# CROSSROADS…

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & Health Volume 2 Issue 7 January 2013

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 December 2012) go to: http://www.spiritualityandhealth.duke.edu/publications/crossroads.html

## LATEST RESEARCH OUTSIDE DUKE

### "Spiritual but not Religious" and Mental Health in the United Kingdom

In 2006-2007, researchers interviewed a random sample of 7,403 community-dwelling persons age 16 and older in the United Kingdom (National Psychiatric Morbidity Study). They administered the revised Clinical Interview Schedule, which makes psychiatric diagnoses based on ICD-10. Participants also completed the Royal Free Interview for religious and spiritual beliefs, a measure of social support, and were screened for psychosis, alcohol use, trauma, eating disorder, problem gambling, and recreational drug use. Results indicated that 35% had a religious understanding of life, 19% had a spiritual understanding (but not religious), and 46% said they were neither spiritual nor religious. Religious persons were 27% less likely to have ever used drugs (OR=0.73, 95% 0.60-0.88) and 19% less likely to be a hazardess drinker (OR=0.81, 95% CI 0.69-0.96). Those with a "spiritual" view of life (but not religious) were more likely to have ever used drugs, be dependent on drugs, have abnormal eating attitudes, experience generalized anxiety disorder, a phobia, or a neurotic disorder, and were 40% more likely to be taking psychiatric medication (OR-1.40, 95% CI 1.05-1.86). Researchers concluded that "People who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder."

*Citation*: King MB, Marston L, McManus S, Brugha T, Metzer H, Bebbington P (2012). Religion, spirituality and mental health: Results from a national study of English households. British Journal of Psychiatry, November 22 [E-pub ahead of print]

*Comment*: This is the largest study to date reporting that those who describe themselves as "spiritual but not religious" (a growing category of people in the U.S. and Europe) have worse mental health. The authors did not explain why those who are spiritual but not religious have worse mental health, although admitted that the study was cross-sectional, so direction of causation could not be determined (i.e., the findings don't tell us whether being spiritual but not religious causes mental illness, or whether mental illness causes people to describe themselves as spiritual but not religious).

### Lack of Spiritual Care at the End of Life

Researchers at the Dana-Farber Cancer Institute examined why spirtual care (SC) is so infrequently provided by oncology nurses and physicians to patients at the end of life. They surveyed 75 patients with advanced cancer receiving palliative radiation therapy, 118 nurses, and 204 physicians at four Boston academic medical centers. Eight examples of spiritual care were provided to illustrate what spiritual care involved, so there was no issue with definitions. Most patients in this study had not received any form of SC from their oncology nurses or physicians (87% and 94%, respectively), despite the fact that patients reported that SC from nurses and from physicians was an important component of cancer care (86% and 87%, respectively). Likewise, most nurses (87%) and physicians (80%) thought that SC should be provided at least occasionally. Nevertheless, only 31% of nurses and 15% of physicians said they frequently or always provided spiritual care. The strongest predictor of whether nurses and physicians provided spiritual care was whether they received training in SC, which most nurses (88%) and physicians (86%) had not. Researchers concluded that most patients, nurses, and physicians feel that SC is appropriate and beneficial for patients at the end of life, but that lack of training is the primary barrier that prevents this from occurring.

*Citation*: Balboni MJ, Sullivan A, Amobi A, Phelps AC, Gorman DP, Zollfrank A, Peteet JR, Prigerson HG, VanderWeele TJ, Balboni TA (2012). Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. Journal of Clinical Oncology, December 17 [E-pub ahead of print]

*Comment*: If there was a time when spiritual care is needed, one would think it is when people with advanced stages of cancer are dying. Health professionals may think that patients' religious communities are providing this care or may defer SC entirely to chaplains. However, when patients are hospitalized they may not have contact with their religious communities (particularly if hospitalized distant from those communities). Furthermore, chaplains may not always be available, since only 54-64% of U.S. hospitals have paid chaplains on staff and those chaplains are often busy trying to cover the entire hospital. Thus, nurses and physicians cannot shirk the responsibility, and this study argues that all health professionals who care for patients with advanced illnesses at the end of life should receive training in SC (in nursing / medical school, residency, and/or fellowship).

### Religion and End of Life Decisions in the ICU

Investigators surveyed physicians, nurses, ICU survivors, and family members of surviving and non-surviving ICU patients in 142 hospitals three months after discharge. The final sample consisted of 304 physicians, 386 nurses, 330 family members, and 248 patients in Sweden, The Netherlands, northern United Kingdom, the Czech Republic, Israel and Portugal. Participants were asked (1) the religion they belonged to and (2) if they considered themselves religious or just affiliated but not religious. For the entire sample, 6% were atheist and religious affiliation was unknown or not given in 23%. Patients and families were more likely to indicate they were religious (60%) than were doctors or nurses (50%). Respondents were asked to imagine they had a

terminal illness and then whether they would want ICU admission, CPR, ventilator support, and active euthanasia if in pain. In the event of a terminal diagnosis, fewer professionals wanted treatment than did patients and families (22% vs. 55%, p<0.001). In all four groups (patients, families, doctors, nurses), those who were more religious were more likely to want treatment. Interestingly, however, fewer doctors/nurses than patients/families wanted active euthanasia (34% vs. 48%), although those who were less religious wanted this more. In contrast, religious respondents were more likely to want their life prolonged as long as possible by all available treatments in any condition.
*Citation*: Bulow HH, Sprung CL, Baras M, Carmel S, Svantesson M, Benbenishty J, Maia PA, Beishuizen A, Cohen S, Nalos D (2012). Are religion and religiosity important to end-of-life decision and patient autonomy in the ICU? The Ethicatt study. Intensive Care Medicine 38:1126-1133
*Comment*: The findings from this study conducted in Northern Europe, Portugal and Israel, are consistent with findings from U.S. studies. Religious persons are more likely to want all available treatments to prolong life, even in end-of-life or medically futile situations. Why is this the case? We don't know. Clearly, more systematic qualitative research is needed to sort this out. However, this fact underscores the need for health professionals to engage in discussions with patient and family members about religious or spiritual issues at this time, especially since health professionals are less likely to be religious than patients/family members and so may not appreciate the role that religion plays in these decisions. Furthermore, it has been shown that when spiritual needs are addressed in patients who are dying, they are much less likely to request high tech, high cost care (see Cancer 2011; 117:5383-5391).

### Prayer, Survival and Quality of Life in Korean Cancer Patients

Researchers interviewed 481 terminally ill cancer patients and followed 97% (466) to their death, assessing use of complementary and alternative (CAM) treatments [including prayer], length of survival, and health-related quality of life. This multi-center, prospective study was conducted in 11 university hospitals and the National Cancer Center in Korea. CAM included use of alternative medical systems (oriental herbal medicine, acupuncture, ayurveda, homeopathy) (13%), mind-body interventions (yoga, meditation, prayer therapy, music/dance therapy, art therapy, horticultural therapy) (18%), biological therapy (medicinal herbs, vitamin supplements, hydroterapy, dietary supplements) (84%), manipulative and body-based therapies (3%), and energy therapies (0.5%). Among patients using some form of CAM, 44% indicated they had a religion, compared to 56% of those not using CAM (p<0.001). There was no significant difference in length of survival between CAM-users and CAM-nonusers. Furthermore, CAM-users experienced significantly great cognitive dysfunction and greater fatigue than CAM-nonusers. In subcategory analyses, those who used mind-body interventions experienced a significant worsening of insomnia and decline in their quality of life compared to non-users. Among mind-body users, those using prayer therapy showed significantly worse survival (HR=1.56, 95% CI 1.00-2.43).
*Citation*: Yun YH, Lee MK, Park SM, Kim YA, Lee WJ, lee KS, Choi JS, Hung KH, Do YR, Kim SY, Heo DS, Kim HT, Park SR (2012). Effect of complementary and alternative medicine on the survival and health-related quality of life among terminally ill cancer patients: a prospective cohort study. Annals of Oncology, October 30 [E-pub ahead of print]
*Comment*: Interestingly, in this Korean study, those who were religious were *less likely* to use CAM (this is the opposite of what is found in the U.S.). Unfortunately, other than asking if they had a religion and if they used "prayer therapy" no further details about religion or prayer were provided. One wonders, however, whether those who were more desperate, sicker, and nearer to death were more likely to turn to prayer therapy for help.

### Religion and Physical Health in Older Israeli Jews

Jeff Levin from the Institute for Sudies of Religion at Baylor University analyzed data from a random national sample of 1,287 Jewish respondents age 50 or over, examining cross-sectional relationships between religious characteristics and physical health (self-rated health, chronic health problems, activity limitations, physical symptoms, and physical functioning). Religious characteristics included participation in synagogue activities in the past month (yes vs. no), frequency of prayer (never [1] to more than once/day [6]), and religious education (yes vs. no). Controlled for in analyses were the confounders age, gender, education, marital status, and birth place. Mediators (variables that might explain correlations between religion and health) included health behaviors (drinking and smoking) and social support (help received from outside the household). Synagogue activities were strongly correlated with frequency of prayer (r=0.51), but less so with religious education (0.27); prayer was moderately correlated with religious education (r=0.40). In uncontrolled analyses, synagogue activity was inversely related to chronic disease and poor physical functioning, and inversely related to drinking and smoking. In contrast, prayer was negatively related to self-rated health, positively related to activity limitation, physical symptoms, poor physical functioning, and need for help from outside the home (all p<0.001). Similarly, religious education was negatively related to self-rated health and positively related to activity limitations, physical symptoms, poor physical functioning, and need for help from outside the home (all p<0.05 to p<0.001). Controlling for both confounders and mediators, synagogue activity remained inversely related to activity limitations (p<0.01), chronic diseases (p<0.05), physical symptoms (p<0.05), and poor physical functioning (p<0.01). In contrast, frequency of prayer remained inversely related to self-rated health (p<0.01), and positively related to activity limitation (p<0.001), physical symptoms (p<0.001), and poor physical functioning (p<0.001). Religious education was inversely related to long-term health problems (p<0.05), but was unrelated to other health measures. Levin concluded that synagogue activity was a significant predictor of better physical health for most indicators, even after adjusting for confounders and mediators. However, frequency of prayer showed the opposite pattern of results (perhaps reflecting its use as a coping behavior with health problems).
*Citation*: Levin J (2012). Religion and physical health among older Israeli Jews: Findings from the SHARE-Israel Study. Israel Medical Association Journal 14(10):595-601.
*Comment*: This is a common pattern seen in large national surveys both in the United States and Canada. Religious attendance is consistently related to better physical and mental health, whereas frequency of prayer is related to worse health. As the author suggests, both findings may in part result from the effects of poor health on religious activity, i.e., preventing religious attendance and increasing use of prayer as a coping mechanism.

### Religion and Self-Rated Health in Rural Greece

Researchers at the University of Athens conducted a cross-sectional survey of 1,519 adults living in the rural region of Tripoli, Greece. The purpose was to examine correlates of self-rated health in the population. Religious involvement was assessed by a 2-item scale asking about frequency of prayer and attendance at religious services. Self-rated health was assessed in the usual manner with five possible responses: poor, fair, good, very good, and excellent. Predictors besides religiosity were age, gender, education, health status, smoking, exercise, diet, and sleep quality. Regression models controlling for these predictors indicated that those with high religiosity were twice as likely as those with low religiosity to rate their health as very good or excellent vs. fair or

poor (OR=2.03, 95% CI 1.01-4.05), and more than twice as likely to rate their health as good vs. fair or poor (OR=2.53, 95% CI 1.38-4.63). Similarly, those with moderate religiosity were twice as likely as those with low religiosity to rate their health as very good or excellent vs. fair or poor (OR=1.93, 95% CI 1.22-3.03), and twice as likely to rate their health as good vs. fair/ poor (OR=2.03, 95% CI 1.34-3.08).
*Citation*: Darviri C, Fouka G, Guardellis C, Artemiadis AK, Tigani X, Alexopoulos EC (2012). Determinants of self-rated health in a representative sample of a rural population. International Journal of Environmental Research and Public Health 9:943-954
*Comment*: Although many U.S. studies report a positive relationship between religiosity and self-rated health, this is one of the few studies of a rural population in Greece. Given the strong relationship between self-rated health and actual physical health and mortality, this report of a gradient of effect of religiosity on self-rated health is particularly significant.

### Does Social Capital Mediate the Relationship between Religion and Health?

Investigators at the University of Arkansas analyzed data from 2006 Social Capital Community Benchmark Survey, a national random sample of 10,828 adults in the U.S. Their aim was to determine whether a measure of social capital mediated the relationship between religious involvement and physical health (self-rated). Religious involvement was measured by a 5-item scale consisting of religious attendance, religious participation outside of worship, religious membership, religious giving, and religious importance. Social capital was assessed by multi-item measures of social trust, informal social interaction, formal group involvement (excluding religious organizations), giving and volunteering, diversity of friendship network, electoral participation, and non-electoral participation. As usual, self-rated health was assessed as poor, fair, good, very good, and excellent. Control variables were age, gender, race, education, marital status, population density, and income. Structural equation modeling was used to analyze these cross-sectional relationships. Results indicated a strong relationship between religiosity and social capital (B=+0.28) and a strong relationship between social capital and self-rated health (B=+0.30). Although there was no *direct* relationship between religiosity and self-rated health, there was a significant *indirect* effect of religiosity on self-rated health through social capital (B=+0.085, p<0.001). The total effect of religiosity on self-rated health was significant (B=+0.10, p<0.001) and largely (85%) mediated by social capital.
*Citation*: Kim-Yeary KH, Ounpraseuth S, Moore P, Bursac Z, Greene P (2012). Religion, social capital, and health. Review of Religious Research 54:331-347
*Comment*: Here is another study examining correlates of self-rated health that reported a significant relationship with religiosity. However, this is the first study to show that the relationship was largely mediated by social capital. Although no direct relationship between religiosity and self-rated health was found, religiosity appeared to influence self-rated health by its effects on boosting social capital, which in turn improved self-rated health [hypothetically speaking, since this was a cross-sectional study]. Social capital is often used as a proxy indicator for community health.

### Religion and Coping in Prostate Cancer Patients Prior to Surgery

Researchers at MD Anderson Cancer Center in Houston, Texas, examined relationships between religious involvement, methods of coping (engagement coping vs. avoidant coping), and mental health in 115 men scheduled for urologic surgery (89% with prostate cancer, mean age 58, 93% Christian). Religious involvement was assessed using the 10-item Hoge intrinsic religiosity scale, a 2-item organizational religiosity scale, and a 3-item private religiosity scale (scores were summed to form a total religiosity score). Coping was assessed by the Brief COPE that measures engagement coping (active coping, planning, acceptance, positive reframing) and avoidant coping (denial and behavioral disengagement). Symptoms of mental distress were assessed using the perceived stress scale (PSS), the impact of events scale (IES), brief symptom inventory (BSI), and profile of mood states (POMS). Social support was assessed using the Medical Outcomes Study Social Support Scale. Results indicated that religiosity was positively and significantly associated with engagement coping, although there was no direct relationship with any of the symptoms distress scales or with social support. However, religiosity did moderate relationships between engagement coping, social support, and mental distress symptoms. Engagement coping was positvely related to to higher IES scores (intrusive or ruminative thoughts, avoidance behaviors) only in those scoring low on religiosity, but not in those scoring high on religiosity. Furthermore, social support was inversely related to PSS and POMS only in those men who scored high on religiosity, but not in those scoring low on religiosity. Researchers concluded that “R/S [religiosity/spirituality] buffered the negative effects of engagement coping on presurgical distress, and…the beneficial effects of social support reducing presurgical distress was only apparent in men who scored high on R/S.”
*Citation*: Biegler K, Cohen L, Scott S, Hitzhusen K, Parker P, Gilts CD, Canada A, Pisters L (2012). Integrative Cancer Therapies 11(3):212-220
*Comment*: While no direct relationship was found between religiosity and mental distress, religiosity served to moderate the effects that other positive behaviors (engagement coping and social support) had on mental distress, i.e., the benefits of those positive behaviors were apparent only present in men with high religiosity. This suggests that researchers should examine how religiosity moderates the effects of other coping behaviors/resources on mental health outcomes (which is seldom done).

### Does Belief in God Affect Psychiatric Treatment Outcomes?

Researchers at McLean Hospital (Harvard Medical School) prospectively followed 159 psychiatric patients in a day-treatment program. Participants were recruited from a cognitive-behavioral therapy partial-hospital program during a 1-year period. Only 5% refused after being approached and only two subjects refused after informed consent. Primary outcomes were treatment response and reduction in depressive symptoms; secondary outcomes were increases in well-being and decreases in self-harm behaviors. Outcomes were assessed at the start and conclusion of the partial-hospital stay, i.e., an average of 10 days. Investigators assessed belief in God, congregational support, treatment credibility, and emotional regulation prior to treatment. Belief in God was measured using a single question: "To what extent do you believe in God?" with responses ranging on a 5-point scale from "Not at all" to "Very." Congregational support was assessed using a 2-item measure of support received (Krause). Treatment credibility/expectancy was measured using the standard 6-item Devilly-Borkovec scale; emotional regulation was assessed by a standard 10-item scale; depression by the 10-item CES-D; and self-harm by the 24-item BASIS-24. Results indicated that neither belief nor congregational support was associated with baseline psychiatric symptoms. With regard to treatment response, however, belief in God was significantly higher among treatment responders compared to non-responders (F=4.8, p<0.05) and was linearly associated with a reduction in depressive symptoms (r=+0.21, p<0.05). In addition, belief in God was associated with both increases in psychological well-being (r=-0.19, p<0.05) and reductions in self-harm (r=+0.24, p<0.01). Relationships between belief in God and changes in depression and self-harm remained statistical significance after controlling for age and gender. Belief

in God was also associated with greater treatment credibility, greater treatment expectancy, and greater religious community support. Further analyses revealed that treatment credibility/expectancy mediated the effects of belief in God on improvement in depressive symptoms. However, when comparing subjects high on both belief in God and treatment credibility/expectancy (n=27) with those high on belief in God but low on treatment credibility/expectancy (n=9), the likelihood of a positive outcome was the same. Researchers concluded that among patients with high belief in God, the effects of belief in God on treatment outcome may be independent of faith in the treatment.
*Citation*: Rosmarin DH, Bigda-Peyton JS, Kertz SJ, Smith N, Rauch SL, Bjorgvinsson T (2012). A test of faith in God and treatment: The relationship of belief in God to psychiatric treatment outcomes. Journal of Affective Disorders, October 7 [Epub ahead of print]
*Comment*: Those with belief in God (52% indicating moderately or very strong belief) were more likely to experience better outcomes from psychiatric treatment compared to those with less strong or no belief in God. This effect was explained by pre-treatment belief in the credibility of the treatment and the expectation of improvement. In our review of the literature on religion/spirituality and optimism in the Handbook of Religion and Health (2012), 80% of studies found that religious persons were significantly more likely to be optimistic. Indeed, such optimism may facilitate response to psychiatric treatment.

### Religion and Loneliness in Later Life

Studying the relationship between religious involvement and loneliness in later life, researchers analyzed data from a population-based sample of 2,165 persons ages 57 to 85 participating in the 2005/2006 U.S. National Social Life Health and Aging Project. Religious involvement was assessed using a single question that assessed how often participants attended religious services within the past 12 months from never (0) to several times a week (6). Social integration was measured by social network size and frequency of contact with network members. Social support was assessed by availability of instrumental and emotional support from friends. Loneliness was assessed with the revised 4-item UCLA Loneliness Scale. Also assessed were depressive symptoms (6-item CES-D), physical health (number of chronic conditions and disability level), and personality (perceived attractiveness and attendance at secular meetings). Also measured was a range of confounders, including age, gender, race, ethnicity, education, employment status, income, marital status, and number of children/grandchildren. Results indicated that religious attendance was inversely related to loneliness ($p<0.001$). Controlling for confounders reduced the relationship some, but the inverse correlation remained significant ($p<0.01$). After controlling for personality and other explanatory variables (except social variables), religious attendance remained inversely correlated with loneliness ($p<0.05$). When social integration and social support were controlled for, however, this explained the inverse relationship between attendance and loneliness. Researchers concluded that the effects of religious attendance on loneliness are indirect, acting through greater social support and social integration.
*Citation*: Rote S, Hill TD, Ellison CG (2012). Religious attendance and loneliness in later life. The Gerontologist, May 2 [E-pub ahead of print]
*Comment*: This study helps to explain how religious attendance might help to buffer against loneliness in later life. With its comprehensive approach to analyzing the data, this paper represents a model for studying the effects of confounders and explanatory variables, considering both the direct and indirect effects of a religious variable on a mental health outcome.

## NEWS

### Spirituality and Healing in Medicine

Harvard Medical School Departments of Psychiatry and Anaesthesia are putting on a 2-credit course in the Spring 2013 in Boston, MA. Course directors are John Peteet, M.D., and Michael D'Ambra, M.D. The faculty will consist of Tracy Balboni, M.D., M.P.H.; Michael Balboni, Ph.D., M.Div.,Th.M.; Terry Bard, D.D., Shan Liu, M.D., M.P.H., and Walter Moczynski, M.Div., M.T.S., D.Min. The first meeting will be held 5:30-7:30P, January 29 (and last class is April 30). Enrollment is limited to 25. The purpose of the course is to provide students and resident physicians with a framework for understanding the spiritual dimension of lives of patients and of spiritual issues they will confront in the practice of medicine. For questions, e-mail Dr. John Peteet at John_Peteet@dfci.harvard.edu.

### Health and the Human Spirit: Shaping the Direction of Spiritual Health Care in Manitoba

The government of the province of Manitoba, Canada, has developed a 4-year spiritual health care strategic plan that could serve as a model for other secular healthcare systems. The core of the plan is promotion (raising awareness), education (maximizing opportunities for knowledge-sharing), integration (building spiritual health care services across the health care continuum), and access (assessing spiritual health needs and enhancing the scope and availability of spiitual health care services). This spiritual care plan is the first attempt of its kind in Canada. The mission is to advance and implement spiritual health care as an integral component of holistic health care in Manitoba. Spiritual health care "involves a recovery of the patient as a person, upholding his or her beliefs and experiences and addressing matters of meaning and hope…As one person in the service of another, spiritual (health) care is therefore literally therapeutic and not an attempt to impose, intervene or control." The manual is available at: http://www.gov.mb.ca/healthyliving/mh/docs/health_human_spirit.pdf.

### Research as a Form of Chaplain Care

Daniel Grossoehme has written a short 2-page editorial in the *Journal of Health Care Chaplaincy* titled "Research *as* a chaplaincy intervention." He leads off by describing the case of a participant in his research study that thanked him for allowing him to participate in the study. This made Grossoehme think that when people are allowed to tell their personal experiences in a research study they often derive immediate therapeutic benefit (even when this is not the intent of the research). He notes that conducting research could be considered a form of chaplain care. The article is well-worth reading for any chaplains interested in conducting research (and even those who are not interested). The article can be found by going to website http://www.ncbi.nlm.nih.gov/pubmed/22029503, and then proceeding to the Taylor & Francis website where the article is posted.

## SPECIAL EVENTS

### Spiritual and Religious Support Conference in Saudi Arabia

(January 1-3, 2013)
This is the first religion/spirituality and health conference to be held in Saudi Arabia. It is supported by the King Fahad Medical City and Islamic Medical Association of North America. The event will begin on January 1 in the King Fahad Medical City main auditorium in Riyadh (and may be broadcast over the Internet). The targeted audience includes religious counselors, spiritual support health professionals, patient affairs and patient relations staff, psychiatrists, social workers, physicians, nurses and all other health care providers (including students). For more

information, contact Ms. Azzah Al-Shehri, the *Patients Spiritual And Religious Support Scientific Committee Coordinator*, at aalshihri@kfmc.med.sa.

**Spiritual Care as a Dimension of Palliative Care** (March 6-7, 2013, Los Angeles, CA)
The City of Hope National Medical Center is presenting this conference with the purpose of providing an opportunity to network with others committed to improving the delivery of spiritual care in palliative care. The National Consensus Project (NCP) Guidelines and National Quality Forum (NQF) Preferred Practices served as the foundation for the recommendations for a Consensus Conference in 2010. A partnership was formed at that time to support nine demonstration projects that model the implementation of these recommendations for other programs to replicate. The present 2-day conference will highlight each of the demonstration sites' accomplishments and success in integrating spiritual care as part of palliative care within their respective institutions. Keynote speakers include Rev. Michael Balboni, Ph.D., Th.M., M.Div.; Betty Ferrell, Ph.D., M.A., FAAN; Christina Puchalski, M.D.; and Carol Taylor, Ph.D., R.N. For more information, see website: http://www.cityofhome.org/nre-spiritual-care-conference.

**David B. Larson Memorial Lecture** (March 7, 2013, in Durham, NC)
The 11th Annual David B. Larson Memorial Lecture will be held at Duke University Hospital North, Room 2001, from 5:30-6:30P on Thursday March 7. The speaker will be George Fitchett, D.Min., Ph.D., who is Professor and Director of Research in the Department of Religion, Health, and Human Values, Rush University Medical Center, Chicago, Ill, where he also holds an appointment in the Department of Preventive Medicine. Dr. Fitchett is trained in both chaplaincy and epidemiology. Using data from a recent study of VA mental health chaplains, Dr. Fitchett will describe current practice in chaplains' spiritual assessment, a model for evidence-based spiritual assessment, and the research needed to develop that model. For details about the location and time of the lecture see website: http://www.spiritualityandhealth.duke.edu/education/larson/index.html.

**Faith Connections on Mental Illness** (March 8, 2013, in Chapel Hill, NC)
This 3rd Annual Conference will focus on the role of religious communities in meeting the needs of those with chronic mental illness. The time is 8:30A-4:00P at St. Thomas More Church. The keynote speaker will be Nancy Kehoe, Ph.D., who is a licensed psychologist, nun in the Society of the Sacred Heart, author of "Wrestling with Our Inner Angels: Faith, Mental illness, and the Journey to Wholeness," and a pioneer in incorporating spiritual and religious beliefs with mental health treatment. For more information, see website: http://www.faithconnectionsonmentalillness.org/.

**Emerging Tools for Innovative Providers:** Interdisciplinary Applications from Spirituality and Health Research (July 22-26, 2013, in Pasadena, CA)
Preparations are now being made to hold a 5-day conference at Fuller Theological Seminary in Southern California on how to integrate the latest findings from spirituality and health research into clinical practice. Presenters will include Ken Pargament and others in the field of spirituality and health. Save the date, as this will be a truly dynamic conference and will include lots of hands-on activities and workshops. For more information, contact Bruce Nelson at NELSONBR@ah.org.

**Duke Summer Spirituality & Health Research Workshops** (August 12-16, 2013, Durham, NC)
Register now to ensure a spot in our 2013 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 has already been done. Those with any level of training or exposure to the topic will benefit from this workshop, from laypersons to graduate students to full-time professors at academic institutions. Over 600 persons have attended this workshop since 2004. Individual mentorship is being provided to those who need help with their research or desire career guidance. Partial **tuition scholarships** will be available for those with strong academic potential and serious financial hardships. For more information, see website: http://www.spiritualityhealthworkshops.org/.

**4th Christian Congress on Health and Spirituality (Christlicher Gesundheitskongress)** (March 27-29, 2014)
The Christian Health Congress (an ecumenical congress for all matters of spirituality and health) is having its 4th conference in Bielefeld, Germany. This conference is for Christians in the health professions. For more information (in German), go to website: http://www.christlicher-gesundheitskongress.de/.

## RESOURCES

**Comprehensive Review of Research on Religion, Spirituality and Health**
Published in December 2012 in ISRN Psychiatry is a review of research on religion, spirituality and health from the late 1800's to 2010. For those who may have difficulty obtaining a copy of the 2012 Handbook of Religion and Health, this article summarizes the research findings contained in that volume (and the 2001 volume). *There is no more updated and comprehensive review of the research in the published literature to date*. The article also discusses the clinical applications of this research to patient care. A pdf of the article can be downloaded from this open access journal *for free* from anywhere in the world. See website: http://www.hindawi.com/isrn/psychiatry/2012/278730/

**Spirituality & Health Research: Methods, Measurement, Statistics, & Resources** (2011)
This book summarizes and expands the content presented in the *Duke Research Workshop on Spirituality and Health*, and is packed full of information necessary to conduct research in this area acquired over 25 years by the author. Available at: http://templetonpress.org/book/spirituality-and-health-research

**Handbook of Religion and Health (2nd Ed)** (2012)
This Second Edition covers the latest original quantitative research on religion, spirituality and health. Religion/spirituality-health researchers, educators, health professionals, and religious professionals will find this resources invaluable. Available, at http://www.amazon.com/Handbook-Religion-Health-Harold-Koenig/dp/0195335953

## FUNDING OPPORTUNITIES

### Templeton Foundation Online Funding Inquiry (OFI)

The Templeton Foundation will be accepting the next round of letters of intent for research on spirituality and health beginning **February 1, 2013**. If the funding inquiry is approved (applicant notified by May 3, 2013), the Foundation will ask for a full proposal that will be due September 2, 2013, with a decision on the proposal reached by December 20, 2013. More information: http://www.templeton.org/what-we-fund/our-grantmaking-process

### Covenant Health Research Centre (CHRC) Grants

CHRC is requesting Letters of Intent for research studies examining the interaction between faith, spirituality, health and healing. Areas of particular interest are the effect of spiritual and religious practices on heath outcomes, mechanisms by which religion and spirituality may impact health, effect of spiritual/religious beliefs on values that affect health-related decision making, the spiritual needs of those receiving healthcare, the efficacy of spiritual interventions as part of health promotion and clinical treatment, the spirituality of healthcare providers, and interpretation of what the findings mean for individuals, congregations, academic communities, and health care providers through transdisciplinary collaboration. The deadline for Letters of Intent is *February 15, 2013*. Applicants will be notified on March 7 if a full proposal is requested, full proposals are due April 15, and applicants will be notified of the decision to fund on May 31. The maximum grant amount is $25,000 CDN. Healthcare providers/clinicians and academic researchers are encouraged to apply. No funding is provided for salary support for the lead applicant. Funds covered requested must cover research-related expenses. For more information: http://www.caritas.ab.ca/Home/Research/ForResearchers/GrantRequests/Faith+Spirituality+Health+Grant

## 2013 CALENDAR OF EVENTS…

**Jan**

1-3 Spiritual and Religious Support Conference
Presenters: Fitzgerald (Stanford), Koenig, others
King Fahad Medical City main auditorium
Riyadh, Saudi Arabia
Contact: Ms. Azzah Al-Shehri (aalshihri@kfmc.med.sa)

15 Religion, Spirituality and Coping with Cancer
Duke Cancer Center, Clinic 3-2
Presenter: Koenig
Durham, North Carolina
Contact: Judy Ridley (ridle001@mc.duke.edu)

24-25 Religion, Spirituality and Health for the Living and the Dying
Presenter: Koenig
The Moorings Presbyterian Church & Avow Hospice
Naples, Florida
Contact: Jim Kirk (jkirk@Moorings-Presby.org)

30 The Role of Spirituality in Palliative Care
Presenter: James Tulsky, M.D., Director, Duke Center for Palliative Care
Center for Aging, 3rd floor, Duke South, Blue Zone, 3:30-4:30
Durham, North Carolina
Contact: Harold G. Koenig (harold.koenig@duke.edu)

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