

CROSSROADS...

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & 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 2018) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

LATEST RESEARCH

Does a Religious Upbringing Make a Difference in Health?

Researchers at the Harvard T. H. Chan School of Public Health analyzed data from the Growing up Today Study (GUTS), a prospective study of 5,681 to 7,458 young persons age 14.7 years at baseline (1999) and followed up for 8-14 years (1999 through 2007-2013). Participants were the children of 116,430 nurses in the Nurses Health Study II. Investigators examined the effects of religious service attendance and prayer/meditation on psychological well-being, mental health, health behavior, physical health, and character strengths across the follow-up period. Religious service attendance was assessed in 1999 with the question "How often do you go to religious meetings or services?"; response categories were: never (1), less than once per week (2), and at least once per week (3). Frequency of prayer/meditation in 1999 was assessed with the question "How often do you pray or meditate?"; responses ranged from never (1) to once per day or more (4). Outcomes were assessed by a number of standard measures. Controlled for in all analyses were sociodemographic characteristics, maternal health, and prior values of the health outcomes when these data were available. **Results:** Young persons who attended religious services at least weekly in 1999 (compared to those who never attended) experienced greater life satisfaction, more positive affect, developed more character strengths, had lower probabilities of marijuana use, were less likely of early sexual initiation, and had fewer lifetime sexual partners. Similar results were obtained for frequency of prayer/meditation. Investigators concluded: "Although decisions about religion are not shaped principally by health, encouraging service attendance and private practices in adolescents who already hold religious beliefs may be meaningful avenues of development and support, possibly leading to better health and well-being."

Citation: Chen Y, VanderWeele TJ (2018). Associations of religious upbringing with subsequent health and well-being from adolescence to young adulthood: an outcome-wide analysis.

American Journal of Epidemiology, E-pub ahead of press (<https://doi.org/10.1093/aje/kwy142>)

Comment: Another large cohort study conducted by researchers in the Harvard School of Public Health demonstrating benefits of religious involvement, in this instance for those in their mid-teens. In a society with few moral guidelines, this is a time in a young persons life that's difficult to get through all in one piece. Religion appears to help them do that.

Do Associations Between Religion and Health Depend on Community Type?

Investigators from the department of sociology at Louisiana State University analyzed data on individuals and U.S. county contexts using multilevel analyses to determine whether the relationship between individual religiosity and health depends on communal religious contexts. In other words, does the relationship between religiosity and health depend on how religious they are and whether they live in a religious or secular area of the country? Researchers analyzed data on a random nationwide sample of 25,862 adults living in 58 counties. The only outcome variable examined was a single question on self-rated health. Religiosity was measured by creating a summary index of frequency of religious service attendance and importance of religion in life (ranging from 2 to 8). County-level religiosity was assessed by the average score on the religiosity summary index across all individuals in that county. Controlled for in all analyses were demographic characteristics (including health infrastructure, minority concentration, and population size at the county level), socioeconomic status, and religious affiliation. **Results:** Participants with a lower level of religiosity had a higher probability of poor health across both low and high religiosity community (county) contexts. However, this health gap was much smaller in secular counties than in religious counties, where the gap was much larger. Thus, highly religious individuals living in communities that were on average more religious had significantly better self-rated health than highly religious individuals living in more secular communities; likewise, individuals with low religiosity report better self-rated health if they are living in secular communities compared to those living in religious communities. The authors explained this finding by the theory that individuals who are highly religious are more likely to be supported within religious contexts, where religiosity has a greater influence on behavior and self-ratings of health. In contrast, nonreligious individuals living in devout religious contexts are likely to have worse self-rated health due to the "secular stigma hypothesis," which argues that devout religious communities have negative effects on the social inclusion of those who are not religious (i.e., discrimination). Researchers found that negative effects on self-rated health among nonreligious persons living in religious communities was 50% stronger than the benefits to self-rated health found among highly religious persons living in religious communities. Researchers concluded: "Consequently, the health gap between religious and nonreligious individuals is largest in religiously devout contexts, primarily due to the negative effects on nonreligious individuals' health in religious contexts."

EXPLORE...in this issue

1-4 LATEST RESEARCH

4-5 NEWS, EVENTS & RESOURCES

5-6 TRAINING, FUNDING Opportunities, and CALENDAR

Citation: Stroope, S., & Baker, J. O. (2018). Whose Moral Community? Religiosity, Secularity, and Self-rated Health across Communal Religious Contexts. *Journal of Health and Social Behavior*, 59(2), 185-199.

Comment: Although the cross-sectional design of this study prevents speculation about direction of effect (i.e., whether religiosity affects self-rated health or whether self-rated health affects religiosity), this is a fascinating study. The results -- if confirmed in prospective studies -- would have considerable implications. One of those implications is that as the U.S. becomes more and more secular, secular people will increasingly rate themselves as healthier, whereas religious people will increasingly rate themselves as less healthy.

Religious Affiliation and Mortality: A Study of Obituaries

Researchers from the department of psychology at Ohio State University examined the religious affiliation in obituaries over a 2-month period listed in the Des Moines Register newspaper (Iowa; n=505 obituaries; Study #1) and in a random sample of obituaries from newspaper websites in 42 cities across the United States (n=1,096 obituaries; Study #2). Regression modeling was used to control for gender and marital status. **Results:** In Study #1, religious affiliation was associated with significantly greater longevity; those affiliated with a religious organization lived almost 10 years longer than those who were not. In Study #2, religious affiliation was also associated with greater longevity; persons whose obituaries mentioned religious affiliation lived about 5 years longer than those whose obituaries did not. When samples were combined, religiosity was found to be associated with more volunteerism and with greater social integration, both of which in turn were associated with greater longevity. Nevertheless, three variables significantly and independently were related to greater longevity (i.e., volunteerism and social integration did not explain the relationship between religious affiliation and longevity). However, "city religiosity" moderated the association between religious affiliation and longevity. In other words, "In highly religious cities, people who were not religiously affiliated had shorter lifespans than those who were religiously affiliated. However, in less religious cities, non-religiously affiliated people lived just as long as the religiously affiliated" (supporting the 'religion-as-social-value' hypothesis).

Citation: Wallace, L. E., Anthony, R., End, C. M., & Way, B. M. (2018). Does religion stave off the grave? Religious affiliation in one's obituary and longevity. *Social Psychological and Personality Science*, E-pub ahead of print.

Comment: Another interesting finding, consistent with the results from the study above for self-rated health (Stroope & Baker). Religious affiliation, however, is not a very in-depth measure of religious involvement, and likely reflects the more social aspects of religion. Those social aspects, while important in the religiosity-mortality relationship, are not the whole story. There is likely to be a threshold of religious involvement and commitment (besides its social aspects) that must be reached before religiosity affects attitudes and behaviors that in turn affect physical health and mortality. Religious affiliation alone may not reach that threshold.

Does Religious Membership in England Impact Well-Being in Later Life?

With regard to a secular context, Europe has moved more rapidly in that direction over the past 75 years than has the United States. In this 10-year prospective study, researchers from the department of behavioral science and health at the University College of London analyzed data on 2,548 adults age 55 or over participating in the English Longitudinal Study of Aging. Type of community group membership was assessed at baseline in 2004/2005, which included eight different categories (one of which was church or

religious groups, engaged in by 24.6%). Well-being was assessed by five different scales including (a) negative affect by the CES-D, (b) positive affect by the CASP-15, (c) life satisfaction by the Satisfaction with Life Scale, and (d and e) two components of hedonic well-being (control/autonomy and self-realization) by the CASP-15. Logistic regression was used to adjust analyses for baseline well-being, demographics, and health-related characteristics. Bidirectional effects were also examined using cross-lagged analyses. **Results:** Membership in education, arts or music groups, church or religious groups, and sports or exercise groups at baseline predicted lower negative affect at follow-up. Membership in church or religious groups, however, was the only type of group membership that predicted higher positive affect at follow-up, controlling for other predictors. Cross-lagged analyses examining reverse causation demonstrated no effect of well-being on membership in church or religious groups. Researchers concluded: "Overall, this study suggests that education, arts or music classes and church or religious groups may support well-being in older age."

Citation: Fancourt, D., & Steptoe, A. (2018). Community group membership and multidimensional subjective well-being in older age. *Journal of Epidemiology & Community Health* 72(5), 376-382. *Comment:* Church or religious group membership predicted both less negative affect and, especially, more positive affect (greater well-being) 10 years later in this study of older adults in England, an increasingly secular region of Europe. Other researchers have reported similar findings in prospective studies across other regions of Europe [see Croezen S, Avendano M, Burdorf A, van Lenthe FJ (2015). Social participation and depression in old age: A fixed-effects analysis in 10 European countries. *American Journal of Epidemiology* 182 (2):168-176].

Religion, Sleep Quality and Pain Intensity in Rural China

Researchers at Central South University and other academic centers in mainland China conducted a cross-sectional survey of 2,052 adults (86% response rate) living in rural areas of Liuyang Hunan Province, with the purpose of examining the relationship between sleep quality, pain severity, and psychosocial factors such as religion. Religion was assessed by a single question that asked whether the participant was a "follower of a certain religion" (10%) or "not a follower of any religion" (90%). Sleep quality was assessed by a visual analog scale ranging from 0 to 10 for the preceding four weeks. Depressive symptoms were assessed with the PHQ-9, whereas health status was assessed by multiple items asking about self-rated physical, mental, and social health using the Self-Rated Health Measurement Scale (SRHMS). Also assessed were anxiety, self-efficacy, and perceived stress, all using standard measures. Controlled for in analyses were gender, age, education, income, and health status. A method called ridge regression was used in multivariate analyses. **Results:** Bivariate analyses indicated that 'followers of a religion' were more likely to have good physical ($r=.10$, $p<0.01$), good mental health ($r=.08$, $p<0.01$), less depression ($r=-.09$, $p<0.01$), less anxiety ($r=-.08$, $p<0.01$), less perceived stress ($r=-.07$, $p<0.01$), better overall sleep ($r=.06$, $p<0.05$), and less pain severity ($r=-.09$, $p<0.01$). However, the final model predicting pain severity included physical health, mental health, depressive symptoms, and sleep quality, but not religion (indirect effects of religion through these variables on pain severity were not examined).

Citation: Liu, X. K., Xiao, S. Y., Zhou, L., Hu, M., Zhou, W., & Liu, H. M. (2018). Sleep quality and covariates as predictors of pain intensity among the general population in rural China. *Journal of Pain Research*, 11, 857-866.

Comment: This paper was not about religion, and religion was measured in a very superficial manner (follower of a religion vs. not). Despite this, bivariate analysis indicated that mental health, physical health, and sleep quality were all better and pain severity

less in those who were religious. Given these associations, it is possible that being a follower of a religion had indirect effects on pain severity through these other variables, although this was not examined. Impressive findings (at least in bivariate analyses) for a secular area of the world where 90% of participants are not religious.

Religiosity, Social Support, and Use of Antidepressant Medication in Brazil

Investigators examined the relationship between religious involvement, social support, and use of antidepressant medications in the past 90 days. Participants were 1,606 adults age 60 or over (mean age 70 years) living in Bambui, a town located southwest of the state of Minas Gerais in Brazil. Religiousness was assessed by frequency of religious attendance, and weekly or more frequent attendance was categorized as high religiousness. Social support was assessed by degree of satisfaction with personal relationships, having friends whom they visited or who visited them, involvement in community associations, and receiving practical help from family members. Regression analyses controlled for social factors, gender, marital status, cognitive dysfunction, depressive symptoms, self-rated health status, number of doctors appointments, and presence of health insurance. **Results:** Religious attendance (weekly or more) was associated with a more than 50% reduction in antidepressant use (OR=0.45, 95% CI 0.29-0.70, $p < 0.001$), independent of other predictors. No association was found between indicators of social support and likelihood of taking antidepressants. Researchers concluded: "Health professionals attending this particular segment of the population (elderly people with depressive disorders) should consider religiousness of patients when [proposing] guidelines [for treating depression] and coping with their mental suffering."

Citation: Vicente, A. R. T., Castro-Costa, É., Firmo, J. D. O. A., Lima-Costa, M. F., & Loyola Filho, A. I. D. (2018). Religiousness, social support and the use of antidepressants among the elderly: a population-based study. *Ciencia & Saude Coletiva*, 23, 963-971.

Comment: This is one of the first studies to examine the relationship between religious attendance and use of antidepressant medication, controlling for multiple indicators of social support. Surprisingly, there was no relationship between social support and antidepressant use. In contrast, religious attendance was associated with a 55% reduction in antidepressant use. Given the cross-sectional nature of these findings, it remains unclear whether religious attendance prevented depression (and therefore reduced the need for antidepressant medication) or whether use of antidepressant medication was associated with an underlying depression that prevented regular religious attendance.

Religious Attendance and Weight

Investigators from the department of sociology at Florida State University and University of Arizona analyzed data from the 2006-2008 U.S. Health and Retirement Study to examine the association between religious attendance and body mass index (BMI) in a nationally representative sample of 11,457 adults age 50 or over. BMI, waist circumference, and waste-to-height ratio were assessed as dependent variables. Religious attendance was determined by the question: "About how often have you attended religious services during the last year?"; responses ranged from "not at all" to "more than once a week." Regression analyses were stratified by race and gender, controlling for age, education, marital status, and religious affiliation. **Results:** No significant association was found between religious attendance and BMI in the overall sample ($B=0.05$, $p > 0.05$). A significant interaction, however, was found between religious attendance and race ($B=0.79$, $p < 0.001$), although the interaction was present only in women ($B=0.83$, $p < 0.001$) not men ($B=0.16$, $p > 0.05$). Religious attendance was associated with greater BMI among Black women, but was

unrelated to BMI in White women. The same pattern was seen for waist circumference and for waist-to-height ratio in Black women; however, in White women, religious attendance was significantly and inversely related to waist circumference and waist-to-height ratio. Researchers concluded "For White women, attendance is either protective or unrelated to body mass. For Black women, attendance is consistently associated with increased body mass. We find that religious attendance is not associated with body mass among the men."

Citation: Godbolt, D., Vaghela, P., Burdette, A. M., & Hill, T. D. (2017). Religious attendance and body mass: an examination of variations by race and gender. *Journal of Religion and Health* 57:2140-2152.

Comment: Given the relationship between obesity and a host of chronic diseases, including diabetes mellitus, cardiovascular disease, several cancers, disability, and reduced longevity, it is essential that Black churches address issues related to diet, exercise and weight among women.

Religious Motivation and Worry about Alzheimer's Disease among Older Adults

Researchers from the department of psychology at the University of Colorado surveyed 83 adults age 60 or over (average age 69) in Colorado Springs to examine the relationship between religious behaviors, religious motivation, and worry about having Alzheimer's Disease. Cognitive functioning was assessed by the 6-item Short Orientation-Memory-Concentration Test; participants who scored above the cutoff for significant cognitive impairment were excluded from the study. Fear of Alzheimer's disease (Dementia Worry) was measured by the Fear of Alzheimer's Disease Scale (FADS). Frequency of religious behaviors was assessed by the 4-item Behavioral Religiosity Survey (prayer, religious attendance, etc.), whereas intrinsic and extrinsic religious motivation were measured by the 14-item Intrinsic/Extrinsic Religiosity Scale (Gorsuch and McPherson). Associations were examined using hierarchical regression. **Results:** After controlling for age, gender, family history of Alzheimer's disease, year of education, and religious behavior, intrinsic religious motivation was inversely related to fear of Alzheimer's disease ($B=-0.56$, $p=0.02$), as was extrinsic-social religious motivation ($B=-0.35$, $p=0.01$), although extrinsic-personal religious motivation was positively related to this fear ($B=0.31$, $p=0.04$). Researchers concluded: "Results suggest internalizing one's religious beliefs and building a social network within a religious community may provide a psychological buffer against DW" [Dementia Worry].

Citation: Roberts, J. R., & Maxfield, M. (2018). Examining the relationship between religious and spiritual motivation and worry about Alzheimer's Disease in later life. *Journal of Religion and Health* 57:2500-2514.

Comment: To our knowledge, this is the first study to examine the relationship between religious behavior, religious motivation, and fear of developing Alzheimer's disease. Interestingly, frequency of religious behavior (praying, religious attendance, etc.) was unrelated to Dementia Worry, whereas the more cognitive and social aspects of religious motivation (internalized religious motivation) were related to less fear of developing dementia.

Provision of Spiritual Care by Hospital Nurses

Investigators from the school of nursing at Loma Linda University surveyed 554 tertiary care hospital nurses to assess frequency of self-reported spiritual care with patients/families during their past 72-80 hours at work, as well as examine correlates of these spiritual care practices. Nurses (average age 39, average 11 years of experience) were employed at an acute tertiary care medical center, a children's hospital, behavioral medical center, and medical/surgical community hospital in Southern California, all associated with Loma Linda Health System, an institution

committed to whole person care. Religious affiliation of nurses was Protestant (48%), generic Christian (27%), or Catholic (17%). Participants were required to be state-licensed RN's and to have provided 36 hours of direct patient care within the previous two weeks. A Spiritual Care Therapeutics Scale was developed to assess 17 different spiritual care activities. Also assessed was religiosity (using the DUREL), daily spiritual experiences (Underwood's DSES), and a question about whether nurses saw themselves as religious and spiritual, spiritual but not religious, religious but not spiritual, or neither. Clinical and religious characteristics associated with spiritual care activities were examined using multiple regression analyses. **Results:** More than two-thirds (67%) of nurses never or rarely asked patients how they could support their spiritual or religious practices, 42% never or rarely took a spiritual history, more than 80% never or rarely documented spiritual care in the patient's chart, and nearly three-quarter (73%) never or rarely arranged for a chaplain to visit a patient. The most frequent spiritual care activities involved being present and actively listening to the patient's story. Nurses most likely to provide spiritual care were those who had received education on spiritual care, indicated that patients brought up spiritual concerns, and had more daily spiritual experiences. Nurses in non-pediatric settings were also more likely to engage in spiritual care activities than were pediatric nurses.

Citation: Mamier, I., Taylor, E. J., & Winslow, B. W. (2018). Nurse spiritual care: Prevalence and correlates. *Western Journal of Nursing Research*, E-pub ahead of press.

Comment: The findings above represent a best-case scenario. In other words, these were nurses who (1) responded to a survey about spiritual care activities (with only a 24% response rate), which means they had an interest in the topic, and (2) nurses working at a faith-based healthcare institution that emphasized whole-person care. Despite this, only 23% often or very often took a spiritual history, and more than two-thirds never or only rarely asked patients how they could support their spiritual or religious practices. The most frequent spiritual care activities were being present and listening to patients. How is that different than simply good nursing care? (nothing specific to spirituality or religion). These findings are remarkable for a profession that used to be made up almost entirely of women in religious orders.

SPECIAL EVENTS

2019 David B. Larson Memorial Lecture

(March 21, Duke University Hospital North, Room 2001, 5:30-6:30P, Durham, NC)

Gail Ironson, M.D., Ph.D., from the department of psychology and psychiatry at the University of Miami, Coral Gables, will give the 2019 DBL Memorial Lecture. Dr. Ironson has over 200 publications in the field of behavioral medicine applied to HIV/AIDS, cancer, and cardiovascular disease, and is past president of the Academy of Behavioral Medicine Research Society (a senior level organization by invitation only). She has directed or co-directed federally funded research studies investigating psychological factors in long survival with HIV/AIDS, stress management in HIV and cancer, massage therapy and immunity, and the biological effects of trauma in underprivileged people, people with HIV, and people at risk for HIV. Finally, she set up and runs the trauma treatment program at the University of Miami Psychological Services Center, which makes available to the community (on a sliding scale basis) both traditional (PE, CPT) and newer (EMDR) approaches to treatment. Her current areas of focus include examining positive psychological factors and health (especially spirituality) and trauma. She is one of the core investigators in the nationwide Templeton Landmark study on Spirituality and Health, and has just completed another study on

treating trauma in men at risk for HIV. All are welcome to attend this lecture, including members of the general public. For more information, contact Harold.Koenig@Duke.edu.

2019 Conference on Medicine and Religion

(March 29-31, Durham, NC)

The theme of this year's conference is: *Medicine and Faithful Responses to Suffering: "My Pain is Always With Me"*. Pain haunts human experience and frequently leads people to seek help from medical practitioners. As many as one in four American adults suffers chronic pain. On one hand, relieving pain seems the most obvious of responsibilities for clinicians. "To cure sometimes, to relieve often, to comfort always," the saying goes. On the other hand, pain often seems to defy medical solutions and to bedevil the efforts of both patients and clinicians. What, then, should we make of pain? What are traditioned practices of responding wisely to pain? What role does medicine play in those practices? Jewish, Christian, and Islamic scriptures and traditions all speak to the experience of pain, why it exists, how it affects an individual and a community, how one might respond faithfully to pain in oneself and in one's neighbor, and what may be hoped for when pain will not go away. The 2019 Conference on Medicine and Religion invites health care practitioners, scholars, religious community leaders, and students to take up these questions about pain by relating them to religious traditions and practices, particularly, but 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. For more information, go to:

<http://www.medicineandreligion.com/>.

RESOURCES

The Psychology of Religion: An Empirical Approach (Guilford Publications, 2018)

From the publisher: "Keeping up with the rapidly growing research base, the leading graduate-level psychology of religion text is now in a fully updated fifth edition. It takes a balanced, empirically driven approach to understanding the role of religion in individual functioning and social behavior. Integrating research on numerous different faith traditions, the book addresses the quest for meaning; links between religion and biology; religious thought, belief, and behavior across the lifespan; experiential dimensions of religion and spirituality; the social psychology of religious organizations; and connections to coping, adjustment, and mental disorder. Chapter-opening quotations and topical research boxes enhance the readability of this highly instructive text. New to this Edition are topics cognitive science of religion; religion and violence; and groups that advocate terrorist tactics; latest empirical findings, including hundreds of new references; expanded discussion of atheism and varieties of nonbelief; more research on religions outside the Judeo-Christian tradition, particularly Islam; state-of-the-art research methods, including techniques for assessing neurological states." Available for \$67.65 at <https://www.amazon.com/Psychology-Religion-Fifth-Empirical-Approach/dp/1462535984>

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 is struggling with a condition called posttraumatic stress disorder (PTSD), then this little book is for you. As a psychiatrist and research scientist for more than 30 years, I've been struck by how many people with PTSD are not being treated correctly for this disorder (and why more than 50% of persons with PTSD continue to suffer disabling

symptoms despite treatment). For that reason, I've written this book to inform those affected by PTSD about the condition and the best whole person treatments available today. I describe here what PTSD is, the causes for it, and the factors that protect against it. I also examine a separate condition called moral injury that often accompanies PTSD and can interfere with recovery unless identified and treated at the same time. I then focus on the best evidence-based treatments for PTSD today -- psychological, medical / pharmacological, and especially, religious or spiritual. 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 at <https://www.amazon.com/dp/172445210X>.

Religion and Mental Health: Research and Clinical Applications

(Academic Press, 2018) (Elsevier)

From the publisher: "[This 384 page volume] summarizes the latest research on how religion may help people better cope or exacerbate their stress, covering its relationship to depression, anxiety, suicide, substance abuse, well-being, happiness, life satisfaction, optimism, generosity, gratitude and meaning and purpose in life. The book looks across religions and specific faiths, as well as to spirituality for those who don't ascribe to a specific religion. It integrates research findings with best practices for treating mental health disorders for religious clients, also covering religious beliefs and practices as part of therapy to treat depression and posttraumatic stress disorder. [In brief, this volume] summarizes research findings on the relationship of religion to mental health, investigates religion's positive and negative influence on coping, presents common findings across religions and specific faiths, identifies how these findings inform clinical practice interventions, and describes how to use religious practices and beliefs as part of therapy." Available for \$72 at <https://www.amazon.com/Religion-Mental-Health-Research-Applications/dp/0128112824>.

Religion and Mental Health Book Series Protestant Christianity and Mental Health: Beliefs, Research and Applications

(CreateSpace Platform, 2017)

Available for \$7.50 at: <https://www.amazon.com/dp/1544642105/>

Catholic Christianity and Mental Health: Beliefs, Research and Applications

(CreateSpace Platform, 2017)

Available for \$7.50 at: <https://www.amazon.com/Catholic-Christianity-Mental-Health-Applications/dp/1544207646>

Islam and Mental Health: Beliefs, Research and Applications

(CreateSpace Platform, 2017)

Available for \$7.50 at: <https://www.amazon.com/Islam-Mental-Health-Research-Applications/dp/1544730330>.

Hinduism and Mental Health: Beliefs, Research and Applications

(CreateSpace Platform, 2017)

Available for \$7.50 at: <https://www.amazon.com/dp/1544642105/>

Judaism and Mental Health: Beliefs, Research and Applications

(CreateSpace Platform, 2017)

Available for \$7.50 at: <https://www.amazon.com/Judaism-Mental-Health-Research-Applications/dp/154405145X/>

Buddhism and Mental Health: Beliefs, Research and Applications

(CreateSpace Platform, 2017)

Available for \$7.50 at <https://www.amazon.com/dp/1545234728/>

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>.

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/>

TRAINING OPPORTUNITIES

Spiritual Competency Training in Mental Health

Spiritual Competency Training in Mental Health (SCT-MH) is a multi-disciplinary online program designed to train mental health providers in basic spiritual and religious competencies (*a program that is now provided free of charge*). The goal of the program is to equip providers with greater confidence and competence in helping clients with religious/spiritual issues. The online training takes six to eight hours to complete and consists of a number of engaging resources and learning activities. The modules cover a number of key topics: common stereotypes about religion/spirituality (RS); the diversity of RS expressions; why it is important to address RS in treatment; the importance of the therapist's own RS attitudes, beliefs, and practices; how to assess RS; how to help clients access RS resources, and; how to respond to RS problems that arise in treatment. Mental health providers (MD, PhD, Masters level) of all disciplines are welcome to participate. Free CE and CME credits are available upon completion of the program. If you are interested in participating, please email Dr. Michelle Pearce at mpearce@som.umaryland.edu for further information or go to this website for the eligibility screen: <http://bit.ly/SCTMH>. Please feel free to share this training program with other colleagues.

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 is now accepting new Online Funding Inquiries (OFIs; essentially letters of intent) through their funding portal. The next deadline for Small Grant requests (\$234,800 or less) and Large Grant requests (more than \$234,800) is **August 30, 2019**. The Foundation will communicate their decision (rejection or invitation to submit a full proposal) for all OFIs by October 4, 2019. JTF's current interests on the interface of religion, spirituality, and health include: (1) research on causal relationships and underlying mechanisms (basic psychosocial, behavioral, and physiological pathways), (2) increasing competencies of health care professionals in working with religious patients and issues (especially in mental health and public health), (3) research involving the development of religious-integrated interventions that lead to improved health, (4) efforts to increase collaboration and rates of referrals between mental health professionals and religious clergy. More information: <https://www.templeton.org/what-we-fund/grantmaking-calendar>.

2018 CSTH CALENDAR OF EVENTS...

Nov

28 **"The Disease of Being Busy": Healing, Wholeness, and the Heart of Islam**
Speaker: Omid Safi, Ph.D.
Professor of Asian and Middle Eastern Studies, Islamic Studies Center, Department of Religion, Duke University, author of *Progressive Muslims*, *Voices of Islam: Voices of Change*, and *Cambridge Companion to American Islam* and numerous other publications on this topic
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

Dec

19 **When Professionals Retire: Critical Transitions in Later Life and the Role of Spirituality**
Speaker: Dan G. Blazer, M.D., PhD
J. P. Gibbons Professor of Psychiatry, Emeritus
Duke University Medical Center
Learning Lab 1502, 1st floor, Duke South, 3:30-4:30
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