Religiosity, Suicidal Ideation and Age

Researchers from Department of Mental Health Policy, NIMH, National Center of Neurology and Psychiatry in Japan, Department of Mental Health Policy at the University of Tokyo, and Departments of Mental Health and Psychiatry at Johns Hopkins University analyzed data from the U.S. National Survey on Drug Use and Health (NSDUH) to examine the relationship between religiosity and suicidal ideation by age group. NSDUH annually collects information on substance use and mental disorders in a nationally representative sample of persons age 12 and older in the U.S. The present sample was made up of cross-sectional data collected annually from 2008 to 2014 on those ages 18 or older (n=260,816). Participants were categorized by age groups 18-25, 26-34, 35-49, 50-64, and 65 and above. Suicidal ideation within the past year was the dependent variable (“At any time in the past 12 months, did you seriously think about trying to kill yourself?”). Religiosity was assessed by (a) importance of religion (“Your religious beliefs are a very important part of your life,” with the response options strongly disagree, disagree, agree, strongly agree (responses were dichotomized into agree and disagree) and (b) frequency of religious attendance during the past 12 months (0 times, 1-2 times, 3-5 times, 6-24 times, 25-52 times, and more than 52 times, i.e., more than weekly). Multinomial logistic regression was used to predict presence of suicidal ideation controlling for sex, race, income, marital status, employment status, education, past year major depressive episode, past year alcohol dependence/abuse, past drug dependence/abuse, and year of survey. Results: The highest prevalence of past year suicidal ideation was among persons ages 18-25 (7.0%), and lowest prevalence was among those ages 65 or older (1.6%). In contrast, religiosity was lowest among those ages 18-25 (65.6% important) and highest among those ages 65 or older (81.4% important). Likewise, 9.4-10.4% of those ages 18-34 reported attending services more than 52 times/year, compared to 20.4% of those age 65 or older. Without covariates in the model, those who indicated that religion was important were less likely to have suicidal ideation in every age group (ages 18-25, OR=0.68; ages 26-34, OR=0.75; ages 35-49, OR=0.84; ages 50-64, OR=0.74; and ages 65 or older, OR=0.58, p<0.01 in all cases). Similar findings were reported for attending religious services more than 52 times/year (ages 18-25, OR=0.88; ages 26-34, OR=0.64; ages 35-49, OR=0.57; ages 50-64, OR=0.57; and ages 65 or older, OR=0.27, p<0.01 in all cases). When covariates were controlled, associations persisted for those indicating religion was important (ages 18-25, OR=0.73; ages 26-34, OR=0.81; ages 35-49, OR=0.83; ages 50-64, OR=0.78; and ages 65 or over, OR=0.54). This was less true for religious attendance, where after controlling for covariates the inverse relationship between attendance and suicidal ideation was reduced to nonsignificance in those ages 18-25, ages 26-34, ages 35-49, and ages 50-64; however, among those ages 65 or older, the association remained significant and robust (OR=0.34, 95% CI 0.20-0.59). Researchers concluded that “Particular attention to religiosity among older adults as a protective factor for suicidal ideation may be helpful in clinical settings.” Citation: Nishi, D., Susukida, R., Kuroda, N., & Wilcox, H. C. (2017). The association of personal importance of religion and religious service attendance with suicidal ideation by age group in the National Survey on Drug Use and Health. Psychiatry Research, E-pub ahead of press (June, 2017) Comment: Given the sampling method (population-based), large sample size, and rigorous control for covariates (including indicators of mental health and substance abuse), these findings are of substantial importance. The results are also consistent with other research that shows that religious involvement is related to better mental health, especially in older adults (although this relationship is not restricted to older adults only, as the findings for religious importance indicate above).

Spirituality and Depression Risk in U.S., China, and India

Investigators at Columbia University in New York City analyzed data on 5,512 participants (mean age 29, 41% women) in the United States (n=1,499), China (n=3,150), and India (n=863). Participants were recruited from crowdsourcing Websites (Zhu-bajie.com and MTurk.com). Spirituality was assessed using the 6-item brief Daily Spiritual Experiences Scale (DSES) and the 23-item Delaney Spirituality Scale (DSS). The Delaney Spirituality Scale assesses a search for meaning, experience of sacredness in nature or in relationships, and a personal connection to the transcendent. Depressive symptoms were assessed with the PHQ-9. Logistic regression was used to assess the relationship between both spirituality measures and severity of depression and suicidal ideation by country. Results: In the U.S., higher spirituality on both measures was associated with about a 50% lower risk of moderate or severe depression (OR’s ranging from 0.47 to 0.57, all p<0.01); in China, the effects were less prominent but still significant at least for the DSS scale (OR’s ranged from 0.64 to 1.01, significant at p<0.01-0.09); and in India, effects were moderate between those in U.S. and China (OR’s ranged from 0.50 to 0.68, with three of four p<0.01). A similar pattern of effects were found for suicidal ideation, although high DSES scores were associated with greater suicidal ideation among those with more...
severe depression (OR=1.54, p<0.05). Researchers concluded that "Spirituality cuts in half the relative risk for depression." Citation: Portnoi, L., McClintock, C., Lau, E., Choi, S., & Miller, L. (2017). Spirituality cuts in half the relative risk for depression: Findings from the United States, China, and India. Spirituality in Clinical Practice. 4(1), 22.

Comment: Interesting study using similar measures of spirituality in three countries with very different religious systems (Christian, Hindu, Buddhist) and conceptualizations of God (monotheistic and pantheistic). Again, though, all analyses were cross-sectional, making it difficult to say how these relationships came about (in terms of causality), and the measures of spirituality were contaminated with indicators of mental health (i.e., experiencing peace, meaning and purpose).

Religiosity and Mental Health in Dutch Adolescents with Psychiatric Problems

Researchers from several universities in The Netherlands prospectively followed 543 pre-adolescents to examine the course of mental health during adolescence; all youth were those referred to a psychiatric outpatient clinic (and so were at risk for mental health problems). Participants were assessed at baseline (T1, ages 10-12), ages 12-14 (T2), ages 14-17 (T3), and T4 (ages 17-21). Religiosity was assessed at baseline only (T1) by asking one of the parents (the mother in 86% of cases), three descriptive questions about religion for herself, her partner, and her son/daughter (the pre-adolescent): are you [your partner, child] a religious person, affiliated with a church, and how often to you [your partner, child] attend religious services. Based on responses to these questions, a 3-category variable was constructed for each family member: (1) no religiosity, (2) passive religiosity, and (3) active religiosity. In addition, the Social Cultural Developments Questionnaire (SOCON) was administered, which includes 36 religiosity questions for adults and 9 religiosity questions for pre-adolescents; the parent (mother) completed the adult religiosity questions for herself and her partner, and pre-adolescents completed the 9 religiosity questions themselves. Pre-adolescents also answered selected adult questions as well. From this information collected by the SOCON, three groups were created: "Christian religiosity," "Humanistic beliefs," and "Denial higher power" (each categorized into low, medium, and high). Child mental health was assessed by the Youth Self Report of the Achenbach System of Empirically Based Assessment during the first three assessments (T1, T2, T3) and by the Adult Self Report version at T4. Mental health problems were categorized into "internalizing" (depression, anxiety) and "externalizing" (aggressive, delinquent behavior). Repeated measures ANOVA was used to analyze the data, with Bonferroni correction for p values (such that p<0.005 indicated statistical significance).

Results: Religious categories for pre-adolescents were 41.1% "no religiosity," 31.1% "passive religiosity," and 10.6% "active religiosity"; for mothers, they were 52.4% no religiosity, 20.5% passive religiosity, and 26.0% active religiosity; for the father, they were 49.9% no religiosity, 13.2% passive religiosity, and 19.9% active religiosity. Religiosity (pre-adolescent, mother, or father) had no effect on mental health outcomes except that female pre-adolescents who scored high on humanistic beliefs experienced an increase of internalizing problem behavior (depression/anxiety) over time. By "humanistic beliefs" this meant acknowledgement to statements such as "To me, God is nothing else than the valuable in the human being" and "God is not up there somewhere, but only in the hearts of people." Lack of an overall effect of religiosity on outcomes, the authors explained, was due to the following: "This [religiosity] may cause some distress as a consequence of being special, i.e., being religious, compared to other use, which may dilute and diminish the association between religiosity and mental health."

Attachment to God and Psychological Well-Being in Older Adults

In this 3-year prospective study, researchers at Baylor University surveyed a random sample of 3,087 adults age 65 or older in 2001 (Wave I) and again in 2004 (Wave II) (average age 75 in 2001), examining the effects of attachment to God on psychological well-being. Also examined were the effects of feeling forgiven by God and transactional forgiveness (i.e., the belief that individuals must change their behavior to receive forgiveness from God). Forgiveness by God was assessed by a single item: "I believe God forgives me for the things I've done wrong." Transactional forgiveness was assessed by a 3-item scale, with each item beginning with "In order to be forgiven by God, I must (a)..." and "promise God I will not make the same mistake again, (c)...correct what I have done wrong." Outcomes were optimism, self-esteem, and life satisfaction, each assessed by 3-item scales. Secure attachment to God was assessed using a 6-item scale (i.e., "I have a close personal relationship with God"; "When I talk to God, I know he listens to me," etc.). Controlled for in all analyses were age, sex, marital status, race, income, education, religious service attendance, and religious affiliation, and Wave I psychological well-being outcomes. Results: Secure attachment to God was positively associated with increases in optimism (B=0.109-0.118, p<0.05) and in self-esteem (B=0.049-0.068, p<0.05 if forgiveness variable excluded), but not in life-satisfaction. Forgiveness by God was associated with increases in self-esteem (B=0.064, p<0.10), but not in optimism or life-satisfaction. A secure attachment to God moderated the relationship between feeling forgiven by God and all three indicators of psychological well-being; among those with a secure attachment, feeling forgiven by God predicted an increase in optimism, in self-esteem, and in life-satisfaction; this was also true for transactional forgiveness, but effects were weaker. Citation: Kent, B. V., Bradshaw, M., & Uecker, J. E. (2017). Forgiveness, attachment to God, and mental health outcomes in older US adults: A longitudinal study. Research on Aging, 0164027517706984.

Comment: This is one more study, this time a longitudinal one with a relatively short follow-up period, showing the direct impact of attachment to God on psychological well-being and the moderating effect that a stable attachment to God has on the relationship between other religious beliefs and well-being (also previously shown for prayer and well-being).

Religiosity, Social Networks and Depressive Symptoms in Older Korean Americans

Researchers in the school of social work at several universities in the United States examined the cross-sectional relationship between religiosity, social networks, and depressive symptoms in 200 Korean Americans age 65 or older. Religiousness/spirituality was assessed with six subscales of the Fetzer Institute's BMMRS (daily spiritual experiences, values and beliefs, forgiveness, private religious practices, religious/spiritual coping skills, and religious support). Social networks were measured by the 12-item Lubben Social Network Scale. Depressive symptoms were assessed by the 30-item Geriatric Depression Scale. Controlled for in all analyses were age, gender, marital status, perceived physical Citation: van der Jagt-Jelisma, W., de Vries-Schot, M., Scheepers, P., van Deurzen, P. A. M., Klip, H., & Buttelaar, J. K. (2017). Longitudinal study of religiosity and mental health of adolescents with psychiatric problems. The TRAILS study. European Psychiatry. Epub ahead of press

Comment: Given the rapid displacement in Europe of religious beliefs with humanistic beliefs, such trends may have unintended consequences for youth, particularly those with emotional problems.
health, education, annual household income, and years in the U.S. Best-subsets regression modeling was used to analyze the data. 

**Results:** Only religious/spiritual coping skills and social networks were inversely related depressive symptoms in best-fitting regression models. Researchers concluded: “Religiousness/spirituality and social networks are important for coping with life stress and may be useful in developing effective healthcare strategies in the management of depression among older Korean Americans.”


**Comment:** Although a small study and a cross-sectional analysis, this is one of the few studies in older Korean Americans and so is worthy of attention.

### Religious Involvement and Cognitive Functioning: Systematic Review

Researchers from the school of public health at the University of Waterloo, Ontario, Canada, systematically reviewed published research on the relationship between religion, spirituality and cognitive functioning in older adults. They identified 17 studies (total n=35,741) that met the eligibility criteria (cohort, case-control, or cross-sectional studies; published between 1990 and 2016; adults age 18 or older; measures of religiosity or spirituality [R/S] included; and cognitive function as the primary outcome). Of the 17 studies identified, 16 were longitudinal or prospective in design, with followups ranging from 12 months to 7 years. **Results:** 82% of studies reported positive associations between R/S and cognitive function. Researchers concluded “Most of the included studies reported positive associations between R/S and cognitive functioning. R/S appears to be protective against cognitive decline in middle- and old-age adults.”


**Comment:** This is the latest systematic review that has confirmed a positive association between religious involvement and cognitive function, but this review is more comprehensive and primarily includes prospective studies.

### A Spiritual Curriculum for General Psychiatry Residents

Academic psychiatrists at Texas Tech University Health Sciences Center (Lubbock, TX) describe in this article a 3-year curriculum on spirituality for psychiatry residents, and report on feedback from 12 residents after going through the program. The objective of the curriculum is to (1) increase awareness of the residents’ own spirituality, (2) elicit a patient history that is respectful of the spiritual, cultural and religious dimension of patients’ lives, (3) respond to the patients’ suffering in a compassionate and caring manner, (4) become aware of the research literature relevant to spirituality and mental health, (5) become familiar with instruments used to measure spirituality, and (6) assess and respond to the spiritual dimensions of mental illness across the lifecycle, particularly with regard to depression, anxiety, grief, addiction and end-of-life issues. The curriculum involves didactics, seminars, and psychotherapy case conferences, often held with chaplains. Residents are also introduced to pastoral care on inpatient psychiatry units, and to spiritual dimensions in hospice care.

**Results:** Psychiatry residents were from seven countries (USA, India, Pakistan, United Arab Emirates, Nigeria, Sierra Leone, and Spain), and included 4 Christians, 4 Hindus, 3 Muslims, and 1 agnostic. Residents overwhelmingly indicated that the curriculum was helpful and meaningful, with 77% saying that addressing spiritual/religious needs of patients was important and appropriate; 69% agreeing strongly to the notion that spirituality is an important dimension in the management of addictions; and 92-100% agreeing that treatments for depression, guilt, or grief might require attention to spiritual issues. The authors concluded that: “Regardless of cultural or religious background, the residents endorsed the curriculum as a worthwhile experience and increased their appreciation of the place of spirituality in the holistic care of patients with psychiatric conditions.”


**Comment:** This is one of a growing number of spirituality curriculums that have been proposed for training psychiatry residents on how to address these issues in clinical practice.

### Religion, Spirituality and Health

This article by VanderWeele and colleagues from the Harvard School of Public Health is directed at medical practitioners. The article briefly summarizes the research on religion and health and discusses clinical applications, both in general practice and in palliative care. Emphasis is placed on the interactions that could occur between clinicians and faith communities, and the authors even make a link between physician well-being and addressing patients' spiritual needs.


**Comment:** A nice short review of the field that stresses applications both in the clinic and in the community. Again, as VanderWeele's article recently appearing in PNAS (August e-newsletter), this piece appearing in JAMA is likely to have considerable impact, especially since it comes from this prominent research group.

### Discussion of Social Determinants in the Religion-Mortality Relationship

VanderWeele and colleagues from the departments of epidemiology and biostatistics at the Harvard School of Public
Health respond to a comment by Neal Krause on social determinants of mortality in the religious attendance-mortality relationship in the Black Women’s Health Study (reported in our June e-newsletter). Interestingly, VanderWeele and colleagues have found that only about 25% of the effect of religious attendance on mortality can be explained by social factors, although in-depth measures of social involvement have rarely been included in such studies. Also discussed in the article is the National Consortium on Psychosocial Stress, Spirituality and Health at Harvard that is now seeking to collect additional data on measures of religiosity/spirituality in African-American, Native American (Lakota), Latino (Puerto Rican), South Asian (Indian) and white American populations, information that may help to disentangle cause-effect relationships through longitudinal studies.

Comment: VanderWeele et al. Respond to “Church attendance and mortality”. American Journal of Epidemiology, 185(7), 526-528

Religiosity, Dietary Habits, and Physical Activity in Minority Women

Researchers at the Baylor College of Medicine and Arizona State University analyzed data from the Health is Power study, a multi-site randomized clinical trial to increase physical activity and improve dietary habits in African-American and Hispanic/Latina-American women in Texas conducted between 2006 and 2008. Participants were 410 women between ages 25 and 60 who were randomly assigned to either a physical activity group or a vegetable/fruit comparison group. Both groups met six times over a 6-month period, focusing on group cohesion and friendly competition (no religious/spiritual aspects to the intervention). Measures of physical activity, fruit/vegetable and fat intake were measured at baseline (T1) and 6-month follow-up (T2).

Measurement of religiosity/spirituality was by the short-form of the Fetzer Institute’s BMRRS at T1 only. Of the 310 initially randomized, 198 completed pre-post outcome measures as above, although complete data on all measures for this analysis was available for only 132 women (32% of the original sample).

Results: Participants increased their physical activity by 15%, their fruit/vegetable intake by 27%, and decreased their fat consumption by 5%. Regression analyses examining the impact of T1 religiosity/spirituality on outcomes between T1 and T2 revealed no significant effect on any outcome after adjustment of demographic characteristics. Investigators recommended more longitudinal studies to explore the role of religiosity on the health of minority women.

Citation: Ansari, S., Soltero, E. G., Lorenzo, E., & Lee, R. E. (2017). The impact of religiosity on dietary habits and physical activity in minority women participating in the Health is Power (HIP) study. Preventive Medicine Reports, 5, 210-213.

Comment: No effects of baseline religiosity on physical activity, fruit/vegetable intake, or fat consumption, although neither intervention included a religious or spiritual component. This is a bit disheartening, given the importance that religion plays in the life, worldview, eating, and physical activity habits of minority women in the U.S. Prior studies have suggested that religiosity increases compliance with health behaviors. Other studies have shown a positive impact for health interventions on diet and weight of minority women when religion/spirituality is utilized as part of the intervention, which the above study did not.

Spiritual/Religious Activity and the Metabolic Syndrome

Investigators at UNC Chapel Hill and eight other U.S. universities analyzed data collected from a prospective study of 3,278 middle-aged and older Hispanic/Latino adults participating in the Hispanic Community Health Study/ Latinos Sociocultural Ancillary Study. Participants were a random sample of adults ages 45-74 living in the Bronx NY, Chicago IL, Miami FL, and San Diego CA. Religious activity was measured at baseline by two items from the 5-item Duke University Religion Index (ORA-organizational religious activity, i.e., religious attendance, and NORA-nonorganizational religious activity, i.e., prayer/Bible study). Spiritual well-being was assessed by the FACIT-Sp, largely a measure of peace, meaning and purpose in life (with smaller relational and faith components). Metabolic syndrome was assessed by enlarged waist circumference (>102 cm in men and >88 cm in women), increased blood pressure (> 130/85) or use of anti-hypertensive medication, increased triglyceride levels (>150 mg/dL), low levels of high density lipoprotein (HDL <40 mg/dL men, <50 mg/dL women), and increased fasting blood glucose (100 mg/dL) or use of anti-diabetic medication. All analyses were cross-sectional and were done at baseline. Regression analyses controlled for sociodemographic covariates and lifestyle factors, and all religious/spiritual variables were included simultaneously in regression models.

Results: No R/S variable (ORA, NORA, meaning, peace, faith, or relational, or total FACIT-Sp score) was significantly associated with the metabolic syndrome in logistic regression analyses. However, R/S variables was significantly associated with various components of the metabolic syndrome. The “meaning” subscale and the total FACIT-Sp score were inversely related to waist circumference (B= -1.38, p=0.01, and B= -0.72, p<0.05, respectively). The “faith” subscale of the FACIT-Sp was inversely related to diastolic blood pressure (B= -0.98, p=0.002). Both NORA and the FACIT-Sp “peace” subscale were related to higher diastolic blood pressure (B= -0.65, p=0.03, and B= -0.71, p=0.02, respectively). The “peace” subscale was also positively related to systolic blood pressure (B= 1.51, p=0.01). When p values were adjusted for multiple comparisons (Bonferroni), only the inverse relationship between the “faith” subscale and diastolic blood pressure remained statistically significant. When patients with coronary heart disease (CHD) were removed from the sample, a significant inverse association between the “faith” subscale and systolic blood pressure also emerged (B= 1.19, p=0.04). No associations were found between R/S characteristics and triglycerides, fasting glucose or HDL cholesterol levels.


Comment: A large important study in Black and Hispanic/Latino Americans. However, all analyses were cross-sectional. Given that religiosity tends to be much higher among minorities in the U.S. (vs. majority Whites), it is unclear how these relationships (or lack of relationship) may have developed over time. Weight has been positively and significantly associated with religiosity in previous studies of minority populations (a negative consequence of social religious activities where potlucks are the rule), which may cancel out some of the other benefits of religious practice on the metabolic syndrome. The authors acknowledged the need for longitudinal studies.
Medicine: From Evidence to Practice (part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

Catholic Christianity and Mental Health: Beliefs, Research and Applications (part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)

Hindusim and Mental Health: Beliefs, Research and Applications (part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)
For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Hindus. Includes original research on current religious beliefs/practices in Hindus from India and throughout the world. Available for $7.50 at: https://www.amazon.com/dp/1544642105/.

Protestant Christianity and Mental Health: Beliefs, Research and Applications (part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)
For mental health professionals, clergy, researchers, and laypersons interested in the relationship between religion, spirituality and mental health in Protestant Christians. Available for $7.50 at: https://www.amazon.com/dp/1544642105.
**Judaism and Mental Health: Beliefs, Research and Applications**  
(part of the Religion and Mental Health Book Series; Amazon: CreateSpace Platform, 2017)  

**You Are My Beloved, Really?**  
(Amazon: CreateSpace Platform, 2016)  
How does God feel about us? This book examines the evidence for God’s love from Christian, Jewish, Muslim, Buddhist and Hindu perspectives based largely on the sacred scriptures from these traditions. 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. Available for $8.78 at: [https://www.amazon.com/You-are-My-Beloved-Really/dp/1530747902/](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](http://www.spiritualityandhealth.duke.edu/index.php/cme-videos)

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

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

**Handbook of Religion and Health (2nd Ed)**  
(Oxford University Press, 2012)  

**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 $34.97 at: [https://www.templetonpress.org/books/spirituality-and-health-research](https://www.templetonpress.org/books/spirituality-and-health-research)

**PRIZES**

**Jean-Marc Fischer Prize**  
The Doctor Jean-Marc Fischer Foundation encourages reflection in the field of human, social and theological sciences by awarding the Jean-Marc Fischer Prize. Three prizes will be awarded in this third contest, which will welcome submissions in French and English from around the world. This year’s theme is *Care and Spirituality*.  

**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 more than $217,400. The next OFI deadline for small grant requests is August 31, 2018, with decisions communicated no later than September 29, 2018. Large Grants are defined as requests for more than $217,400. The deadline for OFIs related to large grant requests is also August 31, 2018. 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 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](https://www.templeton.org/what-we-fund/grantmaking-calendar)
### 2017 CSTH CALENDAR OF EVENTS...

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<td>Islam and Health</td>
<td>Azleena Salleh Azhar</td>
<td>Learning Lab 1502 Blue Zone, 1st floor, Duke South</td>
<td>Harold G. Koenig (<a href="mailto:Harold.Koenig@duke.edu">Harold.Koenig@duke.edu</a>)</td>
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<td>27-30</td>
<td>Religion and Mental Health</td>
<td>Harold G. Koenig, M.D., and others</td>
<td>American Association of Christian Counselors (AACC) World Conference, Nashville, TN</td>
<td>Dina Jones (<a href="mailto:Dina.Jones@aacc.net">Dina.Jones@aacc.net</a>)</td>
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| **October**                                                                                                                |                                                                        |                                     |                                           |
| 25    | Energy Healers: Who They Are and What They Do                                             | Jeff Levin, Ph.D., M.P.H.                                           | University Professor of Epidemiology and Population Health Professor of Medical Humanities Director, Program on Religion and Population Health Baylor University Center for Aging, 3rd floor, Duke South | Harold G. Koenig (Harold.Koenig@duke.edu) |
|       | **Speaker:** Jeff Levin, Ph.D., M.P.H.                                                     |                                                                        |                                     |                                           |
|       | **Contact:** Harold G. Koenig                                                             |                                                                        |                                     |                                           |