

CROSSROADS...

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & Health

Volume 12

Issue 5

Nov 2022

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 issues (July 2007 through October 2022) go to:
<https://spiritualityandhealth.duke.edu/index.php/publications/crossroads/>

LATEST RESEARCH

Religiosity/Spirituality and Cardiovascular Risk Factors in African-Americans

Researchers from the department of cardiovascular medicine at the Mayo Clinic in Rochester, Minnesota, analyzed cross-sectional data on 2,967 African-Americans participating in the Jackson Heart Study collected in 2000-2004 (1,949 women; 1,018 men). The purpose was to examine the relationship between religiosity/spirituality (R/S) and Life's Simple 7 (LS7) (physical activity, diet, BMI, smoking, blood pressure, total cholesterol, fasting plasma glucose). LS7 represents the American Heart Association's intermediate/ideal levels for these cardiovascular measures of health. Religiosity was assessed by frequency of religious attendance, frequency of private prayer, and religious coping. Spirituality was assessed by the 6-item Daily Spiritual Experiences Scale (DSES; made up of two subscales, a theistic and a nontheistic subscale). Logistic regression was used to examine the associations between R/S and each of the LS7 indicators, controlling for age, gender, education, income, and insurance status. **Results:** All measures of religiousness and spirituality were significantly higher in women than in men ($p < 0.001$). With regard to religiosity, frequency of attendance at religious services was associated with a 16% greater likelihood of achieving intermediate/ideal levels of physical activity (OR = 1.16, 95% CI = 1.06-1.26), a 50% greater likelihood of not smoking cigarettes (OR = 1.50, 95% CI = 1.34-1.68), a 12% greater likelihood of not having high blood pressure (OR = 1.12, 95% CI = 1.01-1.24), and 14% more likely to have a high LS7 composite score (OR = 1.14, 95% CI = 1.04-1.24). Those who frequently engaged in private prayer were 12% more likely to achieve intermediate/ideal levels of diet (OR = 1.12, 95% CI = 1.03-1.22) and were 24% more likely not to smoke (OR = 1.24, 95% CI = 1.12-1.39). Participants who engaged in frequent religious coping were 18% more likely to be physically active (OR = 1.18, 95% CI = 1.08-1.28), 10% more likely to eat a healthy diet (OR = 1.10, 95% CI = 1.01-1.20), 32% more likely not to smoke (OR = 1.32, 95% CI = 1.18-1.48), and 14% more likely to achieve a high LS7 composite

score (OR = 1.14, 95% CI = 1.04-1.24). Note that these findings remained significant after controlling further for chronic stress and social network size. With regard to spirituality, overall spirituality (total DSES score) was associated with an 11% greater likelihood of achieving intermediate/ideal levels of physical activity (OR = 1.11, 95% CI = 1.02-1.21) and a 36% greater likelihood of not smoking cigarettes (OR = 1.36, 95% CI = 1.21-1.53). Again, these associations remained statistically significant even after additional controls for chronic stress and social network size. When controlling for chronic stress and social network size, a new association emerged; overall spirituality was associated with a 12% greater likelihood of not having high blood pressure (OR = 1.12, 95% CI = 1.01-1.25). In sex-stratified analyses, effects of both religious attendance and private prayer were significantly greater in men (surprisingly) than in women. In an age-stratified analyses, effects of religiosity on diet were significantly greater among participants less than age 55 (surprisingly) than among older adults. Researchers concluded "Higher levels of religiosity/spirituality were associated with intermediate/ideal cardiovascular health across multiple LS7 indicators. Reinforcement of religiosity/spirituality and lifestyle interventions may decrease overall cardiovascular disease risk among African-Americans."

Citation: Brewer, L. C., Bowie, J., Slusser, J. P., Scott, C. G., Cooper, L. A., Hayes, S. N., ... & Sims, M. (2022).

Religiosity/Spirituality and Cardiovascular Health: The American Heart Association Life's Simple 7 in African Americans of the Jackson Heart Study. *Journal of the American Heart Association*, e024974, 1-14 plus tables.

Comment: These findings also received widespread attention in the national media (e.g., <https://www.nih.gov/news-events/nih-research-matters/spirituality-religion-linked-heart-health-among-black-americans>; <https://www.cnn.com/2022/08/31/health/african-american-religion-heart-health-scli-intl-wellness/index.html>; <https://www.sciencedaily.com/releases/2022/08/220824102911.htm>)

Religious Participation and Future Expectations about Health

Researchers in the department of sociology at Baylor University analyzed cross-sectional data on 1,501 participants in the 5th wave (2017) of the Baylor Religion Survey, a nationally representative survey of the US population. Future health expectations are known to be a predictor of subjective life expectancy and eventual mortality risk, and are thus worthy of study. Future health expectations were assessed by a single question: "On a scale from 0 to 10, where zero represents the worst possible health for you and 10 represents the best possible health for you, please rate your expected health 10 years in the future." Frequency of religious attendance was assessed for two time points: retrospectively-reported religious attendance in childhood at age 12 and current religious attendance. From answers to these questions, 9 categories were created to represent transitions in attendance from childhood to adulthood: low-low, low-moderate, low-high, moderate-low, moderate-moderate, moderate-high, high-low, high-moderate, and high-high. In order to identify factors that

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might help to explain the relationship between religious attendance and future health expectations, mediating variables assessed were sense of personal control (4-item measure), belief in divine control (4-item measure), and health behaviors (2-item measure consisting of smoking and alcohol use). Variables controlled for in regression analyses included education, income, religious tradition, age, race, employment status, gender, presence of children, and physical health conditions affecting activity level.

Results: High-high religious attendance (attending religious services once per week or more both during childhood and currently) was significantly associated with greater future health expectations ($b=0.49$, $SE=0.26$, $p<0.05$). In addition, individuals indicating an increase in religious attendance over time (i.e., moderate-to-high attendance) also reported higher future health expectations ($b=1.11$, $SE=0.37$, $p<0.01$). These findings were independent of the presence of having a limiting physical health problem. In mediation analyses, the associations were explained by higher levels of belief in a sense of divine control and a lower likelihood of engaging in harmful health behaviors, particularly smoking. Researchers concluded: "...religious participation over the life course is an important determinant of future health expectations... Whether based in a realistic assessment of better current health, equipped with more optimism through stronger beliefs in the plan of the divine power, or through avoidance of negative health behaviors, the finding that consistently involved believers report more favorable self-ratings of health should invite further reflection on how religion socializes and prepares adherence to prioritize the future over the here-and-now reality and bolsters well-being in the process."

Citation: Upenieks, L., & Liu, Y. (2022). Does religious participation predict future expectations about health? Using a life course framework to test multiple mechanisms. *Journal of Religion and Health*, 61(3), 2539-2568.

Comment: This is another important study by sociologists at Baylor University that may help to explain why religious persons, particular those who attend religious services more often, are healthier and live longer.

Biblical Literalism and Mental Health

Laura Upenieks in the department of sociology at Baylor University analyzed cross-sectional data on a random national sample of 1,360 participants (54% women) in Wave 3 (2010) of the Baylor Religion Survey. Since the focus was on biblical literalism, participants affiliated with "other religions" and atheists were not included in the analysis. Biblical literalism was assessed by a single question: "Which one statement comes closest to your personal beliefs about the Bible?": (1) The Bible means exactly what it says. It should be taken literally, word-for-word, on all subjects ("received" Bible views); (2) The Bible is perfectly true, but it should not be taken literally, word-for-word. We must interpret its meaning ("active" Bible views); (3) The Bible contains some human error ("unreliable" Bible views); and (4) The Bible is an ancient book of history ("unreliable Bible views). Also assessed were attendance at religious services (1 item); attachment to God (6-item measure); frequency of private prayer (1-item); and self-rated religiosity (1 item). Religious denomination was also asked about (26% Evangelical Protestant, 31% Mainline Protestant, 4% black Protestant, 29% Catholic, 2% Jewish, 8% other). General mental health was assessed by the question: "Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?" Higher scores indicated worse mental health. General anxiety was assessed by four questions: "Over the past month, how often have you felt: (1) nervous, anxious, or on edge; (2) not been able to stop or control worrying; (3) worry too much about different things?"; and (4) during the past 30 days, for how many days have you felt worried, tense, or anxious?" Higher scores indicated greater anxiety.

Regression analyses controlled for demographic covariates (age, marital status, race, education, household income, employment status, and region of US of residence); analyses were stratified by gender. **Results:** With regard to general mental health among women, those indicating biblical literalism (received Bible views; 30% of women) had significantly better mental health compared to non-literalist Bible views ($B=-0.19$, $SE=0.09$, $p<0.05$), an effect that was explained by greater frequency of religious attendance and greater attachment to God (both of which were associated with better general mental health). Likewise, general anxiety scores were lower among women with biblical literalism views ($B=-0.18$, $SE=0.09$, $p<0.05$), an effect that was again explained by frequent religious attendance and greater attachment to God. An interaction was present between biblical literalism and frequency of attendance at religious services, such that the positive effects of biblical literalism on mental health and anxiety symptoms were particularly strong among women who attended religious services weekly or more often (women with biblical literalism views who attended religious services infrequently had worse mental health problems). No associations were found among men. Frequency of prayer was associated with worse general mental health and greater anxiety in both women and men (which was interpreted as a coping response to stress). The researcher concluded: "Regression results suggest that stronger beliefs in biblical literalism are associated with better mental health and lower anxiety, but only among women who attend religious services weekly."

Citation: Upenieks, L. (2022). Does the belief in Biblical literalism matter for mental health? Assessing variations by gender and dimensions of religiosity. *Journal of Religion and Health*, 61(1), 175-202.

Comment: Of particular interest in these findings is that women with literal biblical views who attend religious services infrequently had worse mental health and greater anxiety, the exact opposite of that in women who held literal views of the Bible and attended religious services once a week or more.

Religious Coping and Long-Term Mental Health Outcomes in Survivors of Hurricane Katrina

Researchers in the department of psychology at the University of Massachusetts in Boston, MA, and Yale University School of Public Health in New Haven, CT, analyzed data from the Resilience in Survivors of Katrina (RISK) project, which is an ongoing longitudinal study of low-income, female, primarily Black Hurricane Katrina survivors. The first wave of the survey (baseline, $n=492$) was conducted in November 2003-February 2005 (prior to the hurricane landfall in August 2005); at that time, participants were ages 18-34 and 200% below the federal poverty level. The first follow-up was conducted between March 2006 and March 2007 (F1, $n=402$), the second follow-up was conducted between March 2009 and April 2010 (F2, $n=752$, including 405 surveyed pre-Katrina), and the most recent follow-up was conducted between November 16 and December 2018 (F3, $n=716$, including 373 surveyed pre-Katrina). Religious coping was assessed at F2 with the 14-item Brief RCOPE that includes a 7-item positive religious coping (PRC) subscale and a 7-item negative religious coping (NRC) subscale; questions were asked specifically with regard to their experience coping with Hurricane Katrina. Mental health was assessed by the K-6, a 6-item measure of nonspecific general psychological distress (GPD); this scale was administered at baseline, F2, and F3. Posttraumatic growth (PTG) was assessed by the 21-item Posttraumatic Growth Inventory, which was administered at F2 and F3. Finally, post-traumatic stress (PTS) was measured using the 22-item Impact of Events Scale-Revised, which was also administered at F2 and F3. Potentially confounding factors assessed at baseline were race/ethnicity, age, number of benefits received, supplemental security/disability income, cash assistance, and number of children. Also assessed

at baseline pre-Katrina was frequency of religious attendance and importance of religion; perceived social support at baseline and at F3 by an 8-item version of the Social Provision Scale; optimism at baseline by a 6-item version of the Life Orientation Test-Revised; and hurricane exposure assessed at F1 by experience of any of 12 events as a result of the hurricane (went without freshwater, went without food, etc.) resulting in a scale from 0 to 12. Three multiple linear regressions were used to examine the relationships between PRC/NRC and each of the three outcome variables (posttraumatic growth, posttraumatic stress, and general psychological distress), controlling for demographics, religiosity, social support, optimism, and baseline pre-Katrina general psychological distress. **Results:** Of the 284 participants who completed the W1 (baseline) survey and all three follow-up assessments, 231 completed all of the survey measures (final sample size). Bivariate analyses revealed a positive correlation ($r=0.38$, $p<0.001$) between PRC (F2) and PTG (F3), but no relationship with GPD or PTS. NRC (F2) was positively associated with GPD at F3 ($r=0.18$, $p<0.01$) and PTS at F3 ($r=0.23$, $p<0.001$). Multivariate analyses indicated that PRC (F2) significantly predicted the PTG (F3) eight years later ($b=0.22$, $p<0.01$), with PTG (F2) in the model, but no significant effect was found for NRC. NRC (F2), however, significantly predicted PTS (F3) eight years later ($b=0.14$, $p<0.05$) with PTS (F2) in the model, but no significant effect was found for PRC on this outcome. No significant effect was found for either PRC or NRC (F2) on GPD (F3) eight years later with GPD (F2) in the model. Researchers concluded: "Given that PRC is associated with PTG, facilitating spiritual healing in the aftermath of disaster may be beneficial for those who are inclined to cope with faith."

Citation: Arkin, M., Lowe, S. R., Poon, C., & Rhodes, J. E. (2022). Associations between religious coping and long-term mental health in survivors of Hurricane Katrina. *Psychology of Religion and Spirituality*, EPUB ahead of press

Comment: Although a very complicated research design, the length of follow-up was substantial and the statistical analysis was very well done. The researchers' conclusion above is justified by the data.

Religiosity, Unfair Treatment by Police and Race, and Psychological Well-Being

Sociologists at Baylor University and the University of Texas at San Antonio analyzed data from the Nashville Stress and Health study, a probability-based sample of 1,170 non-Hispanic Blacks (50%) and Whites (50%) ages 22 to 69 living in Davidson County, Tennessee. The purpose was to examine the moderating effects of religiosity on the relationship between unfair treatment by police, race, and psychological well-being. Religiosity was assessed by frequency of attendance at religious services (weekly or more vs. less than weekly), 2-item church-based support ("How often do you see, write, or talk on the telephone with members of your church [place of worship]?"; and "How often do people in your church [place of worship] help you out?"), and divine control (4-item measure; e.g., "I depend on God for help and guidance"). Unfair treatment by police (UTBP) was assessed by a single question: "Have you or anyone close to you ever had the following experiences: been treated unfairly by police (e.g., stopped, searched, questioned, physically threatened, or abused)?" Mental health was assessed by depressive symptoms (measured with the 20-item CES-D) and physical health (measured by 10 indicators of allostatic load: cortisol, epinephrine, norepinephrine, and DHEA-S in urine; diastolic and systolic blood pressure; waste-to-hip ratio; total cholesterol, high-density lipids (HDL), and glycosylated hemoglobin or HgA1C). Scores on allostatic load were summed and then divided into quartiles in terms of risk. Controlled for in regression analyses were age, gender, race, personal income, smoking status, frequency of alcohol use, frequency of illegal drug use, legal problems, and every day racial discrimination; allostatic load analyses were also adjusted for stressful life events and

financial strain in childhood. Analyses were stratified by race.

Results: Blacks were more likely to report unfair treatment by police (UTBP) than whites (46% vs. 18%, $p<0.001$). Among Whites, UTBP was not associated with psychological distress (depressive symptoms), and there were no moderating effects of any religious variable on the relationship between UTBP and psychological distress. In contrast, among Blacks, personal UTBP was significantly associated with psychological distress. Frequency of religious attendance and church-based support both moderated the relationship between UTBP and psychological distress, such that weekly religious attendance buffered the relationship between personal UTBP and depressive symptoms (interaction term $b=-0.34$, $p<0.05$; i.e., the relationship became weaker among those attending religious services at least weekly). Church-based support also significantly buffered the relationship between personal UTBP and psychological distress among Blacks (interaction term $b=-0.11$, $p<0.05$; the relationship became weaker among those with higher church-based support). There was also a significant relationship between UTBP and allostatic load among Blacks (but not Whites), although religious measures did not buffer that relationship. Implications for clergy and faith-based organizations were provided.

Citation: Upenieks, L., & Daniels, C. L. (2022). Unfair treatment by the police and race: Is religiosity a protective resource for well-being. *Social Currents*, 9(4), 387-409.

Comment: A fascinating, well-done study that demonstrates the role that clergy and religious organizations can play in helping to reduce the psychological distress caused by unfair treatment of African Americans by police.

Sexual Identity, Religious Practice, Subjective Health and Well-Being in England

Dean Wilkinson from the faculty of social science at the University of Chester, Chester, United Kingdom, analyzed data from the 2016-2017 Community Life Survey of English citizens. The survey included 6,951 participants (6649 heterosexual, 302 non-heterosexual) who answered both the sexual identity and religious status question. The purpose was to examine the relationships between sexual identity, religious practice, health and well-being. Religious practice was assessed by self-identification as a practicing Christian ($n=1,324$), a non-practicing Christian ($n=2,518$), a practicing Muslims ($n=454$), a non-practicing Muslims ($n=138$), a practicing Hindu ($n=140$), a non-practicing Hindu ($n=98$), and a smaller number of practicing and nonpracticing Buddhists, practicing and nonpracticing Sikhs, and practicing other religions including Jewish, and non-practicing other religions including Jewish. For analysis purposes, participants were divided into those practicing and those not practicing religion. There was also a separate category for those who indicated no religion ($n=2,274$). Sexual identity was assessed by the question, "Which of the follow best describes how you think of yourself?" with response options being heterosexual/straight, gay/lesbian/bisexual (LGBT), or no response. Subjective well-being was assessed by three items assessing satisfaction with life, happiness, and how worthwhile activities were that the person was involved in. Self-rated general health was assessed by the question "How is your health?" with the response options very good, good, fair, bad, and very bad. MANOVA/ANOVA was used to examine the relationships between age, sexual identity, and religious practice, and subjective well-being and self-rated health (with no other control variables). **Results:** Participants demonstrated greater well-being in older age categories (vs. younger) and in heterosexuals (vs. non-heterosexuals). Sexual identity and religious practice, independently, had effects on individual well-being, as did sexual identity and age. Individuals who practiced their religion scored highest on well-being followed by non-practicing, and then by the non-religious. With regard to general health, there was no significant difference between different sexual

identity groups, although non-religious participants reported the lowest mean score for general health. The author concluded: "Whilst religious groups can, and in some cases, provide valuable support networks [citation] and where individuals successfully navigate their sexual and religious identity, they can build good levels of resilience [citation], leading to a positive outcome. These experiences seem to be dependent on "gay-positive" or affirming religious groups [citations]."

Citation: Wilkinson, D. J. (2022). Does sexual identity and religious practice have implications for individual's subjective health and wellbeing? Secondary data analysis of the Community Life Survey. *Mental Health, Religion & Culture*, EPUB ahead of press.

Comment: This study is an important one given the large sample size and research questions asked. However, the presentation makes it difficult to determine what the investigator actually found, with frequent contradictions in the report of results. From our perspective, the most important question was whether practicing a religion helps to generate greater psychological well-being and self-rated health in non-heterosexuals (LGBT), a question that was apparently not answered or no relationship was found. Unfortunately, that was not made clear in this article.

Religion and Maternal/Child Health Outcomes in Southern Asia

Researchers at the University of North Carolina at Chapel Hill, Kabul University in Afghanistan, and universities in India and Pakistan, analyzed data from 57,972 mothers who had children ages 12-23 months and participated in the Demographic and Health Surveys conducted between 2014 and 2018 in Afghanistan, Bangladesh, India, Maldives, Myanmar, Nepal, and Pakistan. The purpose was to examine the relationship between religion and indicators of maternal and child health. Mother's religion was assessed by Muslim (41.2%), Hindu (52.7%), Christian (1.9%), and Buddhist or other (4.2%). Maternal and child health was assessed with the Composite Coverage Index (CCI), which measures family-planning coverage, skilled attendant present at birth, antenatal care, vaccination for tuberculosis, DPT and tetanus vaccinations, measles vaccination, oral rehydration therapy for diarrhea, and seeking care for childhood pneumonia. Higher scores indicated better preventative measures indicative of maternal and child health. Analyses were controlled for family income and maternal education. **Results:** Compared to Muslims, the CCI were higher in Hindus (2.8%, 95% CI = 2.4%-3.1%) and Buddhists (2.0%, 95% CI = 1.2%-2.9%). Researchers concluded: "...maternal and child health outcomes continue to be a concern in South Asia, especially for Muslim women."

Citation: Kachoria, A. G., Mubarak, M. Y., Singh, A. K., Somers, R., Shah, S., & Wagner, A. L. (2022). The association of religion with maternal and child health outcomes in South Asian countries. *Plos One*, 17(7), e0271165.

Comment: Unfortunately, analyses were not controlled for country. This may have been significant since CCI scores were lowest in Muslim countries (e.g., Afghanistan and Pakistan) and highest in Hindu and Buddhist countries (e.g., Nepal, Bangladesh, Myanmar). Simply controlling for family income and maternal education may not be enough, especially given the effects of war on maternal and child health in some countries like Afghanistan.

Religiosity, Mental Health, and Attitudes Towards COVID-19 Pandemic

Sociologists at Cornell University and the University of Toronto analyzed cross-sectional data on a national random US sample of 11,494 adults assessed by the Pew Research Center on March 19-24, 2020, shortly after the WHO declared COVID-19 a global pandemic. The purpose was to examine the association between religious attendance/religious affiliation, mental health, and attitudes towards restrictions during the pandemic. Mental distress

was assessed by five items: "How often in the past seven days have you (1) felt nervous, anxious, or on edge; (2) felt depressed; (3) felt lonely; (4) had trouble sleeping; and (5) felt hopeful about the future" (reverse coded). Responses were summed to create a scale ranging from 5 to 20, with higher scores indicating more mental distress. Participants were also asked 4 questions to assess how much of a threat, if any, they perceived the coronavirus outbreak to be on: (1) the health of the US population, (2) your personal health, (3) the US economy, and (4) your personal financial situation. Support for public health restrictions was also examined by a series of questions asking if the following seven restrictions were necessary or unnecessary: (1) restricting international travel, (2) requiring businesses to close, (3) asking people to avoid large gatherings, (4) canceling sporting and entertainment events, (5) closing K-12 schools, (6) limiting restaurants to carry out, and (7) postponing state primary elections. Finally, five attitudes toward social distancing behaviors were assessed, including (1) visiting with a close friend or family member at home, (2) eating out in a restaurant, (3) attending a crowded party, (4) going to the grocery store, and (5) going to a polling place to vote. Analyses were controlled for age, gender, race, education, metropolitan status, region of US, income, job loss due to the pandemic, political party identification, political ideology, whether prayed for an end to the spread of the coronavirus, and whether attended religious services in person less often or watch religious services online or on TV. **Results:** Frequency of attendance at religious services was associated with significantly less mental distress during the COVID-19 pandemic independent of all of the covariates described above ($b=-0.21$, $p<0.001$). Evangelicals and people who attended religious services more frequently were less likely to see COVID-19 as a threat to themselves and the nation; more likely to think that people were overreacting; less likely to support public health restrictions (especially evangelicals); and more comfortable engaging in public activities. Once politics were taken into consideration (controlled for), however, significant differences between religious groups disappeared. Researchers concluded: "... religion can be a source of comfort and strength in times of crisis, but—at least in the case of the COVID-19 pandemic-- it can also undercut efforts to end the root causes of suffering."

Citation: Schnabel, L., & Schieman, S. (2022). Religion protected mental health but constrained crisis response during crucial early days of the COVID-19 pandemic. *Journal for the Scientific Study of Religion*, 61(2), 530-543.

Comment: These findings make sense in terms of what many have experienced during the COVID-19 pandemic over the past two years.

Religion and Vaccine Hesitancy in Australia

Researchers in the school of historical/philosophical inquiry and school of social science at the University of Queensland, Brisbane, Australia, analyzed data from two nationally representative surveys -- the 2018 Australian Survey of Social Attitudes (AuSSA; $n=1287$) and the Australian data set from the 2018 Welcome Global Monitor (WGM, $n=1003$). These surveys were conducted around the same time, both containing questions about religion, trust, and attitudes toward vaccination. Religion was assessed by religious affiliation in the AuSSA and WGM, and in the AuSSA, a question was also asked about whether participants consider themselves to be religious and spiritual, religious but not spiritual, spiritual but not religious, or not religious or spiritual; in addition, participants were asked whether they were brought up religious. With regard to vaccine hesitancy, questions were asked about whether they through childhood vaccines were effective, whether their doctor or healthcare provider recommended vaccines, and concerns about serious adverse effects of vaccines. Trust was assessed by questions about how much confidence or trust the person had in the federal parliament or national government. **Results:** Only 1%

of AuSSA participants indicated that they had religious reasons for being concerned about vaccines. Among religious participants, only 5% expressed disagreement about the effectiveness of childhood vaccines. When religious participants were asked about concerns about serious adverse effects of vaccines, 45% agreed or were neutral on the issue, compared to 35% of nonreligious participants. As found in the AuSSA survey, there were no significant associations between religion and negative, neutral or positive perceptions about vaccines among WGM participants. However, in correlational analyses, among participants in the AuSSA survey, individuals who stated that they were concerned about adverse effects were significantly more likely to say that they believed both in God and in heaven ($p < 0.0001$). In both surveys, individuals who maintained negative attitudes toward vaccines exhibited lower levels of trust in Australia's government. Researchers concluded that: "Statistical analyses revealed no significant correlations between religion and vaccine hesitancy, while participants with negative vaccine attitudes identified that they do not have religious reasons for being vaccine hesitant. Nonetheless, a higher proportion of respondents with negative vaccine attitudes self-identify as religious or spiritual or maintain pro-religious views... Notably, religious self-identification divides two main groups of vaccine hesitant participants, described as Religious Conservatives and Nonreligious Progressives... What unites these vaccine hesitant participants, however, is a mutual lack of trust in government and scientists."

Citation: Aechtner, T., & Farr, J. (2022). Religion, trust, and vaccine hesitancy in Australia: an examination of two surveys. *Journal for the Academic Study of Religion*, 35(3), 218-244

Comment: Note that this research was conducted in 2018, prior to the appearance of COVID-19. Previous studies conducted during the COVID-19 pandemic have found fairly strong associations between religious involvement and vaccine hesitancy.

Religion and the Eradication of Smallpox

Doug Oman, an adjunct professor in the school of public health at the University of California at Berkeley, provides in this article a historical commentary on the role that religion played in the eradication of smallpox, thus underscoring the importance of religion in religious institutions and public health measures. The writer argues that "religion is among the most powerful human motivators -- perhaps most commonly in ways that support health and well-being." In this commentary, he describes two recent memoirs of smallpox eradication leaders that support this statement, one regarding Larry Brilliant, and the other, by William Foege, who would later become the director of the US Centers for Disease Control and Prevention. Oman concludes: "Religion can be a powerful collaborative force for disseminating not simply recognition of the value of meritorious public health initiatives, but also an active belief in the ability of such efforts to succeed. In social science terms, religion can powerfully boost collective agency..."

Citation: Oman, D. (2022). How religion motivated smallpox eradication. *Public Health*, (6), 12-17.

Comment: In this article, the author documents a historical precedent for the useful role of collaboration between religious organizations and public health agencies. This was an opportunity that may have been missed during the recent COVID-19 pandemic, possibly resulting in the loss of many lives. Let us remember this for future pandemics.

Research on Religion and Body Weight

Investigators from departments of sociology at the University of Texas at San Antonio and Florida State University comprehensively review research on the relationship between religiosity and body weight (body mass index or BMI) in this recently published book chapter. First, they review studies conducted in the United States from 1965 to 2021, and then do the

same for studies conducted internationally. Hundreds of studies were reviewed that reported a total of 563 unique statistical tests, 69% indicating no significant relationship between religion and body weight (BMI); 27% indicating a significant positive relationship between religion and heavier body weight; and 4% indicating that religiosity was associated with lower weight. They then review possible explanations for why religiosity might influence body weight, including obesogenic (leading to heavier weight) and leptogenic (leading to lower weight) mechanisms. Possible explanations for increased body weight among the more religious include the following: (1) since overeating is not a sin, religious organizations tend to focus on food and include food during social events; (2) the sedentary practice of watching religious television or listening to radio shows (vs. physically participating in religious services) may promote snacking and weight gain; (3) discouraging smoking and caffeine intake may remove habits that tend to reduce appetite; (4) religious persons may be more likely to engage in long-term marital relationships and less likely to be active in dating and marriage markets (where the pressure to lose weight in order to be more attractive is higher); and (5) reference group issues may influence weight control (i.e., if everyone in one's social group is overweight, this reduces the pressure to lose weight). The authors then examine moderators of the religion-body mass relationship including gender, race, and age. They conclude with directions for future research, a discussion of theoretical issues, and a focus on methodological issues. The researchers conclude: "Although a large majority of studies show that religion is unrelated to body mass, a non-trivial percentage of previous work suggests that religion tends to favor greater body mass. The least common finding is that religion is associated with leaner body mass."

Citation: Hill, T.D., Galindo, S.M., & Burdette, A.M. (2022). Fit for Christ or gluttons for God? An overview of research on religion and body mass (Ch. 11). In Garcia-Alexander, G., & Poston, D.L. (eds), in *International Handbook of the Demography of Obesity*. Cham, Switzerland: Springer Nature, pp 187-204.

Comment: Although we do not usually review book chapters in Crossroads, this particular chapter, written by some of the top religion-health researchers in the field, is highly relevant to the relationship between religion and health, so readers should be aware of it.

Religiosity and Psychological Health in College Students

Tommie Loraine Hill at the Florida Institute of Technology in Melbourne, Florida, surveyed 206 undergraduate students at the Institute, seeking to examine the cross-sectional relationship between religiosity and psychological health. Religiosity was assessed using intrinsic, extrinsic, and quest religiosity measures (IEQ; Reitsma et al., 2007) and the Duke University Religion Index (DUREL). Mental health was assessed by the Lifestyle and Habits Questionnaire-Brief Version (LHQ-B), a 42-item measure of health-related lifestyles and attitudes, including psychological health. Only bivariate correlations were reported (multivariate analyses controlling for potential confounders was not done). **Results:** A positive correlation was found between intrinsic religiosity and psychological health scores ($r = 0.19$, $p = 0.007$). There was also positive correlation between total DUREL scores and psychological health ($r = 0.23$, $p < 0.001$).

Citation: Hill, T. L. (2022). Religiosity and psychological health: is there a correlation? *SN Social Sciences*, 2(8), 1-7.

Comment: Although a quite modest study (cross-sectional, small sample size, uncontrolled analyses), it is interesting that religiosity is still significantly related to better mental health in today's college students (despite increasing secularization among younger generations).

Religion, Child Abuse, and Substance Abuse in Canada

Investigators in the department of sociology at the University of Toronto analyzed data from the 2014 Canadian General Social Survey that surveyed a nationally representative sample of 32,519 Canadians ages 15 or older. Their primary research question was whether religion moderated the relationship between childhood physical and sexual abuse and drinking, binge drinking, or cannabis use. **Results:** Childhood physical and sexual abuse was positively associated with drinking, binge drinking, and cannabis use. Religious beliefs moderated the association between childhood physical abuse in binge drinking, such that the positive association between childhood physical abuse and binge drinking was stronger among those with greater religious beliefs. Researchers concluded, "Consistent with more recent literature, the present study highlights that the buffering role of religiosity might not apply to substance use within the context of childhood abuse."

Citation: Chai, L., & Xue, J. (2022). Childhood abuse and substance use in Canada: does religion ameliorate or intensify that association? *Journal of Substance Use*, EPUB ahead of press.

Comment: Unfortunately, only the abstract was available for review, not the entire article. As a result, details for this study are few.

Death of a Child, Depressive Symptoms, and Belief in a Divine Plan

Researchers in the school of social sciences, Nanyang Technological University in Singapore, analyzed longitudinal data from participants in the US Health and Retirement Study to examine the relationship between "death of a child prior to midlife" (i.e., prior to age 40) and the experience of depressive symptoms later in life. Investigators were particularly interested in the buffering effects of "belief in a divine plan" on this relationship. Included in the analysis were six waves of data on a baseline sample of 8,248 participants (total of 31,088 observations from 2006 to 2016). Depressive symptoms were assessed by the 8-item short form of the CES-D. Belief in a divine plan was determined by asking participants "How much do you agree or disagree with the statement 'life events unfold according to a divine or greater plan'?" Response options ranged from 0 (strongly disagree) to 5 (strongly agree). Growth curve modeling was used to analyze the data, controlling for age, gender, race/ethnicity, education, household income, marital status, and self-rated health, along with religious affiliation (any affiliation vs. none) and frequency of attendance at religious services. **Results:** Of all participants at baseline, 8.6% experienced the death of a child prior to midlife.

There was a significant correlation between death of a child before midlife and depressive symptoms ($t=5.08, p=0.000$). Nearly three-quarters (74%) demonstrated high level of belief in a divine plan. Participants who experienced the death of a child prior to midlife were more likely to report high belief in a divine plan ($\chi^2= 4.25, p=0.039$). Growth curve modeling demonstrated that child loss interacted with belief in a divine plan to affect the linear growth rate of depressive symptoms ($p=0.027$), such that bereaved parents who reported a high level of belief in a divine plan showed a gradual decline in number of depressive symptoms as they aged (whereas the opposite was true for those with a low level of belief in a divine plan, i.e., they experienced an increase in depressive symptoms with increasing age). Researchers concluded: "Belief in a divine plan has a protective effect on older adults who cope with the aftermath of child loss."

Citation: Jung, J. H., & Lee, H. J. (2022). Death of a child, religion, and mental health in later life. *Aging & Mental Health*, 26(3), 623-631.

Comment: Given the large sample size, long-term follow-up, use of sophisticated statistics (growth curve analyses), and careful control

for covariates (including religious affiliation and religious attendance), the results of this study are scientifically and clinically important.

NEWS

Religion, Spirituality and Psychiatric Practice

Although this is relatively old news (April 2021), we just became aware of this American Psychiatric Association (APA) resource document that provides extensive guidance on how to assess and address religion/spirituality in psychiatric practice. This is the second update of APA's 1989 *Guidelines Regarding Possible Conflict between Psychiatrists Religious Commitments and Psychiatric Practice* (*American Journal of Psychiatry* 1990; 147(4): 542). This update provides more details regarding recommendations for psychiatrists on this topic, and this guidance is endorsed by the APA. Quotes from the guidelines include: "Integrating religious elements into therapy has been shown to enhance the psychiatric outcomes of religious patients, and these techniques can be successfully implemented by religious and nonreligious psychiatrists alike"; "Psychiatrists have a responsibility to ensure that all aspects of treatment, including biological, psychological, social and spiritual/religious are considered in the provision of care to patients;" and, the first sentence of the Conclusion states, "It is important for psychiatrists to explore and understand the religious and spiritual values of their patients as part of their assessment and treatment of mental health disorders." To access the full document, go to:

<https://www.psychiatry.org/Psychiatrists/Search-Directories-Databases/Resource-Documents/2021/Approved-by-the-Joint-Reference-Committee,-April-2>

Duke University's Monthly Spirituality and Health Webinar via Zoom

Our Center's monthly spirituality and health research seminars are now being held by Zoom, and should be assessable to participants wherever they live in the world that supports a Zoom platform. All persons who receive our E-newsletter will be sent a link to join the seminar approximately one week before the seminar is held. When you receive this link, please save the link and forward it to your colleagues and students. This month's seminar is on Tuesday, November 12, 2022, occurring at 12:00-1:00 EST, and will be delivered by **Keisha O'Garro, Psy.D., a chronic pain and traumatic stress expert in the Department of Psychiatry at Duke University Medical Center, in Durham, North Carolina.** The title of her presentation is **Spiritually-Integrated Cognitive Processing Therapy for Moral Injury and PTSD.** The PDFs of the Power Point slides for download and full video recordings of most past webinars since July 2020 are available at <https://spiritualityandhealth.duke.edu/index.php/education/seminar/>. All those who receive this e-newsletter will receive a Zoom link approximately 1 week before the Webinar.

SPECIAL EVENTS

21st David B. Larson Memorial Lecture

(Durham, North Carolina, March 9, 2023, 5:30-6:30P EST, onsite only)

The tentative speaker for the 2023 Larson lecture is Aasim I. Padela, MD, MSc, FACEP. Dr. Padela is Professor of Emergency Medicine, Bioethics and the Medical Humanities at MCW. In addition to being Vice Chair for Research and Scholarship in the Department of Emergency Medicine, he co-leads the Community Engagement Core for the Comprehensive Injury Center, serves on the Council of Faith for the Clinical and Translational Science

Institute at MCW, and holds a faculty appointment in the Center for Bioethics and Medical Humanities in the Institute for Health and Equity. Dr. Padela is an internationally renowned clinician-researcher with scholarly foci at the intersections of healthcare, bioethics, and religion. In addition to maintaining an active clinical, research, and bioethics practice at MCW, he provides public health and bioethics consultation to international organizations, legislative bodies, and in court. Dr. Padela holds an MD with Honors in Research from Weill Cornell Medical College, completed residency in Emergency Medicine with Research Distinction at the University of Rochester, and received an MSc in Healthcare Research from the University of Michigan. He also completed a clinical medical ethics fellowship at the MacLean Center for Clinical Medical Ethics at the University of Chicago, and a research fellowship at the University of Michigan. Prior to that, he received a Bachelor of Science with Highest Distinction in Biomedical Engineering, and a Bachelor of Arts degree with Magna Cum Laude in Classical Arabic and Literature from the University of Rochester. His other notable scholarly training includes visiting fellowships at the Oxford Centre for Islamic Studies and the International Institute for Islamic Thought, research career development as a Robert Wood Johnson Foundation Clinical Scholar and as a John Templeton Foundation Faculty Scholar, and leadership development as a Health Equity Leadership Institute Fellow, a Warner-Reynolds Leadership Fellow, and a Society of Behavioral Medicine Mid-Career Leadership Fellow.

Religion and Medicine Conference

(Columbus, Ohio, March 12-14, 2023)

Abstracts for paper presentations, posters, panel and workshop sessions that address issues at the intersection of medicine and religion, including but not limited to the conference theme must be submitted by Sunday, October 16, 2022. The conference theme this year is “At the Limits of Medicine: Caring for Body and Soul.” The theme of this year’s conference is an invitation to consider the boundaries of medicine—beyond what can be done to what ought to be done—by following the central theme of how medicine seeks to care for souls. As always, the conference organizers welcome a range of interests from practical, clinical presentations to theological and philosophical reflections and more. The 2023 Conference on Medicine and Religion invites clinicians, scholars, clergy, students and others to take up these and other questions related to the intersection of medicine and religion. We encourage participants to address these questions and issues in light of religious traditions and practices, particularly, though not exclusively, those of Judaism, Christianity and Islam. The conference is a forum for exchanging ideas from an array of disciplinary perspectives, from accounts of clinical practices to empirical research to scholarship in the humanities. For more information go to: <http://www.medicineandreligion.com/>.

RESOURCES

Books

Global Perspectives in Cancer Care: Religion, Spirituality, and Cultural Diversity in Health and Healing (Oxford University Press, 2022)

From the publisher: “With cancer ranking as the primary or secondary cause of premature death in almost 100 countries worldwide, the World Health Organization recognized a high level of investment in cancer control and treatment (including palliative care) in 2019... As most countries are facing an overall increase in the absolute number of cancer cases, large geographical diversity in cancer occurrence and variations in the magnitude and profile of the disease still continue between and within world regions.

Specific types of cancer dominate globally: lung, female breast, and colorectal cancer. The regional variations in common cancer types signal the extent to which societal, economic, and lifestyle changes interplay to differentially impact the profile of this most complex group of diseases. Although survival rates for cancer have improved significantly over the past few decades, for each individual, the diagnosis and treatment of cancer are still devastating, affecting the family and community as well. Understanding the cultural, psychological, social, and spiritual dimensions of the cancer sufferer and their family and community will ensure the best care... In this book, we focus on numerous diverse cultures, traditions, and faiths. Many parts of the world are composed of indigenous cultures, with unique spiritual beliefs in addition to the region's primary religion. We present chapters on indigenous religions as well as indigenous traditional healers. People everywhere experience trouble, sorrow, need, and sickness, and they develop skills and knowledge in response to these adversities. This book provides insightful models of these parameters and serves as a valuable resource for health care providers and policymakers by taking a global approach to cultural diversity in the world. By understanding this multiculturalism and the many aspects of psychological, social, and spiritual dimensions of health and healing, we can learn from one another” [abbreviated]. Available for \$66.59 (paperback) from <https://www.amazon.com/Global-Perspectives-Cancer-Care-Spirituality/dp/0197551343/>.

Spiritual Readiness: Essentials for Military Leaders and Chaplains

(Amazon Kindle, 2022)

Spiritual readiness (SR) is the strength of spirit that enables the warfighter to accomplish the mission with honor. Maintaining SR is essential for members of the U.S. Armed Forces and their allies in order to keep the peace and, when necessary, win wars. SR influences all other aspects of warrior readiness – psychological, social, behavioral, and physical. Intended for military leaders, military chaplains, and VA chaplains, this book reviews concerns about warrior readiness, concerns underscored by widespread reports of mental health problems and lack of psychological, social, and behavioral fitness. The book discusses how to measure SR to establish a baseline and then track over time. Non-religious and religious sources of SR are then examined from Eastern, Indic, and Abrahamic faiths. Human flourishing is defined and examined in relationship to warrior readiness. The relationship between SR and human flourishing is then explored, illustrated by a theoretical causal model. Systematic quantitative research is then reviewed that explores how religious involvement affects both (a) the pathways that lead to human flourishing and (b) human flourishing itself. The question of who is responsible for building and sustaining SR in the military is then addressed (government decision-makers, military leaders, behavioral health specialists, medical providers, and especially, military chaplains), followed by a series of chaplain interventions designed to prevent or treat emotional problems that diminish SR. The book concludes with a series of practical recommendations for military leaders to enhance SR among those under their command. The book is available on Amazon Kindle for \$0.99 and the paperback is \$7.22 (printing costs only). Go to <https://www.amazon.com/Spiritual-Readiness-Essentials-Military-Chaplains/dp/B0BBY2JLXB>.

Religion and Recovery from PTSD

(Jessica Kingsley Publishers, December 19, 2019)

From the publisher: “This volume focuses on the role that religion and spirituality can play in recovery from post-traumatic stress disorder (PTSD) and other forms of trauma, including moral injury. Religious texts, from the Bible to Buddhist scriptures, have always contained passages that focus on helping those who have experienced the trauma of war. In this book the authors review and

discuss systematic research into how religion helps people cope with severe trauma, including trauma caused by natural disasters, intentional interpersonal violence, or combat experiences during war." Available for \$19.97 (used) at <https://www.amazon.com/Religion-Recovery-PTSD-Harold-Koenig/dp/1785928228/>.

Religion and Mental Health: Research and Clinical Applications

(Academic Press, 2018) (Elsevier)

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

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

(Amazon: CreateSpace Publishing Platform, 2018)

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

Protestant Christianity and Mental Health: Beliefs, Research and Applications

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

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

Catholic Christianity and Mental Health: Beliefs, Research and Applications

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

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

Islam and Mental Health: Beliefs, Research and Applications

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

For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Muslims. Available for \$7.50 at: <https://www.amazon.com/Islam-Mental-Health-Research-Applications/dp/1544730330>.

Hinduism and Mental Health: Beliefs, Research and Applications

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

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

spirituality and mental health in Hindus. Includes original research on current religious beliefs/practices in Hindus from India and throughout the world. Available for \$7.50 at: <https://www.amazon.com/dp/1544642105/>

Judaism and Mental Health: Beliefs, Research and Applications

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

For mental health professionals, clergy, and researchers interested in the relationship between religion, spirituality and health in Judaism. Available for \$7.50 at:

<https://www.amazon.com/Judaism-Mental-Health-Research-Applications/dp/154405145X/>

Buddhism and Mental Health: Beliefs, Research and Applications

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

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

You are My Beloved. Really?

(Amazon: CreateSpace Publishing Platform, 2016)

From the author: "Simple and easy to read, intended for Christians and non-Christians, those who are religious or spiritual or neither, and is especially written for those experiencing trauma in life (everyone). The book examines the evidence for God's love from Christian, Jewish, Muslim, Buddhist and Hindu perspectives based largely on the sacred scriptures from these traditions. Available for \$8.78 from <https://www.amazon.com/You-are-My-Beloved-Really/dp/1530747902/>.

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

(Templeton Press, 2011)

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

Other Resources

CME/CE Videos (Integrating Spirituality into Patient Care)

Five professionally produced 45-minute videos on **why and how** to "integrate spirituality into patient care" are now available on our website (*for free*, unless CME/CE is desired). Videos are targeted at physicians, nurses, chaplains, and social workers in an effort to help them form **spiritual care teams** to provide "whole person" healthcare that includes the identifying and addressing of spiritual needs. Go to:

<https://spiritualityandhealth.duke.edu/index.php/cme-videos/>.



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

Education (ACCME), to provide continuing education for the health care team.



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INTERPROFESSIONAL CONTINUING EDUCATION

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

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

TRAINING OPPORTUNITIES

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

With support from the John Templeton Foundation, Duke University's Center for Spirituality, Theology and Health is offering nine \$3,600 scholarships to attend the university's 5-day Workshop on conducting research on religion, spirituality, and health. Applications are now being sought for the 2023 workshop to be held August 14-18. These scholarships will cover the \$1200 tuition, up to \$1500 in international travel costs, \$500 in hotel expenses, and \$400 in living expenses. They are available only to academic faculty and highly promising graduate students living in third-world underdeveloped countries in Africa, Central and South America (including Mexico), Eastern Europe and North Asia (Russia and China), and portions of the Middle East, Central and East Asia. The scholarships will be highly competitive and awarded to talented well-positioned faculty/graduate students with the potential to conduct research on religion, spirituality, and health, and serve as research leaders in their part of the world. If you want to know more about this program, contact Harold.Koenig@duke.edu or go to our website for a description of the workshop: <https://spiritualityandhealth.duke.edu/index.php/5-day-summer-research-course>. **Please let your academic colleagues in developing countries know about this unusual and time-limited opportunity.**

Unfortunately, but not surprisingly, the demand for such scholarships has far exceeded availability. Now that we are set up to evaluate potential scholarship recipients, we are hoping to identify individuals or foundations willing to support highly qualified third-world applicants whom we are unable to provide scholarships to in 2023 and the years ahead (this grant ends after the 2023 workshop). A donation of \$3,600 to our Center will sponsor a university faculty member from a disadvantaged region of the world to attend the workshop in 2023 or future years. If you are interested in sponsoring one or more such applicants and want to know more about this program, or have ideas about other sources of support, please contact Harold.Koenig@duke.edu.

Theology, Medicine, and Culture Initiative

The *Theology, Medicine, and Culture Initiative* at Duke Divinity School invites you to consider both residential and hybrid opportunities for theological study and spiritual formation:

Theology, Medicine, and Culture Fellowship

Combining deep formation in Christian thought with practical spiritual disciplines, mentorship, seminars, retreats, and partnership with health-related ministries, the Fellowship equips

participants for a lifetime of wise and faithful healing work. The Fellowship is open to current and future students and practitioners in any of the health professions, as well as to others whose vocations involve full-time work in health-related contexts. Scholarships are available for both one and two-year tracks. [Flexible Hybrid Certificate in Theology and Health Care \(hybrid CTHC\)](#)

This program invites both practicing and future clinicians to be formed intellectually, relationally, and spiritually for excellent and faithful healing work. In the flexible hybrid format, students come together for two separate weeks in person at Duke University and then join for eight months of online learning designed for working clinicians—studying together the difference that Christian faith makes for health care. For more information on both these programs, go to: <https://tmc.divinity.duke.edu/>

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry

The next deadline for Small Grant requests (\$234,800 or less) and Large Grant requests (more than \$234,800) is **August 18, 2023**.

The Foundation will communicate their decision (rejection or invitation to submit a full proposal) for all OFIs by October 13, 2023. Therefore, researchers need to think "long-term," perhaps collecting pilot data in the meantime, with or without funding support. JTF's current interests on the interface of religion, spirituality, and health include: (1) **investigating the causal relationships between health, religion, and spirituality (determining direction of causation in associations reported; identifying the underlying causal mechanisms responsible)**, with a specific focus on longitudinal studies, and (2) **engaging religious and spiritual resources in the practice of health care (increasing the religious and spiritual competencies of health care practitioners; testing the impact of religiously integrated therapies; and increasing the scientific literacy of health care chaplains)**.

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

2022 CSTH CALENDAR OF EVENTS...

Nov

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|-------|---|
| 11/13 | Pullen Memorial Baptist Church (onsite)
Adult Education Class, Raleigh, NC, 9:30-10:30A EST
Title: Religion, Spirituality, and Mental Health
Speaker: Harold G. Koenig, M.D.
Professor of Psychiatry, Duke University Health System
Contact: Dr. Debbi Carter (debbicarter1948@gmail.com) |
| 11/23 | Psychotherapy Essentials
Department of Psychiatry, University of the Philippines Manila, Philippines, 8:00-9:00P EST (online)
Title: Psychiatry and Spirituality: Relationships and Importance in Psychotherapy
Speaker: Harold G. Koenig, M.D.
Contact: Evelyn Gapuz (eggapuz@up.edu.ph) |
| 11/29 | Spirituality and Health Research Seminar
12:00 -1:00 EST (online by Zoom)
Title: Spiritually-Integrated Cognitive Processing Therapy for Moral Injury and PTSD
Speaker: Keisha O'Garro, D.Psy.,
Assistant Professor in Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC
Contact: Harold G. Koenig (Harold.Koenig@duke.edu) |