

CROSSROADS...

Exploring research on religion, spirituality and health

Newsletter of the Center for Spirituality, Theology & Health

Volume 4

Issue 1

July 2014

This newsletter provides updates on research, news and events related to spirituality and health, including educational resources and funding opportunities. **Please forward to colleagues or students who might benefit.** Our goal is to create a community of researchers, clinicians, clergy, and laypersons interested in spirituality and health and keep them informed and updated. An EVENTS CALENDAR concludes the newsletter and describes spirituality and health related presentations happening at Duke and around the world. This is your newsletter and we depend on you to let us know about research, news, or events in this area.

All e-newsletters are archived on our website. To view previous editions (July 2007 through June 2014) go to: <http://www.spiritualityandhealth.duke.edu/index.php/publications/crossroads>

LATEST RESEARCH AT DUKE

Religion and Positive Emotions in Major Depression

Researchers identified a sample of 132 persons with major depressive disorder and chronic medical illness whom they enrolled in a randomized clinical trial (RCT) that compared religious vs. conventional cognitive behavioral therapy (CBT) for the treatment of depression. This article reports on the baseline sample prior to enrollment in the RCT, and so is a cross-sectional study. Correlations were examined between religious involvement, depressive symptoms (Beck Depression Inventory), and positive emotions/attitudes (purpose and meaning in life, optimism, generosity, gratitude) using established scales. Religious involvement was assessed using a range of measures of public religious involvement, private religious involvement, importance of religion, intrinsic religiosity, and daily spiritual experiences.

Results: Although religious involvement was generally unrelated to depressive symptoms in this sample of people with major depression, it was significantly and positively related to each of the positive emotions, attitudes, and behaviors listed above, and these relationships were independent of demographic factors, medical comorbidity, physical functioning, and social support. When all measures of religiosity were combined and all measures of positive emotions/attitudes were combined to increase the overall power of the analysis, although no relationship was found between overall religiosity and depressive symptoms ($F=0.96$, $p=0.43$), a strong relationship was found between religiosity and overall positive emotions, behaviors, and attitudes ($F=7.1$, $p<0.0001$). This finding was present even though depressive symptoms were strongly and inversely related to positive emotions/attitudes (yet not related to religiosity). Researchers concluded that negative affective states (such as depression) and positive affective states (meaning/purpose, optimism, etc.) may not represent two extremes of the same dimension, but might represent distinct dimensions that evolved with different functions.

Citation: Koenig HG, Berk LS, Daher N, Pearce MJ, Belinger D, Robins CJ, Nelson B, Shaw SF, Cohen HJ, King MB (2014). Religious involvement, depressive symptoms, and positive emotions in the setting of chronic medical illness and major

depression. *Journal of Psychosomatic Research*, May 19, E-pub ahead of print

Comment: Although religious involvement may not always prevent depression, it may alter the experience of depression once depression develops. In other words, even if depressed and sad over difficult circumstances related to poor health, those who are religious may be more able to see their lives as having meaning and purpose, to experience more optimism about the future, to continue to be generous toward others, and remain grateful for what they do have.

LATEST RESEARCH OUTSIDE DUKE

Religiosity and Adolescent Substance Use in U.S.

Researchers in the department of sociology at the University of Central Florida and Florida State University analyzed data from the National Survey on Drug Use and Health, which involved a subsample of 17,727 adolescents in the U.S. who were ages 12 to 17. They examined relationships between religious involvement and cigarette smoking, heavy drinking, prescription drug misuse, marijuana use, and other illicit drug use. Religiosity was assessed by four questions measuring frequency of religious attendance, importance of religion, influence of religious beliefs on decision-making, and involvement in church or faith-based activities such as youth groups, prayer groups, etc. Also assessed were attitudes toward substance use by the adolescent respondent, their peers, and parents; psychological well-being (major depression); and demographic characteristics (age, gender, race, and family income). **Results:** Controlling for age, gender, race, family income, and parental attitudes toward substance use, respondent religiosity was inversely related to depression ($B=-0.211$, $p<0.001$), adolescent attitude toward substance use ($B=+0.156$, $p<0.001$), and peer attitude toward substance use ($B=+0.125$), where higher attitude scores indicated more negative views on substance use. Even after controlling for depression, respondent attitude, and peer attitude toward substance use, religiosity was still inversely related to cigarette smoking ($B=-0.159$, $p<0.001$), heavy drinking ($B=-0.190$, $p<0.01$), prescription drug misuse ($B=-0.143$, $p<0.01$), marijuana use ($B=-0.302$, $p<0.001$), and other illicit drug use ($B=-0.185$, $p<0.01$). Not surprisingly, the respondents' attitude toward substance use explained nearly half of the association between religiosity and drug or cigarette use (but did not explain it away).

Citation: Ford JA, Hill TD (2012). Religiosity and adolescent substance use: Evidence from the National Survey on Drug Use and Health. *Substance Use and Misuse* 47(7):787-798

Comment: This is one of the largest studies of American adolescents to examine relationships between religiosity and substance use across a range of alcohol, drug, and tobacco use, and meticulously controls for demographic factors, as well as for parent, adolescent, and peer attitudes toward substance use. Although cross-sectional in nature, the findings are noteworthy given quality of the methods.

EXPLORE...in this issue

1-4 LATEST RESEARCH

NEWS

4-5 EVENTS & RESOURCES

5-6 FUNDING Opportunities & CALENDAR

Religiosity and Contraceptive Use in Unmarried Young Adults

Researchers at Florida State University and several other academic institutions analyzed data from the U.S. National Survey of Reproductive and Contraceptive Knowledge to examine relationships between religiosity, perceived infertility, and inconsistent contraceptive use in a representative sample of 1,695 unmarried young adults age 18 to 29. Perceived infertility was measured by the question, "Some people are unable to become pregnant, even if they want to. How likely do you think it is that you are infertile or will have difficulty getting [a woman] pregnant when you want to?" (46% said unlikely). Inconsistent contraceptive use was determined using questions about the use of birth control pill, condoms, diaphragm, and other hormonal methods; consistency of use was also examined (48% inconsistent). Religiosity was assessed by measures of religious affiliation (25% with no affiliation) and religious attendance (from 1=never to 4=once/week or more) (average 2.48). Logistic regression was used to examine the association between religiosity, perceived infertility, and inconsistent contraceptive use. **Results:** Controlling for demographic and other background characteristics, those indicating a non-Christian religious affiliation (Buddhist, Jewish, Muslim) were 45% less likely than those with no religious affiliation (reference category) to report that they were "not likely" to be infertile (OR=0.55, 95% CI 0.31-0.97, $p<0.05$). Evangelical Protestants, on the other hand, were 71% more likely than those with no religious affiliation to indicate that it was "quite likely" that they were infertile (OR=1.71, 95% CI 1.05-2.77, $p<0.05$), due in large part to having had unprotected sex without becoming pregnant. Furthermore, results indicated that evangelical Protestants were 51% more likely than those with no religious affiliation to inconsistently use contraception (OR=1.51, 95% CI 1.03-2.20, $p<0.05$). The latter relationship remained significant (49% more likely) even after controlling for perceived infertility. Frequency of religious attendance was unrelated to infertility concerns (OR=1.10, 95% CI=0.98-1.23); the relationship with inconsistent contraception use was not examined. Researchers concluded that evangelical Protestants were both more likely to believe that they were infertile and less likely to consistently use contraception.

Citation: Burdette AM, Haynes SH, Hill TD, Bartkowski JP (2014). Religious variations in perceived infertility and inconsistent contraceptive use among unmarried young adults in the United States. *Journal of Adolescent Health* 54(6):704-709

Comment: These findings suggest the perfect recipe for unexpected pregnancy in young unmarried evangelical Protestants (being more likely to think they are infertile and not consistently using contraception). Given conservative attitudes toward dating, sexuality and marriage, and negative attitudes toward abortion, this could put many young evangelical Protestant women and men in a difficult situation (i.e., pregnant if they don't abstain).

Religiosity and Social Support in Norway

Norwegian researchers from a variety of institutions analyzed data from the Norwegian registry to examine the relationship between religiosity and social support. A random sample of 653 persons ages 18-75, along with an oversampling of persons ages 60-75, were identified and completed questionnaires (22% response rate). Of those, measures of religiousness were obtained on 470 participants who comprised the sample for this report. Compared to the general Norwegian population, respondents were more likely to be ages 60-75 (35% vs. 20%). Religious measures included religious affiliation, frequency of religious attendance, frequency of private prayer, religious coping, and self-rated religiosity (44% rated themselves as religious, 52% as non-religious, and 4.5% as a convinced atheist). Also assessed were chronic health problems, extent to which life was viewed as enriching, and their worldview (Christian view, humanistic view, atheistic view, other).

Social support, the primary outcome in this report, was measured using 19 items from the Medical Outcomes Study Social Support Survey, which assessed emotional/informational support, tangible support, positive social interaction, and affectionate support. Analyses were stratified by age (18-39, 40-59, 60-75) and controlled for chronic health conditions and education. **Results:** Overall, those who indicated that they were not religious reported higher tangible support ($p=0.017$) and higher positive social interactions ($p=0.019$). This was particularly true for those ages 60-75 years ($n=158$), in whom tangible support ($p=0.005$), positive social interaction ($p=0.035$), emotional support ($p=0.043$), affectionate support ($p=0.024$), and structural support ($p=0.047$) were all higher among those who were not religious. However, among younger participants (ages 18-39) ($n=57$), structural support was significantly higher among those who were religious ($p=0.022$); among men, tangible support was also significantly higher ($p=0.009$), as was emotional support ($p=0.034$). No significant associations were found in those ages 40-59 regardless of gender.

Citation: Kvande MN, Reidunsdatter RJ, Lohre A, Nielsen ME, Espnes GA (2014). Religiosity and social support: A study in secular Norway. *Review of Religious Research*, May 23, E-pub ahead of print

Comment: To our knowledge, this is the first study to show in older adults that social support is higher in those who are not religious than in those who are religious (the opposite of what is found in 80% of research previously reported). Also of interest is the finding that among younger adults, men in particular, social support was higher among those who were religious compared to the non-religious (again, the opposite of what is usually found). These findings are likely due to the cultural environment found in Norway, although replication of these results is needed.

Feelings About God and Depression in the Netherlands

Dutch researchers analyzed data from the Longitudinal Aging Study of Amsterdam to examine the association between depression, feelings about God, and religious coping over 12 years. A population-based sample of 3,107 community-dwelling participants ages 55-85 were interviewed at baseline in 1992/1993, and then again at three, six, and nine years later. In 2005, twelve years from baseline, 206 participants who scored high on depressive symptoms at any of the four time points plus 137 never depressed respondents were sent and returned a final questionnaire ($n=343$, ages 67-97). Depression at each time point was assessed using the 20-item CES-D. Participants were also categorized as (1) never depressed, (2) past depression (CES-D ≥ 16), but remitted before 2001, (3) past depression, recently remitted (2001-2005), (4) persistent depression (depressed at all time points), and (5) emergent depression (2001-2005). Participants were also categorized by seriousness of depression based on Diagnostic Interview Schedule as (0) never depressed (40%), (1) minor depression (30%), (2) repeated minor depression (21%), or (3) major depression (9%). In 2005, feelings about God were assessed using a 34-item Questionnaire on God Image, with three subscales assessing (a) positive feelings (thankfulness, proximity, trust, security, love), (b) fear of God (fear of being not good enough, fear of punishment, uncertainty, guilt, shame), and (c) feeling wronged by God (disappointment, anger, oppression, loneliness, need of more freedom, dissatisfaction, desolation). Also in 2005, a 9-item brief RCOPE was used to measure religious coping (RC), with 5 items assessing positive RC and 4 items assessing negative RC. Also assessed were religious affiliation (none [35%], Catholic [32%], Protestant [33%]), frequency of religious attendance [30% \geq weekly], and frequency of prayer [49% \geq daily]. Control variables were age, gender, marital status, education. **Results:** Depression was associated with lower scores on positive feelings about God, higher scores on

fear of God and feeling wronged by God, and higher scores on negative religious coping; no association was found with positive religious coping. Depression was especially associated with feelings of uncertainty about God, feelings of desolation, and feelings of being abandoned by God. Researchers concluded that "Religious feelings may parallel the symptoms of anhedonia or a dysphoric mood and could represent the experience of an existential void."

Citation: Braam AW, Schaap-Jonker H, van der Horst MH, Steunenberg G, Beekman AT, van Tilburg W, Deeg DJ (2013). Twelve-year history of late-life depression and subsequent feelings to God. *American Journal of Geriatric Psychiatry*, Aug 20, Epub ahead of print

Comment: The study adds further evidence for an association between negative religious coping (feelings of punishment, abandonment, desolation by God) and depression, which has been reported many times in prior studies. Since religious measures were obtained only in 2005, however, this study does not address the question of whether depression leads to such feelings about God, whether such feelings about God lead to depression, or both.

Religious and Cultural Competence

Healthcare systems in the U.S. and around the world now emphasize the importance of providing culturally competent medical care that takes into consideration patients' cultural. In the present article, Rob Whitley argues that to provide culturally competent psychiatric care, mental health professionals must incorporate patients' religious and spiritual resources and needs into their care. He emphasizes that this is especially important to do in patients from underserved and underprivileged minority backgrounds, who are often devoutly religious. African-Americans are used as an example. Whitley concludes by noting that the historically ambivalent attitudes of mental health professionals toward religion have interfered with their ability to provide culturally competent care to patients, and suggests that increasing attention to the religious background and resources of patients may help to increase access, engagement and satisfaction with psychiatric care (for all patients, but especially for minority populations).

Citation: Whitley R (2012). Religious competence as cultural competence. *Transcultural Psychiatry* 49(2):245-260

Comment: Whitley makes a highly plausible argument that if health professionals wish to provide culturally competent care, then they must address the religious or spiritual needs of patients so that the medical or psychiatric care plan can be developed in light of these. This is especially true since the primary cultural force for many of those from minority communities involves religious beliefs.

Include Religion/Spirituality in Group Counseling?

Researchers at Iowa State University surveyed 164 patients participating in group counseling at nine university counseling centers nationwide. The majority of participants were European American (80%) and female (77%), and came from a wide variety of religious affiliations: Protestant or Catholic (29%), Mormon (6%), Buddhist, Jewish, Unitarian, Hindu, Islam, Bahai, or Taoist (13%), other (19%), agnostic (17%), and atheist (16%) – very different from the religious affiliations of Americans in general (i.e., 76% Protestant or Catholic). Religious commitment was measured using Worthington's 10-item Religious Commitment Inventory; spirituality by the Spiritual Transcendence Index (Seidlitz); religious struggle using a 7-item scale (Astin et al); perceived appropriateness of religious discussion in group (using a subscale of Counseling Appropriateness Check List); preference to discuss religion/spirituality in group counseling using the CAST scale; and perceived appropriateness of religious and spiritual interventions, where clients rated the appropriateness of 22 interventions. Also assessed was group climate-engagement, client bond to group

counselor, therapeutic alliance, current religious worldview, how often the topic of religion came up, and demographic factors (age, sex, ethnicity). **Results:** The appropriateness of addressing religious concerns during group counseling ranged from 59% to 96%, depending on concern (59% for "science conflicting with my religion" to 96% for "confused on some moral questions"). Controlling for other factors using regression analyses, researchers found that those with a majority religious affiliation (Protestants or Catholics=0; everyone else=1) were more likely to view religious concerns as appropriate to discuss during therapy (B=-0.27, p=0.004), as were those with religious struggles (B=0.19, p<0.05). With regard to appropriateness of religious/spiritual interventions, between 10% and 84% of respondents indicated they were appropriate, depending on intervention (10% for "therapist to lead in-session vocal prayer" to 84% for "bring up the topic of spirituality"). Predictors of appropriateness of religious interventions were majority religious affiliation (B=-0.20, p<0.05), greater patient spirituality (B=0.24, p<0.05), greater group engagement (B=0.23, p<0.01), greater religious commitment (B=0.23, p<0.05), weaker (?) therapeutic alliance (B=-0.19, p<0.01), and greater frequency of religious discussions (B=0.19, p<0.01). Predictors of appropriateness of spiritual interventions were greater patient spirituality (B=0.36, p<0.001), greater group engagement (B=0.20, p<0.01), and greater frequency of religious discussions (B=0.17, p<0.05). Finally, with regard to client preference for discussing R/S in group counseling, the majority indicated some preference for discussing religious (52%) or spiritual (75%) concerns in their groups. Predictors of discussing religious concerns were greater religious commitment (B=0.42, p<0.001), greater religious struggle (B=0.19, p=0.002), and greater frequency of religious discussions (B=0.22, p=0.001). Predictors of discussing spiritual concerns were greater patient spirituality (B=0.39, p<0.001), greater religious commitment (B=0.35, p<0.001), greater religious struggle (B=0.24, p=0.001), and frequent religious discussions (B=0.17, p=0.005). Researchers concluded that the majority of patients indicated that religious concerns were appropriate for group counseling and preferred to discuss religious/spiritual concerns with their groups. *Citation:* Post BC, Wade NG (2014). Client perspectives about religion and spirituality in group counseling. *The Counseling Psychologist* 42(5):601-627

Comment: What is striking about this report is that despite a very homogeneous sample of participants (one-third of whom were agnostics or atheists), the majority still felt it was appropriate and preferred to discuss religious/spiritual concerns in their groups.

Spirituality-Infused Activities in Mental Illness Recovery Centers in LA County

Investigators from the school of social work at University of Southern California examined the extent to which "spirituality-infused" activities were offered at 53 wellness and recovery centers in Los Angeles County. In 2011, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) identified spirituality as one of eight wellness dimensions of recovery and one of eleven core recovery factors. For the present report, spiritual-infused activities were defined as integrating broadly spiritual activities within existing interventions and developing new treatments, including yoga or meditation, as well as more explicitly religious interventions (prayer and worship) and religious coping strategies. The sample for this study involved 53 Division of Mental Health-affiliated direct service and contracted peer-run centers in LA County from a list of 60 centers (42 wellness centers and 11 client-run centers). Informants were directors (30%), clinical supervisors, services coordinators, administrative assistants, case managers, therapy interns, or peer advocates at the centers. Interviews were 20 minutes in length on average. The initial question was "Does your center presently have any activities related to spirituality and/or body-mind-spirit

wellness?" Follow-up questions asked about whether the center currently provided any of the following five "spirituality-infused" services: spiritual support groups, services involving religious or faith-based practices/beliefs, programs intended to promote inner peace or wellness, recreational activities, or community-involvement activities. Finally, any spiritual activities not included in the five categories above were inquired about. **Results:** Over three-quarters (77%) indicated that they offered spiritual activities, mind-body-spirit wellness activities, or both. When asked to describe the activities, 25% actually had the word spirituality in the title of the activity (i.e., Spiritual Support Group); 28% reported activities involving meditation; 19% described activities involving mindfulness techniques; and 11% indicated activities involving yoga or tai chi. However, only 5 centers (9%) described activities that had religious themes, such as Bible study. About two-thirds of the centers (64%) offered spiritual support groups, most of which were 12-step recovery groups or spiritually-focused process groups. Religious programming was the least common activity reported, with 28% of centers reporting activities involving organized religion such as Christianity or Buddhism. Researchers concluded that "the traditional religious-centered definitions of spirituality-infused services have been expanded to include recreational, wellness, support group, and community-inclusion activities..."

Citation: Yamada AM, Subica AM, Kim MA, Nguyen KV, Lim CS, Mancuso LL (2014). State of spirituality-infused mental health services in Los Angeles County wellness and client-run centers. Administration and Policy in Mental Health and Mental Health Services Research, January 24, E-pub ahead of print

Comment: To our knowledge, this is one of the first attempts to determine whether SAMHSA-based recommendations to include spiritual activities in mental illness recovery centers are being followed. Not surprisingly, religious elements are only a small minority of the spiritual activities that take place in these centers, as secular systems of this type have expanded the definition of spirituality to include almost any type of human activity (except religious activity).

Religion, Spirituality and Schizophrenia

This article provides a comprehensive review of research on religion, spirituality and schizophrenia. Reviewers discuss religious delusions and hallucinations in schizophrenia, as well as the role that religion plays in social integration, protection from suicide, reduced rates of substance abuse, coping with the illness, and treatment compliance and recovery.

Citation: Grover S, Davuluri T, Chakrabarti S (2014). Religion, spirituality and schizophrenia: A review. Indian Journal of Psychological Medicine 36(2):119-124

Comment: Given the lack of information on religious involvement and chronic mental illness in general, this article is a welcome relief, and has nearly 80 citations.

Spiritual Needs of Hospitalized Older Asian Patients

Researchers at Arizona State University analyzed data from a national sample of 805 Asians age 50 or over who were discharged from a hospital during a 12-month period (42% ages 50-64, 40% ages 65-79, and 18% age 80 or over). Participants were asked in a single question how well hospital staff addressed their spiritual needs on a 5-point scale from 1 (very poor) to 5 (very good). Data were obtained from Press Ganey Association, which does the post-hospitalization patient satisfaction surveys. Overall satisfaction with services was also assessed using the sample 5-point response scale. Structural equation modeling was used to analyse the data, and the focus of this paper was on mediators of the relationship between satisfaction with spiritual needs met and overall satisfaction with care. Mediators included satisfaction with admission process, room quality, food services, nursing staff, tests and treatments, visitors, physicians, and discharge process.

Results: The primary mediators were satisfaction with nursing staff, physicians, the discharge process, visitors, and the admissions process. No information was provided on the prevalence of spiritual needs, the ratings of how well spiritual needs were addressed, or the magnitude of the relationship between satisfaction with spiritual needs being met and overall satisfaction with care.

Citation: Hodge DR, Sun F, Wolosin RJ (2014). Hospitalized Asian patients and their spiritual needs: Developing a model of spiritual care. Journal of Aging and Health, E-pub ahead of print
Comment: This report focuses primarily on identifying factors that might explain the relationship between satisfaction with the quality of spiritual care provided and overall satisfaction. Unfortunately, it does not provide information on the particular types of spiritual needs that Asian patients have, the extent to which their spiritual needs were being addressed by health professionals, or the strength of the relationship between satisfaction with spiritual care and satisfaction with overall care. Hopefully, the latter information will be reported in a future publication.

SPECIAL EVENTS

Emerging Tools for Innovative Providers 2014: Interdisciplinary Spiritual Care Applications with Immediate Impact (Pasadena, California, July 28-Aug 1, 2014)

This 5-day workshop, being held at Fuller Theological Seminary about 25 minutes from Hollywood, focuses on identifying spiritual interventions with immediate impact in healthcare settings. The goal is to identify brief, short-term interventions that interrupt the psychological stress reactions in response to illness and the immunological and hormonal changes that adversely affect health. Physicians, nurses, social workers, and chaplains are the target audiences for this workshop. Participants will work with each other and with workshop faculty to develop tools for assessing and addressing the spiritual and emotional needs of patients in their own unique settings, whether that be medical hospitals and clinics, mental health, substance abuse, or community health environments. Faculty include Ken Pargament, Gail Ironson, Jeffrey Dusek, Kevin Reimer, Alexis Abernethy, Sheryl Tyson, Lee Berk, Douglas Nies, Bruce Nelson, and Harold Koenig. A yearly West Coast conference targeted specifically at clinicians, this is the premier workshop in the U.S. that focuses on integrating spirituality into patient care. See website: <http://www.emergingtoolsforinnovativeproviders.com/>.

Islamic Bioethics Seminar (University of Chicago, Chicago, IL (August 1-3, 2014)

This three-day workshop will provide an in-depth introduction into the field of Islamic bioethics and will cover key concepts within Islamic theology, law and ethical frameworks as they relate to bioethics. In addition, participants will gain practical skills and tools that enable them to read Islamic bioethics literature and engage in moral reasoning about clinical ethics cases. Allied health professionals, academic researchers, bioethicists, chaplains, Imams and policy makers all will leave equipped with an enhanced literacy in Islamic bioethics. For more information about the schedule, lecture titles and faculty, go to website: <https://pmr.uchicago.edu/page/aug-bioethics>.

Duke Spirituality & Health Research Workshops (Durham, NC) (August 11-15, 2014)

Our 2014 summer research workshop on spirituality & health is full and bursting at the seams, although there is still room for participants (if mentorship is not needed). The workshop is designed for those interested in conducting research in this area or learning more about the research that is now being done. Those with any level of training or exposure to the topic will benefit from

this workshop, from laypersons to graduate students to full-time professors at leading academic institutions. Over 650 persons from all over the world have attended this workshop since 2003. Individual mentorship is being provided to those who need help with their research or desire career guidance. Partial **tuition scholarships** will be available for those with strong academic potential and serious financial hardships. For more information, see website:

<http://www.spiritualityandhealth.duke.edu/index.php/5-day-summer-research-course/>.

RESOURCES

Health and Well-being in Islamic Societies

(Springer International, 2014)

Muslim beliefs and practices based on the Qu'ran and Hadith are outlined in detail, as are health-related Islamic practices and moral standards. Christian beliefs and health-related practices are also summarized, and both differences and similarities to Muslim beliefs and practices are examined. After summarizing research on religiosity and health in Christians, the core of the book focuses on research on religiosity and health in Muslim populations and compares the health of Muslims with that of other religious groups. Topics covered include mental disorders (depression, suicide, anxiety, psychosis, alcohol and drug abuse/dependence), positive emotions (well-being, happiness, optimism, hope, sense of control), personality traits (extraversion, neuroticism, agreeableness, etc.), social factors (marital stability, social support, social capital), health behaviors (exercise, diet, weight, smoking), and physical health (heart disease, hypertension, stroke, dementia, immune function, endocrine function, diabetes, cancer, overall mortality, etc.). This is the first comprehensive review of research on religion and health in Muslim populations. The book concludes with applications for clinical practice and the need for cooperation between Muslims and Christians for the purposes of enhancing public health. Available for \$63.99 at: <http://www.amazon.com/Health-Well-Being-Islamic-Societies-Applications/dp/331905872X>

Congregational Social Work: Christian Perspectives

(North American Association of Christians in Social Work, 2014)

This volume offers a compelling account of the many ways social workers serve the church as leaders of congregational life, of ministry to neighborhoods locally and globally, and of advocacy for social justice. Based on the most comprehensive study to date on social work with congregations, the book shares illuminating stories and experiences from social workers engaged in powerful and effective work within and in support of congregations throughout the US. This important new work includes chapters on topics such as "What is Church Social Work?"; "Congregations as Context for Social Work"; "Social Workers as Congregational Leaders"; and "Leading from Charity to Justice," for example. Available (\$44.96) at: <http://www.amazon.com/Congregational-Social-Work-Christian-Perspectives/dp/0971531889>.

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 by identifying and addressing the spiritual needs of patients. Chapters are targeted to the needs of physicians, nurses, chaplains and pastoral counselors, mental health professionals, social workers, and occupational and physical therapists. Available (\$22.36) at: <http://templetonpress.org/book/spirituality-patient-care>.

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. Spirituality and health researchers, educators, health professionals, and religious professionals will find this resource invaluable. Available (\$105.94) at: <http://www.amazon.com/Handbook-Religion-Health-Harold-Koenig/dp/0195335953>

Spirituality & Health Research: Methods, Measurement, Statistics, & Resources (Templeton Press, 2011)

This book summarizes and expands the content presented in the Duke University's Summer Research Workshop on Spirituality and Health (see above), and is packed full of information helpful in performing and publishing research on this topic. Available (\$39.96) at: <http://templetonpress.org/book/spirituality-and-health-research>.

Spiritually Integrated Psychotherapy (Guilford Press, 2011)

Written by the master of spiritually-integrated psychotherapy, Kenneth Pargament. From Amazon.com: "From a leading researcher and practitioner, this volume provides an innovative framework for understanding the role of spirituality in people's lives and its relevance to the work done in psychotherapy. It offers fresh, practical ideas for creating a spiritual dialogue with clients, assessing spirituality as a part of their problems and solutions, and helping them draw on spiritual resources in times of stress. Written from a nonsectarian perspective, the book encompasses both traditional and nontraditional forms of spirituality. It is grounded in current findings from psychotherapy research and the psychology of religion, and includes a wealth of evocative case material. Available (\$23.68) at: <http://www.amazon.com/Spiritually-Integrated-Psychotherapy-Understanding-Addressing/dp/1609189930>

FUNDING OPPORTUNITIES

Templeton Foundation Online Funding Inquiry (OFI)

The Templeton Foundation will be accepting the next round of letters of intent for research on spirituality and health between August 1, 2014 - October 1, 2014. If the funding inquiry is approved (applicant notified by November 5, 2014), the Foundation will ask for a full proposal that will be due March 2, 2015, with a decision on the proposal reached by June 19, 2015. The three main areas in religion, spirituality and health that the Foundation funds are: (1) research on causal mechanisms (basic psychosocial, behavioral, and physiological pathways), (2) increasing competencies of health care professionals in working with religious patients (physicians, but also psychologists and experts in public health), and (3) research involving the development of religious-integrated interventions that lead to improved health. More information: <http://www.templeton.org/what-we-fund/our-grantmaking-process>

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Published by the Center for Spirituality, Theology & Health
DUMC Box 3400, Durham, NC 27710

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2014 Csth Calendar of Events...

July

- 8 **Religion, Spirituality and Health**
Adventist World Health Conference
Geneva, Switzerland
Speakers: Hefti, Koenig (via Skype), & others
Contact: Carlos Fayard (CFayard@llu.edu)
- 10 **Religion, Spirituality and Mental Health**
Pine Rest Christian Mental Health Services
Grand Rapids, MI
Speaker: Koenig
Contact: Vitaliy Voytenko (Vitaliy.Voytenko@PineRest.org)
- 30 **A Missionary in the Foreign Fields of Academic Psychiatry**
Speaker: Dan G. Blazer, M.D., Ph.D.
J.P. Gibbons Professor of Psychiatry and Behavioral Sciences (emeritus), Department of Psychiatry, DUMC
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)
- July 28-
Aug 1 **Integrating Spirituality into Patient Care**
Fuller Theological Seminary
Pasadena, California
Speakers: Pargament, Ironson, Koenig, others
Contact: Bruce Nelson (Bruce.Nelson@ah.org)

August

- 11-15 **Duke Summer Research Workshop**
Durham, North Carolina
Presenters: Blazer, Oliver, Kinghorn, Carson, & Koenig
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)
- 20 **Religious Intolerance in the Armed Forces**
Speaker: Michael L. "Mikey" Weinstein, Esq.
President, Military Religious Freedom Foundation
Center for Aging, 3rd floor, Duke South, 3:30-4:30
Contact: Harold G. Koenig (Harold.Koenig@duke.edu)