Impact of Spiritual and Religious Coping on PTSD

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Abstract

Religion and spirituality can offer a powerful narrative and transcendent meaning in the face of trauma. When an individual uses religious beliefs or practices as a way of adapting to physical, psychological, and social challenges, this is termed religious or spiritual coping. Research on religious and spiritual coping suggests that purpose and meaning in life are associated with lower levels of PTSD symptoms and higher levels of positive emotions, but when an individual's belief system is unable to make sense of the trauma or assist the individual in finding an integrated narrative, then the trauma can trigger a newfound questions about the existence of God and meaning in life. Spiritual struggle can result in greater levels of PTSD symptoms and complications on the path to recovery. This chapter will

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C.R. Martin et al. (eds.), *Comprehensive Guide to Post-Traumatic Stress Disorders*,
DOI 10.1007/978-3-319-08359-9_49

describe what religious and spiritual coping is, how it is associated with PTSD, and how clinicians can ethically and effectively integrate religious and spiritual dimensions into clinical work.

List of Abbreviations

MRP	Mantram repetition program
PRACTICE	Psychoeducation and parental treatment, relaxation, affective expression and modulation, cognitive coping skills, trauma narrative and cognitive processing of the trauma, in vivo desensitization to trauma reminders, conjoint parent–child sessions, and enhancing safety and future development
PTSD	Post-traumatic stress disorder
SHAT	Spiritual-hypnosis assisted therapy
ST	Spirituality and trauma
TF-CBT	Trauma-focused cognitive behavior therapy

Introduction

The way in which a person processes a stressor is critical in determining the experience of trauma and PTSD symptoms. When the trauma can be synthesized into an integrated and meaningful narrative, PTSD symptoms are less likely to emerge. Religion and spirituality can offer an influential narrative and transcendent meaning in the face of trauma. Research on PTSD and religious and spiritual coping suggests that meaning in life is associated with lower levels of PTSD symptoms and higher levels of positive emotions, whereas spiritual struggle is related to higher levels of PTSD symptoms and negative emotions (Ano and Vasconcelles 2005). Therefore, these dimensions of life deserve consideration in the treatment of PTSD.

Before beginning a discussion on religion, spirituality, and coping with PTSD, religion and spirituality must be defined. Unfortunately, this is a difficult task, due to the multidimensional and dynamic nature of religion and spirituality. Throughout history, religion and spirituality have been defined as overlapping, distinct, and/or related, depending on the historical and social context. Today, many view spirituality as an individualistic construct and religion as a more traditional term, related to organized religious institutions. What's more, for many individuals, religion and spirituality are polarized, with religion depicted as bad and spirituality as good. Pew research suggests that more Americans than ever are defining themselves as "spiritual, but not religious" (2008), a trend that may mirror an antiauthoritarian wave in the USA.

Pargament (2013) offers operational definitions of religion and spirituality that encompass both traditional and modern meanings. He writes that spirituality is the "search for the Sacred," with the Sacred being that which is divine, transcendent, and boundless. He also writes that spirituality is often experienced as a journey, with the Sacred being the destination. Therefore, many paths can be taken to search for the

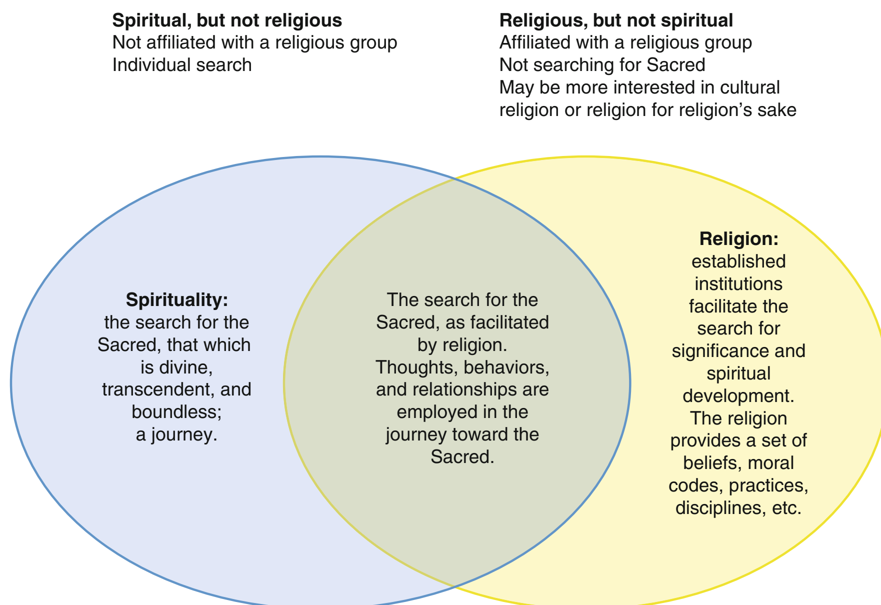

Fig. 1 Contemporary definitions of religion and spirituality

Sacred, including daily meditation practices, social interactions, or vocational activities. This definition does not specify the particulars of the Sacred, the house of worship, or practices. In contrast, religion can be defined as "the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality" (Pargament 2013). Therefore, religious institutions encourage their members to participate in a set of spiritual practices, disciplines, and moral codes designed to strengthen spirituality and character. In both religion and spirituality, an individual's whole being can be directed toward the Sacred. Thoughts, emotions, behaviors, and relationships focus on the Sacred and spirituality is developed (Fig. 1).

Coping is another multidimensional process, engaging an individual's thoughts, emotions, behaviors, and relationships to deal with difficulties of life. Religious and spiritual coping, therefore, is using religious and spiritual means to deal with stress. This may involve praying to God for support or healing, reading inspirational materials, or meeting with members of one's faith community. Koenig (2013) uses the term religious/spiritual coping to mean "the use of religious beliefs or practices as a way of adapting" to physical, psychological, and social challenges. He and others note that religious or spiritual coping can have positive effects or negative, depending on how the religion and spirituality are used and how this impacts the individual in trouble.

Positive religious coping strengthens a person's spirituality and/or religion, and the person often experiences growth in a time of distress, whereas negative religious coping – sometimes referred to as spiritual struggle – is experienced as distress in a

time of difficulty. Positive religious coping can be a protective factor as beliefs are endorsed, protective behaviors are engaged, and support from faith communities is accessed (Bryant-Davis and Wong 2013). Spiritual struggle may include questioning the Sacred, feeling spiritual strain, feeling abandoned by God, frustration, or anger. Common questions include “Why me?” or “Why am I not getting better when I’ve worked so hard to make good decisions and devote myself to my faith?” Remaining stuck in this strain is an independent predictor of poor outcomes and greater mortality in medical patients (Koenig 2013; Pargament et al. 2004). In the following sections, spiritual and religious coping will be described, theoretical frameworks will be discussed, and the association with physical and psychological well-being will be explained. Finally, models will be offered for integrating spiritual and religious coping into interventions for PTSD.

Religious and Spiritual Coping

Resources are challenged, and beliefs about the world can be shaken during times of stress. Traumatic stressors, such as war, rape, torture, abuse, or natural disasters, are especially terrifying and may also prompt an individual to ask existential questions regarding life, death, and the existence of God. Trauma also prompts individuals to reach out for comfort, support, and power, which may also include calling out for help from God or looking to a spiritual community. It is not surprising that those who identify as religious are most likely to rely on their religion and spirituality in times of distress. For example, after September 11th, Meisenhelder and Marcum (2004) surveyed Presbyterian clergy and found that 92 % turned to God for support and 74 % prayed. But we also see that those who are less religious may also turn to religion and spirituality. According to a review by Gall and Guirguis-Younger (2013), the majority of family members of homicide victims, bereaved parents, and female survivors of domestic abuse report relying on God as a source of comfort and strength in the aftermath of the trauma. Religious and spiritual coping may be uniquely helpful in these circumstances, as they tap a connection with the transcendent world that may offer fresh meaning, hope, coherence, and reassurance.

Authors have suggested various models to explain how religious and spiritual coping help individuals cope with trauma, including a cognitive model, a transactional model, and a spiritual process model (Gall and Guirguis-Younger 2013). The cognitive model suggests that religion and spirituality operate as an orienting framework or schema, determining how a situation is perceived and appraised, what resources are activated, and what coping devices are used to respond to the stressor (Dull and Skokan 1995; Pargament 1997). The transactional models suggest that the impact of stress is mediated by cognitive appraisals and the selection of coping strategies. This model suggests that religious and spiritual coping is multidimensional, including personality factors, appraisals, behaviors, resources, and meaning making (Lazarus and Folkman 1984). Finally, the spiritual process models suggest that the relationship with the Sacred is developed through phases, including discovery, conservation, transformation, conservation, abandonment, and

new discovery (Pargament 1997). Within this model, the stressor is part of the spiritual development process and can encourage new growth or abandonment of faith, depending on the developmental phase. Regardless of the model used, it is clear that religious and spiritual coping offers positive benefits for both physical and psychological well-being, while spiritual struggle post-trauma can exacerbate distress and physical illness.

In order to study religious and spiritual coping, authors have asked a variety of questions and a number of scales have been developed. Some researchers ask general questions about religious beliefs and practices, such as participation in religious activities, church attendance, private prayer time, or subjective commitment to spiritual or religious beliefs. This research suggests that health is connected to religion and spirituality, but it is still unclear what factors mediate the relationship between health and religion. Furthermore, mixed results suggested that asking questions about general participation or beliefs offered a limited understanding of the complexity of the issues. For example, two similar people could attend religious services equally and have very different psychological experiences, from feeling positive support to feeling alone and desperate. Therefore, tools were developed to study specific behaviors, positive religious coping, and spiritual struggle. One of the most common measurement tools is the Brief RCOPE by Pargament et al. (1998). The larger version of the RCOPE is a 63-item scale with 21 subscales that represent the 2 higher-order factors of positive and negative religious coping. The brief version assesses the same higher-order factors and religious coping more efficiently by using only 14 items. Positive religious coping strategies include methods such as seeking spiritual support, religious forgiveness, and seeking benevolent religious appraisals. Negative coping methods include demonic religious appraisals, spiritual discontent, and punitive religious reappraisals. Research suggests that the type of religious coping shapes the relationship between religious coping and outcome (Ano and Vasconcelles 2005).

The Relationship Between Religious/Spiritual Coping, Psychological Well-Being, and Physical Health

Research on religious coping is growing, with an increasingly large body of literature suggesting that religious and spiritual coping has implications for psychological and physical health. Religious beliefs can be translated into coping methods, such as searching for meaning and significance, sensing emotional comfort, achieving intimacy with others, and seeking spiritual support in times of stress. In general, positive religious and spiritual coping is linked with lower levels of distress, less depression and anxiety, and less perceived post-traumatic or stress-related symptoms (Gall and Guirguis-Younger 2013; Meisenhelder and Marcum 2004). In survivors of child abuse, sexual violence, intimate partner violence, community violence, and war, spiritual and religious coping is associated with decreased psychological distress (Bryant-Davis and Wong 2013). In one study examining the protective psychosocial factors associated with lower PTSD and depressive symptoms in

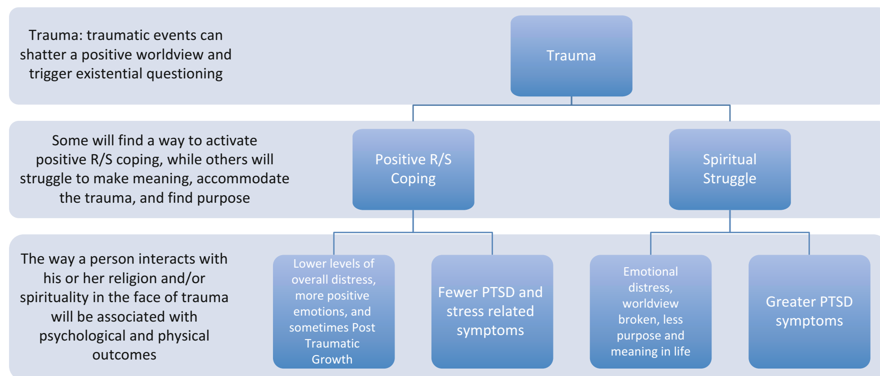

Fig. 2 Flow from trauma to coping and outcome

adult survivors of the 2005 Pakistan earthquake, purpose in life was associated with lower symptom levels and higher positive emotions (Feder et al. 2013). A study examining urban African American adolescents suggested that daily spiritual experiences moderated the effect of exposure to violence in the community and positive religious coping contributed to satisfaction in life and positive affect (Shannon et al. 2013). Schemas and worldviews offered by religion and spirituality can aid in the meaning-making process and aid an individual in finding significance in the face of life altering events. Some authors even suggest that positive religious coping is associated with post-traumatic growth or adaptations in perceived sense of self, relationships with others, philosophy of life, spirituality, and new possibilities (Gerber et al. 2011).

Other research suggests that there may be a link between PTSD symptoms and spiritual struggle or distress. In other words, greater use of negative religious coping (conflict with God, questioning religious beliefs, blaming God, etc.) can cause emotional distress, physical symptoms, and an increase in PTSD symptoms. Some suggest that this may occur because traumatic events can shatter an individual's positive worldview (Janoff-Bulman 1989). As Gerber et al. (2011) describe, when an individual's belief system is unable to sustain the meaning-making process or assist the individual in finding purpose, then the trauma can trigger a newfound questioning of God, justice, and life purpose, which can result in greater levels of PTSD symptoms and complications in the path to recovery. This appears to be true within the USA and abroad. For example, among torture survivors in Africa, negative religious coping was found to be associated with symptoms of PTSD and depression (Leaman and Gee 2012; Fig. 2).

A burgeoning literature has explored the relationship of religious and spiritual coping to adjustment among those experiencing medical stressors, spawning several useful literature reviews. Although the investigation of religious and spiritual coping and physical health stressors is not all directly relevant to the relationship of religious and spiritual coping to PTSD, there is some overlap in these domains of study. In order to remain focused toward the topic of PTSD, a full review of religious,

spiritual, and physical health factors will not be presented here, but an overview is provided to respect the overarching principles regarding religion, spirituality, and coping with various stressors and the fact that many chronic or severe physical health stressors are commonly comorbid to PTSD. The study of the functions or effects of religious and spiritual coping is often organized to differentially explore the relationship of religion and spirituality to mental health, social health, spiritual health, and physical health. Even within the exploration of physical health and medical stressors, however, the outcomes of religious and spiritual coping on physical, mental, social, and spiritual health are differentiated, with particular focus of how these domains respond after diagnosis and treatment of acute or chronic health conditions (e.g., Koenig 2013).

The use of religious and spiritual coping among those experiencing medical stressors appears to vary tremendously, with some evidence that 90 % of people hospitalized in the USA report the use of religious and spiritual coping (Koenig 1998), while 43 % of patients with advanced cancer in Norway reported no belief in God and 45 % stating that religious and spiritual coping yielded no comfort while dealing with their medical stress (Ringdal et al. 1996). Empirical studies have suggested positive and effective coping results for those facing medical illness regarding mental health, social support and social health, and functional physical outcomes following medical diagnoses. However, the research is not unequivocal, and there is some evidence that religion and spirituality, for some individuals, interfered with accessing and/or adjusting well to medical treatment.

As a follow-up to the expanding literature and literature reviews, a recent series of three meta-analyses were conducted to evaluate relationship of religious and spiritual coping among individuals with cancer to mental health outcomes (Salsman et al. 2014), physical health outcomes (Jim et al. 2014), and social health outcomes (Merluzzi et al. 2014), respectively. The meta-analysis regarding religious and spiritual coping and mental health adjustment following cancer included 129 effect sizes. The analysis addressing physical health included 77 effect sizes, and the analyses addressing social health employed 53. Across all studies, these analyses considered the impact of three aspects of religious and spiritual coping: affective religious endeavors, behavioral religious functions, and cognitive religious coping. These factors represent both the subscales of measures used in the studies and the conceptualizations of religion and spirituality as meaning making (aka cognitive religious and spiritual coping), religious and spiritual practice (aka behavioral religious and spiritual coping), and emotional support (aka affective religious and spiritual coping) discussed elsewhere. With only slight variation across outcomes, the affective religious and spiritual coping showed the strongest effect, with more significant relationships and stronger effect sizes than for either cognitive or behavioral elements of religious and spiritual coping. This overarching finding, distilled from meta-analyses, emphasizes that the effect of religion and spirituality to produce sensations of calm, peace, and reassurance appears sustaining in the face of cancer diagnosis and treatment. It may also indicate a role of religion and spirituality that, in addition to meaning making and behavioral activation toward practices that engage social support, may constitute emotional processing and management of

psychophysiological arousal that may be important for those experiencing overwhelming traumas. In addition, empirical studies have documented PTSD following cancer diagnosis and treatment, and there is a need for thorough exploration regarding the impact of religious and spiritual coping specifically on PTSD symptoms following cancer.

Connections Between Spirituality, Religiosity, and Well-Being

In an effort to better understand *how* spiritual and religious coping impacts well-being, Siegel et al. (2001) reviewed the literature and proposed three pathways by which religion and spirituality influence the coping process and adjustment to illness. They suggest that religion and spirituality (1) offer an interpretive framework, (2) enhance coping efforts, and (3) facilitate access to social support and integration (Fig. 3). According to Siegel et al., possessing a strong spirituality or identifying with a religion offers an interpretive framework by which the individual can find meaning in their distress and shape their appraisal processes. A traumatic event, whether it be an act of violence, disaster, or life-threatening illness, often causes an individual to feel a loss of control and self-worth and threatened worldview. Finding meaning allows the individual to form stable and adaptive schema, and using a spiritual or religious schema may provide a sense of coherence through which the individual can interpret a negative event or experience an opportunity for

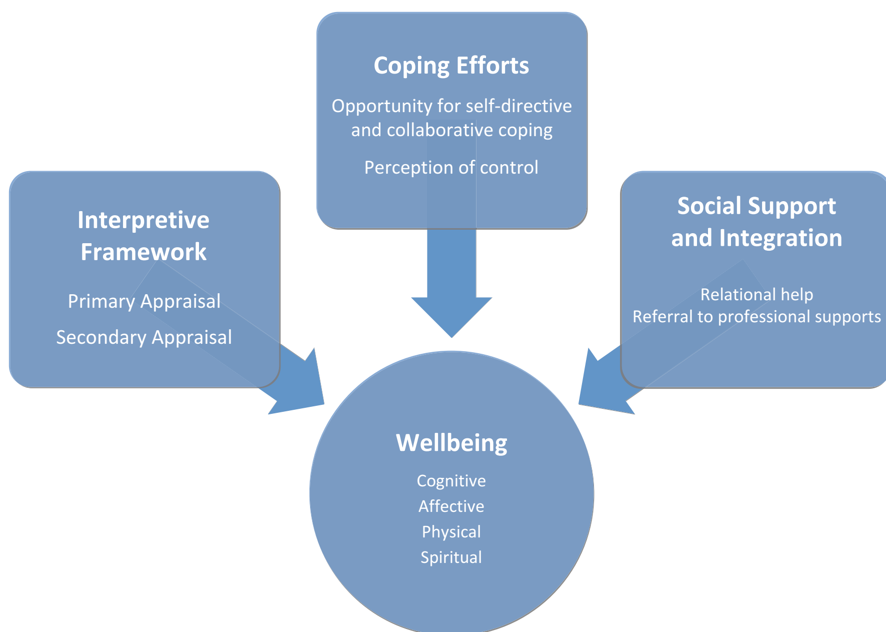

Fig. 3 Pathways to well-being

spiritual growth. Believing in God's will or a more enduring meaning from a higher power can minimize the impact of negative events and protect spiritual individuals against fears of vulnerability and unpredictability.

Appraisal processes can be shaped through two avenues: primary appraisal or the evaluation of the significance of an event for one's well-being and secondary appraisal, the evaluation of coping resources and expectations regarding coping outcomes (Lazarus and Folkman 1984). These processes are influenced by individuals' perceived ability to control events, the degree to which the traumatic situation violates their values and goals, and the perception of the quantity and quality of their coping resources. Religious and spiritual beliefs may offer perspectives through which to appraise negative life events as less threatening yet still validate their traumatic nature or consequences. For example, illness or traumatic life events may be understood as an opportunity to demonstrate or strengthen one's faith (Pargament and Park 1995; Conwill 1986) and as part of an ultimately benevolent God's plan (Pargament and Park 1995). Research has supported a positive correlation between religiousness and more positive reappraisals of stressful life events (Carver et al. 1989; Dunkel-Schetter et al. 1992; Pargament et al. 1992). Further, belief in their ability to receive God's benevolent intervention through prayer, faith, and active collaboration can give individuals the confidence in a powerful resource to cope with crisis (Dull and Skokan 1995; Pargament et al. 2003). More recent literature on this pathway suggests that general religiousness and the belief that God was in control are related to primary appraisals and relevance to an individual's life, whereas specific beliefs regarding denomination of faith is associated with secondary appraisals and an individual's evaluation of coping resources (Newton and McIntosh 2009).

The second pathway that Siegel et al. (2001) proposed, the enhancement of coping efforts, is influenced by the impact of spirituality on an individual's feelings of mastery, control, and self-worth. Perception of control, particularly an internal locus of control, has been most consistently associated with better psychological adjustment; however, in some circumstances, external or vicarious control can enhance adjustment, such as belief that an omnipotent and benevolent God is ultimately in control even when the individual does not feel in control (Jenkins and Pargament 1988; Ladd and McIntosh 2008). Spirituality and religion provide opportunities for active coping through prayer and rituals (Mattlin et al. 1990; Pargament et al. 1992) and the chance to form a collaborative problem-solving relationship with God (Pargament et al. 1988; Ellison 1993). These self-directive and collaborative active coping styles were correlated with greater self-empowerment, personal control, and higher self-esteem. Self-esteem can be further enhanced or preserved through devotional activities that establish a relationship of unconditional positive regard from an omnipotent and benevolent God and the perceived achievement of spiritual growth (Pargament et al. 1990; Ellison 1993). Religion often emphasizes the importance and worth of individuals beyond their physical state, allowing individuals to find confidence in their spiritual qualities, morality, active involvement in religious community, and service to others (Ellison and Levin 1998; Ellison 1993).

The final pathway proposed by Siegel et al. (2001) is the facilitation of access to social support and promotion of social integration. Involvement with religious institutions and congregations allows individuals in difficult life situations to receive reliable emotional, cognitive, and material support, with many institutions offering formal aid or counseling programs or referral sources. Contact with social networks that share one's important religious or spiritual beliefs and values may be perceived as more supportive and reliable than other more secular or shallow social circles (Ladd and McIntosh 2008). This social support and spiritual system can also facilitate the integration of traumatic events into an individual's coherent schema about the world and the self, which leads to more favorable mental health outcomes (Ladd and McIntosh 2008). Religiosity and spirituality can predict higher positive affect and lower odds of new mental or physical ailments (McIntosh et al. 2011). The congregation or spiritual family can ultimately serve as the extension of a reliable, available, and protective attachment figure in a deity (Kirkpatrick 1992).

Practice and Procedures

Although research suggests that religious and spiritual coping can facilitate overall well-being, there are few models for the integration of religion and spirituality into treatment for PTSD, and even fewer of these models have been empirically studied. Reviewed below are a few approaches designed to integrate religious and spiritual coping for those with PTSD (Table 1).

The military setting appears to offer the most consistent integration of religious and spiritual coping. Some of the areas of integration include the Warrior Transition programs, the military chaplaincy, 12-step programs, and mindfulness- and acceptance-based treatments. One particular intervention, described by Foy et al. (2013), is a manualized eight-session group treatment protocol that closely aligns with the three pathways of spiritual coping outlined by Siegel et al. (2001). This spirituality and trauma (ST) intervention was developed to promote "reexamination and reintegration of personal spirituality among those suffering from combat-related PTSD" (Foy et al. 2013). The three primary goals of ST can be seen to correspond – although perhaps not intentionally – with the Siegel et al. pathways, listed in parentheses:

To encourage patient's understanding of the role and value that healthy spirituality can play as a healing resource in coping with traumatic events and reconnecting with religious traditions or exploring new spiritual expressions relevant to patients' experiences (enhancing coping efforts regarding traumatic events)

To facilitate cognitive processing of the meaning and personal significance the individual places onto the traumatic experience and reframe understanding in more healthy and adaptive ways (offering an interpretive framework and appraisal process for meaning making)

To increase perceived social support and encourage healthy family and community support systems (facilitating access to social support and social integration)

Table 1 Select models for the integration of religion and spirituality into treatment for PTSD

Model	Population	Aim	Program	Reference
Spirituality and trauma (ST)	Military, combat veterans	"To promote reexamination and reintegration of personal spirituality among those suffering from combat-related PTSD"	8-session group treatment	Foy et al. (2013)
Mantram repetition program (MRP)	Military and veterans	To focus attention on the present moment and regulate emotion	The MRP intervention can be delivered in a group or individual format. The three tools are the silent repetition of a sacred word or phrase, slowing down, and one-pointed attention	Bormann et al. (2012)
Spiritually focused group intervention for older adults	Older adults, age 55 and over	To establish meaning in trauma by using spiritual recovery strategies and religious traditions	Psychoeducation, cognitive restructuring, and skill-building 11 group intervention	Bowland et al. (2012)
Trauma-focused cognitive behavioral therapy (TF-CBT)	Children	To ethically integrate religious and spiritual coping into a CBT for children	PRACTICE components address spirituality	Walker et al. (2010)

Didactic presentations, group member interactions, and large and small group discussions are used to accomplish these goals. More detailed information regarding the group is available in the chapter by Foy et al. (2013).

Mindfulness- and meditation-based interventions are also used with the military population and veterans with chronic PTSD. Bormann et al. (2012) used a mantram repetition program (MRP), which consisted of three tools for focusing attention on the present moment and regulating emotion: silent repetition of a sacred word or phrase to train attention and awareness; "slowing down" to think and act deliberately, intentionally, and carefully; and "one-pointed attention," the emphasis of purposeful concentration on one thing at a time rather than multitasking. Six, 90-min weekly group sessions were used to compare an MRP group to a treatment as usual (TAU, case management as needed) group. Research suggests that MRP results in significantly greater PTSD symptom reduction according to both self-report and clinician-rated PTSD measures, as well as self-reported significant improvements in depression, mental health status, and spiritual well-being compared with TAU subjects (Bormann et al. 2012). Veterans may find mindfulness- and

meditation-MRP-based interventions appealing because it does not focus on trauma or utilize medication and can be especially useful for improving chronic PTSD symptoms in veterans when combined with exposure-based treatments of PTSD.

As individuals age, spirituality can become more important and more highly utilized to establish meaning in traumatic life experiences. Bowland et al. (2012) evaluated the effectiveness of a manualized psychoeducation, cognitive restructuring, and skill-building group intervention with women aged 55 years and older who were victims of interpersonal trauma. The 11-session group explored personal spiritual histories in relation to traumatic experiences, spiritual qualities members wanted in their lives, positive and negative spiritual coping, and spiritual needs and struggles during life. Members examined psychological struggles as challenges that might have spiritual solutions. Spiritual recovery strategies and religious traditions as coping mechanisms were discussed, and the final sessions focused on forgiveness, letting go, and hope for their future. After participating in the group, the women had significantly lower depressive, anxiety, post-traumatic stress, and physical symptoms than the women in a control group, and gains were maintained at 3-month follow-up.

Children too can suffer from PTSD, and trauma-focused cognitive behavior therapy (TF-CBT) is an empirically supported treatment for childhood physical and sexual abuse. Just as adults can carry complex views of religion and spirituality in light of experiencing a traumatic event, children can also integrate negative messages or positive comfort into their spirituality due to trauma. The treatment components of TF-CBT are summarized with the PRACTICE acronym, which stands for psychoeducation and parental treatment, relaxation, affective expression and modulation, cognitive coping skills, trauma narrative and cognitive processing of the trauma, in vivo desensitization to trauma reminders, conjoint parent–child sessions, and enhancing safety and future development. Walker et al. (2010) created a model of religion and spirituality assessment and treatment in TF-CBT. The authors addressed spirituality issues within each of the PRACTICE treatment components, including education on how trauma can threaten spiritual beliefs, parent understanding of their own religious beliefs regarding parenting, modifying mindfulness and relaxation breathing to include focus on the spiritual or Divine, incorporating passages or songs from sacred texts into elements of thought stopping and positive imagery and self-talk, addressing and challenging cognitive distortions related to religion and spirituality, finding parallels of the client's experience and suffering in their religious tradition, processing religious and spiritual meaning with the parent and child together, and using religion and spirituality to enhance the child's sense of safety and well-being. This model provides a base for clinicians to ethical integration of religious and spiritual coping into a trauma-focused CBT for children.

While exposure-based CBT approaches to the treatment of PTSD are considered the "gold standard" of interventions, other treatments have emerged that consider the cultural and spiritual aspects of diverse people in non-Western cultures. For example, the people of Bali are largely of the Hindu faith, and traditional healers rely on an understanding of the mind, body, and spirit to help their patients reach internal

harmony. Lesmana et al. (2009) used a single session of spiritual-hypnosis assisted therapy (SHAT) in the treatment of children with PTSD symptoms after the 2002 Bali terrorist attack. SHAT incorporated the traditional meditation and spiritual practice of the Balinese Hindus into guided hypnosis that emphasized reframing traumatic memories that were obscuring their spirit, expressing emotion and visualizing the past, and believing that the power of God would give them strength to cope with their emotions and memories of the experience. Hypnotic suggestion also guided the children to see their experience from the perspective of the present moment and accept that the trauma was in the past and that they would be able to face new challenges in life without the burdens of the past trauma. SHAT, in contrast to CBT and other exposure therapies, utilized the elements of spirituality and faith as the central role in treatment, rather than systematic desensitization and cognitive processing. Treatment results showed a significant reduction in PTSD symptom scores, and over three-quarters of the group maintained improvement at 2-year follow-up.

The reviewed treatments suggest that integrating religious and spiritual coping into treatment for PTSD can be beneficial for many different populations with various types of traumatic experiences. While more research is needed to replicate these findings and further understand the role of spiritual struggle in treatment for PTSD, the research presented offers important suggestions for clinicians looking for new techniques to support survivors of trauma.

Key Facts

1. According to a recent Harris Poll (November 2013), 74 % of US adults believe in God, indicating that a majority of patients seen by clinicians in the USA may have spiritual or religious beliefs that could impact their treatment.
2. The APA calls psychologists to practice culturally competent psychotherapy, which includes respecting and responding to a patient's spiritual and religious beliefs and worldview.
3. Spirituality and religion are related, but not identical. At one time, religion was a general term used in psychology to describe anything having to do with the transcendent, but this is now considered the realm of spirituality, and religion is associated with organized religious institutions and traditions.
4. Religiousness and spirituality are multidimensional constructs, involving the cognitive, affective, relational, moral, social, cultural, and personal realms.
5. Religious and spiritual coping burst onto the scene in 1997 when Pargament published *The Psychology of Religion and Coping: Theory, Research, Practice*.
6. Patients differ in their religious and spiritual beliefs, motivations, values, practices, commitment, development, and history. An individual's experience in the aftermath of trauma will depend on their unique religiosity and spirituality.
7. Knowing the role of religion and the patient's preferred religious resources can empower the therapist to integrate religious resources into therapy to facilitate the goals of therapy.

Summary Points

1. Spirituality can be defined as the search for the Sacred, with the Sacred being that which is divine, transcendent, and boundless.
2. Religion occurs within the context of established institutions that are designed to facilitate spirituality.
3. Religious and spiritual coping is the use of religious beliefs or practices as a way of adapting to physical, psychological, and social challenges.
4. Positive religious and spiritual coping mechanisms can include prayer, turning to God or the Sacred for support and healing, reading inspirational materials, and participating in one's faith community. Positive religious and spiritual coping is linked with lower levels of distress, less depression and anxiety, and less perceived post-traumatic or stress-related symptoms.
5. Negative religious and spiritual coping, also called spiritual struggle, can include questioning God or the Sacred, feeling angry toward the Sacred, and using demonic or punitive religious appraisals. Spiritual struggle is linked with higher levels of distress, an increase in physical symptoms, and PTSD.
6. Several authors suggest that there are three pathways by which religion and spirituality influence the coping process: (1) offering an interpretive framework with which to find meaning and shape the appraisal process; (2) enhancing coping efforts that impact an individual's feelings of mastery, control, and self-worth; and (3) facilitating access to social support and integration.
7. There are few models for integration of religion and spirituality into treatment for PTSD; however, the military setting offers many active duty programs, 12-step programs, and mindfulness- and acceptance-based programs. In particular, the manualized group treatment protocol described in Foy et al. (2013) offers soldiers and veterans an opportunity to reexamine and reintegrate personal spirituality after suffering combat-related PTSD.

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