CROSSROADS…

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & Health Volume 4 Issue 12 June 2015

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 May 2015) go to: http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads

LATEST RESEARCH FROM DUKE

Therapeutic Alliance: Religious vs. Conventional Psychotherapy

The therapeutic alliance (TA) between therapist and patient is now recognized as one of the most important factors that influences response to treatment in psychotherapy, accounting for more than 50% of the entire treatment effect. Researchers at Duke University and collaborating centers examined the effects of religiously-integrated CBT (RCBT) vs. conventional CBT (CCBT) on therapeutic alliance in persons with major depression and chronic medical illness. They hypothesized that a treatment integrating religious clients' beliefs into therapy would enhance the TA over and above that achieved by CCBT in those who are at least somewhat religious or spiritual. In this multi-center study, 132 participants were randomized to either RCBT or CCBT and effects on TA (measured by the Penn Helping Alliance Questionnaire) were compared throughout the 12-week course of therapy. **Results**: TA scores early in therapy predicted a decline in depressive symptoms over time independent of treatment group (p=0.002). Comparing the two treatments, as hypothesized, there was a marginally significant difference in TA scores at 4 weeks that favored RCBT (p=0.076). However, the mixed effects model that compared trajectories of change in TA throughout the 12 week follow-up indicated a significant group by time interaction that favored the CCBT group (p=0.04, d=0.30). Researchers concluded that while RCBT produces a marginally greater improvement in TA initially compared to CCBT, CCBT soon catches up.

Citation: Koenig HG, Pearce MJ, Nelson B, Shaw SF, Robins CJ, Daher N, Cohen HJ, King MB (2015). Effects of religious vs. standard cognitive behavioral therapy on therapeutic alliance: A randomized clinical trial. Psychotherapy Research, Feb 11 [E-pub ahead of print]

Comment: This was a surprising finding, i.e., that establishment and maintenance of the TA is similar in religious-integrated vs. conventional psychotherapy. However, one of the reasons for this finding we think is that the RCBT intervention manual used here was 30% longer than the conventional CBT manual, meaning that therapists had about one-third more material to cover during their sessions than did therapists providing conventional therapy. This left less time for RCBT therapists to simply listen to patients' concerns and develop the therapeutic relationship.

LATEST RESEARCH OUTSIDE DUKE

Spirituality and Depression Following Birth in African-American Women

Nearly 40% of AA women experience depressive symptoms following childbirth. Researchers from the department of psychology at UCLA analyzed data on 702 low-socioeconomic status African-American (AA) women ages 18 to 40, examining the effect of religiosity/spirituality on trajectories of change in depressive symptoms during the year after childbirth. Participants were primarily from Baltimore (33%), Washington DC (29%), and North Carolina (26%), and a few were from Chicago (6%) and Los Angeles (6%). Participants were on average 25 years old, had 12.7 years of education, and a mean per capita household income of $10,336/year. Women were interviewed in-person in their homes at 2-16 weeks (T1), 6-10 months (T2), and 12-15 months (T3) post-partum. Religion/spirituality was measured at T2 using items from the Fetzer Multidimensional Measurement of Religiousness/Spirituality instrument. Self-rated religiosity and frequency of religious attendance were combined to form a 2-item measure of religiosity. Participants were also asked to what extent they found strength and comfort in religion, felt deep inner peace or harmony, experienced a divine presence in their lives, and considered themselves a spiritual person, items which formed a 4-item measure of spirituality. Depressive symptoms were assessed with the 10-item Edinburgh Postnatal Depression Scale which was administered at T1, T2, and T3, and social support was assessed at T3 with two items measuring availability of emotional support and three items assessing perceived family support. Control variables were age, ethnicity, education, relationship status with baby's father, and income. Growth curve models were used to estimate the effect of spirituality and religiosity on trajectory of change in depressive symptoms. **Results**: Bivariate correlations indicated a significant inverse relationship between T2 and T3 depressive symptoms and T2 religiosity and spirituality. The correlation between T2 depressive symptoms and T2 religiosity was r=-0.09 (p<0.05) and with T2 spirituality was r=-0.20 (p<0.001); for T3 depressive symptoms, it was r=-0.08 (p<0.05) for T2 religiosity and r=-0.15 (p<0.001) for T2 spirituality. With regard to trajectory of change in depressive symptoms over time, there was a significant interaction between spirituality and time (p<0.01) such that changes in depressive symptoms from T1 to T2 differed by level of spirituality; Patricipants scoring 1 standard deviation (SD) below the mean had a significant increase in depressive symptoms from T1 to T2 (B=0.50, p=0.02), whereas those scoring at the mean or 1 SD above the mean had no change in depressive symptoms. With regard to religiosity, there was also a significant interaction between religiosity and time (p=0.02). Participants with religiosity that was 1 SD below the mean had a significant increase in depressive symptoms from T1 to T2 (B=0.59, p=0.01), whereas

those scoring at the mean or 1 SD above the mean had no change in depressive symptoms. Religiosity (T2) was a significant predictor of decrease in depressive symptoms from T1 to T2 postparum (B=-0.20, p<0.05), after controlling for sociodemographic, relationship status, SES, and social support variables in the model. Spirituality (to which religiosity was highly correlated at r=0.57) mediated this relationship. Researchers concluded that "Spirituality and religiosity each independently predicted changes in depressive symptoms, and low levels predicted increases over time …Religiosity and spirituality functioned as significant, interrelated protective factors in this study, which provides novel insight about low income African-American women after childbirth."
Citation: Cheadle ACD, Schetter CD, Lanzi RG, Vance MR, Sahadeo LS, Shalowitz MU, and the Community Child Health Network (2015). Spiritual and religious resources in African American women: Protection from depressive symptoms after childbirth." Clinical Psychological Science 3(2):283-291
Comment: This is an important study, showing an effect of both religiosity and spirituality on depressive symptoms during the first year after childbirth. However, one of the four items measuring spirituality was confounded by an indicator of positive emotions ("I feel deep inner peace and harmony") which likely explained why spirituality mediated the effects of religiosity on depressive symptoms.

Spirituality, Psychosocial Stress, and Metabolic Risk Factors

Researchers from the department of health promotion and development at the University of Pittsburg and department of behavioral sciences at Athens State University (Alabama) examined the moderating role of spirituality in the relationship between psychosocial stress and metabolic risk factors such as BMI, fasting glucose and insulin levels in 406 Afro-Caribbean immigrants to the US Virgin Islands (67% female, 50% single, 43% less than high school education, and mean age 48). Spirituality was assessed using a 15-item subscale of Rogers' Life Attitude Inventory (LAI). This subscale measures feelings and expressions of hope, sense of daily contentment or peace, feelings of connection to others, and connection to a higher power. The spirituality score was dichotomized into those with low (n=109), moderate (n=121), and high spirituality (n=103). A 10-item subscale of the LAI was used to measure psychosocial stress. Fasting glucose and insulin values were used to estimate insulin resistance (HOMA-IR). Also assessed were smoking status and alcohol consumption. **Results**: There was no relationship between spirituality and HOMA-IR or psychosocial stress, although psychosocial stress was positively correlated with HOMA-IR (r=0.13, p<0.05). After controlling for other factors including demographics, smoking, alcohol use, and BMI, psychosocial distress was positively correlated with HOMA-IR (i.e., insulin resistance) (B=0.421, SE=0.173) and waist circumference (B=9.08, SE=2.44), but only in those with low spirituality scores. Researchers concluded that "Spirituality appears to attenuate the association of psychosocial stress to waist circumference and insulin resistance among Afro-Caribbean immigrants in the USVI."
Citation: Tull ES, Doswell WM, Cort MA (2015). Spirituality moderates the relationship of psychosocial stress to metabolic risk factors among Afro-Caribbean immigrants in the US Virgin Islands. Journal of Racial and Ethnic Health Disparities 2:132-138
Comment: The primary weakness of this study is that researchers (again) used a measure of spirituality that was highly contaminated with indicators of positive mental health (hope, peace, social connections). Only the section assessing connection with a higher power was distinctively spiritual in that measure, making it difficult to determine whether it was the positive mental health or the spirituality that actually moderated the association between psychosocial stress and metabolic risk.

Religiosity/Spirituality and Self-Harm in Primary Care Medical Patients

Researchers at Sycamore Primary Care Center in Miamisburg, Ohio, surveyed 306 consecutive primary care outpatients assessing the relationship between religiosity/spirituality (R/S), non-suicidal self-harm behavior, and suicide attempts. Four measures of R/S were used: (1) "To what extent do you consider yourself a religious person?" (2) "To what extent do you consider yourself a spiritual person?" (3) "To what extent is your religion involved in understanding or dealing with stressful situations in any way?" and (4) the 12-item FACIT-Sp. A 22-item Self-Harm Inventory was used to assess past histories of self-harm. The six self-harm behaviors in this study were overdosed, cut self on purpose, burned self on purpose, hit self, banged head on purpose, and scratched self on purpose. Attempted suicide was also asked about. **Results**: 70.6% indicated no self-harm behavior, 11.4% indicated a self-harm behavior other than suicide attempt, and 18.0% reported having attempted suicide at some time in their lives. Participants who considered themselves a religious person were less likely to perform self-harm behaviors or attempt suicide (p<0.01), whereas those who consider themselves a spiritual person were not more or less likely to perform self-harm behaviors or attempt suicide (p<0.60). Extent to which religion was involved in understanding/dealing with stressful situations was associated with a lower likelihood of self-harm behaviors and attempted suicide (p<0.05). Scores on the FACIT-Sp were also inversely related to self-harm behaviors and suicide attempts. No variables were controlled for these analyses. Researchers concluded that "considering oneself a religious person and reporting a general sense of R/S well-being offered the most protective effect to participants."
Citation: Sansone RA, Wiederman MW (2015). Religiosity/spirituality: Relationships with nonsuicidal self-harm behaviors and attempted suicide. International Journal of Social Psychiatry [E-pub ahead of print].
Comment: This is one of the few studies examining religiosity/spirituality and self-harm behaviors in primary care medical outpatients, and so is particularly relevant. Religiosity clearly afforded some protective advantage. Unfortunately, the finding that the FACIT-Sp was inversely related to self-harm behaviors is not particularly surprising. The FACIT-Sp primarily measures meaning and purpose in life, so finding that those with more meaning and purpose in life are less likely to commit self-harm behaviors or attempt suicide, is not all that surprising.

Awareness of God and Attitudes Toward Death in Women with Type II Diabetes in Iran

Investigators in the department of psychology at Islamic Azad University in Sari, Iran, surveyed 100 women with type II diabetes who were being seen as outpatients at Imam Khomeini Hospital (average age 48, more than half with less than a high school diploma, and 55% with yearly incomes of less than $2520). Their purpose was to examine the association between various dimensions of spirituality and death attitudes. Spirituality was assessed using the 47-item Spiritual Assessment Inventory (Hall & Edwards, 2002), which has six subscales divided into (1) awareness of God and (2) relationship with God (realistic acceptance, disappointment, grandiosity, instability, and impression management). The 32-item Death Attitude Profile-Revised (DARP) was used to assess death attitudes. The DARP measures five dimensions: fear of death, death avoidance, neutral acceptance, approach acceptance, and escape acceptance (with 'approach acceptance' considered the most positive attitude). **Results**: The strongest correlate of the 'approach acceptance' attitude toward death was awareness of God (r=0.389), whereas grandiosity and impression management dimensions of relationship with God were also positively correlated with approach

acceptance (r=0.371 and r=0.337, respectively). Having an unstable relationship with God was positively associated with death avoidance and escape avoidance (unhealthy attitudes toward death).
Citation: Nozari M, Khalilian A, Dousti Y (2014). Spiritual development and death attitudes in female patients with type II diabetes. Iranian Journal of Psychiatry and Behavioral Sciences 8 (3): 58-64
Comment: This is one of the first studies to examine how awareness of God and the nature of one's relationship with God relates to attitudes about death in diabetic patients from an Islamic country, which could impact compliance with their medical regimen.

Religious Coping and Caring for Family with Serious Mental Illness

Investigators from the Center for Integrative Medicine at the University of Maryland and other academic institutions examined the role that religious coping plays in the lives of 436 caregivers of a family member with serious mental illness (recruited from the National Alliance for the Mentally Ill [NAMI] in Maryland). Caregivers were 61% parents and 76% women. Religious coping was assessed by the 4-item subscale of the COPE (Carver): (1) "I put my trust in God"; (2) "I seek God"; (3) "I try to find comfort in my religion"; and (4) "I pray more than usual." Caregiver involvement, burden, appraisal of experiences, problem-focused coping, and family functioning were also assessed, along with psychological distress (CES-D, Brief Symptom Inventory) and use of mental health services. **Results**: Not surprisingly, religious coping was more common among women, non-whites, and those with lower incomes. Religious coping was also higher if the caregiver provided more care to the mentally ill family member, if the caregiver lived with the family member, and if the caregiver was the primary family member providing most of the support. Religious coping was positively associated with greater worry, greater objective burden, frequency of hospitalizations of family member in past 5 months, and greater likelihood that the family member was homeless in the past 12 months. However, religious coping was also associated with better personal experiences in the caregiving role, better relationship with mentally ill family member, and other indicators of positive caregiver appraisals of their situation, as well as with positive problem focused coping and emotion focused coping (but was inversely associated with knowledge-based coping). Caregivers who employed more religious coping were less likely to be receiving support from mental health programs/services or be involved in counseling with a private therapist. Researchers concluded that "Caregivers who use more religious coping may have an especially high need for mental health education and mental health services."
Citation: Pearce MJ, Medoff D, Lawrence RE, Dixon L (2015). Religious coping among adults caring for family members with serious mental illness. Community Mental Health Journal, April 21 [E-pub ahead of print]
Comment: Of particular interest here is that religious coping was highest among those who were most involved in the care of the family member, lived with the family member, and cared for a family member who was more severely ill. Despite this, caregivers used less mental health services themselves and were more likely to appraise their caregiving as a positive experience.

Intrinsic Religiosity and Mental Health in Mormon Youth

Investigators at Brigham Young University conducted three studies of three different samples of students ages 17 to 26 (total n=898) at Brigham Young University. The purpose was to examine relationships between religiosity, spirituality and indicators of mental health and positive psychological functioning. In the first study, 247 students were assessed using the 20-item Religious Orientation Scale (ROS, intrinsic-extrinsic), 24-item Christian Orthodoxy Scale, and 20-item Religious Fundamentalism Scale. Anxiety was measured using the 20-item State-Trait Anxiety Inventory; depression by the 21-item Beck Depression Inventory; perfectionism by the 10-item Burns scale; and pride, guilt, etc., by the Test of Self-Conscious Affect. In the second study, 310 students participated and were administered the 160-item Religious Status Inventory, assessing eight dimensions of Christian religiosity, and the Multidimensional Self-Esteem Inventory. In the third study, 341 students were assessed with the ROS, the 15-item Self-Transcendence Scale (Reed), 26-item Eating Attitudes Test (EAT), two meaning in life questionnaires (10-item MIQ and SMILE), and 53-item Brief Symptom Inventory (BSI). **Results**: In the first study, regression analyses indicated significant inverse relationships between depressive symptoms and both intrinsic religiosity ($p<0.01$) and fundamentalism ($p<0.05$), and between anxiety and intrinsic religiosity ($p<0.001$). In the second study, greater religiosity was generally predictive of greater self-esteem, with models explaining between 20% and 33% of the variance in self-esteem. In the third study, intrinsic religiosity was strongly and positively associated with the presence of greater meaning in life ($r=0.53$, $p<0.001$), and was inversely associated with BSI anxiety ($r=-0.19$, $p<0.001$), BSI depression ($r=-0.26$, $p<0.001$), BSI obsessive-compulsive symptoms ($r=-0.13$, $p<0.05$), and total BSI score ($r=-0.22$, $p<0.001$). No association was found with EAT scores. Researchers concluded, "These findings are consistent with many prior studies that have found religiousness and spirituality to be positively associated with better mental health and positive psychosocial functioning in adolescents and young adults."
Citation: Sanders PW, Kawika Allen GE, Fischer L, Richards PS, Morgan DT, Potts RW (2015). Intrinsic religiousness and spirituality as predictors of mental health and positive psychological functioning in the Latter-Day Saint adolescents and young adults. Journal of Religion and Health 54:871-887.
Comment: Religion definitely makes a difference if you are a Mormon young adult.

Core Self-Evaluations, Views of God, and Intrinsic Religiosity

Researchers in the management and leadership departments at La Salle University and Auburn University surveyed 220 adults to examine relationships between core self-evaluations and religious factors. Participants came from a response pool of over 50,000 volunteers at Syracuse University (New York). Inclusion criteria were over age 18, employed for at least one year, and working in the US. Average age was 39 years, 75% were White, 53% women, and 47% were college graduates. Response rate was 83% for those who received the questionnaire. Atheists (n=41) were deleted from the sample because the authors thought that religious constructs were not applicable to atheists. The 12-item Intrinsic/Extrinsic Revised Scale (Gorsuch & McPherson, 1989) was administered along with a 14-item Views of God Scale (with two subscales: viewing God as loving and viewing God as punishing) and a 3-item general religiosity scale (assessing frequency of religious attendance, prayer, and self rated religiosity). Core evaluations of self were based on traits such as self-esteem, general self efficacy, low neuroticism, and internal locus of control, and were measured using the 12-item Core Self-Evaluations Scale. **Results**: After controlling for general religiosity, intrinsic religiosity was unrelated to positive core self-evaluations. However, extrinsic religious motivation was inversely related to positive core self-evaluations ($B=-0.12$, $p<0.05$), as was viewing God as punishing ($B=-0.20$, $p<0.01$). In contrast, viewing God as loving was positively correlated with to positive core self-evaluations ($B=0.17$, $p<0.01$).

Citation: Smither JW, Walker AG (2015). The relationship between core self-evaluations, use of God, and intrinsic/extrinsic religious motivation. Psychological Reports 116:647-662
Comment: Although the findings are as expected (except lack of a relationship with intrinsic religiosity), removal of atheists from the sample may have limited the range of religiosity and thus reduced the power to detect effects in the analyses. The nature of the sample (well-educated, younger, white adult volunteers) may also have influenced the results in various ways.

Does Islam Defer Crime in Turkey?

Ozden Ozbay, a researcher on the faculty of communication, department of public relations & advertising at Cumhuriyet University, Sivas, Turkey, analyzed data collected from 619 undergraduate university students, 352 academic and nonacademic staff at a public university, and 498 shop owners. The study was conducted in a small city with a population of 105,000 located in the central Anatolian region in Turkey. Crime was assessed in *university students* by (1) a 20-item scale assessing current deviance by assessing acts performed in the past school year (bearing knives, fighting, assault, cheating, etc.), (2) 6-item scale assessing life-time deviance (stealing, using drugs, engaging in violence, etc.), and (3) 5-item violent deviant acts scale (fighting, assaulting someone, carrying knives, guns, performing other violent acts). Alcohol use was also assessed. Crime in *university staff* and *shop owners* was assessed using the 6-item life-time deviance scale and the 5-item violent deviant acts scale. Alcohol use was assessed in shop owners but no university staff. Religiosity was assessed in different ways depending on the particular population: in *students*, (1) family religiosity was assessed with a single question on a 10-point scale from none to completely; (2) students' belief in fate was assessed similarly; and (3) students' religiosity was assessed with a 9-item religious practices scale. *University staff* were asked to (1) rate their religiosity on a 10 point scale; (2) their belief in fate on a 3 point scale; (3) ideology of the newspaper they read (religious vs. non-religious); (4) if they displayed religious symptoms in office (yes vs. no); and (5) political identity (Turkish nationalists, religious, apolitical, or leftist). *Shop owners* were assessed on (1) belief in fate, (2) ideology of newspaper, and (3) political identity; they were also asked (4) which type of TV channel they watched the most (religious vs. non-religious). **Results** for *university students*: Current deviance/crime was significantly and inversely related to family religiosity, youth's religiosity, and belief in fate. In *university staff*, neither life-time deviance nor violence was associated with religiosity, although having religious symptoms in office (picture of Rumi, sayings from the Qur'an, religious plants, etc.) was significantly and positively associated with greater life-time deviance and performance of violent acts. For *shop owners*, no relationships were found. Regression analyses confirmed the inverse relationships in university students between youth religiosity and current and lifetime deviance (both $p<0.01$), but relationship between religious symbols in office and life-time deviance/violence in university staff weakened to non-significance (belief in fate remained associated with violent acts). The researcher concluded that "some religious measures deterred individuals themselves engaging in deviance and alcohol use. No relationship was found between Islam and violence."
Citation: Ozbay O (2015). Does Islam deter crime in a secular Islamic country? The case of Turkey. Contemporary Social Science [Epub ahead of print]
Comment: This is an interesting study despite being a bit hard to follow with different measures used in different populations. Religiosity (Islam) deterred crime and deviant acts in university students. The positive relationship between displaying religious symbols in office for university academic and non-academic staff is difficult to interpret since this relationship lost statistical significance when other variables (gender, occupational position, belief in fate) were controlled.

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

Researchers in the department of psychology at University of South Alabama and Fuller Theological Seminary, along with the National Center for PTSD and other universities, examined the direct and indirect associations between spirituality, forgiveness and quality of life in 678 U.S. veterans with PTSD. Participants were those admitted between 2003 and 2007 to a 60-90 day VA residential PTSD treatment program for persons with severe PTSD that had not improved sufficiently with outpatient treatment. Religiousness/spirituality was assessed with the Brief Multidimensional Measure of Religiousness and Spirituality (Fetzer); included were general self-ratings of religiosity and spirituality, the 6-item Daily Spiritual Experiences Scale, 5-item private religious practices, 6-item positive and negative religious coping, and a 2-item scale on religious attendance and participation in other religious groups. Forgiveness was assessed with a 3-item forgiveness measure (Mauger et al). Also assessed was combat exposure, PTSD symptoms (PCL-M), and quality of life (WHOQOL-brief) (the dependent variable). Structural equation modeling was used to analyze the data. **Results**: The mean PCL-M score was 64, and 90% of participants exceeded the clinical threshold of 50 for PTSD. R/S was positively associated with forgiveness, but was not directly associated with QOL (with forgiveness in the model). Forgiveness, in turn, was strongly associated with greater QOL. The indirect effect of R/S through forgiveness on QOL, however, was significant ($B=0.29$, $p=0.001$). Researchers concluded that "…forgiveness could be a critical pathway for promoting QOL as veterans attempt to recover from their posttraumatic symtomatology in treatment settings."
Citation: Currier JM, Drescher KD, Holland JM, Lisman R, Foy DW (2015). Spirituality, forgiveness, and quality of life: Testing a mediational model with military veterans with PTSD. International Journal for the Psychology of Religion, in press [at Researchgate.net]
Comment: Forgiveness appears to be a key mediating factor in the relationship between religiosity/spirituality and quality of life in veterans with severe PTSD. This was a very well done study in a large sample of veterans with severe, treatment resistant symptoms. The findings are also consistent with the explanation that it was the R/S that **enabled** veterans to forgive, and that targeting only forgiveness (without also addressing R/S) might not have the desired effect on QOL.

NEWS

A Sad Goodbye

On Saturday, May 16, 2015, Dr. John M. Templeton, Jr., died at the age of 75. Dr. Templeton was born on Feb. 19, 1940, in New York City. He received a BA in history from Yale University in 1962 and medical degree from Harvard Medical School in 1968. He began his medical training in pediatric surgery at the Children's Hospital of Philadelphia in 1973 and returned there in 1977 after serving as a physician in the U.S. Navy for two years. He and his wife, Josephine, a pediatric anesthesiologist, developed a specialty in dealing with conjoined twins. Dr. Templeton was director of the trauma program and a professor of pediatric surgery at the University of Pennsylvania before leaving in 1995 to become president of the John Templeton Foundation and became chairman of the Foundation after the death of his father, Sir John M. Templeton in 2008. Dr. Templeton is survived by his wife, two daughters, six grandchildren and a brother, Christopher.

Dr. Templeton was a great man in many ways, and we will miss him dearly.

The End of Religion

The cover story on the homepage of CNN on May 12, 2015, declared "Millennials leaving church in droves, study finds" (http://www.cnn.com/2015/05/12/living/pew-religion-study/). The story was based on results from a national U.S. survey of 35,000 adults conducted by the Pew Foundation Research Center between June 4 and Sept 30, 2014. Millennials are those born between 1981 and 1997, and younger millennials (which the story focuses on) were born between 1990 and 1997. The 2014 Religious Landscale Survey is the most comprehensive survey of religious characteristics of Americans to date (http://www.pewforum.org/religious-landscape-study/). The results of this survey, however, is not the last word – as the CNN headline would suggest. For readers wanting to know the "real story," go to the following link of a symposium at Baylor University where sociologist Dr. Byron Johnson describes what the Pew survey found and what it means: https://www.youtube.com/playlist?list=PL0JmtbsEea3iZ6GLoOIsEHrKZUKiZ5J7Z.

SPECIAL EVENTS

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

(Pasadena, California, July 27-31, 2015)
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 to register for 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

Testing Prayer: Science and Healing

(Harvard University Press, 2012)
A description of the book on Amazon.com: "In Candy Gunther Brown's view, science cannot prove prayer's healing power, but what scientists can and should do is study prayer's measurable effects on health. If prayer produces benefits, even indirectly (and findings suggest that it does), then more careful attention to prayer practices could impact global health, particularly in places without access to conventional medicine. Drawing on data from Pentecostal and Charismatic Christians, Brown reverses a number of stereotypes about believers in faith-healing. Among them is the idea that poorer, less educated people are more likely to believe in the healing power of prayer and therefore less likely to see doctors. Brown finds instead that people across socioeconomic backgrounds use prayer alongside conventional medicine rather than as a substitute. Dissecting medical records from before and after prayer, surveys of prayer recipients, prospective clinical trials, and multiyear follow-up observations and interviews, she shows that the widespread *perception* of prayer's healing power has demonstrable social effects, and that in some cases those effects produce improvements in health that can be scientifically verified." Available for $14.99 (used) at: http://www.amazon.com/Testing-Prayer-Candy-Gunther-Brown/dp/0674064674

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/

EDUCATIONAL OPPORTUNITIES

Master of Arts in Education Offered at Columbia University

Columbia's Institute for Spirituality, Mind and Body is offering a Master of Arts degree, with a concentration in Spirituality Mind Body. According to the Institute's website, it is "intended for students interested in the field of Clinical Psychology and the mental health professions at large. This introductory-level graduate program provides foundational knowledge of psychopathology, treatment theories, and research methods. It is ideally suited for applicants who are looking to strengthen their background prior to applying to doctoral psychology programs. In addition, it is well matched for candidates who do not hold undergraduate degrees in psychology and who wish to gain exposure to the field. SMBI is part of the clinical psychology program at Teachers College, which offers degrees at both the masters and doctoral level." For more information, see: http://spiritualitymindbody.tc.columbia.edu/degree-programs/.

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry (OFI)

At this time, it is not clear 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…

June

24 Spiritually-Oriented Cognitive Processing Therapy (CPT) for the Treatment of Moral Injury in Active Duty Soldiers and U.S. Veterans: A research proposal and discussion
Speaker: Harold G. Koenig, M.D.
Professor of Psychiatry & Behavioral Sciences, Duke
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

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

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