

Religion, Spirituality, & Mental Health:

Research and Clinical Applications

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Overview

1. Religion vs. spirituality: same or different
2. Research on religion and mental health
3. Theoretical model explaining effects
4. Religious/spiritually-integrated psychotherapies
5. Conclusions
6. Further resources

Religion vs. Spirituality:

Are they the same or different?

Religion, unpopular, potentially divisive

Spirituality, popular, inclusive, common to all, self-defined

Through most of recorded history, spirituality and religion have been considered largely synonymous

Within the past 30 years, with secularization, spirituality in academic settings has become separated from religion

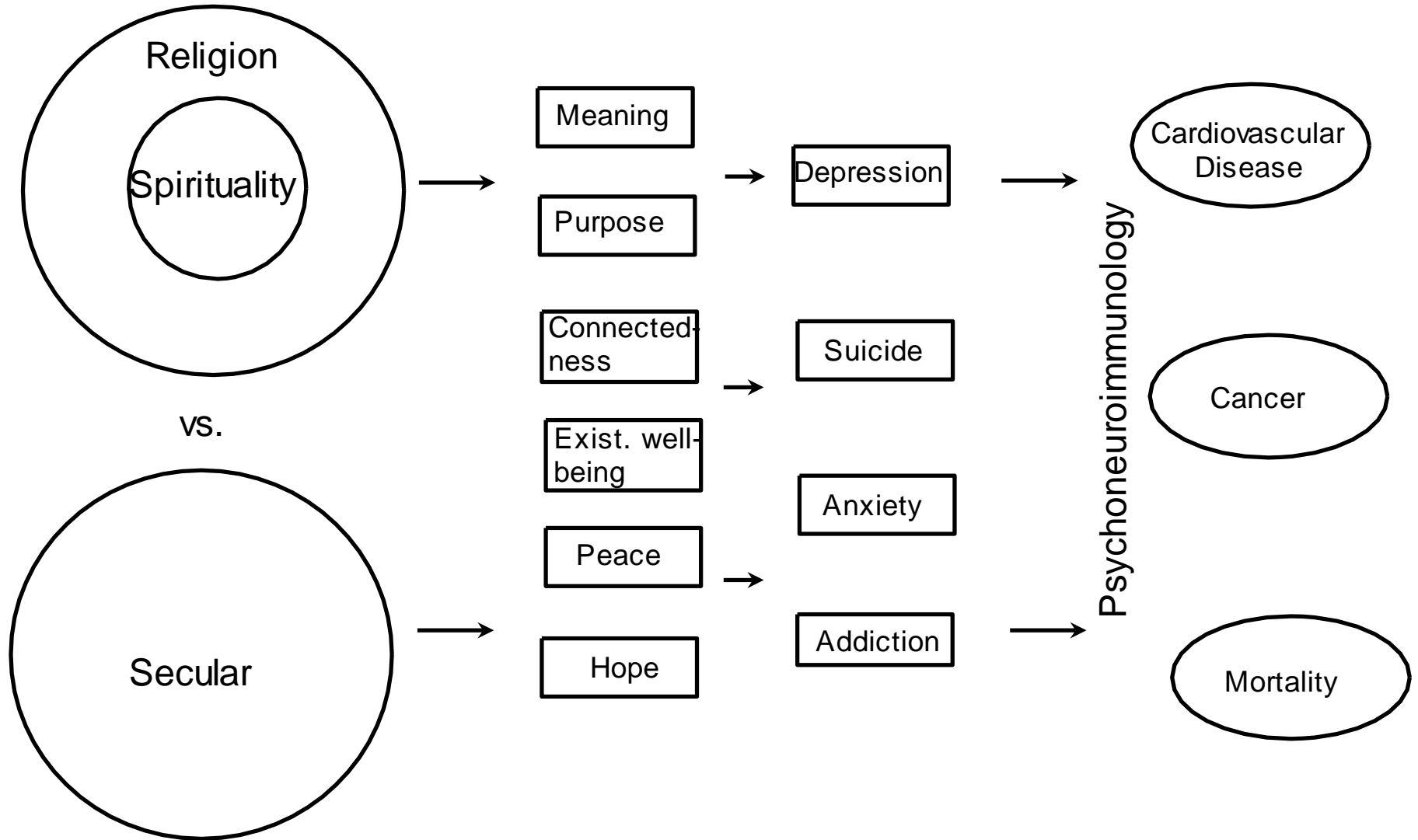
Spirituality: An Expanding Concept



Source

Mental Health

Physical Health



Source

Mental Health

Physical Health

Spirituality

Religion

vs.

Secular

Meaning

Purpose

Connected-
ness

Exist. well-
being

Peace

Hope

Depression

Suicide

Anxiety

Addiction

Cardiovascular
Disease

Cancer

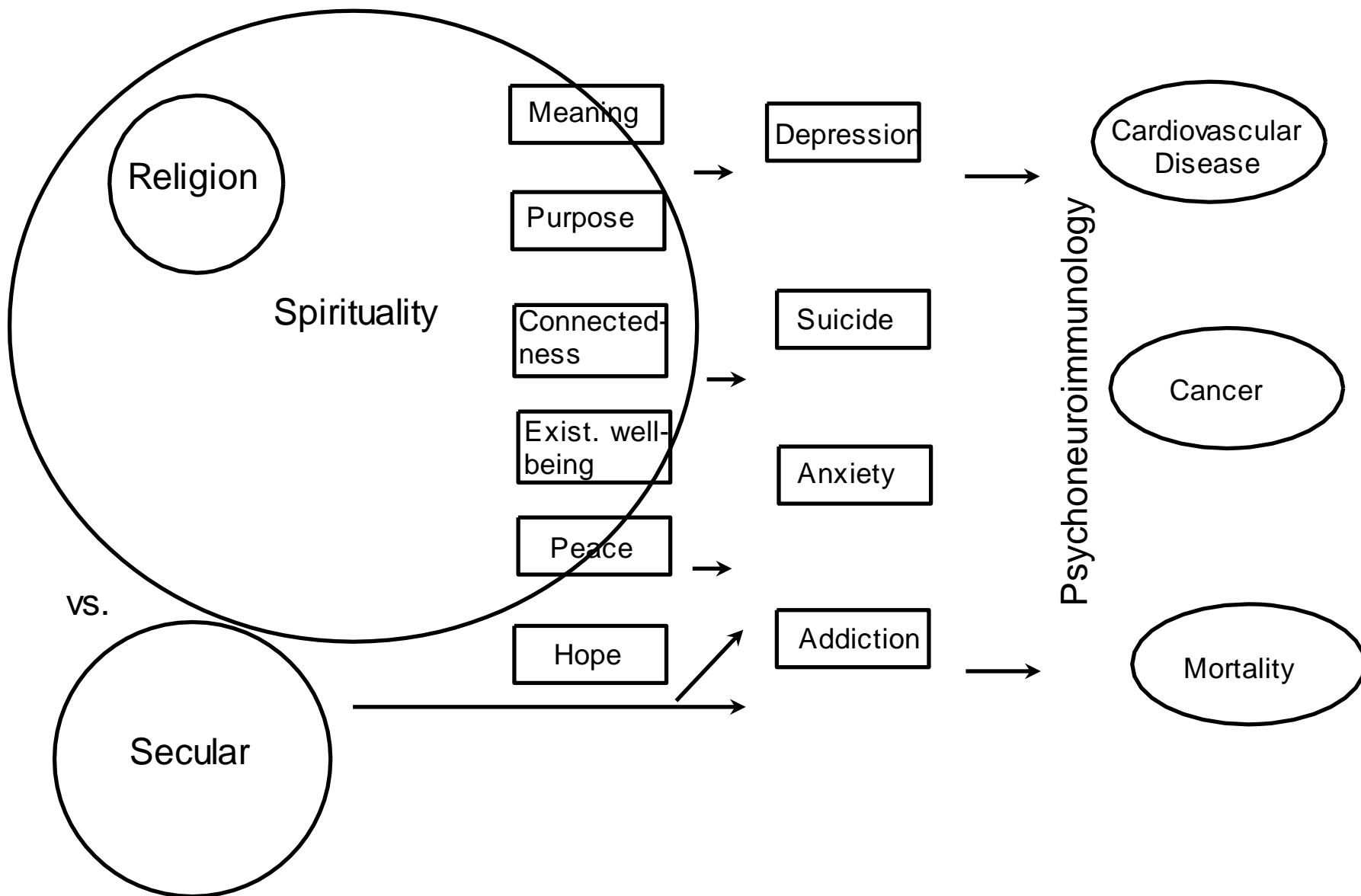
Mortality

Psychoneuroimmunology

Source

Mental Health

Physical Health



Final Thoughts on Definitions

1. In discussing the research, I'm going to mostly use the term "religion," since that is what can be measured, and is sufficiently distinct to avoid conceptual overlaps with mental and physical health (the outcomes).
2. When measuring spirituality for research, measures should not be contaminated with positive psychological states or positive character traits. This will help to avoid defining spirituality **a-priori** as good mental health (and the tautological associations that will otherwise result).
3. In clinical settings, a broadly inclusive term such as spirituality should be used and defined by patients themselves, so as to maximize connection, engagement and conversation.

Research on Religion, Spirituality and Mental Health

Review of the Research

Handbook of Religion and Health, 3rd ed.
(Oxford University Press, 2022, forthcoming)

*Religion and Mental Health: Research &
Clinical Applications*
(Academic Press, 2018)

Koenig, H. G., Al-Zaben, F., & VanderWeele, T. J. (2020). Religion and psychiatry: Recent developments in research. *British Journal of Psychiatry Advances*, 26(5), 262-272.

Koenig, H. G., Peteet, J. R., & VanderWeele, T. J. (2020). Religion and psychiatry: Clinical applications. *British Journal of Psychiatry Advances*, 26(5), 273-281.

Depression

One of the most common emotional disorders in the world (and disabling), especially among medical patients.

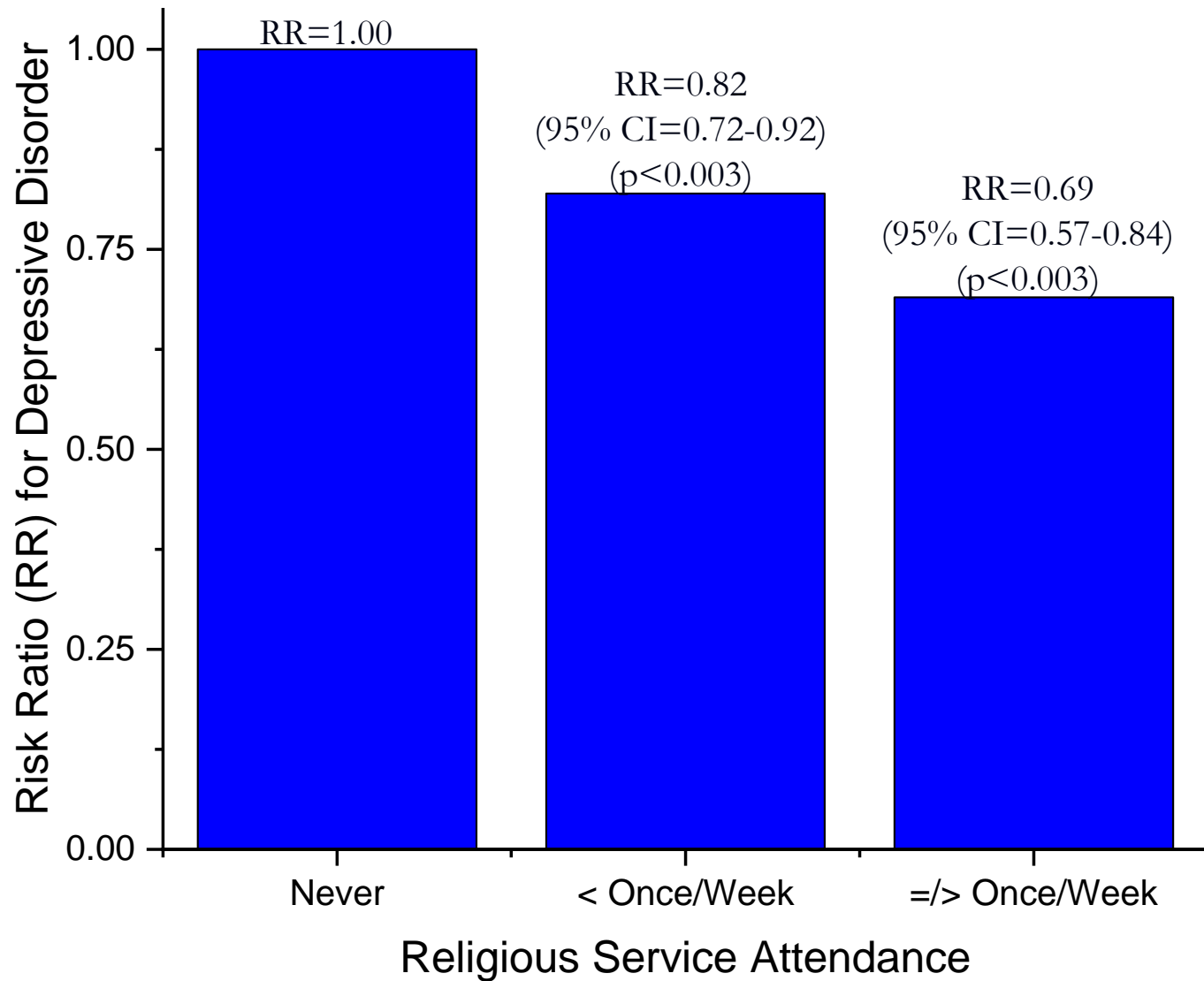
Religious involvement is related to:

Less depression, faster recovery from depression

272 of 444 studies (61%)

[67% of best]

More depression (6%)



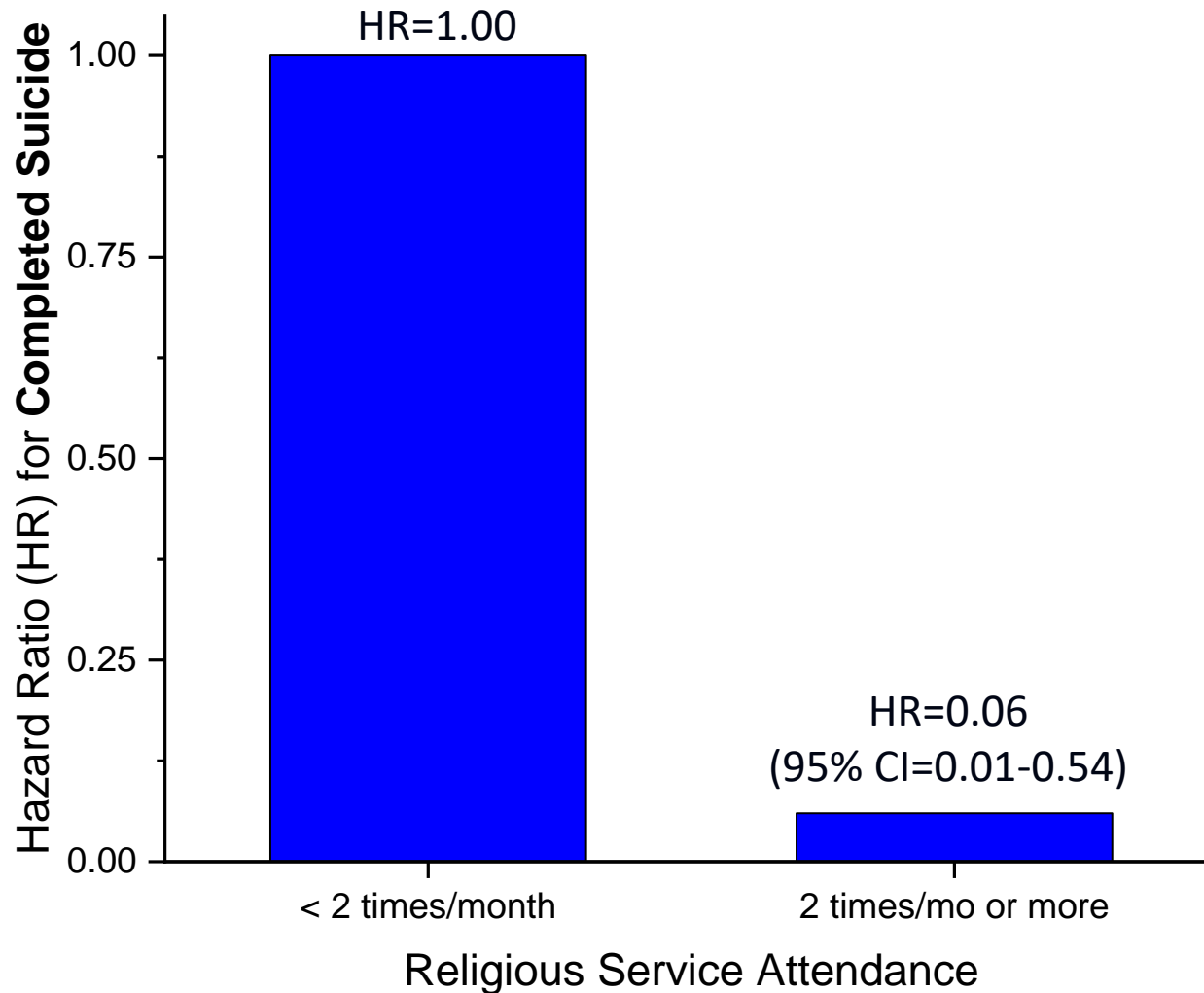
Chen et al. (2020). Religious-service attendance and subsequent health and well-being throughout adulthood: evidence from three prospective cohorts. *International Journal of Epidemiology* (<https://doi.org/10.1093/ije/dyaa120>) [3-6 year prospective study of 9,862 young adults (ave. age 23) followed from 2007 to 2010-2013; two dozen covariates controlled for, along with p values corrected for examination of multiple outcomes using the conservative Bonferroni correction]

Suicide

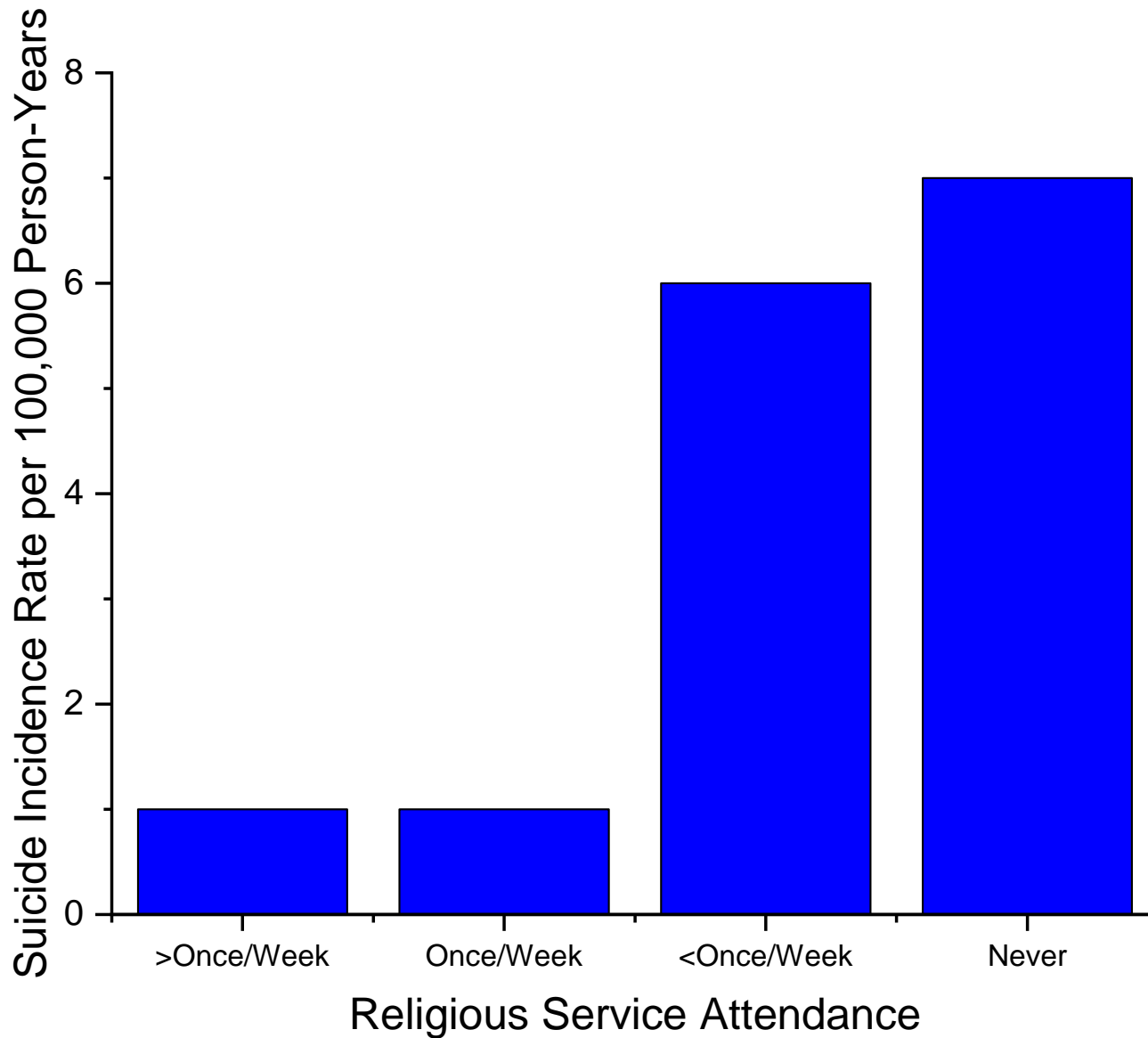
(systematic review)

Religious involvement is related to:

Less suicide and more negative attitudes toward suicide
(106 of 141 or 75% of studies)

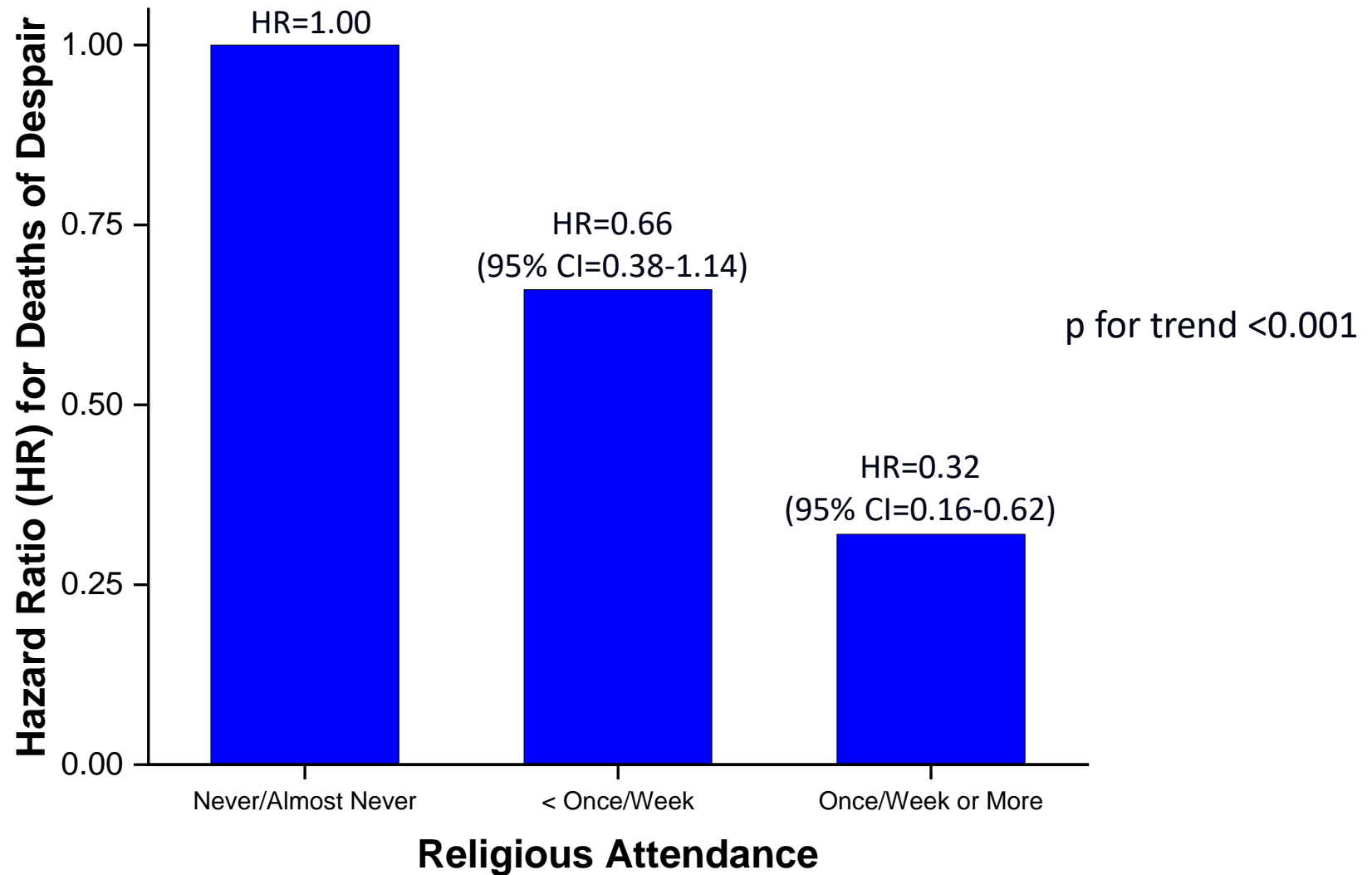


Kleiman, E. M., & Liu, R. T. (2014). Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. *British Journal of Psychiatry*, 204(4), 262-266. [18-year prospective study from 1988/1994 to 2006 involving a random U.S. national sample of **20,014 persons age 18 years or over (NHANES-III)**; findings remained significant after controlling for gender, age, size of household, previous suicide attempt, and marijuana use]



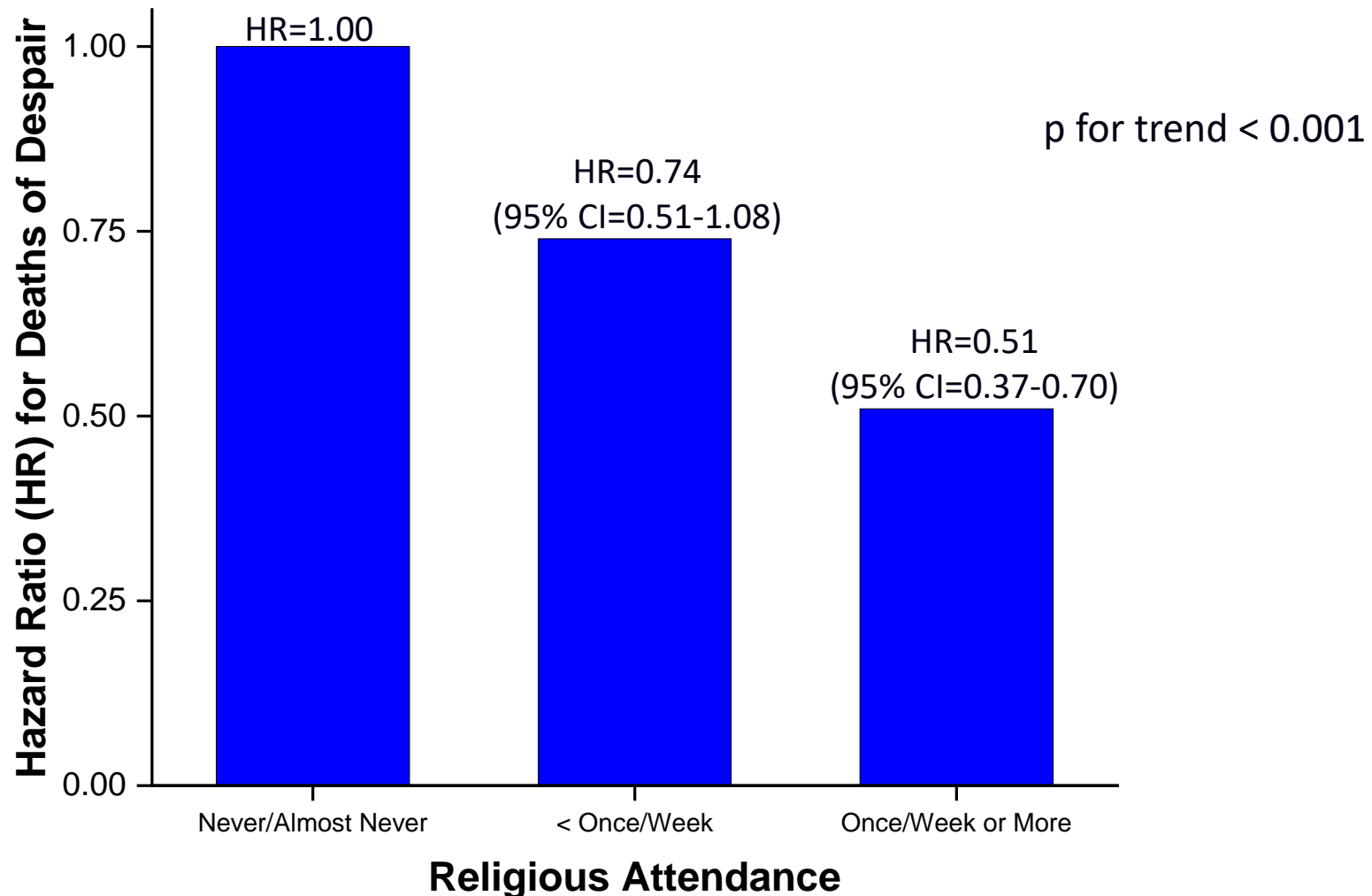
Nurses Health Study: 89,708 women followed from 1996 to 2010 (**HR=0.16, 95% CI 0.06-0.46**)
VanderWeele et al (2016). JAMA Psychiatry (Archives of General Psychiatry) 73(8):845-851

Religious Attendance and Deaths of Despair Among U.S. Health Professionals (Women)



Chen, Y., et al. (2020). Religious service attendance and deaths related to drugs, alcohol, and suicide among US health care professionals. *JAMA Psychiatry*, 77(7), 737-744. [16-year prospective study (Nurses Health Study-II, 2001-2017) of **66,492 women** examining “deaths of despair” (from **drugs, alcohol, or suicide**); Cox proportional hazards regression models controlling for 25 demographic, psychological, social, and physical health covariates]

Religious Attendance and Deaths of Despair Among U.S. Health Professionals (men)



Chen, Y., Koh, H. K., Kawachi, I., Botticelli, M., & VanderWeele, T. J. (2020). Religious service attendance and deaths related to drugs, alcohol, and suicide among US health care professionals. *JAMA Psychiatry*, 77(7), 737-744. [26-year prospective study (Health Professionals Follow-up Study, 1988-2014) of **43,141 men** (dentists, pharmacists, optometrists, osteopaths, podiatrists, veterinarians) examining “deaths of despair” (from drugs, alcohol, or suicide); Cox proportional hazards regression models age adjusted]

Alcohol Use/Abuse/Dependence

(systematic review)

Religious involvement is related to:

Less alcohol use / abuse / dependence
240 of 278 studies (86%)

[90% of best designed studies]

Illicit Drug Use

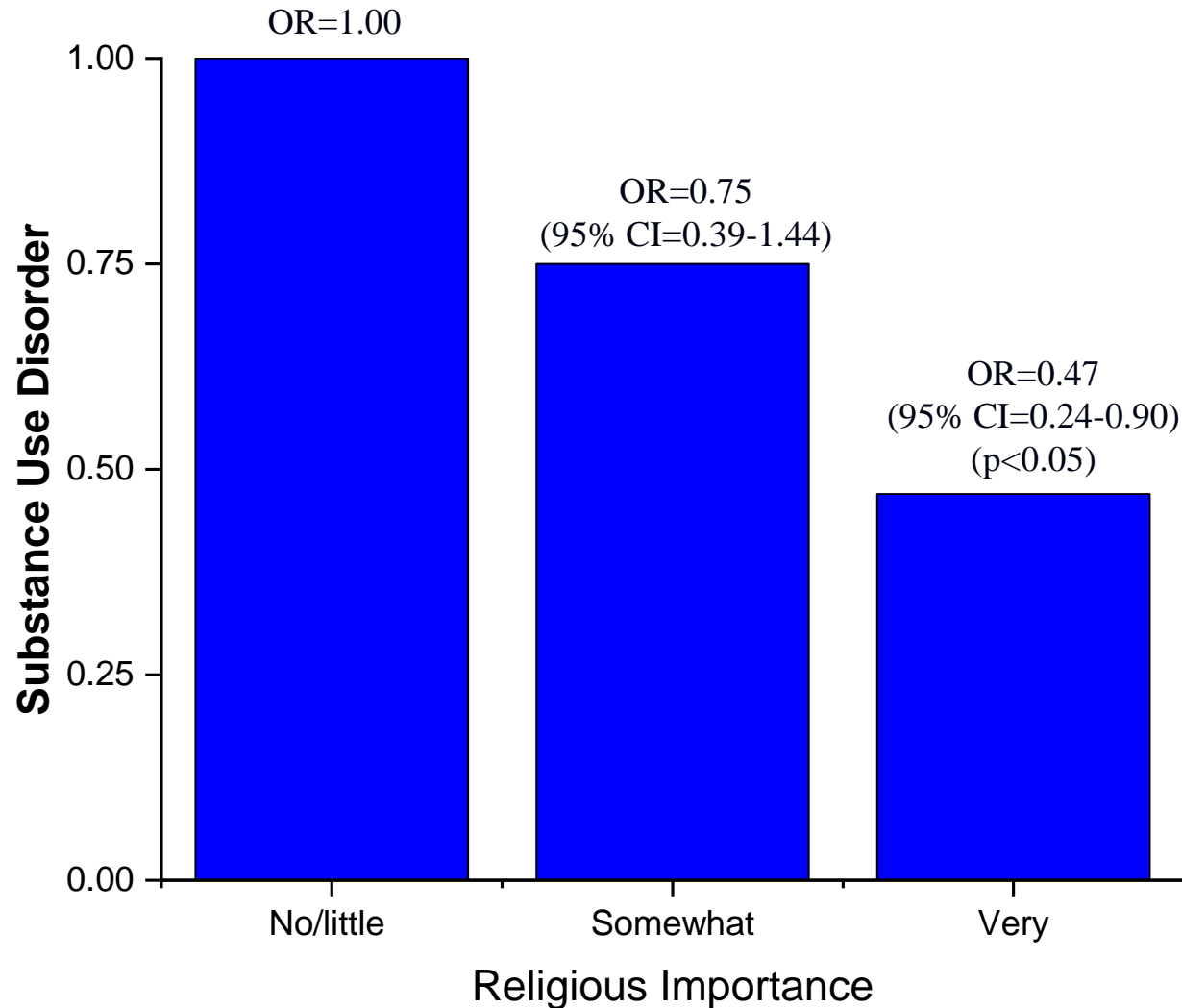
(systematic review)

Religious involvement is related to:

Less drug use / abuse / dependence
155 of 185 studies (84%)

[86% of best designed studies]

[95% of RCT or experimental studies]



Lalayants, M., Oyo, A., & Prince, J. D. (2020). Religiosity and outcomes among child welfare-involved youth. Child and Adolescent Social Work Journal, 37(3), 251-261. **(18-month prospective study of a national random sample of 474 U.S. adolescents ages 11-16 after a formal Child Protective Services investigation for child abuse/neglect; ORs adjusted for gender, age, race/ethnicity, living arrangement, type of abuse, family stress, social support, mental illness and caregiver, parenting skills, inappropriate use of discipline, history of arrest, youth depression, youth trauma)**

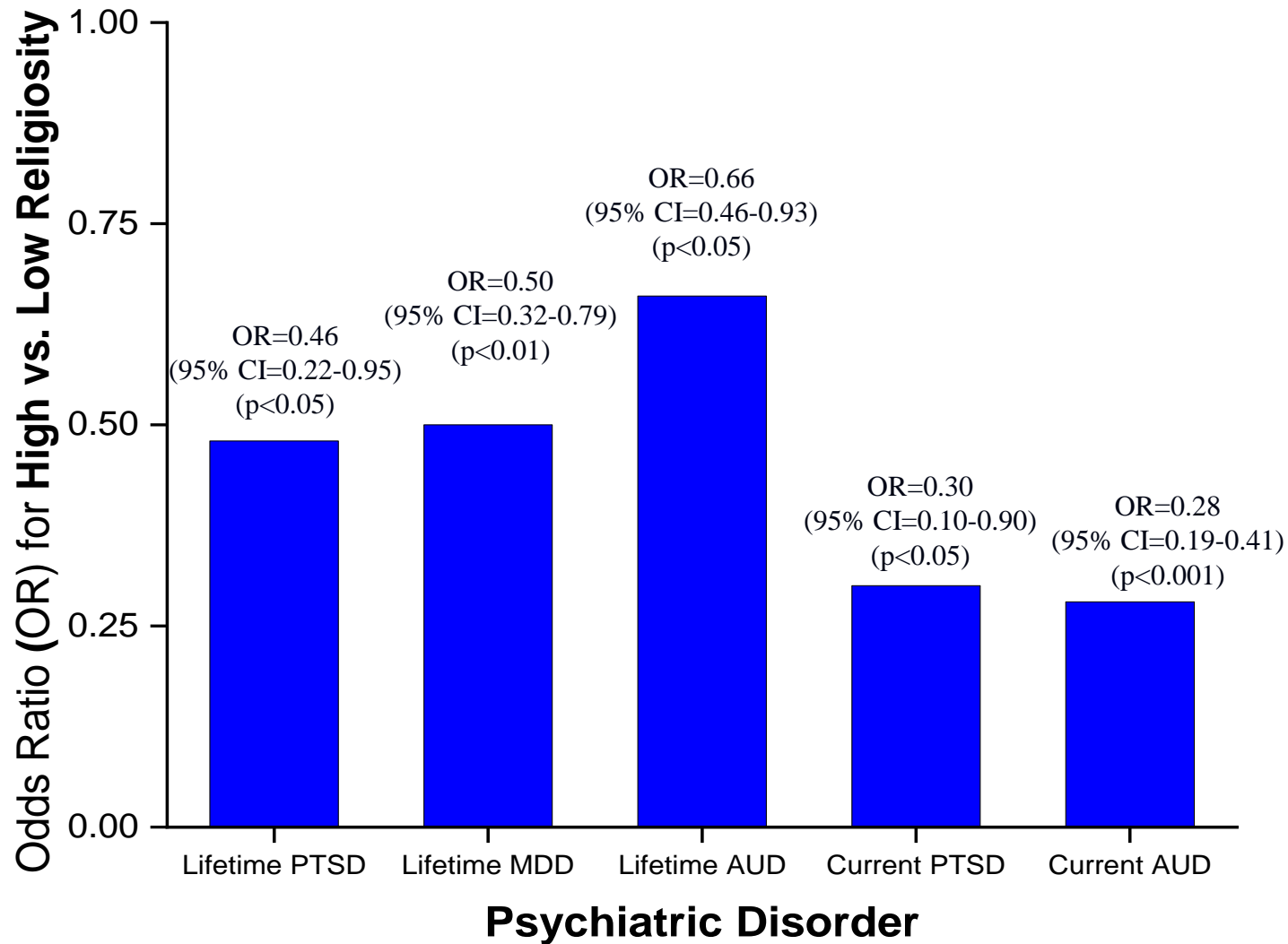
Anxiety and PTSD

Religious involvement is related to:

Less anxiety in 147 of 299 studies (49%)

More anxiety in 33 of 299 studies (11%)
(31 of 33 being cross-sectional)

Of 40 experimental studies or clinical trials, 29 (73%)
reported significant reduction in anxiety with religious
or spiritual interventions.



Sharma, V., Marin, D. B., Koenig, H. G., Feder, A., Iacoviello, B. M., Southwick, S. M., & Pietrzak, R. H. (2017). Religion, spirituality, and mental health of US military veterans: Results from the National Health and Resilience in Veterans Study. *Journal of Affective Disorders*, 217, 197-204. [cross-sectional study of **nationally representative sample of 3,151 U.S. Veterans**; religiosity assessed by Duke University Religion Index (DUREL)]

Well-being and Happiness

(systematic review)

Religious involvement is related to:

Greater well-being and happiness
256 of 326 studies (79%)

[82% of best]

Lower well-being or happiness (3 of 326 studies, <1%)

Meaning, Purpose, Hope, Optimism

(systematic review)

Religious involvement is related to:

Greater meaning and purpose

42 of 45 studies (93%)

[100% of best]

Greater hope

29 of 40 studies (73%)

Great optimism

26 of 32 studies (81%)

All of the above have consequences for patients' motivation for self-care and efforts toward recovery

Social Support

(systematic review)

Religious involvement is related to:

- Great social support
(61 of 74 studies) (82%)

Delinquency and Crime

(systematic review)

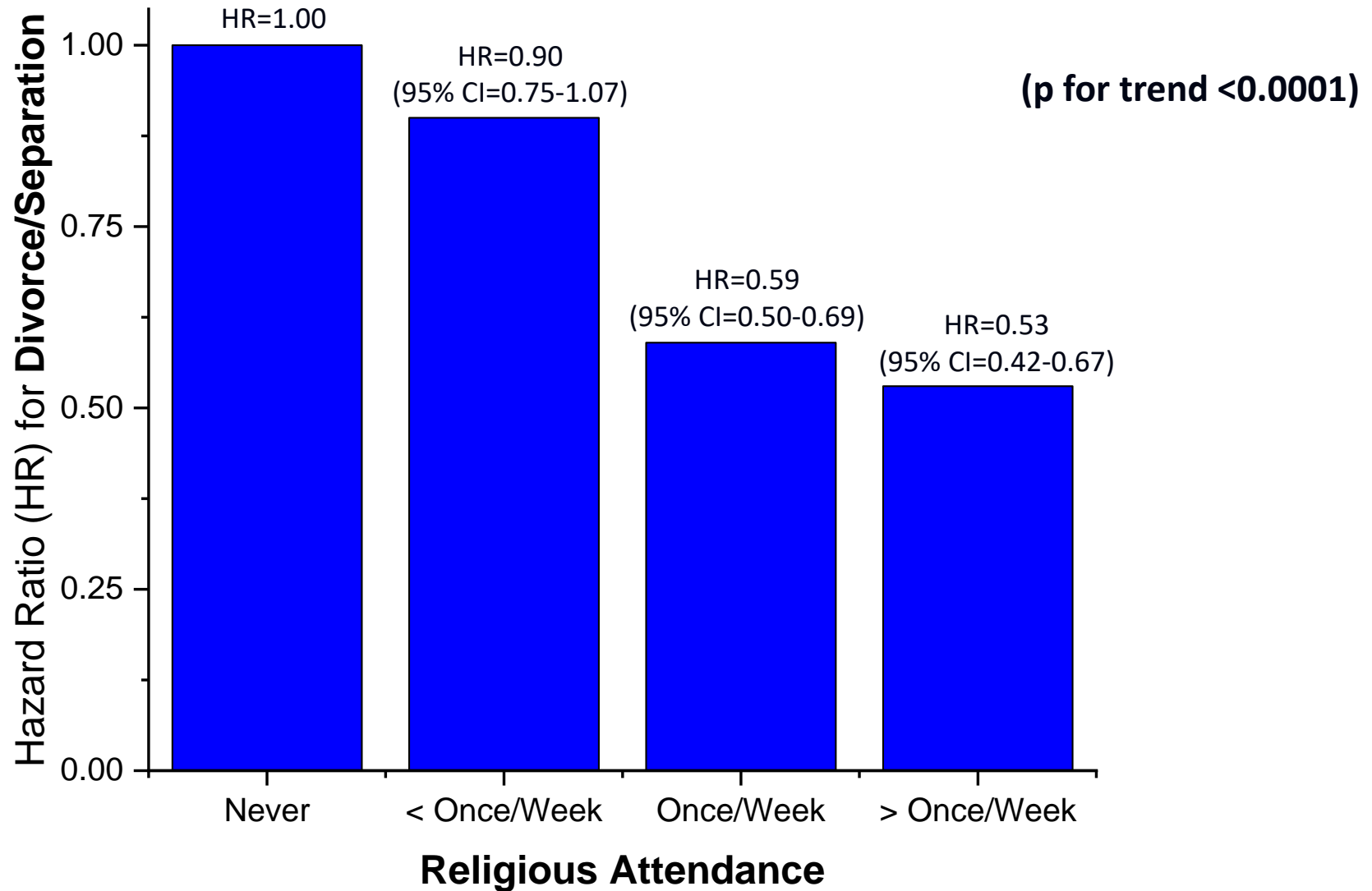
At least 104 quantitative peer-reviewed studies have now been published that have examined the spirituality-delinquency/crime relationship. Of those, 82 (79%) reported inverse relationships between spiritual involvement and delinquency or crime.

Of the 60 best studies, 82% found significant inverse relationships.

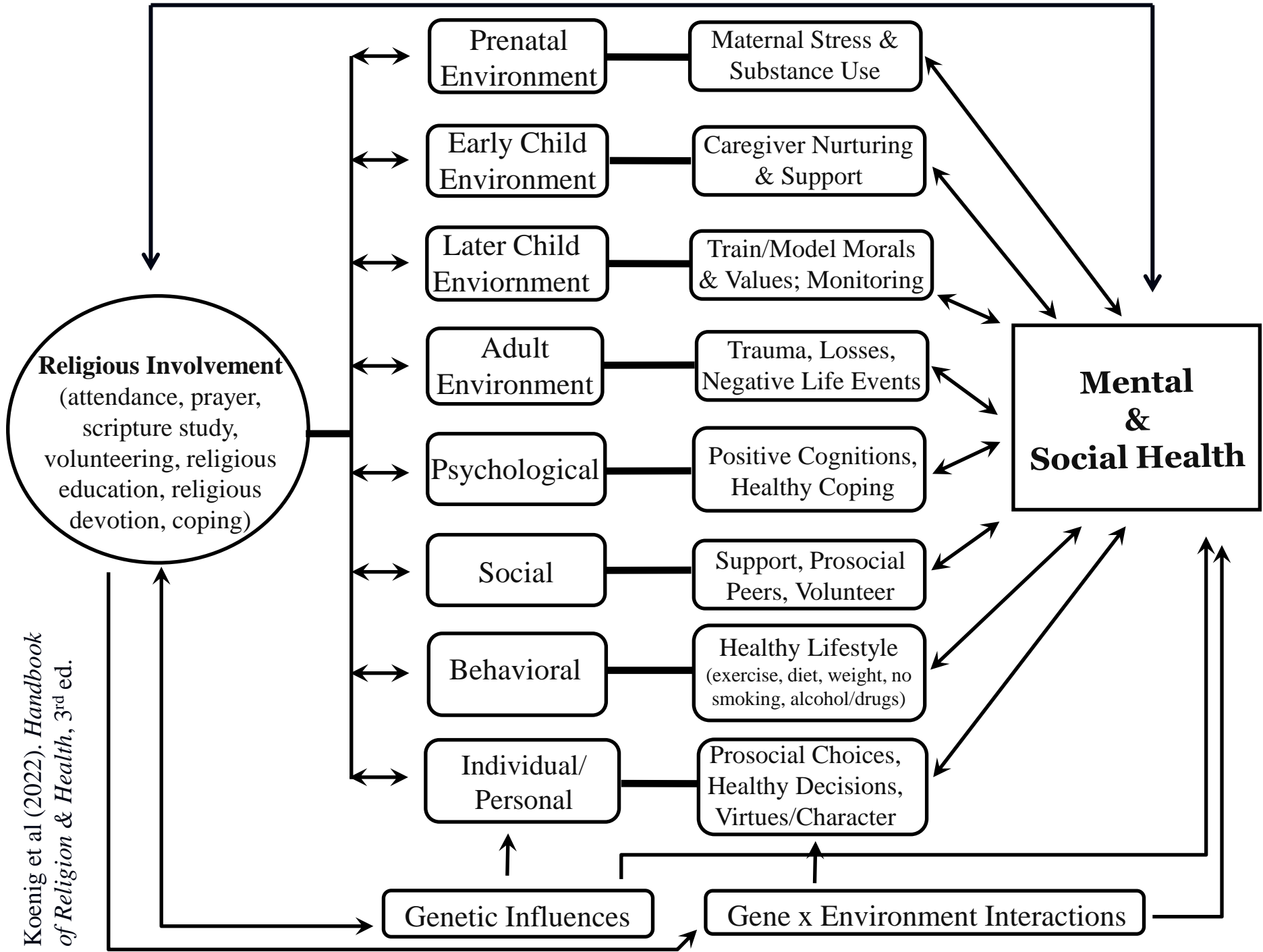
Marital Stability and Satisfaction

Religious involvement is related to:

Great marital stability - less divorce, greater satisfaction, less spousal abuse, less cheating on spouse, more likely to have intact family with two parents in home (68 of 79 studies or 86% of all quantitative studies)



Li, S., Kubzansky, L. D., & VanderWeele, T. J. (2018). Religious service attendance, divorce, and remarriage among US nurses in mid and late life. *PloS One*, 13(12), e0207778. [14-year follow-up (1996-2010) of 66,444 initially married women; Cox proportional hazard model and multivariate logistic regression used to control for 24 sociodemographic and health covariates, including 1992 religious attendance]



Religiously-Integrated Psychotherapies

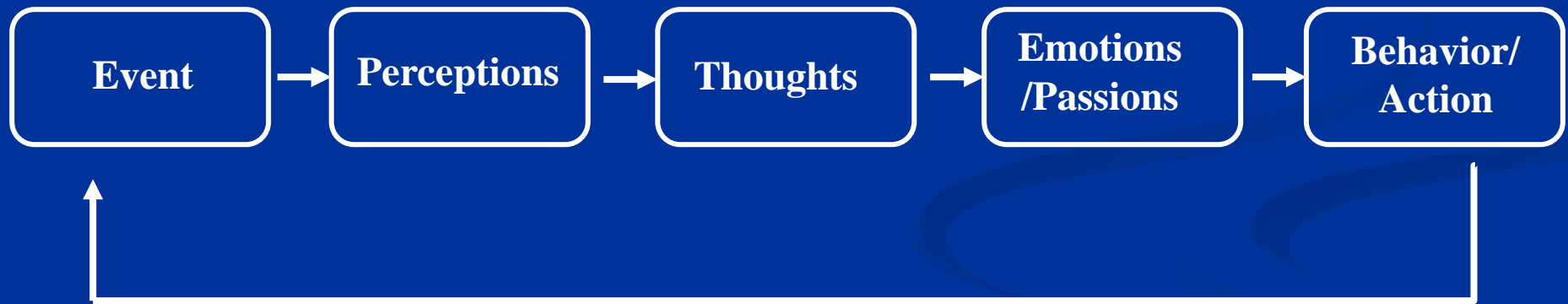
Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington Jr, E. L. (2018). Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis. Journal of Clinical Psychology, 74(11), 1938-1951.

Summarized the results of 97 outcome studies (the majority targeting depression or psychological distress) involving 7,181 subjects that examined the efficacy of tailoring psychotherapy to patients' R/S beliefs (R/S-adapted psychotherapy). Compared to no treatment, R/S-adapted psychotherapy resulted in significant improvement in clients' psychological outcomes ($g=0.74, p < 0.000$). When compared to any form of secular psychotherapy, effects were likewise superior ($g = 0.33, p < 0.001$). In more rigorous additive studies (where R/S was added to a standard treatment and then compared with the standard treatment), R/S-accommodated psychotherapies were equally effective to standard approaches ($g = 0.13, p = 0.258$).

Religiously-Integrated Psychotherapy Examples

1. Cognitive behavioral approaches for emotional disorders
2. Religiously-integrated cognitive-behavioral therapy (RCBT) for depression and anxiety
3. Religiously-integrated cognitive processing therapy (RCPT) for moral injury and PTSD

Cognitive-Behavioral Model



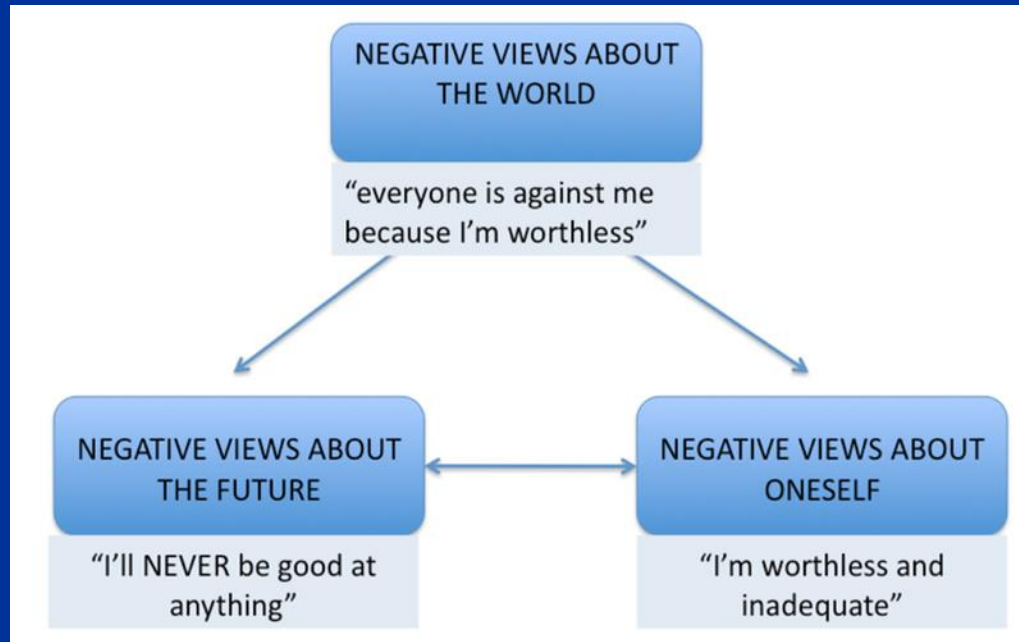
How is this model operationalized in Cognitive Behavioral Therapy?

Cognitive Behavioral Intervention Model

Negative emotions are generated by and maintained by:

- (1) negative automatic thoughts
- (2) dysfunctional, maladaptive, inaccurate assumptions
- (3) exaggerated pattern of thought not based on facts, and
- (4) negative behavior that follows and reinforces negative thoughts/assumptions

- (a) Help the person become aware of what they are doing, i.e., that their painful emotions are being generated by their negative pattern of thinking (homework).
- (b) In RCBT, help the person think differently (cognitive restructuring) and behave differently based on what the Scriptures say.



Religiously-Integrated Cognitive Behavioral Therapy (RCBT) for Depression, Anxiety, & Distressing Emotions

Therapist manuals, participant workbooks, lecture and training videos available for free download at:

<https://spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals>

Versions of RCBT available

Christian

Jewish

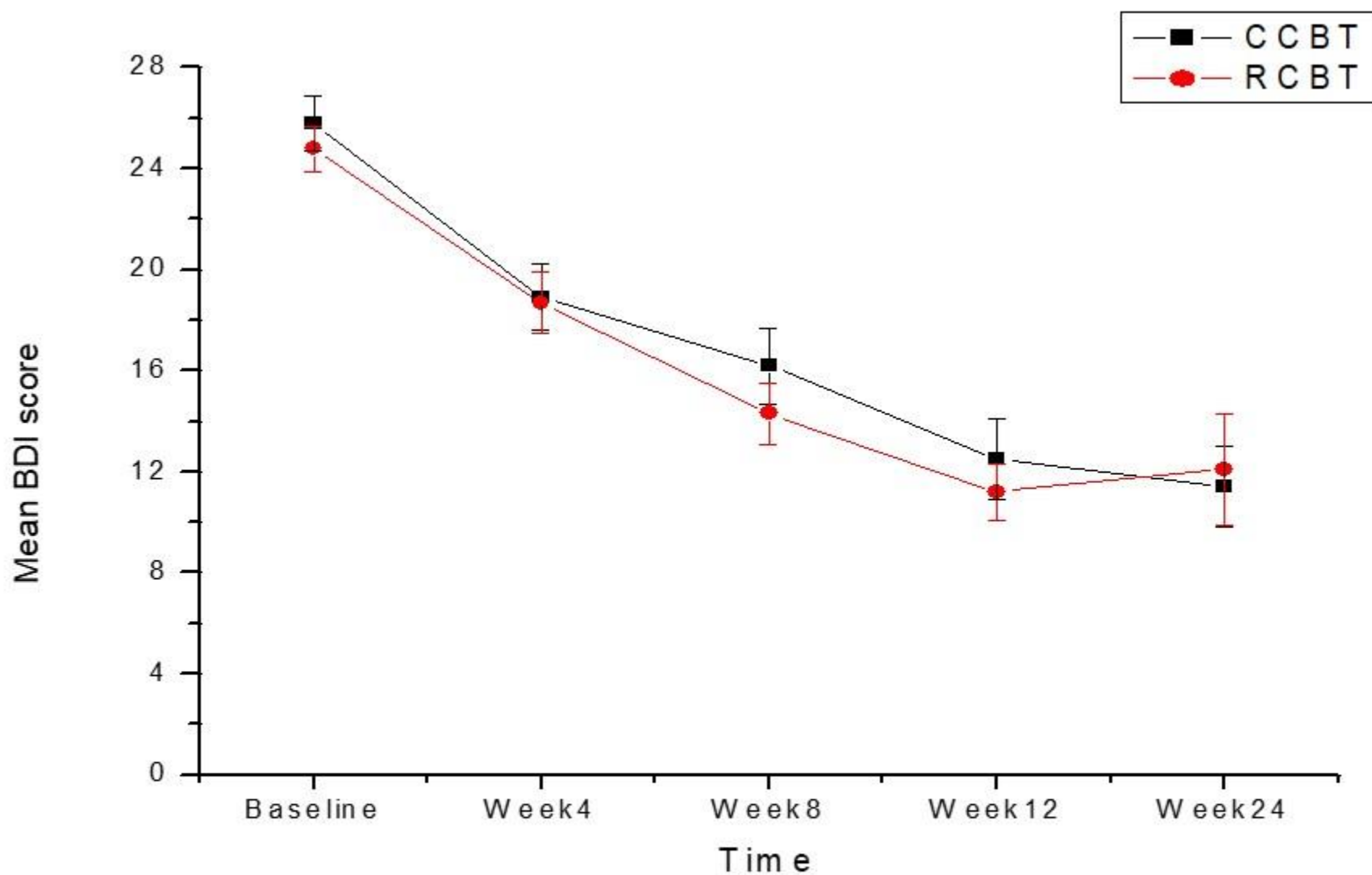
Muslim - Shia

Muslim - Sunni

Muslim - Urdu (Pakistan)

Hindu

Buddhist



Cohen's $d=3.02$ for **RCBT** and $d=2.39$ for CCBT; $d=0.12$ for difference (slightly favoring RCBT)

Citation: Koenig et al. Journal of Nervous and Mental Disease 2015; 203(4):243-251

S/R Interventions for Moral Injury and PTSD

- Spiritual-Integrated Cognitive Processing Therapy (SICPT) and Religion-Specific Interventions
- Clergy/Counselor Religion-Specific Intervention

What is “Moral Injury”?

According to Litz et al. (2009) “moral injury involves an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness...” (i.e., inner conflict over transgression of moral values)

Moral injury is a relatively new syndrome (yet quite old) that often occurs in the setting of trauma, such as Post-Traumatic Stress Disorder (PTSD), but MI is distinct and separate from PTSD

MI also often occurs in:

- first responders, i.e., police, firemen, or emergency medical personnel
- civilians experiencing severe trauma
- healthcare professionals (often the cause of burnout)

Moral Injury has both **psychological** and **spiritual** dimensions



Killing
Violence to others
Witnessing violence
Not protecting
Morally compromising position
Witnessing others, especially leaders, violate moral codes
De-humanizing others (the enemy)
Plundering the enemy (dead or alive)
Rape, torture (victim or perpetrator)

Transgress
moral code

**Moral
Injury**
(religious)

Religious Struggles
Loss of Religious
Faith

**Moral
Injury**
(psychological)

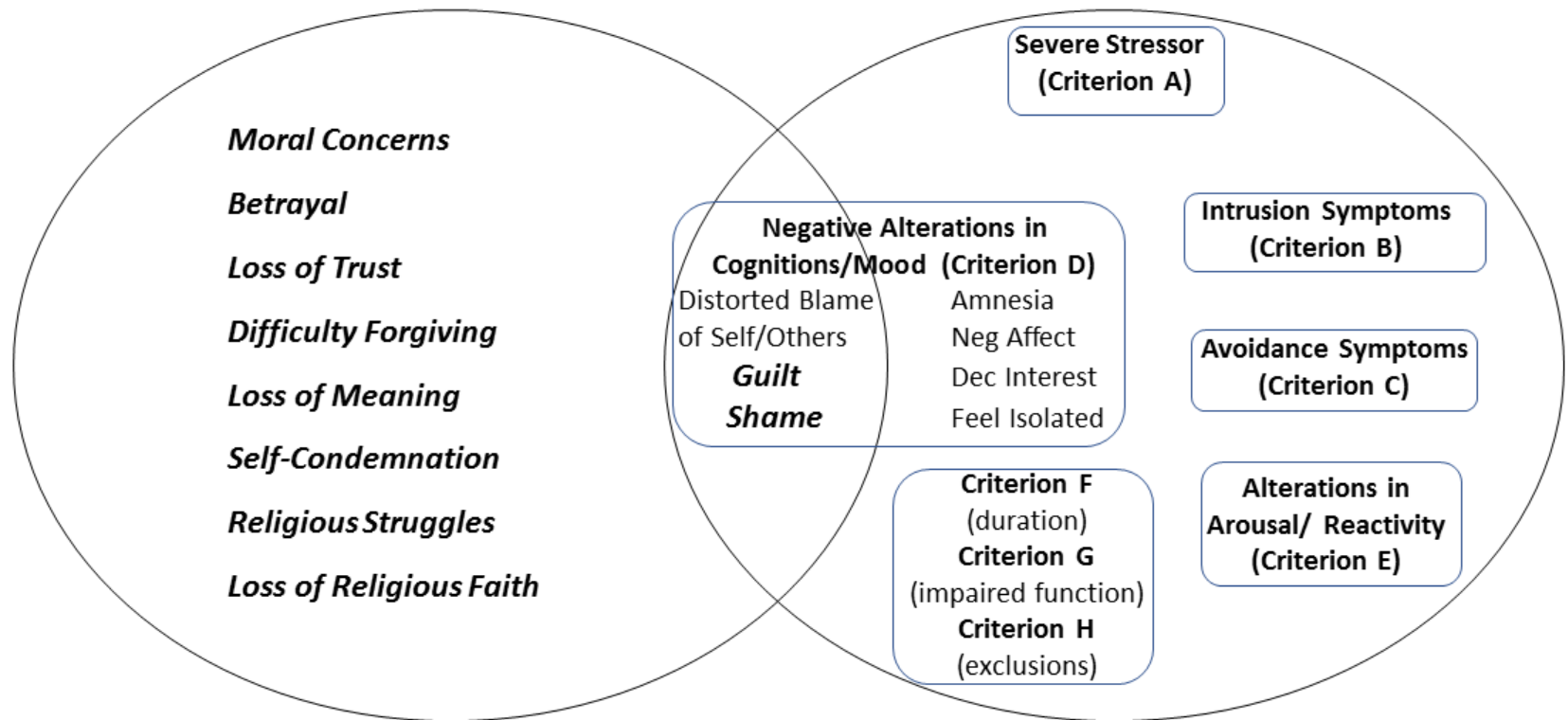
Guilt
Shame
Moral Concerns
Feeling Betrayed
Loss of Trust
Difficulty Forgiving
Loss of Meaning/Purpose
Self-Condernation

**Clinical
Outcomes**

PTSD Symptoms
Depression
Anxiety
Substance Abuse
Relationship Prob
Pain
Physical Disability

Moral Injury

DSM-5 PTSD



How to Identify It

- 45-item Moral Injury Symptom Scale-Military Version (MISS-M-LF)
- 10-item MISS-M-Short Form (MISS-M-SF)

Koenig, H. G., Youssef, N. A., & Pearce, M. (2019). Assessment of moral injury in veterans and active duty military personnel with PTSD: a review. *Frontiers in Psychiatry*, 10, 443

<https://www.frontiersin.org/articles/10.3389/fpsy.2019.00443/full>

Spiritually-Integrated CPT (SICPT)

A manual-based structured psychotherapeutic intervention for **Moral Injury** in those experiencing severe trauma

A 12-session in-person individual treatment delivered over 6 weeks at 2 sessions/week

SICPT is a spiritual/religiously-integrated intervention using a CPT framework

By reducing moral injury, the goal is to decrease trauma symptoms and comorbid conditions (depression, anxiety, substance abuse, relationship problems, etc.)

Several versions: broad “spiritual” version, plus religiously-integrated versions:

Christian, Jewish, Muslim, Hindu, Buddhist

Pearce, M., Haynes, K., Rivera, N. R., & Koenig, H. G. (2018). Spiritually integrated cognitive processing therapy: a new treatment for post-traumatic stress disorder that targets moral injury. Global Advances in Health and Medicine, 7,

<https://journals.sagepub.com/doi/full/10.1177/2164956118759939>

12-Session SICPT Outline (broadly spiritual version)

- 1 - Introduction : Moral Injury and Rationale for SICPT:** Symptoms of PTSD; goals of SICPT; review stuck points handout; brief review of traumatic event. Practice assignment: Write **initial Impact Statement** with focus on moral injury/impact on conscience, God, others, world.
- 2 - The Meaning of the Event and Spirituality:** Patient reads Impact Statement. Begin to identify stuck points. **Identify moral injury and impact on spiritual beliefs/practices**. Introduce of A-B-C Worksheets (WS); explanation of relationship between thoughts, feelings, behavior. Practice assignment (PA): Complete 1 A-B-C sheet each day; **complete Spiritual Resources Worksheet**.
- 3 – Spiritual Resources and Moral Injury:** Review A-B-C practice assignment. **Review spiritual resources**. Introduce Intention for **Kind Attention and Compassion** & discuss how fits within client's spiritual belief system. PA: reassign A-B-C WS, complete **Core Values** WS, read **Prodigal son** story.
- 4 – Kind Attention & Compassion:** Review A-B-C WS on inner conflict/moral injury (ICMI). Review setting Intention for **Kind Attention and Compassion toward ICMI**. Introduce **spiritual distress & grief**. Introduce **spiritually-oriented Challenging Questions** WS to challenge stuck points. PA: Complete spiritually-oriented Challenging Questions WS; read WS on **spiritual reactions to ICMI**.
- 5 - Challenging Questions & Spiritual Distress:** Review **spiritually-oriented Challenging Questions** WS. Review **spiritual distress/grief and Lament**. Distinguish between different types of Guilt. Introduce **ritual of confession** to deal with guilt. Introduce Patterns of Problematic Thinking WS. PA: Complete spiritually-oriented Challenging Questions WS; chose confession ritual to practice daily
- 6 – Confession Ritual and Problematic Thinking:** **Review spiritual confession ritual** & problematic thinking WS. **Introduce stages of self, other, Divine Forgiveness**. Introduce Challenging Beliefs WS. PA: Complete **Challenging Beliefs WS** daily related to forgiving self, others, God.

12-Session SICPT Outline

- 7 – Forgiveness I and Challenging Beliefs:** Review Challenging Beliefs and Forgiveness WS's related to forgiveness stuck points. Introduce final REACH forgiveness steps. Introduce Trust for self, others, and God. PA: Complete REACH WS, read Trust Module.
- 8 – Trust and Forgiveness II:** Review Challenging Beliefs WS regarding forgiveness and trust stuck points. Discuss judgment issues, review REACH forgiveness WS. Introduce Making Amends. Introduce Esteem for Self, Others, & God. PA: Read Esteem Module.
- 9 - Esteem and Making Amends:** Review Challenging Beliefs WS on beliefs hindering making amends and esteem. Review Making Amends WS, Verbal Blessing WS. Introduce Power/Control (P/C) issues related to self, others and God; Introduce Spiritual Discrepancies re P/C.
- 10 – Power, Control, & Spiritual Discrepancies:** Discuss P/C and self-blame; address Spiritual Discrepancies related to P/C. Introduce Intimacy issues related to self, others, & God. Introduce Spiritual Partnerships. PA: Read Intimacy Module.
- 11 – Intimacy and Spiritual Partnerships:** Discuss issues related to increasing intimacy/participation in Spiritual Community. Introduce Safety issues as related to self, others, and God. Introduce Post-Traumatic Growth. PA: Write final impact statement.
- 12 – Safety and Post-Traumatic Growth:** Have patient read the final Impact Statement. Therapist reads the first Impact Statement and then compares differences. Identify any remaining stuck points related to ICMI, review course of treatment and client's progress, help client identify goals for future and "Paying it forward" to others, family, spiritual community, those in need.

Therapist Manuals and Patient Workbooks

Spiritually-Integrated Cognitive Processing Therapy

- SICPT Manual (michelle.pearce@umaryland.edu)
- Therapist workbook and religion-specific modules
- Patient workbooks

Conclusions

1. Religious involvement (RI) is related to better mental, social, and behavioral health, and improves these aspects of health over time
2. Religiously-integrated psychotherapeutic interventions have been developed for many disorders, especially depression, anxiety, and other forms of internal emotional distress

Further Resources



Books and Manuals

1. Religious-integrated cognitive behavioral therapy (CBT) for depression and anxiety; multiple manuals in a wide range of faith traditions:

<https://spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals/>

2. Religion and Recovery from PTSD

(<https://www.amazon.com/Religion-Recovery-PTSD-Harold-Koenig-ebook/dp/B07WQ34JTN>)

3. Spiritually-Integrated Cognitive Processing Therapy

- SICPT Manual (michelle.pearce@umaryland.edu)
- Therapist workbook
- Patient workbook

Manualized Structured 12-Session Pastoral Care Intervention for Moral Injury

Designed as a counselor, chaplain, or community clergy “pastoral care” intervention

Heavily Bible-based for Christian version
(and similarly, heavily scripture based for Jews, Muslims, Buddhists, and Hindus based on their core religious scriptures: Torah and Talmud, Qur'an and Hadith, Dhammapada, Bhagavad Gita)

12 weekly sessions, each 50-min long, targeting each of the 12 symptoms of Moral Injury: guilt, shame, moral concerns, feelings of betrayal, loss of meaning/purpose, loss of trust, difficulty forgiving, self-condemnation, religious struggles, and loss of faith

Harold.Koenig@duke.edu for manuals

The 15-item Mental Health Spiritual History

1. “Do you consider yourself religious or spiritual person, or neither?”
2. “If religious or spiritual, ask: “Explain to me what you mean by that?”
3. If neither religious nor spiritual, ask: “Was this always so?” If no, ask: “When did that change and why?” [Then *end the spiritual history for now*, although may return to it after therapeutic relationship established]
4. “Do you have any religious or spiritual beliefs that provide comfort?”
5. If yes, ask: “Explain to me how your beliefs provide comfort.” If no, ask: “Is there a particular reason why your beliefs do not provide comfort?”
6. “Do you have any religious or spiritual beliefs that cause you to feel stressed?”

The Mental Health Spiritual History (continued)

7. If yes, ask: “Tell me about that change and why you think the change occurred.”

8. “Do you have any spiritual or religious beliefs that might influence your willingness to take medication, receive psychotherapy, or receive other treatments that may be offered as part of your mental health care?”

9. “Are you an active member of a faith community, such as a church, synagogue, mosque, or temple?”

10. If yes, ask: “How supportive has your faith community been in helping you?” If no, ask: “Why has your faith community not been supportive?”

11. “Tell me a bit about the spiritual or religious environment in which you were raised. Were either of your parents religious?”

12. “When you were a child, were your experiences positive or negative ones in your family environment?”

The Mental Health Spiritual History (continued)

13. “Have you ever had a significant change in your spiritual or religious life, either an increase or a decrease?”

14. “Do you wish to incorporate your spiritual or religious beliefs in your treatment?” If yes, ask: “How would you like to do this?”

15. “Do you have any other spiritual needs or concerns that you would like addressed in your mental health care?”

Source: *Religion and Mental Health: Research & Clinical Applications* (Academic Press, 2018)

Monthly FREE e-Newsletter

CROSSROADS...

Exploring Research on Religion, Spirituality & Health

- Summarizes latest research
- Latest news
- Resources
- Events (lectures and conferences)
- Funding opportunities

To sign up, go to website: <http://www.spiritualityandhealth.duke.edu/>

Summer Research Workshop

August 14-18, 2023

Durham, North Carolina

5-day intensive research workshop focus on what we know about the relationship between spirituality and health, clinical applications, how to conduct research, and how to develop an academic career in this area. Faculty includes leading spirituality-health researchers at Duke, Yale University, Emory, and elsewhere.

- Strengths and weaknesses of previous research
- Theological considerations and concerns
- Highest priority studies for future research
- Strengths and weaknesses of measures of religion/spirituality
- Designing different types of research projects
- Primer on statistical analysis of religious/spiritual variables
- Carrying out and managing a research project
- Writing a grant to NIH or private foundations
- Where to obtain funding for research in this area
- Writing a research paper for publication; getting it published
- Presenting research to professional and public audiences; working with the media

Partial tuition Scholarships are available

If interested, contact Dr. Koenig: Harold.Koenig@duke.edu

Spirituality & Health Research

Methods
Measurement
Statistics
and Resources



Harold G. Koenig, MD

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Welcome

The Center was founded in 1998, and is focused on conducting research, training others to conduct research, and promoting scholarly field-building activities related to religion, spirituality, and health. The Center serves as a clearinghouse for information on this topic, and seeks to support and encourage dialogue between researchers, clinicians, theologians, clergy, and others interested in the intersection.



Mission

The five main goals of the Center are to:

- Conduct research on religion, spirituality and health
- Train those wishing to do research on this topic
- Interpret the research for clinical and societal applications
- Explore the meaning of the research for pastors and theologians
- Discuss how theological input can advance the research



Upcoming Events

16th Annual 5-day Spirituality and Health Research Workshop (August 12-16, 2019)

Monthly Research Seminars

Recent News

[Religion and Mental Health Review \(new\)](#)

[Resources on Moral Injury](#)

[Special Issue on Moral Injury in *Frontiers in Psychiatry*](#)

[2017 Mental Health and Religion Book Series](#)

[Health and Well-being in Islamic Societies](#)

[Latest Research on Spirituality and Health at Duke](#)

Questions and Discussion