

# 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, and events in this area.

All e-newsletters are archived on our website. To view previous editions (July 2007 through June 2016) go to:

<http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

## LATEST RESEARCH

### Religious Attendance and Mortality in U.S. Women

Researchers from the department of epidemiology, Harvard School of Public Health, examined the effects of religious attendance in 1996 on overall and cause-specific mortality in a cohort of 74,534 women followed for 18 years from 1996 to 2012. There were 13,537 deaths occurring during the 1,104,175 person-years of follow-up. Religious attendance was assessed with a single question, "How often do you go to religious meetings or services?" Response options were "more than once a week," "once a week," "1-3 times per month," "less than once per month," and "never (or almost never)." Religious attendance in 1992 was controlled for as a covariate, and those who had diagnoses of cardiovascular disease or cancer before 1996 were excluded. The primary outcomes were all-cause and cause-specific mortality. In addition to 1992 attendance, other covariates were age, alcohol consumption, physical exercise, multivitamin use, hypertension, hypercholesterolemia, diabetes, menopausal state, physical exam in past two years, healthy eating score, smoking status, body mass index, husband's educational level, physical functioning, social integration (assessed by marital status, other group participation, number of close friends, number of close relatives, number of close friends seen at least once per month, number of close relatives seen at least once per month), living alone, median family income, geographical region, and depression in 1992 (assessed by CES-D). Mediators after the 1996 religious attendance exposure included depressive symptoms, smoking, alcohol consumption, diet quality, number of close friends and having someone close to talk to, optimism, and phobic anxiety. Deaths were identified through reports from next of kin and the National Death Index. **Results:** Compared to women who never attended religious services, all cause mortality among women attending more than once/week (after adjusting for covariates) was HR was 0.67 (95% CI 0.62-0.71), i.e., a 33% reduction in mortality; for weekly attendance, the HR was 0.74 (95% CI 0.70-0.78), i.e., a 26% reduction in mortality; and for less than weekly attendance, the HR was 0.87 (95% CI, 0.81-0.92), i.e., a 13% reduction in mortality. The significance level for a trend in the relationships was

$p < 0.001$  (indicating a dose-effect response). For cause-specific mortality, the HR was 0.73 (95% CI, 0.62-0.85) for cardiovascular disease (also  $p < 0.001$  for trend) and the HR was 0.79 (95% CI, 0.70-0.89) for cancer (also  $p < 0.001$  for trend). Religious attendance was associated with lower mortality from cerebrovascular disease and other cardiovascular diseases; it was also associated with significantly lower breast cancer and colorectal cancer mortality. No association with incidence of breast cancer or cardiovascular disease was found. Effects (all-cause mortality) were largest for African-American women (HR=0.64, 95% 0.46-0.90). Effects were comparable for Protestants and Catholics. Mediation analysis revealed that depressive symptoms mediated 11%, cigarette smoking 22%, optimism 9%, and social integration 23% of the effect, with 35% of the effect unexplained. The authors note that this is the first report on religious attendance and mortality that includes repeated measures of religious attendance, takes into account reverse causation, and controls for time-dependent confounders using proportional hazard and marginal structural models. With regard to clinical implications, the authors conclude: "Our results do not imply that healthcare professionals should prescribe attendance at religious services, but for those who already hold religious beliefs, attendance at services could be encouraged as a form of meaningful social participation."

*Citation:* Li S, Stampfer MJ, Williams DR, VanderWeele TJ (2016). Association of religious service attendance with mortality among women. *JAMA Internal Medicine* 176(6):777-785.

*Comment:* This is an extraordinary report with impeccable statistical analyses that confirms much of the earlier research demonstrating a positive association between religious attendance and length of survival. Since mortality is often an indicator of the cumulative effects of a health behavior over a person's lifetime, these findings also suggest a positive association between religious attendance and health more generally. Lower depressive symptoms, greater optimism, better health behaviors, and greater social integration helped to explain the effect in this study, but not all of it. Particularly notable is that social factors explained less than one-quarter of the effect, suggesting that the way that religious attendance affects health may be a lot more than just social support.

### Belief in God among American Jews

A 2013 Pew Research Center survey of the U.S. population found that only 34% of Jews said they were certain that God exists, 43% believed but were uncertain, and 23% reported not believing at all. Another recent survey found that two-thirds of U.S. Jews see no conflict between being Jewish and not believing in God. Silverman and colleagues at the University of Arizona question those figures. They conducted in-depth qualitative interviews with 35 local Jews (8 clergy and 27 lay members of Reform and Conservative synagogues) and a quantitative online survey of 72 American Jews. **Results:** The findings suggest that Jews' beliefs about God are complex and dynamic, and there are historical philosophical, theological and cultural reasons for that. Simple yes/no responses on a questionnaire cannot adequately account for that complexity. Many U.S. Jews believe in God (nearly three-quarters), although they hold a variety of images of what God is

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like – images that range from a “benevolent personal being” to a “mystical cosmic force” to an “ineffable being who is unknowable and incomprehensible” (benevolent personal being image was most likely, or at least had the highest rating in the quantitative survey). The in-depth interviews, however, suggested that these images of God are relatively unstable and less strongly held compared to images held by other religious groups like Christians and Muslims. Researchers concluded that “no single research method is sufficient for fully assessing and interpreting Jewish representations of God” and that “an iterative mixed-methods approach...can play an essential role in exploring the dynamic and diverse experiences of different religious traditions, practices, and beliefs.”

*Citation:* Silverman GS, Johnson KA, Cohen AB (2016). To believe or not to believe, that is not the question: The complexity of Jewish beliefs about God. *Psychology of Religion and Spirituality* 8(2):119-130

*Comment:* This is an excellent study on the wide range of beliefs that U.S. Jews have about God. Clearly, the issue is much more complex than just believing or not believing.

### Religiosity and Traumatic Stress in Israeli Soldiers following Combat

Researchers in the department of sociology at Northwestern University in the U.S. and Ashkelon Academic College in Israel surveyed 54 Israeli soldiers returning from combat (Israeli-Gaza war) examining the moderating effect of religiosity on traumatic stress symptoms. Also examined were the mediating effects of self-efficacy and social support. Half of participants were religious (Orthodox belief and practice) and half were not religious (secular or traditional). Traumatic stress was assessed using the self-report version of the 20-item PTSD checklist for DSM-V (PCL-5); social support by a 3-item emotional support scale (a subscale of the 2-Way Social Support Scale; Shakespeare-Finch); and self-efficacy by the 10-item Hebrew adaptation of the General Self-Efficacy Scale (Zeidner). Hierarchical multiple regression was used to examine predictors of PTSD symptoms on the PCL-5. **Results:** Religiosity (1= religious, 0=non-religious) was significantly and inversely related to PTSD symptoms ( $r=-0.37$ ,  $p<0.01$ ), as was social support ( $r=-0.39$ ,  $p<0.01$ ). Regression analyses, controlling for degree of direct exposure to trauma, self efficacy and social support, revealed a significant relationship between religiosity and PTSD symptoms ( $B=-0.33$ ,  $p=0.006$ ). There was also a significant interaction between religiosity and self-efficacy, such that religiosity moderated the relationship between self-efficacy and PTSD symptoms (i.e., self-efficacy was associated with lower PTSD symptoms especially in those who were religious).

*Citation:* Israel-Cohen Y, Kaplan O, Noy S, Kashy-Rosenbaum G (2016). Religiosity as a moderator of self-efficacy and social support in predicting traumatic stress among combat soldiers. *Journal of Religion and Health* 55:1160-1171

*Comment:* Even with this relatively superficial measure of religiosity (Orthodox vs. Secular or Traditional) and small sample, religious involvement appeared to buffer the effects of combat on development of PTSD symptoms. These findings were independent of level of exposure to traumatic events. In addition, greater self-efficacy was associated with lower PTSD symptoms, but primarily in those who were religious. These findings support the development of spiritually-oriented treatments for military personnel with PTSD symptoms.

### Prayer and General Health of Adult Men in Iran

Investigators in the faculties of medicine and nursing at Semnan University in Semnan, Iran, examined the relationship between prayer attendance and general health among a random sample of 470 adult males in the urban city of Semnan. Most participants were between the ages of 20 and 40 years (80%), and about half (49%) had less than a high school diploma and were unmarried

(47%). Frequency of prayer was assessed using a five-point: (1) “I do not say prayers” (14%); (2) “I usually say prayers, but sometimes very late” (33%); (3) “I say prayer at the prescribed time, but I do not perform Nafilahs” (18%) [supererogatory prayers or Nafilahs prayers are prayers that the Muslim performs in addition to the obligatory prayers, in order to pay more attention to God]; (4) “I say prayers on time” (26%); and (5) “I say prayers on time, and I perform Nafilahs” (9%). The General Health Questionnaire (GHQ-28) was used to assess physical symptoms, anxiety/insomnia, social dysfunction, and depression; those who score 23 or higher are considered to have general health impairment. Stepwise logistic regression was used to estimate odds ratios and 95% confidence intervals, controlling for smoking, education level, and comorbidity. **Results:** Men who did not say their prayers were nearly 3 times more likely to have health impairment compared to those who said their prayers on time and performed Nafilahs ( $OR=2.87$ , 95%  $CI= 1.23-6.70$ ,  $p=0.015$ ). According to researchers: “In conclusion, the findings show that increasing the degree of people’s belief in prayer can lead to improved general health.”

*Citation:* Sotodehasl N, Ghorbani R, Maydavi-Nejad G, Hajji-Aghajani S, Mehdizadeh J (2016). Prayer attendance and general health in the Iranian adult urban population. *Journal of Religion and Health* 55:110-118.

*Comment:* In this study that takes place in a very religious Middle Eastern country, religious activity (prayer) is inversely associated with health impairment in cross-sectional analyses. How interesting that the exact opposite appears to be the finding in secular Europe, where chronic illness and poor health appear to be positively associated with religious activity (especially with private religious activity). Stay tuned for a future published report on a large study of religious activity and health in Northern Europe.

### Belief in God vs. Belief in Science: Which One is Related to Greater Psychological Well-Being?

Researchers at Allamaeh Tabataba’i University, Tehran, Iran, and the University of Oregon examined relationships between religious and scientific attitudes, life satisfaction, happiness, and self-esteem in 474 Iranian Muslim university students (age range 18 to 55, mean 22.6 years). Religiosity was assessed using the 14-item Religious Orientation Scale-Revised (Gorsuch & McPherson) and the 14-item Muslim Attitudes toward Religion Scale (Muslim religiosity) (Wild & Joseph). “Belief in science,” in turn, was assessed by the 16-item Attitudes toward Science and Technology Scale. Also administered were the 12-item Hope Scale, 20-item Purpose in Life Scale, and 15-item Templer Death Anxiety Scale (as possible mediators). Finally, the primary outcome (psychological well-being) was measured using standard multi-item scales of happiness (Lyubomirsky), satisfaction with life (Diener), and self-esteem (Rosenberg). Structural equation modeling was used to examine the mediating effects of hope, purpose in life, and death anxiety on relationships between religiosity, belief in science, and psychological well-being. **Results:** Muslim religiosity was positively correlated with happiness ( $r=0.17$ ,  $p<0.01$ ), life satisfaction ( $r=0.34$ ,  $p<0.01$ ), and self-esteem ( $r=0.18$ ,  $p<0.01$ ). It was also correlated with purpose in life ( $r=0.30$ ,  $p<0.01$ ) and hope ( $r=0.35$ ,  $p<0.01$ ), yet was associated with greater death anxiety ( $r=0.12$ ,  $p<0.01$ ). Similar but somewhat weaker relationships were found between more general religious orientation and well-being. “Belief in science” was also correlated with life satisfaction ( $r=0.13$ ,  $p<0.01$ ) and self-esteem ( $r=0.17$ ,  $p<0.01$ ), but not with happiness ( $r=0.03$ ,  $p=ns$ ). It was, however, related to greater purpose in life ( $r=0.25$ ,  $p<0.01$ ) and hope ( $r=0.27$ ,  $p<0.01$ ) (no association with death anxiety [ $r=0.03$ ,  $p=ns$ ]). In structural equation models, hope, purpose in life, and death anxiety fully mediated the relationships between psychological well-being and both religiosity and belief in science.

*Citation:* Aghababael N, Sohrabi F, Eskandari H, Borjali A, Farrokhi N, Chen AJ (2016). Predicting subjective well-being by religious and scientific attitudes with hope, purpose in life, and death anxiety as mediators. Personality and Individual Differences 90:93-98

*Comment:* So, does belief in God or belief in Science correlate more strongly with psychological well-being in young Iranian college students? Based on the strengths of the correlations, it is a close call (although correlations were slightly larger for religiosity). Regardless, both relationships appear to be mediated largely by hope and purpose in life.

### Religious “Disaffiliation” and Health

Many studies have examined the relationship between religious involvement and health, as we regularly summarize in this E-newsletter. However, what happens to health when people leave the religious faith of their youth and transition to no religious affiliation in adulthood? This is the question that researchers from the National Center for Health Statistics in Hyattsville, Maryland, asked. They analyzed data from pooled General Social Survey (GSS) samples surveyed from 1973 through 2012, yielding a random sample of 34,565 adults in the U.S. This large sample allows determination of religious switching behaviors not possible otherwise. The GSS collects information on religious affiliation that allows individuals to be categorized based on standard denominational groups. The religious dissatisfaction measure used in this study was developed by taking into account the religion in which the participant was raised and their current religious affiliation: (1) raised and remain religious (consistently affiliated, 87%); (2) raised religious but switched to no religious affiliation (disaffiliates, 8%); (3) raised with no religious affiliation and switched to religious (convertors, 2%); and (4) raised and remain with no religious affiliation (consistently unaffiliated, 3%). In addition, researchers considered disaffiliation specific to the following denominations: evangelical Protestants, mainline Protestants, Catholics, and “high cost” groups (Mormons, Jehovah’s Witnesses, Seventh-day Adventists). The dependent variable in this study was self-reported health (excellent, good, fair, poor), which was dichotomized into excellent/good and fair/poor categories for analysis. Happiness was also assessed with a single question with responses of “not too happy” (12%), “pretty happy” (56%), and “very happy” (32%). Health and well-being was compared between those who remained religious (consistently affiliated) and disaffiliates, controlling in regression models for age, sex, race, geographic region, and year of interview. **Results:** Disaffiliates experienced poorer physical health (OR=1.21,  $p<0.01$ ) and lower well-being (OR=1.30,  $p<0.01$ ) than the consistently affiliated. Similar relationships were present when comparing disaffiliates with the consistently *unaffiliated* and with convertors. Relationships were mediated by frequency of religious attendance, since disaffiliates attended religious services less frequently. With regard to prevalence rates of switching in different denominations, disaffiliates were most likely present (13%) among the high cost group (Mormons, Jehovah’s Witnesses, Seventh-day Adventists) and among Catholics (9.3%), compared to Evangelical Protestants (7.2%) and mainline Protestants (8.3%). The effects of disaffiliation on poor health were especially strong in the “high cost” group (OR=2.75) and in Evangelical Protestants (OR= 1.33); disaffiliation was also a particularly strong correlate of low happiness in Evangelical Protestants (OR=1.54).

*Citation:* Fenelon A, Danielsen S (2016). Leaving my religion: understanding the relationship between religious disaffiliation, health, and well-being. Social Science Research 57:49-62

*Comment:* A fascinating study that examines the effects of changing one’s religious affiliation from childhood to being unaffiliated in adulthood. If this is true, then one might expect that as the United States becomes more secular, health and well-being of the population may also change.

### Religious/Spiritual Struggles and Personality

Investigators at Case Western Reserve University and Bowling Green State University conducted an online survey of 1,047 U.S. adults and 3,083 undergraduate university students to examine the relationship between religious/spiritual (R/S) struggles and personality traits. Personality traits were measured using the 44-item Big Five Inventory. Religiosity was assessed using the Religious Belief Salience Scale (4-item measure, Blaine & Crocker), and R/S struggles were assessed using the 26-item Religious and Spiritual Struggles Scale (Exline et al., 2014). Both current and lifetime R/S struggles were measured. Psychological well-being was assessed using the 14-item Mental Health Continuum-Short Form. **Results:** Lifetime and current R/S struggles were both inversely correlated with the personality traits “agreeableness” and “conscientiousness,” whereas they were positively correlated with “neuroticism” and “openness to new experiences” in both adult and college samples. R/S struggles were also correlated with lower psychological well-being, independent of both personality traits and religiosity. Finally, religiosity in both samples was correlated with greater psychological well-being, independent of personality traits and R/S struggles. Researchers concluded: “We found that lifetime history of R/S struggles and current R/S struggles both showed robust links to the Big Five, and yet they also explained incremental variance (above and beyond the Big Five and religiosity) in various aspects of well-being.”

*Citation:* Wilt JA, Grubbs JB, Pargament KI, Exline JJ (2016). Religious and spiritual struggles, past and present: relations to the Big Five and well-being. International Journal for the Psychology of Religion, May 2, E-pub ahead of press

*Comment:* Religious/spiritual struggles, regardless of how they are measured, have been consistently associated with worse mental and physical health for the last two decades. This study shows that such struggles are related to lower agreeableness, lower conscientiousness, and lower psychological well-being, and that overall religiosity is associated with greater well-being, even after common personality traits are taken into account.

### Religion and Stress in Young Parents

Investigators at Baylor University and Louisiana State University analyzed data from the National Longitudinal Study of Adolescent to Adult Health (NLSAHH) to examine the relationship between “parenting satisfaction,” “parenting stress,” and religious involvement in young parents. The sample was Wave 4 of NLSAHH when participants were ages 24-34 years old, and consisted of 4,191 mothers and 2,113 fathers. All variables were from Wave 4 except for region, race, and gender (Wave 1). Parenting satisfaction was measured with a single question: “How much do you agree or disagree with the following statement?:” “I am happy in my role as a parent”; there were 5 possible response options ranging from “strongly disagree” to “strongly agree” (79% strongly agreed). Parenting stress was also assessed with a single question: “How much do you agree or disagree with the following statement?:” “I feel overwhelmed by the responsibility of being a parent”; there were 5 response options ranging from “strongly disagree” to “strongly agree” (13% agreed/strongly agreed). Religious involvement was assessed by religious affiliation (including 15% of participants who were unaffiliated), frequency of attendance at religious services, importance of religion, and frequency of private prayer. A series of five multivariate logistic regression models were developed for each outcome, and analyses were conducted separately in mothers and fathers, controlling for race/ethnicity, education, household income, employment status, homeowners status, number of co-resident biological children, and marital status. Analyses were also stratified by living situation. **Results:** With regard to *parental satisfaction* among mothers (controlling for religious affiliation), frequency of religious service attendance (OR=1.15,  $p<0.01$ ),

importance of religion in daily life (OR=1.30,  $p<0.01$ ), and frequency of personal prayer (OR 1.09,  $p<0.001$ ) were all positively related to greater parental satisfaction. Parental satisfaction was particularly high among cohabitating mothers (vs. married or single) who were black Protestants. With regard to parental satisfaction among fathers, similar relationships were found: frequency of religious attendance (OR=1.15,  $p<0.05$ ), importance of religion (OR=1.50,  $p<0.01$ ), and personal prayer (OR=1.08,  $p<0.05$ ) were all related to fathers' parental satisfaction. Fathers affiliated with "other religion" category (Jews, Buddhists, Muslims, Mormons, etc.), however, experienced lower parental satisfaction (OR=0.41,  $p<0.01$ ). With regard to *parental stress* among mothers, only religious affiliation emerged as a predictor. Compared to conservative Protestants, Catholic affiliation was associated with significantly greater stress (OR=2.50,  $p<0.001$ ), as was being unaffiliated with a faith tradition (OR=1.65,  $p<0.05$ ) and those affiliated with "other religion" (OR=1.83,  $p<0.05$ ). Religious affiliation was particularly associated with stress among cohabitating (vs. married or single) mothers with mainline Protestant, Catholic, or other religious affiliations (compared to conservative Protestants). No other religious variable was associated with parental stress in mothers once affiliation was controlled for. With regard to parental stress among fathers, no significant associations were found with any religious characteristics; in subgroup analyses among married fathers, however, mainline Protestant affiliation (vs. conservative Protestant) was associated with greater parental stress. Researchers concluded that "Religion has a generally positive influence on parenting attitudes among young parents—both mothers and fathers—in diverse family structures."

*Citation:* Henderson WM, Uecker JE (2016). The role of religion in parenting satisfaction and parenting stress among young parents. Sociological Quarterly, E-pub ahead of press (doi: 10.1111/tsq.12147)

*Comment:* Although all associations were cross-sectional in nature, preventing conclusions about direction of causation, the quality and large size of the NLSAHH sample contributes to the relevance of the findings (along with careful control for covariates). Possible explanations for the findings are provided in the paper.

### Intercessory Prayer for Disruptive Behaviors in Advanced Dementia

Researchers in the departments of nursing at the University of Iowa and University of Wisconsin examined the effects of distant intercessory prayer (DIP) in a single group experimental study intended to reduce disruptive behaviors in six terminally ill patients with late stage dementia. Patients resided in a locked dementia unit at a Catholic, non-profit long-term care facility in the Midwest U.S. Intercessory prayer for 12 weeks was provided by two groups of Catholic sisters, one offering the Lord's Prayer for the patients twice a day, and a second group of Catholic sisters who provided intercessory prayer via the Latria modality ("perpetual adoration"). In addition, six nuns who worked as CNAs (certified nurses assistants) at the facility offered the Lord's Prayer as DIP for a specifically assigned participant twice a day (these nuns worked outside of the locked dementia unit in the intermediate care nursing section). Those caring for the patients at the facility (and doing the ratings) were blinded to which patients on the dementia unit were receiving DIP. Disruptive behaviors were assessed from 3 weeks pre-intervention (baseline) through the 12-week intervention and for 3 weeks post-intervention using the Brief Agitation Rating Scale (BARS). BARS is a subsection of the Cohen-Mansfield Agitation Inventory that measures physical aggression and verbal aggression (kicking, hitting, pinching, and grabbing along with distressing delusions and hallucinations, as well as restlessness irritability resistance to caregiving, scolding, criticizing, yelling, and swearing). Disruptive behaviors were assessed every eight hours (every shift) and documented in

patients' medical records; both the CNAs and supervisory nurses made separate recordings. Antipsychotic medication use was also assessed and measured throughout the study. **Results:** Participants were ages 71 to 95, and four were female and two were male. Two of the six patients died during the study. Four of the six subjects had either a reduction in the dose or discontinuation of their antipsychotic medications. There was also a trend towards reduction in disruptive behaviors during the intervention although it did not reach statistical significance due to small numbers [ $F(2,3)=2.73$ ,  $p<0.114$ ]. The average number of disruptive behaviors decreased from 3.22 at baseline to 3.05 during the three-month intervention to 2.56 during the 3-week follow-up period (based on CNA ratings). The effect size of the treatment based on CNAs' documentation was  $d=0.27$  and based on nurses' documentation was 0.31 (a small effect size). The study authors concluded: "This study suggests that it is feasible to improve the life quality of patients in the terminal phase of their illness through prayer reducing their need to respond to life in a disturbed manner."

*Citation:* Struve AR, Lu DF, Hart LK, Keller T (2016). The use of intercessory prayer to reduce disruptive behaviors of patients with dementia: a pilot feasibility study. Journal of Holistic Nursing 34 (2): 135-145

*Comment:* Well, this was quite a study. I doubt that the study results were fabricated, and the statistical analyses appeared solid. AND the cost and side-effects of the intervention were minimal. Even a small effect might make a big difference in these patients and their caregivers.

### Effects of Prayer on Migraine Headaches: a Randomized Clinical Trial

Investigators in the Shefa Neuroscience Center and the Kerman University of Medical Sciences in Tehran, Iran, examined the effects of in-person prayer on intensity of migraine headache pain. This randomized controlled trial involved 92 patients (89% women, 100% Muslim) who were randomly assigned to two groups, one in which participants received 40 mg of propranolol twice a day for 2 months (group A) and the other in which participants received the same dose of propranolol with prayer (group B). All participants met criteria for migraine headache with or without aura based on criteria established by the International Headache Society; all other headache patients were excluded. The prayer group participated in an 8-week, weekly intercessory prayer program with each session lasting 45 minutes; no other information about the prayer intervention was provided in the study report. Pain reduction was assessed at baseline and after three months using a visual analog scale administered by registered nurses who were specialists in pain management and did not know which patients were in which groups (blinded). **Results:** the average score on the visual analog scale (0-10) in groups A and B at baseline were 5.7 ( $\pm 1.9$ ) and 6.5 ( $\pm 1.9$ ), respectively ( $p>0.05$ ). Likewise, gender, marital status, level of education, age and duration of disease were similar in both groups. Three months after the intervention, pain intensity scores were 5.4 ( $\pm 1.1$ ) in Group A and 4.2 ( $\pm 2.3$ ) in Group B. The difference between groups using Student's t-test was significant at  $p<0.001$ . Researchers concluded: "The present study revealed that prayer can be used as a nonpharmacologic pain coping strategy in addition to pharmacologic intervention for this group of patients."

*Citation:* Tajadini H, Zangiabadi N, Divsalar K, Safizadeh H, Esmaili Z, Raiei H (2016). Effective prayer on intensity of migraine headache: a randomized clinical trial. Journal of Evidence-Based Complementary & Alternative Medicine, E-pub ahead of press

*Comment:* Another study with extraordinary findings. Unfortunately, few details were provided with regard to the prayer intervention, design, or results (i.e., who administered the prayer intervention; was it in-person onsite or distant; did the control group have comparable amounts of "attention"; how many

participants dropped out of the study; why did nurses rate the visual analogue scale and not participants; etc.). If the study results can be replicated by a different research group in a different setting, the researchers' conclusions may indeed be important (especially for anyone who's ever had a migraine headache).

## SPECIAL EVENTS

### Duke University Spirituality & Health Research Workshop

(Durham, North Carolina, August 15-19, 2016)  
**Only a few more spots are left in the 2016 Workshop.** Those wanting to attend need to register ASAP. Individual mentorship spots are now available only on the day after the workshop, Saturday August 20, and are limited to 30 min per participant. There will be an extraordinary array of speakers and participants this year. Presentors are from Johns Hopkins School of Nursing, Yale University School of Medicine, Duke University Medical Center, and the the Veterans Administration. Participants from Botswana, Nigeria, Canada, Curacao, Switzerland, Turkey, Saudi Arabia, and other countries around the world will be present. Participants from a wide range of faith traditions will be present, including those from Christian, Muslim, Sufi, and other religious and spiritual backgrounds. Join the party! See website: <http://www.spiritualityhealthworkshops.org/>.

## RESOURCES

### Spirituality and Narrative in Psychiatric Practice

(Royal College of Psychiatrists, 2016)  
Edited by the United Kingdom's giants in the spirituality and psychiatry world, Christopher Cook, Andrew Powell, and Andrew Sims have put together quite a book for mental health professionals. From the publisher: "For people with mental illness, spirituality and faith are closely connected with questions of relationship, transcendence, and finding meaning and purpose in life - questions best approached by way of narrative (or story)... This book breaks new ground by using narrative to explore the importance and challenge of spirituality in clinical psychiatric practice by including narrative excerpts and case illustrations to show how spiritual concerns can be included in a range of psychiatric treatment options. It also explores the ethical and professional dilemmas spirituality still raises in mental healthcare. There are contributions from patients, chaplains, and leading psychiatrists and clinical psychologists." Available for \$60.00 at: [https://www.amazon.com/Spirituality-Narrative-Psychiatric-Practice-Stories/dp/1909726451?ie=UTF8&\\*Version\\*=1&\\*entries\\*=0](https://www.amazon.com/Spirituality-Narrative-Psychiatric-Practice-Stories/dp/1909726451?ie=UTF8&*Version*=1&*entries*=0).

### The Immoral Landscape [of the New Atheism] (2015)

From the publisher: "‘Religion poisons everything.’ So say Christopher Hitchens and the entire cast of New Atheists. If you want to make the world a better place, the New Atheists would thus recommend getting rid of religion. But John Gravino disagrees. In *The Immoral Landscape*, John Gravino argues that the real problem with the world is not religion; it is human nature. And the problem with our human nature is located in our minds. The key to making the world a better place, therefore, depends on the healing of the human mind. But how exactly do we go about the important business of healing our minds? The world of science has been amazingly successful in so many areas, but the one glaring exception to the nearly flawless track record of the sciences is in the study of mental disorder... John Gravino offers an explanation. Science is unable to cure the mind because the

mind is a fundamentally different organism. The human mind is spiritual, not physical; and thus, it obeys the spiritual laws of the universe. If you want to make the world a better place, John Gravino argues that getting rid of religion—the true source of the spiritual laws of the universe—is the worst thing you can do..." Available for \$16.95 at: <https://www.amazon.com/Immoral-Landscape-New-Atheism-Everything/dp/1515380866/>.

### You Are My Beloved. Really?

(CreateSpace publishing platform, June 2016)  
From the publisher: "How does God feel about us? Are we his beloved, as some claim? Or is this just fantasy and wishful thinking? The author, a psychiatrist and medical researcher, examines the evidence for God's love from Christian, Jewish, Muslim, Buddhist and Hindu perspectives based largely on the sacred scriptures from these traditions. Not a theologian, the author draws from his 30+ years in clinical practice, his research background, and his personal life in taking a practical approach to the subject. Those of any age with an open mind – especially if having a hard time in life -- will find this book enlightening, inspiring, and possibly healing. Written for Christians, non-Christians, those who are religious, those who are spiritual, and those who are neither." Dedicated to Veterans and active duty Service Members. Plans are to use this version in a future clinical trial examining spirituality-oriented cognitive processing therapy for moral injury in PTSD; however, it is written for a much broader audience than just those with PTSD. Illustrated compact paperback version is now available for \$8.90: <https://www.amazon.com/You-are-My-Beloved-Really/dp/1530747902/>.

### The Spirituality of Age: A Seeker's Guide to Growing Older

(Park Street Press, 2015)  
From the publisher: "As we enter the years beyond midlife, our quest for an approach to aging takes on added urgency and becomes even more relevant in our daily lives. Empowering a new generation of seekers to view aging as a spiritual path, authors Robert Weber and Carol Orsborn reveal that it is by engaging with the difficult questions about loss, meaning, and mortality-- questions we can no longer put off or ignore--that we continue to grow. In fact, the realization of our full spiritual potential comes about not by avoiding the challenges aging brings our way but by working through them... Coming from Catholic Jesuit and Jewish backgrounds respectively, as well as drawing from the latest research in psychological and religious theory, Weber and Orsborn provide their own conversational and candid answers to the 25 key questions, supporting their insightful and compassionate guidance with anecdotes, inspirational readings, and spiritual exercises..." Available in paperback for \$12.76 at: <https://www.amazon.com/Spirituality-Age-Seekers-Guide-Growing/dp/1620555123>.

### CME/CE Videos: Integrating Spirituality into Patient Care

Due to the generous support of the Templeton Foundation and Adventist Health System, five professionally produced 45-minute videos on **why and how** to "integrate spirituality into patient care" are now available on our website (*for free*, unless CME/CE is desired). Videos are targeted at physicians, nurses, chaplains, and social workers in an effort to help them form **spiritual care teams** to provide "whole person" medical care that includes the identifying and addressing of spiritual needs. No other resource like this currently exists. Go to: <http://www.spiritualityandhealth.duke.edu/index.php/cme-videos>.

## Health and Well-being in Islamic Societies

(Springer International, 2014)

What exactly do Muslims believe? How do these teachings line up with Christian beliefs? While differences and similarities between Christian and Muslim beliefs and practices are examined, the core of the book focuses on research exploring religiosity and health in Muslim populations. Available for \$53.22 at:

<http://www.amazon.com/Health-Well-Being-Islamic-Societies-Applications/dp/331905872X>

## Spirituality in Patient Care, 3rd Ed

(Templeton Press, 2013)

The 3rd edition provides the latest information on how health professionals can integrate spirituality into patient care. Chapters target physicians, nurses, chaplains and pastoral counselors, mental health professionals, social workers, and OT/PT. Available for \$21.23 (used) at: <http://www.amazon.com/Spirituality-Patient-Care-When-What/dp/1599474255/>.

## Handbook of Religion and Health (2nd Ed)

(Oxford University Press, 2012)

This Second Edition covers the latest original quantitative research on religion, spirituality and health (more than 3300 studies in 2010). Spirituality and health researchers, educators, health professionals, and religious professionals will find this resource invaluable. Available for \$132.51 (used) at:

<http://www.amazon.com/Handbook-Religion-Health-Harold-Koenig/dp/0195335953>

## Spirituality & Health Research: Methods, Measurement, Statistics, & Resources

(Templeton Press, 2011)

This book summarizes and expands the content presented in the Duke University's Summer Research Workshop on Spirituality and Health (see above), and is packed full of information helpful in performing and publishing research on this topic. Available for \$38.20 (used) at: <http://www.amazon.com/Spirituality-Health-Research-Measurements-Statistics/dp/1599473496/>

## FUNDING OPPORTUNITIES

### Templeton Foundation Online Funding Inquiry (OFI)

The next deadline for "small grants" submission is August 31, 2016 [a small grant is considered less than \$217,400], with decision made by September 30. The next deadline for "large grants submission" (greater than \$217,400) is also August 31, 2016, with a decision made by September 30. 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 psychologists and experts in public health), and (3) research involving the development of religious-integrated interventions that lead to improved health. More information: <https://www.templeton.org/what-we-fund/grantmaking-calendar>.

## 2016 CSTH CALENDAR OF EVENTS...

### July

- 10 **Faith and Health**  
Speaker: Koenig  
St. Philips Episcopal Church, 10:00-10:50  
Durham, North Carolina  
Contact: Claudia Svava ([cjsvara@gmail.com](mailto:cjsvara@gmail.com))
- 20 **Faith-Based Partnerships in Global Health and Medicine**  
Speaker: Jeff Levin, Ph.D., M.P.H., University Professor of Epidemiology and Population Health, Baylor University Center for Aging, 3rd floor, Duke South, 3:30-4:30  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))

### August

- 1-2 **Training for U.S. Special Forces Chaplains**  
Joint Special Operations University (JSOU)  
MacDill Air Force Base, Tampa, FL (8:30A-12:30 noon)  
Speaker: Koenig  
Contact: Not open to public
- 15-19 **Duke University Spirituality & Health Research Workshop**  
Durham, North Carolina  
Speakers: Blazer, Oliver, Doolittle, Kinghorn, Hamilton, Carson, Williams, H Koenig, C Koenig  
Contact: Harold G. Koenig ([Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu))
- 31 **The Power of Religious Song**  
Speakers: Dr. Luke A. Powery, Dean, Duke Chapel, & Dr. Jill Hamilton, Associate Professor of Nursing, Johns Hopkins School of Nursing  
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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**PLEASE Partner with us to help the work to continue...**

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