# 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, or events in this area.

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

## LATEST RESEARCH OUTSIDE DUKE

### Changes in American Adolescent Religious Orientation 1966-2014

Researchers at San Diego State University and Case Western Reserve analyzed data from four nationally representative surveys involving 11.2 million adolescents and young adults to examine changes in religious involvement from 1966 to 2014. **Results**: Twice as many 12th graders in 2010-13 indicated never attending religious services compared to 1976-79 (21% vs. 10%). There was also a drop at the other end in terms of high religious attendance (once/week or more) among 12th graders from 40% in 1975-1979 to 30% in 2010-14. Most of that decline occurred between 1975-79 and 1985-89 (40% to 33%). In addition, twice as many 12th graders reported "none" for religious affiliation in 2010-14 compared to 1975-79 (23% vs. 10%). For college students, 25% indicated "none" for religious affiliation in 2010-14 compared to 9% in 1966-69, with most of the increase occuring between 1995-99 and 2010-14 (14% to 25%). These findings are consistent with a 4-fold increase in mothers of college students reporting "none" for religious affiliation, which increased from 3% in 1970-74 to 12% in 2010-14 (with a smaller proportionate increase from 7% to 17% in fathers). While 0.93% of college students planned to become clergy in 1965-69, this dropped more than half to 0.40% in 2010-14. Researchers indicated that the declines were larger among girls, Whites (little change was seen among Blacks), and those living in the Northeastern U.S. They also indicated that the declines were coexistent with increases in median family incomes, higher materialism, more positive self-views, and lower social support. These changes, investigators said, were due to time-period or generation effects – not due to age.

*Citation*: Twenge JM, Exline JJ, Grubbs JB, Sastry R, Campbell WK (2015). Generational and time period differences in American adolescents' religious orientation, 1966-2014. PLoS One, May 11, E-pub ahead of print (doi: 10.1371/journal.pone.0121454. eCollection 2015)

*Comment*: This report, together with recent surveys by the Pew Foundation (see June newsletter), suggests a true decline in religious involvement among youth and young adults in the U.S. This does not mean, however, that young people have become generally non-religious, since nearly 80% of 12th graders (including 73% of college students) still attend religious services and nearly one-third (30%) attend weekly or more. Furthermore, 75% of college students still indicate a religious affiliation. Thus, while secularization is making inroads among the youth (partly, perhaps, because of effects on the parents of the youth), an absolute increase of only 14% in college students claiming "none" for religious affiliation from 1966 to 2014 is not a huge change. According to this study, though, these changes correspond to an increase in average income, emphasis on materialism, and increase in independence. It will be interesting to see whether young adults shift back towards religion as they grow older, experience changes in income, and become less independent as health problems mount with increasing years.

### Religiosity of American vs. Kuwaiti College Students

Investigators at the University of Alexandria (Egypt) and Stockton University (New Jersey) administered a single religiosity question to college students at Kuwait University (presumably Muslim, although not specified) and to students at Stockton University (presumably Christian, although not specified), comparing the results. The question was: "What is your level of religiosity in general?" with response options ranging from 0 to 10. **Results**: Average ages of Kuwait and American students were 20.8 and 21.8 years, respectively; gender was 82% women in both samples. Kuwaiti students scored 43% higher than American students on religiosity (6.47, SD=1.78, vs. 4.51, SD=2.53, $t=7.86$, $p<0.0001$). Researchers concluded that "Religion may play a stronger role for Kuwaiti undergraduate students than for American undergraduate students."

*Citation*: Abdel-Khalek AM, Lester D (2015). Self-reported religiosity in Kuwaiti and American college students. Psychological Reports 116 (3): 1-4

*Comment*: Although not terribly surprising, especially given the study just before this one on the exit of U.S. young adults from the church, this suggests that religion (Islam) may be continuing to thrive among the youth in the Middle East, while religion (Christianity) declines among American youth. A more concentrated investment by churches and parents in the U.S. on the spiritual lives of young people may be necessary to stop or slow down the current bleed (due to secular cultural forces intensely affecting youth at every level).

### Predictors of Chinese Christians' Religious Involvement in China

Researchers at the University of Hong Kong and several other academic institutions in China conducted a 3-wave prospective survey of Christians via the Internet to examine psychological predictors of religious attendance, cessation of religious attendance, and leaving the Christian faith altogether. Participants were recruited through mass e-mails sent to universities and community colleges in Hong Kong and Macao, e-mails and public announcements at churches in Hong Kong, by Internet advertising, and by snowballing. A total of 8,233

individuals completed the questionnaire in the first wave; after exclusions and removal of those with incomplete data, the Wave I sample consisted of 2,331 who were Christian (83% from 320 churches located in Hong Kong, Macao, the rest of China, and other parts of the world). Of those, 1,264 completed the Wave II survey 4 months later and 932 completed the Wave III survey 8 months later (12 months after Wave I). Thus, a total of 932 Chinese Christians completed all three waves of the online survey (92% from Hong Kong). Church attending Christians at Wave I were those who answered affirmatively to the question: "Did you in the past 4 weeks attend church?" If the response was negative to this question at Wave II, Wave III, or both (following a positive response at Wave I), participants were categorized as having exited or being unstable in church attendance. In addition, participants who self-identified as Christians at all three waves were categorized as "religiously steadfast," whereas those who indicated Christian at Wave I but not at Wave II, Wave III, or both were categorized as having exited the faith (or not steadfast). Demographic, socioeconomic, and other religious characteristics were also assessed. The 50-item Big Five NEO personality inventory was used to measure psychological characteristics (extroversion, conscientiousness, agreeableness, openness to experience). The 57-item Schwartz Value Survey assessed 10 values of importance to respondents. **Results**: Characteristics of the 932 respondents were 70% female, 40% full-time students, 48% less than 20,000 HK$ (2,600 US$) household income, 80% were unmarried, and mean age was 29.4 years; 62% were baptized, average length of conversion was 10.6 years, and 77.5% were church attendees at all three waves (i.e., stable in church attendance). Hierarchical logistic regression analyses indicated that those who *stopped* or were *unstable* in church attendance were not baptized at Wave I and attended churches that were smaller in size. With regard to personality characteristics, after controlling for other predictors, those who stopped/unstable were less likely to be extroverted, less likely to be conscientious, and more likely to be open to experiences (i.e., more intellectual). In addition, those exiting the church were more likely to be hedonistic (pleasure seeking) and power-oriented (preferring status and domination of others). Participants who were more likely to exit the Christian faith were those who were full-time students (vs. non-students), those who did not attend church services at Wave I, were less extroverted, and more likely to be self-directed, stimulation seeking, and power oriented. Researchers concluded that the findings demonstrated "temporal precedence of certain personality and value constructs over church attendance and steadfastness in faith."
*Citation*: Hui CH, Lau EYY, Lam J, Cheung SF, Lau WWF (2015). Psychological predictors of Chinese Christians' church attendance and religious steadfastness: A three-wave prospective dtudy. Psychology of Religion and Spirituality, April 27, E-pub ahead of print
*Comment*: A fascinating study of young adult Chinese Christians in China, a group about which little is known based on systematic research, particularly with regard to stability in religious activity and consistency in self-identification as Christian.

## Religious Involvment and Suicide in Trinidad and Tobago Youth

Researchers at Luther College, Loma Linda University, Harvard, and Alabama State University analyzed data from the Trend Research Empowering National Development study of 4,448 adolescent and young adults in Trinidad and Tobago (Caribbean islands with the highest suicide rates of the entire Caribbean, higher even than the U.S.). The aim was to examine relationships between religious involvement and suicidal tendencies (past 12-month suicidal ideation, plans for suicide, suicide attempts, and treatment for suicidal tendencies). Religious involvement was assessed by religious affiliation (21% Pentecostal, 20% Hindu, 7.4% Adventist, 7.4% Baptist, 4% none), self-perceived religiousness, religious attendance, frequency of prayer, and frequency of reading religious books, listening to rleigious music, and watching religious programs on TV. Control variables were race, sex, education, and parental education. **Results**: Nearly one-quarter of these adolescents and young adults (23%) had suicidal ideation and 20% had actually planned suicide in the past year. Controlling for demographics and other measures of religious involvement, there was a tendency ($p<0.10$) for Methodists and Seventh-Day Adventist (SDA) youth to have less suicidal ideation and less planned suicide (SDA youth especially). Overall, self-rated religiosity was related to less suicide ideation (OR=0.86, $p<0.01$) and less planned suicide (OR=0.78, $p<0.001$). Likewise, frequency of religious attendance was related to less suicide ideation (OR=0.94, $p<0.05$) and fewer suicide attempts ($p<0.01$). Finally, frequency of prayer was related to less suicide ideation (OR=0.92, $p<0.01$) and less planned suicide (OR=0.90, $p<0.001$). Researchers concluded that "Religiousness may offer benefits for adolescents and young adults in Trinidad and Tobago by reducing the likelihood that they engage in suicide thoughts and behaviors."
*Citation*: Toussaint L, Wilson CM, Wilson LC, Williams DR (2015). Religiousness and suicide in a nationally representative sample of Trinidad and Tobago adolescents and young adults. Social Psychiatry and Psychiatric Epidemiology, E-PUB ahead of press
*Comment*: As in much previous research, investigators found that religious involvement was cross-sectionally related to lower rates of suicide ideation and suicide plans, and for religious attendance, fewer suicide attempts. These findings are important given the high rates of suicide in this part of the world among the youth. What is unclear is how changing religious involvement due to secularization will influence suicide rates in the future. As the authors acknowledge, the results have implications for counselors, clergy, teachers and others working with adolescents and young adults in the Caribbean.

## Religion and Mental Health Service Use by African American Youth

Investigators at Washington University in St. Louis analyzed data from the National Survey of American Life that captured data on African-American youth ages 18 to 29 (N=806). They examined "evaluated need" for mental health services determined by the presence of a DSM-IV diagnosis of mood disorder, anxiety disorder, substance use disorder, or impulse control disorder (47% had an evaluated need). Mental health services use was assessed across the individual's lifetime (25% had seen a mental health professional or medical professional for a mental disorder). Also assessed was the use of a religious or spiritual advisor like a minister, priest, or rabbi to talk about their problems. **Results**: The findings indicated that females, individuals with an "evaluated need" for services, and those who had received religious/spiritual support were more likely to have used mental health services.
*Citation*: Williams SL, Cabrera-Nguyen EP (2015). Impact of lifetime evaluated need on mental health service use among African-American emerging adults. Cultural Diversity & Ethnic Minority Psychology, April 6, E-pub ahead of print
*Comment*: There has been much concern that those who are more religious are less likely to seek care from mental health professionals. The results here, however, suggest that among African-American youth, such concerns are unfounded. Young Black adults who receive counseling from a religious or spiritual advisor are even more likely to seek mental health services. Seeing a minister, priest or rabbi probably increases the likelihood of referral and contact with a mental health professional.

## Religiosity and HIV Risk Behaviors among Black Women

Researchers at the University of North Carolina at Chapel Hill and several other universities analyzed data from a cross-sectional survey of 1,013 Black women from four rural counties in the Southeastern U.S., examining the relationship between religiosity and the women's sexual behaviors and perceptions of their partners' HIV infection risk characteristics. Participants were (a) self-identified as African-American, ages 18-59, (b) reported intercourse with a man within the past 12 months, (c) were not previously diagnosed as HIV-infected, and (d) were from two rural counties in northeastern Alabama and eastern North Carolina (counties known to have the highest rates of HIV infection among Black women). Religious practices were assessed by frequency of religious attendance ("organizational" religiosity), frequency of prayer, reading religious books, and viewing or listening to religious TV/radio ("non-organizational" religiosity). Religiosity/spirituality was assessed by two questions asking about (1) spiritual beliefs as the basis for the woman's approach to life and (2) having a personal relationship with God. High risk sexual behaviors for female participants were: having 8+ lifetime sex partners, more than 1 sex partner in past year, concurrency of sex partners in past 12 months, no condoms with 2+ partners; high risk HIV infection behaviors for the woman's partner were: partner concurrency with another partner, partner incarceration, partner with a sexually transmitted disease (STD) in past 12 months, and partner's use of drugs. **Results**: The average age of women in the sample was 33, income was $1000-2000/mo, and 56% were single/never married. In multivariate analyses, high private or non-organizational religious activity was associated with fewer lifetime partners, a lower likelihood of having more than one sex partner in past year, concurrent sexual partners in past year, or a partner with an STD, but a greater likelihood of having a partner who used drugs. High religious attendance was associated with a lower likelihood of having more than one sex partner in past year, concurrency of partners in past year, and a partner with concurrent relationships. Higher spirituality was associated with a lower likelihood of having more than one partner in past year and concurrent partners in past year. Investigators concluded: "As we hypothesized, high organizational religiosity, high non-organizational religiosity, and high spirituality were associated in adjusted models with having fewer risky personal sexual behaviors in the past 12 months…Non-organizational religious activity [private religious activity] was most strongly protectively associated with participants' own risk characteristics…" Fewer relationships were found between religiosity/spirituality and high risk *partner* characteristics, although there was definitely a relationship with private religious activities.

*Citation*: Ludema C, Doherty IA, White BL, Simpson CA, Villar-Loubet O, McLellan-Lemal E, O'Daniels CM, Adimora AA (2015). Religiosity, spirituality, and HIV risk behaviors among African American women from four rural counties in the southeastern U.S. Journal of Health Care for the Poor and Underserved 26(1):168-181.

*Comment*: Religious involvement – especially private religious activity, perhaps the best indicator of internalized religiosity – was associated with less personal and partner sexual behaviors that increase the risk of HIV transmission. Religious involvement, then, could make a real difference in the level of risk that Black women in the Southeast U.S. have of contracting HIV infection.

## Religious Commitment and Well-Being in African American Adults

Investigators at several universities in Kentucky, Texas, Virginia, Georgia, and Michigan surveyed a convenience sample of 199 African Americans ages 18 to 64 (average age 27.8 years, 67% women, and average income $47,000 per year. Three-quarters of the sample were Christian, but the study also included agnostic, atheist, Buddhist, Muslim, and Hindu participants, as well as members of other religious groups. Religious commitment was measured using the 10-item Religious Commitment Inventory (Worthington). Racial/ethnic identity was assessed by the 12-item Multi-group Ethnic Identity Measure, satisfaction with life by Diener's 5-item SWLS, and meaning in life by the 10-item Meaning in Life Scale (Steger). **Results**: In bivariate analyses, religious commitment was strongly and positively related to racial/ethnic identity (i.e., having a clear sense of one's ethnic background and what it means) ($r=0.35$, $p<0.01$), satisfaction with life ($r=0.31$, $p<0.01$), and meaning in life ($r=0.42$, $p<0.01$). In multivariate analyses controlling for gender, age, and economic factors, religious commitment completely mediated the positive effects of that racial/ethnic identity appeared to have on satisfaction with life and partially mediated the effects of racial/ethnic identity on meaning in life.

*Citation*: Ajibade A, Hook JN, Utsey SO, Davis DE, Van Tongeren DR (2015). Racial/ethnic identity, religious commitment, and well-being in African Americans. Journal of Black Psychology, E-pub ahead of print

*Comment*: Although the findings of this small, cross-sectional study involving a convenience sample of self-selected participants are not unexpected or earth-shaking, the way that religious involvement mediated the relationship between having a strong sense of ethnic identity and two measures of psychological well-being is impressive and worth reporting.

## Religiosity/Spirituality and Treatment Response in Depressed Korean Outpatients

Investigators in the department of psychiatry at the Catholic University of Korea examined the effects of baseline religiosity/spirituality on the *course of depression* in 232 outpatients during a 6-month treatment period. Participants were consecutively seen patients ages 18-65 visiting the Mood and Anxiety Disorder Unit at Seoul's St. Mary's Hospital between July 2012 and August 2013. All participants met DSM-IV diagnostic criteria using the MINI Neuropsychiatric Interview for depressive disorder. Excluded were those with a lifetime diagnosis of psychotic disorder, bipolar disorder, mental retardation, or mental disorder associated with a general medical condition. Baseline religious measures were denomination, frequency of religious attendance, and importance of religion in life. Spirituality was assessed using a Korean version of the 12-item FACIT-Sp. Depression outcome was measured using the Clinical Global Impression Severity (CGI-S) scale and the Clinical Global Impressions Improvement (CGI-I) scale. Depressive symptoms were also assessed with the Beck Depression Inventory (BDI); anxiety symptoms by the State-Trait Anxiety Inventory; alcohol use by the Alcohol Use Disorder Identification Test (AUDIT); and purpose in life by the 10-item PIL scale (Crumbaugh). Demographic factors assessed included age, education, gender, marital status, and employment status. **Results**: Mean age of participants was 47 years and 57% were female; nearly 70% of participants had major depresssive disorder at baseline. The overall response rate based on the CGI-I (i.e., very much improved or much improved) was 44.8% at the final visit. Bivariate analyses indicated that treatment response was positively associated with higher personal importance of religion ($p=0.005$) and higher spirituality (FACIT-Sp) ($p=0.024$). Multivariate regression models that controlled for treatment duration, baseline symptom severity on the BDI, and marital status (variables significantly associated with treatment outcome in bivariate analyses) revealed that both high personal importance of religion and high spirituality were significantly and positively predictive of treatment response (OR=1.92, 95% CI 1.07-3.44, and OR=2.26, 95% CI 1.22-4.18, respectively).

*Citation*: Kim NY, Hugh KJ, Chae JH (2015). Effects of religiosity and spirituality on the treatment response in patients with depressive disorders. Comprehensive Psychiatry 60:26-34
*Comment*: Studies examining the effects of religious involvement on treatment response are critically needed, especially in non-Western populations and especially for depression (given its high prevalence and association with disability). The only weakness of this study was the assessment of spirituality using the FACIT-Sp, which is basically a measure of positive mental health (i.e., having high meaning and purpose in life). Finding that those with high meaning and purpose in life recover more quickly than those without meaning or purpose is not that surprising. While personal importance of religion in life was a predictor of treatment response, frequency of religious attendance in this study was not.

## Religious Involvement and Mental Disorders in Mainland China

Researchers in the School of Public Health at Ningxia Medical University in Yinchuan, China, and Duke University analyzed data from a representative sample of 2,770 community-dwelling adults in the province of Ningxia located in western China. The purpose was to examine the relationship between religious involvement and prevalence of mental disorders. Mental disorders were diagnosed using the WHO's Composite International Diagnostic Interview (CIDI). Note that while religious involvement is relatively infrequent in most of China, this region of western China (near Mongolia) is made up of about one-third Muslim residents (primarily among those of Hui ethnicity). Religious involvement was measured here using single items assessing religious attendance and importance of religion in daily life; participants were also categorized as high vs. low on religiosity based on their responses to these two questions. Demographic characteristics controlled for in the analyses were age, gender, education, marital status, rural vs. urban residence, ethnicity, migration experience, and economic development of geographical region of residence. Overall physical health status and presence of diabetes, hypertension, and physical pain were also assessed and controlled for. **Results**: Religious affiliation of participants was 8.9% Buddhist/Taoist, 39.8% Muslim, 2.0% Christian/Catholic, and 49.3% no affiliation. Approximately one in five participants (22.0%) was diagnosed with a mental disorder using the CIDI (a mood disorder, anxiety disorder, or alcohol use disorder). Participants with less education, female gender, from economically developing regions, migrants from other areas of China, living in rural settings, or overall poor health were more likely to have a mental disorder. Bivariate analyses indicated that those with a religious affiliation (vs. none), those who frequently participated in religious services (vs. infrequent), those for whom religion was very important (vs. not important), and those with high overall religiosity (vs. low) were *more likely* to have a mood disorder ($p<0.001$) or an anxiety disorder ($p<0.001$); alcohol use disorder, in contrast, was nearly 4 times more frequent in those for whom religion was not very important (OR=3.84, $p<0.05$). Multivariate analyses indicated that after controlling for demographic characteristics and physical health, those with a religious affiliation were 40% more likely to have a mental disorder (OR=1.4, 95% CI 1.0-1.8, $p<0.05$), especially an anxiety disorder (OR=1.6, 95% CI 1.2-2.2, $p<0.01$). Degree of religiosity (as opposed to simple affiliation), in contrast, was unrelated to mental disorder after controlling for demographic and physical health characteristics. Stratifying analyses by ethnicity and age revealed that the positive relationship between religious affiliation and mental disorder was found only in those of Han ethnicity (i.e., non-Muslims), and only in those of Han ethnicity who were younger (less than 50 years of age). When analyses in participants of Hui ethnicity (Muslims) were stratified by age, religious affiliation was associated with greater mental disorder only in those who were older (> age 50). Investigators concluded that "In contrast to most previous studies in Western populations, religious involvement is less likely to be inversely related to mental disorder in mainland China although this association varies by age and ethnic group."
*Citation*: Wang Z, Koenig HG, Zhang Y, Ma W, Huang Y (2015). Religious involvement and mental disorders in Mainland China. PLOS One, June 1, E-pub ahead of print (DOI:10.1371/journal.pone.0128800)
*Comment*: This is one of the first studies to examine the relationship between religious involvement and mental disorder using a structured psychiatric interview in a random sample of community dwelling adults in mainland China. Of course, the unique ethnic characteristics of the sample may have influenced the findings, limiting generalization of these findings to the rest of China.

## Physician Communications with Patients about Religion/Spirituality

In this study, researchers in the department of family medicine at the Uniformed Services University of the Health Sciences and other U.S. universities explored the differences in physician communication in response to "patient inquiry" vs. "patient disclosure." A total of 27 faculty and resident family physicians from a community hospital were presented with a structured clinical examination with a standardized patient. The primary outcome was the *physician's response* in terms of (1) displaying physician control (physician asserts communicative control), (2) partnership-building with patient (physician assesses patient input for decision-making and partners with him/her), (3) and supportive messages (physician expresses positive emotional support to patient). Physicians were assigned (alternate clustered assignment) to one of two conditions: (1) a standardized patient who *disclosed their own* religion/spirituality to the physician (i.e., "I guess I am sort of frightened, but then I tell myself you know that I am a woman of faith") (n=13), or (2) a standardized patient who inquired about what the *physician thought* about how God or religion might (i.e., "I'm just wondering, do you think that God could help heal me?") (n=14). Physicians were blinded to the religion/spiritual topic and the respective condition. Coders determined which category of response the physician gave; agreement between coders on classification was high (alpha > 0.90). **Results**: Physicians were from a variety of religious faiths including 22.2% agnostic or atheist, 29.6% Catholic, and 37% Protestant. Results indicated that *physician control* messages were more likely to occur when the patient "inquired" about the physician's opinion regarding religion/spirituality ($p<0.01$), whereas *physician support* messages were significantly more likely in the "disclosure" condition ($p<0.05$). Researchers concluded that "Training physicians to anticipate and respond to patient disclosure and inquiry [regarding religion/spirituality] will increase the likelihood they can enact patient-centered strategies."
*Citation*: Ledford CJ, Canzona MR, Seehusen DA, Cafferty LA, Schmidt ME, Huang JC, Villagran MM (2015). Differences in physician communication when patients ask versus tell about religion/spirituality: a pilot study. Family Medicine 47 (2) 138-142
*Comment*: Interesting how physicians showed resistance when patients asked them anything concerning their opinion about religion/spirituality and then sought to gain control over the situation (likely due to anxiety over the topic or uncertainty on how to respond). When patients revealed their own spirituality without asking the physician's opinion, physicians were less likely to control the interaction and were more likely to be supportive. Although there are issues with regard to the methodology of this study (i.e., including inexperienced residents, small sample size, nonrandom assignment, unclear categories distinguishing inquiry from disclosure), the results make sense. Physician responses involving control are probably even more likely if the patient asks the physician about the physician's own religious or spiritual beliefs

(which is a common fear that prevents physicians from taking a spiritual history).

### Spiritual Needs of American Indians

Social work researcher David R. Hodge from Arizona State University and Robert J Woloson from the Press Ganey Survey Corporation examined data from a national sample of 1,281 American Indians to determine predictors of satisfaction with the way spiritual needs were met during hospitalization. They point out that since the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) requires spiritual assessments to determine and address patients' spiritual needs during hospitalization, it is important to determine the extent to which the unique spiritual needs of American Indians are being addressed satisfactorily. **Results**: Although details are lacking, given that only the abstract was available for review, important factors affecting satisfaction are: the discharge process, physician care, room quality, and nursing care are important factors in the addressing American Indian spiritual needs. Given the important role of the discharge process, authors point out that there is an opportunity and need for social workers to address the spiritual needs of these patients.
*Citation*: Hodge DR, Wolosin RJ (2015). Addressing the spiritual needs of American Indians: Predictors of satisfaction. Social Work in Healthcare, February 12, E-pub ahead of print
*Comment*: To our knowledge, this is one of the first articles to examine the extent to which spiritual needs of American Indians are being satisfactorily met in hospital settings.

### Integration of Spirituality into Social Work Practice

Researchers at Baylor University and the University of Houson (Texas) conducted a national survey of clinical social workers to determine attitudes and behaviors related to integrating spirituality into clinical practice. Participants were a random national sample of clinical social workers (CSW) identified by the National Social Worker Finder. Of 1000 CSW contacted, 48% responded and 44% (n=442) completed all items on the online survey. Questions on the survey included the 5-item Duke University Religion Index (DUREL), two religious/spiritual (R/S) items from the General Social Survey, the 40-item Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS), and items used in prior studies of practitioners. The RSIPAS consists of four subscales: (1) self-efficacy with regard to integrating clients R/S into practice; (2) attitudes toward integrating clients' R/S into practice; (3) perceived feasibility to engage R/S in practice; and (4) actual behaviors reflecting the integration of clients' R/S into practice. **Results**: Mean age of respondents was 57 years; 87% were white; average length of experience in clinical practice was 23 years; and 20% were Protestant, 13% Catholic, 22% Jewish, 6% Buddhist, and 20% none. Positive attitudes toward integrating spirituality into practice were common; self-efficacy in terms of actually doing so was high; and the majority indicated that integrating spirituality into social work was possible (53% said that they had been adequately trained to integrate R/S into therapy). Behaviors, on the other hand, that involved actually integrating spirituality into routine social work with patients were infrequent (only 11% often or very often sought out consultation on how to address clients' R/S issues in treatment). Only two factors predicted scores on the RSIPAS (attitudes, self-efficacy, feasibility, behaviors): the intrinsic religiosity of the participant (B=2.38, t value 10.8, p<0.001) and prior training on how to integrate spirituality into clinical practice (B=12.93 t=7.83, p<0.001).
*Citation*: Oxhandler HK, Parrish DE, Torres LR, Achenbaum WA (2015). The integration of clients' religion and spirituality in social work practice: A national survey. Social Work, May 5, E-pub ahead of print
*Comment*: While most social workers have positive attitudes toward integrating spirituality into clinical practice and believe they can do so, they are not now regularly addressing clients' religious or spiritual needs as part of clinical practice. As suggested by the authors (and the findings), inclusion of this topic as part of the routine training of social workers will be necessary to change behavior in this regard.

## SPECIAL EVENTS

### Emerging Tools for Innovative Providers 2015: Spiritual Transformation Impact & Outcomes

(Pasadena, California, July 27-31, 2015)
**LAST CHANCE** to register for this 5-day seminar at *Fuller Theological Seminary* (about 25 minutes from Hollywood) has become the premier event in the U.S. that focuses on integrating spirituality into patient care. During the seminar, participants from different backgrounds develop both a broad vision of the role that spirituality plays as a health or mental health determinant and also specific applications that they can implement into their own practice, discipline, and workplace. To achieve this goal, teams will form on Monday, continue to work in mentored settings at designated times throughout the week, and then report back their accomplishments on Friday. Explore how the significant accumulation of spirituality and health research over the last 25+ years translates into useful applications for healthcare and other human services providers. Participants will work with leaders in the field to integrate findings from spirituality and health research into clinical practice, including medical practice, psychology, sociology, and education. Faculty this year include Stephen Post, Alexis Abernethy, Sheryl Tyson, Lee Berk, Douglas Nies, Bruce Nelson, Steven Cole, Robert Emmons, Peter Hill, and Harold Koenig. For more information, go to website: http://emergingtoolsforinnovativeproviders.com.

### 12th Annual Duke Spirituality & Health Research Workshop (Durham, NC) (Aug 10-14, 2015)

**There are still a few spots left** in our 2015 summer research workshop on spirituality & health. The workshop is designed for those interested in conducting research in this area or learning more about the research that is now being done. Those with any level of training or exposure to the topic will benefit from this workshop, from laypersons to graduate students to seasoned researchers and professors at leading academic institutions. Over 700 persons from all over the world have attended this workshop since 2004. Individual mentorship is being provided to those who need help with their research or desire career guidance (early registration required to assure mentorship). Partial **tuition scholarships** are available for those with strong academic potential and serious financial hardships. For more info, see website: http://www.spiritualityhealthworkshops.org/.

## RESOURCES

### New CME/CE Videos

Five professionally produced 45-minute videos on **why and how** to "integrate spirituality into patient care" are now available for viewing on our website (*for free*, unless CME/CE is desired) due to the genereous support of the Templeton Foundation and Adventist Health System. These videos are specifically targeted at physicians, nurses, chaplains, and social workers to help them form spiritual care teams that will enable them 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.

### Health and Well-being in Islamic Societies

(Springer International, 2014)

As ISIS marches across the Middle East, conducting ethnic cleansing, beheading Westerners, and rewarding their soldiers with women they've captured along the way –justifying these activities by pointing to the Qur'an – what exactly do Muslims believe? What is contained in and emphasized in the Qur'an? In this volume, Muslim beliefs and practices based on the Qu'ran and Hadith are outlined in detail, as are health-related Islamic practices and moral standards. Differences and similarities between Christian and Muslim beliefs and practices are examined. Much of this information will be a real eye-opener to readers. The core of the book, though, focuses on research on religiosity and health in Muslim populations and compares the health of Muslims with that of other religious groups. Available for $53.15 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 by identifying and addressing the spiritual needs of patients. Chapters are targeted to the needs of physicians, nurses, chaplains and pastoral counselors, mental health professionals, social workers, and occupational and physical therapists. 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/

## FUNDING OPPORTUNITIES

### Templeton Foundation Online Funding Inquiry (OFI)

It remains unclear whether the Templeton Foundation will accept letters of intent for research on spirituality and health between August 1, 2015 - October 1, 2015, as usual. There are rumors that they will skip that funding cycle due to available funds. Stay tuned for news on this issue. 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.

## 2015 CSTH CALENDAR OF EVENTS…

### July

22 Faith-Based Partnerships in Global Health and Medicine
Speaker: Jeff Levin, Ph.D., M.P.H.
University Professor of Epidemiology and Population Health, and Professor of Medical Humanities, Baylor University
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

27-31 Emerging Tools for Innovative Providers 2015: Spiritual Transformation Impact & Outcomes
Fuller Theological Seminary, Pasadena, California
Speakers: Stephen Post, Alexis Abernethy, Sheryl Tyson, Lee Berk, Douglas Nies, Bruce Nelson, Steven Cole, Robert Emmons, Peter Hill, Harold Koenig
Contact: http://emergingtoolsforinnovativeproviders.com

### August

10-14 Spirituality and Health Research Workshop
Speakers: Blazer, Oliver, Kinghorn, Carson, Williams, Koenig
Durham, North Carolina (see website for location)
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

26 Religion, Spirituality and Health in the Christian Science Tradition
Speaker: Cynthia Barnett
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)



### PLEASE Partner with Us

http://www.spiritualityandhealth.duke.edu/about/giving.html