CROSSROADS…

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & Health Volume 6 Issue 9 March 2017

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 February 2017) go to: http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads

LATEST RESEARCH

Religion and Well-being in Canada

Researchers analyzed data from the Ethnic Diversity Survey of Statistics Canada, a random national sample of 41,695 persons aged 15 to 65 years in order to examine the relationship between religious involvement and psychological well-being. Psychological well-being was assessed by a single question: "Using a scale of 1 to 5 where 1 means not satisfied at all and 5 means very satisfied, all things considered, how satisfied are you with your life as a whole these days?" Analyses were stratified by religious affiliation. Controlled for in all analyses were education, income, immigrant status, Francophone, trust, gender, and urban vs. rural residence. **Results**: Participants were 42% Catholic, 27% Protestant, 16% none, and less than 2% Jewish or Muslim. Average well-being on a 0 to 5 scale was similar among Catholics (4.3), Protestants (4.8), Jews (4.2), Muslims (4.2), and "none" (4.1). Likewise, the percentage of those who indicated they were "very satisfied" with life were similar in Catholics (48.9%), Protestants (49.2%), Jews (42.8%), Muslims (48.0%), and was greater among those with any religion compared to those with no religious affiliation (36.9%). In multivariate models examining satisfaction with life, religious affiliation was not a significant predictor once demographic characteristics and religious activity were controlled for. Greater religious involvement overall (importance of religion, private religious activities, and religious attendance) was related to greater well-being, an effect that was equally strong in Catholics and Protestants.
Citation: Dilmaghani, M. (2017). Religiosity and subjective well-being in Canada. Journal of Happiness Studies, Jan 3, E-pub ahead of print.
Comment: Although the measure of well-being and indicators of religiosity were pretty simple and relatively superficial, the quality and size of the sample makes this an important study, especially coming from Canada.

Religion, Childhood Adversity, and Adult Mental Health in the U.S.

Jong Hyun Jung in the department of sociology at Purdue University (Indiana) analyzed longitudinal data on a random sample of 1,635 U.S. adults (MIDUS study) to examine whether religiosity buffes the effects of childhood adversity on positive and negative emotions experienced in adulthood. Participants were assessed in 1995 (Wave 1) and again in 2005 (Wave 2). Negative affect was assessed with a 6-item scale examining hopelessness, nervousness, resltessness or fidgetiness, sadness, lack of motivation, and feelings of worthlessness. Positive affect was measured with a 6-item scale assessing calmness/peacefulness, cheerfulness, happiness, fullness of life, being in good spirits, and being satisfied with life. Childhood adversity was assessed with a 14-item measure of physical or emotional abuse, family instability, and financial strain. Religious involvement was assessed at Wave 1 by frequency of religious attendance, importance of religion in life, importance of sending one's child for religious instruction, closeness of identification with members of one's religion, and importance of marrying others from the same religion; spirituality was assessed by a 2-item measure of self-rated spirituality. Controlled for were age, gender, race, marital status, and education. Regression models were used to analyze the data; mental health measures assessed at Wave I were controlled for in all analyses examining Wave 2 outcomes. **Results**: Physical or emotional abuse was present in 64.3% of participants, family instability in 18.8%, and financial strain in 54.1%. Childhood adversity did not predict "negative affect" over time, and consequently, religiosity had no buffering effect (since there was nothing to buffer). However, childhood abuse (but not family instability or financial strain) predicted lower levels of "positive affect" during adulthood, and there was a significant interaction between religiosity and childhood abuse on positive affect. Among those with low religiosity, childhood abuse significantly decreased adult positive affect ($b=-0.036$, $p<0.01$), while among those with high religiosity, no adverse effect on positive affect/mood in adulthood was observed ($b=-0.005$, p=ns). The same finding was reported for those who were high on self-rated spirituality. The researcher concluded that "religious salience and spirituality buffer the noxious effects of childhood abuse on change in positive affect over time."
Citation: Jung JH (2017). Childhood adversity, religion, and change in adult mental health. Research on Aging, E-pub ahead of press
Comment: Longitudinal findings in a relatively large representative sample of U.S. adults are always important to take note of. These results add to the evidence that religious/spiritual involvement is particularly helpful for buffering the adverse effects that childhood abuse has on positive emotions during adulthood (although effects appear to be less so for negative emotions).

Perspectives of Cancer Patients regarding Spirituality and Health in India

Kumar and colleagues in the department of community medicine at the Government Medical College and Hospital in Chandigarh, India, conducted a study of 1,117 cancer patients attending the radiotherapy outpatient department of the Government Medical College and Hospital. The purpose was to examine how patients feel about spirituality as a complementary and alternative medicine (CAM) practice in the treatment of cancer. Participants were selected using a systematic sampling design such that every 3rd new patient being seen in the radiotherapy outpatient department was included. **Results**: Participants were 55% female, and religious affiliations were 73% Hindu, 21% Sikhism, and 3.5% Islam. Participants were asked to rank the importance of physical, mental, spiritual, and social health (as a CAM treatment method); 40% ranked physical health 1st place, 33% ranked mental health 1st place, 21% ranked spiritual health 1st place, and 4% ranked social health 1st place. Opinions with regard to spiritual health were inquired about. Although 35% indicated that they did not know what spiritual health refers to, the three most common opinions were: "one who is spiritual falls sick less frequently" (18%); spiritual health is "a cycle of 'Karma.' Whatever happens, it has to happen, and it is because of our earlier deeds" (6%); and "people who believe in God are psychologically more healthy" (3%). With regard to the relationship between spirituality, health and religion, the three most common responses were "all are interrelated" (38%); there is "no relationship" (9%); and "spirituality leads to good health" (7%). When asked about components of the spiritual healing process among those who sought a cancer cure through this method (n=380), the most common responses were "prayers" (51%), "meditation" (35%), and "spiritual time with nature" (27%). When asked the question "who is your spiritual mentor/Guru?", the most common responses were "no one" (65%) and "spiritual leaders" (25%). When asked about types of spiritual distress experienced, the three most common responses were "anger toward God" (26%), variation in mood (51%), and change in behavior (35%); only 26% said they had never experienced any spiritual distress. When asked about situations in which people turn to spirituality, 77% said this occurs after a serious illness or loss; the next most common response was "when wishes are fulfilled" (12%). When asked if spirituality was a component of health, 73% indicated "strongly" or "very strongly" that it is. With regard to the role that spirituality plays in health, 45% indicated that "spirituality can [help] cope with illness in a better way"; 43% said that "spiritual doctors/practitioners can deal better with illness"; and 45% indicated that "recovery becomes faster with blessings of God." With regard to faith, 97% said they "have faith in God" and 82% said that "faith in God has[a] role in recovering from disease" (as a method of curing cancer). With regard to change in faith in God after suffering with cancer, 69% said that having cancer increased their faith, whereas only 3% said that it decreased their faith. When asked if spirituality can cure cancer completely, 91% said yes and only 4% said no. Interestingly, only 15% of the entire sample said that they practiced Yoga (women more than men), and only 16% said that Yoga was helpful in curing cancer. In contast, 58% said that they practiced meditation. With regard to problems seeking spiritual care, only 29% reported no problem in this regard. Researchers concluded that the "…spiritual dimension of health is very important and it should be given priority."

Citation: Kumar, D., Goel, N. K., Pandey, A. K., & Dimri, K. (2017). Perspectives of cancer patients regarding spirituality and its role in cancer cure. International Journal of Community Medicine and Public Health, *3*(8), 2248-2257.

Comment: The review of this study, particularly the results, is longer and more detailed here than usual, given the large systematically acquired sample of cancer patients. The reason is that this study is one of the largest focused on cancer patient spirituality in India ever published. The information presented here on patients' perspectives is very detailed and provides an objective look at how patients in India perceive the role of spirituality in their cancer and its treatment,. The contributions of this study to the field of spirituality and health far outweigh its weaknesses, which include problems with English grammar, interpretation of the results, and inconsistencies between tables and text.

Spiritual Care for Cancer Patients in Iran

Investigators from the department of community medicine, community psychiatry and several other schools at the Iran University of Medical Sciences and several universities in Iran sought to develop guidelines for healthcare providers (medical team) when assessing and addressing the spiritual needs of patients with cancer. This includes taking a spiritual history, determining which patients are spiritual care candidates, identifying the main components of spiritual care, deciding who should provide spiritual care, what a spiritual care setting is, and what resources and facilities are needed to provide spiritual care. The authors conclude that "Health policymakers should also seek to motivate and train health service providers to offer these services and facilitate their provision and help with widespread implementation."

Citation: Memaryan, N., Jolfaei, A. G., Ghaempanah, Z., Shirvani, A., Vand, H. D., Ghahari, S., & Bolhari, J. (2016). Spiritual Care for Cancer Patients in Iran. Asian Pacific Journal of Cancer Prevention 17(9), 4289-4294.

Comment: This article summarizes a statement made by members of a consensus panel composed of psychologists, psychiatrists, community medicine physicians, oncologists, pastoral counselors, and experts in Islamic ethics, theology, and philosophy. Not surprisingly, spiritual care has become an increasing priority in this deeply religious country.

End-of-Life Care for Ethnic and Religious Minorities

Physicians from the department of internal medicine, division of palliative care, at the Mayo Clinic (Rochester, Minnesota) describe a Muslim female patient with metastatic cancer from Bahrain, and the ethical and religious challenges they faced when caring for her. Those challenges centered around her praying for a miracle to cure her terminal illness and the desire that everything should be done in the meantime to keep her alive. After describing the case, the authors define the problem, discuss the challenges encountered, and provide a framework for providing care to patients like the women described. This includes eliciting the patient's explanatory model of illness, addressing the patient's religious/spiritual values, determining the patient's and family's desired approach to telling the patient the truth about the terminal nature of the illness, seeking an understanding of the patient's family's role in the care process (and decision-making), and finally negotiating religious, spiritual and cultural conflicts. An example of how to apply the framework is described in a dialogue between a patient and a physician.

Citation: Partain DK, Ingram C, Strand JJ (2017). Mayo Clinic Proceedings 92(1):147-152

Comment: The relevance of this brief report is that it was written by academic physicians caring for terminally ill patients. It provides a lot of practical information and a framework for addressing religious issues in terminal patients from a variety of religious traditions, and is published in a highly credible academic journal, the Mayo Clinic Proceedings.

Screening for Religious/Spiritual Distress

King and colleagues from the Seattle Cancer Care Alliance (made up of several institutions located around the United States) sought to identify a brief screening measure for religious/spiritual distress in a sample of 1449 U.S. adults with various forms of cancer requiring hematopoietic cell transplantation. The majority of

participants were over age 50 (72%), about half were male, 93% white, 68% Christian and 19% atheist/agnostic/none; 47% had leukemia, 18% had lymphoma/Hodgkin's disease, and 15% had multiple myeloma; and the majority (58%) had received their transplant within the past 10 years. Six screening measures (most being single questions) were examined: (#1) "Do you struggle with the loss of meaning and joy in your life?" (meaning/joy); (#2) "Do you currently have what you would describe as religious or spiritual struggles?" (self-described struggle); (#3) "Are you at peace?" (peace); (#4) the Revised Rush Religious Struggle Protocol (after asking the patient about the importance of R/S in their life, if R/S is important, a question is asked about how much support R/S is providing to them as they cope; if not providing much support, then *possible R/S distress* is indicated; for those who indicate that R/S is not important to them, they are asked if R/S has ever been important in their life, and if not, then again *possible R/S distress* may be indicated as a possible trigger for the change) (Rush Protocol); (#5) "Does your religion/spirituality provide you all the comfort and strength you need from it right now?" (comfort/strength); and (#6) "spiritual/religious concerns" (one item on the National Comprehensive Cancer Network's distressed thermometer and problem checklist) (S/R concerns). In addition, information was collected on diagnosis, year of diagnosis, year of transplant, age, gender, race, ethnicity, faith tradition, and spiritual/religious identity (50% both, 33% spiritual only, 6% religious only, 11% neither). Responses to these screening measures were compared to what was designated the "gold standard," which was responses to the negative religious coping (NRC) subscale of the Brief RCOPE, where *R/S spiritual distress* was determined if participants responded "somewhat" on at least three of the 7 items or had a score of "quite a bit" on any one of the 7 items. **Results**: With regard to detecting R/S distress, sensitivity and specificity (respectively) for each of the six screening measures was determined: 60% and 65% for #1; 54% and 77% for #2; 45% and 83% for #3; 42% and 81% for #4; 42% and 85% for #5; and 27% and 89% for #6. Thus, the most *sensitive* measure of R/S spiritual distress was #1 (meaning/joy), whereas the least sensitive was #6 (S/R concerns). The most *specific* measure was #6 (S/R concerns), whereas the least specific measure was #1 (meaning/joy). Therefore, the measure with the best balance of sensitivity and specificity was #2 (self-described struggle, i.e., a single question asking "Do you currently have what you would describe as religious or spiritual struggles?").
Citation: King, S. D., Fitchett, G., Murphy, P. E., Pargament, K. I., Harrison, D. A., & Loggers, E. T. (2017). Determining best methods to screen for religious/spiritual distress. Supportive Care in Cancer, 25(2), 471-479.
Comment: Apparently, the best way to detect R/S distress is to ask patients whether or not they have religious or spiritual struggles. Amazing how a simple direct question can produce results.

U.S. Physicians' Perceptions Concerning Relevance of Religion in Clinical Interaction

Aaron Frazen from Hope College analyzed data on a national sample of 1,144 U.S. physicians to examine how physicians feel about the connection between religion and health. Participants were asked five questions regarding the relevance of R/S to health: "When religious/spiritual issues come up in discussions with patients, how often do you respond in the following ways" (never, always or not applicable): (1) "I listen carefully and empathetically," (2) "I try to change the subject in a tactful way," (3) "I encourage patients in their own religious/spiritual beliefs and practices," (4) "I espectfully share my own religious ideas and experiences," and (5) "I pray with the patient." Physicians were also asked two questions about self-rated religiousness or spirituality that enabled the creation of four categories: spiritual but not religious (SBNR), religious but not spiritual (RBNS), religious and spiritual (RAS), and not religious or spiritual (NROS). Finally, participants were asked "How much influence do you think religion/spirituality has on patients' health?" (with responses from "very much" to "very little to none." Religious affiliation, religious experiences, practices, and coping were also assessed. Religious barriers to addressing spiritual issues (insufficient time, etc.) were assessed as well, along with whether any formal training on integrating spirituality into patient care had been received. Path analyses was used to assess factors related to belief that religion matters for health outcomes. **Results**: Male respondents, Catholics (vs. Protestants), resident physicians, and those who were board certified, internists and pediatricians (vs. family physicians) were *less likely* to believe that R/S impacts health outcomes. Strongest predictors of relevance of R/S to health were frequency of attendance at religious services, having a spiritual experience working with patients, using religion to cope, higher intrinsic religiosity, and self-categorization as RAS. In other words, physician religiosity was the strongest factor predicting the perceived relevance of R/S to health. Perceived relevance to health was also a primary mediator explaining what physicians considered behaviors to their sharing personal R/S beliefs with patients, willingness to listen to patients' R/S views, changing the subject away from R/S, encouraging patients' own R/S beliefs, and prayer with patients. The researcher concluded that physicians' own R/S beliefs, values, and experiences appear to drive whether they perceive that R/S is related to health outcomes, which in turn drives their R/S behaviors with patients in clinical settings.
Citation: Franzen, A.B. (2017). Is this relevant?: Physician perceptions, clinical relevance, and religious content in clinical interactions. Journal for the Scientific Study of Religion, E-pub ahead of press
Comment: The findings above (corroborated by many other studies) are the opposite of the way things "should be" in patient-centered medical practice. Rather than being centered on the physician's own personal R/S beliefs, physician behaviors should be determined by the importance of R/S to the patient and the impact it has on patient health outcomes based on the available research.

Perspectives on Spiritual Care by Nursing Students in Saudi Arabia

Researchers in the department of nursing at Shaqra University and University of Ha'il in Saudi Arabia surveyed 338 nursing students in a baccalaureate nursing program on their attitudes toward spirituality and the provision of spiritual care. Average age of participants was 23.7 years, 50% were male, 70% single, and one-third had some experience providing spiirtual care to patients or had attended educational activities related to providing spiritual care. This survey included only Saudi nationals, students in years 2 through 4, and those who volunteered to participate. In addition to collecting information on demographics, the 35-item Spiritual Care-Giving Scale (Tiew & Creedy, 2012) was administered, which consists of five factors: (1) attribute for spiritual care, (2) defining spiritual care, (3) spiritual care attitude, (4) spiritual perspective, and (5) spiritual care values. **Results**: Women, second year students, and those who had educational training on how to integrate spirituality were more likely to provide spiritual care. Scores on each of the five dimensions of spiritual care, however, were lower among these Saudi nursing students than found in studies of nurses in Singapore, Jordan, and South Africa, which was attributed to the lack of education in Saudi nursing schools on how to provide spiritual care.
Citation: Cruz JP, Alshammari F, Alotaibi KA, Colet PC (2017). Spirituality and spiritual care perspectives among baccalaureate nursing students in Saudi Arabia: A cross-sectional study. Nurse Education Today 49:156-162
Comment: This article is summarized here because of the rarity of research on spirituality in nursing care from Saudi Arabia, a deeply religious Muslim country. Surprisingly, only one-third of nursing

students had any training in this regard. The reason may be that patients ordinarily receive spiritual care from family members and Imams, rather than from healthcare staff. However, further research is needed to substantiate this speculation.

Does Religion Prevent or Facilitate the Treatment of HIV?

Haley Kendrick from the department of sociology at the Universty of Alabama at Birmingham systematically reviewed the literature to determine the extent to which religion/spirituality (R/S) tends to prevent or facilitate the treatment of patients with HIV. Religion has a long-standing reputation of being a barrier to HIV treatment. A total of 33 empirical studies were identified after excluding 110 reports because they were not empirical, were outside of the U.S., did not report outcomes of interest, lacked individual level analysis, or were not limited to participants with HIV. A wide range of measures of R/S were employed, including daily spiritual experiences, meaning, values, religious beliefs, prviate religious practices, religious coping, religious support, religious/spiritual history, organizational religiosity, and religious preference.
Results: Of the 33 studies, 24 reported at least one measure of R/S was associated with significantly *better* HIV treatment adherence; 12 studies with significantly worse adherence; and 7 studies reported no association. With regard to improved adherence, R/S coping was the most consistent positive predictor of the R/S dimensions assessed.
Citation: Kendrick HM (2017). Are religion and spirituality barriers or facilitators to treatment for HIV: A systematic review of the literature. AIDS Care, July 13, E-pub ahead of press
Comment: This report is the most comprehensive review of the relationship between religion/spirituality and HIV treatment adherence, and provides a number of directions for future research in this area.

Attachment to God and Obesity

Researchers in the school of public health at the University of Michigan (Ann Arbor) analyzed data from a national random sample of 1,497 U.S. adults, assessing attachment to God, church-based spiritual/emotional support, and obesity to determine relationships between these constructs. Anxious attachment to God was assessed with a 3-item measure developed specifically for the study and based on the work of Beck and McDonald (2004). An example of one of the three items was “I often worry about whether God is pleased with me.” Obesity was determined by measurement of body mass index (BMI) in the usual manner (kg/m^2) and defined as 30 or higher. Spiritua and/emotional support from members of one’s congregation were assessed using 3-item scales developed by the authors (Krause, 2008). Religious variables controlled in the analysis included frequency of church attendance, prviate prayer, and religious preference. Demmographic controls were age, education, gender, and marital status. **Results**: No direct relationship was found between an anxious attachment to God and likelihood of being obese. However, there was a significant interaction between an anxious attachment to God and spiritual/emotional support on likelihood of obesity. Having an anxious attachment to God was associated with *greater obesity* only in those who receive little spiritual/emotional support from members of their congregation. In contrast, anxious attachment to God was associated with less obesity in those having high spiritual/motional support from fellow congregants.
Citation: Krause N, Hayward RD (2017). Anxious attachment to God, spiritual support, and obesity: Findings from a recent nationwide survey. Journal for the Scientific Study of Religion, E-pub ahead of press
Comment: Since these are cross-sectional relationships, it is difficult to determine the direction of causation here. These results may also mean that greater obesity among those who have an anxious attachment to God leads to less spiritual/emotional support from fellow congregants (vs. spiritual/emotional support from fellow congregants buffering the effects of an anxious attachment to God on obesity). Regardless, given the epidemic of obesity in the U.S., these findings have important implications.

Religiosity and Mental Health among Latino College Students in the Southeastern U.S.

Researchers from the department of psychology at Virginia Commonwealth University (Richmond, VA) analyzed data from a convenience sample of 198 Latina/o college students to examine relationships between cultural stressors, cultural buffers, and mental health. Participants were ages 18-25 years (mean 20.6), 70% females, 43% first-generation college students, 70% Catholic and 15% Protestant, with 9% no religious affiliation. Measures administered were the 36-item Mexican American Cultural Value Scale (which included a 7-item religiosity subscale and three 5-6 item subscales assessing "familism"), the 17-item Brief Perceived Ethnic Discrimination Questionnaire Community Version, the 15-item Riverside Acculturation Stress Inventory, and the 14-item Depression Anxiety and Stress Scale (DASS). An example given of a "familism" item was, "Family provides a sense of security because they will always be there for you"; an example of a religiosity item was, "It is important to follow the Word of God." Regression analyses were used to examine correlations and moderators. **Results**: Uncontrolled correlations indicated that religiosity was significantly and positively correlated with familism (with the total score and all subscales) (r's ranging from 0.36 to 0.44, all $p<0.01$), traditional gender roles ($r=0.36$, $p<0.01$), and was inversely correlated with depressive symptoms ($r=-0.16$, $p<0.05$), anxiety symptoms ($r=-0.20$, $p<0.01$), and overall stress level ($r=-0.21$, $p<0.01$). Among students with low levels of religiosity, there was a significant correlation between aculturation stress and anxiety symptoms ($B=0.45$, $p<0.001$), but this was not present among those with high levels of religiosity. A similar relationship was found for perceived discrimination and anxiety symptoms, where the correlation was significant again only in those with low religiosity ($B=0.60$, $p<0.001$). Researchers concluded that religiosity buffers the effects that perceived discrimination and acculturation stress have on anxiety symptoms.
Citation: Corona, R., Rodríguez, V. M., McDonald, S. E., Velazquez, E., Rodríguez, A., & Fuentes, V. E. (2017). Associations between cultural stressors, cultural values, and Latina/o college students' mental health. Journal of Youth and Adolescence, *46*(1), 63-77.
Comment: Latina/o young persons face a variety of stressors when they leave home to attend college. This study suggests that higher levels of religiosity seems to help them to cope better, particularly with issues related to enculturation stress and perceived discrimination (part of which may be through familism, with which religiosity was strongly correlated)

Religion and Postpartum Depression in Rural Hispanics in California

Researchers in the nursing program at Azusa Pacific University and California State University (San Bernadino) surveyed 223 Hispanic women within 12 months of delivery (excluded were women with mental illness and those taking medication for mental problems). The purpose was to identify risk factors related to post-partum depression (PPD). Average age of women was 28.4 years, two-thirds had completed high school, nearly 40% had an annual household income of less than $10,000, and 70% were Catholic. The 10-item Edinburgh Postnatal Depression Scale (EPDS) was used to identify women at risk for PPD. The 12-item MSPSS assessed social support from family, friends, and significant other. The 5-item Duke Religion Index (DUREL) was used to assess three dimensions of religiosity (organizational, non-

organizational, and intrinsic religiosity). Also assessed were exercise, nutrition, responsible health practices, and psychological well-being using the SRAHP (Becker et al., 1993). **Results**: 42.6% of participants scored 10 or higher on the EPDS, indicating high risk for PPD. Women without PPD were more likely to be engaged in organizational religious activities (attending religious services), more likely to be engaged in non-organizational activities (prayer, meditation, reading scripture), and more likely to score high on intrinsic religiosity. Multivariate analyses were not done for predictors of PPD, and only correlations were presented.
Citation: Kim Y, Dee V (2017). Self-care for health in rural Hispanic women at risk for post-partum depression. Maternal & Child Health Journal 21:77-84
Comment: This is a simple correlational cross-sectional study in a convenience sample of Hispanic women within 1-year of childbirth that seeks to identify risk factors for postpartum depression. All indicators of religious involvement were higher among those without PPD symptoms. Whether PPD leads to a reduction in religious activities or whether religious activities prevent PPD remains to be determined.

Spiritual Practices and Life Satisfaction in Catholic Pastoral Workers

Arndt Bussing and colleagues from the Institute of Integrative Medicine at Witten/Herdecke University and other universities in Germany surveyed 1,826 Catholic pastoral workers (65% priests and 35% non-ordained pastoral assistants and parish workers) from 4 of the 27 German Catholic dioceses. The purpose was to identify factors related to life satisfaction, which was measured by Diener's 5-item Satisfaction with Life Scale. Assessed were daily spiritual experiences (6-item DSES), frequency of religious activities (Holy Eucharist, Liturgy of the Hours, private prayers, participation in sacramental Confession), and importance of spiritual practices (17-item version SpREUK-P). The SpREUK-P assesses five major domains of spiritual practice: religious practices, prosocial-humanistic practices, existentialistic practices, gratitude/awe, and spiritual mind-body practices. Regression modeling was used to identify independent predictors of life satisfaction. **Results**: Significant predictors of life satisfaction among priests were perception of the transcendent, low levels of spiritual dryness, and importance of gratitude/awe. These predictors explain 31% of the variance in global life satisfaction. In pastoral workers, life satisfaction was associated with low levels of spiritual dryness and importance of gratitude/awe, which explain 17% of the variance. Thus, while much of pastoral workers' life satisfaction depended on sources other than spirituality, for priests, life satisfaction was more dependent on their religious experience and commitment.
Citation: Büssing, A., Frick, E., Jacobs, C., & Baumann, K (2016). Self-Attributed Importance of Spiritual Practices in Catholic Pastoral Workers and their Association with Life Satisfaction. Pastoral Psychology, Dec 14, E-pub ahead of press
Comment: This is one of the few studies examining predictors of life satisfaction in Catholic priests, and comparing them to predictors of life satisfaction in Catholic pastoral workers.

Spiritual Coping Strategies among Rheumatoid Arthritis Patients in Poland

Polish researchers examined the relationship between posttraumatic growth (PTG) and spirituality in 250 patients with rheumatoid arthritis (RA) in Poland. Stress coping strategies were assessed by the Mini-COPE, spirituality by the Self-Description Questionnaire, social support by the Berlin Social Support Scales, and PTG by a Polish adaptation of the PTG Inventory. **Results**: Among characteristics most strongly related to PTG was "returned to religion," acceptance, spirituality, and social support. Unfortunately, only the abstract was readily available, so few details are presented here.
Citation: Rzeszutek, M., Oniszczenko, W., & Kwiatkowska, B. (2017). Stress coping strategies, spirituality, social support and posttraumatic growth in a Polish sample of rheumatoid arthritis patients. Psychology, Health & Medicine, Jan 12, E-pub ahead of print.
Comment: An interesting study in a relatively large group of Polish patients with rheumatoid arthritis, a disease in which very little is known with regard to the relationship between religion, spirituality, and coping (especially in Poland).

NEWS

Harvard School of Public Health Videos on Religion and Health Symposium

Videos of presentations given at the day-long symposium held on December 2, 2016, which was attended by 125 persons from across the Harvard community and the U.S., are now available for viewing: http://projects.iq.harvard.edu/rshm/events-videos.

SPECIAL EVENTS

15th Annual David B. Larson Memorial Lecture

(Durham, North Carolina, March 9, 2017)
Please come to the David B. Larson Lecture on Religion, Spirituality and Health. No reservations are required. The 15th annual lecture is being given by John R. Peteet, M.D., Associate Professor, Psychiatry, Harvard Medical School, fellowship site director, Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, and physician in psychiatry at the Brigham and Women's Hospital, Boson. The title is: *A Fourth Wave of Psychotherapies: Moving Beyond Recovery Toward Well Being*. The event will be held at Duke Hospital North, Room 2001, from 5:30-6:30P on Thursday, March 9, 2017. Mark your calendars now. For more information, go to: http://www.spiritualityandhealth.duke.edu/index.php/scholars/david-b-larson.

Conference on Medicine & Religion

(Houston, TX, March 24-26, 2017)
The 2017 Conference conveners invite health care practitioners, scholars, religious community leaders, and students to address questions associated with the theme, "Re-Enchanting Medicine." An array of disciplinary perspectives are welcomed, from empirical research to scholarship in the humanities to stories of clinical practice**.** See website: http://www.medicineandreligion.com/.

9th Annual Muslim Mental Health Conference

(East Lansing Marriott at University Place, April 14-15, 2017)
Sponsored by Michigan State University's Department of Psychiatry, the focus is on understanding addiction among Muslim populations or more generally the topic of Muslim mental health. Suggested topics include faith-based cultural competency, treating and understanding addiction, smoking cessation, substance use, gambling or gaming addiction, trauma-informed care for Muslims, spirituality and therapy, cultural diversity within Muslim populations, experiences of marginalization, role of Imam/Islamic centers in mental health services, help seeking and mental health stigma, family therapy, and Islamic history of mental health interventions. For more information go to: http://www.psychiatry.msu.edu/about/news/9th-mmh-conference.html or send e-mail to: msummhconference@gmail.com.

14th Annual Duke University Summer Research Workshop

(Durham, North Carolina, August 14-18, 2017)
Register **now** to attend this one-of-a-kind 5-day training session on how to design research, get it funded, carry it out, analyze it, publish it, and develop an academic career in the area of religion, spirituality and health. The workshop compresses training material that was previously taught during our 2-year Duke post-doctoral fellowship, so the curriulum is packed. Leading religion-health researchers from Duke, Yale and Emory serve as workshop faculty. If desired, participants will have the option of a 30-minute one-on-one with Dr. Koenig or another faculty mentor of their choice (early registration will ensure a mentorship spot, since these are limited). Nearly 750 academic researchers, clinical researchers, physicians, nurses, chaplains, clergy, and students at every level in medicine, nursing, social work, chaplaincy, public health, psychology, counseling, sociology, theology, and rehabilitation specialty (as well as interested members of the general public) have attended this workshop since 2004. Participants from every faith tradition and region of the world usually come to this workshop, and this year should be no exception. Partial tuition scholarships are available. To learn how to register, go to: http://www.spiritualityandhealth.duke.edu/index.php/5-day-summer-research-course.

RESOURCES

Trauma, Meaning, and Spirituality: Translating Research into Clinical Practice (APA Press, 2017)

From the publisher: "Trauma represents a spiritual or religious violation for many people. Survivors attempt to make sense out of painful events, incorporating that meaning into their current worldview in either a harmful or a more helpful way. This volume helps mental health practitioners—many of whom are less religious than their clients—understand the important relationship between trauma and spirituality, and how to best help survivors create meaning out of their experiences. Drawing on relevant theories and research, the authors present a new conceptual framework, the Reciprocal Meaning-Making Model, demonstrating how it can guide both assessment and treatment. Through the use of case material, the authors examine a range of spiritual views, traumas, and posttraumatic reactions that are reflective of the population as a whole rather than targeting only specific religions or cultural perspectives. Given the lack of scientific literature on the topic, this book fills an important gap, and will appeal to clinicians and researchers alike." Available for $48.75 at: https://www.amazon.com/Trauma-Meaning-Spirituality-Translating-Research/dp/143382325X

Choosing Our Religion: The Spiritual Lives of America's Nones (Oxford University Press, 2017)

From the publisher: "To the dismay of religious leaders, study after study has shown a steady decline in affiliation and identification with traditional religions in America. By 2014, more than twenty percent of adults identified as unaffiliated--up more than seven percent just since 2007. Even more startling, more than thirty percent of those under the age of thirty now identify as "Nones"--answering "none" when queried about their religious affiliation. Is America losing its religion? Or, as more and more Americans choose different spiritual paths, are they changing what it means to be religious in the United States today? Available for $27.59 at https://www.amazon.com/Choosing-Our-Religion-Spiritual-Americas/dp/0199341222

If Your Heart is like My Heart: A Pilgrimage of Faith & Health (Leafwood, 2017)

From the publisher: "Awaken the imagination to what is possible when people of faith respond to God's call. We've forgotten that the key to being healthy is realizing we're not on the path alone. When we're not well, it affects the entire system in which we live and work and play. When we grasp our shared humanity rather than resisting it, the mirror becomes less dim, and we begin to cast light on questions of health and healthcare. Wholeness and wellness are necessities for the kind of world we want to create, a world that regards individuals with worth and dignity because God regards them that way. Bound up in our shared humanity is our shared pilgrimage of health and faith. In community, both in body and spirit, we journey together toward the heart of God." Available for $14.99 at: https://www.amazon.com/If-Your-Heart-Like-Pilgrimage/dp/0891124063

You Are My Beloved. Really? (CreateSpace publishing platform, 2016)

How does God feel about us? 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 going through hard times -- will find this book enlightening, inspiring, and possibly transforming. Written for Christians, non-Christians, those who are religious, those who are spiritual, and those who are neither. Compact paperback version (6 x 4 inches, with illustrations) available for $8.78: https://www.amazon.com/You-are-My-Beloved-Really/dp/1530747902/

CME/CE Videos (Integrating Spirituality into Patient Care)

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" healthcare that includes the identifying and addressing of spiritual needs. Go to: http://www.spiritualityandhealth.duke.edu/index.php/cme-videos.

Health and Well-being in Islamic Societies (Springer International, 2014)

The core of the book focuses on research exploring religiosity and health in Muslim populations. Available for $57.89 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. Available for $14.15 (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 3,300 studies prior to 2010). Available for $139.99 (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 Annual Summer Research Workshop on Spirituality and Health. Available for $29.15 (used) at: http://www.amazon.com/Spirituality-Health-Research-Measurements-Statistics/dp/1599473496/

JOBS
USSOCOM Spiritual Performance Education and Training Coordinator (Tampa, FL)
Now open for application (although this position may be filled by March 1, so don't be too disappointed). If interested, click on link: http://careers.hjf.org/psc/eapp/EMPLOYEE/HRMS/c/HRS_HRAM.HRS_CE.GBL

COURSES / WORKSHOPS
Chaplaincy Research Summer Institute
The Transforming Chaplaincy project will hold the first Chaplaincy Research Summer Institute the last week of July 2017 in Chicago. For more information, go to: http://www.researchliteratechaplaincy.org/summer-research-institute/

Writing Workshop
Lisa Feldman Barrett and David DeSteno of Northeastern University will be hosting a three-day writing workshop, funded by The John Templeton Foundation, for natural scientists, social scientists, and philosophers looking to communicate their ideas to the public via articles and essays in major media outlets. Led by *New York Times* editor James Ryerson, who has two decades of experience working with and editing academics, the workshop will focus on how to conceptually frame scholarly work for a wider audience, how to structure the writing of such pieces, and how to most effectively "pitch" editors at magazines and newspapers. The workshop will take place at Northeastern University in Boston from June 2-4, 2017. Applications will consist of a brief bio and a portfolio of (1) three short descriptions of pieces the applicant might like to write (no more than a paragraph each); (2) a brief writing sample, which can be a stand alone piece or a passage from a longer work, and of an academic or popular nature (no longer than 1,500 words); and (3) a CV. Applicants will be selected based on each portfolio's potential to interest non-scholarly readers. Although applications were due February 1, late applications may be considered. If interested go to: www.northeastern.edu/cos/workshop-scholars-writing-public/

AWARDS AND PRIZES
Expanded Reason Awards
The University Francisco de Vitoria, in collaboration with the Joseph Ratzinger / Benedict XVI Vatican Foundation, have launched the Expanded Reason Awards with the objective of promoting research and academic innovation in the spirit of Benedict XVI's proposal to broaden the horizons of reason. 100,000 € will be awarded in four prizes of 25,000 € each, two for teaching and two for research. The awards seek works that relate scientific and professional disciplines to philosophy and/or theology and to those human reflections that elevate the human person to a spiritual dimension beyond the empirical and mathematical. This program is targeting professors and university researchers, individually or as a working group, who are able to embrace and explore aspects of their particular science that go beyond the purely empirical, to understand their own subject in a broader way (expanded reason). The category of Research must present a work that integrates a specific science with philosophy or theology by addressing some areas of the humanities, specifically four questions: an anthropological one, an epistemological one , and ethical one, and one related to meaning. These questions seek to understand how a proposal is integrated into a broader sense of reason. The category of Teaching requires the presentation of academic programs or syllabi that integrate the same questions as above with a detailed explanation of how it happens in the learning experience. The deadline for submissions is April 30, 2017. For more information go to: http://www.expandedreasonawards.org/

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry

The John Templeton Foundation is now accepting new funding requests through their Online Funding Inquiry (OFI) site. Small Grants are defined as requests for $217,400 or less. The next OFI deadline for small grant requests is **August 31, 2017**, with decisions communicated no later than September 29, 2017. Large Grants are defined as requests for more than $217,400. The deadline for OFIs related to large grant requests is also August 31, 2017. All decisions on large grant OFIs are communicated by September 29. The three main areas in religion, spirituality and health that the Foundation funds are: (1) research on causal mechanisms (basic psychosocial, behavioral, and physiological pathways), (2) increasing competencies of health care professionals in working with religious patients (physicians, but also pscyhologists and experts in public health), and (3) research involving the development of religious-integrated interventions that lead to improved health. More information: https://www.templeton.org/what-we-fund/grantmaking-calendar

PLEASE Partner with us to help the work to continue…

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

2017 CSTH CALENDAR OF EVENTS…

March

9 — A Fourth Wave of Psychotherapies: Moving Beyond Recovery Toward Well Being
15th Annual David B. Larson Memorial Lecture
Speaker: John R. Peteet, M.D.
Associate Professor of Psychiatry, Harvard
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

24-25 — Re-Enchanting Medicine
Conference on Medicine & Religion
Houston, Texas
Speakers: Balboni, Peteet, Curlin, Koenig, etc.
Contact: : http://www.medicineandreligion.com/

28 — Spirituality and Health in the Military
2017 Air Force Chaplain Corps Summit
San Antonio, Texas
Speaker: Koenig and others
Contact: Christian Chae (Christian.J.Chae.mil@mail.mil)

29 — Influence of healing prayers on neuronal functioning in adults with depression and childhood stress: A new therapeutic approach
Speakers: Peter Boelens, Ramiro Salas, Phil Baldwin
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

30 — Religion, Spirituality and Health: What is the connection?
West Chester University Distinguished Speaker Series
West Chester, Pennsylvania, 6:30-8:30P
Speaker: Koenig
Contact: Dr. Donald McCown (dMcCown@wcupa.edu)

April

21-22 — Integrating Spirituality into Patient Care
Adventist Health Services
Hammond Beach Resort, Palm Coast, Florida
Speakers: Koenig and others
Contact: Ted Hamilton (Ted.Hamilton@AHSS.ORG)

26 — Does Religion Really Poison Everything? A Critical Review of New Atheist Perspectives on Religion
Speaker: John Gravino
Author, "The Immoral Landscape [of the New Atheism]"
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

29 — The Impact of the Church on Mental Health
2017 Spring Summit on The Church and Mental Health
Lynchburg, Virginia
Speakers: Koenig and others
Contact: Dina Jones (Dina.Jones@aacc.net)