CROSSROADS…

Exploring research on religion, spirituality and health

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This newsletter provides updates on research, news and events related to spirituality and health, including educational resources and funding opportunities. **Please forward to colleagues or students who might benefit.** Our goal is to create a community of researchers, clinicians, clergy, and laypersons interested in spirituality and health and keep them informed and updated. An EVENTS CALENDAR concludes the newsletter and describes spirituality and health related presentations happening at Duke and around the world. This is your newsletter and we depend on you to let us know about research, news, and events in this area.

All e-newsletters are archived on our website. To view previous editions (July 2007 through Nov 2015) go to: http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads

LATEST RESEARCH

Spiritual Peace and Mortality in Patients with Congestive Heart Failure

Investigators at the University of Connecticut and other U.S. universities conducted a 5-year prospective study of 191 patients with congestive heart failure (63% with NYHA stage II and 25% with stages III or IV), examining the effects of spirituality at baseline on mortality. Spirituality was assessed with a single item measuring frequency of attendance at religious services (rated on a 0 to 4 scale) and a single item measuring "spiritual peace" from the 6-item Daily Spiritual Experiences scale ("I feel deep inner peace or harmony" rated on a 1 to 6 scale). Also assessed were co-morbid health conditions, cigarette smoking, alcohol use, adherence to a healthy life style, depressive symptoms, and social support. Cox proportional hazards regression was used to examine time to death, controlling for covariates. **Results**: A total of 61 participants died (32%) during the 5-year follow-up. The correlation between spiritual peace and religious attendance was moderately strong ($r=0.33$, $p<0.001$). After controlling for age, NYHA class, co-morbid health conditions, depressive symptoms, healthy lifestyle adherence, smoking, and alcohol consumption, the presence of spiritual peace was a significant predictor of mortality risk (HR=0.80, 95% CI0.67-0.95, $p=0.01$), i.e., spiritual peace decreased the risk of mortality by 20%. Researchers concluded that, "Experiencing spiritual peace, along with adherence to a healthy lifestyle, were better predictors of mortality risk in this sample of CHF patients than were physical health indicators such as functional status and comorbidity."
Citation: Park CL, Aldwin CM, Soyoung C, George L, Suresh DP, Bliss D (2015). Spiritual peace predicts 5-year mortality in congestive heart failure patients. Health Psychology, E-pub ahead of press
Comment: While an important finding, since spiritual peace was a stronger predictor of survival than several kwown and well-established predictors of survival, this finding relates primarily to the psychological construct of inner peace and harmony. There is nothing distinctive about this construct that makes it spiritual, although deep inner peace and harmony may *result from* spiritual involvement (the strong relationship with church attendance is notable). It is not terribly surprising, though, that CHF patients who experience deep inner peace and harmony live longer than those who do not. It is very surprising, though, that neither depressive symptoms nor social support predicted survival, while inner peace and harmony did and did so more strongly than did NYHA class or number of co-morbid medical problems.

Intrinsic Religiosity and Hypertension

To examine the relationship between intrinsic religiosity and hypertension, researchers at Loma Linda University analyzed cross-sectional data on 9,581 middle-aged and older North American Seventh-Day Adventists (SDA). The mean age of the sample was 61 years; two-thirds were White; two-thirds were female; and 43% had an undergraduate or graduate degree education. One-third of the sample (35%) reported a diagnosis of hypertension. In terms of health behaviors, 56% were vegetarian, 33% were involved in a regular exercise program, and 94% did not currently use alcohol. Church attendance was "often" in 91% of participants. Intrinsic religiosity was assessed using the 3-item subscale of the Duke University Religion Index (DUREL), with response options ranging on a 7-point Likert scale from "not true" (1) to "very true"(7). Hypertension was self-reported. Researchers sought to validate this self-reported diagnosis in a subsample of 495 participants who had their blood pressure (BP) physcially measured; systolic BP was significantly higher in those who self-reported hypertension than in those who did not ($p<0.0005$); likewise, diastolic BP was significantly higher in those reporting hypertension compared to those who did not ($p<0.0005$). Perceived stress, neuroticism, depression, and spiritual meaning were examined as possible mediators. Logistic regression was used to analyze the data. **Results**: Level of intrinsic religiosity was inversely related to hypertension (B=-0.13, SE 0.03, OR=0.88, 95% CI 0.83-0.92, $p<0.0001$). Only older age, Black race, lower BMI, and eating a vegetarian diet were as strongly related to hypertension as was intrinsic religiosity. Even after controlling for perceived stress, neuroticism, depression, and spiritual meaning, the inverse relationship between hypertension and intrinsic religiosity persisted (B=-0.09, OR=0.92, $p<0.01$). Investigators concluded, "This finding is particularly important because it suggests that religiosity and not just lifestyle is related to lower risk of hypertension, a leading cause of death in the USA."
Citation: Charlemagne-Badal SJ, Lee JW (2015). Intrinsic religiosity and hypertension among older North American Seventh-Day Adventists. Journal of Religion and Health, see http://doi.org/10.1007/s10943-015-0102-x
Comment: Reported here was a robust association independent of diet and other health behaviors and only minimally mediated by perceived stress, neuroticism, depression, and spiritual meaning. In participants whose BP was actually measured, the average systolic BP of those with self-reported hypertension was only 133.8 and the average diastolic BP was only 75.3 (however, many were taking medication to control their hypertension). Although the present study is cross-sectional and does not allow causal inferences, the inverse association between religiosity and hypertension may be one reason why SDA's (a very religious group) live on average 4 years longer than Americans in general.

Religious Social Support and Hypertension

In a second report from the study above, researchers prospectively followed 5,720 of the 9,581 SDA cohort for 4 years, identifying 534 new cases of self-reported hypertension. Religious support was assessed with the 12-item Krause support scale that is made up of four 3-item subscales (emotional support given, emotional support received, negative interaction, and anticipated support). Demographic controls included age, gender, education, and financial status. Assessed as mediators were religious attendance, BMI, exercise, alcohol intake, and diet (all measured using single items). Logistic regression was used to control for demographic characteristics and examine mediators. **Results:** In cross-sectional analyses, after controlling for demographics and other subscales of religious support, the *anticipated support* subscale significantly predicted a lower likelihood of self-reported hypertension (OR=0.85, 95% CI 0.78-0.92, p<0.001). Adding religious attendance and health behaviors to the model mediated only a small proportion of this effect (increasing the odds ratio from 0.85 to 0.89). However, adding BMI to the model completely accounted for the effect (OR=0.93, 95% CI 0.86-1.02). In longitudinal analyses that examined the development of new cases of self-reported hypertension during the 4-year follow-up in those without hypertension at baseline (n=534), anticipated religious socal support again predicted a lower likelihood of hypertension after controlling for demographics and other subscales of religious support (OR=0.83, 95% CI=0.70-0.97, p=0.02). Adding church attendance and health behaviors to the model had little effect (increasing OR from 0.83 to 0.84). Adding BMI again accounted for most of the relationship (OR=0.86, 95% CI 0.73-1.01, p=0.065).
Citation: Charlemagne-Badal SJ, Lee JW (2015). Religious social support and hypertension among older North American Seventh-Day Adventists. Journal of Religion & Health.
http://doi.org/10.1007/s10943-015-0104-8
Comment: These findings suggest that lower weight (body-mass index) was the primary factor that explained why anticipated religious support reduced the likelihood of self-reported hypertension. Even though baseline health behaviors were controlled, this finding is likely the consequence of faithfully following the SDA diet, exercising regularly, otherwise living a healthy lifestyle, and having strong family values and social ties. This may only be the tip of an iceberg, given the short follow-up period (4 years). Longer follow-up might increase the power of the analysis to detect an even larger effect. Future waves of data collection will help to determine if the finding strengthens or diminishes over time.

Religiosity and Psychological Well-being in Asian American Adolescents

Given the dirth of information on religion and mental health in Asian American adolescents (AAA), researchers in the department of psychology at Wake Forest University (Winston-Salem, North Carolina) examined the effects of religious identity and religious participation on emotional well-being in this population. Participants were 180 AAA ages 13 to 18 years old (mean age 15 years, 60% female) attending six public high schools in the southeastern U.S. Religious affiliations were Shamanism/Animism (25%), Christian not specified (21%), Catholic (10%), Hindu (10%), Buddhist (8%), Muslim (4%), and none specified (16%). Religious identity was assessed using a standard 8-item measure that examined the *regard* and the *centrality* of religion in life. Religious participation was assessed by a 2-item scale of frequency of attendance at religious services and involvement in other religious activities. Psychological well-being was measured in terms of self-esteem (Rosenberg), depressive symptoms (CES-D), positive and negative affect (Mroczek), and meaning in life (Steger). Hierarchical linear modeling (HLM) was used to examine longitudinal associations over 4 years between religiosity and well-being, controlling for gender and generational status.

Results: Religious identity did not change over the 4-year follow-up; religious participation, however, increased. Religious identity was significantly associated with higher self-esteem, greater positive affect, the presence of meaning in life, and reduced depressive symptoms (the latter only in females), whereas religious participation was associated with positive affect and the presence of meaning in life.
Citation: Davis RF, Kiang L (2015). Religious identity, religious participation, and psychological well-being in Asian American adolescents. Journal of Youth and Adolescence, see
http://doi.org/10.1007/s10964-015-0350-9
Comment: The role of religion in the mental health of Asian American adolescents is poorly understood, and this is one of the few longitudinal studies that have examined the topic. The religious diversity in this sample is interesting, with the most common affiliation being Shamanism/Animism (25%). This is likely due to a large proportion of adolescents here from a Hmong ethnic background (28%). The increase in religious participation over time should also be noted, given the usual pattern of decline in religious attendance found in most studies of Caucasian American adolescents.

Religion and Well-being in Norway

Researchers at the Norwegian University of Science and Technology in Trondheim analyzed cross-sectional data on 528 adults (ages 18 to 75, mean age 51, 56% women) using structural equation modeling (SEM) to estimate relationships between church attendance, religious experience, and well-being, stratifying analyses by gender. Church attendance was assessed using a 3-item scale (King and Hunt, 1972); religious experience was measured using the 12-item Religious Experience Questionnaire (Edwards, 1976) that assesses both positive religious experiences (e.g., “My relationship with God is characterized by close fellowship”) and negative religious experiences (e.g., “I experience feelings of anger or resentment toward God”). Psychological well-being was assessed with the 10-item existential well-being subscale of the SpiritualWell-being Scale. **Results**: Both women and men were highly educated (42% and 44% with university degrees), and most were members of the Church of Norway (79% and 81%). Religious experience (assessing a personal connection with God) was significantly higher in women than in men (p=0.01). In men, church attendance and positive religious experiences were unrelated to well-being, whereas negative religious experiences were strongly inversely related to well-being (r=-0.35, p<0.001). In women, both church attendance (r=0.18, p<0.05) and positive religious experience (r=0.23, p<0.001) were associated with well-being, whereas negative religious experiences was inversely related (r=-0.26, p<0.01). SEM analyses, which controlled for education, age, and health status, revealed that church attendance was a significant positive correlate of well-being in men (B=0.31, p<0.01), whereas positive religious experience was a positive correlate of well-being in women (B=0.31, p<0.01); negative religious experience was related to lower well-being in both men and women (both B=-0.29, p<0.05). Researchers concluded that, “The present findings suggest that men may benefit more from active religiousness, whereas women may benefit more from affective religiousness.”
Citation: Kvande MN, Klockner CA, Mielsen ME (2015). Church attendance and religious experience: Differential associations to well-being for Norwegian women and men? Sage Open, in press (DOI: 10.1177/2158244015612876, published online October 30, 2015)
Comment: Researchers examined a relatively large national random sample of Norwegian adults, using a high quality statistical method (SEM) that carefully controlled for confounders. They administered standard scales that appropriately distinguished psychological well-being from spirituality, which researchers seldom do. The findings underscore the importance of church

attendance in the well-being of Norwegian men and a personal connection with God in the well-being of Norwegian women.

Spirituality and Satisfaction in Parents of Children Seen in Primary Care

Benjamin Doolittle and colleagues at Yale University School of Medicine surveyed 127 parents of children (ages 7-18) who presented for medical care at an urban primary care clinic in New Haven, CT. Parents were 60% Latino, 84% had an income of <$20,000 per year, and 51% had children with chronic medical illness. The purpose of this study was to examine the relationship between spirituality, satisfaction with life, and emotional coping. Spirituality was assessed using the Spiritual Involvement and Beliefs Scale (SIBS); life satisfaction with the 5-item Satisfaction with Life Scale (Diener); and emotional coping using the COPE Inventory. The SIBS assesses several aspects of spirituality, including internal beliefs, external practices, personal/relational humility, and existential beliefs. **Results** indicated that external practices (i.e., frequency of participation in religious services, prayer services, other spiritual activities) were associated with greater life satisfaction ($r=0.23$, $p<0.01$). In addition, scores on personal/relational humility (i.e., forgiveness and reconciliation) were also associated with greater life satisfaction ($r=0.18$, $p<0.05$). Researchers concluded that, "Encouraging patients' involvement in religion and certain coping strategies, especially among those families coping with children with special health care needs, may improve life saitsfaction."

Citation: Doolittle B, Courtney M, Jasien J (2015). Satisfaction with life, coping, and spirituality among urban families. Journal of Primary Care & Community Health 6(4):256-259

Comment: This is one of the first studies to examine the relationship between spirituality and life satisfaction in parents, the majority of whom were coping with children who had chronic disease. These families, the majority of whom were Hispanic, had a lot to cope with – given that most had to subsist on less than $20,000 per year (the poverty level for a family of 4 being $23,500).

Religious Coping Moderates the Effects of Early Trauma on Physical Health in Women

Researchers at the Johns Hopkins University school of nursing analyzed data from a cross-sectional study of 10,283 Seventh-Day Adventists in North America, examining the effects of early traumatic stress (ETS) on mental and physical health and the buffering effect that religious coping has on this relationship. Religious coping was assessed with single items measuring positive religious coping (PRC) ("When I face problems I try to make sense of it with God") and negative religious coping (NRC) ("When I face problems I feel God is punishing me"). ETS was assessed by exposure to one or more of the following: physical abuse, psychological abuse, sexual child abuse, neglect, or witnessed parental abuse. Mental and physical health were assessed using the SF12. **Results**: In men, the adverse effect of ETS on physical health was surprisingly reduced in those with *higher* NRC. In women, the effect was the reverse, i.e., the adverse effects of ETS on physical health were increased in those with higher NRC, but reduced in those with higher PRC (as was predicted). Investigators concluded that "…this finding suggests the potential benefit of facilitating PRC especially among women survivors [of early life trauma]…"

Citation: Reinert KG, Campbell JC, Bandeen-Roche K, Sharps P, Lee J (2015). Gender and race variations in the intersection of religious involvement, early trauma, and adult health. Journal of Nursing Scholarship. See http://doi.org/10.1111/jnu.12144.

Comment: This is another interesting report from the NIH-funded Biopsychosocial Religion and Health Study involving North American SDA. It is the first study to find a strong interaction between early life traumatic stress, physical health, religious coping, *and gender*, such that effects of religious coping (especially negative religious coping) on physical health in men were the opposite of those found in women.

Suicidal Behavior and Religious/Spiritual Involvement in Veterans with PTSD

Investigators from the Department of Veterans Affairs, University of South Alabama, and University of Rochester (NY) examined the association between a history of suicide thoughts or attempts, religious attendance, religious coping, and daily spiritual experiences. The sample consisted of 472 Veterans admitted to a residential treatment program for PTSD (90% Vietnam Veterans). History of suicidal thoughts and attempts were assessed with two questions asked on initial admission to the program: "Have you ever had serious thoughts of committing suicide?" and "Have you attempted suicide in your lifetime?" A 2-item measure of organizational religious activity, a single question assessing private religious activity, a 6-item measure of daily spiritual experiences, a 3-item measure of positive religious coping (PRC), and a 3-item measure of negative religious coping (NRC) were administered, with items taken from the Fetzer Institute's Brief Multidimensional Measure of Religiousness and Spirituality. The PTSD checklist and Combat Experiences Scale were also administered, and information was collected on age, gender, ethnicity, marital status, and religious affiliation. Multivariate analysis of covariance was used to examine cross-sectional relationships, controlling for age, gender, ethnicity, combat exposure, and severity of PTSD symptoms. **Results**: Veterans who indicated higher NRC experienced more suicidal ideation ($p=0.001$) and made more suicide attempts ($p=0.002$), whereas those with greater involvement in church or other spiritual communities (higher organizational religiosity) were less likely to experience suicidal ideation ($p=0.008$) and somewhat less likely to have attempted suicide ($p=0.078$). More daily spiritual experiences were also associated with less suicidal ideation ($p=0.034$). Researchers concluded: "The findings suggest that enhanced or diminished spiritual functioning is associated with suicidal thoughts and attempts among Veterans dealing with PTSD."

Citation: Kopacz MS, Currier JM, Dresher KD, Pigeon WR (2015). Suicidal behavior and spiritual functioning in a sample of Veterans diagnosed with PTSD. Journal of Injury & Violence Research 8(1), see http://doi.org/10.5249/jivr.v8i1.728

Comment: At a time when our military and the Veterans Administration are trying to stem the tide of increasing suicide, particularly among those with PTSD, these findings are highly relevant. They support the development of faith-based interventions in the prevention and treatment of suicidal tendencies in active duty military and combat Veterans.

Spirituality, Forgiveness, and Quality of Life in Veterans with PTSD

Investigators in the department of psychology at the University of South Alabama, National Center for PTSD, and several other U.S. universities analyzed cross-sectional data on 678 Veterans during the first week after admission to a 60 to 90-day VA residential PTSD program (2003-2007). All participants had severe PTSD symptoms not responding to outpatient treatment. Average age was 52 years; 95% were men; and 58% were Caucasian. Spirituality was measured using items taken from the Brief Multidimensional Measure of Religiousness and Spirituality (BMMRS). These included self-rated religiosity and spirituality, daily spiritual experiences, spiritually-oriented values, private religious practices, positive religious coping, negative religious coping,and organizational religiousness (higher scores on these measures indicated lower religious/spiritual activity). Forgiveness of self, others, and God was assessed using a 3-item measure

(Mauger). Quality of Life (QOL) was assessed using the WHOQOL-bref that assesses physical, psychological, social, and environmental aspects of QOL. Structural equation modeling was used to assess the direct and indirect effects of spirituality (via forgiveness) on QOL. Combat exposure and PTSD symptoms were measured as covariates. **Results**: Spirituality (assessed by the 8 dimensions above) was significantly associated with forgiveness and QOL, and forgiveness was strongly associated with QOL. Including forgiveness in the model completely explained the relationship between spirituality and QOL. The total indirect effect of spirituality on QOL through forgiveness, however, was significant (B=0.29, p=0.001). Researchers concluded that: "higher levels of spiritual functioning were associated with fewer forgiveness problems among these Veterans, and their propensity to forgive self and others was also concurrently linked with QOL."
Citation: Currier JM, Drescher KD, Holland JM, Lisman R, Foy DW (2015). Spirituality, forgiveness, and quality of life. International Journal for the Psychology of Religion, http://doi.org/10.1080/10508619.2015.1019793
Comment: The authors indicate that this is the first study to assess how spirituality influences QOL among Veterans with PTSD. Increasing the capacity to forgive self, others, and God appears to be front and center in explaining how spirituality improves QOL in Veterans with severe PTSD symptoms. Psychologist Joseph Currier, the lead author, will present on moral injury at Duke's Center for Spirituality, Theology and Health on Dec. 19 (see Calendar).

Faith and Quality of Life in Cancer Patients

Researchers at Biola University, Rush University, and the Behavioral Research Center of the American Cancer Society (ACS) analyzed data from 8,405 participants in the ACS's Study of Cancer Survivors-II. The aim was to examine how the "Faith" dimension of the 12-item FACIT-Sp is relates to quality of life (QOL). The FACIT-Sp assesses three dimensions: Meaning, Peace, and Faith (each measured by 4 items). The questions making up the Faith dimension are: "I find comfort in my faith or spiritual beliefs;" "I find strength in my faith or spiritual beliefs;" "My illness has strengthened my faith or spiritual beliefs;" and "I know whatever happens with my illness, things will be okay." QOL was assessed with the SF-36, which produces a mental health component score (SF36-MCS) and a physical health component score (SF36-PCS). Variables controlled for in analyses were age, gender, race, marital status, education, income, language, and region of country. **Results**: In uncontrolled analyses, Faith was strongly related to Meaning (r=0.40) and Peace (r=0.43), less strongly with the SF36-MCS (r=0.23), and least strongly with the SF36-PCS (r=0.053) (all p<0.001). Meaning and Peace were strongly related to SF36-MCS (r=0.53 and r=0.64, respectively) and to SF-36-PCS (r=0.27 and r=0.25, respectively). Mediation analyses revealed that Faith had a significant positive total effect on mental health (SF36-MCS) (B=0.530, p=0.000), mediated largely by its association with greater Meaning. Faith also had a significant positive total effect on physical health (SF36-PCS) (B=0.20, p=0.000), mediated largely by both Meaning and Peace. Investigators concluded that "The study findings suggest that faith makes a significant contribution to cancer survivors' functional QOL."
Citation: Canada AL, Murphy PE, Fitchett G, Stein K (2015). Re-examining the contributions of faith, meaning, and peace to quality of life: A report from the American Cancer Society's Studies of Cancer Survivors-II (SCS-II). Annals of Behavioral Medicine, see http://doi.org/10.1007/s12160-015-9735-y
Comment: As readers may know from our previous comments about the FACIT-Sp in this newsletter, we are not fans of this measure of spirituality, given it's overlap with (and contamination by) indicators of mental health. Even the Faith subscale is a pretty poor measure, since the questions tap feelings of comfort and strength, and the 4th item ("I know whatever happens with my illness, things will be okay") has nothing distinctively spiritual about it at all. Nevertheless, the association between the Faith subscale and both mental and physical health in this large sample of cancer survivors is notable, and these researchers at least made an attempt to disentangle the meaning and peace indicators of QOL from the faith component, which is commendable.

Measures of Spirituality Contaminated by Well-being Items

Researchers from the Helen Dowling Institute's Center for Psycho-Oncology in the Netherlands examined spirituality measures used in 58 studies that examined the relationship between spirituality and well-being or distress published in eight well-cited journals (Annals of Behavioral Medicine, Journal of Behavioral Medicine, International Journal of Behavioral Medicine, Psycho-Oncology, Journal of Consulting and Clinical Psychology, Supportive Care in Cancer, Journal for the Scientific Study of Religion, and Psychology of Religion and Spirituality). **Results**: A total of 26 of 58 studies (45%) used spirituality scales where psychological well-being items made up 25% or more of the scale.
Citation: Garssen B, Visser A, de Jager Meezenbroek E (2015). Examining whether spirituality predicts subjective well-being: How to avoid tautology. Psychology of Religion and Spirituality, March 30
Comment: This shocking finding suggests that nearly 50% of studies reporting positive relationships between spirituality and emotional well-being or distress are contaminated with items measuring the outcome itself. A significant relationship between spirituality and well-being reported in these studies, then, is a circular finding that is tautological and therefore meaningless. These studies are simply measuring spirituality as well-being and then correlating it with well-being. This is a serious problem.

Spiritual History Taking in Palliative Care: No Benefit in Belgium

Researchers in the department of general practice at the Catholic University of Leuven conducted a randomized clinical trial to examine the benefit of health professionals conducting a structured spiritual history. In addition to health professionals, participants included palliative care patients receiving home care (i.e., patients with progressive, life-threatening disease with a prognosis of 2 months or more). Participants in the study included 204 nurses, 41 physicians, and 99 patients. Only 49 patient-provider dyads, however, completed the entire study, 25 in the intervention group and 24 in the control group (less than 50% study completion rate). The spiritual history was based on the "moriendi" model, which "has its roots in the Middle Ages and sketches five temptations that present themselves to the dying person: the loss of faith, the loss of one's confidence in salvation, the hanging on to temporal affairs, the inability to deal with pain and suffering, and the pride." The model used here, however, was "updated…to modern culture and challenges…autonomy, boundaries of medical actions, dealing with suffering, the farewell, guilt, and questions about belief and meaning." The questions that comprised the spiritual history were: (1) "What gives you strength in this situation?"; (2) "Who/what inspires you?"; (3) "Whom are you holding onto?"; (4) "Can you let go of life?"; (5) "How are you holding up?"; (6) "What do you want us to do?"; (7) "If you look back upon your life, what do you feel?"; (8) "Are there important things to tell or discuss with anybody?"; (9) "What does death mean to you?"; (10) "Do you feel supported by any faith or belief?"; (11) "Do you have a chance to be yourself?"; (12) "Are you leaving this world in a way that fits you?" Authors indicated that the spiritual history took about 1 hour to complete. Patients randomized to the control group received usual care. The primary outcome was spiritual well-being (FACIT-Sp), and secondary

outcomes were quality of life (EORTC QLQ-C30), pain, and patient-provider trust. Patient outcomes were assessed at baseline and 6 weeks later. **Results**: No difference was found between treatment groups on any of the outcomes, i.e., spiritual well-being, QOL, pain, or patient-provider trust.
Citation: Vermandere M, Warmenhoven F, Van Severen E, De Lepeleire J, Aertgeerts B (2015). Spiritual history taking in palliative home care: A cluster randomized controlled trial. Palliative Medicine. See http://doi.org/10.1177/0269216315601953
Comment: Considering the content of the spiritual history, which focused primarily on psychological issues, rather than on anything distinctively religious or spiritual, the results are not surprising. Only one question addressed "faith or belief." The average time to administer this 12-question spiritual history took nearly1 hour, making it completely impractical for most health care settings. The less than 50% completion rate and small sample are also notable, making it difficult to generalize results of this study to a broader patient group. Thus, while the idea was a good one, the spiritual history chosen was primarily psychological and impractical in length, and the design and execution of the clinical trial was lacking. Perhaps if the spiritual history had included items from the original model developed in the Middle Ages (rather than adapting it to modern times), the results would have been different.

NEWS

Islamic Orthodoxy: In Need of an Update?

(October 5, 2015) Ebrahim Moosa, professor of Islamic Studies at the University of Notre Dame's Keough School of Global Affairs, has written a brief (2 page) articulate and powerful piece that addresses how radical groups such as ISIS have been able to use Islamic teachings to meet their goals. He states: "Islamic orthodoxy, which controls mosques and institutions worldwide, is out of step with the world in which the majority of Muslims live…Once a robust intellectual tradition, today Islamic orthodoxy is in serious need of a makeover… Groups such as Islamic State propound archaic teachings still held to be true by many orthodox authorities. These include enslaving prisoners of war and taking female prisoners as concubines. Because mainstream Islam has not truly defused these theological hand grenades by explaining how they apply to the modern world, groups like Islamic State… can view these dangerous teachings as the true ideals of Islam…In my view, a doctrinal overhaul is the best long-term antidote to the radicalism and senseless interpretations that masquerade as Islam." Read the entire piece to appreciate the depth and importance of his message (originally published in the Washington Post). The voices of Dr. Moosa and other moderate Muslim leaders are desperately needed in these times to counter the message of radicalized Muslim groups that we hear daily in the media. See: http://www.theage.com.au/comment/confronting-the-problem-with-Isalmic-Orthodoxy-20151004-gk0qgd.html

SPECIAL EVENTS

Emotional Wellness Summit – Orlando 2016

(Orlando, Florida, January 13-17, 2016)
According to organizers, "This emotional wellness summit is designed for health professionals, health leaders, pastors and individuals wanting to learn more about prevention, treatment and recovery strategies for better mental health. Information shared will be evidence-based and wholistic, highlighting the role of faith communities and faith-based institutions in enhancing the mental and emotional wellbeing of individuals and families in the community… The Health Ministries departments of the North American Division, Inter-American Division and South American Division [of *Adventist Health Ministries*] are excited to announce our amazing lineup of speakers and great array of seminars in the area of mental and emotional health. Prepare to be inspired and taught by leaders in the faith and health movement as we look at issues related to: addiction prevention and recovery; comprehensive health ministry (mental health for ministerial families, youth, women and others); enhancing brain health; faith-based and community partnerships for improving mental health; healthcare institutions and innovative approaches to fostering mental health; trauma & resilience… featured speakers include Dr. Viviek Murthy, US Surgeon General (invited); Peter Landless, MD, Health Ministries Director; Daniel R. Jackson, President, North American Division; Lowell Cooper, MPH, Vice President, General Conference; David R. Williams, PhD, Professor, Harvard; Kiti Frier Randall, PhD, Director, Psychological Services Department of Pediatrics, Loma Linda University; Kenneth Pargament, PhD, Department of Psychology, Bowling Green State University." For more info, go to: http://www.emotionalwellnesssummit.com/.

1st International Congress on Religious/Spiritual Counseling and Care (Istanbul, Turkey, April 7-10, 2016)

As described by the Conference organizers: "This international congress on religious-spiritual counselling-care aims to put forward the positive aspects of religious, spiritual and moral values and evaluate their contributions to as well as to raise awareness of the services they have offered and are still providing to civil society at individual, institutional and societal levels. It intends particularly to focus on, highlight and examine how religious and spiritual-moral values have played/still play a significant role and function in reforming inmates in prisons, being a source of hope and morale for patients in hospitals, providing morale and offering communal spirit and atmosphere for lonely and elderly people in social services, motivating national/civic and patriotic values, and beliefs for military personnel in army, and in relationships and communication in family therapy. The congress will also seek to address and analyze problems encountered with and policies applied for while offering and providing services in areas in question. Again such a gathering will bring scholars and professionals together who do research on and work in Religious-Spiritual counselling and care in different traditions, religions and political cultures throughout the world as well as to share and exchange their experiences and forge cooperation in shared and common interest areas. Finally, the gathering and cooperation provide an opportunity for official and conventional religious and civil authorities how to improve and enhance their services and programs in their respective and responsible institutions." This is an important meeting in a part of the world where religious dialogue in the health arena cannot be emphasized enough. Istanbul (formerly Constantinople) is also an incredibly beautiful city. Deadline for abstract submissions is December 1, 2015. See website: http://mdrk.org/en.

4th International Conference of the British Association for the Study of Spirituality (BASS)

(Manchester, UK, May 23-26, 2016)
The theme of the 2016 conference is: "Can spirituality transform our world? New frontiers in understanding and exploring contemporary spiritualities." As described by the conference conveners: "Three day conference bringing together researchers and scholars from a range of academic disciplines and the creative arts with policy-makers and practitioners from the caring professions, education sector and business communities, to consider the state of play in spirituality studies as well as the dynamic relationship between spirituality and contemporary society." Keynote speakers include Prof. Emeritus David Aldridge (Nordoff/Robbins Zentrum, Witten, Germany), Dr Fiona Gardner (La Trobe University, Melbourne, Australia), Prof. Mel Gray

(University of Newcastle, New South Wales, Australia), Prof. Graham Harvey (Open University, Milton Keynes, UK), Dr Mike King (freelance scholar), and Prof. Philip J. Larkin (University College Dublin, Dublin, Ireland). The conference will be held at the Chancellors Hotel and Conference Centre, Manchester, UK (www.chancellorshotel.co.uk). For further information and bookings visit: www.basspirituality.org.uk. For any enquiries, contact Prof. Emeritus Margaret Holloway (m.l.holloway@hull.ac.uk).

2nd International Conference in Spirituality in Healthcare (Dublin, Ireland, June 23, 2016)

The School of Nursing and Midwifery at Trinity College (University of Dublin) is planning it's second international conference. Keynote speakers will be Jean Watosn (Founder of Watson Caring Science Institute) and Katherine Piderman, Ph.D., department of chaplain services, Mayo Clinic, Rochester, Minnesota. This is an interdisciplinary conference. For more information, contact Professor Fiona Timmins (timminsf@tcd.ie).

10th North American Conference on Spirituality and Social Work (Vancouver, British Columbia, June 23-25, 2016)

As described by conference organizers, "This international conference will bring together academics, practitioners, and students to discuss and explore the theme of *spirituality and well-being* and the corresponding relevance for professional practice, teaching and research. Within this overall theme presentations and workshops are invited on related topics and issues such as spirituality and its relevance for end of life care, the place of spirituality in family and personal health, social justice, and community well-being, and diverse expressions of spirituality. This international conference provides an exciting opportunity for an exchange of scholarship and knowledge between Canadian and international participants from social work and various disciplines. The conference will stimulate dialogue and the sharing of resources on spirituality in research, professional practice, education, and social action." Abstract submissions are invited for academic papers, experiential workshops and panel presentations. Abstracts must be tied to one of the conference themes. Proposals from students and practitioners are welcome. Proposals should be submitted to spirit2016@unbc.ca by December 15, 2015. Information on Pre-Conference Workshops, Registration and Accommodation will be published in December 2015. For more information, go to website: http://www.spiritualityandsocialwork.ca/.

RESOURCES

CME/CE Videos (CSTH, July 2015)

Due to the generous support of the Templeton Foundation and Adventist Health System, 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" medical care that includes the identifying and addressing of spiritual needs. No other resource like this currently exists. Go to: http://www.spiritualityandhealth.duke.edu/index.php/cme-videos.

Tools from Psychiatry for the Journey of Faith

(Camden House, 2015)

From the author: Just as science can be misused to deal with matters for which it has no expertise or authority, so psychiatry and psychology miss the mark when they present themselves as competent to address questions that belong to the realm of faith. Science as well as psychiatry and psychology, however, are extremely useful when their theories and techniques are applied within the framework of a Biblically-based world view. In "Tools from Psychiatry for the Journey of Faith," Irving S. Wiesner, M.D., a committed Jewish Christian as well as a practicing psychiatrist for over 40 yrs, demonstrates how to examine the underlying motives and roots of our thinking, emotions and behaviors. We bring our past experiences, both good and bad, into our present day relationships as singles, in our marriages and families and in the church. Available soon from: https://getmynewbook.com/ or https://www.camden-house.com/default_camden.asp.

Health and Well-being in Islamic Societies

(Springer International, 2014)

What exactly do Muslims believe? What is contained in and emphasized in the Qur'an? How do these teachings line up with Christian beliefs? While differences and similarities between Christian and Muslim beliefs and practices are examined, the core of the book focuses on research exploring religiosity and health in Muslim populations, comparing the health of Muslims with that of other religious groups. Available for $53.22 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. Chapters target physicians, nurses, chaplains and pastoral counselors, mental health professionals, social workers, and OT/PT. Available for $21.23 (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. Spirituality and health researchers, educators, health professionals, and religious professionals will find this resource invaluable. Available for $132.51 (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 Summer Research Workshop on Spirituality and Health (see above), and is packed full of information helpful in performing and publishing research on this topic. Available for $38.20 (used) at: http://www.amazon.com/Spirituality-Health-Research-Measurements-Statistics/dp/1599473496/

EDUCATION

Chaplain Research Training Program

The "Transforming Chaplaincy: Promoting Research Literacy for Improved Patient Outcomes" project will better equip hospital chaplains to use research to guide, evaluate and advocate for the spiritual care they provide. The project seeks to close the gap between hospital chaplains' current limited research literacy and the importance of evidence-based care for all members of the health care team. The project is co-led by George Fitchett and Wendy Cadge. The project's key training opportunities will include a fellowship program that will pay for 16 board-certified chaplains to complete a two-year, research-focused Master of Science or Master of Public Health degree in epidemiology, biostatistics or

public health at an accredited school of public health. In addition, curriculum development grants will be awarded to 70 ACPE-accredited clinical pastoral education (CPE) residency programs to support incorporation of research literacy education in their curricula. Finally, with the support of the professional chaplaincy and pastoral education organizations (APC, ACPE, NACC, AJC) an online continuing education course, "Religion, Spirituality and Health: An Introduction to Research," will be made available at no cost to members of these organizations. Further information is available at the project website www.researchliteratechaplaincy.org.

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry (OFI)

The next submission of OFI is anticipated to be in February 2016. 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: http://www.templeton.org/what-we-fund/our-grantmaking-process.

PLEASE Partner with us to help the work to continue…

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

2015-2016 CSTH CALENDAR OF EVENTS…

December

6 Integration of Spirituality into Healthcare
Sao Paulo Adventist University
Sao Paulo, Brazil
Speaker: Harold G. Koenig (via Skype)
Contact: Gina Abdala (gina.abdala@usp.br)

8-11 Spirituality and Health Session
Cuban Society of Clinical Neurophysiology
Havana, Cuba
Speakers: Robert Hesse (onsite), Pargament, Koenig and others (via Skype)
Contact: Robert Hess (rjhe@att.net)

16 Moral injury in Veterans with PTSD
Speaker: Joseph M. Currier, PhD
Assistant Professor and Director of Clinical Training
Department of Psychology, University of Alabama (Mobile)
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

20 Religion, Spirituality and Medicine
Coptic Medical Association of North America Annual Student Chapter Conference, Newark, NJ
Speaker: Koenig and others
Contact: Melanie Masoud (melanie.masoud@dm.duke.edu)

January

14 Religion, Spirituality and Mental Health
Emotional Health Summit, Orlando, Florida
Speaker: Pargament (onsite), Koenig (via Skype) and others
Contact: Dr. Katia Reinert (KatiaReinert@nadadventist.org)

27 Hindu Chaplain and Executive Coach
Speaker: Madhu Sharma
Madhu Sharma
Hindu chaplain, Duke University
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)