

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 May 2013) go to:
<http://www.spiritualityandhealth.duke.edu/publications/crossroads.html>

LATEST RESEARCH

Definitions of Spirituality in Nursing Research

Researchers from Johns Hopkins University School of Nursing and Duke University Medical Center have written an article published in a top nursing journal (*Journal of Advanced Nursing*) that critiques the current definition of spirituality that is now being used in this rapidly growing area of nursing research. They claim that existing definitions of spirituality in nursing research include positive emotional status such as meaning, purpose, general well-being, peacefulness, etc.) which confound relationships found between spirituality and mental health outcomes. This critique is based on a systematic review of the nursing literature between 2007 and 2011 (Medline and CINAHL). A total of 20 original data-based articles with nurses as the first author were identified that measured spirituality and its relationship with a mental health outcomes. Studies are presented in a table that describes the authors, design and instruments used, definitions that include religion, and issues in measurement that could result in mental health confounding. Results indicated that 75% of article included some aspect of religious involvement in assessing spirituality and 35% measured spirituality using scales contaminated with items assessing mental health. The authors concluded that the definition and measurement of spirituality in nursing research was highly inconsistent, and that a significant proportion of studies reported potentially circular results (where both the spiritual predictor variable and the mental health outcome included indicators of mental health). They recommend that the definition and assessment of spirituality focus on religious involvement since this will provide a more uniform and consistent measure and would avoid the problem of uninterpretable, tautological findings.

Citation: Reinert KG, Koenig HG (2013). Re-examining definitions of spirituality in nursing research. *Journal of Advanced Nursing*, March 9 (E-pub ahead of print)

Comment: No comment necessary here. But see next study summarized below, which provides a nice example of the problem. Although the following study was not conducted by nurse researchers, the issue of measurement contamination is just as widespread among researchers in psychology and other health disciplines.

Spiritual Well-being and Menopausal Symptoms

Investigators at the Psychology and Health Research Unit at the Instituto Universitario in Lisbon, Portugal, examined the cross-sectional relationship between spiritual well-being and menopausal symptoms in 710 peri- and post-menopausal women (ages 42 to 60) recruited through schools and universities in Lisbon. Spirituality was assessed using the Portuguese version of the Spiritual Well-being Questionnaire, a 20-item measure of personal, communal, environmental, and transcendental spiritual well-being. Note that items assessed on this scale include love of other people, forgiveness, connection with nature, sense of identity, awe, trust, self-awareness, harmony, peace, joy, inner peace, meaning in life, etc. Self-rated physical and psychological health were also assessed. Menopausal symptoms were assessed using the MMSI-38 that assesses depressive mood, anxiety, aches and pains, loss of control, vasomotor symptoms, etc. (38 total symptoms). Structural equation modeling (SEM) was used to analyze the data controlling for numerous confounders including age, marital status, parity, professional status, income education, and menopausal status. Spiritual well-being was significantly and inversely related to depressed mood, cognitive impairment, aches and pains, perceived loss of control anxiety, vasomotor, sexual symptoms, and reported skin and facial hair changes. Authors concluded that "Therefore, spirituality can have a positive impact on the menopausal symptoms' reporting."

Citation: Pimenta F, Maroco J, Ramos C, Leal I (2013).

Menopausal symptoms: Is spirituality associated with the severity of symptoms? *Journal of Religion and Health*, March 8 [E-pub ahead of print]

Comment: A great conclusion -- if only the data actually supported it. Unfortunately, the measure of spiritual well-being used in this study was highly confounded with items tapping good mental health (peace, joy, love, harmony, inner peace). This measure of spirituality will always be inversely related to negative emotional symptoms associated with menopause, whether spirituality has anything to do with it or not, simply because the spiritual well-being measure is a measure of emotional health. The relationships, then, are tautological and uninterpretable, regardless of the sophistication of the statistical method (SEM). Some day journal reviewers will catch on and studies such as this one will have a hard time getting published.

Belief in God and Psychiatric Treatment Outcomes

Researchers in the department of psychiatry at McLean Hospital, Harvard Medical School, examined relationship between belief in God and treatment outcome. This was a prospective study of 159 patients in a day-treatment program (mean age 33.7 years, 61% female, 45% college graduates). Participants were interviewed on admission and at the time of discharge (an average of 10 days later). On admission, patients were asked "To what extent do you believe in God or a higher power?" (responses ranged from 1 [not at all or no belief at all] to 5 [very or strong sense of belief]). Primary outcomes were treatment response (defined as a score of 6.4 or lower on the CES-D) and reduction in depressive symptoms; secondary outcomes were improvement in psychological well-being and reduction in self-harm. Religious denominations were Catholic (22.6%), Protestant or other Christian (20.1%), and

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Jewish (6.9%); 38.4% indicated none. **Results:** A total of 54.7% indicated very or moderate belief in God, and 47.7% indicated fair, slight, or no belief. Belief in God on admission was unrelated to pre-treatment symptom levels. However, belief in God was higher among treatment responders compared to non-responders ($F=4.8$, $p<0.05$) and there was a significant linear relationship between belief and reduction in depressive symptoms ($r=0.21$, $p<0.05$). Belief in God was also related to greater increases in psychological well-being ($r=0.19$, $p<0.05$) and reductions in self-harm ($r=0.24$, $p<0.01$). These results were independent of treatment credibility/expectancy (faith in the treatment).

Citation: Rosmarin DH, Bigda-Peyton JS, Kertz SJ, Smith N, Rauch SL, Bjorgvinsson T (2013). A test of faith in God and treatment: The relationship of belief in god to psychiatric treatment outcomes. Journal of Affective Disorders 146:441-446

Comment: Even for the Northeastern US, this was not a very religious sample (38% no affiliation, 27% little or no belief in God). Nevertheless, when belief in God was present, participants appeared to respond better to traditional psychiatric treatments (an effect that appeared to be independent of belief that the treatment would work). This finding is consistent with other studies, for example, that have found that patients with panic disorder respond more vigorously to secular cognitive-behavioral therapy if they are religious. More studies examining interactions between religious involvement and treatment response are needed (and are fairly simple and inexpensive to conduct, since they only require researchers to measure religious involvement at baseline).

Views of God and Mental Health

Researchers at Marymount Manhattan College, Center for Psychosocial Research (NY), Healthcare Chaplaincy (NY), and University of Texas analyzed data from a national survey of 1,426 adults (out of 7,000 approached) to examine the relationship between beliefs about God and mental health. Beliefs about God were assessed by asking respondents to what extent they endorsed on a 1-4 scale adjectives that described God as: absolute, just, punishing, wrathful, critical, severe. Average scores were used to create three categories: punitive God (high on punishing and wrathful), deistic God (absolute and just), and benevolent God (low scores on critical and severe). Standard scales were used to measure generalized anxiety, social anxiety, paranoia, obsessional thoughts, and compulsive behaviors.

Controlled for were age, gender, race, education, marital status, religiousness (assessed by self-rated religiosity and frequency of religious attendance), and belief in God (4-point scale of certainty). **Results** indicated that belief in a punitive God was associated with more social anxiety, paranoia, obsessional thinking, and more compulsions, whereas belief in a benevolent God was associated with the opposite (all associations significant). Belief in a deistic God was not related to mental symptoms. Finally, religiousness was inversely related to both generalized anxiety and paranoia, whereas simple belief in God (regardless of kind of God) was not related to any mental symptoms.

Citation: Silton NR, Flannelly KJ, Galek K, Ellison CG (2013). Beliefs about God and mental health among American adults. Journal of Religion and Health, April 10 [Epub ahead of print]

Comment: Although this is a cross-sectional study with a low response rate (20%), the findings provide some interesting hypotheses for testing in longitudinal studies or even in randomized clinical trials. Might altering a person's view of God from punitive to benevolent using a cognitive-behavioral intervention result in lower anxiety, decreased paranoia, and reduced obsessive-compulsive symptoms? [or alternatively, might **treating** a person's anxiety, paranoia, and OCD symptoms with medication improve their view of God!]

Religiosity and Mental Health: Based on Cultural Values Only?

Researchers at the Berlin Institute of Psychology have challenged the hypothesis that there is something specific to religiosity that explains the higher self-esteem and better psychological adjustment associated with it, claiming that psychological benefits of religiosity are found only in specific cultures where religiosity is supported. If true, the relationship between religiosity and better mental health could result not from the benefits of religiosity per se, but rather from the support that religiosity receives within the larger cultural framework (i.e., "religiosity-as-social-value" hypothesis). To test this hypothesis, researchers analyzed data from 187,957 person (average age 37) who participated in an online-dating site (eDarling) involving participants from 11 European countries. Personal religiosity was assessed by agreement to a single religiosity item: "My personal religious beliefs are important to me." Psychological adjustment was assessed by asking respondents to indicate agreement to each of 10 adjectives used to describe themselves: adaptable, calm, cheerful, content, energetic, healthy, optimistic, positive, resilient, and stable. A social esteem scale was also administered. Country-level religiosity was determined based on the average respondent score on three questions, one assessing interest in church involvement and two assessing self-rated importance of religiosity (including the question used above to assess personal religiosity). **Results:** Overall, personal religiosity was correlated with greater self-esteem ($r=+0.11$) and with psychological adjustment ($r=+0.13$). However, there was an interaction between person-level religiosity and country-level religiosity. Only in religious countries, not non-religious countries, was there a positive relationship between religiosity and self-esteem or psychological adjustment. In non-religious countries such as Sweden, no such relationships were found. Research concluded that religiosity appeared to benefit people in countries that valued religiosity but not in secular countries -- apparently confirming the "religiosity-as-social-value" hypothesis.

Citation: Gebauer JE, Sedikides C, Neberich W (2012).

Religiosity, social self-esteem, and psychological adjustment: On the cross-cultural specificity of the psychological benefits of religiosity. Psychological Science 23(2):158-160.

Comment: Interesting cross-sectional finding that suggests religiosity is only beneficial to mental health in European countries that value religiosity, implying that it is cultural/social factors that explain the relationship, not anything unique to religiosity. Unfortunately, there are plenty of problems with this study's methodology besides its cross-sectional nature, especially the particular sample (younger people trying to secure a romantic date [which might influence their responses]) and the way that country religiosity was measured (including same question used to assess personal religiosity). Nevertheless, this is not the first time that such a finding has been reported (see results from Gallup World Poll - <http://www.gallup.com/poll/116449/Religion-Provides-Emotional-Boost-World-Poor.aspx>). Not considered by researchers, however, is a particular dynamic that is present in secular countries, but is not as much a factor in religious countries. Given that religion is often used as a coping behavior when people are in distress, in secular countries it takes a lot more distress before people buck the social trend and turn to religion for comfort; thus, religiosity acts as a marker for distress in non-religious countries. This dynamic could disguise any benefits derived from religiosity, especially in a cross-sectional study. Thus, before concluding that the benefits religiosity are only cultural/social, research is needed that not only follows people over time (prospectively) but also takes into account the dynamic above.

Update: An attempt to replicate the study's findings above (Gebauer et al., 2012) has recently been accepted for publication (May 24) in the Journal of Religion and Health: "Is the Connection between Religiosity and Psychological Functioning due to

Religion's Social Value? A Failure to Replicate" (by Steven Pirutinsky), and will soon be available online.

Religiosity and Mood in Bipolar Disorder

Researchers in the department of psychiatry at the Federal University of Juiz de Fora, Brazil, surveyed 168 outpatients with bipolar disorder (92% of the qualifying patients of a single clinician), examining relationships between religiosity and mood symptoms (depression and mania). Bipolar disorder was diagnosed using clinical criteria (DSM-IV-R); mania symptoms by the Young Mania Rating Scale; depressive symptoms by the Montgomery-Asberg Depression Scale; and quality of life using the World Health Organization brief QOL scale. Religiosity was measured using the DUREL and the brief RCOPE. Two questions regarding treatment were also asked, including whether there was a conflict between their religion or religious leader and treatment, and whether that conflict affected the treatment of their bipolar disorder. Controlled for in the analysis were age, gender, race, education, and employment status. **Results:** Neither religious attendance nor private religious activities were related to depressive or manic symptoms, history of suicide attempts, or hospitalizations. Intrinsic religiosity and positive religious coping, however, were inversely related to depressive symptoms (OR=0.19, 95% CI 0.06-0.57, and OR=0.25, 95% CI 0.09-0.71, respectively), but not to mania or other outcomes. Negative religious coping, surprisingly, was not related to any outcome. However, those with no religious affiliation (12% of respondents) were over four times as likely to have significant depression (OR=4.21, 95% CI 1.22-14.52). Intrinsic religiosity was positively related to all four quality of life outcomes (physical, psychological, social, and environmental). Finally, one-third of respondents indicated there was conflict between their religion/religious leader and their treatment, and one-quarter said this interfered with their treatment.

Citation: Stroppa A, Moreira-Almeida A (2013). Religiosity, mood symptoms, and quality of life in bipolar disorder. Bipolar Disorder [E-pub ahead of print]

Comment: Although this study was cross-sectional and all patients came from a single clinician (lead author), the findings are important in that intrinsic religiosity was consistently related to less depression and higher quality of life, whereas there was no relationship with manic symptoms (despite the known relationship between mania and hyper-religiosity). Also important was that in one-third of cases there was conflict between their religion or religious leader and the current treatment (medication), and this often interfered with treatment compliance.

Spirituality and Religion in Oncology

A psychiatrist and a theologian from Harvard's Dana Farber Cancer Institute in Boston have written a nice summary of research on religion/spirituality and adjustment in cancer patients, and more importantly, describe clinical implications and applications for health professionals. Numerous topics are addressed in this article, including how to go about providing spiritual care, psychological struggles that cancer patients deal with (identity/worth, hope, meaning/purpose, connectedness), role of spirituality in medical decision-making, attitudes of oncologists and cancer nurses toward spirituality, and other issues. Authors also provide a list of web-based resources and books that health professionals can turn to for more information on the topic. They round out their discussion by describing the challenges that health care providers face in addressing the spiritual aspects of oncology care, including issues of religious diversity in end-of-life care and how to effectively organize and deliver spiritual care.

Citation: Peteet JR, Balboni MJ (2013). Spirituality and religion in oncology. CA: A Cancer Journal for Clinicians, April 26 [E-pub ahead of print]

Comment: A fine and balanced review by top scholars in the field.

Chaplaincy and Mental Health Care: US Department of Defense and the VA

Researchers at Duke University and U.S. Department Health Clinical Center surveyed 440 Veterans Administration (VA) and 1,723 Department of Defense (DOD) chaplains to examine the differences in role that these chaplains play in the mental health care of active U.S. military personnel and veterans. DOD chaplains were younger (82% vs. 23% under age 55), less likely to be female (4% vs. 17%), less likely to be African-American (7% vs. 18%), less likely to be board certified (25% vs. 49%), more likely to be Evangelical Protestant (53% vs. 26%) and less likely to be Catholic (8% vs. 21%), and much more likely to have been deployed to Iraq (68% vs. 7%) or Afghanistan (43% vs. 6%). DOD chaplains were also less likely to be working in an inpatient psychiatric setting (29% vs. 58%), outpatient mental health setting (19% vs. 34%), or outpatient substance abuse program (13% vs. 32%). DOD chaplains were more likely to have to deal with relationship/family stress, work stress, and anger, whereas VA chaplains were more likely to encounter problems with anxiety, alcohol abuse, and depression. Barriers to integrating chaplaincy into the traditional mental health care system were examined. DOD and VA chaplains reported rarely making referrals to mental health (37% vs. 43% less than monthly or never) or receiving referrals from mental health (74% vs. 36% less than monthly or never). Fewer DOD than VA chaplains felt their work was understood (46% vs. 56%) or valued (70% vs. 85%) by MH professionals. Authors suggested that approaches to improve collaboration and integration include: (1) train chaplains and MH care providers together, (2) improve documentation in medical record by chaplains, (3) promote models that encourage teamwork, and (4) increase opportunities for interactions between VA and DOD chaplains to improve continuity of care for active soldiers transitioning to veteran status.

Citation: Nieuwsma JA, Rhodes JE (2013). Chaplaincy and mental health in the Department of Veterans Affairs and Department of Defense. Journal of Health Care Chaplaincy 19:3-21

Comment: An excellent article examining the similarities and differences between DOD and VA chaplains. The article thoroughly discusses the barriers they face and presents potential solutions for overcoming those barriers at the individual training level and the organization level, and explores future research to help guide these efforts. We need a strong military, and addressing our soldiers' spiritual needs is one way to assure that.

Religion, Spirituality and Health Care in the UK

This article discusses issues related to religion and spirituality in the care of patients from diverse religious traditions in the United Kingdom. The author, from the Department of Theology and Religion at the University of Birmingham, presents a clear and balanced discussion directed at **health care administrators** who may be unfamiliar with the role that religion plays in health and the seeking of health care services. First, he discusses prevalent attitudes that patients and health care professionals have toward religion. Second, he describes the right that patients in the UK have (established by the 1991 National Health Service Patient Charter) to have their religious and spiritual needs met within the health care system, and the confusion that exists on what this means and how to accomplish it. Third, he discusses the meaning of the terms religion and spirituality and their history of use within health care. Finally, the author notes several practical points related to working with religious groups and individuals, including that (1) not all religious groups are the same, (2) religious communities are internally very diverse, (3) not all religious individuals relate to their religion the same way, (4) health care professionals often ignore the big picture in which religious believers situate their lives, (5) the need to understand religious

views of health and health care, and (6) the ubiquity of religion in health care (despite efforts to exclude it).

Citation: Pattison S (2013). Religion, spirituality and health care: Conclusions, tensions, opportunities. *Health Care Analysis*, April 9 [E-pub ahead of print]

Comment: Excellent article well-worth reading and available online

NEWS

New Study: Religion, Caregiver Stress, and Telomere Length

Caregiver stress is a serious problem with health consequences including hypertension, stroke, coronary artery disease, and early mortality. Emerging evidence suggests that caregiver stress, depression, and low social support are associated with *telomere shortening* (an indicator of cellular aging), especially among women caregivers. Factors related to caregiver adaptation, dealing with depression, reduction of stress, and increased social support may be particularly important, especially for women caregivers. If psychosocial, cultural, and religious factors were linked to slower telomere shortening in female caregivers, then novel preventive strategies to support and enhance psychosocial resources could be developed to provide hope and relief, helping to maintain health and possibly extend longevity. In light of these considerations, the Duke's Center for Spirituality, Theology and Health is **now recruiting** female caregivers age 40 to 75 to participate in a study to determine relationships between psychosocial, behavioral factors, and telomere length. Participants in central North Carolina are being asked to complete a single 30-minute questionnaire and give a blood sample; \$100 is being offered for time and effort. For more info:

http://www.spiritualityandhealth.duke.edu/resources/pdfs/Caregiver_Color_Flyer.pdf.

SPECIAL EVENTS

Emerging Tools for Innovative Providers: Interdisciplinary Applications from Spirituality and Health Research (Pasadena, California) (July 22-26, 2013)

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. **Scholarships** are available. For more information, contact Bruce Nelson at NELSONBR@ah.org or go to website: www.EmergingToolsForInnovativeProviders.com.

Spirituality and Good Practice in Mental Health Care (Durham, United Kingdom, July 10-12)

The National Health Service is sponsoring a 3-day conference at St. Johns College, Durham University (founded by Act of Parliament in 1832, one of the first universities to open in England for more than 600 years and the third oldest university in England). The conference focuses on religious psychotherapy for depression in chronic illness; research on the relationship between religion, spirituality and mental health; spiritual care of patients and mental health care staff; spirituality in nursing care; and other issues related to addressing the spiritual needs of patients with mental health problems. There will be several panels of discussants and spiritual practice workshops throughout the three days, including a tour of historic Durham Cathedral that houses University College (the oldest inhabited university building in the world). Speakers

include Dr. Charles Fernyhough (department of psychology, Durham University), Professor Douglas Davies (department of theology), Dr. Linda Ross (department of care sciences/nursing, University of Glamorgan), and Dr. Harold Koenig (Duke University). If you would like to submit a paper or workshop, abstracts of no more than 200 words should be forwarded immediately to Paul Walker at paul.walker8@nhs.net. For more info, go to website:

<http://www.teww.nhs.uk/For-professionals/Conferences/Spirituality-and-good-practice-in-mental-health-care/>

5th International Conference on Ageing and Spirituality

(Edinburgh, Scotland, July 7-10)

The conference is intended for both those with an academic interest and those with more practical experience through involvement in the care industry or as informal carers. Conference includes a mixture of master classes, workshops, academic papers and presentations on projects. Keynote speakers include Elizabeth Mackinlay, Susan McFadden, John Swinton, Rabbi Wittenberg, and others. Focus will be on finding meaning in later life, dementia, spiritual care planning, and reducing social isolation. See website: https://events-made-easy.com/Client_Event_Sites/test8008/2011-10-105/cgi-bin/php/home.php.

Duke Summer Spirituality & Health Research Workshops

(Durham, NC) (August 12-16, 2013)

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 leading 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/>.

RESOURCES

Spirituality in Patient Care, 3rd Ed (Templeton Press, 2013)

Since the publication of the first and second editions of *Spirituality in Patient Care* in 2002 and 2007, the book has earned a reputation as *the* authoritative introduction to the subject for health professionals interested in identifying and addressing the spiritual needs of patients. All chapters are updated with the latest information, trends in health care, research studies, legal issues, and healthcare standards requiring sensitivity to all patients' spiritual needs. Chapters are targeted to the needs of physicians, nurses, chaplains, mental health professionals, social workers, and occupational and physical therapists. See website: <http://templetonpress.org/book/spirituality-patient-care> (to be available in June; can be pre-ordered for \$22.36).

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. Religion/spirituality-health researchers, educators, health professionals, and religious professionals will find this resource invaluable. Available, 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 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. Book available for purchase (\$39.96) at: <http://templetonpress.org/book/spirituality-and-health-research>. For a comprehensive review of this text, see Matthew Porter's review in the December 2012 online edition of *Journal of Religion and Health* (<http://link.springer.com/article/10.1007/s10943-012-9666-x>).

Funding Opportunities

George Family Foundation Grants

This foundation gives out small grants (\$2,500 to \$55,000) for projects that promote integrated approaches to health and healing. They seek to fund programs and initiatives that advance an integrated, patient-centered approach to healing, encouraging people to take responsibility for their health supported by a diverse team of healthcare providers. They are also interested in enhancing the positive impact of religious faith and spiritual connection. They fund programs that contribute to interfaith harmony and that enrich the inner lives of individuals, families and communities. Grants awarded in 2011 totalled \$200,000. For more information, to to website:

<http://www.georgefamilyfoundation.org/about/>.

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 between **August 1 and October 1, 2013**. If the funding inquiry is approved (applicant notified by November 5, 2013), the Foundation will ask for a full proposal that will be due March 3, 2014, with a decision on the proposal reached by June 20, 2014. 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: <http://www.templeton.org/what-we-fund/our-grantmaking-process>.

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Website:
<http://www.spiritualityandhealth.duke.edu/about/giving.html>

2013 CALENDAR OF EVENTS...

June

- 11 **Caregiver Stress in Parkinson's Disease**
Parkinson's Disease Support Group, 10:30-11:30A
Croasdaile Retirement Community, Durham, North Carolina
Presenter: Harold G. Koenig, M.D.
Contact: Arlene D'Alli (arlene.dalli@dm.duke.edu)
- 20 **Spirituality and Aging**
Therapeutic Yoga for Seniors Program, 2:00-3:30
Center for Living, Durham, North Carolina
Presenter: Harold G. Koenig, M.D.
Contact: Carol Krucoff (ckrucoff@gmail.com)
- 26 **Religion, Spirituality & Health: The Sociological Perspective**
Presenter: Linda K. George, Ph.D.
Professor, Department of Sociology, Duke University
Durham, North Carolina
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)
- 28 **Religion, Spirituality & Mental Health**
Yale University Department of Psychiatry
New Haven, CT
Presenter: Harold G. Koenig, M.D.
Contact: Dr. Farah Rahiem (mailto:farah.rahiem@yale.edu)

July

- 10-11 **Spirituality and Mental Health Care Conference**
Durham University
Durham, England
Presenter: Koenig and others
Contact: Dr. Christopher Cook (c.c.h.cook@durham.ac.uk)
- 18 **Spirituality, Aging, and Caregiver Stress**
The Cedars of Chapel Hill, Chapel Hill, North Carolina
Presenter: Harold G. Koenig, M.D.
Contact: Tara Pierce (tpierce@cedarsofchapelhill.com)
- 22-26 **Emerging Tools for Innovative Providers: Interdisciplinary Applications from Spirituality and Health Research**
Fuller Theological Seminary, Pasadena, California
Speakers: Pargament, Koenig, and others
Contact: Bruce Nelson (NELSONBR@ah.org)
- 31 **Integrating Chaplaincy and Mental Health Care: Lessons from the Departments of Veterans Affairs and Defense**
Presenter: Jason Nieuwsma, Ph.D.
Associate Director, VA Mental Health & Chaplaincy
Assistant Professor, Department of Psychiatry, DUMC
Durham, North Carolina
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)