

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 August 2016) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

LATEST RESEARCH

Religious Service Attendance and Depression in Women

Investigators at Harvard's T.H. Chan School of Public Health examined the effects of religious attendance on the development of physician-diagnosed clinical depression, regular anti-depressant use, or severe depressive symptoms in 48,984 US nurses (mean age 58) followed from 1996 to 2008. Religious attendance was assessed in 1992, 1996, 2000, in 2004 with the question "How often in the past year do you attend religious services?" (more than once per week, once per week, 1 to 3 times per month, less than once per month, and never or almost never). Researchers also examined the effect of depression in 1996 and 2000 on subsequent religious service attendance in 2004 and 2008. Multivariate logistic regression and marginal structural models were used to estimate odds ratios, enabling researchers to tease out the feedback between religious attendance and depression and account for reverse causation and time-dependent confounding. All analyses were controlled for sociodemographic, social interaction and support, lifestyle factors, health behaviors, medical conditions, and physical functioning. **Results:** Compared to women who never or almost never attended religious services (the reference category), those who attended religious services weekly or more were 25% less likely to develop depression (OR=0.75, 95% CI 0.67-0.84) and those who attended services more than weekly had nearly a 30% less likely to develop depression (OR=0.71, 95% CI 0.62-0.82). Compared to women who were not depressed, those who were depressed were less likely to subsequently attend religious services once per week or more (OR=0.74, 95% CI 0.68-0.80). Researchers concluded that "In this study of US women, there is evidence that higher frequency of religious service attendance decreased the risk of incident depression and women with depression were less likely to subsequently attend services."

Citation: Li S, Okereke OI, Chang SC, Kawachi I, VanderWeele TJ (2016). Religious service attendance and lower depression among women - A prospective cohort study. *Annals of Behavioral Medicine*, July 16, E-pub ahead of press.

Comment: This is one of the largest studies that has examined the relationship between religious attendance and depression. All analyses were controlled for social support and social interactions, ruling out the possibility that effects were due to social factors alone. It appears that religious attendance helps to prevent the development of depression, and depression can prevent religious attendance as well. Thus, the direction of the causation is going in both ways here. The inverse relationship between religious attendance and depression often reported in cross-sectional studies, then, is likely the summation of these two effects.

Religious Participation and Cortisol Levels 10 Years Later

Researchers in the department of psychology at Wayne State University analyzed data from the Midlife in the United States (MIDUS) study and the National Study of Daily Experiences (NSDE) to examine the relationship between religious participation and salivary cortisol levels. Cortisol is a hormone that increases during psychological stress or depression as part of the neuroendocrine stress response. Religious participation (assessed as a combination of frequency of religious attendance and frequency of attending other religious groups) was measured at Wave I of the MIDUS study in 1995-1996. A proportion of those who participated in Wave I of the MIDUS study also participated in Wave II of the NSDE study (2004-2009), when they had their salivary cortisol levels measured. Salivary cortisol was collected on 4 consecutive days, 4 times daily immediately upon awakening, 30 minutes later, just before lunch, and at bedtime, allowing for a diurnal curve of cortisol release to be examined. A steep diurnal curve is known to be healthy whereas a flat diurnal curve is known to be unhealthy (indicates stress/depression). Besides religious participation at MIDUS Wave I, religious coping was assessed at Wave II (2004-2006) using a 4-item measure of positive religious coping and a 2-item measure of religious struggle ("I wonder whether God has abandoned me" and "I feel God is punishing me for my sins or lack of spirituality"). Hierarchical Linear Modeling (HLM) was used for all analyses, controlling for age, gender, ethnicity, education, waist circumference, and wake time. **Results:** Religious participation in 1995-1996 predicted a steeper (healthier) cortisol slope 10 years later across the four days of saliva sampling (B=-0.002, SE=0.001, p<0.05). Religious struggle at the 10-year follow-up was associated with a flatter cortisol slope (unhealthy). Higher religious participation in 1995-1996 predicted lower levels of religious struggle at the 10-year follow-up (B=-0.05, SE=0.01, p<0.001). When religious struggle was included in the model with religious participation, the relationship between religious participation and diurnal cortisol slope was slightly weakened to nonsignificance (B=-0.002, SE=0.001, p=0.055). Researchers concluded that "These findings identify religious struggle as a mechanism through which religious participation impacts diurnal cortisol levels and suggest that diurnal cortisol is a possible pathway through which aspects of religion influenced long-term physical health."

Citation: Tobin ET, Slatcher RB (2016). Religious participation predicts diurnal cortisol profiles 10 years later via lower levels of religious struggle. *Health Psychology*, E-pub ahead of press.

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Comment: The finding that religious participation affects cortisol levels 10 years later is remarkable. Admittedly, the primary effect was relatively weak and the moderating effect of religious struggle was marginal. Nevertheless, these findings are consistent with and extend previous research examining relationships between religiosity and stress hormones (and adds to our biological understanding of the mechanism by which religious participation may affect physical health and longevity).

Intrinsic Religiosity Mediates Relationship between Religious Attendance and Well-Being

Investigators in the departments of psychology at Brigham Young University and the University of Colorado at Denver recruited 855 college students (average age 19.5) who attended three universities located in the Midwestern, Northeastern, and Intermountain regions of the United States. The aim was to examine the relationship between religious attendance and well-being and determine mediators of this relationship. Religious attendance was dichotomized into “weekly or more” vs. “less than weekly or no attendance.” Intrinsic religiosity was assessed using the intrinsic religiosity subscale of the Age-Universal Scale (I/E-R) developed by Gorsuch and McPherson (1989); intrinsic religiosity is the extent to which people try to live their religion in their daily lives. Well-being was assessed using the 84-item Weinberger Adjustment Inventory (WAI), which has subscales measuring depression, anxiety, denial of distress, and well-being. Social support was assessed by the Instrumental Support Evaluation List (Cohen et al., 1985). Path models were used to analyze the data, controlling for age and gender. **Results:** Religious attendance was inversely associated with depressive symptoms through intrinsic religiosity ($B=-0.91, p \leq 0.01$); attendance was also inversely associated with anxiety symptoms, again acting through intrinsic religiosity ($B=-0.10, p \leq 0.01$); attendance was also positively related to denial of distress, acting again through intrinsic religiosity ($B=0.04, p \leq 0.05$); finally, attendance was related to well-being acting through denial of distress ($B=-0.02, p < 0.05$), all independent of social support. Researchers concluded that: “This suggests that the mental health benefits of religious service attendance are not simply the result of increased social support or a certain response style on questionnaires; rather, it appears that the relationship is at least partly the result of people trying to live their religion in their daily lives.”

Citation: Steffen PR, Masters KS, Baldwin S (2016). What mediates the relationship between religious service attendance and aspects of well-being? *Journal of Religion and Health*, February 19, E-pub ahead of press.

Comment: This study, as it claims, adds to the literature because it helps to explain “how” religious attendance influences depression and other indicators of mental health via specific aspects of religious commitment. Again, the effects appear to be independent of social support, a finding that conflicts with claims that social factors are the primary mechanism through which religious attendance affects mental health.

Is Certainty of Belief (whether Religious or Atheist) Related to Mental Health?

Investigators at the Palo Alto VA and University of Louisville recruited an online sample from community forums such as Facebook and Reddit. Subforums on atheism, agnosticism, Christianity, Islam, Judaism, and spiritual but not religious persons were targeted. Of the 7,538 who responded, 4,667 completed questionnaires and gave consent. Participants were 78.2% white, 60.7% male, and average age was 27.4 years. The sample was made up of 37.2% atheists, 19.2% agnostics, 10.5% spiritual but not religious, 11.0% Christians, 3.1% Buddhist, and 1.2% Jews; Muslims, Hindus and those those with missing data comprised the balance of 17.2%. Dogmatism (“unchangeable, unjustified

certainty”) was assessed using the 20-item Altemeyer DOG scale. *Existential* dogmatism was assessed by endorsement of an item about the certainty of God’s existence (ranging from “absolutely certain God exists” to “absolutely certain God does not exist”). In addition, 3 other items were added to this measure: “Regarding God’s existence or nonexistence, my beliefs are correct and represent truth”; “I consider my beliefs to be strong”; and “There is nothing that could convince me differently” (with agreement rated on a 0 to 7 scale). Religiosity was assessed with 5 items from the Transcendent subscale of the Spiritual Health and Life Orientation Measure (SHALOM) (i.e., importance of “personal relationship with the Divine/God,” “prayer life,” “worship of the Creator,” “oneness with God,” and “peace with God”). Mental health was assessed with the 20-item Positive and Negative Affect Schedule, the 6-item Gratitude Questionnaire, the 8-item Hope Scale, and the 5-item Satisfaction with Life Scale. Social support was assessed by the 6-item Social Support Questionnaire (Sarason). In addition, geographic location, gender, race, education, age, and income were assessed and controlled for. **Results:** Existential dogmatism was significantly and positively related to all five mental health scales at $p < 0.01$. There was no significant difference on any of the 5 mental health scales between theistic ($n=348$) and atheistic ($n=515$) participants who indicated absolute certainty of belief, except that theistic participants scored higher than atheistic on gratitude ($p < 0.001$). These findings caused researchers to conclude that those who were absolutely certain of God’s existence or nonexistence had largely similar levels of mental health. Structural equation modeling was used to determine whether existential dogmatism or religiosity was a stronger predictor of mental health; results indicated that they were equally predictive of mental health. Researchers concluded: “The implications of this study are that secular and religious adherents have similar levels of mental health, which is contrary to expectations based on the previous literature.”

Citation: Moore JT, Leach MM (2016). Dogmatism and mental health: a comparison of the religious and secular. *Psychology of Religion and Spirituality* 8 (1): 54-64.

Comment: Although the majority of the sample was a highly selected group of young white non-Christian males (a demographic known to be the least religious of all groups) and the amount of variance in mental health explained by existential dogmatism $< 1.5\%$, the findings are notable. The sample size was large, the measures were reasonable, and the approach to analyzing the data was generally appropriate. Certainty of belief, then, may play a role in the association between religion and mental health, although further research in more representative samples with prospective data is needed to confirm these findings.

Religion, Spirituality, Substance Abuse and Depression in Black Male Homosexuals

Researchers at General Theological Seminary and the University of Alabama analyzed data from the 2005 CDC Brothers y Hermanos Survey that included 1,141 black men who have sex with men (MSM). Approximately half of the sample was recruited from New York City and the other half from Philadelphia. The objective was to assess the relationship between religiosity, spirituality, substance abuse, and depression. Religiosity was assessed with a 4-item index made up of the following items: “How often have you attended a place of worship during the past six months other than for a wedding or funeral?”; “I am able to be open about my sexuality in my religious community”; “My religious beliefs make me feel bad about having sex with other men;” and “I often have to choose my religious beliefs over my desire to be with a man.” Spirituality, on the other hand, was assessed with a 3-item index composed of the following questions: “I always seek guidance from a higher power in times of need”; “My spiritual connection with a higher power helps me cope with negative beliefs that other people have about homosexuality;” and “My

spiritual beliefs encourage me to do everything I can to stay healthy.” Depression was assessed by asking respondents how many days they were depressed in the last week and in the last month. Substance abuse was assessed with single questions asking about use of cocaine, alcohol, binge alcohol, methamphetamine, crack, ecstasy, marijuana, heroin, poppers, and nonprescription drugs. No variables were controlled in analyses. **Results:** Religiosity was negatively associated with use of ecstasy ($r=-0.06$, $p=0.04$) and popper use ($r=-0.07$, $p=0.02$), and positively associated with cocaine ($r=0.10$, $p=0.001$) and crack use ($r=0.11$, $p=0.0001$), but was *unrelated to depression* (Table 4 in article). Spirituality was inversely related to alcohol use ($r=-0.12$, $p<0.0001$), cocaine use ($r=-0.07$, $p=0.02$), and crack use ($r=-0.12$, $p<0.0001$), and was also unrelated to depression. However, another confusing set of chi-square tests and odds ratios were also provided, with conflicting and questionable claims that religiosity was *positively associated with depression*, cocaine, crack, poppers, and ecstasy use (complete statistics were not provided, only p values) (Tables 5-6). The OR's for the claimed positive relationship between religiosity and substance use were reported to be 0.95 ($p=0.001$) for cocaine, 0.94 ($p=0.0001$) for crack, and -1.05 ($p=0.03$) for lower use of poppers. The OR's presented for spirituality and lower substance use were -1.06 ($p<0.01$) for alcohol and -1.05 ($p=0.03$) for crack [Note: OR's do not occur in the negative “-”; OR's range from 0 to 1.0 when indicating lower risk, and are >1.0 for higher risk]. Authors conclude that: “Religiosity and spirituality were associated with substance use among Black MSM. Black MSM with higher religiosity scores also tended to report more use of crack, cocaine, and poppers as well as report being depressed in the past week.”

Citation: Watkins TL, Simpson C, Cofield SS, Davies S, Kohler C, Usdan S (2016). The relationship of religiosity, spirituality, substance abuse, and depression among black men who have sex with men (MSM). *Journal of Religion and Health* 55:255-268

Comment. The presentation of results and conclusions is so confusing that it is surprising the paper was published. Here are just a few concerns: the authors (1) confuse “predictors” with “outcomes”, (2) confuse odds ratios with beta values (how do you get a negative odds ratio?), (3) base claims on p values without complete statistics, (4) measure religiosity in highly biased and negative ways (see above items), (5) and measure spirituality in highly biased and positive ways. We summarize this study here only because research in general is limited on the relationship between religiosity and mental health in this population. While the report does not add to the literature, it is presented as an example of a poorly done study with intriguing although largely unjustified findings.

“Spiritual” Peace Predicts 5-Year Mortality in Congestive Heart Failure

Researchers at the University of Connecticut and Oregon State University recruited 191 patients with congestive heart failure (CHF) to complete at baseline survey and then tracked participants for 5 years to assess predictors of mortality. One-third of the sample (32%) died during follow-up. Religious attendance was assessed by a single item in the usual manner. “Spiritual peace” was measured by agreement with the statement “I feel deep inner peace or harmony.” Cox proportional hazards regression was used to analyze the data, controlling for age, NYHA class, health conditions, depressive symptoms, adherence, smoking, and alcohol consumption. **Results:** “Spiritual peace” but not religious attendance predictor a decreased risk of dying during follow-up ($HR=0.80$, 95% CI 0.67-0.95). Researchers concluded that: “Experiencing spiritual peace, along with adherence to a healthy lifestyle, were better predictors of mortality risk in the sample of CHF patients than were physical health indicators such as functional status and comorbidity.”

Citation: Park CL, George L, Aldwin CM, Choun S, Suresh DP, Bliss D (2016). Spiritual peace predicts 5-year mortality in congestive heart failure patients. *Health Psychology* 35 (3): 203-210

Comment. Interesting results, but here is the question: What exactly makes “deep inner peace and harmony” deserving of the descriptor “spiritual” (rather than simply considering it an indicator of mental health, which it is)? Although religious attendance did not predict survival time, attendance was strongly associated with spiritual peace ($r=0.33$, $p<0.001$), and was associated with better health and better adherence to treatment. Unfortunately, researchers did not examine the *indirect effects* of religious attendance on survival through spiritual peace and better adherence to treatment.

Religiosity, Discrimination and Mental Health in African-American vs. Caribbean Black Youth

Investigators at Washington University in St. Louis and four other American universities analyzed data from 1,161 youth ages 13 to 17 years participating in the National Survey of American Life (NSAL) (807 African-American and 354 Caribbean Black). The purpose was to examine the buffering effects that religiosity might have on feelings of discrimination. Religiosity was measured using three indicators of religious involvement: religious attendance, subjective religiosity and frequency of prayer. Discrimination was assessed with the 10-item Every Day Discrimination Scale (Williams et al., 1997). Also assessed were depressive symptoms using the 12-item brief CES-D, self-esteem using the 10-item Rosenberg Self-Esteem Scale, and perceived stress using the 14-item Perceived Stress Scale (Cohen). Control variables were gender, age, household income, and immigration status. **Results:** Correlational analysis of revealed different results in African-American and Caribbean Black youth. In African-Americans, frequency of prayer was significantly and positively related to self-esteem ($r=0.08$, $p<0.05$) (the only significant finding). In Caribbean Blacks, subjective religiosity was positively associated with self-esteem ($r=0.10$, $p<0.05$) and was negatively associated with depressive symptoms ($r=-0.12$, $p<0.05$) and with perceived stress ($r=-0.12$, $p<0.05$). Hierarchical regression analysis revealed no interaction between discrimination and any measure of religiosity in African-Americans. However, in Caribbean Black youth, a significant interaction emerged between discrimination and church attendance ($p<0.01$) in predicting depressive symptoms. In those who attended religious services infrequently, there was a positive association between racial discrimination and depressive symptoms; this relationship, however, was not present among youth who frequently attended religious services. The same interaction with attendance was reported for racial discrimination and perceived stress. Researchers concluded: “Findings indicate that religious involvement was a protective factor for Caribbean black adolescents but not for African American youth.”

Citation: Butler-Barnes, Martin PP, Copeland-Linder N, Seaton EK, Matusko N, Caldwell CH, Jackson JS (2016). The protective role of religious involvement in African American and Caribbean Black adolescents' experiences of racial discrimination. *Youth & Society*, E-pub ahead of press

Comment. The findings here (interaction with religiosity) are consistent with those reported among Caribbean Black adults in the NSAL that focused on chronic health problems and depression [see Assari S (2014)]. Chronic medical conditions and major depressive disorder: Differential role of positive religious coping among African Americans, Caribbean blacks and non-Hispanic whites. *International Journal of Preventive Medicine* 5(4):405-413]. In the latter study, the positive relationship between chronic medical conditions and major depressive disorder was much weaker in those with high religious coping, but this occurred again only in Caribbean Black adults (not African Americans or

White Americans). The present study found that the relationship between discrimination and poor mental health was present only in less religious Caribbean Black youth (religiosity made little difference in African Americans). As in adults, this suggests that religiosity may be a more important factor in maintaining mental health among Caribbean Blacks than in African Americans.

Prayer Coping and Trauma Disclosure in Recently Deployed U.S. Veterans

Investigators at Fuller Theological Seminary, University of South Alabama, and the Minneapolis VA examined relationships between prayer coping, attitudes toward trauma disclosure, PTSD symptoms and depression among 110 US veterans recently returning from deployment to Iraq or Afghanistan. Participants were recruited from the Minneapolis VA within six months of returning from combat zones. Sample consisted of 80% men, average age 31, 93% Caucasian white, 53% Protestant and 29% Catholic, with an average 14.2 years of education (at least some college). The Prayer Functions Scale (PFS, Bade & Cook, 1997) was used to assess "ways in which the veterans utilize prayer as a means of coping with difficulties in life." The PFS is a 58-item measure consisting of four subscales: 17-item Acceptance subscale (request from God for understanding in circumstances), 14-item Assistance subscale (request for God to come alongside during hard times), 11-item Calm and Focus subscale (request from God for inner resources to cope with obstacles), and 4-item Deferring/Avoiding subscale (request for God to intervene and quickly make changes in stressful situation). The Disclosure of Trauma Questionnaire (DTQ) consists of three subscales: 11-item Urge to Talk subscale, 13-item Reluctance to Talk subscale, and 10-item Emotional Reactivity Subscale. Combat exposure (CES), social support (MOSSSS), PTSD symptoms (PCL-C), and depressive symptoms (BDI-II) were assessed using standard scales. **Results:** Bivariate analyses revealed that the DTQ Urge to Talk subscale was positively related to all 4 PFS subscales (acceptance, $r=0.37$, $p<0.001$; calm and focus, $r=0.39$, $p<0.001$; assistance, $r=0.30$, $p<0.01$; and defer/avoid, $r=0.25$, $p<0.05$). No significant relationships were found between PFS subscales and other DTQ subscales; furthermore, no significant association was found between PFS subscales and PTSD or depressive symptoms. In multivariate analyses, stepwise regression was performed to examine relationships to PTSD and depressive symptoms; first, combat exposure and social support were entered, then disclosure attitudes, and finally the four prayer functions. Results indicated that prayer for assistance was associated with less PTSD symptoms ($B=-0.32$, $SE=0.16$, $p<0.05$). In the regression model for depressive symptoms, prayer for calm and focus was inversely related to depressive symptoms ($B=-0.20$, $SE=0.07$, $p<0.01$), while defer/avoid prayer was positively associated with depressive symptoms ($B=0.09$, $SE=0.04$, $p<0.05$). Researchers concluded: "These findings support emerging ideas about prayer as a form of trauma disclosure and highlight the relevance of this approach in coping for veterans as they readjust to civilian life."

Citation: Tait R, Currier JM, Harris JI (2016). Prayer coping, disclosure of trauma, and mental health symptoms among recently deployed United States veterans of the Iraq and Afghanistan conflicts. *International Journal for the Psychology of Religion* 26:31-45

Comment: This study adds to research demonstrating the importance of religious activities in coping with trauma experienced by active-duty military and veterans during and after their deployment to combat theaters. Prayer, being the most intimate of religious activities, appears to play a role in helping veterans to talk more about their trauma (disclosure is known to be a key factor in recovery from trauma).

Religiosity and Dialysis Adherence among Hemodialysis Patients in Brazil

Researchers in the department of clinical medicine at the Federal University of Ceara in Fortaleza, Brazil, examined the relationship between religiosity, medication adherence, and adherence to dialysis sessions in 202 dialysis patients (61% male, average age 53 years). Religiosity was assessed with the 5-item Duke University Religion Index; depressive symptoms by the PHQ-9; quality of life by the SF-36; and medication adherence by the 8-item Morisky Medication Adherence Scale. **Results:** Between one-third and one-half of the sample (40.6%) had poor medication adherence, and nearly one-quarter (24%) missed 3 or more dialysis sessions in the previous 6 months. No association in bivariate or multivariate analyses was found between religiosity and medication adherence scores. However, organizational religiosity (frequency of religious attendance) and intrinsic religiosity (degree of religious commitment) were both associated with better adherence to dialysis sessions ($B=0.26$, $p=0.004$, and $B=0.23$, $p=0.03$, respectively). Researchers concluded that: "Religiosity was associated with dialysis adherence but not with medication adherence."

Citation: De Medeiros CMMF, Arantes EP, Tajra RDP, Santiago HR, CarvalhoAF, Liborio AB (2016). Resilience, religiosity and treatment adherence in hemodialysis patients: A prospective study. *Psychology, Health & Medicine*, June 1, E-pub ahead of press

Comment: Since only the abstract was available, details of the methodology and findings are lacking. Nevertheless, compliance with treatment is an important outcome that religious involvement may influence, as suggested in the present study for attending dialysis sessions.

Role of Religion in Recovery from Psychosis

Qualitative researchers from the division of health research at Lancaster University in the United Kingdom conducted interviews with 10 persons suffering from psychosis (recovered). Using a social constructionist grounded theory methodology, several processes were identified by which religious beliefs and activities influenced recovery. These included use of scripture and rituals, establishing a connection with God, efforts to maintain religious rituals, guidelines from religion for decision-making and relating to others, religion enhancing psychological well-being, and religious beliefs helping to make sense of psychotic experiences. Researchers concluded that mental health services for those suffering from psychotic illnesses should consider religious beliefs and practices as resources for recovery.

Citation: Heffernan S, Neil S, Thomas Y, Weatherhead S (2016). Religion in the recovery journey of individuals with experience of psychosis. *Psychosis*, May 18, E-pub ahead of press

Comment: Only the abstract was available, so study details are lacking. However, given that mental health professionals have claimed for years that religion exacerbates psychosis, this study suggests that it may serve as a resource in recovery, at least for some patients.

Non-Pathological Possession vs. Dissociative Identity Disorder

Researchers from the Center for Research in Psychology at Coventry University (England) and the Federal University of Juiz de Fora (Brazil) reported the case of a 55 year old woman (DSJ) who leads an Afro-Brazilian religious group (*Umbanda*, a religious group related to Spiritism). While possession experiences are a crucial part of this religion, modern psychiatry doesn't see it this way. For those experiencing symptoms of possession, DSM-5 lists numerous criteria that would qualify it for a dissociative identity disorder (DID, sometimes called multiple personality disorder), such as intrusive thoughts, lack of control over

possession state, and heightened anxiety, loneliness, amnesia and family conflict. In this case, the research subject DSJ during her childhood and early adulthood displayed all five DSM-5 criteria for DID. However, from her late 20s to the present, DSJ regularly experienced possession states that she reported were under her control, and she found them religiously meaningful. During her adult life, she met only three of the five DSM-5 criteria for DID. For the past three decades she had been involved in the Umbanda religion, provided regular counseling to others, and had reportedly healed over 150 people. She is now highly esteemed as an Umbanda religious leader and is treated as a wise figure chosen by the gods or spirits for her gift. In this role, she performs healing and divination, and offers spiritual advice to those reporting unusual or anomalous experiences. She has never been to see a psychiatrist or clinical psychologist and does not use drugs or alcohol, although often drinks wine or cachaca, a distilled alcoholic Brazilian drink, when in a possession state. This case report describes her experiences from age 7 (when she began having intuitions, premonitions, and trance states) through her teenage years (when she felt anguished, lonely and afraid of being considered crazy), through her adult life after she entered the Umbanda religion (at age 28 she sought help there for intensified possession experiences). Being part of the Umbanda religion provided a meaningful framework in a supportive community that helped her to make sense of and control her possession states.

Citation: Delmonte R, Lucchetti G, Moreira-Almeida A, Farias M (2016). Can DSM-5 differentiate between non-pathological possession in dissociative identity disorder? A case study from an Afro-Brazilian religion. *Journal of Trauma & Dissociation*, January 5, E-pub ahead of press.

Comment: This case report provides an in-depth analysis of the differences between pathologic dissociative identity disorder and controlled possession states as part of an established religion, and illustrates how one can transition into another. Umbanda and Spiritist-type religions may provide an explanatory framework and a supportive environment that allows for the integration of otherwise pathological mental experiences that can result in a relatively healthy and functional lifestyle. This case report suggests a viable alternative to antipsychotic drugs, side-effects of those medications, social ostracization, and possibly institutionalization that might otherwise have been DSJ's experience in a North American or European setting.

SPECIAL EVENTS

Symposium on Health, Religion, and Spirituality in Public Health (Cambridge, MA, December 2, 2016)

Mark your calendars for a day long symposium titled: "Harvard Symposium on Advancing Health, Religion, and Spirituality: From Public Health to End of Life." The focus will be on how religion and spirituality in concert with public health and the practice of medicine may alleviate illness and promote human well-being more generally and also at the end of life. The location is the Harvard Chan School of Public Health, and the time is 10:30A-5:00P. Invited panelists and speakers include Ken Pargament, Daniel Sulmasy, Christina Puchalski, Tyler VanderWeele, Tracy Balboni, and Harold Koenig. For more information, go to: <http://projects.iq.harvard.edu/rshm/home> or contact Dr. Michael Balboni at Michael_Balboni@dfci.harvard.edu.

Conference on Medicine & Religion

(Houston, TX, March 24-26, 2017)

The 2017 Conference conveners invite health care practitioners, scholars, religious community leaders, and students to address questions associated with the theme, "Re-Enchanting Medicine," by relating its questions to religious traditions and practices. An

array of disciplinary perspectives are welcomed, from empirical research to scholarship in the humanities to stories of clinical practice. Invited are abstracts for 75-minute panel and workshop sessions, 15-minute paper presentations (with 10 minutes discussion), and posters. Also invited is student participation in an essay contest. **Deadline for abstract submission is September 30, 2016.** See website: <http://www.medicineandreligion.com/>.

RESOURCES

Oxford Handbook of New Religious Movements, Vol II (Oxford University Press, 2016)

From the publisher: "The study of New Religious Movements (NRMs) is one of the fastest-growing areas of religious studies, and since the release of the first edition of The Oxford Handbook of New Religious Movements in 2003, the field has continued to expand and break new ground. In this all-new volume, James R. Lewis and Inga B. Tollefsen bring together established and rising scholars to address an expanded range of topics, covering traditional religious studies topics such as "scripture," "charisma," and "ritual," while also applying new theoretical approaches to NRM topics. Other chapters cover understudied topics in the field, such as the developmental patterns of NRMs and subcultural considerations in the study of NRMs.

The first part of this book examines NRMs from a social-scientific perspective, particularly that of sociology. In the second section, the primary factors that have put the study of NRMs on the map, controversy and conflict, are considered. The third section investigates common themes within the field of NRMs, while the fourth examines the approaches that religious studies researchers have taken to NRMs. As NRM Studies has grown, subfields such as Esotericism, New Age Studies, and neo-Pagan Studies have grown as distinct and individual areas of study, and the final section of the book investigates these emergent fields." Available for \$150.00 at: <https://global.oup.com/academic/product/the-oxford-handbook-of-new-religious-movements-9780190466176?cc=us&lang=en&>.

Religion, Personality, and Social Behavior (Psychology Press, 2014)

From the publisher: "Psychological interest in religion, in terms of both theory and empirical research, has been constant since the beginning of psychology. However, since the beginning of the 21st Century, partially due to important social and political events and developments, interest in religion within personality and social psychology has increased. This volume reviews the accumulated research and theory on the major aspects of personality and social psychology as applied to religion. It provides a high quality integrative, systematic, and rigorous review of that work, with a focus on topics that are both central in personality and social psychology and have allowed for the accumulation of solid and replicated and not impressionist knowledge on religion. The contributors are renowned researchers in the field who offer an international perspective that is both illuminating, yet neutral, with respect to religion. The volume's primary audience is academics, researchers, and advanced students in social psychology, but it will also interest those in sociology, political sciences, and anthropology." Available for \$59.95 (new) at: <https://www.amazon.com/Religion-Personality-Behavior-Vassilis-Saroglou/dp/1848726651/>.

You Are My Beloved. Really? (CreateSpace publishing platform, 2016)

From the publisher: "How does God feel about us? Are we his beloved, as some claim? Or is this just fantasy and wishful thinking? The author, a psychiatrist and medical researcher,

examines the evidence for God's love from Christian, Jewish, Muslim, Buddhist and Hindu perspectives based largely on the sacred scriptures from these traditions. Not a theologian, the author draws from his 30 years in clinical practice, his research background, and his personal life in taking a practical approach to the subject. Those of any age with an open mind -- especially if going through hard times -- will find this book enlightening, inspiring, and possibly healing. Written for Christians, non-Christians, those who are religious, those who are spiritual, and those who are neither." Dedicated to Veterans and active duty Service Members. Planning to use this version in a future clinical trial examining spirituality-oriented cognitive processing therapy for moral injury in PTSD; however, it is written for a much broader audience than those with PTSD. Compact paperback version (6 x 4 inches, with illustrations) 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 \$46.00 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 (OFI)

The John Templeton Foundation is now accepting new funding requests *at any time of the year* through their OFI form. Small Grants are defined as requests for \$217,400 or less. OFI

deadlines for small grant requests this year are **August 31** and **November 30**, with decisions communicated no later than the end of September and December (respectively). Large Grants are defined as requests for more than \$217,400. The Foundation has only one deadline per year for OFIs related to large grant requests on **August 31**. All decisions on large grant OFIs will be communicated by the end of September. 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>

2016 CSTH CALENDAR OF EVENTS...

September

- 2 **Religion, Spirituality and Medicine**
Speaker: Koenig
Campbell University School of Osteopathic Medicine
Lillington, North Carolina
Contact: Joseph Cacioppo (<mailto:cacioppo@campbell.edu>)
- 16 **Megatrends: Mental Health, Faith, and the Future**
American Association of Christian Counselors (AACC)
National Conference (Friday 3:15-5:00)
Dallas, Texas
Contact: Dina Jones (Dina.Jones@aacc.net)
- 28 **Review of Buddhism and Health Studies**
Speaker: Carol Weingarten, M.D., Ph.D.
Adjunct Assistant Professor of Psychiatry, DUMC
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

October

- 26 **Religion, Spirituality & Care Delivery: Views of Veterans with Advanced Illness and VA Staff**
Speaker: Nathan Boucher, DrPH, PA-C, MPA, CPHQ
Post-Doctoral Fellow, GRECC, Durham VAMC
Center for Aging, DUMC
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

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