Religion and Psychiatry:
Recent Developments in Research and Clinical Applications

Harold G. Koenig, M.D.
Professor of Psychiatry and Behavioral Sciences
Associate Professor of Medicine
Duke University Health System, Durham, North Carolina USA
Adjunct Professor, King Abdulaziz University, Jeddah, Saudi Arabia
Adjunct Professor, Ningxia Medical University, Yinchuan, People's Republic of China
Visiting Professor, Shiraz University of Medical Sciences, Shiraz, Iran

DukeMedicine

Overview

1. Religion and spirituality – what do these terms mean?
2. Research on religion and mental health
3. Theoretical model explaining effects
4. Effects of mental health on religious involvement
5. Brief update on clinical applications
6. Conclusions
7. 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

Religion

Beliefs, practices, and rituals related to the 'transcendent," where the *transcendent* is that which relates to the mystical, supernatural, or God in Western religious traditions, or to Ultimate Truth, Reality, or Enlightenment, in Eastern traditions. May also involve beliefs about spirits, angels, or demons. Usually involves specific beliefs about the life after death and rules to guide behaviors in this life. Religion is often organized and practiced within a community, but it can also be practiced alone and in private, outside of an institution. Central to its definition is that religion is rooted in an established tradition that arises out of a group of people with common beliefs and practices concerning the transcendent. Religion is a unique construct, whose definition is generally agreed upon.

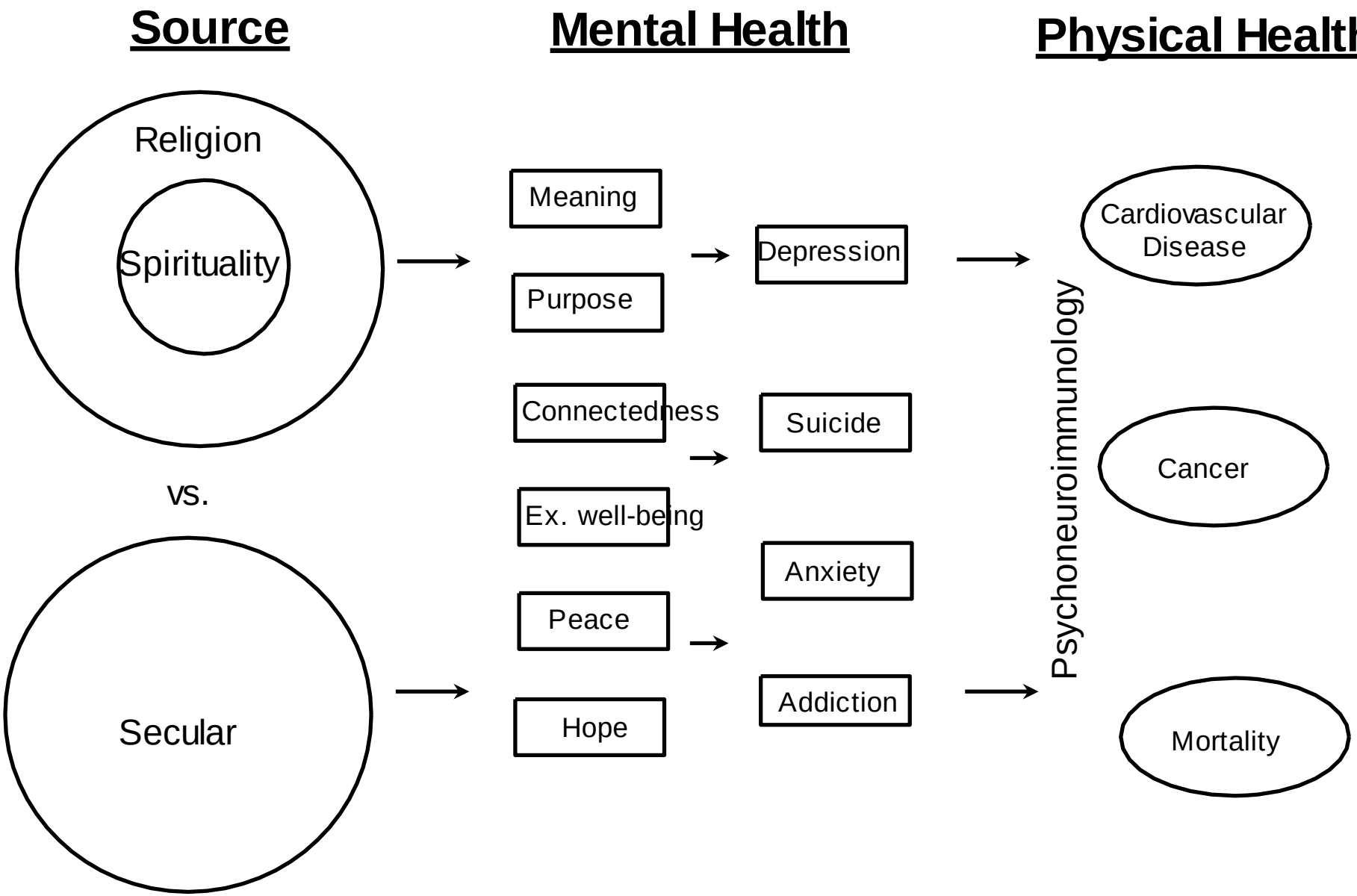
Spirituality

A popular expression today preferred over religion. Today, spirituality is considered personal, something individuals define for themselves. It is often free of rules, regulations, and responsibilities associated with religion. One can be spiritual, but not religious. In fact, a "secular spirituality" is often emphasized in circles where religion is in disfavor. Thus, spirituality is seen as non-divisive and common to all, both religious and secular.

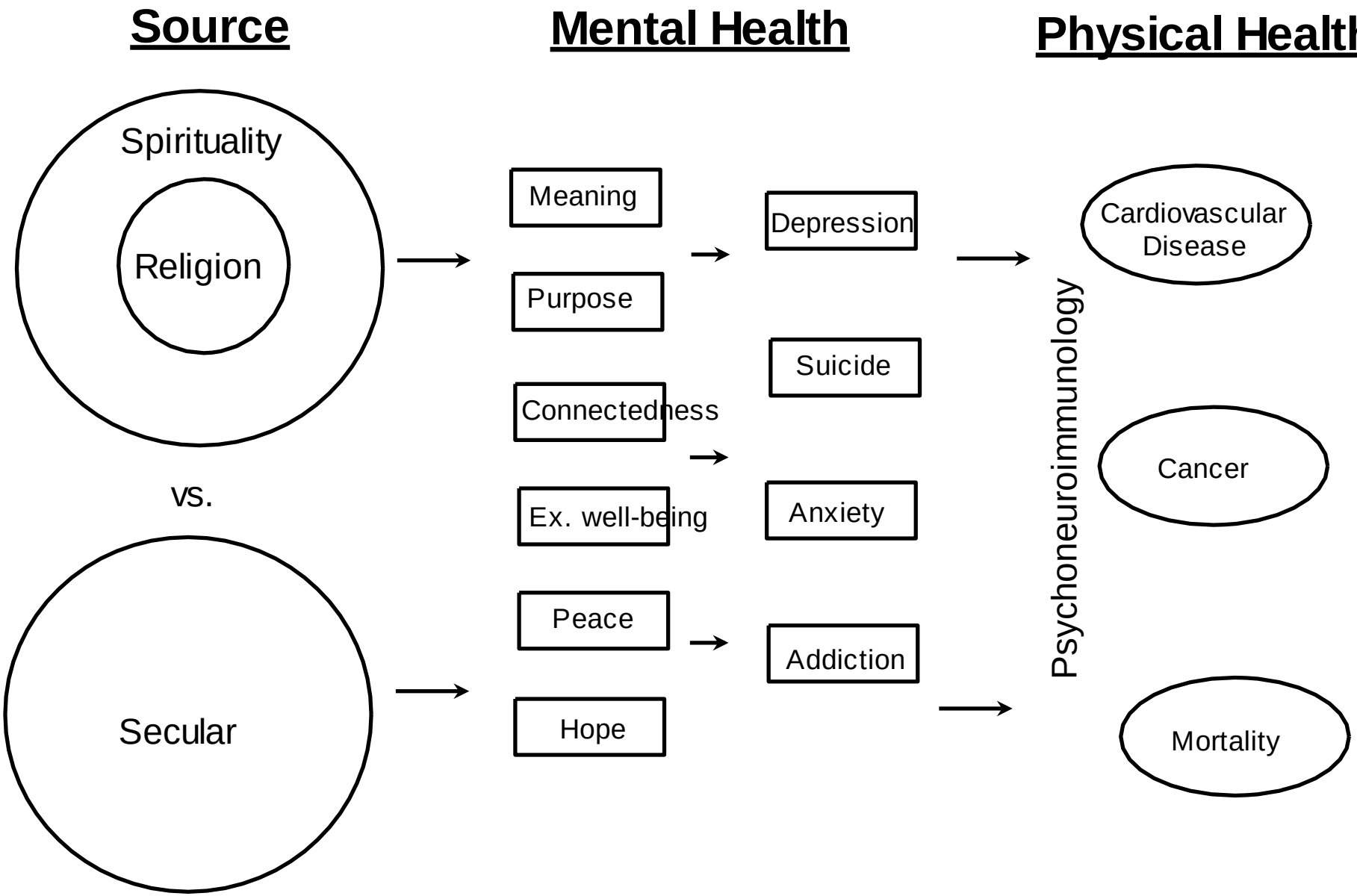
The term spirituality is especially useful in clinical settings. However, because of its vague and nebulous nature, it is difficult to measure and quantify.

Spirituality: An Expanding Concept

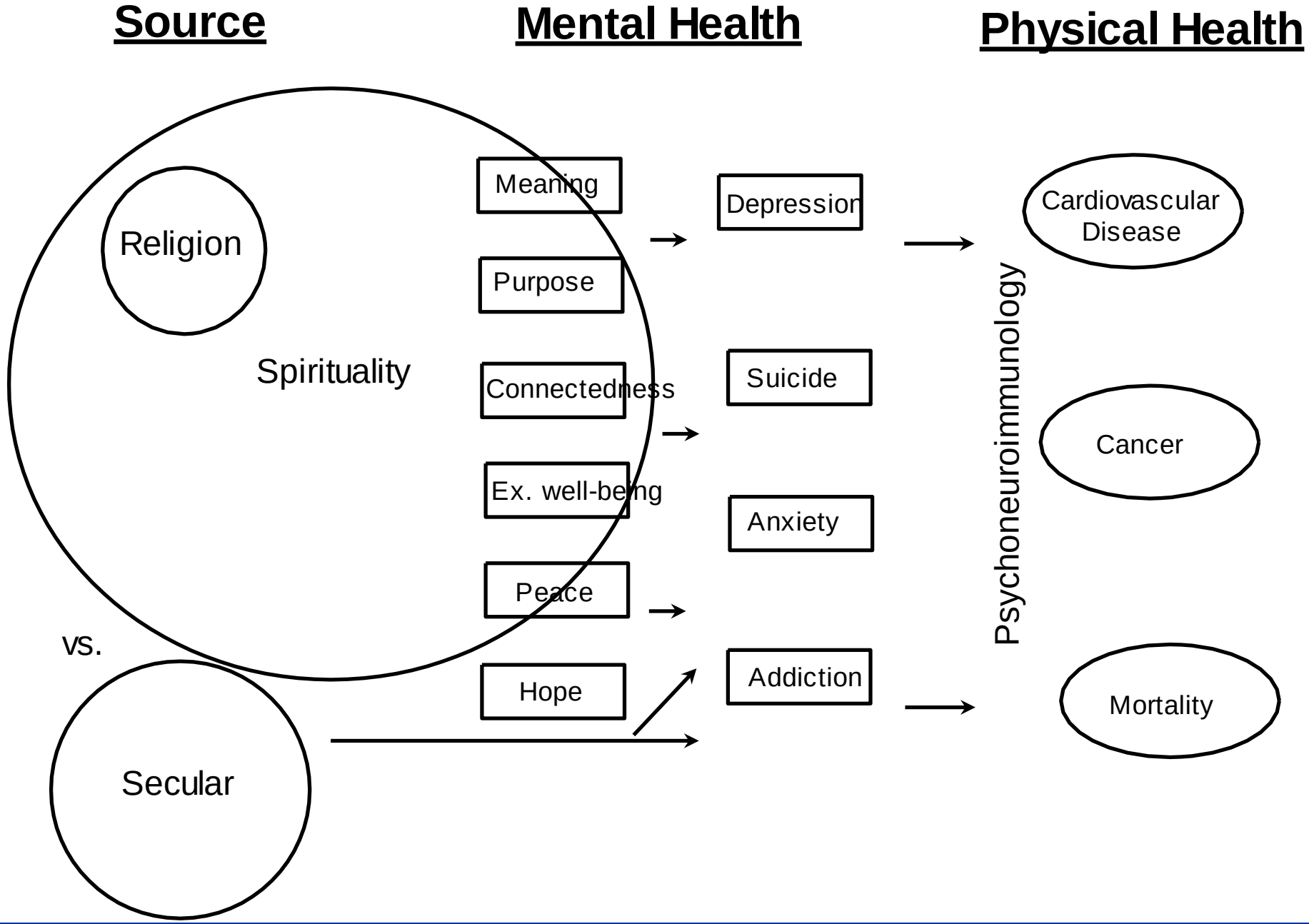
Traditional-Historical Understanding



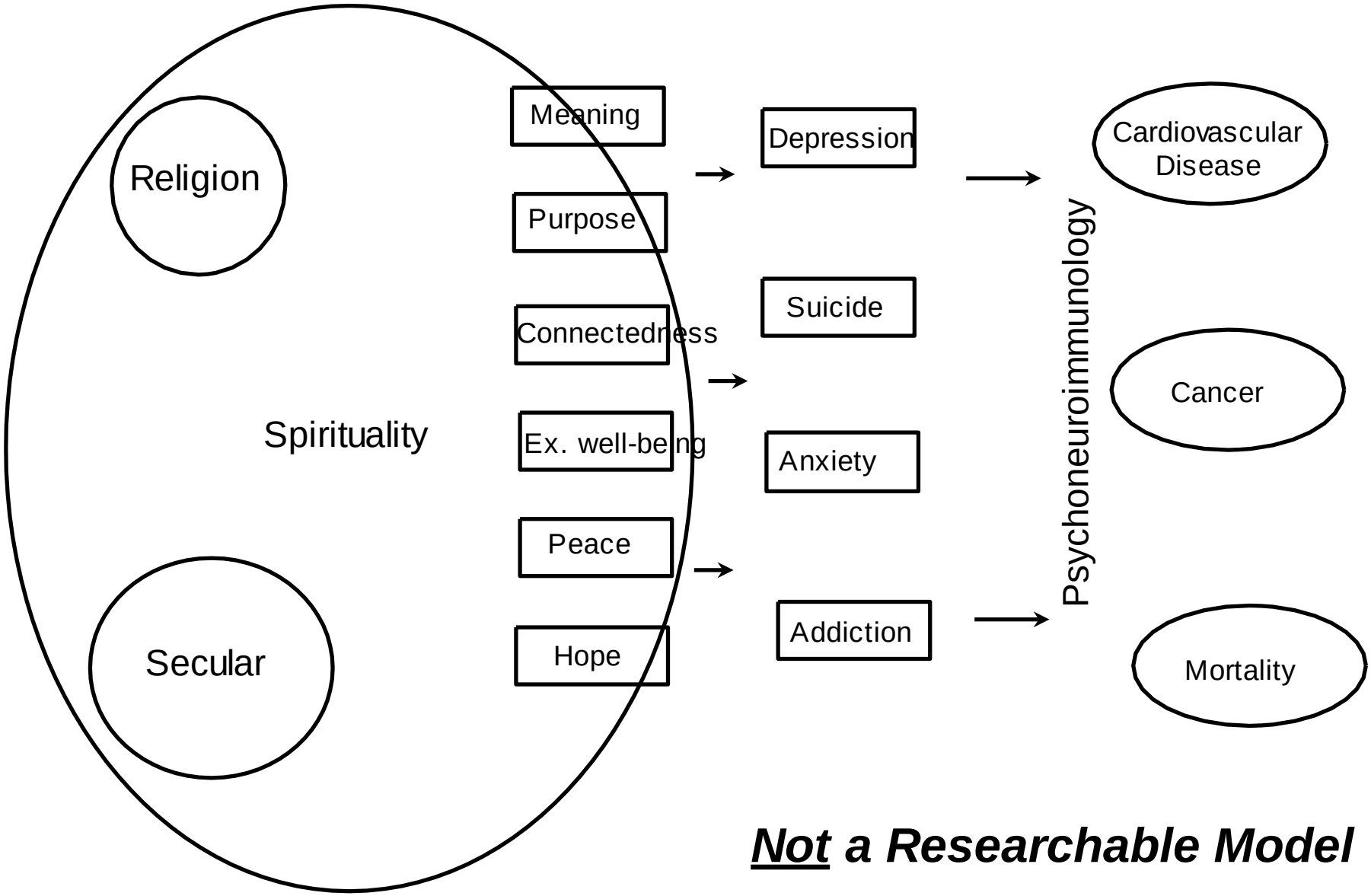
Modern Understanding



Modern Understanding - Tautological Version



Modern Understanding - Clinical Application only



***Not* a Researchable Model**

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 and Psychiatry

1. Is religion good for mental health?

2. Do religious beliefs increase resilience and improve psychological and social functioning?

3. Are the same benefits derived from being "spiritual but not religious"?

Sigmund Freud
Future of an Illusion, 1927

"Religion would thus be the universal obsessional neurosis of humanity... If this view is right, it is to be supposed that a *turning-away from religion is bound to occur with the fatal inevitability of a process of growth*…If, on the one hand, religion brings with it obsessional restrictions, exactly as an individual obsessional neurosis does, on the other hand *it comprises a system of wishful illusions together with a disavowal of reality, such as we find in an isolated form nowhere else but amentia, in a state of blissful hallucinatory confusion*…"

Religion as a Coping Behavior

1. Many persons turn to religion to maintain their emotional stability

2. Religion used to cope with common problems in life, especially in high stress situations

3. Religion often used to cope with challenges such as:
   - uncertainty
   - fear
   - anxiety
   - situations where control may be difficult

Religious Coping – does it help?

Research on Religion 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.

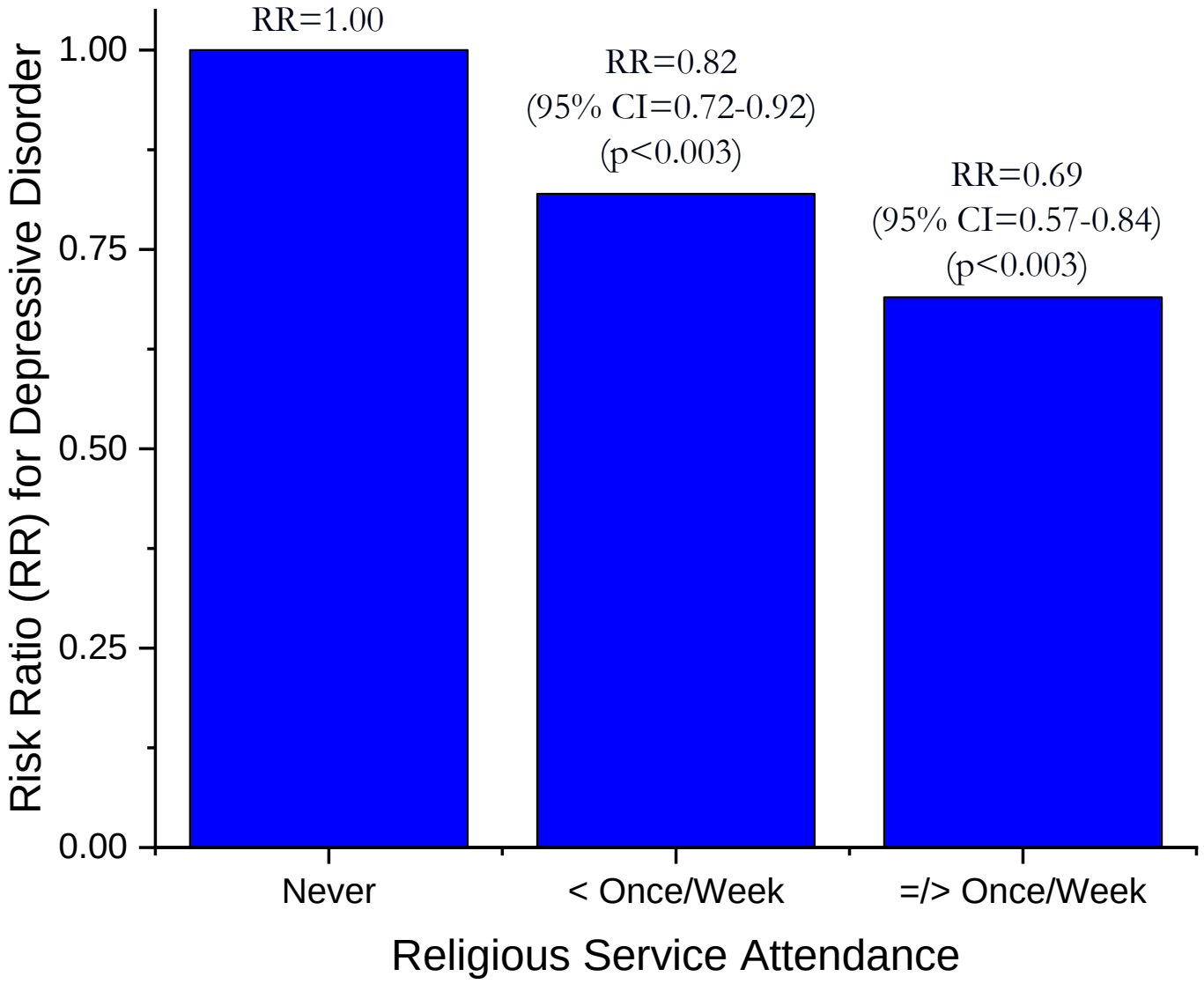
Depression

One of the most common emotional disorders in the world, particularly among those undergoing high stress situations for prolonged periods of time

Religious involvement is related to (systematic review of quantitative studies published prior to 2011:

Less depression, faster recovery from depression
272 of 444 studies (61%)
[67% of the highest quality studies]

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 49(6), 2030-2040 [**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]

JAMA Psychiatry
Formerly Archives of General Psychiatry

February 2014, Vol 71, No. 2 >

< Previous Article

Next Article >

Original Investigation | February 2014

Neuroanatomical Correlates of Religiosity and Spirituality

A Study in Adults at High and Low Familial Risk for Depression

Lisa Miller, PhD[1,2]; Ravi Bansal, PhD[2,3]; Priya Wickramaratne, PhD[2,4,5]; Xuejun Hao, PhD[2,3]; Craig E. Tenke, PhD[6]; Myrna M. Weissman, PhD[2,4,5]; Bradley S. Peterson, MD[2,3]

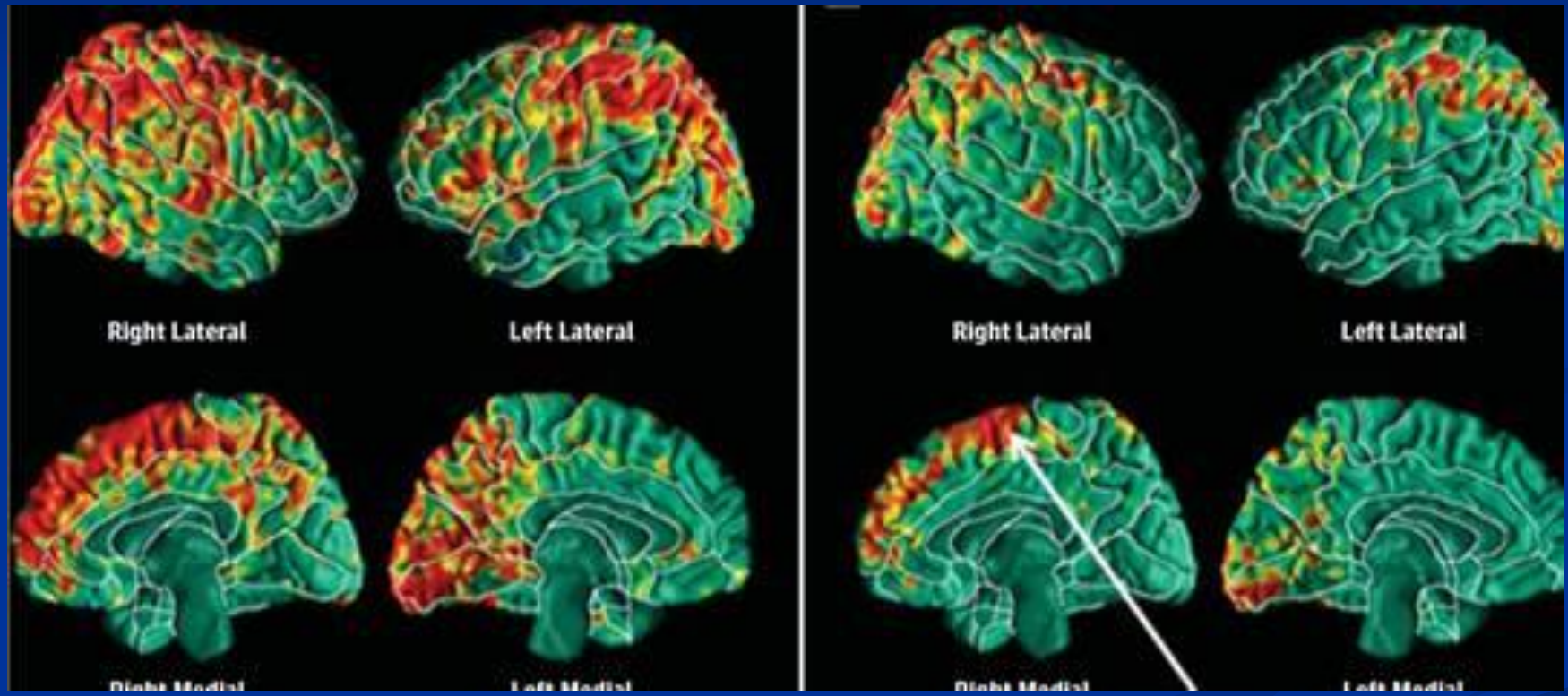
[+] Author Affiliations

JAMA Psychiatry. 2014;71(2):128-135. doi:10.1001/jamapsychiatry.2013.3067.

ABSTRACT

Religion/Spirituality and Cortical Thickness: A structural *MRI Study*

Areas in red indicate reduced cortical thickness



Religion NOT very important

Religion very important

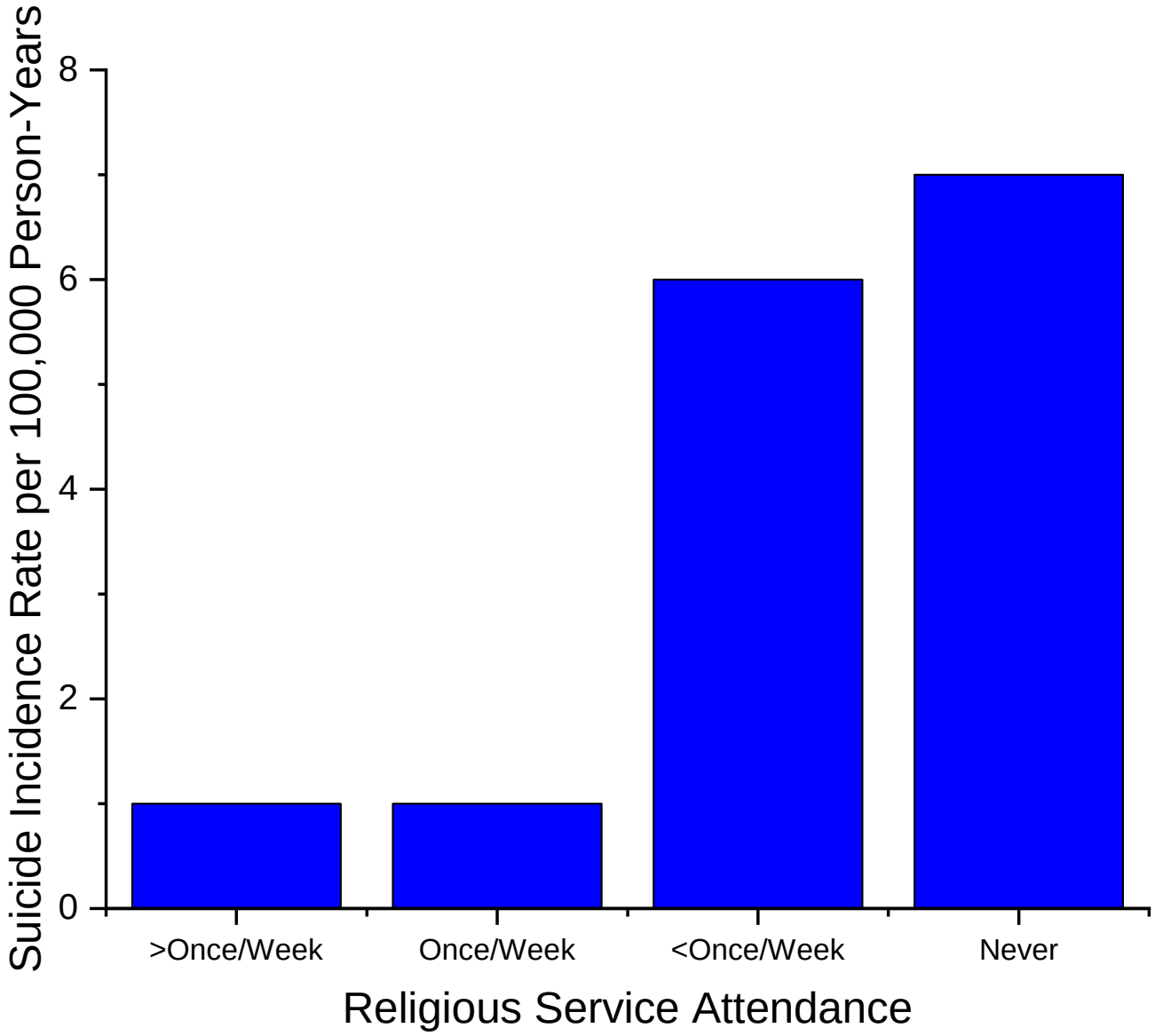
Citation: Miller L et al (2014). Neuroanatomical correlates of religiosity and spirituality in adults at high and low familial risk for depression. JAMA Psychiatry 71(2):128-35

Suicide

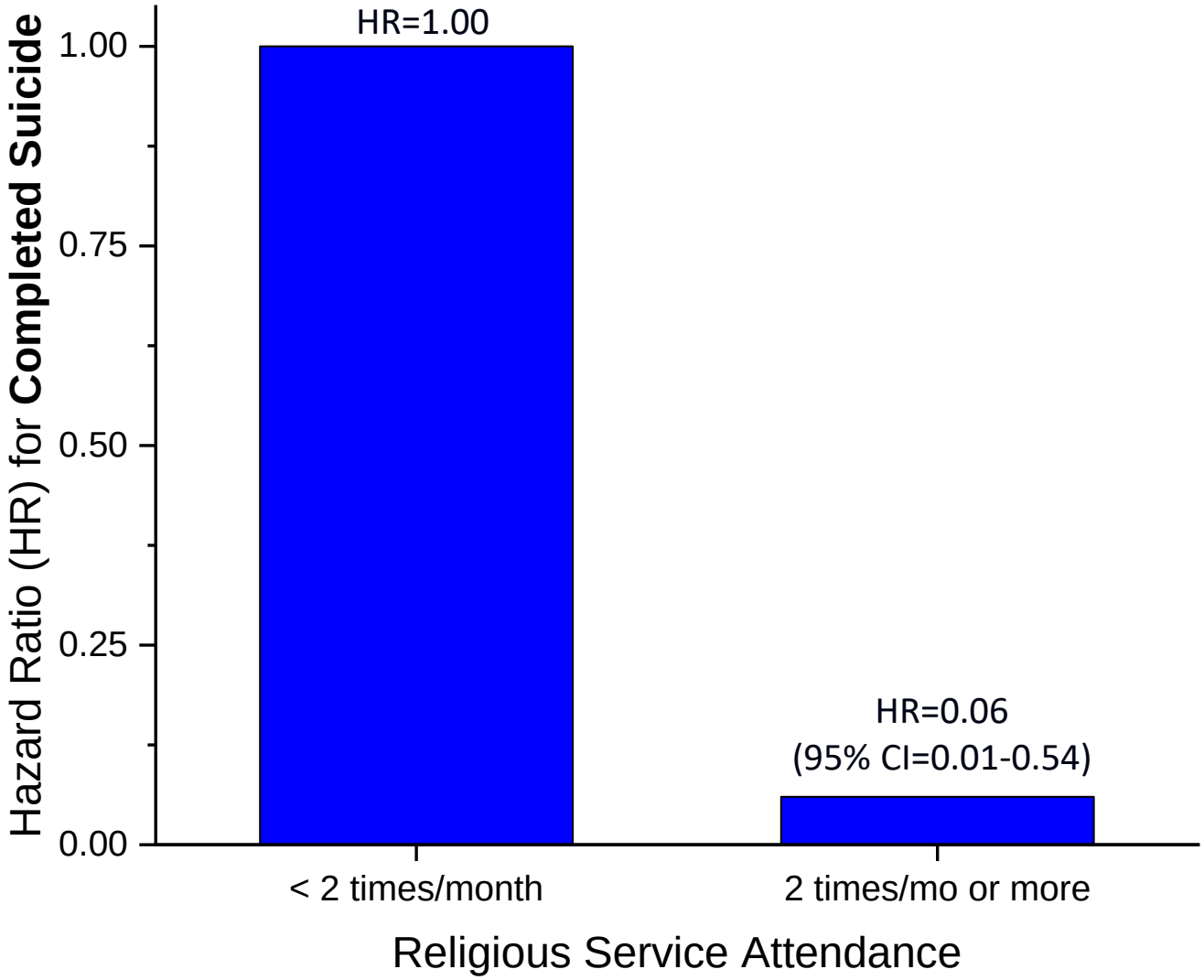
(systematic review)

Religious involvement is related to:

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

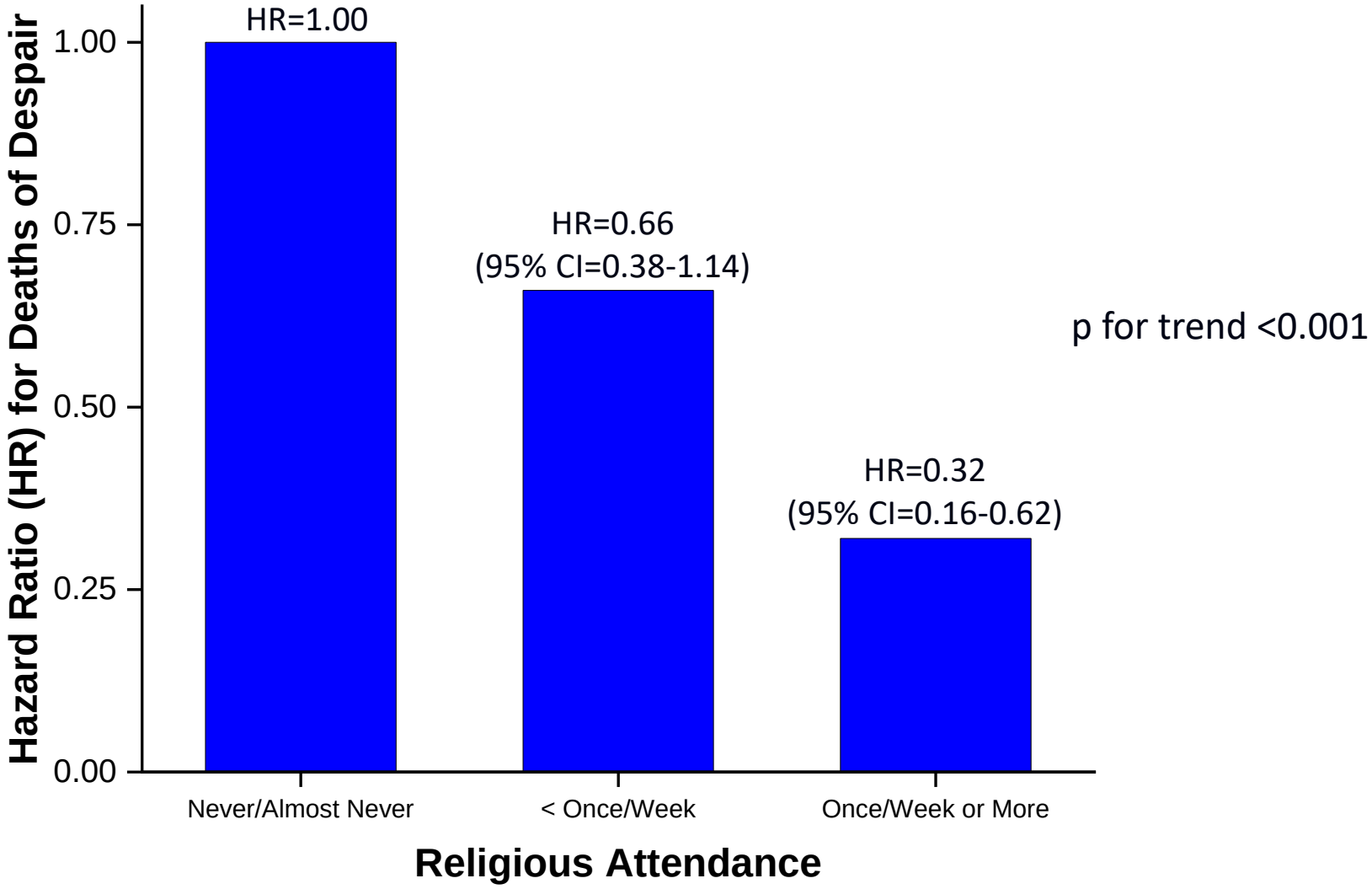


Nurses Health Study: 89,708 women followed from 1996 to 2010 (**HR=0.16**, 95% CI 0.06-0.46)
VanderWeele et al (2016). JAMA Psychiatry (Archives of General Psychiatry) 73(8):845-851



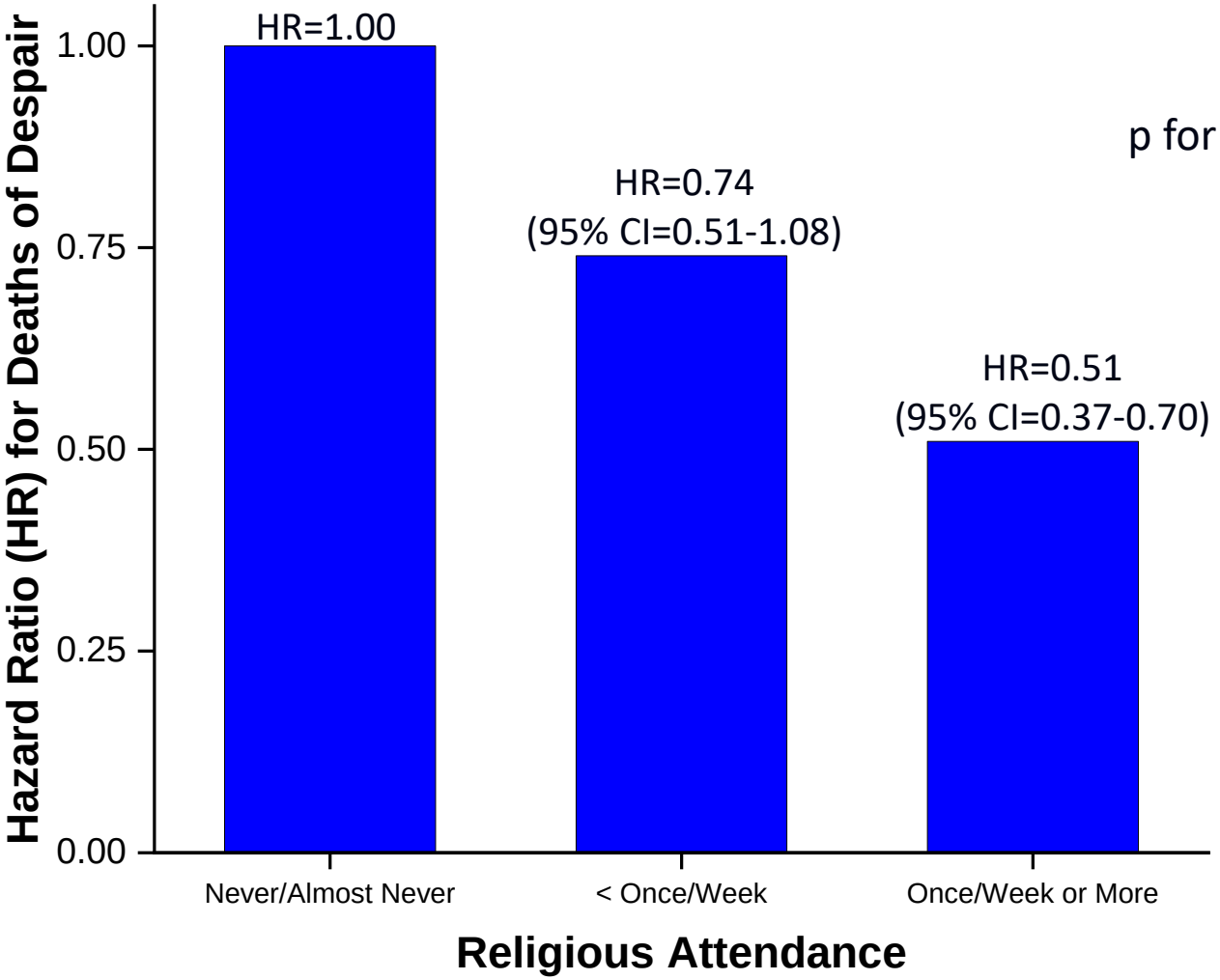
Kleiman, E. M., & Liu, R. T. (2014). Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. British Journal of Psychiatry, *204*(4), 262-266. [18-year prospective study from 1988/1994 to 2006 involving a random U.S. national sample 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]

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 only**]

Anxiety and PTSD

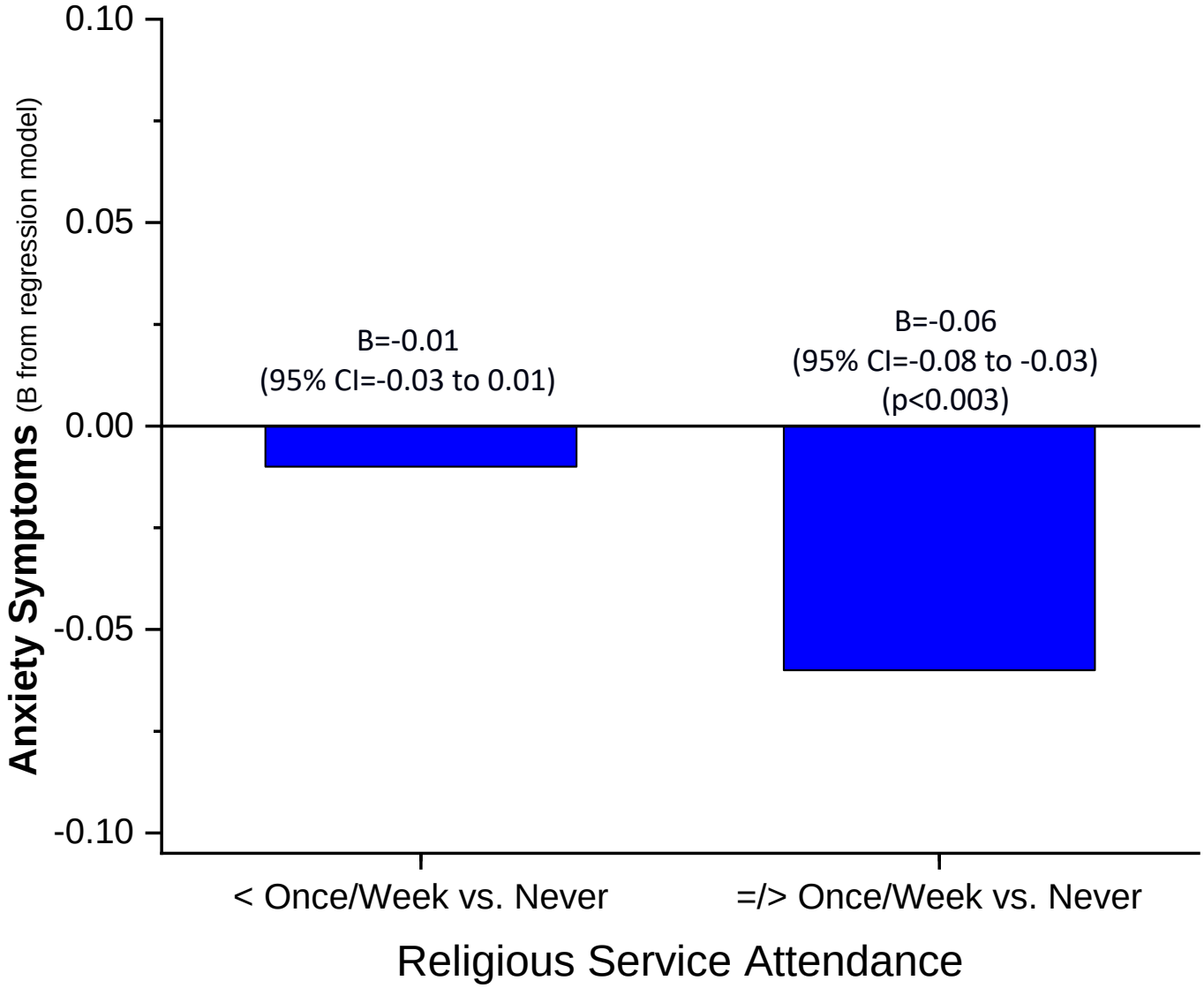
(systematic review)

Religious involvement is related to:

Less anxiety
(147 of 299 or 49% of studies)

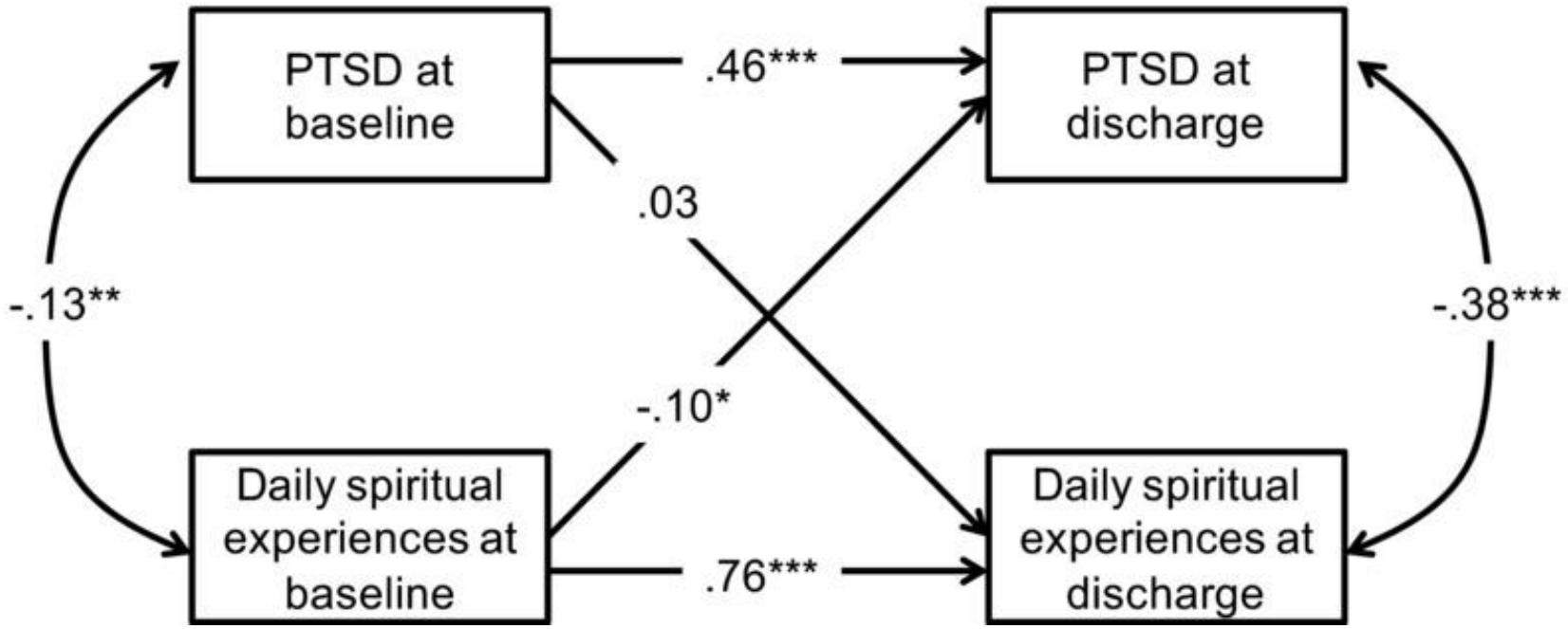
More anxiety
(33 of 299 or 11% of studies, 31 cross-sectional)

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

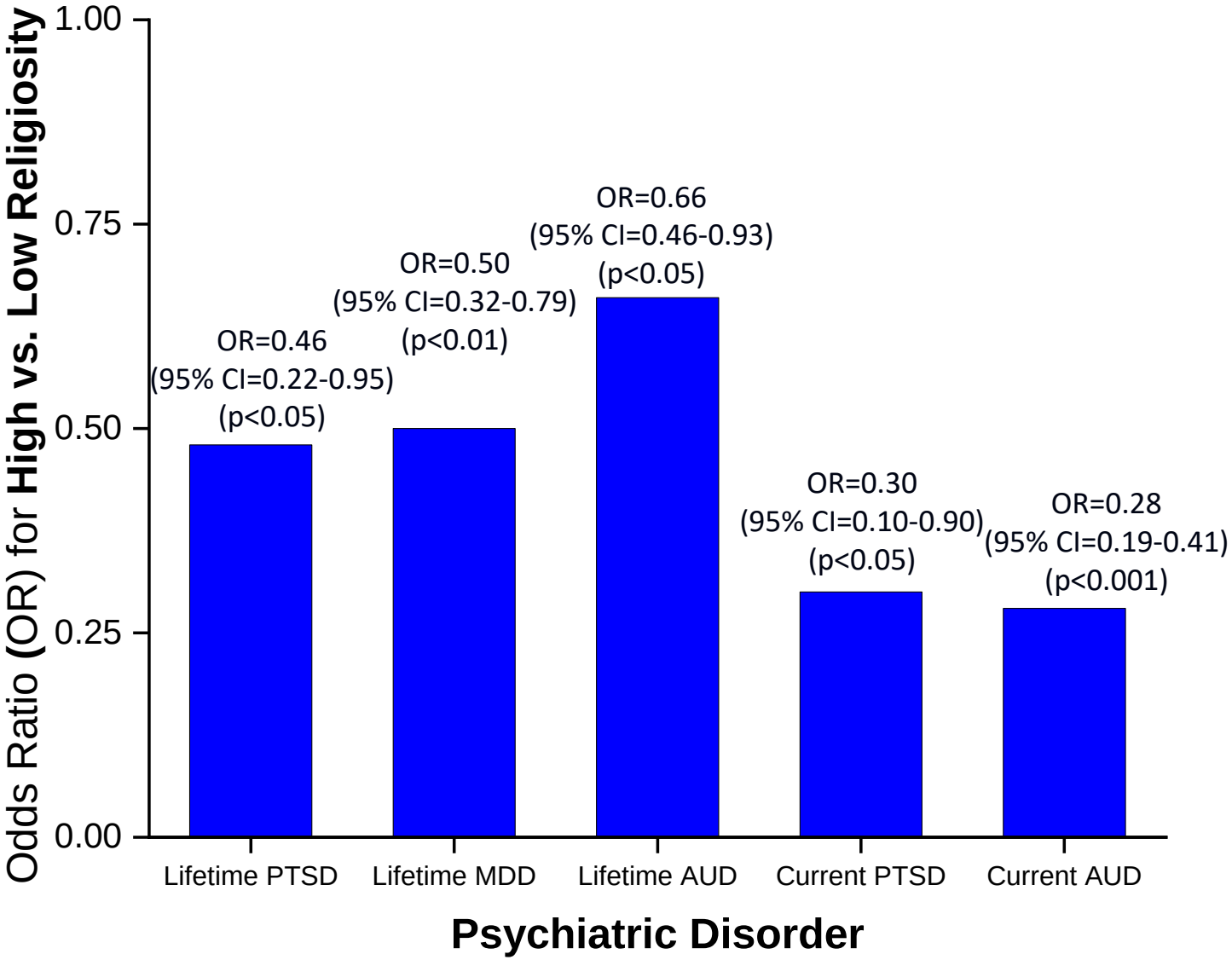


Chen et al (2020). International Journal of Epidemiology (https://doi.org/10.1093/ije/dyaa120) [*Nurses Health Study* II: **7-12 year prospective study 68,300 nurses** (ave. age 47) followed from 2001 to 2008-2013, B=standardized ES, Bonferroni corrected

Daily Spiritual Experiences in the Prediction of Outcomes of PTSD Treatment for U.S. Military Veterans



Currier, J. M., Holland, J. M., & Drescher, K. D. (2015). Spirituality factors in the prediction of outcomes of PTSD treatment for US military veterans. Journal of Traumatic Stress, *28*(1), 57-64. (**Prospective study of 532 Veterans with severe PTSD**, followed from admission to residential treatment program for PTSD to discharge, **60-90 days later**; results from cross-lagged analyses)



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**; multivariable logistic regression analyses controlling for age, gender, race, employment status, household income, military enlistment status, branch of service, number of years in military]

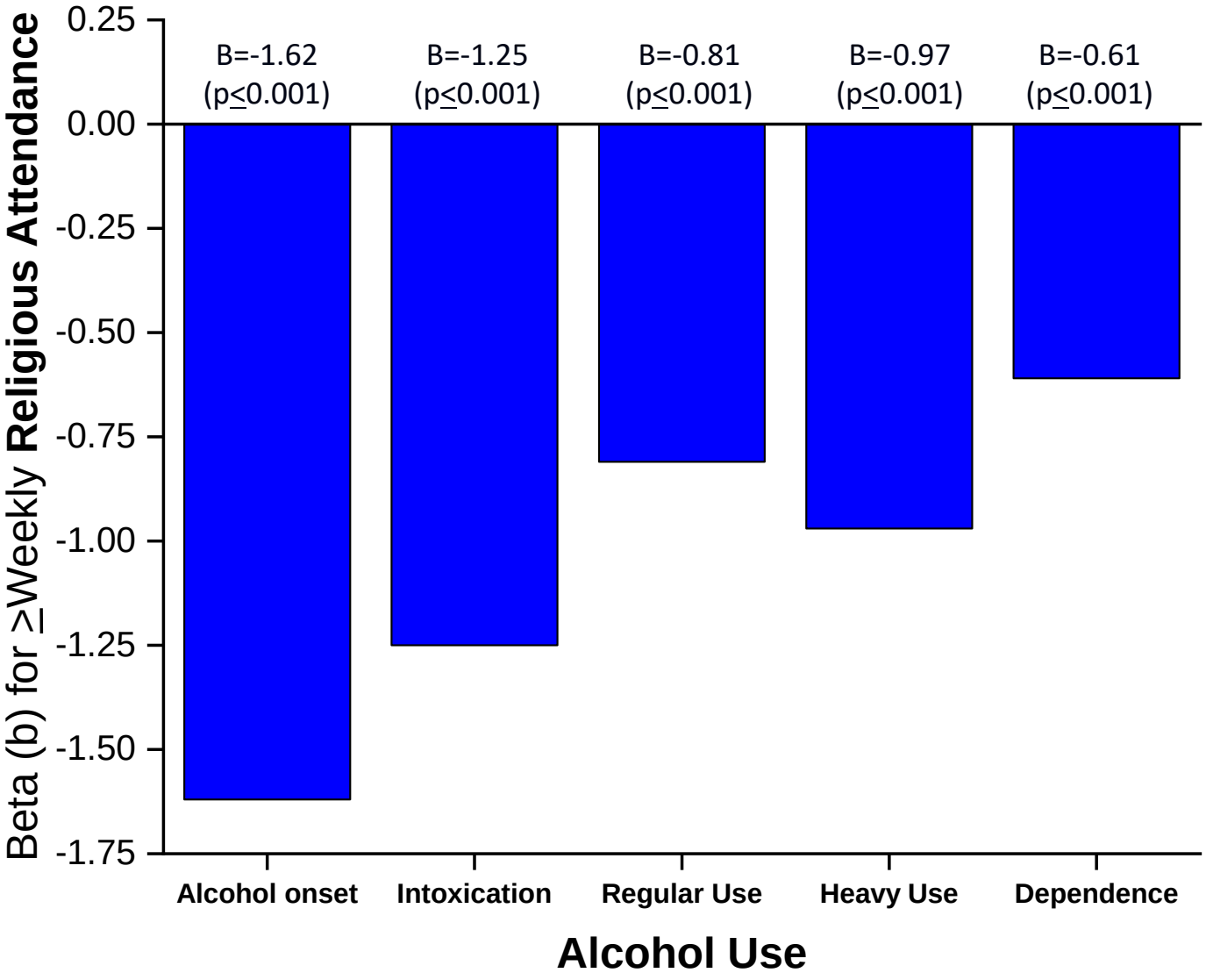
Alcohol Use/Abuse/Dependence

(systematic review)

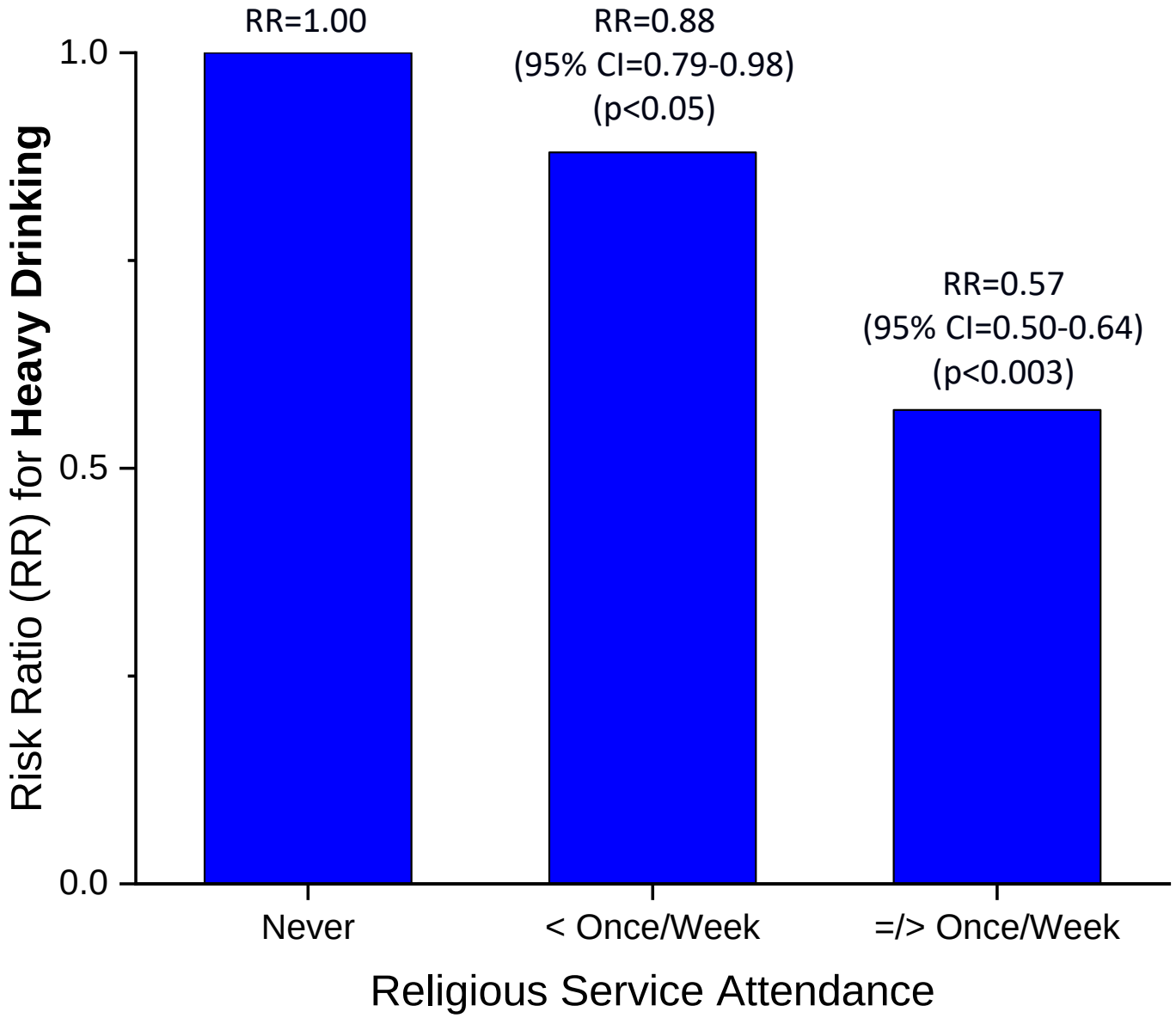
Religious involvement is related to:

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

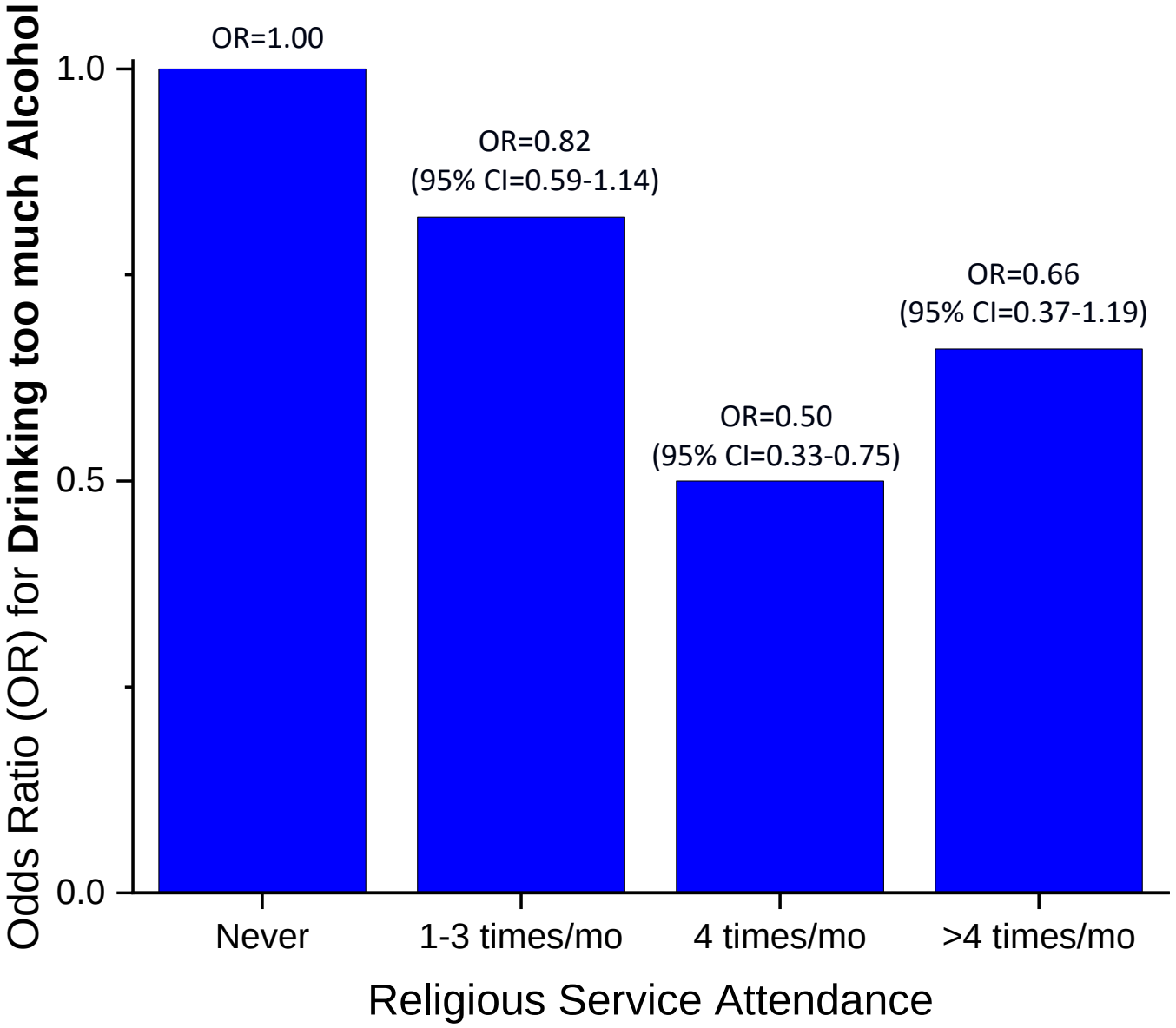
[90% of best designed studies]



Haber et al. (2012). Alcohol milestones, risk factors, and religion/spirituality in young adult women. Journal of Studies on Alcohol and Drugs, *73*(1), 34-43. [**Cross-sectional study of 4,002 adolescents/young adults (ages 16-22 years) in Missouri**; logistic regression analyses controlled for fathers and mothers education, income, age, presence of ADHD, ODD, CD, MDD, trauma, parenting inconsistencies, parent-child arguments, parental divorce/separation, existential well-being, and several religious variables]



Chen et al (2020). International Journal of Epidemiology 49(6), 2030-2040
[*Nurses Health Study* II: **7-12 year prospective study of 68,300 nurses** (ave. age 47) followed from 2001 to 2008-2013,p value Bonferroni corrected for examining multiple outcomes]



Pawlikowski et al.(2019). European Journal of Public Health 29(6), 1177-1183 [*Polish Social Diagnosis Study*: **4-year prospective study of 6,488 adults** (ave. age 49) followed from 2011 to 2015

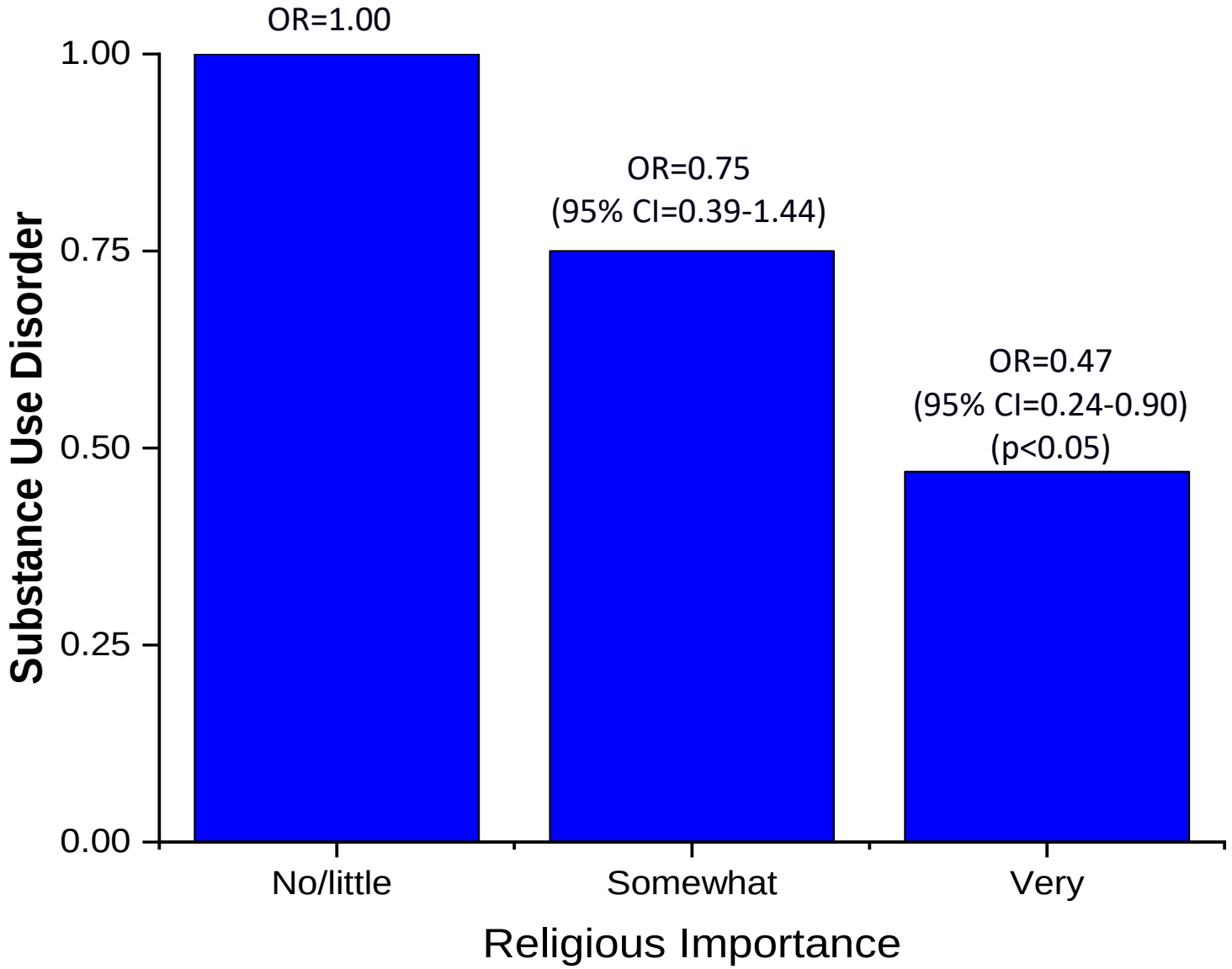
Illicit Drug Use
(systematic review)

Religious involvement is related to:

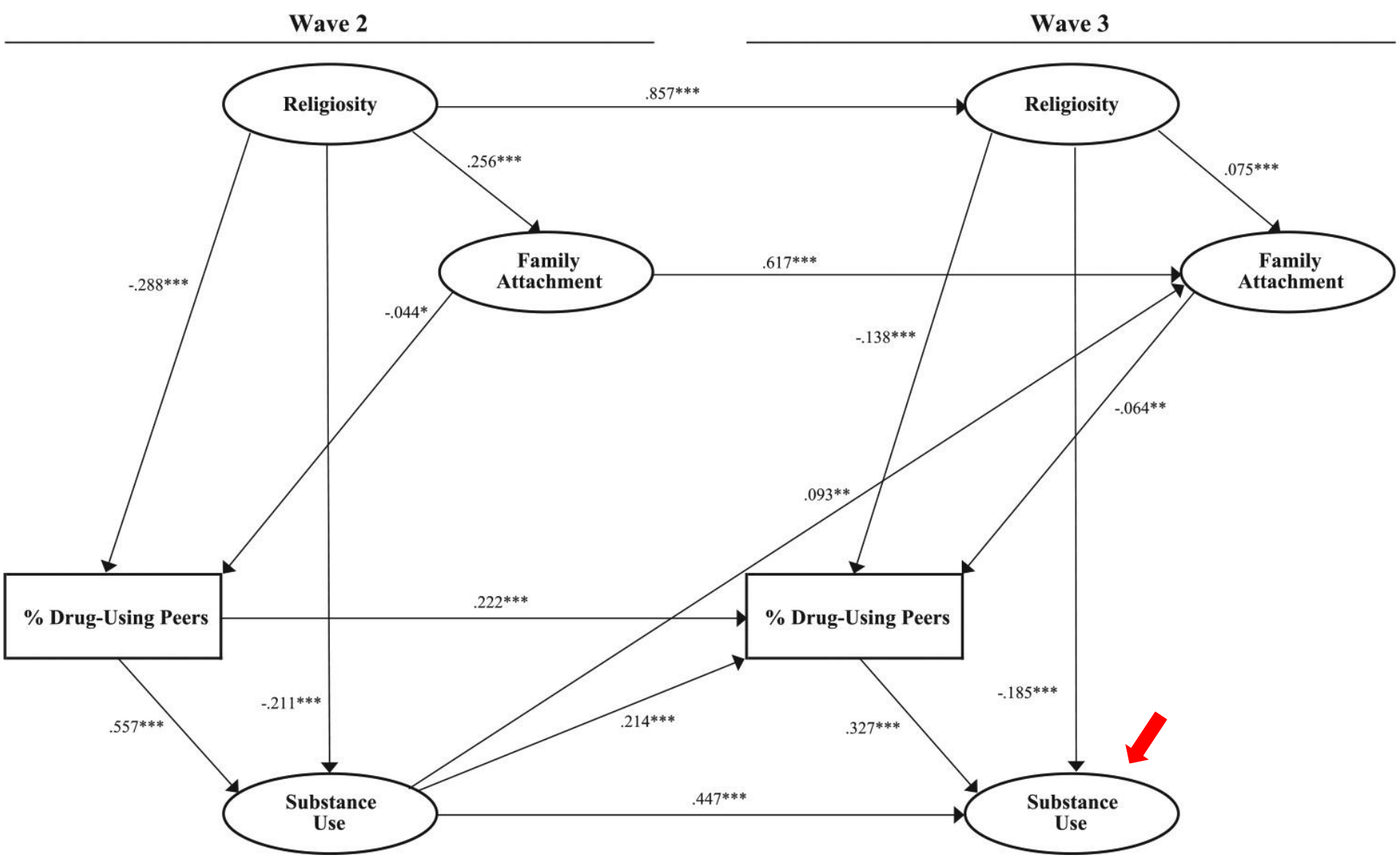
Less drug use / abuse / dependence
155 of 185 studies (84%)

[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,



Thomson Jr, R. A. (2016). More than friends and family? Estimating the direct and indirect effects of religiosity on substance use in emerging adulthood. Journal of Drug Issues, *46*(4), 326-346. [**2-3 year prospective study of a U.S. nationally random sample of 2,185 teenagers ages 13-19** using longitudinal SEM to analyze the data,; religiosity at Wave 2 (2005) had a significant indirect effect on Substance Use at Wave 3 (2007-2008) through Wave 3 Religiosity ($z=-6.5$, $p<0.0001$) and Wave 2 Substance Use ($z=-6.5$, $p<0.0001$) in this; substance use=alcohol, cigarettes, marijuana; religiosity=importance, prayer, Bible reading, attending religious services, attending religious education classes]

Well-being and Happiness

(highly correlated with psychological resilience)

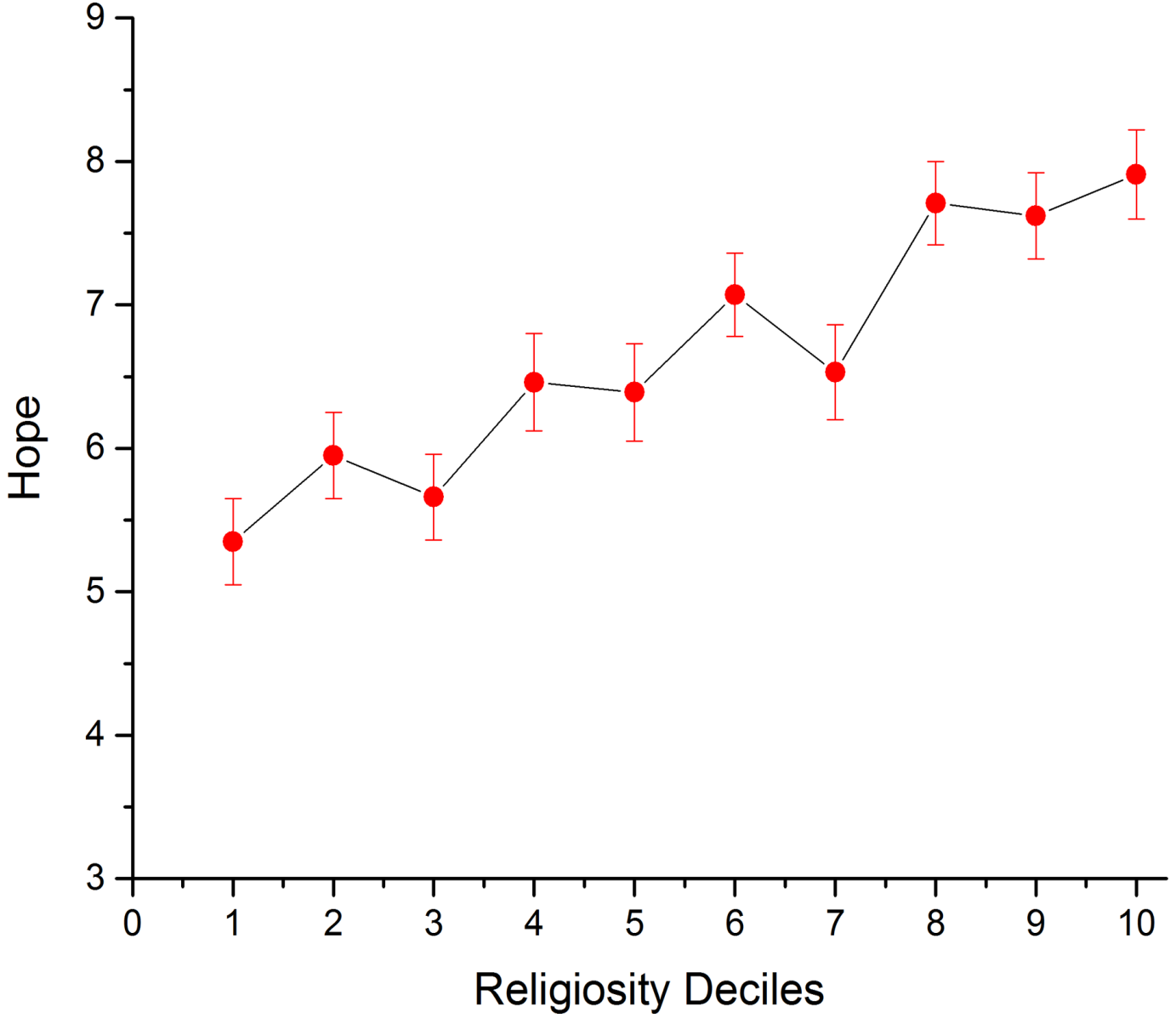
Religious involvement is related to:

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

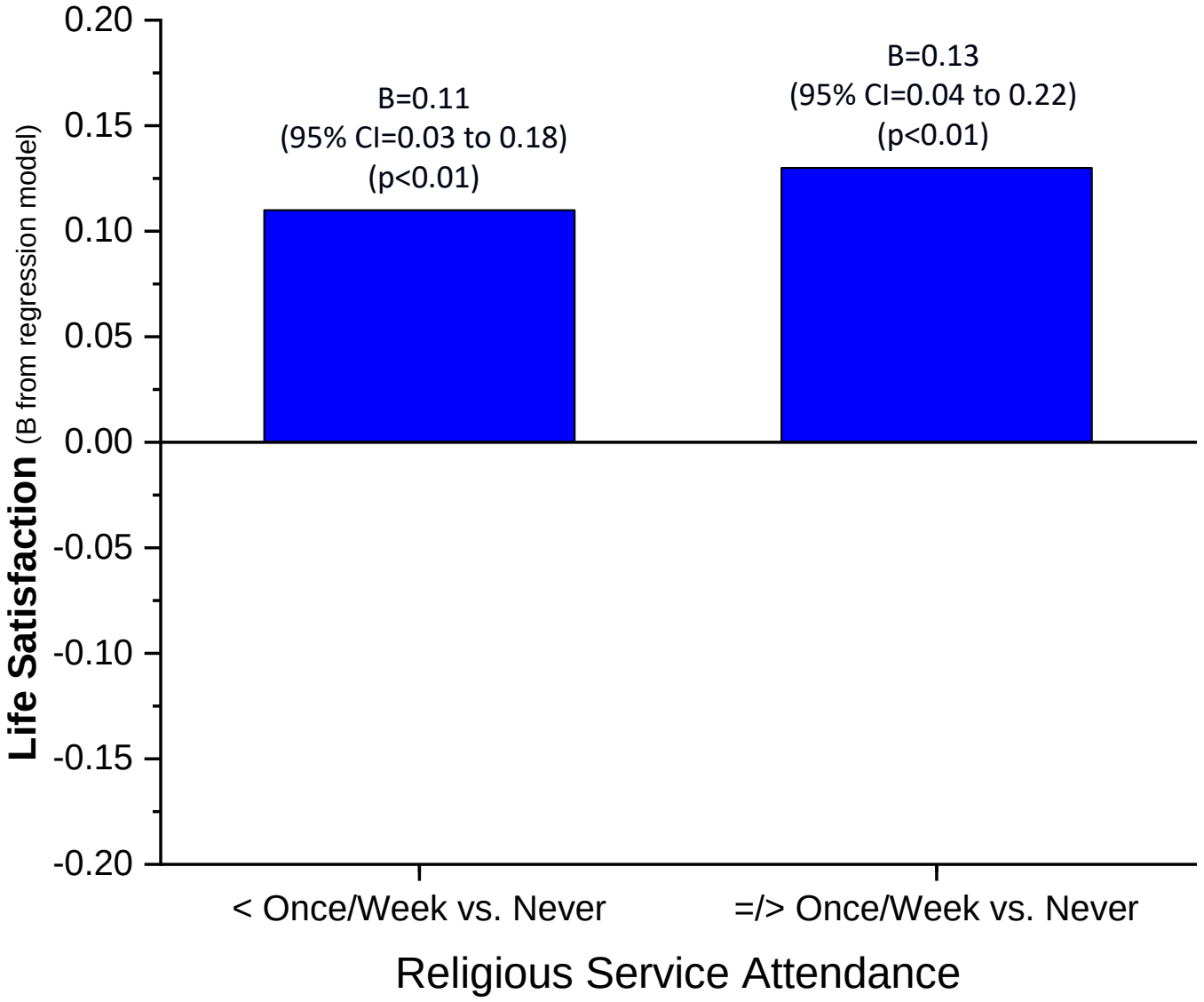
[82% of best quality studies]

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

Religiosity and Hope in 590 U.S. Veterans/Active Duty Military

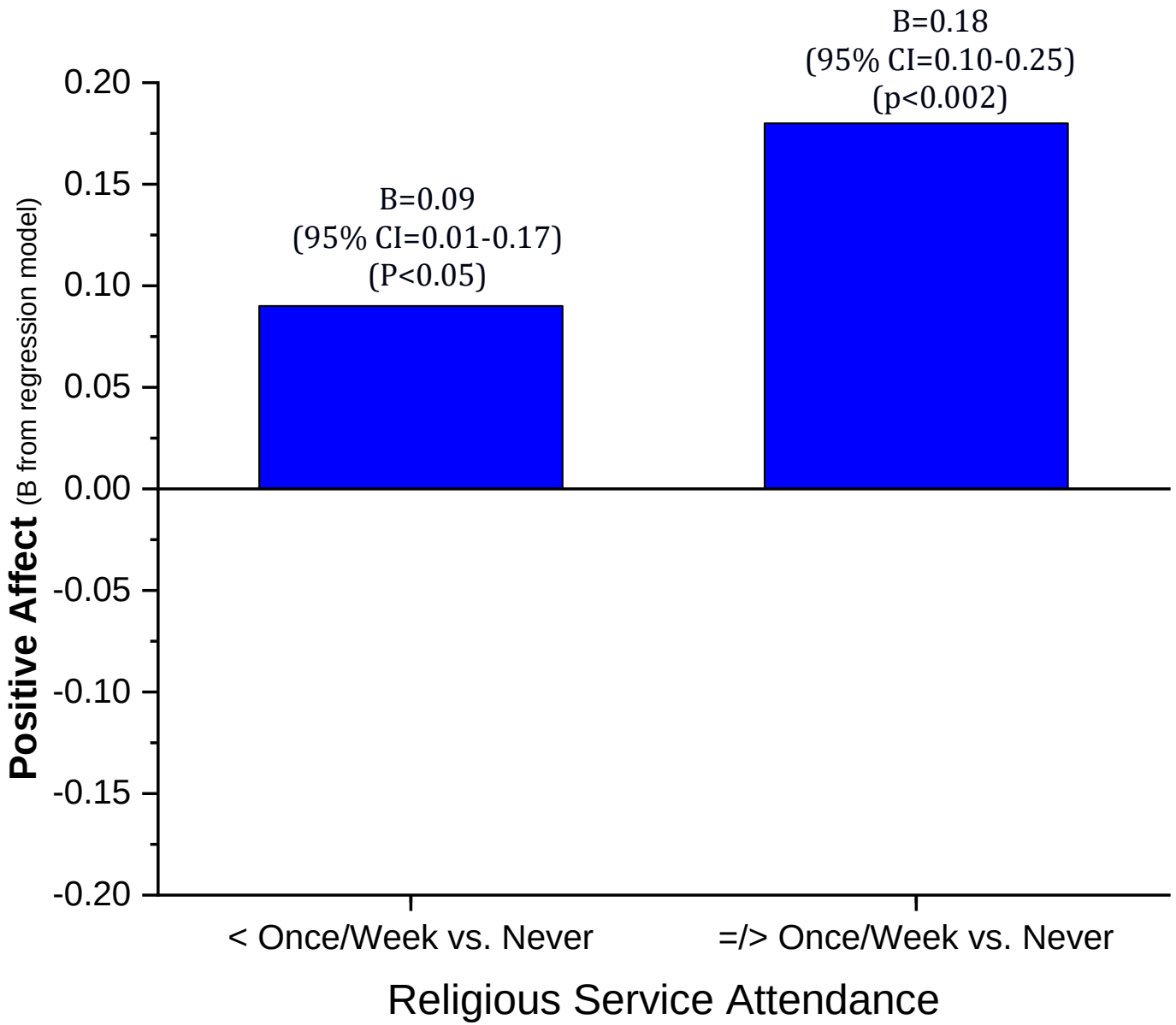


Koenig, H. G., Youssef, N. A., Smothers, Z., Oliver, J. P., Boucher, N. A., Ames, D., ... & Haynes, K. (2020). Hope, religiosity, and mental health in US veterans and active duty military with PTSD symptoms. Military Medicine, *185*(1-2), 97-104.



Chen et al (2020). International Journal of Epidemiology 49(6), 2030-2040

[*Growing Up Today Study*: 3-5 year prospective study of 9,862 adults (ave. age 23) followed from 2007 to 2010-2013, B=standardized ES, Bonferroni corrected]



Chen, Y., & VanderWeele, T.J. (2018). Associations of religious upbringing with subsequent health and well-being from adolescence to young adulthood: an outcome-wide analysis. American Journal of Epidemiology, *187*(11), 2355-2364 (average age 15, followed from 1999 to 2007-2013, n=5,681-7,458; outcome-wide analysis, Bonferroni corrected, B=standardized ES)

Meaning, Purpose, Hope, Optimism

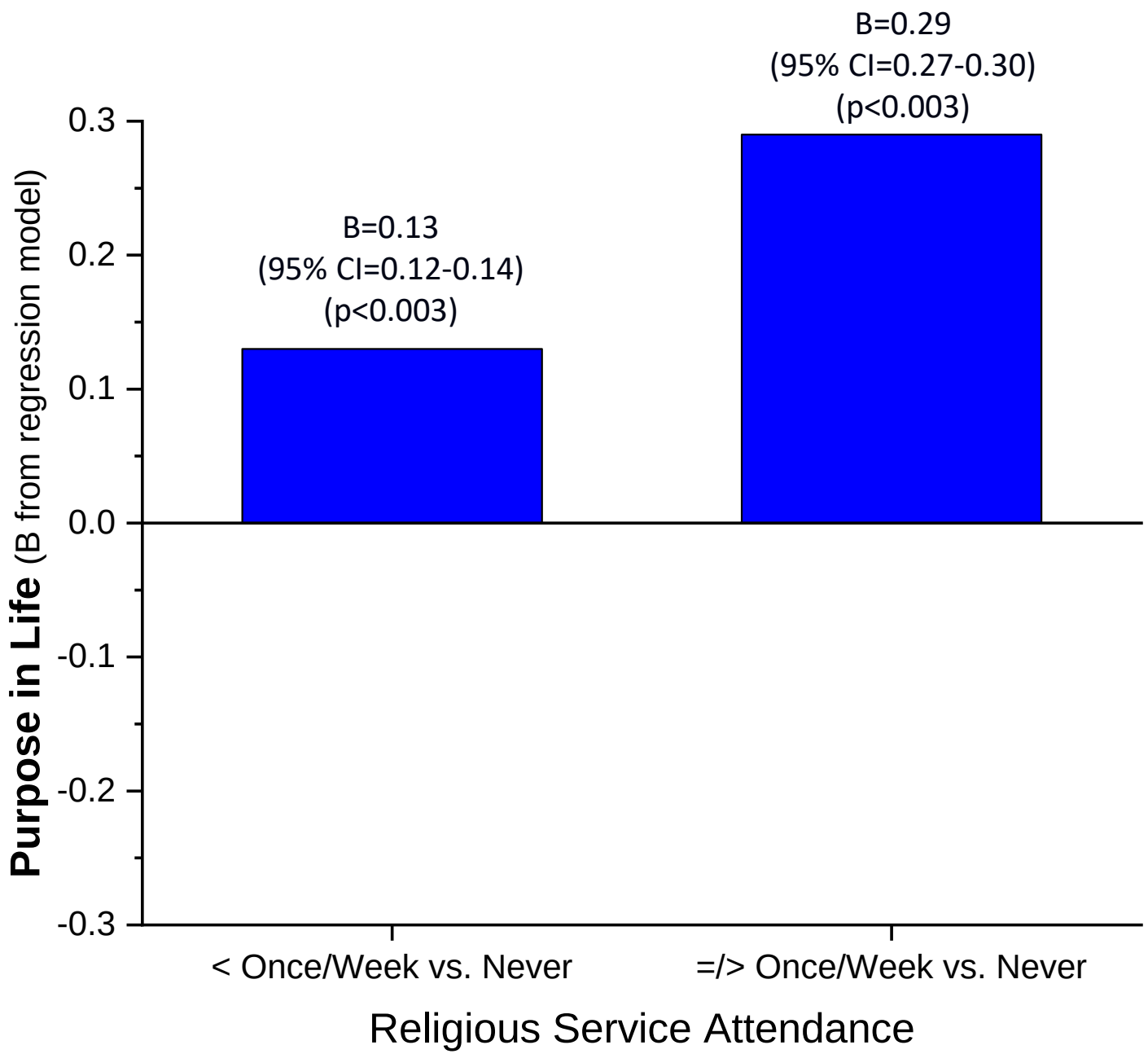
(the driving force to motivate action and recovery)

Religious involvement is related to:

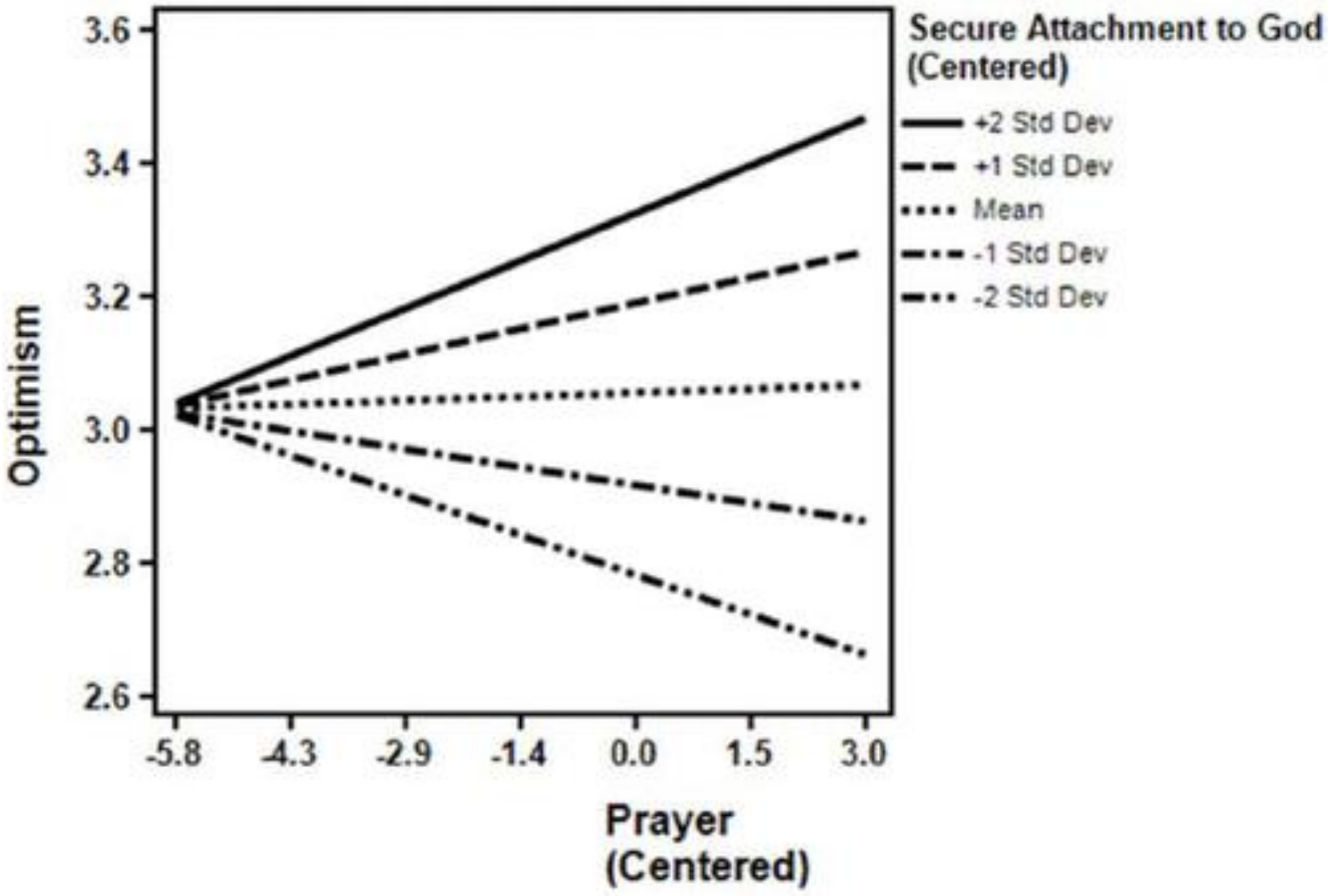
Greater meaning and purpose
42 of 45 studies (93%)
[100% of best]

Greater hope
29 of 40 studies (73%)

Great optimism
26 of 32 studies (81%)



Chen et al (2020). International Journal of Epidemiology 49(6), 2030-2040 [**7-12 year prospective study** of 68,300 nurses (ave. age 47) followed from 2001 to 2008-2013, B=standardized ES, Bonferroni corrected

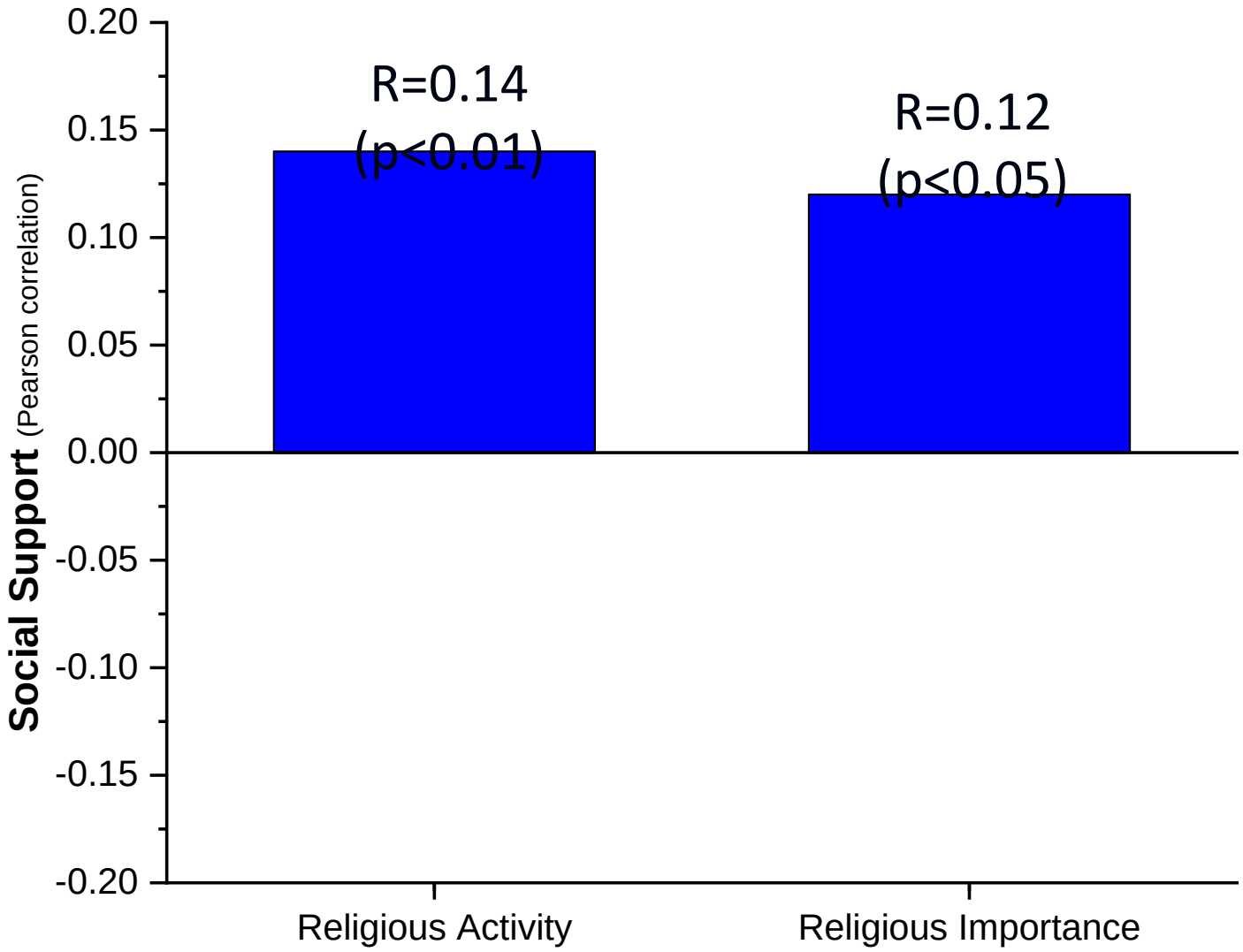

Secure Attachment to God (Centered)
+2 Std Dev
+1 Std Dev
Mean
-1 Std Dev
-2 Std Dev
Optimism
3.6
3.4
3.2
3.0
2.8
2.6
-5.8
-4.3
-2.9
-1.4
0.0
1.5
3.0
Prayer (Centered)

Social Support

(family back home, team member)

Religious involvement is related to:

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

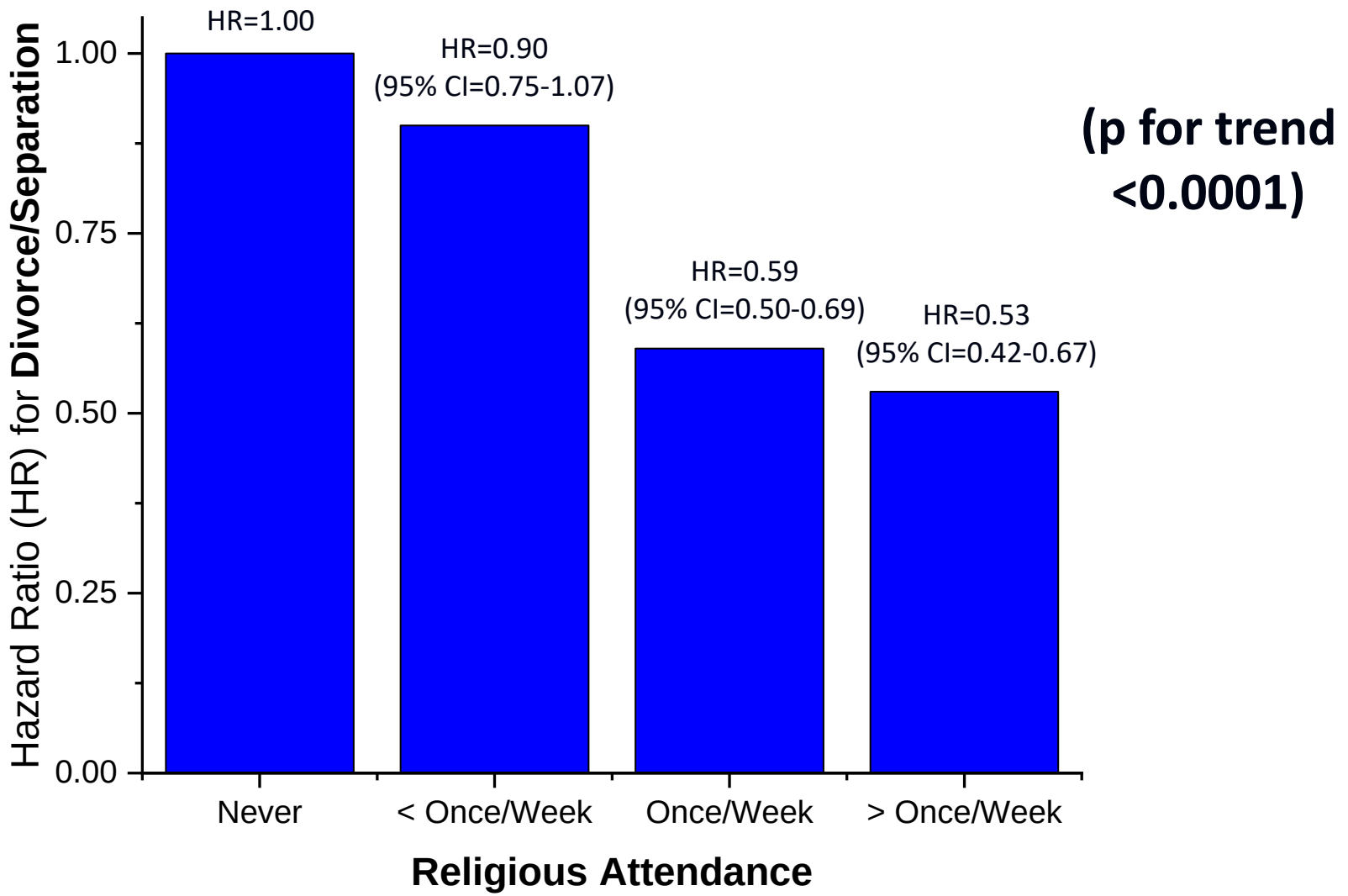


Milevsky, A. (2017). Religiosity and social support: A mediational model of adjustment in emerging adults. Mental Health, Religion & Culture, *20*(5), 502-512. [Cross-sectional study of 432 young adults ages 17-22 years in Pennsylvania; religious activity = frequency of attending religious services, religious classes, Bible study groups, or church activities; religious importance = importance of religion in life]

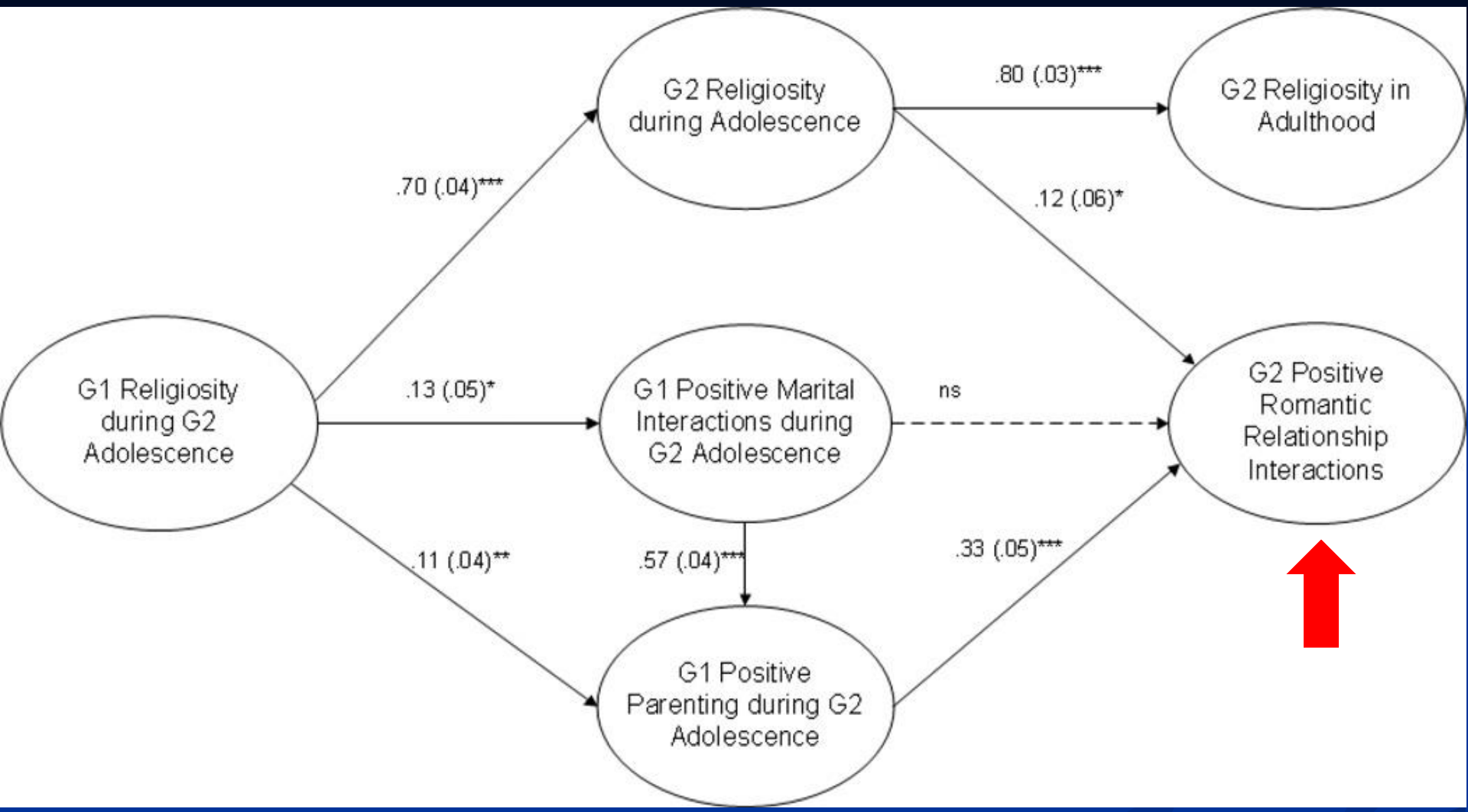
Marital Stability and Satisfaction

Religious involvement is related to:

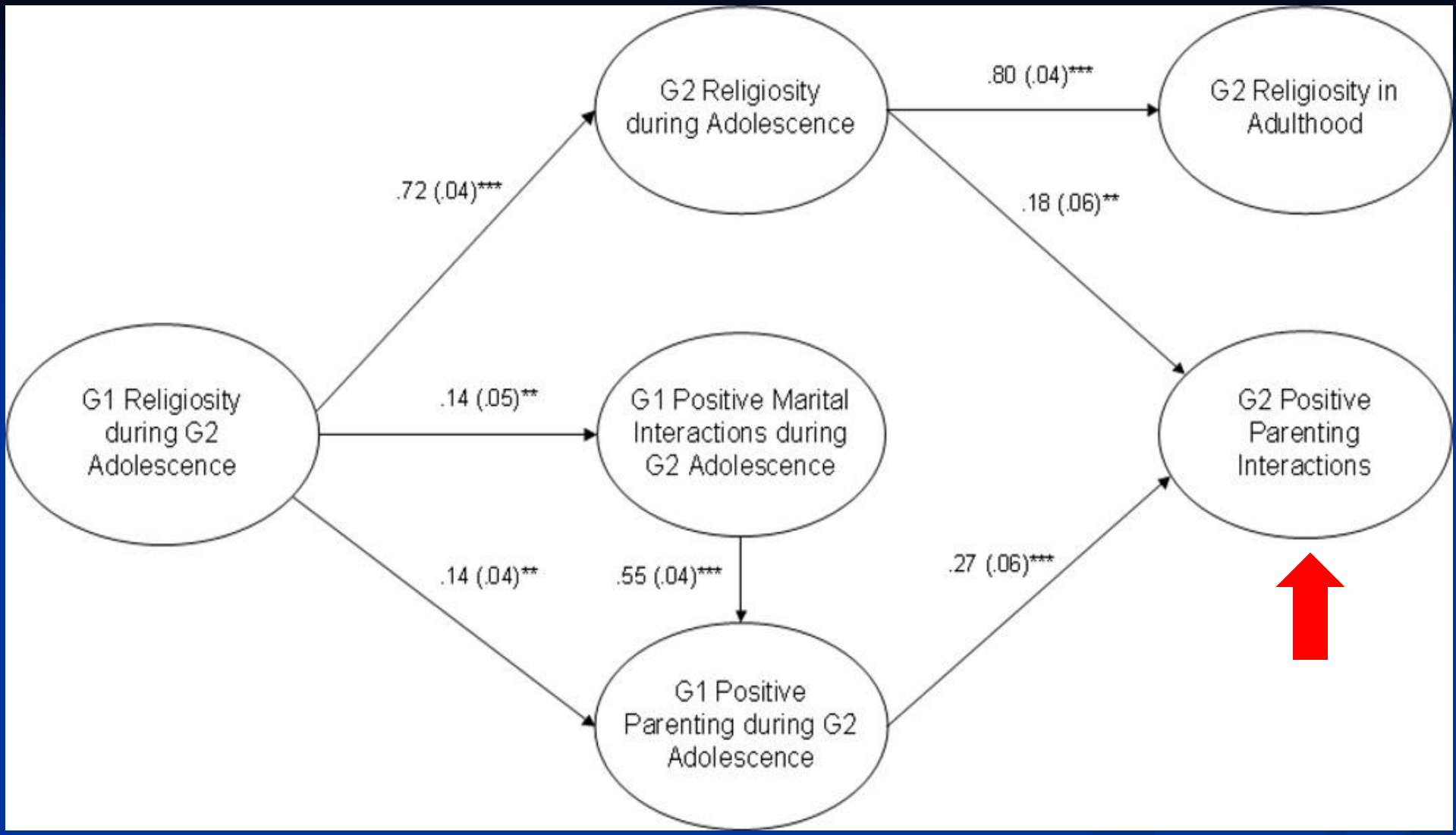
Great marital stability - less divorce, greater satisfaction, less spousal abuse, less cheating on spouse, more likely to have intact family with two parents in home (68 of 79 studies or 86% of all quantitative studies)



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 prospective study of 66,444 initially married women from 1996-2010**; Cox proportional hazard model and multivariate logistic regression used to control for 24 sociodemographic and health covariates, including 1992 religious attendance]



Spilman et al. (2013). Incorporating religiosity into a developmental model of positive family functioning across generations. Developmental Psychology, *49*(4), 762. [**20-year prospective study** [Iowa]; structural equation model predicting G2 romantic relationship interactions, controlling for G1 gender, G2 gender, G1 per capita income, G1 education, G1 religious affiliation, and G2 agreeableness and conscientiousness; standardized regression coefficients (standard errors); N = 446; **p <0.05, **p <0.01, ***p <0.001*]



Spilman et al. (2013). Incorporating religiosity into a developmental model of positive family functioning across generations. Developmental Psychology, *49*(4), 762. [**20-year prospective study** (Iowa); structural equation model predicting G2 romantic relationship interactions, controlling for G1 gender, G2 gender, G1 per capita income, G1 education, G1 religious affiliation, and G2 agreeableness and conscientiousness; standardized regression coefficients (SE); N = 279; **p <0.05, **p <0.01, ***p <0.001*]

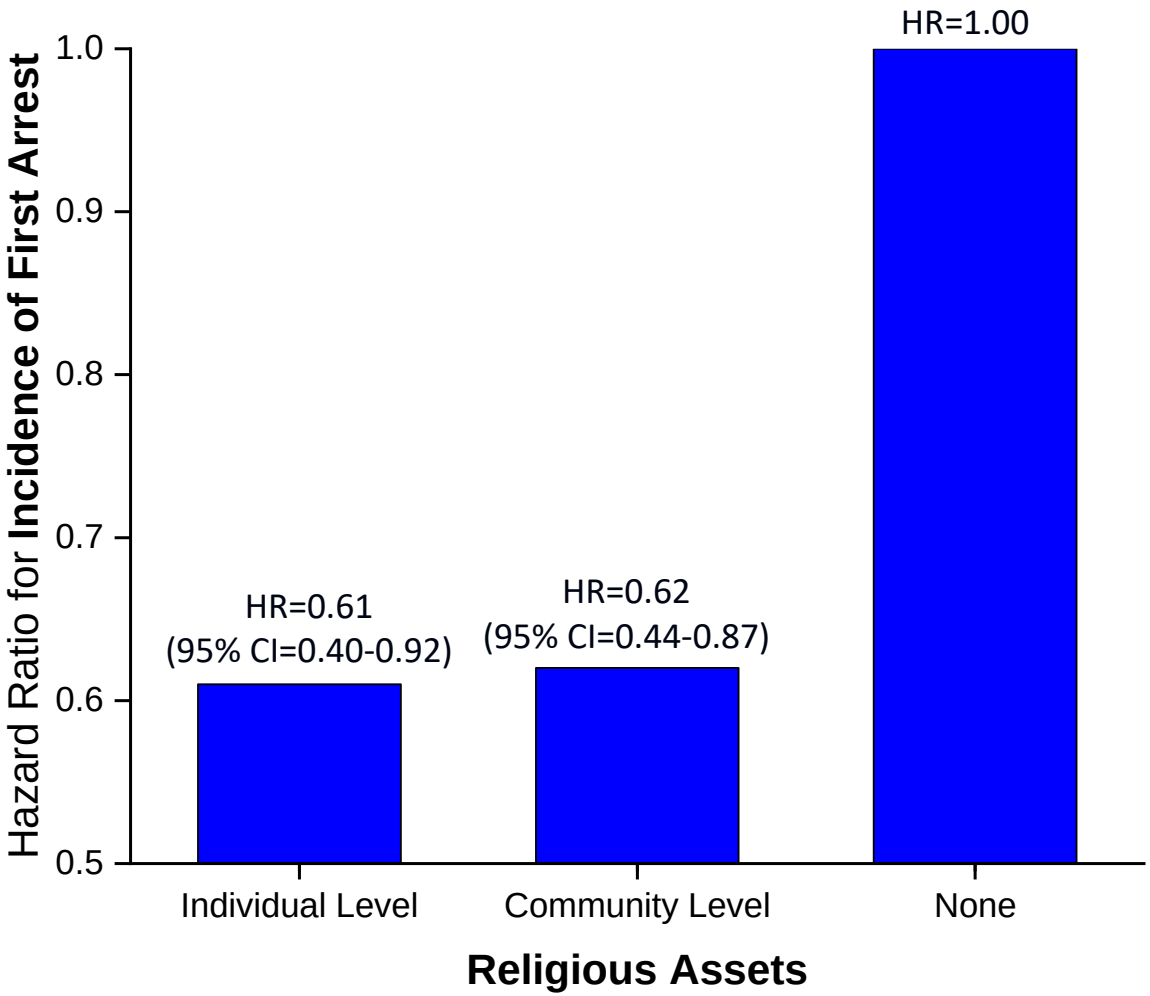
Delinquency and Crime

(systematic review)

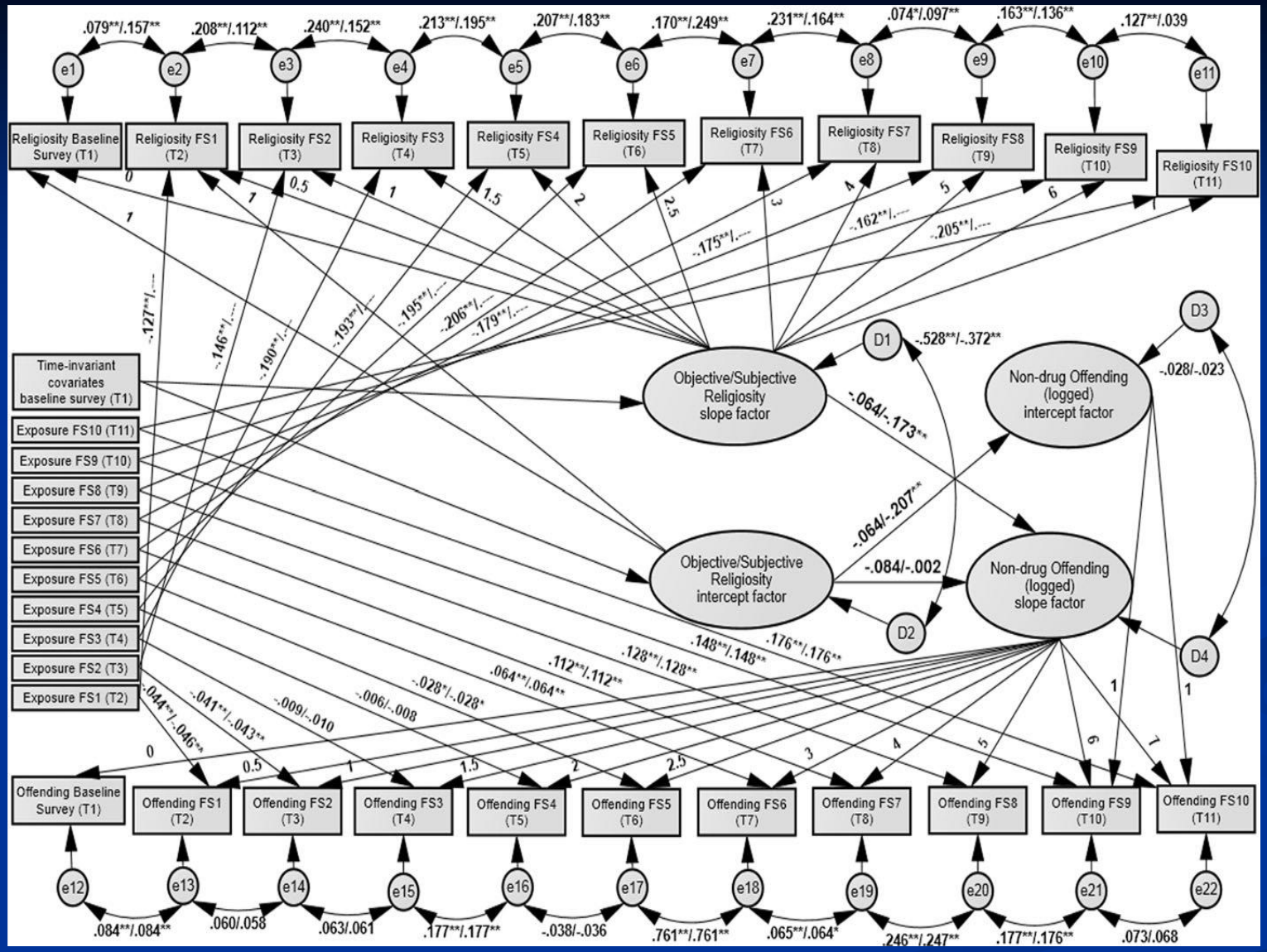
At least 104 quantitative peer-reviewed studies have now been published that have examined the spirituality-delinquency/crime relationship. Of those, 82 (79%) reported inverse relationships between spiritual involvement and delinquency or crime.

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

Of the studies published during the past 10 years that have examined relationships between spiritual involvement and school performance (GPA or persistence to graduation), all 11 (100%) indicated that spiritual students performed significantly better.



Lensch et al. (2019). A longitudinal study of the protective influence of youth assets on juvenile arrest. Journal of Public Health, pp 1-7, https://doi.org/10.1093/pubmed/fdz119 [**5-year prospective study of stratified systemic sample of 1,111 hig risk youth ages 12-17** from a Midwestern city in Oklahoma; individual religiosity="participation in religiosity" and community religiosity="use of time for religion"; Cox proportional hazards regression used to examine incidence of first arrest, controllin for gender, age, race, income, family structure, parental neighborhood support, parental informal social control, parental psychological sense of community, and parental neighborhood concerns, along with community involvement, positive peer role models, non-parental adult role models, school connectedness, and use of time in groups/sports]



Juvenile offenders who increasingly attended religious activities, perceived religion to be important and helpful in their lives, and experienced God's care and love and a close personal relationship to God, increased their crime/marijuana use over time more slowly …juvenile offenders who increased in religiosity were likely to decelerate or desist from crime and drug use because they were likely to increase in impulse control and suppression of aggression and decrease in moral disengagement and legal cynicism.

Jang, S. J. (2019). Religiosity, crime, and drug use among juvenile offenders: A latent growth modeling approach. Journal of Quantitative Criminology, *35*(1), 27-60 (**7-yr prospective study of 1,289 juvenile offenders ages 14-17**; multivariate linear latent growth model used to control for covariates)

Spiritual But Not Religious

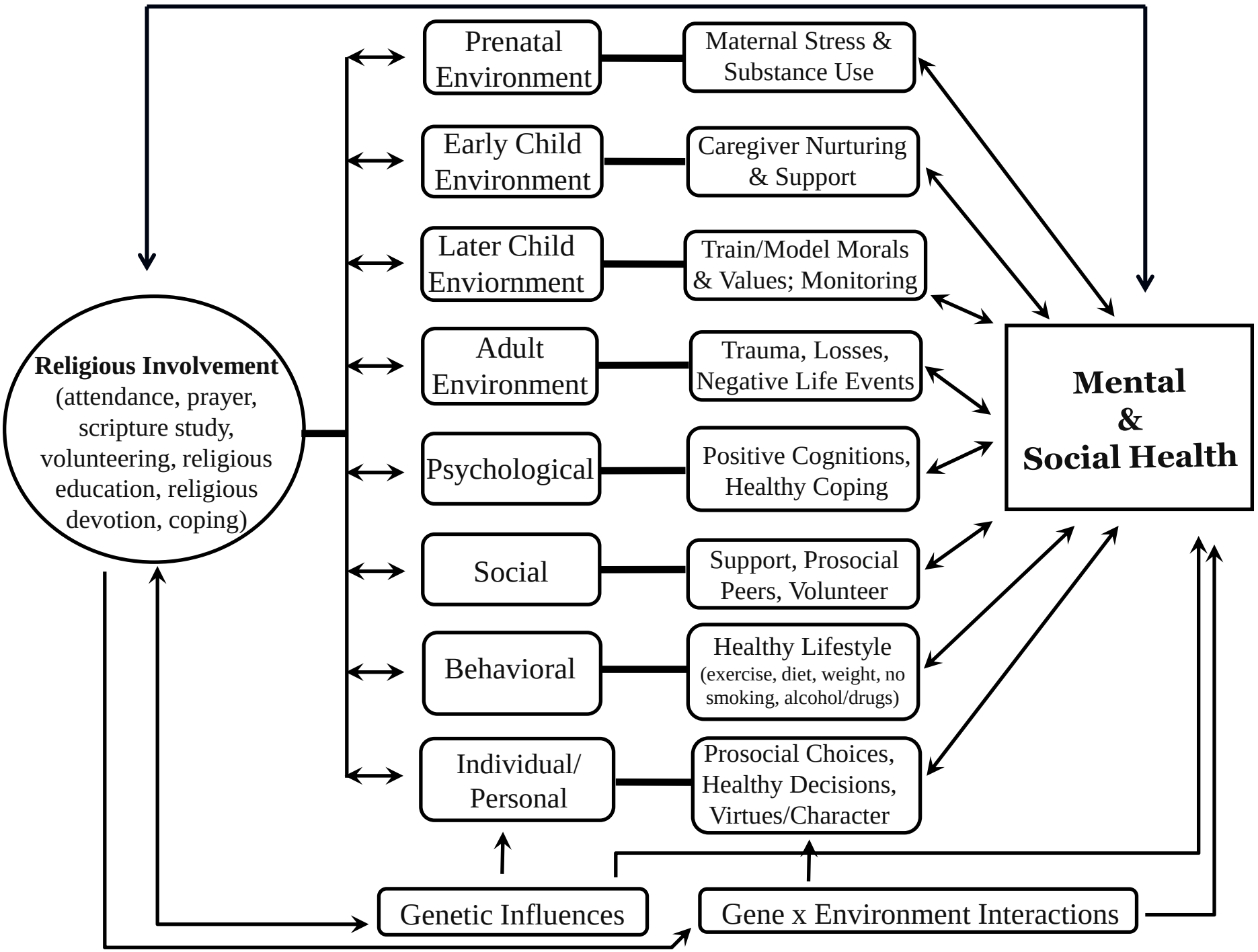
Followed 8,318 medical outpatients in United Kingdom, Spain, Slovenia, Estonia, The Netherlands, Portugal and Chile. AIM: determine if baseline spiritual or religious (S/R) beliefs predict onset of MDD during 12-mo f/u. S/R beliefs measured by (1) whether understanding of life is primarily religious, spiritual, or neither, and (2) if S/R, how strongly held. CIDI used to make the diagnosis of MDD at 6 and 12 mo follow-ups. Controlled for: gender, age, education, marital status, employment status, ethnicity, and history of depression. SLE in past 6 mo and social support examined as mediators. **Results:** Adjusting for confounders and mediators, those with **a spiritual view (but not religious)** were more likely to experience MDD over the next 12 months compared to those with a secular view (OR=1.32, 95% CI 1.02-1.70). When analyses stratified by country, effect especially significant in UK (OR 2.68, 95% CI 1.52-4.71, $p<0.01$).

Citation: Leurent B et al (2013). Spiritual and religious beliefs as risk factors for the onset of major depression: An international cohort study. Psychological Medicine, 43(10):2109-2120

Spiritual But Not Religious

King et al. investigated associations between a spiritual or religious understanding of life and psychiatric symptoms in 7,403 people in England. They found religious people were similar to those who were neither religious nor spiritual with regard to the prevalence of mental disorders, except that those who were religious were less likely to have ever used drugs or to be a hazardous drinker. On the other hand, spiritual people (spiritual but not religious) were more likely than those who were neither religious nor spiritual to have (a) ever used or to be dependent on drugs, (b) abnormal eating attitudes, and (c) generalized anxiety disorder, any phobia or any neurotic disorder.

King M, Marston L, McManus S, Brugha T, Meltzer H, Bebbington P. Religion, spirituality and mental health: results from a national study of English households. British Journal of Psychiatry. 2013; 202(1):68-73.


Religious Involvement
(attendance, prayer, scripture study, volunteering, religious education, religious devotion, coping)
Prenatal Environment
Maternal Stress & Substance Use
Early Child Environment
Caregiver Nurturing & Support
Later Child Enviornment
Train/Model Morals & Values; Monitoring
Adult Environment
Trauma, Losses, Negative Life Events
Psychological
Positive Cognitions, Healthy Coping
Social
Support, Prosocial Peers, Volunteer
Behavioral
Healthy Lifestyle
(exercise, diet, weight, no smoking, alcohol/drugs)
Individual/ Personal
Prosocial Choices, Healthy Decisions, Virtues/Character
Mental & Social Health
Genetic Influences
Gene x Environment Interactions

Impact of Mental Health on Religious Involvement

Depends on type of mental health problem and type of religious involvement:

- Depression may increase or decrease religious involvement (prayer may increase, religious attendance may decrease)

- Anxiety usually increases religious involvement (except perhaps social anxiety disorder or some cases of PTSD)

- Severe mental disorders (psychotic disorders, severe personality disorders) often reduce religious attendance, although may increase prayer, if distressing to the individual

Applications in Mental Health Care

- Health professionals should take a spiritual history -- talk with patients about these issues
- Respect, value, support beliefs and practices of **the patient**
- Identify the spiritual needs of the patient
- Ensure that someone meets patients' spiritual needs (pastoral care)
- Pray with patients if **patient requests**
- Work with the faith community, if patient consents

From: Spirituality in Patient Care (Templeton Foundation Press, 2013)

The Spiritual History[1]

1. Do your beliefs provide comfort?

2. Are your beliefs a source of stress?

3. Do you have beliefs that might influence your medical decisions?

4. Are you a member of a faith community, such as a church, synagogue, or mosque? If yes, is it supportive?

5. Do you have any other spiritual concerns that you'd like someone to address?

[1]**Adapted from Koenig HG (2002). Journal of the American Medical Association (JAMA) 288 (4): 487-493**

Conclusions from Clinical Applications

1. The clinical applications are vast in terms of provision of mental health and pastoral care services

2. Encourage behavioral health providers and chaplains to take a detailed spiritual history on all of those who come for help

3. Be alert for signs of Moral Injury, and refer such individuals to those who can help them work through the psychological and the religious issues involved

4. Support the religious beliefs/practices of those who are religious, and provide them with the resources necessary to practice their faith

5. For those who are not religious, support the beliefs/practices that provide them with meaning, purpose, optimism, and other prosocial and team-building attitudes that promote psychological resilience in high stress situations

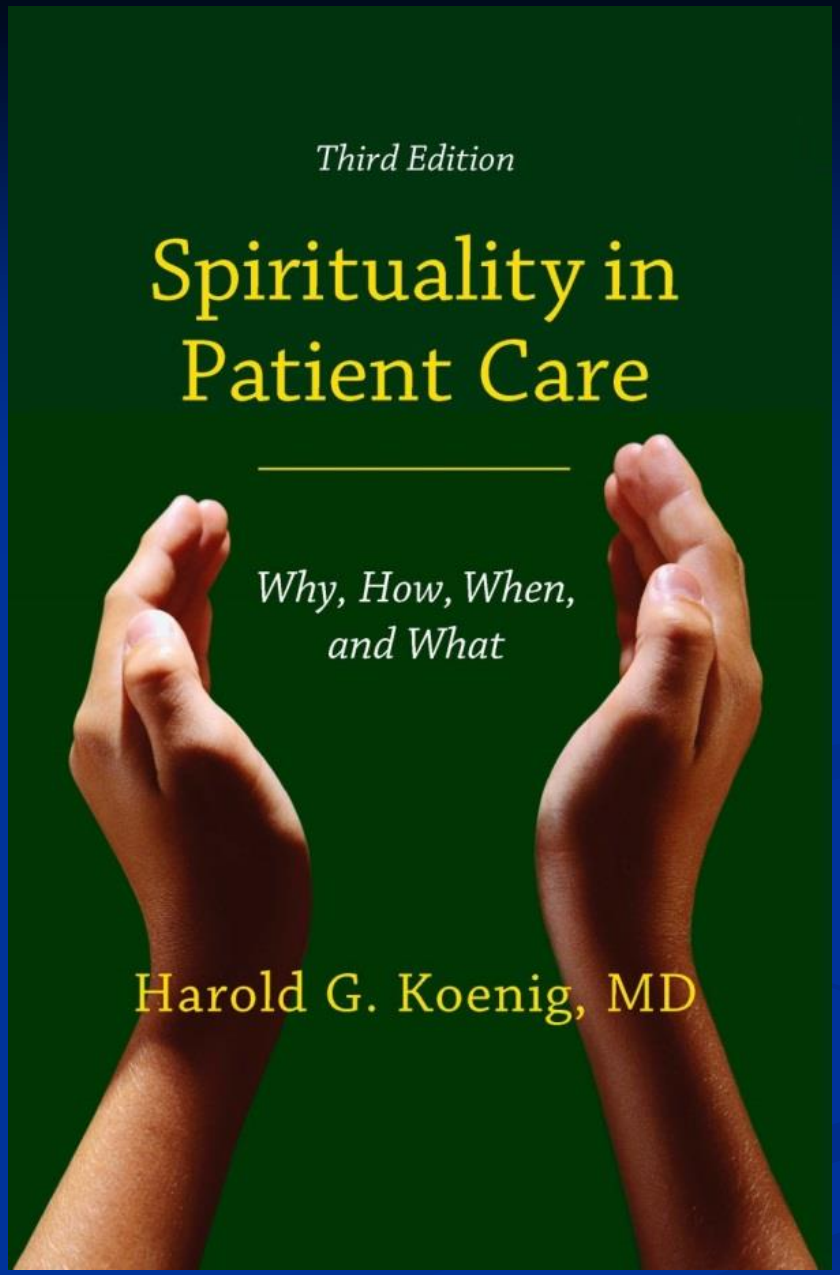
Further Resources

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/


Third Edition
Spirituality in Patient Care
Why, How, When, and What
Harold G. Koenig, MD

Spirituality & Health Research

Methods
Measurement
Statistics
and Resources

Harold G. Koenig, MD

Summer Research Workshop

August 15-19, 2022

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

www.spiritualityandhealth.duke.edu

health.duke.edu

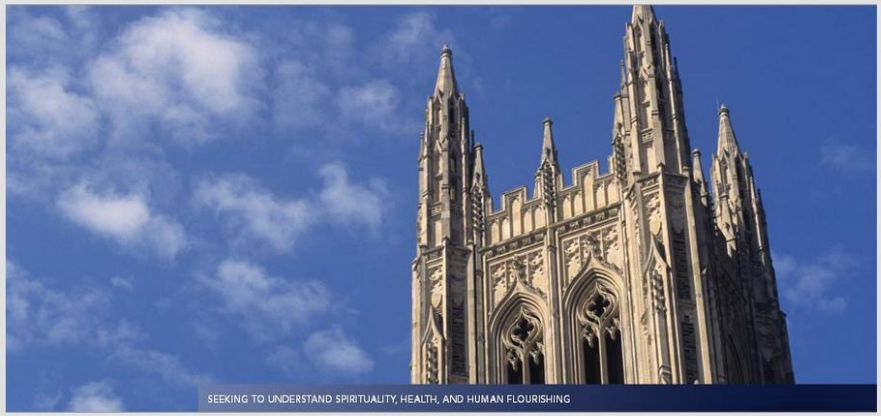
CENTER FOR SPIRITUALITY, THEOLOGY AND HEALTH
DUKE UNIVERSITY

Duke University | Duke Medicine | DukeHealth

Home | Scholars | Education | Research | Publications | Opinion | Religious CBT | CME Videos | About Us | Contact | News

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

Questions and Discussion