

# CROSSROADS...

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & 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 February 2015) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

## LATEST RESEARCH OUTSIDE DUKE

### Religion and Post-Traumatic Growth in U.S. Veterans

Researchers in the Department of Veterans Affairs and in the Department of Psychiatry at Yale University analyzed data from the National Health and Resilience in Veterans Study, a survey of a nationally representative sample of 3,157 veterans (mean age 60.3 years) conducted in Oct-Dec 2011. The measures administered included a Trauma History Screen, a 17-item PTSD Checklist (PCL-S), and a 10-item Post-Traumatic Growth Inventory-Short Form (PTG). PTG was assessed in terms of growth in the development of more intimate relationships, recognition of new possibilities or paths for one's life, greater sense of personal strength, greater spiritual development, and greater appreciation for life. In addition, 15 validated measures were administered and the results factor analyzed to come up with eight factors (physical health, mental health, substance abuse, protective psychosocial characteristics, social connectedness, altruism, spirituality, and active life-style). The spirituality factor consisted of attending religious services, private religious activities, and intrinsic religiosity, questions from the Duke Religion Index. Bivariate and multivariate analyses examined correlates of PTG. **Results:** Bivariate analyses indicated that each aspect of the spirituality factor (attendance, private religious activity, intrinsic religiosity) was positively and significantly associated with overall PTG ( $r=0.19-0.34$ , all  $p's < 0.001$ ). In multivariate analyses that controlled for other risk factors, the summed spirituality factor was significantly and positively related to every aspect of PTG, including growth in intimate relationships (standardized  $B=0.18$ ,  $p < 0.001$ ), growth in new possibilities ( $B=0.19$ ,  $p < 0.001$ ), growth in personal strength ( $B=0.14$ ,  $p < 0.001$ ), spiritual growth ( $B=0.45$ ,  $p < 0.001$ ), and growth in appreciation for life ( $B=0.13$ ,  $p < 0.001$ ). In fact, of the 21 predictors that were examined, the spirituality factor was the second strongest predictor of overall PTG ( $B=0.25$ ). In post-hoc regression analyses, only PTSD-related re-experiencing symptoms ( $B's 0.18-0.27$ ), purpose in life ( $B's 0.04-0.16$ ), number of close friends and relatives ( $B's 0.05-0.11$ ), and *intrinsic religiosity* ( $B's 0.09-0.31$ ) were independent predictors of total PTG

and subscale scores. After controlling for number of lifetime traumatic events and lifetime PCL-S, the traumatic event most strongly associated with an increase in spiritual growth was life-threatening illness or injury (partial  $r=0.12$ ,  $p < 0.001$ ). Researchers concluded that "...interventions geared toward helping trauma-exposed US veterans process their re-experiencing symptoms, and to develop greater social connections, sense of purpose and intrinsic religiosity may help promote PTG in this population."

*Citation:* Tsai J, El-Gabalawy, Sledge WH, Southwick SM, Pietrzak RH (2015). Post-traumatic growth among veterans in the USA: Results from the National Health and Resilience in Veterans Study. *Psychological Medicine* 45:165-179

*Comment:* As the U.S. military seeks ways to increase soldier resiliency (a major program now in progress aimed at reducing suicide rates), the findings in U.S. veterans above appear relevant.

### Religious Affiliation and Dementia in Taiwanese Elders

Researchers from the departments of epidemiology, geriatrics, internal medicine, and neurology from National Taiwan University conducted a case-control study involving 280 patients with Alzheimer's disease (AD) and 138 with vascular dementia (VD) (over age 60) recruited from academic medical centers in North Taiwan. The aim of this report was to examine the association between religious affiliation and dementia. Cases with dementia were compared to 466 healthy age-matched controls. Patients with a history of depression, Parkinson's disease, hemorrhagic stroke, large-vessel cerebral infarction, and brain tumor were excluded. Standard criteria were used to make the diagnoses of AD and VD. Three religious groups were compared: Taoism, Buddhism, and Christianity (Catholicism and Protestantism); these groups were compared to a reference category made up of those without a religious affiliation. Also assessed were religious activities (dichotomized into once/week vs. less than once/week), as well as leisure activities such as exercise and entertainment activities).

**Results:** Among those with AD, the distribution of religious affiliation was 35% no affiliation, 55% Taoism or Buddhism, and 10% Christianity; among those with VD, 38% had no religious affiliation, 55% were affiliated with Taoism or Buddhism, and 7% with Christianity; among controls, religious affiliation was no affiliation 34%, Taoism or Buddhism 51%, and Christianity 15%. After adjusting analyses for age, gender, and education, Christians were 59% less likely than those with no religious affiliation to have AD (OR=0.41, 95% CI 0.23-0.75), and 58% less likely to have VD (OR=0.42, 95% CI 0.19-0.94). Controlling for the presence of the apoE4 gene increased the OR in VD to 0.43 (95% CI 0.19 to 1.00,  $p > 0.05$ ), but the association in AD persisted (OR=0.46, 95% CI 0.26-0.81). The association in AD was particularly strong in women (OR=0.38, 95% CI 0.15-0.92), and in those involved in 3 or more leisure activities per week, especially exercise (OR=0.33, 95% CI 0.14-0.77). Researchers concluded: "Chinese participants having Christianity affiliation showed decreased AD risk. Moreover, the protective effect was more evident in women and in participants who exercised regularly." They hypothesized that this was due to the fact that Christianity encouraged a healthy lifestyle, cognitive stimulating activities, increased social networks, and

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better coping behaviors (Christians were more involved in religious activities compared to those without a religious affiliation and to those with Tao and Buddhist affiliations).

*Citation:* Lin KP, Chou YC, Chen JH, Chen CD, Yang SY, Chen TF, Sun Y, Wen LL, Yip PK, Chu YM, Chen YC (2015). Religious affiliation and the risk of dementia in Taiwanese elderly. Archives of Gerontology and Geriatrics, E-pub ahead of print

*Comment:* This may be the first study to report an association between religious affiliation and the prevalence of Alzheimer's disease. The findings make sense, given the importance of social interactions, decreased stress, and cognitive stimulating activities in helping to prevent cognitive decline with aging. Since this was a cross-sectional study, though, the direction of causation cannot be determined and there may have been other factors related to both Christianity and Alzheimer's disease that were not measured or controlled for.

### Oncology Clinicians' Perception of their Role in Providing Spiritual Care

Researchers in the Harvard School of Public Health and Dana-Farber Cancer Institute surveyed 322 oncology nurses (n=118) and oncology physicians (n=204) (63% response rate) at four Boston hospitals (Beth Israel, Boston University, Brigham & Women's, and Dana-Farber), asking these clinicians about how they perceived their role in providing spiritual care (SC). Spiritual care was defined as "care that supports the spiritual health of patients"; spiritual was defined as "a search for or connection to what is divine or sacred." Appropriateness of SC was assessed by describing 8 examples of ways that oncology physicians and nurses can support the spiritual health of patients, with each being rated on a scale from 1 ("never appropriate") to 6 ("always appropriate"). Clinician religiosity was also assessed by single questions asking about religious affiliation, self-rated religiosity, frequency of religious attendance, and extent to which religious/spiritual beliefs influenced their practice of medicine (called "intrinsic religiosity"). Self-rated spirituality was also assessed. Participants were asked who they thought should have the role of providing spiritual care (hospital chaplain, patients' spiritual community, nurses, doctors, or social workers). Finally, frequency of spiritual care was assessed ("How often do you offer any type of spiritual care during the course of your relationship with an advanced, incurable cancer patient?" on a 1-7 scale from never to always). **Results:** Nurses were significantly more religious and more spiritual than physicians. Nurses were more likely than physicians to identify themselves as Catholic (61% vs. 23%), whereas physicians were more likely than nurses to identify themselves as Jewish (25% vs. 5%). Nurses were more likely than physicians to report that the role of the physician was to provide SC (69% vs. 49%,  $p<0.001$ ), to report that the role of nurses was to provide SC (73% vs. 49%,  $p<0.001$ ), and to report that the role of social workers was to provide SC (81% vs. 63%,  $p=0.001$ ). The only predictor among nurses of the appropriateness of providing SC was older age (adjusted  $OR=1.08$ , 95%  $CI 1.01-1.16$ ,  $p=0.02$ ); predictors among physicians was greater intrinsic religiosity ( $p=0.01$ ), self-rated religiosity ( $p=0.03$ ), and self-rated spirituality ( $p<0.001$ ). Researchers concluded that "Spiritual care training that includes improved understanding of clinicians' appropriate role in SC provision to severely ill patients may lead to increased SC provision."

*Citation:* Rodin D, Balboni M, Mitchell C, Smith PT, VanderWeele TJ, Balboni TA (2015). Whose role? Oncology practitioners' perceptions of their role in providing spiritual care to advanced cancer patients. Supportive Care in Cancer, Jan 28, E-pub ahead of print

*Comment:* Physician religiosity or spirituality again seems to drive physicians' attitudes toward the provision of spiritual care, not the importance of spirituality to the patient. What is surprising, though, is that nearly 50% of physicians (who in this sample were

oncologists practicing in top academic institutions in the less religious northeast US) believe that it is their role to provide spiritual care to patients.

### Faith and Futility in the ICU

Described here is the case of an elderly man (James) with multiple severe medical problems that the best of modern medical treatment cannot reverse. He is very near death with no hope of surviving a meaningful life, and is in fact unconscious with only corneal reflexes, indicating severe and irreversible loss of brain function, and is only being kept alive by a ventilator and feeding tubes. His son Paul, who considers himself a prophet, says that God has told him that his father will recover and walk out of the hospital. Consequently, he is praying for a miracle and refuses to give permission to the medical team to allow his father to die. Two articulate, sensitive, and rational commentaries follow the case. The first commentary describes the vulnerabilities present in this case, including those of James, Paul, the hospital staff, the institution, and the community, and reviews the laws and the duties of the hospital and physician. The second commentary emphasizes the importance of patients' and family members' religious beliefs, and the need for caregivers to try to understand and accommodate those beliefs through sensitive conversations and actions. The limitations of accommodation are also emphasized, including the limits of religiously based decision-making – especially when the beliefs of the surrogate decision maker conflict with both the patient's best interests and wishes and with the teachings of the patient's religious community (which may serve in some cases as a substitute for an advanced directive).

*Citation:* Mendola A, Bock GL (2015). Faith and futility in the ICU. Hastings Center Report, January-February: 9-10

*Comment:* The case presented here illustrates why some religious persons and families demand expensive futile medical care towards the end of life (see JAMA 2009; 301(11): 1140–1147). The commentaries that follow provide important guidelines on how to deal with situations involving end-of-life decision-making when the religious beliefs of a surrogate decision-maker conflict with what is reasonable medical care, while at the same time considering the rights of the individuals, family, and communities involved. This brief article is highly recommended for physicians and other clinicians who care for dying patients.

### Differences in Physician Communication Regarding Spirituality

Faculty in the department of family medicine at the Uniformed Services University of the Health Sciences (Bethesda, MD) examined differences in physician communication in response to patient *inquiry to the physician* about religion/spirituality (R/S) vs. *patient disclosure* of their own R/S. Family medicine faculty (n=5) and residents of a community-based family medicine department (n=22) were exposed to a structured clinical exam of a standardized patient regarding R/S that involved *inquiry* ("I'm just wondering, do you think that God could help heal me?"; "Do you think that my getting sick is part of God's plan for me?"; "If you were ever in a situation like I am, and you didn't know what was happening...would you pray?") or *disclosure* ("I guess I am sort of frightened, but then I tell myself you know that I am a woman of faith"; "As you've been working here at the hospital, and you see so many ill patients, you must see some divine comfort in prayer here"; "I wanted to talk with you because I respect your opinion. It just means a great deal to me, so I just wanted to have a conversation about my faith and its flow in recovery"). The outcome was how physicians responded to these situations – either communicating messages of physician-control, partnership-building, or supportive-talk. **Results:** In situations involving *inquiry* regarding the physician's thoughts about or own R/S, physicians communicated more control messages (e.g., "I'd rather take it back to you. You're the first priority"; or "This is your diagnosis.

This is about you; it's really not about me.”), and gave fewer messages indicating support (e.g., “I think that’s a good thing to do [prayer] especially if you have a strong faith. I think that’s a great way to kind of help release some of the anxiety that you have”). Researchers concluded that physician training should focus on “teaching residents how to be sensitive to the R/S context of their patients and to recognize their own intuitive reactions to patient communication in that context.”

*Citation:* Ledford CJW, Canzona MR, Seehusen DA, Cafferty LA, Schmit ME, Huang JC, Villagran MM (2015). Differences in physician communication when patients as versus tell about religion/spirituality. *Family Medicine* 47 (2):138-142

*Comment:* This is a fascinating study that documents systematically what many of us have experienced when R/S issues come up during the clinical encounter. Physicians tend to get defensive when patients ask anything regarding the physician’s R/S beliefs, opinions, or activities. The authors stress that defensiveness is a natural reaction that needs to be recognized by the physician since this could impede their ability to provide supportive patient-centered responses.

### Religion, Social Capital, and Health in African Americans

Researchers from the School of Public Health at the University of Maryland analyzed data collected from a national probability sample of 803 African Americans, assessing the inter-relationships between religious beliefs/behaviors, social capital, and mental/physical health. Religious beliefs were assessed with a 3-item index (“I am often aware of the presence of God in my life”; “I have a personal relationship with God”; “When I am ill, I pray for healing”). Religious behaviors were likewise assessed by a 3-item index (“About how many times a month do you usually attend religious services?”; “Besides attending services, about how many times a month do you take part in other religious activities like Bible study, choir rehearsal, or ministry meetings?”; “I talk openly about my faith with others”). Social capital was measured using a 9-item instrument consisting of three 3-item subscales: social support (e.g., “If I needed a ride to the doctor, I would be likely to call a neighbor for a ride”), interconnectedness (e.g., “Most people in this community can be trusted”), and community participation (e.g., “If there is a problem in my community, people who live there can get it solved”). Physical and emotional functioning was assessed with the SF-12, whereas depressive symptoms were measured using the CES-D. Structural equation modeling (SEM) was used to analyze the relationships. **Results:** Bivariate relationships indicated a positive association between religious behaviors and two of the three domains of social capital (interconnectedness [ $r=0.12$ ,  $p<0.01$ ] and community participation [ $r=0.13$ ,  $p<0.01$ ]). The social capital subscale interconnectedness, in turn, was inversely related to depressive symptoms. Consequently, there was an indirect relationship between religious behaviors and depressive symptoms ( $p<0.05$ ) mediated by interconnectedness. No significant relationship was found between religious beliefs and any social capital variables or health outcomes. The SEM confirmed these bivariate relationships. Researchers concluded that “...religious behaviors/participation is associated with greater trust in and commitment to local communities among African Americans. This, in turn, is related to lower experience of depressive symptoms...If individuals can take optimal advantage of resources that their faith community can provide, mental health outcomes in African American communities may be enhanced.”

*Citation:* Holt CL, Clark EM, Wang MQ, Williams BR, Schultz E (2015). The religion-health connection among African Americans: What is the role of social capital? *Journal of Community & Applied Social Psychology* 24 (1):1-18

*Comment:* Social capital is often considered a measure of community health. Here is another study showing that religious

involvement (especially religious community activity) may be an important factor that influences the social capital of communities, minority communities in particular, and in this way enhances the mental health of individuals in these communities. Since this was a cross-sectional study, longitudinal research is needed to determine whether such associations are causal and the direction of the causation.

### Mental Health and Religious Service Non-Attendance in Australia

Investigators from the School of Medicine at the University of Notre Dame Australia and the School of Social Sciences, University of New South Wales, analyze data from a survey of a nationally representative sample of Australians that assessed religious practices and mental health. Unfortunately, only the abstract of the article was available, limiting the details that can be reported about the study. Researchers examined and compared the demographic and mental health characteristics of (a) non-religious individuals, (b) religious persons who attended religious services, and (c) religious persons who did not attend religious services. “Religious” persons were defined here as those indicating a religious affiliation. **Results:** Religious non-attendees were more likely to be non-Christian than were religious attendees, and more likely to report worse mental health than either religious attendees or non-religious persons. Researchers acknowledged that this study could not determine whether poor mental health was the result or the cause of non-attendance at religious services given the cross-sectional nature of the design. They concluded, however, that Australians who report a religious affiliation but do not attend religious services are quite different from Australians who do not indicate a religious affiliation.

*Citation:* Waters EK, Millard HM, Doyle Z (2015). Losing hope: Mental health and religious service non-attendance in Australia. *Mental Health, Religion & Culture*, Jan 30, E-pub ahead of print

*Comment:* Many assume that those who say they have a religious affiliation but do not attend religious services are similar to those who report no religious affiliation. This study disproves that assumption in a national random sample of Australians.

### Child Abuse, Religion, and Mental Health in Adult Jewish Women

Researchers examine the impact of recalled sexual, physical and/or emotional abuse on the mental health of adult Jewish women. Participants ranged in religiosity from those who were rigorously devout ultra-Orthodox (*Haredi*) to those who were non-religious secular Jews. Investigators hypothesized that religiosity might reduce the likelihood of childhood abuse and mitigate the psychological consequences that such abuse may have on later mental health. Participants were recruited from primary health care clinics in Jerusalem and the surrounding suburban areas. Recruitment was systematic with all women age 20+ being invited to participate. Childhood abuse was assessed using a global measure of physical, sexual, or verbal abuse, measuring both abuse as a child (ACA) and abuse within the past year (ARA). Mental health was assessed using the Brief Symptom Inventory (BSI) that consists of three subscales: depression, anxiety, and somatization. **Results:** Participants were Jewish women from Ultra-Orthodox ( $n=261$ , mean age 36.3), Modern Orthodox ( $n=181$ , mean age 37.1), Traditional ( $n=167$ , mean age 47.5), and Secular ( $n=181$ , mean age 44.0) traditions. Surprisingly, the frequency of reported childhood abuse (45.0%) and recent abuse (35.8%) was not significantly different between groups. However, mental health based on the total BSI score was better in the Ultra-Orthodox and Modern Orthodox women than in the Traditional and Secular women ( $p<0.01$ ). In multivariate analyses that controlled for age, marital status, income, and education, religious orientation remained significantly associated with distress level ( $p=0.019$ ),

with the most religious (Ultra and Modern Orthodox) experiencing less distress. Thus, Ultra Orthodox Jewish women (whose lives are firmly rooted in religious rituals and beliefs) had better mental health compared with non-religious respondents. However, among survivors of childhood abuse, distress rates did not differ between religious and nonreligious women. Unresolved anger was the second strongest predictor of mental distress among the Ultra Orthodox, even after controlling for childhood abuse and demographics. According to researchers, "Abusive traumas in childhood seriously compromise religiosity's generally positive role. Indeed, less trust in and alienation from God in the aftermath of child abuse has been well documented."

*Citation:* Feinson MC, Meir A (2015). Exploring the mental health consequences of childhood abuse and the relevance of religiosity. *Journal of Interpersonal Violence* 30(3):499-521

*Comment:* The findings make sense. While religiosity is related to better mental overall, when Ultra Orthodox Jewish women are abused as children (physical, sexual or verbal), this may generate feelings of betrayal, alienation from God, and ultimately lead to unresolved anger.

### Religious Coping and Drinking Outcomes in Alcohol Dependent Adults

Investigators at the Center for Alcohol and Addiction Studies at Brown University in Rhode Island followed 116 alcohol-dependent adults (53% women, average age 37) from 2 weeks after entering outpatient treatment to 6 months after treatment. **Results:** Although details are lacking (given that only the abstract was available), religious coping at 6 months predicted fewer heavy alcohol use days and fewer drinks per day. General coping explained the relationship (i.e., religious copers were more likely to use healthy coping activities, which accounted for improved drinking outcomes). Researchers concluded that "Coping skills training that includes religious coping skills, as one of several coping methods, may be useful for a subset of adults early in recovery."

*Citation:* Martin RA, Ellingsen VJ, Tzilos GK, Rohsenow DJ (2015). General and religious coping predict drinking outcomes for alcohol dependent adults in treatment. *American Journal on Addictions* (American Academy of Addiction Psychiatry), Feb 6, Epub ahead of print.

*Comment:* Given the lack of details in the abstract, it is not clear if this was a cross-sectional study or a longitudinal study. Participants were certainly followed for 6 months, but whether religious coping was measured at baseline or only at 6 months is not clear.

### Assessing the Spiritual Needs of Caregivers

In this article a physician at the Mayo Clinic (Rochester, Minn) has provided a tool (Key Questions) for health professionals to help them assess the spiritual needs of caregivers. To facilitate memory, the mnemonic "SIDNEY AC" was developed: (1) Has faith or spirituality been of **Support** as you face your loved one's illness? (2) Is spirituality **Important** to you, as you provide support for your loved one? (3) Is your spirituality similar or **Different** from your loved one's spirituality? (4) Have you encountered spiritual **Needs** that you have as a family caregiver? (5) What has this caregiving **Experience** been like for you? (6) Have **You** been able to find meaning in your caregiving experience? (7) Do you have a faith community, minister, or clergy **Available** to you? (8) Has your spirituality **Changed** since your loved one became ill? Also provided here are Key Concepts (presence, listening deeply, witness, acts of compassion [PLiWA]) and Key Resources (caring nurses, chaplains, community clergy [Triple C]). The goal is to empower health professionals with tools to care for the caregiver.

*Citation:* Mnemonics for assessing and addressing spiritual care needs of the caregiver. *Southern Medical Journal* 108(1):67-68

*Comment:* These mnemonics should be useful for all clinicians (physicians, nurses, social workers, chaplains) and community clergy who attend to the needs of family caregivers of patients.

## LATEST RESEARCH FROM DUKE

### Religion and Quality of Life in People Living with HIV/AIDS

Researchers in the school of nursing at Emory University and department of psychiatry at Duke University collected data on a convenience sample of 292 people living with HIV/AIDS (PLWH) recruited from an outpatient infectious disease clinic or an AIDS service organization in the Raleigh-Durham area of North Carolina. Religiosity/spirituality (R/S) was assessed using a 33-item version of the Brief Multidimensional Measure of Religiousness/Spirituality (Fetzer Institute) and the 14-item Brief RCOPE (7-item negative religious coping [RC] and a 7-item positive RC subscales). Depressive symptoms was measured by the 20-item CES-D; medication adherence by the 5-item Antiretroviral General Adherence Scale; social support by the 12-item Social Support Questionnaire; and quality of life by the SF-36 (assessing mental and physical QOL). **Results:** Using hierarchical linear regression to control for covariates, researchers found that religious attendance (B=0.13) and self-rated religiosity (B=0.16) were significantly and positively related to mental QOL, and positive religious coping was associated with general QOL (B=0.24). As expected, negative RC was inversely related to mental QOL (B=-0.18). Overall, participants with poorer QOL were found to pray less than daily, attend religious services less than weekly, and were more likely to describe themselves as less religious or not religious at all. Given these associations with overall QOL, researchers recommended that religious involvement be routinely assessed in PLWA.

*Citation:* Dalmida SG, Koenig HG, Holstad MM, Thomas TL (2015). Religious and psychosocial covariates of health-related quality of life in people living with HIV/AIDS. *HIV/AIDS Research and Treatment* 1(1):1-15

*Comment:* The relationship between religious involvement and quality of life among people living with HIV/AIDS is not well-studied. Stigma often plays a role in excluding individuals with this illness from religious communities, since HIV/AIDS is often associated with drug use, homosexuality, and bisexuality. This study suggests that when PLWA do become involved in religion, this seems to make a positive difference in their QOL (except for those who experience religious struggles or engage in negative religious coping). Because associations identified here are cross-sectional, inferences regarding causality cannot be made, underscoring the need for future longitudinal research and clinical trials.

## NEWS

### Call for Proposals for Special Issue

An American Psychological Association (APA) Division 36 journal, *Journal of Religion and Spirituality* (editor Ralph Piedmont), has issued a call for proposals for a special issue. This journal publishes articles employing experimental and correlational methods, qualitative analyses, and critical reviews of the literature. Clinically relevant issues surrounding training, professional development, and practice are also considered. Special issues are guest edited by the person submitting the proposal under the direction of the Journal. Submitters will need to provide CV's for all guest editors. The submission should make clear whether it involves a general call for papers or whether it entails invitations to specific authors. Suggested topics for the special issue include interdisciplinary, methodology/qualitative, health-related, diversity, "hot new topics," positive psychology, special populations, and

spiritual assessment. Deadline for submission of proposals is **March 15, 2015**. Send proposals to the Journal Editor, Ralph Piedmont ([rpiedmont@loyola.edu](mailto:rpiedmont@loyola.edu)), who may also be contacted for more information.

### Call for Papers

*Practical Matters* is now accepting submissions on religious practices and practical theology for 2015-2016. The journal will feature articles on the theme of religious place-making, sacred spaces, and *d*splacement as religious practices. Potential topics range from official religious architecture to the establishing of (unofficial) home shrines, from the experiences of hajj to the reproduction of holy sites in local communities, from the sales of earth gathered from sacred sites to the use of water from local shrines as radiator fluid, from scarification as a way of mapping the cosmos onto the body to accounts of the cosmos in images of the body, from pilgrimages willingly undertaken to the displacement of religious communities... The journal includes both peer-reviewed articles (Features and Analyzing Matters) as well as non-peer reviewed content that presents the thoughtful reflections of teachers and practitioners (Practicing Matters and Teaching Matters). *Practical Matters* accepts submissions that incorporate a variety of media and genres. For additional instructions on submissions, more information on our peer-review process or to read current and past issues of *Practical Matters*, visit our website: <http://www.practicalmattersjournal.org/>. A project of the Candler School of Theology and The Graduate Division of Religion at Emory University, *Practical Matters* is an online journal placing scholars of religious practice in conversation with practical theologians.

### SPECIAL EVENTS

#### 13th Annual David B. Larson Memorial Lecture

(Rm 2001 Duke Hospital North, Durham, North Carolina, **March 3, 2015, 6:00-7:00P**)

This year's speaker is **David R. Williams**, the Florence Sprague Norman and Laura Smart Norman Professor of Public Health at the Harvard School of Public Health (HSPH) and Professor of African and African American Studies and of Sociology at Harvard University. According to Dr. Williams, "This presentation will provide a brief overview of the association between religious attendance and health. It is widely recognized that religious attendance is the religious variable that is most consistently predictive of health. However, our understanding is limited regarding the mechanisms and pathways that link participation in religious services to good health. The presentation takes a detailed look at two empirical attempts to identify *why* religious attendance was associated with better health. One focused on mortality and the other on mental health outcomes. Both analyses found that even after all potential mediators were considered, there was a significant residual relationship between attendance and health. The presentation concludes with promising directions for future research that seeks to get a clearer understanding of exactly what it is about religious attendance that can lead to enhanced health and well-being." The lecture is free and open to the general public. The presentation *will not* be recorded. For more info, see website: <http://www.spiritualityandhealth.duke.edu/index.php/scholars/david-b-larson>.

#### 4th Annual Conference on Religion and Medicine

(Hyatt Regency, Cambridge, **March 6-8, 2015**)

According to the conference program, "Contemporary western culture divides care of the soul from care of the body, apportioning the former to religious communities and the latter to medicine. The division of spiritual and material care of the human person has allowed us to meet many clinical needs efficiently, but it has also

wrought unwanted outcomes, including increased mechanization of care and isolation in the experiences of illness and dying. Remedying this situation will require reengaging some critical questions: In what sense is illness a spiritual and/or religious experience? How should particular spiritual and religious needs of patients be addressed and by whom? What is at stake and what is experienced, spiritually, among those who care for patients? How may the powerful social and intellectual forces that continue to dehumanize the patient experience and the practices of health care be overcome? What do religious traditions teach us about these questions?" Conference conveners invite students, health care practitioners, scholars, and religious leaders to take up these questions and discuss their implications for contemporary medicine, doing so with reference to religious traditions and practices, particularly those of Judaism, Christianity, and Islam. For more information, go to: <http://www.medicineandreligion.com/>.

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

(Pasadena, California, July 27-31, 2015)

This 5-day workshop 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 workshop, 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) (August 10-14, 2015)

**Now is the time** to register for a spot 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** will be available for those with strong academic potential and serious financial hardships. For more info, see website: <http://www.spiritualityhealthworkshops.org/>.

### RESOURCES

#### Care Giving for Alzheimer's Disease: A Compassionate Guide for Clinicians and Loved Ones (Springer, April 2015)

As described by publishers: "Veteran clinicians [Verna Benner Carson, Katherine Vanderhorst, Harold G. Koenig] offer a unique framework for understanding the psychological origins of behaviors

typical of Alzheimer's and other dementias, and for providing appropriate care for patients as they decline. Guidelines are rooted in the theory of retrogenesis in dementia--that those with the condition regress in stages toward infancy--as well as knowledge of associated brain damage. The objective is to meet patients where they are developmentally to best be able to address the tasks of their daily lives, from eating and toileting to preventing falls and wandering. This accessible information gives readers a platform for creating strategies that are respectful, sensitive, and tailored to individual needs, thus avoiding problems that result when care is ineffective or counterproductive." Examples of chapter titles include: "Abilities and disabilities during the different stages of Alzheimer's disease"; "Strategies for keeping the patient's finances safe"; "Pain in those with dementia, and why it is frequently ignored"; "Help! I've lost my mother and can't find her!"; "Sexuality and intimacy in persons with dementia"; and "Instructive vignettes of successful caring interventions." This book gives down-to-earth, practical, hands-on advice to family members, caregivers, and clinicians on how to care for someone with dementia across the various stages of disease. Available for \$50.70 at: [http://www.amazon.com/Care-Giving-Alzheimers-Disease-Compassionate/dp/1493924060/ref=sr\\_1\\_4?s=books&ie=UTF8&qid=1423861999&sr=1-4](http://www.amazon.com/Care-Giving-Alzheimers-Disease-Compassionate/dp/1493924060/ref=sr_1_4?s=books&ie=UTF8&qid=1423861999&sr=1-4)

### **Faith from a Positive Psychology Perspective**

(Springer, 2015)

As described by the publishers: "Psychologists have traditionally focused on the treatment of mental illness from a perspective of repairing damaged habits, damaged drives, damaged childhoods, and damaged brains. In recent years, however, many psychological researchers and practitioners have attempted to re-focus the field away from the study of human weakness and damage toward the promotion of a positive psychology of well-being among individuals, families, and communities. One domain within the field of positive psychology is the study of religious faith as a human strength that has the potential to enhance individuals' optimal existence and well-being. This book highlights religious faith from a positive psychology perspective, examining the relationship between religious faith and optimal psychological functioning. It takes a perspective of religious diversity that incorporates international and cross-cultural work. The empirical literature on the role of faith and cognition, faith and emotion, and faith and behavior is addressed including how these topics relate to individuals' mental health, well-being, strength, and resilience. Information on how these faith concepts are relevant to the broader context of relational functioning in families, friendships, and communities is also incorporated. Available for \$99.43 at: [http://www.amazon.com/Faith-Positive-Psychology-Perspective-Miller-Perrin/dp/9401794359/ref=sr\\_1\\_1?s=books&ie=UTF8&qid=1423862089&sr=1-1&keywords=Faith+from+a+Positive+Psychology+Perspective](http://www.amazon.com/Faith-Positive-Psychology-Perspective-Miller-Perrin/dp/9401794359/ref=sr_1_1?s=books&ie=UTF8&qid=1423862089&sr=1-1&keywords=Faith+from+a+Positive+Psychology+Perspective)

### **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 \$57.73 (used) 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 (\$22.36) at: <http://templetonpress.org/book/spirituality-patient-care>.

### **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 (\$124.31, 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 (\$39.96) at: <http://templetonpress.org/book/spirituality-and-health-research>.

## **JOBS**

### **Columbia University (NYC) Research Position**

Myrna Weissman recently announced a new position that is immediately available. Funded by a grant from the Templeton Foundation, her research group is continuing their study of the effects of religion and spirituality on brain function and clinical outcome (see January 2014 issue of JAMA Psychiatry). She is eager to hire a young, energetic, ambitious PhD with experience publication and scientific interest in this areas who would act as project coordinator. There is an opportunity to undertake independent analysis, publication of the data and to build a career in this areas. They have an expert team of people in imaging and ERG researchers who would collaborate and assist in writing up this portion, and have excellent statistical and analytic support. Dr. Weissman's team wants to start ASAP since they are going to collect new data on the range of religious experiences as well as to analyze our existing data from the three generation study. Columbia is an excellent place to work and NY an exciting place to live. Those with these qualification please should send their CV to Dr. Weissman ([WEISSMAN@nyspi.columbia.edu](mailto:WEISSMAN@nyspi.columbia.edu)).

## **FELLOWSHIPS**

### **David B. Larson Fellowship in Spirituality and Health**

Jason Steinhauer at the U.S. Library of Congress announced this month the opening of applications for the fellowship: "The John W. Kluge Center at the Library of Congress is delighted to announce we are currently accepting applications for the David B. Larson Fellowship in Health and Spirituality. The deadline is **April 17, 2015**. This post-doctoral fellowship is designed to continue Dr. Larson's legacy of promoting meaningful, scholarly study of these two important and increasingly interrelated fields. The Fellowship seeks to encourage the pursuit of scholarly excellence in the scientific study of the relation of religiousness and spirituality to

physical, mental, and social health. The Fellowship provides an opportunity for a period of six to twelve months of research in the at the Library of Congress through residency in the Library's John W. Kluge Center. The stipend is \$4,200 per month...We encourage you to visit our website to see full eligibility and application details at <http://www.loc.gov/kluge/fellowships/larson.html>."

### Theology, Medicine and Culture Fellowship

The Duke Divinity School is now accepting fellowship applications from "students and practioners in health professions, as well as others with full-time vocations to health-related contexts, to participate in a program of theological formation that will equip them for faithful, disciplined, and creative engagement with contemporary practices of health care...TMC Fellows will study in one of the residential master's degree programs of Duke Divinity School (MACS, MTS, MDiv, ThM), and will combine this academic study with structured mentorship, retreats and seminars, and church and community-based practica. Through special grant support, the Fellowship will offer students tuition grants of at least 50 percent for the first year of study with additional scholarship support available on a competitive basis." Application deadline is **March 1, 2015**. For more information go to: <http://sites.duke.edu/tmcfellowship/>.

### FUNDING OPPORTUNITIES

#### Templeton Foundation Online Funding Inquiry (OFI)

The Templeton Foundation is now accepting letters of intent for research on spirituality and health between February 2, 2015 - **April 1, 2015**. If the funding inquiry is approved (applicant notified by May 1, 2015), the Foundation will ask for a full proposal that will be due September 1, 2015, with a decision on the proposal reached by December 21, 2015. 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...

### March

- 3 **Religious Attendance and Health: Findings, Questions and Directions**  
Speaker: David R. Williams, Ph.D.  
Florence Sprague Norman & Laura Smart Norman  
Professor of Public Health; Professor of African and African American Studies and of Sociology, Harvard University  
Duke North, Room 2001, 6:00-7:00P  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))  
For more info:  
<http://www.spiritualityandhealth.duke.edu/index.php/scholars/david-b-larson>
- 25 **A Diagnosis of the Allergy to Science in Seminaries**  
Speaker: Nick Carter  
President Emeritus, Andover Newton Theological Seminary  
Center for Aging, 3rd floor, Duke South, 3:30-4:30  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))

### April

- 1 **Religion, Spirituality and Medicine**  
Duke University School of Medicine  
Durham, North Carolina, Trent-Seamans Center, 3:00P  
Speaker: Koenig  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))
- 25 **Holistic Health Interventions for Clergy: Lessons Learned about Faith and Health Behavior Change**  
Speaker: Rae Jean Proeschold-Bell, Ph.D  
Co-PI for the Clergy Health Initiative  
Rachel Meyer  
Director, Program Development and Operations, Clergy Health Initiative  
Center for Aging, 3rd floor, Duke South, 3:30-4:30  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))

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