

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 October 2016) go to:
<http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

LATEST RESEARCH

Religiosity and Well-Being among Healthy Women in Middle Age and Later Life

Grace Wyshak from Harvard's TH Chan School of Public Health analyzed data from a cross-sectional study of 93,676 U.S. women ages 49-79 participating in the Women's Health Initiative and Observational Study (WHI OS). Participants were 83% white, 8% black and 4% Hispanic. Religious affiliations were 7% none, 27% Catholic, 10% Baptist, 6% Episcopalian, 7% Lutheran, 10% Methodist, 7% Presbyterian, 12% other Christian, 8% Jewish, and the remainder (6%) Buddhist, Hindu, Muslim, and other. The only measure of religious involvement (besides denomination) was "receiving strength or comfort from religion" (none, a little, a great deal). Measures of well-being included overall self-rated health, depression, happiness, emotional well-being, satisfaction with life, quality of life and social support, all assessed using single questions except for depression and social support which were assessed by multi-item scales. **Results:** Nearly two-thirds of American women (63.0%) indicated that they received a great deal of comfort and strength from religion. Analyses indicated that while comfort from religion was associated with lower income, lower education, and worse overall health, it was at the same time associated with greater happiness, emotional well-being, greater satisfaction with life, social support, and higher quality of life ($p < 0.0001$ for all analyses).

Citation: Wyshak G (2016). Income and subjective well-being: new insights from relatively healthy American women, ages 49-79.

PLOS One 11(2): e0146303, doi:10.1371/journal.pone.0146303

Comment: The quality and size of the sample makes up for the deficiencies in measures of predictors and dependent variables, and the weak presentation and statistical analyses. Longitudinal analyses of data collected on this cohort will be particularly important in future identification of trajectories of change and in determining direction of causation.

Religiosity and Health Behaviors among University Students Worldwide

Researchers examined relationships between religiosity and health risk behaviors in 20,222 undergraduate students from twenty-six low, middle, and high income countries (Asia, Africa, and the Americas). Religiosity was assessed using the 5-item Duke University Religion Index (DUREL), which assesses organized religious activity (ORA), non-organized religious activity (NORA), and intrinsic religiosity (IR). Health behaviors included 4 addictive risk behaviors (tobacco use, binge drinking, past 12 months illicit drug use, gambling once a week or more), 6 nutrition risk behaviors (skipping breakfast, no avoidance of dietary fat, no effort to eat fiber, eating less than 5 servings of fruits/vegetables daily, usually adding salt to food, eating red meat at least once a day), 4 sexual risk behaviors (two or more sexual partners in past 12 months, ever had a sexually transmitted infection, inconsistent condom use, and no contraceptive use in past 12 months), and 4 injury risk behaviors (not wearing seatbelt, drinking and driving, physical fighting, carrying a weapon to school). Physical inactivity was assessed using a standard measure, and oral health risk by a 2-item measure. Multivariate analyses controlled for age, gender, family wealth, and resident status. **Results:** Over 40% of students attended religious services at least once a week or more and 36% practiced non-organized religious activity (prayer, meditation, scripture reading) at least daily or more. Logistic regression models indicated that high ORA was associated with *greater* addictive behaviors (OR=1.39, 95% CI 1.26-1.53), *greater* sexual risk behaviors (OR=1.30, 95% CI 1.17-1.45), *greater* injury risk behavior (OR=1.13, 95% CI 1.03-1.24), and *greater* oral health risk behavior (OR=1.35, 95% CI 1.21-1.50), but also with *less* nutrition risk behavior (OR=0.85, 95% CI 0.74-0.87) and *less* physical inactivity (OR=0.91, 95% CI 0.84-0.99). High NORA, in contrast, was associated with *less* addictive risk (OR=0.82, 95% CI 0.74-0.91), *less* nutrition risk (OR=0.62, 95% CI 0.56-0.68), *less* sexual risk (OR=0.74, 95% CI 0.67-0.83), *less* injury risk (OR=0.75, 95% CI 0.70-0.84), and *less* oral risk behavior (OR=0.85, 95% CI 0.76-0.95), but with *greater* physical inactivity (OR=1.24, 95% CI 1.13-1.36). IR was related to less addictive risk, sexual risk, and injury risk, but higher nutrition risk, physical inactivity, and oral risk (i.e., more diet-related risks).

Citation: Peltzer K, Pengpid S, Amuleru-Marshall O, Mufune P, Zeid AA (2016). Religiosity and health risk behavior among university students and 26 low, middle and high income countries. *Journal of Religion and Health* 55:2131-2140

Comment: With an extraordinarily diverse and large sample of university students from many areas of the world, these findings are important and revealing. It appeared that religious involvement was inconsistently related to risk behavior, depending on the type of religious activity. Nonorganizational religious activities such as prayer, meditation, and scripture study (and to some extent intrinsic religiosity, except for diet-related risks) were uniformly associated with lower risk behaviors. The situation was less clear for organized religious activity (religious attendance), which surprisingly was related to greater addictive risk, sexual risk, injury risk, and oral health risk.

EXPLORE...in this issue

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Religious Involvement and Caregiver Adaptation

Researchers at Duke University's Center for Aging and Glendale Adventist Medical Center examined the relationship between religious involvement and indicators of caregiver adaptation in 251 stressed female family caregivers living in central North Carolina and southern California. Participants were ages 40-75 years, 37% African-American and 85% Christian. Religious involvement was measured using a 41-item scale that included organizational and non-organizational religiosity (Duke University Religion Index), the 10-item Intrinsic Religiosity Scale (Hoge), the 10-item Belief into Action Scale (BIAC), 12-item Religious Support Scale (Krause), and 7-item negative RCOPE (Pargament). Caregiver adaptation was assessed using the 10-item Perceived Stress Scale (Cohen), the 22-item Zarit Burden Interview, and the 20-item CES-D Depression scale. Social support was assessed with the 12-item Social Support Questionnaire, and health behaviors such as cigarette smoking, physical exercise, alcohol intake, and BMI were also measured. Control variables included the 26-item OARS medical illness limitations scale, along with 6-item physical ADL and 8-item instrumental ADL scales. **Results:** After controlling for age, race, education, caregiver health, care recipient's health, social support and health behaviors, religious involvement was associated with significantly better caregiver adaptation, especially in caregivers ages 58-75 and in spouse caregivers. Religious involvement was especially associated with lower perceived stress in African-American caregivers.

Citation: Koenig, H. G., Nelson, B., Shaw, S. F., Saxena, S., & Cohen, H. J. (2016). Religious involvement and adaptation in female family caregivers. *Journal of the American Geriatrics Society* 64(3):578-583.

Comment: This is the most recent study to link religious involvement with better adaptation among stressed family members caring for loved ones with dementia, neurological disabilities, and other severe disabling illnesses. The geographical diversity of the sample, comprehensive measure of religiosity, and careful control for confounders are particular strengths of this study.

Functional Impairment, Depression, and Spirituality/Religiosity in Sri Lankan Spinal Cord Injury Patients

Investigators recruited a sample of 62 patients with spinal cord injury from inpatient medical records in a rehabilitation facility in Ragama, Sri Lanka. Spirituality/religiosity (S/R) was measured by the 6-item BENEFIT scale, composed of the following questions: "My S/R brings a deeper connection with my neighbors and the world around me"; "My S/R helps me to manage my life more consciously"; "My S/R helps me to cope better with my illness"; "Being engaged in S/R helps restore me to mental and physical health"; and "In everyday life, my S/R promotes my inner strength" (score range 0-24). Depressive symptoms were measured by the 21-item BDI-II, and functional status by the 17-item Spinal Cord Independence Measure III (SCIM-III) and Sheehan Disability Scale (SDS). Linear regression was used to control for age, marital status, and income. **Results:** Participants were 90% male, 67% married, median age 37 years, 85% Buddhist, 7% Hindu, 5% Catholic, and 3% Muslim. Two thirds were tetraplegic (all four limbs paralyzed). Average score on the BENEFIT scale was 21 out of a maximum possible 24, indicating substantial "benefit" from their S/R. Self-perceived functional disability was the strongest correlate of depression severity ($B=0.54$, $p<0.0001$). However, the second strongest predictor of depressive symptoms was S/R ($B=-0.31$, $p<.05$). Researchers concluded that, "The findings emphasize the need for rehabilitative programming to support patients' S/R activities and mental well-being, promoting reintegration into their community roles."

Citation: Xue, S., Arya, S., Embuldeniya, A., Narammalage, H., da Silva, T., Williams, S., & Ravindran, A. (2016). Perceived functional impairment and spirituality/religiosity as predictors of depression in a Sri Lankan spinal cord injury patient population. *Spinal Cord*, May 3. doi: 10.1038/sc.2016.56. [Epub ahead of print] *Comment:* Although this was a cross-sectional study and sample size was small, the findings in this largely Buddhist and relatively young sample of severely disabled males are important, as there is very little research on religion/spirituality from this part of the world (especially in the severely disabled). The high level of benefit from S/R perceived by participants is noteworthy.

Religion and HIV Risk Among Homosexual Men in China

Researchers examined the relationships between religion, religiosity and HIV sexual risk in 400 "men who have sex with men" (MSM) in China. Religious affiliations were Christian, Muslim, and Buddhist. Since only the abstract was available, details of methodology were not available and therefore limit our description of this study. **Results:** Buddhists were more likely to report unprotected intercourse (adjusted OR= 2.06, 95% CI=1.13-3.75) and more sexual partners (OR 1.95, 95% CI=1.16-3.27) than other religions. In contrast, Muslims had significantly lower likelihood of reporting unprotected intercourse (adjusted OR=0.33, 95% CI=0.15-0.73). Among Christians, reports of anal intercourse were significantly lower (OR = 0.49, 95% CI= 0.27-0.88). Reports of forced sex were associated with increased participation in social religious activities (OR=1.25, 95% CI= 1.02-1.52) and private religious activities (OR=1.30, 95% CI= 1.04-1.61). Researchers concluded that "The sustained growth of multiple religious traditions in China may have important implications for HIV vulnerability among religious minority MSM."

Citation: Pan SW, Zhang Z, Li D, Carpiano RM, Schechter MT, Ruan Y, Spittal PM (2016). Religion and HIV sexual risk among men who have sex with men in China. *Journal of Acquired Immune Deficiency Syndrome*, Jul 6, Epub ahead of print

Comment: This is likely the first study to examine the relationship between religion and sexual activity risk for HIV among homosexual men in China. The relationship between religion and forced sex may have been due to religious/psychological conflicts over the sexual activity (with religious individuals more likely to indicate that sex was forced upon them against their will).

Religious Involvement and Health over Time in African Americans

Investigators from the center on aging and health at Johns Hopkins University, Saint Louis University, and the University of Maryland prospectively followed a national sample of 290 African-Americans over 2.5 years. The effects of religious involvement on mental and physical health (assessed using the SF-12) were examined. Religious involvement at baseline was assessed by a 9-item scale assessing religious belief (I feel the presence of God in my life; I have a close personal relationship with God) and religious behaviors (religious attendance, involvement in other church activities, talking about faith with others, etc.). Data were analyzed using a cross-lagged panel methodology. **Results:** Religious belief at Wave 1 predicted better physical health at Wave 2 ($B=0.11$, $p=0.01$); however, religious behaviors at Wave 1 did not ($B=-0.01$, $p=ns$). Likewise, religious belief at Wave 1 predicted better mental health at Wave 2 ($B=0.13$, $p=0.01$), but again, religious behavior did not ($B=-0.03$, $p=ns$). No evidence was found that health at Wave 1 affected changes in either religious belief or religious behavior at Wave 2. Researchers concluded: "The results of these analyses support contentions from numerous previous studies that religious involvement can have a positive impact on both physical and mental health."

Citation: Roth DL, Usher T, Clark EM, Holt CL (2016). Religious involvement and health over time: Predictive effects in a national sample of African Americans. Journal for the Scientific Study of Religion 55(2):417-424

Comment: Although sample size was small and made up only a relatively small subset of the original sample (n=803), any longitudinal study of effects of religious or spiritual involvement on health is worth noting, especially one that examines cross-lagged effects and gives some indication of direction of causation (in this case, that direction appears to have been from religious involvement to health).

Religious Well-being among Abused Suicidal African American Women

Investigators at Marymount University in Arlington, VA, and Emory University in Atlanta, GA, examined the buffering effect of recent abuse (within past year) on suicidal thoughts in 111 African American women ages 18-56 years (average 37). The majority of women were unemployed and had a family monthly income of \$500 or less. Religious and existential well-being were assessed with the Spiritual Well-being Scale (which is made up of two 10-item subscales assessing existential and religious well-being). Suicidal thoughts were measured using the 21-item Beck Scale for Suicidal Ideation, and relationship conflict was measured using the 39-item Conflict Tactics Scale (measure of intimate partner violence or IPV). Controlled for in analyses were age, education, employment status, income, and homelessness status. Results: Existential well-being (EWB) and religious well-being (RWB) were both inversely related to suicidal thoughts, and EWB (but not RWB) was inversely related to IPV. Path analysis revealed that while EWB mediated the relationship between IPV and suicidal thoughts, RWB did not. However, the strongest correlation among all variables was the correlation between RWB and EWB ($r=0.63$). Researchers concluded that: "Culturally-informed, meaning-making interventions to enhance existential well-being appear to be effective in reducing suicidal ideation in this population."

Citation: Fischer NL, Lamis DA, Petersen-Coleman MN, Moore CS, Zhang H, Kaslow NJ (2016). Mediating effects of existential and religious well-being among abused suicidal African American women. Journal of Family Violence, Aug 2, E-pub ahead of print

Comment: Although religious well-being (RWB) did not mediate the relationship between IPV and suicidal thoughts, these relationships are difficult to interpret. While IPV appeared to reduce EWB (inverse association), it had no significant effect on RWB ($r=-0.10$, $p=ns$). The relationship between RWB, IPV, and mental health is likely to be a complex one, and this study provides only a snapshot of these relationships at a single point in time. Greater religiosity (as evidenced by RWB) may cause women to stay with their abusing partner longer (because of religious prohibitions against divorce/separation), which may reduce existential well-being, and consequently affect suicidal thoughts in different ways. Since all these relationships are cross-sectional, the resulting relationships are likely a summation of several complex effects; furthermore, causal directions are unknown, underscoring the importance of future research examining these relationships over time in prospective studies. This study, however, is at least a start.

Religious/Spiritual Issues in Disasters and Emergencies

Psychiatrist Sam Thielman and his colleague Glenn Goss examine ethical issues religious or spiritual dimensions that responders to disasters must deal with. They examine issues such as "dual agency" (working for two separate entities, i.e., their employer/sponsor and the patient) and other "conflict of interest" concerns. This includes issues that may come up when faith-based organizations and secular government organizations are

responding to disasters. Emphasis is placed on the primacy of the patient and their needs, which may be different from the needs of the responders' employers/sponsors. They also discuss issues related to making psychiatric diagnoses such PTSD, depression, and anxiety (and treating them), when some symptoms resulting from trauma may not be pathological reactions but are rather ways of working through issues that may be important for the eventual psychological integration of the trauma. The authors also discuss psychosocial and educational interventions that may help those exposed to religious or political persecution (e.g., refugees), and how to avoid unintentionally harming them. These interventions include narrative, brief, and reconciliation approaches, focus on building resilience and post-traumatic growth, informed by knowledge about local religious and cultural issues.

Citation: Thielman SB, Goss G (2016). Ethical considerations for mental health providers responding to religious and spiritual issues in disasters and emergencies. Spirituality in Clinical Practice 3(3):171-174

Comment: An important, well-written article that addresses ethical, spiritual, religious, and culture factors that providers of mental health care to victims of disaster and trauma need to be aware of, issues that may be strongly affected by local religious or spiritual beliefs.

Causal Inference and Longitudinal Data Analysis

VanderWeele and colleagues from the Harvard Chan School of Public Health discuss the topic of causal inference in longitudinal data analysis as it applies to religion and health research. They examine the types of causal questions that can be addressed with standard regression analyses that control for confounders and explanatory variables (and their limitations). Emphasis is placed on exposures that may change over times (such as religious attendance or religious coping) in response to trauma, stress, or mental disorder like depression. In particular, they focus on new classes of causal models such as marginal structural models that take into account feedback between the exposure and the outcome (i.e., take into account the effects of the outcome on the exposure). This is particularly important in religion and health research, since health outcomes such as depression or severe illness can also influence religious involvement. Finally, they provide suggestions on how to strengthen research on religion and health by focusing on longitudinal data and considering these factors when conducting statistical analyses.

Citation: VanderWeele TJ, Jackson JW, Li S (2016). Causal inference and longitudinal data: A case study of religion and mental health. Social Psychiatry and Psychiatric Epidemiology, September 8, E-pub ahead of press

Comment: An important article for all religion-health researchers to read. Note that the concerns of feedback between exposure and outcome include not only the impact that depression can have on decreasing religious attendance (as a cause for a negative or inverse relationship between depression and attendance), but also the impact that psychological distress can have on increasing religious involvement (as a cause for a positive relationship -- or a weaker negative relationship -- between psychological distress and religious involvement). In both cases, analyzing data using marginal structural models and similar methods may help to ferret out the chicken from the egg.

Religion, Spirituality and Medicine among Austrian Medical Students

Investigators from the department of psychoanalysis and psychotherapy at the Medical University of Vienna, surveyed 1,400 medical students (distributed across all four years) on beliefs and practices related to religion/spirituality (R/S). Participants were 60% women. Survey was anonymous. Questions included self-rated religiosity and self-rated spirituality. They were also asked if they had reflected on their own personal R/S beliefs; if they would

speaking about R/S with their patients; if they thought R/S belonged in the patient's medical history; if they thought the patient's R/S enable them to cope; if they would involve a chaplain in the care of patients; and who should discuss R/S issues with patients.

Results: 21.9% agreed or strongly agreed to being a religious person, while 62.7% did not agree or strongly disagreed. Likewise, 20.1% agreed or strongly agreed to being a spiritual person, while the 57.5% did not agree or strongly disagreed. Approximately 60% of students said they had reflected on their own personal R/S beliefs. Most students (86%) indicated that they would speak about R/S with patients if the patient wants; 35.7% indicated they would talk about R/S issues with patients even if the patient didn't request; 12.1% agreed or strongly agreed that they felt uncomfortable talking about R/S issues with patients. With regard to the spiritual history, 13.7% indicated that the R/S of the patient belonged in their medical history, although 76% indicated that they thought R/S might affect how well a patient with cancer copes with their illness, and 86% indicated that they would involve a chaplain if they felt it was important. With regard to whose role it was to address R/S issues, 95% indicated the chaplain, 90% indicated the patient's partner, 85% indicated close friends, 53% indicated nurses, and 55% said it was the role of the physician.

Citation: Rassoulian, A., Seidman, C., & Löffler-Stastka, H. (2016). Transcendence, religion and spirituality in medicine: Medical students' point of view. *Medicine* 95(38):e4953

Comment: This study provides a glimpse on the attitudes of a large sample of future physicians at a secular European university. How interesting that more than half (55%) indicated that it was the role of the physician to address R/S issues with patients; in contrast, only 14% indicated that a spiritual history should be part of the medical history.

Spiritual History Taking by Canadian Family Physicians

Researchers in the department of family medicine at McMaster University in Hamilton, Ontario, and Western University in London, Ontario, surveyed 155 family physicians in outpatient practices in the Kitchener-Waterloo, Ontario area (response rate=90%), examining the degree to which physicians spoke with their patients about religious/spiritual issues. Participants were 60% male; 80% were over age 40 (mean age 48.9 years); 85% had been in practice for 10 years or more (20.8 years average); and the majority (50.4%) took care of 2000 or more patients (average size of practice 1900). **Results:** 82% of physicians indicated they had religious or spiritual beliefs, and 51.8% said that they asked patients about their religious or spiritual beliefs at least sometimes (4.4% indicated most of the time). Most respondents (95%) were at least somewhat comfortable asking patients about R/S, and nearly two-thirds indicated it was at least sometimes important to ask patients about their R/S beliefs. On the other hand, 51.5% said that R/S beliefs were not relevant to healthcare, and 22.4% said that it was not their business to ask. The majority (58.2%) indicated that lack of time was the main reason for not asking, whereas lack of training was the next most common reason (17.2%); 12.7% indicated that discomfort and 8.2% indicated that negative past experiences were reasons for not asking. "Comfort level" was significantly associated with belief that it was important to ask patients about R/S ($p=0.004$), that it was the physician's business to ask ($p=0.003$), and that lack of training was one reason for not asking ($p=0.007$). Researchers concluded that: "Physician comfort levels with asking patients about religious and spiritual beliefs can be addressed through adequate training and education."

Citation: Lee-Poy, M., Stewart, M., Ryan, B. L., & Brown, J. B. (2016). Asking patients about their religious and spiritual beliefs: Cross-sectional study of family physicians. *Canadian Family Physician* 62(9): e555-e561.

Comment: This may be the first study of Canadian family physicians examining their attitudes toward asking patients about R/S (i.e., taking a spiritual history). Given the relatively secular nature of Canadian society, it is remarkable that more than half of these physicians (51.8%) indicated that they at least sometimes asked patients about their R/S beliefs (although it is also notable that 48.2% never or rarely did so). Family physicians in the United States are the medical professionals most likely to have positive views toward taking a spiritual history and integrating spirituality into patient care (and they are also the most appropriate medical specialist to do so given their long-term relationships with patients and their families). Discomfort with the topic **due to lack of education/training** appears to be an influential factor on whether or not physicians talk with patients about these issues in Canada, as it is in the United States.

The Spiritual History in Psychiatry

Vahid Payman, a psychogeriatrician at Middlemore Hospital in Auckland, New Zealand, argues in this article that psychiatrists should take a religious and spiritual history as part of their evaluation and treatment of patients. First, he describes why taking such a history is necessary, including the benefits to both psychiatrists and patients, and reviews some of the research that backs up this suggestion. Second, he describes the indications and the contraindications to taking a spiritual history. Third he describes a variety of religious/spiritual assessment tools such as the SPIRITual History, the Royal College of Psychiatrists' Assessment tool, and the FICA (including the entire FICA in the article). Finally, he argues that training programs for psychiatrists should include modules on how to address religious/spiritual issues in clinical practice, and encourages practicing psychiatrists to learn more about the world's different major religious belief systems (Hinduism, Buddhism, Judaism, Zoroastrianism, Christianity, Islam, Baha'i, and indigenous religions).

Citation: Payman V (2016). The importance of taking a religious and spiritual history. *Australasian Psychiatry* 24 (5): 434-436

Comment: Psychiatrists are becoming more and more open to assessing and addressing patients' religious/spiritual issues in clinical practice, as evidenced by this article in a secular psychiatric journal.

User Views on Chaplain Mental Health Services in the UK's National Health System (NHS)

Investigators from the spiritual and pastoral care department at Ashworth Hospital Parkbourn in Liverpool England conducted interviews with 22 service users across the directorates of a large mental health NHS Trust to assess their views on the quality of spiritual care services and desired changes they would like to see. Grounded theory was used in this qualitative research study.

Results: Participants had a wide range of religious affiliations from none/atheist ($n=3$) to Church of England ($n=5$), Roman Catholic ($n=8$) and others. Six categories of response were identified: (1) meeting of spiritual care, (2) benefits of spiritual care, (3) role of religion, (4) qualities of a good chaplain, (5) who talks to chaplains, (6) chaplains as part of the multidisciplinary team. Researchers found that spiritual care was poorly defined and meant different things to different people. Religious support was a key element, although this was not the only element. Helpful services provided by chaplains included listening, prayer, spiritual advice/guidance, provision of Holy Communion, provision of confession, and normalizing faith. Participants indicated that chaplains help them in many ways including "feeling at one with God, expecting God would directly intervene or providing hope and strength." Personal and spiritual qualities of the "good chaplain" were described by participants as follows: (1) personal qualities: non-judgmental, honest, approachable, trustworthy, genuine, kind, friendly, empathetic, not rushing, and knowledge of the mental health system; (2) spiritual qualities: be a "man of God", be a church

leader/spiritual trainer, having a prayerful life, having a genuine relationship with God, reading the word of God, ability to represent multiple faiths, and being a channel of the grace of God. Researchers concluded: "To service users with strong spiritual beliefs, supporting their spiritual resilience is central to their care and well-being."

Citation: Raffay J, Wood E, Todd A (2016). Service user views of spiritual and pastoral care (chaplaincy) in NHS mental health services: a co-produced constructivist grounded theory investigation. *BMC Psychiatry* 16: 200, doi:10.1186/s12888-016-0903-9

Comment: An interesting article that underscores the role that chaplains play in the secular mental health care system of the United Kingdom.

SPECIAL EVENTS

Harvard Symposium on Health, Religion, and Spirituality in Public Health

(Cambridge, MA, December 2, 2016)

A day long symposium titled: "Harvard Symposium on Advancing Health, Religion, and Spirituality: From Public Health to End of Life" is being hosted by the Harvard Chan School of Public Health (10:30A-5:00P). The focus is on how religion and spirituality in concert with public health and the practice of medicine may alleviate illness and promote human well-being more generally and at the end of life. Invited panelists and speakers include Ken Pargament, Daniel Sulmasy, Christina Puchalski, Tyler VanderWeele, Tracy Balboni, Harold Koenig, and others. For more information, go to:

<http://projects.iq.harvard.edu/rshm/event/harvard-symposium-advancing-health-religion-and-spirituality> or contact Dr. Michael Balboni at Michael_Balboni@dfci.harvard.edu.

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. Conference planners invite the submission of abstracts for oral presentations and posters that are due November 15, 2016. For more information go to:

<http://www.psychiatry.msu.edu/about/news/9th-mmh-conference.html> or send e-mail to: msummhconference@gmail.com.

RESOURCES

Faith Versus Fact: Why Science and Religion are Incompatible (Penguin, 2016)

With nice endorsements by Richard Dawkins ("A superbly argued book") and Sam Harris ("A profound and lovely book . . . showing that the honest doubts of science are better . . . than the false certainties of religion"), this volume is described by the publisher in one line: "The New York Times bestselling author of *Why Evolution is True* explains why any attempt to make religion compatible with science is doomed to fail." A more detailed description of the book follows: "In this provocative book, evolutionary biologist Jerry A. Coyne lays out in clear, dispassionate detail why the toolkit of science, based on reason and empirical study, is reliable, while that of religion—including faith, dogma, and revelation—leads to incorrect, untestable, or conflicting conclusions. Coyne is responding to a national climate in which more than half of Americans don't believe in evolution, members of Congress deny global warming, and long-conquered childhood diseases are reappearing because of religious objections to inoculation, and he warns that religious prejudices in politics, education, medicine, and social policy are on the rise. Extending the bestselling works of Richard Dawkins, Daniel Dennett, and Christopher Hitchens, he demolishes the claims of religion to provide verifiable "truth" by subjecting those claims to the same tests we use to establish truth in science. Coyne irrefutably demonstrates the grave harm—to individuals and to our planet—in mistaking faith for fact in making the most important decisions about the world we live in." Available for \$12.65 at <https://www.amazon.com/Faith-Versus-Fact-Religion-Incompatible/dp/0143108263>.

You Are My Beloved. Really? (CreateSpace publishing platform, 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 going through hard times -- 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. Planning 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 those with PTSD. 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 (How to integrate 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 \$46.00 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>

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry (OFI)

The John Templeton Foundation is now accepting new funding requests *at any time of the year* through their OFI form. Small Grants are defined as requests for \$217,400 or less. The last OFI deadline for small grant requests in 2016 is **November 30**, with decisions communicated no later than the end of December.

Large Grants are defined as requests for more than \$217,400. The Foundation has only one deadline per year for OFIs related to large grant requests. In 2016, it was August 31. In 2017, the deadline is likely around the same date. All decisions on large grant OFIs are communicated by the end of September. 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>

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/>

2016 CSTH CALENDAR OF EVENTS...

November

- 1 **Religion, Spirituality and Medicine**
Annual Joint Internal Medicine-Family Medicine Grand Rounds, University of Oklahoma Health Sciences Center
Speaker: Koenig
Oklahoma City, Oklahoma
Contact: Crystal Pearson (Crystal-Pearson@ouhsc.edu)
- 3 **Religion and Health: Latest Research and Applications**
Glendale Medical Center Rounds
Speaker: Koenig
Los Angeles County, California
Contact: Bruce Nelson (NelsonBR@ah.org)
- 30 **Spirituality and Palliative Care: Results of a State of the Science Conference**
Speaker: Karen Steinhauser, Ph.D.
Associate Professor of Medicine, DUMC
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

December

- 2 **Harvard Symposium on Advancing Health, Religion, and Spirituality in Public Health**
Cambridge, MA
Speakers: VanderWeele, Balboni, Koenig, others
Harvard Medical School and Harvard T.H. Chan School of Public Health
Contact: Dr. Michael Balboni (Michael_Balboni@dfci.harvard.edu)
- 21 **Theology and Mental Health**
Speaker: Warren Kinghorn, ThD, MD
Associate Professor of Psychiatry, DUMC
Assistant Research Professor of Pastoral and Moral Theology, Duke Divinity School
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)

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