U.S.  
Military Academy at West Point  
Center for Aging, 3rd floor, Duke South, 3:30-4:30  
**Contact:** Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))

### December

- 20 **Buddhism and Health: Part II**  
**Speaker:** Carol Weingarten, M.D., Ph.D.  
Adjunct Assistant Professor, Duke Department of  
Psychiatry & Behavioral Sciences  
Center for Aging, 1st floor, Duke South, 3:30-4:30  
[Learning Lab 1502 Blue Zone]  
**Contact:** Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))

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<http://www.spiritualityandhealth.duke.edu/index.php/partner-with-us>