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## Trauma and Spirituality

“When I was a child, I spoke as a child, I understood as a child,  
I thought as a child: but when I became (an adult) I put away  
childish things. For now we see through a glass darkly; but then face to face:  
now I know in part; but then shall I know even as also I am known.”

(The Bible: I Corinthians 13, 9–13)

### 1. Introduction

The biblical passage quoted above reflects what trauma survivors experience: they view themselves and the world dismally, as if through a glass, a psychological experience in which inner representations of self and world are disrupted, colouring all future perceptions. An understanding of the unique inner, the experience of survivors is essential, as helpers guide the survivor gradually to transform these disrupted representations of self and world, into a new reality that is both adaptive and positive.

Since the early 2000s, several biblical scholars have increasingly come to regard the concept of trauma as a powerful interpretative lens to understand some of the most difficult and painful texts in the Bible. The use of trauma does not constitute a method of interpretation, but a frame of reference that, when coupled with diverse forms of biblical criticism, can yield interesting results

in the study of biblical literature.<sup>1</sup> There are three dominant threads informing biblical trauma hermeneutics: psychology, sociology, and literary and cultural studies. Psychology contributes to our understanding of the effects of trauma on individuals and on those processes that facilitate survival, recovery, and resilience. Sociology provides insights into collective dimensions of traumatic experience. Literary and cultural studies open pathways for exploring the role and function of texts as they encode and give witness to traumatic suffering and construct discursive and aesthetic spaces for fostering recovery and resilience.<sup>2</sup> In this paper, the focus is on insights from psychology, and relationships between psychological trauma – post-traumatic stress disorder (PTSD), spirituality and religiosity.

## 2. Defining Trauma

The term trauma comes from the Greek language and means injury or wound; the term traumatic first appeared in the Oxford English Dictionary in 1656, under the definition “pertaining to wounds or wound healing”. In the 19th century, it was first used in a psychiatric context when the German neurologist Herman Oppenheim introduced the term traumatic neurosis.<sup>3</sup> However, we are able to find descriptions of traumatic reactions much earlier in history. From Antiquity onwards, chroniclers report isolated cases of their war heroes suffering from agitation, stupor, and terrifying nightmares. Herodotus, in his description of the battle on the Marathon Field from 490 BC, describes the condition of the soldier Epizelus, who became blind after witnessing the death of his friend. Given that he was not injured, we can assume that the cause of his blindness was psychogenic, that is, the trauma that happened to him.<sup>4</sup> Up until the 18th century, what we refer to as psychological trauma today, was mostly found

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<sup>1</sup> D. Garber, *Trauma Theory and Biblical Studies*, “CurBR” 14 (2015), pp. 24–44.

<sup>2</sup> C. G. Frechette, E. Boase. *Defining “Trauma” as a Useful lens for Biblical Interpretation*, in: C.G. Frechette & E. Boase (eds.), *Bible through the Lens of Trauma*, Atlanta 2016, SBL Press, pp. 1–23.

<sup>3</sup> G. C. Lasiuk, K. M. Hegadoren, *Posttraumatic Stress Disorder Part I: Historical Development of the Concept*, “Perspectives in Psychiatric Care” 42 (2015) 1, pp. 13–20.

<sup>4</sup> Herodotus, *The Histories*, Idaho 2013, Roaman Roads Media.

in literary works.<sup>5</sup> During the American Civil War, Arthur Meyers coined the term “soldier’s heart” to describe a disorder involving extreme fatigue, dyspnea, palpitations, sweating, tremors, and occasionally complete syncope often seen among soldiers engaged in combat.<sup>6</sup> During World War I, the British military psychiatrist Charles Samuel Meyers introduced the term “shell shock”, which refers to states of freezing, stupor, emotional unavailability, loss of control, and severe anxiety.<sup>7</sup> World War II brought about new clinical experiences, and the descriptions of the condition of soldiers and civilians are focused on psychophysiological reactions and loss of impulse control, as well as severe biological, psychological, and social consequences of people who survived the experiences of concentration camps, including a reduced ability to cope with psychological and biological stressors later in life.<sup>8</sup> Faced with the profound consequences of another devastating war – the Vietnam War – during which in its 20 years, 700,000 soldiers (almost a quarter) sought psychological help<sup>9</sup> and studies on rape victims,<sup>10</sup> experts of the American Psychological Association in the new edition of DSM III<sup>11</sup> introduce the diagnosis of PTSD as a separate identity within the group of anxiety disorders. Twelve symptoms of the disorder are described, divided into three groups: reliving the trauma, numbness and withdrawal, and characteristics that did not exist before the traumatic event.

Within the diagnosis, a distinction is made between the acute form of PTSD, when the symptoms are present for less than six months, and the chronic form,

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<sup>5</sup> P. Birmes, L. Hatton, A. Brunet, L. Schmitt, *Early historical literature for post-traumatic symptomatology*, “Stress and Health” 19 (2003) 1, pp. 17–26.

<sup>6</sup> G. C. Lasiuk, K. M. Hegadoren, *Posttraumatic Stress Disorder Part I: Historical Development of the Concept*, “Perspectives in Psychiatric Care” 42 (2015) 1, pp. 13–20.

<sup>7</sup> G. C. Lasiuk, K. M. Hegadoren, *Posttraumatic Stress Disorder Part I: Historical Development of the Concept*, “Perspectives in Psychiatric Care” 42 (2015) 1, pp. 13–20; Herodotus, *The Histories*, Idaho 2013, Roaman Roads Media.

<sup>8</sup> B. A. van der Kolk, A. C. McFarlane, L. Weisaeth (eds.), *Traumatic Stress – The Effects of Overwhelming Experience on Mind, Body, and Society*, New York 1996, The Guilford Press.

<sup>9</sup> M. Crocq, L. Crocq, *From shell shock and war neurosis to posttraumatic stress disorder: a history of psychotraumatology*, “Dialogues in Clinical Neuroscience” 2 (2000) 1, pp. 47–55.

<sup>10</sup> G. C. Lasiuk, K. M. Hegadoren, *Posttraumatic Stress Disorder Part I: Historical Development of the Concept*, “Perspectives in Psychiatric Care” 42 (2015) 1, pp. 13–20; Herodotus, *The Histories*, Idaho 2013, Roaman Roads Media.

<sup>11</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.), 1980.

when the symptoms are present for longer than six months. In DSM-IV<sup>12</sup>, criterion A (traumatic stressor) is more clearly defined, which implies real or possible death, or a threat to personal or other's bodily integrity, and a person reacts to such an event with an intense feeling of fear, helplessness, or horror. Three groups with a total of 17 symptoms were defined: reliving the event, avoiding stimuli related to the trauma, and heightened arousal. Concerning the previous version of the DSM, a criterion was introduced, that the disorder must cause clinically significant disturbances in social, work, or other functions. In 2013, the fifth and current revision of the DSM<sup>13</sup> was issued, and there were several changes in the diagnostic criteria for PTSD. Firstly, the classification was changed and it was placed in the group of disorders related to trauma and stress. Criterion A now includes four ways of exposure to the traumatic event(s), including indirect exposure, and includes three new symptoms that are divided into four clusters: intrusive symptoms, avoidant, negative changes in cognition and behavior related to the traumatic event, and significant changes in mood and reactivity.

To sum up, we could say that psychological trauma is the unique individual experience of an event or enduring conditions, in which: (1) the individual's ability to integrate his/her emotional experience is overwhelmed, or (2) the individual experiences (subjectively) a threat to life, bodily integrity, or sanity. Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.<sup>14</sup> Traumatic life events have a diverse and often dramatic impact on the body, self-structure, and soul of the survivor. Trauma, too, may produce a state of dispiritedness and lead the survivor to question the meaning of life and existence and the motives of God.

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<sup>12</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), 1994.

<sup>13</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), 2013.

<sup>14</sup> E. Giller, *What is Psychological Trauma*, <http://www.theannainstitute.org/What%20Is%20Psychological%20Trauma.pdf?contentID=88>, (26.09.2022).

### 3. Psychological theories of PTSD

Social-cognitive theorists postulate that PTSD symptoms result from trauma that shatters one's basic assumptions about the vulnerability of the self and the safety of the world, or reinforces pre-existing negative beliefs.<sup>15</sup> Faulty beliefs and misconceptions including self-blame and guilt, and overgeneralized problems concerning safety, trust, control, esteem, and intimacy, prevent the trauma from being integrated into memory.<sup>16</sup> Human beings search for the meaning of life and diligently attempt to discover and possess it. Indeed, for centuries, the living religions of the world have provided people searching for the truth of life, with all that they need to live, namely, faith, hope, love, and a certain measure of insight.<sup>17</sup> Therefore, religious and spiritual cognitions should be also considered in the context of trauma, because religious beliefs comprise a substantial part of many people's global meaning system and therefore inform their coping responses<sup>18</sup>; and because they address issues of existential meaning, which may be called into question by trauma.<sup>19</sup> More often than not, the religious meaning system provides a helpful vehicle for making sense of seemingly random, nonsensical, or tragic events, by viewing them as part of a larger, more benign plan.<sup>20</sup> Moreover, religion can be involved in changing the appraised meaning of a stressful situation by (1) providing a means to make more benign reattributions, (2) helping the individual to see the positive aspects of the stressful situation, (3) facilitating perceptions of stress-related growth. Alternatively, while religion is often helpful in times of stress, it can also be a source of stress if religious beliefs or attributions suggest maladaptive ways of understanding an event.

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<sup>15</sup> R. Janoff-Bulman, *Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct*, "Social Cognition" 7 (1989) 2, pp. 113–136.

<sup>16</sup> P. A. Resick, K. S. Calhoun, *Posttraumatic stress disorder*, in: D. H. Barlow (ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual*, New York 2001, The Guilford Press, pp. 60–113.

<sup>17</sup> J. P. Wilson & T. A. Moran, *Psychological Trauma: Posttraumatic Stress Disorder and Spirituality*, "Journal of Psychology and Theology" 26 (1998) 2, pp. 168–178.

<sup>18</sup> C. Park, *Religion as a Meaning-Making Framework in Coping with Life Stress*, "Journal of Social Issues" 61 (2005) 4, pp. 707–729.

<sup>19</sup> R. Janoff-Bulman, *Shattered assumptions: Towards a new psychology of trauma*, New York 1992, Free Press.

<sup>20</sup> K. I. Pergament, *The Psychology of Religion and Coping: Theory, Research, Practice*, New York 1997, The Guilford Press.

According to the cognitive model of Ehlers and Clark<sup>21</sup>, persistent PTSD occurs when an individual cognitively processes a traumatic event and/or its consequences in a way that immediately causes a feeling of threat. The model further proposes two processes by which this occurs: (1) individual differences in the evaluation of the traumatic event and/or its consequences and (2) individual differences like the event's memory and association with the existing autobiographical memory. It is hypothesized that, unlike individuals who recover naturally, individuals with persistent PTSD cannot see the trauma as a time-limited event that has no overall negative value for their future. The model proposes that these individuals are characterized by idiosyncratic negative appraisals of the traumatic event and/or its consequences that have the combined effect of creating a sense of serious immediate threat. This threat can be external (eg, the world is a more dangerous place) or, very often, internal (e.g. a threat to one's view of oneself as a capable/acceptable person who will be able to achieve important life goals). As a consequence of the negative evaluation of the event, symptoms of reliving, excitement, anxiety, and other emotional responses appear. Perceived threat prompts a series of behavioral and cognitive responses that seek to reduce threat and stress, but consequently perpetuate the disorder. The feeling of threat can also arise from the generalization of danger from a traumatic event to everyday activities, or as a result of the perception of the behavior of close people that causes the individual to feel unaccepted, lacking care or guilty. Previous experiences of traumatization, weakness or helplessness increase the risk of evaluating oneself as incapable of effective action and of perceiving oneself as extremely sensitive to danger. Furthermore, due to fragmented traumatic memory, lack of complete context of time and place, and inadequate integration of information into the autobiographical knowledge base, the individual experiences symptoms of imposition, anxiety, and tension.

Mowrer's two-factor theory of learning fear and anxiety is the basis of several theoretical models of the emergence and development of clinical symptoms of PTSD.<sup>22</sup> In the first phase, a person exposed to a traumatic event acquires fear through classical conditioning, where previously neutral stimuli (eg sound,

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<sup>21</sup> A. Ehlers, D. M. Clark, *A cognitive model of posttraumatic stress disorder*, "Behaviour Research and Therapy" 38 (2000), pp. 319–345.

<sup>22</sup> S. P. Cahill, E. B. Foa, *Psychological theories of PTSD*, in: M. J. Friedman, T. M. Keane & P. A. Resick (eds.), *Handbook of PTSD: Science and practice*, New York 2007, The Guilford Press, pp. 55–77.

time of day, smells), through pairing with the traumatic event, begin to cause intense anxiety. Through the process of higher-order conditioning and stimulus generalization, anxiety can also be caused by stimuli that are similar to the stimuli that were present during the traumatic event. The model suggests that re-experiencing a traumatic event is part of the normal recovery process, however, when there is a high degree of generalization and higher-order conditioning, chronic PTSD develops. On the other hand, the process of instrumental conditioning, leads to another factor, avoidance of both conditioned and unconditioned stimuli. This process persists because it leads to reduced anxiety. Despite criticism that this theory does not explain properly why some people develop PTSD and others do not, and the impossibility of distinguishing the etiology of PTSD from other anxiety disorders, this theory does a good job of explaining a wide range of potential triggers and the physiological and emotional arousal caused by them, and is still supported in the literature.

#### 4. Neurobiology of PTSD

From a biological point of view, PTSD is a long-term consequence of the organism's failure to recover from a traumatic situation, that is, from the biological consequences of recalling an event that is no longer happening in real-time.<sup>23</sup> Modern brain imaging methods have made it possible to learn important information about the structure, neurochemistry, and function of the amygdala, medial pre-frontal cortex, and hippocampus in the development of PTSD.<sup>24</sup> In studies that induced PTSD symptoms with traumatic audio recordings, lower brain activation and reduced blood flow in the area of the medial prefrontal regions, which are responsible for the regulation of emotional response through inhibition of the amygdala, and hyperactivity of the amygdala itself, were found. Furthermore, research has shown that the hippocampus in PTSD has a reduced volume, except in children with PTSD, where its volume is normal.<sup>25</sup> The re-

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<sup>23</sup> R. Yahuda, *Biological Factors Associated with Susceptibility to Posttraumatic Stress Disorder*, "Canadian Journal of Psychiatry" 44 (1999), pp. 34–39.

<sup>24</sup> L. M. Shin, S. L. Rauch, R. K. Pitman, *Amygdala, medial prefrontal cortex, and hippocampal function in PTSD*, "Annals New York Academy of Sciences" 1071 (2006), pp. 67–79.

<sup>25</sup> M. A. W. Rinne-Albers, N. J. A. van der Wee, F. Lamers-Winkelmann, R. R. J. M. Vermeiren, *Neuroimaging in children, adolescents and young adults with psychological trauma*, "European Children and Adolescence Psychiatry" (2013), pp.1–11.

duction of the hippocampus also means disturbances in its function, which in PTSD, is manifested by a direct impact on cognitive functions, declarative memory, excessive generalizations of fear, and difficulty in distinguishing what is harmful from that which is harmless.<sup>26</sup> Furthermore, intrusive symptoms may be related to the inability of higher brain structures (hippocampus, medial frontal cortex) to moderate the arousal and distress that is processed through the amygdala in response to the recall of the traumatic event. Regarding the physiology of PTSD, it includes the dysregulation of neurochemical systems with the release of stress-related hormones, such as adrenaline, cortisol, vasopressin, noradrenaline, and endogenous opioids.<sup>27</sup> There is a chronically disturbed regulation of the hypothalamic-pituitary-adrenal axis (HPA-axis). Unlike a normal acute stress reaction, where an elevated level of the corticotropin-releasing hormone leads to increased secretion of cortisol, in PTSD sufferers, the levels of cortisol in the blood are permanently lowered. This is explained by the increased negative coupling in the HPA axis that occurs during the development of PTSD. The HPA axis becomes more sensitive to cortisol and shuts down before cortisol can adequately limit the response of the sympathetic nervous system. Such dysfunctional physiological response to stress leads to prolonged increased reactivity of the sympathetic nervous system and is manifested by a prolonged fear reaction and chronically increased excitement in PTSD sufferers.<sup>28</sup>

## 5. Defining Spirituality and Religiosity

Religion and religiosity have always been important topics of study in psychology because they represent a significant modifier of the value structure, as well

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<sup>26</sup> C. Heim, C. B. Nemeroff, *Neurobiology of posttraumatic stress disorder*, “CNS Spectrums” 14 (2009) 1, pp. 13–24.

<sup>27</sup> J. E. Sherin, C. B. Nemeroff, Post-traumatic stress disorder: the neurobiological impact of psychological trauma, “Dialogues in Clinical Neuroscience” 13 (2011), pp. 263–278.

<sup>28</sup> S. P. Cahill, E. B. Foa, *Psychological theories of PTSD*, in: M. J. Friedman, T. M. Keane & P. A. Resick (eds.), *Handbook of PTSD: Science and practice*, New York 2007, The Guilford Press, pp. 55–77; M. A. W. Rinne-Albers, N. J. A. van der Wee, F. Lamers-Winkelmann, R. R. J. M. Vermeiren, *Neuroimaging in children, adolescents and young adults with psychological trauma*, “European Children and Adolescence Psychiatry” (2013), pp. 1–11.



as an important predictor of a wide range of behaviors and attitudes.<sup>29</sup> There are numerous ways of defining religion and religiosity, and within psychology, religion is most often defined as a system of understanding beliefs, behaviors, rituals, and ceremonies, through which individuals or communities put themselves in a relationship with God or the supernatural world, and often in a relationship with each other; from which (system) a religious person acquires a series of values according to which the natural world is measured and judged.<sup>30</sup> Religiosity is defined on an individual level and refers to an individual's interest in religion, and engagement in religious activities, and represents an internal attitude, personal commitment, and belief in the existence of some transcendental being, implying living by that attitude.<sup>31</sup> Spirituality and religiosity are often considered to be independent constructs that represent individual and institutional experiences, respectively. Researchers have conceptualized spirituality as a private experience<sup>32</sup> that promotes a process of growth. According to Hill and Pargament<sup>33</sup>, spirituality is a construct that can be understood as a search for the sacred. This process may not necessarily take place in a particular religious institution,<sup>34</sup> as it involves the attribution of meaning to one's personal experience. Religiosity, on the other hand, can be defined as a commitment to the beliefs and practices recognized by a specific organized sacred institution such as a church, synagogue, or mosque.<sup>35</sup> This may include prayer, reading holy scripts, and regularly attending services. The goal of studying religiosity and spirituality within psychology is to understand how an individual develops

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<sup>29</sup> D. Ljubotina, *Razvoj novog instrumenta za mjerenje religioznosti*, "Zbornik sažetaka XIV. Dani psihologije u Zadru", Zadar 2004, Sveučilište u Zadru.

<sup>30</sup> Š. Š. Čorić, *Psihologija religioznosti*, Jastrebarsko 2003, Naklada Slap.

<sup>31</sup> N. M. Lambert, D. C. Dollahite, *How religiosity helps couples prevent, resolve and overcome marital conflict*, "Family relations" 55 (2006), pp. 439–449.

<sup>32</sup> M. Good, T. Willoughby, *Adolescence as a Sensitive Period for Spiritual Development*, "Child Development Perspectives" 2 (2008) 1, pp. 32–37.

<sup>33</sup> P. C. Hill, K. I. Pargament, *Advances in the Conceptualization and Measurement of Religion Spirituality – Implications for Physical and Mental Health Research*, "American Psychologist" 58 (2003) 1, pp. 64–74.

<sup>34</sup> Š. Š. Čorić, *Psihologija religioznosti*, Jastrebarsko 2003, Naklada Slap.

<sup>35</sup> E. P. Shafranske, H. N. Malony, *Clinician psychologist' religious and spiritual orientations and their practice of psychotherapy*, "Psychotherapy" 27 (1990), pp. 72–78; D. Ljubotina, *Razvoj novog instrumenta za mjerenje religioznosti*, "Zbornik sažetaka XIV. Dani psihologije u Zadru", Zadar 2004, Sveučilište u Zadru.

his religious attitude and the influence of that attitude on the daily functioning of the individual.<sup>36</sup>

## 6. Relationship between Trauma and Spirituality/Religiosity

Part of the devastation of trauma is the damage done to a person's sense of trust and security in the world, which is an integral part of many areas of life. It influences one's sense of self, one's relationships with others, and an individual's concept of spirituality. Viewing a trauma survivor's relationship with God through the lens of attachment theory, illustrates the degree to which a survivor's relationship with higher power can be damaged. As children expect their parents to provide comfort, safety, and protection, humans ask the same of their God.<sup>37</sup> The spiritual relationship with a higher person is based on the expectation that the higher power will be protective in times of difficulty or danger, the same as a parent is for a child. This basic agreement was breached when the relationship with the higher power did not prevent the traumatic event.<sup>38</sup> Very often a traumatic event forces the individual to acknowledge that life is not always fair. This assumption of fairness is a fundamental worldview that trauma fractures. People may question the balance of power between good and evil, creating additional religious and spiritual issues.<sup>39</sup> As mentioned before, despite some devastating consequences, trauma can also be a catalyst for spiritual growth.<sup>40</sup> A traumatic event may overwhelm the soul's ability to contain it and fit it into the larger spiritual consciousness. As a result, processing a traumatic event almost always leads to a search for new meaning and purpose, as well as a need for the soul to expand enough to contain trauma.

Traumatic experiences can have a positive and negative effect on a person's spirituality, that is, the experience of severe trauma can lead a person to turn

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<sup>36</sup> L. M. Shin, S. L. Rauch, R. K. Pitman, *Amygdala, medial prefrontal cortex, and hippocampal function in PTSD*, "Annals New York Academy of Sciences" 1071 (2006), pp. 67–79.

<sup>37</sup> Š. Š. Ćorić, *Psihologija religioznosti*, Jastrebarsko 2003, Naklada Slap.

<sup>38</sup> R. Janoff-Bulman, *Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct*, "Social Cognition" 7 (1989) 2, pp. 113–136.

<sup>39</sup> S. Smith, *Exploring the Interaction of Trauma and Spirituality*, "Traumatology" 10 (2004) 4, pp. 231–243.

<sup>40</sup> M. Good, T. Willoughby, *Adolescence as a Sensitive Period for Spiritual Development*, "Child Development Perspectives" 2 (2008) 1, pp. 32–37.

to religion, while others blame God for their negative and difficult experiences.<sup>41</sup> Religion is often perceived as a source of comfort, meaning, and purpose for individuals exposed to a traumatic experience<sup>42</sup> and can render suffering more bearable.<sup>43</sup> In literature, we find two types of religious traits: intrinsic and extrinsic religiosity. Intrinsic religiosity is defined as religiosity that is focused on God or faith, rather than on the possible benefits that would result from that faith, while extrinsic religiosity is defined as the instrumental use of religion for possible benefits.<sup>44</sup> Research has shown that intrinsic religiosity in the first few months after a traumatic experience, is associated with an increased intensity of PTSD symptoms, while one year after the traumatic event, it is associated with a reduced intensity of PTSD symptoms.<sup>45</sup> Immediately after a person is exposed to some kind of trauma, a discrepancy arises concerning previous beliefs, and leads to the development of psychological distress and internal religious struggles that last until the person is once again able to rationally and consciously evaluate the stressful event, and in such way, to approach the resolution of PTSD symptoms.<sup>46</sup> Moreover, there are many studies on how individuals use religion to cope with times of stress or difficulty.<sup>47</sup> Religious coping refers to religious behavior or thoughts occurring in response to a specific situation, usually, one that is stressful or traumatic. Positive religious coping with stress includes religious

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<sup>41</sup> G. W. Allport, Personal religious orientation and prejudice, "Journal of Personality and Social Psychology" 5 (1967) 4, pp. 432–443.

<sup>42</sup> H. S. L. Jim, J. E. Pustejovsky, C. L. Park, S. C. Danhauer, A. C. Sherman, G. Fitchett et al., *Religion, spirituality, and psysical health in cancer patients: A meta-analysis*, "Cancer" 121 (2015) 21, pp. 3760–3768.

<sup>43</sup> B. Wansink, C. S. Wansink, *Are there Atheists in Foxholes? Combat Intensity and Religious Behaviour*, "Journal of Religion and Health" 52 (2013) 3, pp. 768–779.

<sup>44</sup> R. Janoff-Bulman, *Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct*, "Social Cognition" 7 (1989) 2, pp. 113–136.

<sup>45</sup> S. Mihaljević, B. Augst-Margetić, B. Vuksan-Ćusa, E. Koić, M. Milošević, *Hopelessness, suicidality and religious coping in Croatian war veterans with PTSD*, "Psychiatria Danubina" 24 (2012) 3, pp. 292–297.

<sup>46</sup> P. C. Hill, K. I. Pargament, *Advances in the Conceptualization and Measurement of Religion Spirituality – Implications for Psysical and Mental Health Research*, "American Psychologist" 58 (2003) 1, pp. 64–74.

<sup>47</sup> R. G. Tadeschi, L. G. Calhoun, *The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma*, "Journal of Traumatic Stress" 9 (1996) 3, pp. 455–471; M. Good, T. Willoughby, *Adolescence as a Sensitive Period for Spiritual Development*, "Child Development Perspectives" 2 (2008) 1, pp. 32–37.

forgiveness, seeking spiritual support and connection, and benevolent spiritual assessment, religious interactions, that are based on trust, hope, and faith. Negative religious coping implies experiencing a stressful/traumatic event as God's punishment or demonic activity, and it can lead to questioning God, and his love., They become anxious, believing that God or the spiritual community has somehow abandoned them, with the result that they experience anger, fear, or doubt.<sup>48</sup> Individuals who possess a strong relationship with a God before trauma, are more likely to benefit from their faith, and more likely to emerge from the ordeal with their beliefs essentially intact. People with more tenuous or unstable religious attachments, may discover that their faith is easier to lose and harder to benefit from.

In war veterans, the level of posttraumatic stress symptoms was associated with more positive religious coping, which was also associated with post-traumatic stress growth after various types of war trauma, while negative religious coping was consistently associated with higher levels of post-traumatic stress symptoms.<sup>49</sup> Currier, Holland, and Drescher<sup>50</sup> examined longitudinal associations between spirituality and PTSD among veterans in a residential treatment program for combat-related PTSD. They found that different dimensions of spirituality have been associated with adaptive and maladaptive responses to trauma among military veterans. Spirituality variables were concurrently associated with the veteran's PTSD symptom severity. Moreover, improvements in spiritual functioning (e.g. higher adaptive aspects, less negative religious coping) were associated with reductions in PTSD symptoms. Most importantly, according to longitudinal design, Currier and colleagues<sup>51</sup> found that spirituality factors at the start of treatment were uniquely predictive of PTSD symptom severity. Specifically, veterans who scored higher on adaptive dimensions of spirituality (daily spiritual experiences, forgiveness, spiritual practices, positive religious coping, and organizational religiousness) on intake, fared

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<sup>48</sup> L. M. Shin, S. L. Rauch, R. K. Pitman, *Amygdala, medial prefrontal cortex, and hippocampal function in PTSD*, "Annals New York Academy of Sciences" 1071 (2006), pp. 67–79.

<sup>49</sup> I. A. Florez, L. J. Allbaugh, C. E. Harris, A. C. Schwartz, N. J. Kaslow, *Suicidal ideation and hopelessness in PTSD: Spiritual well-being mediates outcomes over time*, "Anxiety and Stress Coping" 31 (2018) 1, pp. 46–58.

<sup>50</sup> J. M. Currier, J. M. Holland, K. D. Drescher, *Spirituality Factors in the Prediction of Outcomes of PTSD Treatment for U.S. Military Veterans*, "Journal of Traumatic Stress" 28 (2015), pp. 57–64.

<sup>51</sup> S. Smith, *Exploring the Interaction of Trauma and Spirituality*, "Traumatology" 10 (2004) 4, pp. 231–243.

significantly better in this program. An opposite pattern emerged for negative religious coping. Veterans who began the program feeling abandoned by God or a Higher Power, punished for perceived acts of wrong-doing or spiritual weakness, and attempting to disengage from God or a Higher Power, fared worse in the program. Research has suggested that these maladaptive ways of drawing upon spirituality in the coping process, could be a warning sign for moral injury, which is characterized by a pervasive constellation of inappropriate guilt, anger, self-recrimination, and self-handicapping behaviors and alienation that emerges after witnessing or participating in warzone events that challenge one's basic sense of humanity.<sup>52</sup> On the other hand, interestingly, symptoms of PTSD at baseline did not predict any of the spirituality variables at post-treatment.

Research also reveals that there are smaller changes in religious beliefs among people who have experienced a natural disaster when compared to people who have been exposed to the traumatic experience for a longer period of time, such as the population of war veterans who have greater changes in religious beliefs.<sup>53</sup> The intensity of combat in which war veterans participated and turned to prayer is positively related, even 50 years after experiencing the traumatic experience. Furthermore, among the group of veterans who evaluated their war experience as positive, those who did not participate in the combat sector or participated only in milder forms of combat, it was observed that they attend church ceremonies less often when compared to those who evaluate their war experience as negative. As the intensity of involvement in the combat sector grew, so did the number of their visits to church. These results point to the conclusion that the intensity of combat can be related to the later level of religious activity, and that the relationship between religion and combat experience can vary significantly depending upon the way a person retrospectively looks at his combat or traumatic experience.<sup>54</sup>

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<sup>52</sup> B. T. Litz, N. Stein, E. Delaney, L. Lebowitz, W. P. Nash, C. Silva, S. Maguen, *Moral injury and moral repair in war veterans: A preliminary model and intervention strategy*, "Clinical Psychology Review" 29 (2009) 8, pp. 695–706.

<sup>53</sup> E. P. Shafranske, H. N. Malony, *Clinician psychologist' religious and spiritual orientations and their practice of psychotherapy*, "Psychotherapy" 27 (1990), pp. 72–78; D. Ljubotina, *Razvoj novog instrumenta za mjerenje religioznosti*, "Zbornik sažetaka XIV. Dani psihologije u Zadru", Zadar 2004, Sveučilište u Zadru.

<sup>54</sup> K. E. Cherry, L. Sampson, P. F. Nezat, A. Cacamo, L. D. Marks, S. Galea, *Long-term psychological outcomes in older adults after disaster: relationships to religiosity and social support*, "Aging and Mental Health" 19 (2015) 5, pp. 430–443.

## 7. Healing the Traumatized Soul

Prior to this century, there is little evidence of significant conflict between mental health professionals and pastoral counselors. Beginning with the first decade of the 20th century, however, psychology appeared intent on ignoring the spiritual dimension of human existence to “establish itself as an empirical science rather than a speculative discipline.”<sup>55</sup> However, during the last three decades, empirical psychology has broadened its horizons, and since both, psychology and theology acknowledge the inner world of the individual, significant progress has been made and many integrative models of assistance, especially to trauma survivors, have been developed.<sup>56</sup> Religion, faith, and spirituality are significant life issues for many people, so they represent potential sources of support and inner strength for victims, and is important to address this issue during the therapy process.

From a clinical standpoint, there are several options for addressing spiritual concerns in treating trauma survivors. Spirituality and/or religion may be beneficial in the context of trauma treatment. However, including spiritual components in treatment is not particularly common and many therapists may be unfamiliar with or uncomfortable with the notion.<sup>57</sup> Therefore, mental health clinicians might assume a multi-disciplinary approach and seek support from chaplains or other ministry professionals in their work.<sup>58</sup> Moreover, mental health providers must also take the time to examine and know their belief systems and spiritual background.<sup>59</sup> Incorporating a spiritual component into trauma treatment involves both preparation and exploration. There is no one “right” way to include spirituality in treatment. Factors such as the clinician’s position on religion, the client’s willingness to explore that area, the circumstances

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<sup>55</sup> R. Janoff-Bulman, *Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct*, “Social Cognition” 7 (1989) 2, pp. 113–136.

<sup>56</sup> R. Janoff-Bulman, *Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct*, “Social Cognition” 7 (1989) 2, pp. 113–136; S. Smith, *Exploring the Interaction of Trauma and Spirituality*, “Traumatology” 10 (2004) 4, pp. 231–243.

<sup>57</sup> M. Good, T. Willoughby, *Adolescence as a Sensitive Period for Spiritual Development*, “Child Development Perspectives” 2 (2008) 1, pp. 32–37.

<sup>58</sup> S. Smith, *Exploring the Interaction of Trauma and Spirituality*, “Traumatology” 10 (2004) 4, pp. 231–243.

<sup>59</sup> M. Good, T. Willoughby, *Adolescence as a Sensitive Period for Spiritual Development*, “Child Development Perspectives” 2 (2008) 1, pp. 32–37.

of the traumatic event, as well as any time limitations that may occur as a result of managed care, need to be taken into account. Since many trauma survivors suspect that matters of faith and religion are not appropriate subject matter, the therapist may consider initiating discussion in these areas. One might explore religious histories, as well as changes in belief and spirituality following traumatization. It is imperative to recognize that, initially, traumatized persons may be reluctant to articulate spiritual feelings. Those who feel they have been abandoned by God, fear that their anger and bitterness will be perceived as irrational. Some who are struggling with survivor guilt fear that expressing their thoughts and feeling will allow the therapist to confirm that the immensity of their perceived sinfulness will not tolerate divine forgiveness. Those who are disillusioned and may have abdicated their spiritual creeds because they find little in which to believe. Still, others may be reluctant to discuss issues of faith and spirituality, because the severity of their trauma has left them feeling unprotected, unworthy, and oftentimes disconnected from the Divine. Issues such as these must be probed into slowly and carefully. Unhealthy spiritual feelings and inaccurate or immature perceptions of God should be examined in therapy, but only in a timely, prudent, and sensitive manner.<sup>60</sup>

Victims of psychological trauma and PTSD desire normalcy. They long for an end to their isolation and alienation; they long for an end to the numbing, the intense anger, and the purposeful distancing that keeps them distanced from others. Therefore, therapists and pastoral counselors must strive to unstill the traumatized with a spirit of optimism that enables trauma survivors to move beyond the simplistic concept of faith as a theoretical understanding of things uncertain. The optimism which inspires a deep and transcending faith and spirituality empowers the survivor to move beyond doubt, beyond the anxiety of meaninglessness and despair, to a mature and absolute faith. As a result of extreme trauma, traditional religious symbols frequently lose their meaning and power. Absolute faith, however, encourages one to be courageous, despite catastrophic trauma, despite the realities of a chaotic world, and despite one's finite existence. Absolute faith equips the trauma victim with courage which is "rooted in the God who appears when God has disappeared in the anxiety of doubt."

To conclude, although empirical psychology and theology are different, these disciplines are far from incompatible. Rather, both are crucial elements

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<sup>60</sup> R. Janoff-Bulman, *Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct*, "Social Cognition" 7 (1989) 2, pp. 113–136.

of a holistic agenda designed to revitalize, transform, and heal those people who experience great psychological and spiritual pain, due to catastrophic psychological trauma which the person experienced.

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