CROSSROADS…

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & Health Volume 7 Issue 3 September 2017

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

LATEST RESEARCH

Religiosity, Suicidal Ideation and Age

Researchers from Department of Mental Health Policy, NIMH, National Center of Neurology and Psychiatry in Japan, Department of Mental Health Policy at the University of Tokyo, and Departments of Mental Health and Psychiatry at Johns Hopkins University analyzed data from the U.S. National Survey on Drug Use and Health (NSDUH) to examine the relationship between religiosity and suicidal ideation by age group. NSDUH annually collects information on substance use and mental disorders in a nationally representative sample of persons age 12 and older in the U.S. The present sample was made up of cross-sectional data collected annually from 2008 to 2014 on those ages 18 or older (n=260,816). Participants were categorized by age groups 18-25, 26-34, 35-49, 50-64, and 65 and above. Suicidal ideation within the past year was the dependent variable ("At any time in the past 12 months, did you seriously think about trying to kill yourself?"). Religiosity was assessed by (a) importance of religion ("Your religious beliefs are a very important part of your life," with the response options strongly disagree, disagree, agree, strongly agree (responses were dichotomized into agree and disagree) and (b) frequency of religious attendance during the past 12 months (0 times, 1-2 times, 3-5 times, 6-24 times, 25-52 times, and more than 52 times, i.e., more than weekly). Multinomial logistic regression was used to predict presence of suicidal ideation controlling for sex, race, income, marital status, employment status, education, past year major depressive episode, past year alcohol dependence/abuse, past drug dependence/abuse, and year of survey. **Results**: The highest prevalence of past year suicidal ideation was among persons ages 18-25 (7.0%), and lowest prevalence was among those ages 65 or older (1.6%). In contrast, religiosity was lowest among those ages 18-25 (65.6% important) and highest among those ages 65 or older (81.4% important). Likewise, 9.4-10.4% of those ages 18-34 reported attending services more than 52 times/year, compared to 20.4% of those age 65 or older. Without covariates in the model, those who indicated that religion was important were less likely to have suicidal ideation in every age group (ages 18-25, OR=0.68; ages 26-34, OR=0.75; ages 35-49, OR=0.84; ages 50-64, OR=0.74; and ages 65 or older, OR=0.58, p<0.01 in all cases). Similar findings were reported for attending religious services more than 52 times/year (ages 18-25, OR=0.88; ages 26-34, OR=0.64; ages 35-49, OR=0.57; ages 50-64, OR=0.57; and ages 65 or older, OR=0.27, p<0.01 in all cases). When covariates were controlled, associations persisted for those indicating religion was important (ages 18-25, OR=0.73; ages 26-34, OR=0.81; ages 35-49, OR=0.83; ages 50-64, OR=0.78; and ages 65 or over, OR=0.54). This was less true for religious attendance, where after controlling for covariates the inverse relationship between attendance and suicidal ideation was reduced to nonsignificance in those ages 18-25, ages 26-34, ages 35-49, and ages 50-64; however, among those ages 65 or older, the association remained significant and robust (OR=0.34, 95% CI 0.20-0.59). Researchers concluded that "Particular attention to religiosity among older adults as a protective factor for suicidal ideation may be helpful in clinical settings."

Citation: Nishi, D., Susukida, R., Kuroda, N., & Wilcox, H. C. (2017). The association of personal importance of religion and religious service attendance with suicidal ideation by age group in the National Survey on Drug Use and Health. Psychiatry Research, E-pub ahead of press (June, 2017)

Comment: Given the sampling method (population-based), large sample size, and rigorous control for covariates (including indicators of mental health and substance abuse), these findings are of substantial importance. The results are also consistent with other research that shows that religious involvement is related to better mental health, especially in older adults (although this relationship is not restricted to older adults only, as the findings for religious importance indicate above).

Spirituality and Depression Risk in U.S., China, and India

Investigators at Columbia University in New York City analyzed data on 5,512 participants (mean age 29, 41% women) in the United States (n=1,499), China (n=3,150), and India (n=863). Participants were recruited from crowdsourcing Websites (Zhubajie.com and MTurk.com). Spirituality was assessed using the 6-item brief Daily Spiritual Experiences Scale (DSES) and the 23-item Delaney Spirituality Scale (DSS). The Delaney Spirituality Scale assesses a search for meaning, experience of sacredness in nature or in relationships, and a personal connection to the transcendent. Depressive symptoms were assessed with the PHQ-9. Logistic regression was used to assess the relationship between both spirituality measures and severity ofdepression and suicidal ideation by country. **Results**: In the U.S., higher spirituality on both measures was associated with about a 50% lower risk of moderate or severe depression (OR's ranging from 0.47 to 0.57, all p<0.01); in China, the effects were less prominent but still significant at least for the DSS scale (OR's ranged from 0.64 to 1.01, significant at p<0.01-0.09); and in India, effects were moderate between those in U.S. and China (OR's ranged from 0.50 to 0.68, with three of four p<0.01). A similar pattern of effects were found for suicidal ideation, although high DSES scores were associated with greater suicidal ideation among those with more

severe depression (OR=1.54, p<0.05). Researchers concluded that "Spirituality cuts in half the relative risk for depression."
Citation: Portnoff, L., McClintock, C., Lau, E., Choi, S., & Miller, L. (2017). Spirituality cuts in half the relative risk for depression: Findings from the United States, China, and India. Spirituality in Clinical Practice, *4*(1), 22.
Comment: Interesting study using similar measures of spirituality in three countries with very different religious systems (Christian, Hindu, Buddhist) and conceptualizations of God (monotheistic and pantheistic). Again, though, all analyses were cross-sectional, making it difficult to say how these relationships came about (in terms of causality), and the measures of spirituality were contaminated with indicators of mental health (i.e., experiencing peace, meaning and purpose).

Religiosity and Mental Health in Dutch Adolescents with Psychiatric Problems

Researchers from several universities in The Netherlands prospectively followed 543 pre-adolescents to examine the course of mental health during adolescence; all youth were those referred to a psychiatric oupatient clinic (and so were at risk for mental health problems). Participants were assessed at baseline (T1, ages 10-12), ages 12-14 (T2), ages 14-17 (T3), and T4 (ages 17-21). Religiosity was assessed at baseline only (T1) by asking one of the parents (the mother in 86% of cases), three descriptive questions about religion for herself, her partner, and her son/daughter (the pre-adolescent): are you [your partner, child] a religious person, affiliated with a church, and how often to you [your partner,child] attend religious services. Based on responses to these questions, a 3-category variable was constructed for each family member: (1) no religiosity, (2) passive religiosity, and (3) active religiosity. In addition, the Social Cultural Developments Questionnaire (SOCON) was administered, which includes 36 religiosity questions for adults and 9 religiosity questions for pre-adolescents; the parent (mother) completed the adult religiosity questions for herself and her partner, and pre-adolescents completed the 9 religiosity questions themselves. Pre-adolescents also answered selected adult questions as well. From this information collected by the SOCON, three groups were created: "Christian religiosity," "Humanistic beliefs," and "Denial higher power" (each categorized into low, medium, and high). Child mental health was assessed by the Youth Self Report of the Achenbach System of Empirically Based Assessment during the first three assessments (T1, T2, T3) and by the Adult Self Report version at T4. Mental health problems were categorized into "internalizing" (depression, anxiety) and "externalizing" (aggressive, delinquent behavior). Repeated measures ANOVA was used to analyze the data, with bonferonni correction for p values (such that p<0.005 indicated statistical significance).
Results: Religious categories for pre-adolescents were 41.1% "no religiosity," 31.1% "passive religiosity," and 10.6% "active religiosity"; for mothers, they were 52.4% no religiosity, 20.5% passive religiosity, and 26.0% active religiosity; for the father, they were 49.9% no religiosity, 13.2% passive religiosity, and 19.9% active religiosity. Religiosity (pre-adolescent, mother, or father) had no effect on mental health outcomes except that female pre-adolescents who scored high on humanistic beliefs experienced an increase of internalizing problem behavior (depression/anxiety) over time. By "humanistic beliefs" this meant acknowledgement to statements such as "To me, God is nothing else than the valuable in the human being" and "God is not up there somewhere, but only in the hearts of people." Lack of an overall effect of religiosity on outcomes, the authors explained, was due to the following: "This [religiosity] may cause some distress as a consequence of being special, i.e., being religious, compared to other use, which may dilute and diminish the association between religiosity and mental health."
Citation: van der Jagt-Jelsma, W., de Vries-Schot, M., Scheepers, P., van Deurzen, P. A. M., Klip, H., & Buitelaar, J. K. (2017). Longitudinal study of religiosity and mental health of adolescents with psychiatric problems. The TRAILS study. European Psychiatry, Epub ahead of press
Comment: Given the rapid displacement in Europe of religious beliefs with humanistic beliefs, such trends may have unintended consequences for youth, particularly those with emotional problems.

Attachment to God and Psychological Well-Being in Older Adults

In this 3-year prospective study, researchers at Baylor University surveyed a random sample of 3,087 adults age 65 or older in 2001 (Wave I) and again in 2004 (Wave II) (average age 75 in 2001), examining the effects of attachment to God on psychological well-being. Also examined were the effects of feeling forgiven by God and transactional forgiveness (i.e., the belief that individuals must change their behavior to receive forgiveness from God). Forgiveness by God was assessed by a single item: "I believe God forgives me for the things I've done wrong." Transactional forgiveness was assessed by a 3-item scale, with each item beginning with "In order to be forgiven by God, I must (a)… ask God to forgive me, (b)… promise God I will not make the same mistake again, (c)…correct what I have done wrong." Outcomes were optimism, self-esteem, and life satisfaction, each assessed by 3-item scales. Secure attachment to God was assessed using a 6-item scale (i.e., "I have a close personal relationship with God"; "When I talk to God, I know he listens to me," etc.). Controlled for in all analyses were age, sex, marital status, race, income, education, religious service attendance, and religious affiliation, and Wave I psychological well-being outcomes. **Results**: Secure attachment to God was positively associated with increases in optimism (B=0.109-0.118, p<0.05) and in self-esteem (B=0.049-0.068, p<0.05 if forgiveness variable excluded), but not in life-satisfaction. Forgiveness by God was associated with increases in self-esteem (B=0.064, p<0.10), but not in optimism or life-satisfaction. A secure attachment to God moderated the relationship between feeling forgiven by God and all three indicators of psychological well-being; among those with a secure attachment, feeling forgiven by God predicted an increase in optimism, in self-esteem, and in life-satisfaction; this was also true for transactional forgiveness, but effects were weaker.
Citation: Kent, B. V., Bradshaw, M., & Uecker, J. E. (2017). Forgiveness, attachment to God, and mental health outcomes in older US adults: A longitudinal study. Research on Aging, 0164027517706984.
Comment: This is one more study, this time a longitudinal one with a relatively short follow-up period, showing the direct impact of attachment to God on psychological well-being and the moderating effect that a stable attachment to God has on the relationship between other religious beliefs and well-being (also previously shown for prayer and well-being).

Religiosity, Social Networks and Depressive Symptoms in Older Korean Americans

Researchers in the school of social work at several universities in the United States examined the cross-sectional relationship between religiosity, social networks, and depressive symptoms in 200 Korean Americans age 65 or older. Religiousness/spirituality was assessed with six subscales of the Fetzer Institute's BMMRS (daily spiritual experiences, values and beliefs, forgiveness, private religious practices, religious/spiritual coping skills, and religious support). Social networks were measured by the 12-item Lubben Social Network Scale. Depressive symptoms were assessed by the 30-item Geriatric Depression Scale. Controlled for in all analyses were age, gender, marital status, perceived physical

health, education, annual household income, and years in the U.S. Best-subsets regression modeling was used to analyze the data. **Results**: Only religious/spiritual coping skills and social networks were inversely related depressive symptoms in best-fitting regression models. Researchers concluded:
"Religiousness/spirituality and social networks are important for coping with life stress and may be useful in developing effective healthcare strategies in the management of depression among older Korean Americans."
Citation: Lee, Y. S., Park, S. Y., Roh, S., Koenig, H. G., & Yoo, G. J. (2017). The role of religiousness/spirituality and social networks in predicting depressive symptoms among Older Korean Americans. Journal of Cross-Cultural Gerontology, *32*(2), 239-254.
Comment: Although a small study and a cross-sectional analysis, this is one of the few studies in older Korean Americans and so is worthy of attention.

Religiosity and Quality of Life among Hemodialysis Patients in Saudi Arabia

Researchers at Shagra University, King Khalid University, and other Saudi and non-Saudi universities surveyed 168 hemodialysis patients at three hospitals in Saudi Arabia. Arabic versions of the 13-item Muslim Religious Index (Al Zaben et al), Spiritual Coping Strategies scale (Cruz et al) and Quality of Life Index Dialysis (Ferrans & Powers) were used to collect the data in this cross-sectional study. Regression analyses were used to analyze the data. **Results**: Religiosity and religious coping were greater among older and unemployed patients. Religious practices, intrinsic religious beliefs, and religious coping were all significantly and positively related to greater health-related QOL. Researchers recommended that religiosity should be integrated into the health-care of dialysis patients to help them achieve their overall optimum health.
Citation: Cruz, J. P., Colet, P. C., Alquwez, N., Inocian, E. P., Al-Otaibi, R. S., & Islam, S. M. S. (2017). Influence of religiosity and spiritual coping on health-related quality of life in Saudi haemodialysis patients. Hemodialysis International, *21*(1), 125-132.
Comment: This study confirms earlier reports in Saudi dialysis patients that have found less depression and better physical health among the more religious (Al Zaben et al., 2015; Journal of Religion and Health 54(2):713-730). These studies are cross-sectional, however, and prospective studies are needed to provide evidence for direction of effect.

Religious Involvement and Cognitive Functioning: Systematic Review

Researchers from the school of public health at the University of Waterloo, Ontario, Canada, systematically reviewed published research on the relationship between religion, spirituality and cognitive functioning in older adults. They identified 17 studies (total n=35,741) that met the eligibility criteria (cohort, case-control, or cross-sectional studies; published between 1990 and 2016; adults age 18 or older; measures of religiosity or spirituality [R/Si] included; and cognitive function as the primary outcome). Of the 17 studies identified, 16 were longitudinal or prospective in design, with followups ranging from 12 months to 7 years. **Results**: 82% of studies reported positive associations between R/Si and cognitive function. Researchers concluded "Most of the included studies reported positive associations between R/Si and cognitive functioning. R/Si appears to be protective against cognitive decline in middle- and old-age adults."
Citation: Hosseini, S., Chaurasia, A., & Oremus, M. (2017). The effect of religion and spirituality on cognitive function: A systematic review. The Gerontologist, E-pub ahead of press.
Comment: This is the latest systematic review that has confirmed a positive association between religious involvement and cognitive function, but this review is more comprehensive and primarily includes prospective studies.

A Spiritual Curriculum for General Psychiatry Residents

Academic psychiatrists at Texas Tech University Health Sciences Center (Lubbock, TX) describe in this article a 3-year curriculum on spirituality for psychiatry residents, and report on feedback from 12 residents after going through the program. The objective of the curriculum is to (1) increase awareness of the residents' own spirituality, (2) elicit a patient history that is respectful of the spiritual, cultural and religious dimension of patients' lives, (3) respond to the patients' suffering in a compassionate and caring manner, (4) become aware of the research literature relevant to spirituality and mental health, (5) become familiar with instruments used to measure spirituality, and (6) assess and respond to the spiritual dimensions of mental illness across the lifecycle, particularly with regard to depression, anxiety, grief, addiction and end-of-life issues. The curriculum involves didactics, seminars, and psychotherapy case conferences, often held with chaplains. Residents are also introduced to pastoral care on inpatient psychiatry units, and to spiritual dimensions in hospice care. **Results**: Psychiatry residents were from seven countries (USA, India, Pakistan, United Arab Emirates, Nigeria, Sierra Leone, and Spain), and included 4 Christians, 4 Hindus, 3 Muslims, and 1 agnostic. Residents overwhelmingly indicated that the curriculum was helpful and meaningful, with 77% saying that addressing spiritual/religious needs of patients was important and appropriate; 69% agreeing strongly to the notion that spirituality is an important dimension in the management of addictions; and 92-100% agreeing that treatments for depression, guilt, or grief might require attention to spiritual issues. The authors concluded that:
"Regardless of cultural or religious background, the residents endorsed the curriculum as a worthwhile experience and increased their appreciation of the place of spirituality in the holistic care of patients with psychiatric conditions."
Citation: McGovern, T. F., McMahon, T., Nelson, J., Bundoc-Baronia, R., Giles, C., & Schmidt, V. (2017). A descriptive study of a spirituality curriculum for general psychiatry residents. Academic Psychiatry, E-pub aheadof press.
Comment: This is one of a growing number of spirituality curriculums that have been proposed for training psychiatry residents on how to address these issues in clinical practice.

Religion, Spirituality and Health

This article by VanderWeele and colleagues from the Harvard School of Public Health is directed at medical practitioners. The article briefly summarizes the research on religion and health and discusses clinical applications, both in general practice and in palliative care. Emphasis is placed on the interactions that could occur between clinicians and faith communities, and the authors even make a link between physician well-being and addressing patients' spiritual needs.
Citation: VanderWeele TJ, Balboni TA, Koh, HK (2017). Health and spirituality. Journal of the American Medical Association, July 27, E1-E2, E-pub ahead of press
Comment: A nice short review of the field that stresses applications both in the clinic and in the community. Again, as VanderWeele's article recently appearing in PNAS (August e-newsletter), this piece appearing in JAMA is likely to have considerable impact, especially since it comes from this prominent research group.

Discussion of Social Determinants in the Religion-Mortality Relationship

VanderWeele and colleagues from the departments of epidemiology and biostatistics at the Harvard School of Public

Health respond to a comment by Neal Krause on social determinants of mortality in the religious attendance-mortality relationship in the Black Women's Health Study (reported in our June e-newsletter). Interestingly, VandeWeele and colleagues have found than only about 25% of the effect of religious attendance on mortality can be explained by social factors, although in-depth measures of social involvement have rarely been included in such studies. Also discussed in the article is the *National Consortium on Psychosocial Stress, Spirituality and Health* at Harvard that is now seeking to collect additional data on measures of religiosity/spirituality in African-American, Native American (Lakota), Latino (Puerto Rican), South Asian (Indian) and white American populations, information that may help to disentangle cause-effect relationships through longitudinal studies.
Citation: VanderWeele, T. J., Palmer, J. R., & Shields, A. E. (2017). VanderWeele et al. Respond to "Church attendance and mortality". American Journal of Epidemiology, *185*(7), 526-528
Comment: Discussions such as this one, published in the top epidemiological/public health journal in the world, will inevitably advance our knowledge about the religion-health relationship through high quality research designs and sophisticated methods of data analysis.

Religiosity, Dietary Habits, and Physical Activity in Minority Women

Researchers at the Baylor College of Medicine and Arizona State University analyzed data from the Health is Power study, a multi-site randomized clinical trial to increase physical activity and improve dietary habits in African-American and Hispanic/Latina-American women in Texas conducted between 2006 and 2008. Participants were 410 women between ages 25 and 60 who were randomly assigned to either a physical activity group or a vegetable/fruit comparison group. Both groups met six times over a 6-month period, focusing on group cohension and friendly competition (no religious/spiritual aspects to the intervention). Measures of physical activity, fruit/vegetable and fat intake were measured at baseline (T1) and 6-month follow-up (T2). Measurement of religiosity/spirituality was by the short-form of the Fetzer Institute's BMMRS at T1 only. Of the 310 initially randomized, 1998 completed pre-post outcome measures as above, although complete data on all measures for this analysis was available for only 132 women (32% of the original sample).
Results: Participants increased their physical activity by 15%, their fruit/vegetable intake by 27%, and decreased their fat consumption by 5%. Regression analyses examining the impact of T1 religiosity/spirituality on outcomes between T1 and T2 revealed no significant effect on any outcome after adjustment of demographic characteristics. Investigators recommended more longitudinal studies to explore the role of religiosity on the health of minority women.
Citation: Ansari, S., Soltero, E. G., Lorenzo, E., & Lee, R. E. (2017). The impact of religiosity on dietary habits and physical activity in minority women participating in the Health is Power (HIP) study. Preventive Medicine Reports, *5*, 210-213.
Comment: No effects of baseline religiosity on physical activity, fruit/vegetable intake, or fat consumption, although neither intervention included a religious or spiritual component. This is a bit disheartening, given the importance that religion plays in the life, worldview, eating, and physical activity habits of minority women in the U.S. Prior studies have suggested that religiosity increases compliance with health behaviors. Other studies have shown a positive impact for health interventions on diet and weight of minority women when religion/spirituality is utilized as part of the intervention, which the above study did not do.

Spiritual/Religious Activity and the Metabolic Syndrome

Investigators at UNC Chapel Hill and eight other U.S. universities analyzed data collected from a prospective study of 3,278 middle-aged and older Hispanic/Latino adults participating in the Hispanic Community Health Study/ Latinos Sociocultural Ancillary Study. Participants were a random sample of adults ages 45-74 living in the Bronx NY, Chicago IL, Miami FL, and San Diego CA. Religious activity was measured at baseline by two items from the 5-item Duke University Religion Index (ORA-organizational religious activity, i.e., religious attendance, and NORA-nonorganizational religious activity, i.e., prayer/Bible study). Spiritual well-being was assessed by the FACIT-Sp, largely a measure of peace, meaning and purpose in life (with smaller relational and faith components). Metabolic syndrome was assessed by enlarged waist circumference (>102 cm in men and >88 cm in women), increased blood pressure (> 130/85) or use of anti-hypertensive medication, increased triglyceride levels (>150 mg/dL), low levels of high density lipoprotein (HDL <40 mg/dL men, <50 mg/dL women), and increased fasting blood glucose (100 mg/dL) or use of anti-diabetic medication. All analyses were cross-sectional and were done at baseline. Regression analyses controlled for sociodemographic covariates and lifestyle factors, and all religious/spiritual variables were included simultaneously in regression models. **Results**: No R/S variable (ORA, NORA, meaning, peace, faith, or relational, or total FACIT-Sp score) was significantly associated with the metabolic syndrome in logistic regression analyses. However, R/S variables was significantly associated with various components of the metabolic syndrome. The "meaning" subscale and the total FACIT-Sp score were inversely related to waist circumference (B=-1.38, p=0.01, and B=-0.72, p<0.05, respectively). The "faith" subscale of the FACIT-Sp was inversely related to diatolic blood pressure (B=-0.98, p=0.002). Both NORA and the FACIT-Sp "peace" subscale were related to higher diastolic blood pressure (B=0.65, p=0.03, and B=0.71, p=0.02, respectively). The "peace" subscale was also positively related to systolic blood pressure (B=1.51, p=0.01). When p values were adjusted for multiple comparisons (Bonferroni), only the inverse relationship between the "faith" subscale and diastolic blood pressure remained statistically significant. When patients with coronary heart disease (CHD) were removed from the sample, a significant inverse association between the "faith" subscale and systolic blood pressure also emerged (B=-1.19, p=0.04). No associations were found between R/S characteristics and triglycerides, fasting glucose or HDL cholesterol levels.
Citation: Brintz, C. E., Birnbaum-Weitzman, O., Llabre, M. M., Castañeda, S. F., Daviglus, M. L., Gallo, L. C., ... & Penedo, F. J. (2017). Spiritual well-being, religious activity, and the metabolic syndrome: results from the Hispanic Community Health Study/Study of Latinos Sociocultural Ancillary Study. Journal of Behavioral Medicine, 1-11.
Comment: A large important study in Black and Hispanic/Latino Americans. However, all analyses were cross-sectional. Given that religiosity tends to be much higher among minorities in the U.S. (vs. majority Whites), it is unclear how these relationships (or lack of relationship) may have developed over time. Weight has been positively and significantly associated with religiosity in previous studies of minority populations (a negative consequence of social religious activities where potlucks are the rule), which may cancel out some of the other benefits of religious practice on the metabolic syndrome. The authors acknowledged the need for longitudinal studies.

SPECIAL EVENTS

10th 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 Mentel 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.

RESOURCES

Buddhism and Mental Health: Beliefs, Research and Applications

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

From the publisher: "This book is for mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Buddhists. A description of the life of the Buddha, original Buddhist scriptures, beliefs and practices is followed by a systematic review of research conducted in Buddhist populations, and then by recommendations for practice based on research, clinical experience, and common sense. In this volume, which is well-documented and extensively cited, the author bring together over 50 years of research that has examined how religious faith impacts the mental health of Buddhists, including original research not reported elsewhere on current religious beliefs and practices of Buddhists and their relationship with well-being." Available for $7.50 at https://www.amazon.com/dp/1545234728/

Spirituality and Religion Within the Culture of Medicine: From Evidence to Practice

(Oxford University Press, 2017)

From the publisher: [This book] provides a comprehensive evaluation of the relationship between spirituality, religion, and medicine evaluating current empirical research and academic scholarship. In Part 1, the book examines the relationship of religion, spirituality, and the practice of medicine by assessing the strengths and weaknesses of the most recent empirical research of religion/spirituality within twelve distinct fields of medicine including pediatrics, psychiatry, internal medicine, surgery, palliative care, and medical ethics. Written by leading clinician researchers in their fields, contributors provide case examples and highlight best practices when engaging religion/spirituality within clinical practice. This is the first collection that assesses how the medical context interacts with patient spirituality recognizing crucial differences between contexts from obstetrics and family medicine, to nursing, to gerontology and the ICU. Recognizing the interdisciplinary aspects of spirituality, religion, and health, Part 2 of the book turns to academic scholarship outside the field of medicine to consider cultural dimensions that form clinical practice. Social-scientific, practical, and humanity fields include psychology, sociology, anthropology, law, history, philosophy, and theology. This is the first time in a single volume that readers can reflect on these multi-dimensional, complex issues with contributions from leading scholars. In Part 3, the book concludes with a synthesis, identifying the best studies in the field of religion and health, ongoing weaknesses in research, and highlighting what can be confidently believed based on prior studies. The synthesis also considers relations between the empirical literature on religion and health and the theological and religious traditions, discussing places of convergence and tension, as well as remainingopen questions for further reflection and research. This book will provide trainees and clinicians with an introduction to the field of spirituality, religion, and medicine, and its multi-disciplinary approach will give researchers and scholars in the field a critical and up-to-date analysis. Available for $58.21 at https://www.amazon.com/Spirituality-Religion-Within-Culture-Medicine/dp/0190272430

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.

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

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/

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/

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. 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 $61.75 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 $116.26 (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 $34.97 at: https://www.templetonpress.org/books/spirituality-and-health-research

PRIZES

Jean-Marc Fischer Prize

The Doctor Jean-Marc Fischer Foundation encourages reflection in the field of human, social and theological sciences by awarding the Jean-Marc Fischer Prize. Three prizes will be awarded in this third contest, which welcomes submissions in French and English from around the world. This year's theme is *Care and Spirituality*. Any professional in the field of health (doctor, psychologist, nurse, chaplain, etc.) can submit a dossier on the theme "Care and Spirituality", as described below. The deadline for submission of applications is 31 October 2017. For more information, go to: http://fondationdocteurjmf.ch/wp-content/uploads/2017/06/Prix-J.M.-Fischer-2017-2018-Anglais.pdf. Application packages and questions should be sent by e-mail to: philippe.huguelet@hcuge.ch.

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 pscyhologists 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…

September

20 Islam and Health
Speaker: Azleena Salleh Azhar
Muslim Chaplain
Learning Lab 1502 Blue Zone, 1st floor,
Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

27-30 Religion and Mental Health
American Association of Christian Counselors (AACC)
World Conference, Nashville, TN
Speaker: Harold G. Koenig, M.D., and others
Contact: Dina Jones (Dina.Jones@aacc.net)

October

25 Energy Healers: Who They Are and What They Do
Speaker: Jeff Levin, Ph.D., M.P.H.
University Professor of Epidemiology and Population Health
Professor of Medical Humanities
Director, Program on Religion and Population Health
Baylor University
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

PLEASE Partner with us to help the work to continue…

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