

A Spiritual Perspective on Trauma Care

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1. Introduction

In this essay, I explore the intersection between spirituality and trauma and with a view to better understanding trauma related spiritual distress and the mechanisms that establish and sustain it. I affirm the contention that it is quite possible to incorporate “spiritual content... into scientifically based treatment approaches,” thereby making them “more accessible (and effective) to clients for whom spirituality is of central importance” (Miller & Thoreson, 1999, pp. 12-13). I propose that the meaning/control/connection paradigm provides a conceptual framework that satisfies both these objectives.

2. Spirituality and the experience of trauma

a. Trauma

An event can be defined as personally traumatic if it is extremely distressing, poses a significant challenge or threat (directly or indirectly) to well-being, at least temporarily overwhelms an individual's usual coping mechanisms, and results in some degree of functional impairment in one or more of the physical, cognitive, emotional, behavioural, and spiritual domains (Everly & Mitchell, 1999, pp. 2-3; Brymer et al., 2006, p. 5; Wooding & Raphael, 2012, p. 10; Briere & Scott, 2015, p. 10).

Traumatic events can be grouped into six broad categories: violent crime, crisis prone situations, the onset or recurrence of mental illness, natural disasters, accidents, and transitional or developmental stressors or events (Roberts, 2005, p. 4). The literature further suggests that the type of traumatic stressor/event is less predictive of distress than three other factors: the perceived intensity of the experience, a range of predisposing factors in the life of the at-risk individual, and their level of resilience (McFarlane, 1990, p. 42).

Trauma is always experienced in a social context. First, social context shapes the way that individuals perceive and understand trauma. Trauma is expressed by different cultures in “endlessly complex and unique forms” (Watters, 2010, p. 3) and the treatment of trauma-related distress should not be limited to Western “psychosocial, pharmacological, and cognitive-behavioural interventions at the individual level” (Moghimi, 2012, p. 32). Second, the effects of trauma are both personal and corporate.

We are fundamentally social creatures—our brains are wired to foster working and playing together. Trauma devastates the social-engagement system and interferes with cooperation, nurturing, and the ability to function as a productive member of the clan (Van der Kolk, 2014, Epilogue, para. 7).

Because the core assumptions underlying psychological health are formed in a social context, recovery from trauma requires not only addressing personal psychological issues but also “the reconstruction of these assumptions as part of the social system in which they live” (Gordon, 2004, p. 9).

The literature suggests that around 90% of Australians will be exposed, either directly or indirectly, to at least one traumatic event during their lifetime. For some, particularly those working in the emergency services sector, health sector, or defense forces, these are frequent occurrences. The lifetime prevalence of Post-traumatic Stress Disorder resulting from exposure to severe trauma in the Australian general population is 12.2% and the 12-month prevalence is 6.4% (ABS, 2008, pp. 27-28).

b. Spirituality

Spirituality is, in essence, an information processing system in the human brain that finds meaning and purpose in life events by integrating them into a coherent narrative frame and uses meaning as a tool for coping and problem solving. Spirituality is a universal (Covey, 2004, p. 34), complex, and multi-faceted construct involving phenomenological, cognitive, and behavioural components (MacDonald et al., 2015, p. 5). Definitions of spirituality in the literature vary widely but five characteristics are common to most.

First, spirituality is oriented around the search for meaning, purpose, and direction in life (Siporin, 1985, p. 210; Emmons, 2003, p. 92; Connor et al., 2003, p. 487; Murray et al., 2004, p. 40). Spirituality provides interpretative criteria in the form of the personal values, beliefs, and priorities of an individual with which they can subjectively assess and evaluate actions and events and their contribution to the fulfillment of purpose-oriented goals. These criteria are, in turn, influenced by upbringing, culture, religion, and experience.

Second, spirituality includes a striving for “transcendental values” and the knowledge of an “ultimate reality” or “power apart from one’s own existence” (Siporin, 1985, p. 210; Connor et al., 2003, p. 487; Emmons, 2003, p. 92). While the search for meaning and purpose is a subjective exercise, transcendence allows for a more objective evaluation of events and actions. Transcendence requires that the individual step back and “view life from a larger, more objective perspective” (Piedmont, 1999, p. 988) shaped by a set of fundamental principles

that are universal, permanent, external, and independent of self (Covey, 2004, pp. 322-323).

Third, spirituality involves an awareness of connection and belonging. As part of a transcendent perspective, it enables an individual to perceive the fundamental unity and complex interconnectedness of life resulting in a sense of belonging and commitment to the well-being others (Piedmont, 1999, p. 988; Siporin, 1985, p. 210; Connor et al., 2003, p. 487; Emmons, 2003, p. 92) and “a deep sense of engagement and responsibility” with and for the larger whole (Zohar & Marshall, 2001, p. 221).

Fourth, spirituality serves as “a source of intrinsic motivation that drives, directs, and selects behaviours” (Piedmont, 1999, p. 988). It prioritises actions that contribute to the fulfilment of purpose-oriented goals and the well-being of the larger whole.

Finally, spirituality is dynamic. Definitions of spirituality use the terminology of “striving”, “pursuit”, and “searching” (Siporin, 1985, p. 210; Emmons, 2003, p. 92; Connor et al., 2003, p. 487; Murray et al., 2004, p. 40; Pargament et al., 2008, p. 399). Spirituality involves a movement from one state to another. This can include a process of searching for and discovering the sacred or meaningful, a process of conserving or sustaining a relationship with the sacred once it has been found, and “a process of transformation in the character or place of the sacred in the person’s life as a result of internal or external stressors” (Pargament et al., 2008, p. 400). In other words, where circumstances cannot be changed, spirituality enables people to change themselves in such a way as to “rise above such conditions” (Frankl, 2004, p. 133).

The terms “religion” and “spirituality” are often used interchangeably but are not synonymous. This distinction is important, leading some to conclude erroneously that spiritual concerns are unimportant for them because they are not religious. Spirituality is a universal “attribute of individuals” whereas religion is “an organized social entity” (Miller & Thoreson, 1999, p. 6). Religion is an “extrinsic aspect of spirituality” (Connor et al., 2003, p. 487) characterized by “a particular set of beliefs, practices, or experiences” (Pargament et al., 2008, p. 400). Religion gives expression to spirituality in a way that is meaningful for some people, while others express their spirituality in more secular ways. The “beliefs, practices, or experiences” of an individual’s faith tradition are a significant contributor to the criteria and principles used to interpret and evaluate life events.

c. The intersection between trauma and spirituality

Because spirituality is a universal aspect of the human condition, spiritual issues

are an inescapable part of the experience of trauma (Pargament et al., 2008, p. 398). Spiritual issues are almost always present for clients with psychological trauma as they wrestle with questions about the meaning of life, suffering, good versus evil, guilt, and forgiveness (Grame et al., 1999, p. 223). “Many problems faced by clients have a spiritual aspect, especially grief and loss issues” (Roberts, 2005, p. 385). Coping with the experience of trauma can be thought of as “a spiritual process” (Adams, 1995, p. 201) which sits alongside physical, cognitive, emotional, and behavioural processes. Given the mounting body of evidence that individuals utilize religious and spiritual forms of coping and problem solving in the face of adversity, the need for mental health interventions that specifically account for spiritual and religious forms of coping is very real (Bryant-Davis & Wong, 2013, p. 681).

3. A reluctance to engage with the spiritual domain

That being said, there has, in the past, been a reluctance amongst health professionals to engage with the spiritual dimension of trauma. Four reasons have been given to explain this.

First, many are not adequately trained in how to recognize the manifestations of spiritual distress or symbolic requests for spiritual care, and they simply do not have sufficient time to address what are often perceived as lower priority issues (Miller & Thoreson, 1999, p. 9; McCord et al., 2004, p. 356; Monareng, 2013, p. 6; McCormick, 2014, para. 24). Miller notes that “clinical training programs typically do little to prepare their students for professional roles with people who vary widely in their spiritual and religious backgrounds” (Miller, 1999, p. 254). However, this is changing.

Second, in a largely secular society, health care professionals cannot be expected to have a sufficiently detailed understanding of the broad spectrum of religious or spiritual practices and beliefs they may encounter (McCormick, 2014, para. 1). This is less of an issue than one might suppose. A grasp of the five characteristics of spirituality described above, rather than a detailed understanding of specific religious beliefs, in conjunction with making a genuine effort to “understand something about their clients’ spiritual beliefs, practices, and experiences” (Miller & Thoreson, 1999, p. 12) is usually sufficient.

Third, health care professionals are wary of crossing “ethical and professional boundaries by appearing to impose their views on patients” (McCord et al., 2004, p. 356; McCormick, 2014, para. 24). In fact, therapy is never value free. It is neither possible, nor helpful, for a therapist to prevent their spiritual values from influencing the therapeutic process (Richards et al., 1999, p. 135). Provided they ensure that the values of both therapist and client are made explicit and they demonstrate a “profound respect for spiritual, religious, and cultural diversity”

(Miller & Thoreson, 1999, p. 12), the likelihood of a therapist imposing their personal values on a client is minimised and a pathway is created for a healthy therapeutic dialogue about a client's spiritual concerns (Richards et al., 1999, pp. 140, 146, 150).

Fourth, and perhaps most significantly, there has been a failure to clearly define and distinguish between the constructs of psychological distress and spiritual distress, with the consequence that spiritual concerns are sometimes misdiagnosed as psychosocial and treated as such, and some appropriate and very effective spiritual resources for addressing them are either ignored or underutilized (Sermabeikian, 1994, p. 182). The result of this lack of differentiation is that a trauma affected person's genuine spiritual concerns become "quasi-indicators of mental health", leading to a false association between spirituality and physical and mental health (Koenig, 2007, p. S45). Moghimi has similarly noted that reducing "the human experience to a medical category with a specific treatment" is not without consequences (Moghimi, 2012, p. 35). The failure to sensitively address the spiritual component of trauma communicates a lack of understanding and concern for the traumatized person and they can become "hardened and numb—without faith, trust, or hope" (Koenig, 2006, p. 11).

4. Spiritual distress and the mechanisms that establish and sustain it

Given the fourth concern above, how are we to distinguish between the constructs of psychological and spiritual distress? Distress in any domain - physical, cognitive, emotional, behavioural, or spiritual - is distinguished by the "mechanisms that establish and sustain it" (Smelser, 2004, pp. 38-39). For example, "the mechanisms associated with psychological trauma are the intrapsychic dynamics of defence, adaptation, coping, and working through..." (Smelser, 2004, pp. 38-39). The mechanisms associated with spiritual trauma are quite different. Herman describes them as the "ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1997, p. 33).

An analysis of the medical and nursing literature on trauma and spirituality confirms this. The literature identifies a range of concerns that patients self-identify as spiritual and which fall naturally into three broad categories following Herman's schema: first, meaning, purpose, direction, and value; second, self-efficacy and control; and third, connectedness. These align, in turn, with the first three characteristics of spirituality described above. The last two characteristics describe ways that spirituality facilitates action to satisfy these needs. When the needs for meaning and purpose, control, and connection are unsatisfied, spiritual distress results.

A spiritually resilient individual is someone who has a clear sense of their identity and reason for being, often expressed in the form of purpose-oriented goals. They can use meaning as a tool for coping and problem-solving. They can identify pathways and take positive action towards realising their purpose-oriented goals. They remain connected to supportive others.

5. Meaning and purpose

a. Description

The first broad category of spiritual concern is the need to find meaning, purpose, direction, and value in life. Making sense of life experiences, traumatic or otherwise, is a universal, existential need and a primary life motivation (Kierkegaard, 1987, p. 231; Frankl, 2004, p. 105). People are inherently “reflective and inquiring beings” (Kant, 2003, p. 587) with an “inborn need to make sense of experience, to look for relationships, to identify causes and effects” (Ashbrook & Albright, 1999, p. 9). People are also self-determining. That is, rather than being controlled by events, they have the capacity to decide what they will become. “One of the main features of human existence is the capacity to rise above such conditions, to grow beyond them. Man is capable of changing the world for the better if possible, and of changing himself for the better if necessary” (Frankl, 2004, p. 133). A person can conceptualise their desired future state, evaluate their behaviour options in terms of the contribution each makes to bringing about that state, and make choices accordingly (Baumeister, 1991, p. 33). These choices are expressed in the form of purpose-oriented goals which are unique and specific to each individual (Frankl, 2004, p. 105) at a given moment in time (Frankl, 2004, p. 113).

A sense of meaning or purpose is achieved when life experiences are integrated into a “meaningful pattern” or “coherent narrative frame” that spans an individual’s remembered past, their present experience, and their desired future (Baumeister, 1991, p. 33; Baumeister & Wilson, 1996, p. 324; Bering, 2003, p. 117). Meaning/purpose becomes a problem-solving tool when it enables an individual to understand how a present difficult situation can make a positive contribution to achieving a desired future (Highfield & Cason, 1983, p. 188; Moadel et al., 1999, p. 380; Murray et al., 2004, p. 41). A loss of meaning results when purpose-oriented goals are not satisfied (Baumeister, 1991, p. 29) and the world comes to be seen as “an unpredictable, uncontrollable and dangerous place in which one is helpless to affect fate, or burdened by real or imagined feelings of responsibility for the fate of the victims” (Marmar et al., 1996, p. 80).

b. Indicators of distress

Indicators of a loss of meaning or purpose include: existential dissatisfaction

(Sartre, 1992, p. 477), anxiety or anxiety-related behaviours in response to threats (Harmon-Jones et al., 1997, p. 24; Pyszczynski et al., 1997, p. 2), feelings of meaninglessness, inauthenticity, and guilt (Sartre, 1992, pp. xxxviii-xxxix), lowered self-esteem (Pyszczynski et al., 1997, p. 2; Pyszczynski et al., 2004, pp. 436-437), the loss of criteria for evaluating decisions and actions (Baumeister, 1991, p. 33), the loss of motivation “to move forward... in spite of fears” (Crocker & Nuer, 2004, p. 4), the loss of a sense that life is worthwhile, having no reason to live, having no hope for the future, being unsure of who they are, being unable to develop new frames of meaning capable of incorporating the life truths exposed by their experiences of trauma, and asking questions like “Where do I fit in?” or “What have I done to deserve this?” (Highfield & Cason, 1983, p. 188; Herman, 1997, pp. 33, 51; Grant, 1999, p. 9; Murray et al., 2004, p. 41; Koenig, 2006, p. 10; McClung, 2006, p. 148).

c. Distress minimisation

How does the attribution of meaning or purpose to a traumatic event contribute to distress minimisation? Four mechanisms of action can be identified.

Affirmation and assimilation

First, the disconfirmation of fundamental goals and core beliefs is, in itself, a source of distress. It has been suggested that spiritual/religious beliefs serve a distress buffering function because they are “less subject to empirical disconfirmation” than other beliefs and are therefore “more resilient than empirical assumptions about the world” (Overcash et al., 1996, p. 456). It would appear that any action to strengthen cultural worldviews and self-esteem will make the individual less prone to exhibiting anxiety or anxiety-related behaviour in response to threats (Harmon-Jones et al., 1997, p. 24). Moreover, assimilating difficult events into the “coherent narrative frame” provided by existing spiritual/religious beliefs removes the necessity of having to accommodate or change empirical beliefs to be consistent with the experience (Overcash et al., 1996, p. 463).

Orientation

Flowing from this, the ability to integrate trauma into a meaningful framework allows a survivor to “ultimately move forward in the adaptation and resolution process” (Gall et al., 2007, p. 115). It enables them to see their activities as “oriented toward a purpose” (Baumeister, 1991, p. 32) or as steps towards a desirable outcome or better future (Baumeister & Wilson, 1996, p. 322) and provides the motivation to strive to attain that future (Brenner et al., 2009, p. 394). Even unpleasant experiences have value and worth in so far as they contribute towards achieving this better future (Baumeister, 1991, p. 33). Interestingly, life

can still be considered meaningful even if purpose-oriented goals are never reached provided that the desired, future state is clearly conceptualized, current behaviours are evaluated in the light of progress towards the goal, and choices are made that contribute towards achieving the goal (Baumeister, 1991, p. 33).

Explanation

Third, spiritual/religious beliefs offer comfort by providing “a reason (or suggest that a reason is known to a higher power) for events that science and logic cannot satisfactorily explain” (Davis & Nolen-Hoeksema, 2001, p. 732) and “answers to seemingly unanswerable questions” (Pargament et al., 1990, p. 814).

Protection and buffering

Fourth, a sense of meaning or purpose functions as a protective shield against mortality salience, that is, the “awareness of the horrifying possibility that we humans are merely transient animals groping to survive in a meaningless universe” (Pyszczynski et al., 2004, p. 436).

6. Control

a. Description

The second broad category of spiritual concern is the need for self-efficacy or control. Control can be defined as the ability to minimize uncertainty about the outcome of life events, to predict beneficial courses of action, to have confidence in the efficacy of one’s chosen course of action to achieve the desired outcome, to exercise some degree of control, either directly or indirectly, over events, and to have access to the information and resources/spiritual resources necessary to make and implement decisions to realise life goals (Highfield & Cason, 1983, p. 188; Moadel et al., 1999, p. 380; Hermann, 2001, p. 69; Murray et al., 2004, p. 41; Hermann, 2006, p. 742). Individuals need to find “a stable niche in a predictable environment” (Long, 1977, p. 420). This is “a primary and fundamental motivating force in human life and one of the most important variables governing psychological well-being and physical health... The need to be and feel in control is so strong that individuals will produce a pattern from noise to return the world to a predictable state” (Whitson & Galinski, 2008, pp. 115, 117). Control overlaps with self-esteem, one aspect of which is “confidence in our ability to cope with the basic challenges of life” (Branden, 1992, p. vii). A traumatic event is, by definition, uncontrollable, violating this fundamental need and causing distress. There is strong correlation between higher levels of cognitive anxiety and a greater discrepancy between the actual control an individual has and the degree of control they believe they ought to have (Wilkinson & Chamove, 1992, pp. 71-72).

b. Indicators of distress

Indicators of the loss of self-efficacy or a sense of control include feeling frustrated, anxious, depressed, useless, helpless, powerless, lost, disoriented, ineffective, without control, lacking confidence, and unable to move forward (Highfield & Cason, 1983, p. 188; Herman, 1997, p. 33; Grant, 1999, p. 8; Murray et al., 2004, p. 41; McKay, 2010, p. 216). Some negative behavioural responses include the abuse of power, revenge-seeking behaviour (McKay, 2010, pp. 238-239), superstitious rituals, and the embracing of conspiracy beliefs (Whitson & Galinski, 2008, p. 115).

c. Distress minimisation

How does a sense of control contribute to distress minimisation? Six possible mechanisms of action have been suggested.

Benign external control

First, these beliefs provide “an external framework of control more benign than other external frameworks such as beliefs in powerful others or chance” (Pargament et al., 1990, p. 814). This results in an awareness of the limits of personal agency, lifts the burden of personal responsibility, and fosters a reliance on others.

Hope and self-acceptance

Second, a relationship with a benevolent higher power “helps the survivor to maintain a sense of hope and self-acceptance in the face of the consequences of his or her traumatic history” (Gall et al., 2007, p. 114).

Stability and security

Third, a relationship with a benevolent God or higher power provides a stable and secure base “from which to approach a difficult and/or stressful situation” and a place of sanctuary in an out-of-control world (Gall et al., 2007, p. 114).

Tolerance and benefit finding

Fourth, the belief in a benevolent higher power provides distress tolerance/buffering, emotion regulation, and enables benefit finding and the reframing of personal challenges as opportunities for growth (Ironson et al., 2011, p. 421).

Compensatory responses

Fifth, the feelings of powerlessness engendered by a lack of control can lead to very strong compensatory responses directed at regaining some measure of control. These include taking “assertive, decisive” action “to influence others when such influence is advantageous” and the avoidance of “unpleasant outcomes or failures by manipulating events to ensure desired outcomes” (Burger & Cooper, 1979, p. 383). However, when it comes to minimizing distress, it appears that almost any action to regain some measure of control, regardless of whether or not it is effective, will have the effect of decreasing the stressfulness of the situation (Park & Folkman, 1997, pp. 126-127).

One common compensatory response is causal attribution. Five possible causal agents can be identified: self, chance, others, natural causes, and God or a higher power. Attributing cause, blame, or responsibility, to powerful others means that an event is no longer random and restores a sense of predictability. Aligning with powerful others then provides a sense of indirect or secondary control. The belief in “a universal power, perceived transcendence, or divine intervention in one’s life” provides a sense of indirect control over otherwise uncontrollable events (White et al., 2008, p. 10). What an individual believes about the nature of the causal agent also affects the outcome. For example, the belief in a good, just, benevolent, personal God and “the experience of God as a supportive partner in coping” is predictive of positive outcomes (Pargament et al., 1990, pp. 793, 803; Gall et al., 2007, pp. 104, 109; Johnstone & Yoon, 2009, p. 428; Ironson et al., 2011, p. 420; Bryant-Davis & Wong, 2013, p. 677) whereas the belief in a distant, angry, and punishing God is predictive of poorer outcomes (Pargament et al., 1990, p. 814; Gall et al., 2007, p. 201; Johnstone & Yoon, 2009, p. 423).

Illusory pattern perception

Sixth, when an individual is unable to gain a sense of control objectively, is that they may seek to gain it perceptually through “illusory pattern perception.” This is “the identification of a coherent and meaningful interrelationship among a set of random or unrelated stimuli (such as the tendency to perceive false correlations, see imaginary figures, form superstitious rituals, and embrace conspiracy beliefs, among others)” (Whitson & Galinski, 2008, p. 115). Illusory pattern perception is not necessarily maladaptive. While not preferable, it does have the short-term benefits of decreasing depression and anxiety, creating confidence, increasing agency, and allowing the individual to engage rather than withdraw from their environment. The negative aspects can be moderated by giving individuals the opportunity to self-affirm important values and beliefs. Those who do so see less non-existent patterns and perceive less likelihood of conspiracy (Whitson & Galinski, 2008, p. 117).

7. Connection

a. Description

The third broad category of spiritual concern is the need for connection, specifically the need to maintain positive supportive relationships with peers, friends, family, or a higher power. It includes the knowledge that there is continuity of relationships, even in the midst of chaos, that the suffering individual is not alone, and that there are external sources of strength on which to draw (Hermann, 2001, p. 69; Murray et al., 2004, p. 41; Hermann, 2006, p. 742). “One of the ironies in trauma recovery is that the traumatic event can disrupt support networks at the very time they are most needed” (Lyons, 1991, p. 101).

Psychology defines the human need for connection as “a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships...” A characteristic of these relationships is an “affective concern for each other's welfare” (Baumeister & Leary, 1995, p. 497). From an evolutionary perspective, these relationships had important survival implications through food sharing, cooperative hunting, defense, and the shared care of young. The need for connection is affiliated with a range of other behaviours, namely achievement, approval, and intimacy. People place greater value on those achievements that are validated and appreciated by others, approval is a prerequisite for forming social bonds, and intimacy is a defining quality of close relationships (Baumeister & Leary, 1995, p. 498).

b. Indicators of distress

An unsatisfied need for connection can be seen in “a variety of ill effects, such as signs of maladjustment or stress, behavioral or psychological pathology, and possibly health problems” (Baumeister & Leary, 1995, p. 500). The affective indicators of an unmet need for connection include: lowered self-esteem, loneliness, feelings of isolation and abandonment, feelings of disconnection from human and divine systems of care and protection, social anxiety resulting from threatened or actual exclusion from important social groups, depression, jealousy where rejection results from the presence of a third party, and attributing the cause of rejection to characteristics of the rejecting person, personal inadequacies, or environmental factors, sadness, hurt feelings, jealousy, guilt, shame, embarrassment, grief, and failure (Baumeister & Leary, 1995, pp. 506-507, 509; Herman, 1997, pp. 33, 51; Grant, 1999, p. 10; Kelly, 2001, pp. 295-299; Leary et al., 2001, p. 160; Murray et al., 2004, p. 41; Koenig, 2006, p. 10; McClung et al., 2006, p. 148; Mellor et al., 2008, p. 214). Cognitive indicators include attributing cause or responsibility for a lack of connection to the negative characteristics or personality of others and a commensurate desire to avoid future contact with these people, to personal inadequacies, or to uncontrollable

circumstances (Kelly, 2001, pp. 299-300). Behavioural indicators include conciliatory behaviour, passive-aggressive behaviour, increased aggression, disruptiveness, restlessness, oversensitivity, and a reluctance or refusal to interact with family and friends (Kelly, 2001, pp. 300-301). Physiological indicators include lowered immune function and greater physical health problems amongst unattached people (Baumeister & Leary, 1995, pp. 508-509).

c. Distress minimisation

The specific mediators between the experience of connection and coping with the effects of exposure to trauma are unclear, however, three observations can be made.

Strength in continuity

First, the continuity of positive supportive relationships in the midst of trauma is a significant source of strength (Hermann, 2001, p. 69; Murray et al., 2004, p. 41; Hermann, 2006, p. 742).

Hope and self-acceptance

Second, a sense of emotional connection with God or a higher power is an “important correlate of positive outcomes” (Pargament et al., 1990, p. 814) and may protect against distress by providing a greater sense of personal hope and self-acceptance and by serving as stable and secure base “from which to approach a difficult and/or stressful situation” (Gall et al., 2007, pp. 112-114).

Setting realistic limits

Third, emotional connection has the effect of balancing personal effort and a realistic “recognition of the limits of personal agency” with “the knowledge that the deity will be there to make events endurable” (Pargament et al., 1990, pp. 814-815). I would suggest that the benefits attributed to a sense of emotional connection with God or a higher power - personal hope and self-acceptance, a secure base from which to operate, and the knowledge of external sources of support - are true of all positive supportive relationships.

8. Four keys to effective spiritual trauma care

The goal of trauma care is to assist a trauma sufferer to regain “short- and long-term adaptive functioning and coping” (Brymer et al., 2006, p. 5). The experience of trauma impacts on individuals across the physical, cognitive, emotional, behavioural, and spiritual domains. Effective solutions will similarly address each domain, however, positive improvements in any one domain are likely to result in benefits in the others. In the spiritual domain, we provide trauma care by

assisting the individual to utilise their spiritual information processing system to make sense of their experience, gain a degree of control, either directly or indirectly over their experience, and remain connected to sources of support.

Engaging the spiritual information processing system requires, first, that we recognize it. Spirituality is a part of the human condition, spiritual issues are an inescapable component of the experience of trauma, and individuals, knowingly or unknowingly, use spiritual forms of coping and problem solving in the face of adversity. *Spirituality matters to many trauma-affected people.*

Second, engagement does not require agreement with specific spiritual or religious belief systems, however, it does require that we are fully present with a trauma affected individual and *demonstrate a genuine respect for their deeply held spiritual beliefs and practices.* This, in turn, requires an awareness of the fact that people use their spirituality to:

- Find meaning and facilitate problem solving,
- Provide an objective perspective on events,
- Strengthen their sense of belonging to and responsibility for others,
- Motivate action, and
- Achieve personal growth.

Third, we must make a concerted effort to understand how the individual's spiritual/religious beliefs and practices have found expression in their pre-trauma, peri-trauma, and post-trauma experience to achieve the outcomes described in the previous paragraph. In other words, we need to *listen to the story of their spiritual journey. Where have they come from? Where are they going? How has this event impacted on the journey? How have their spiritual/religious beliefs and practices satisfied the five functions of spirituality described above?* The answers to this last question will likely provide pathways for achieving the goals of spiritual trauma care listed below.

A range of spiritual assessment/spiritual history tools have been developed by clinicians to facilitate the process of spiritual assessment and information gathering. Some examples include FICA (Puchalski & Romer, 2000), HOPE (Anandarajah & Hight, 2001), CSI-MEMO (Koenig, 2002), FAITH (King, 2002), and Four FACTs (LaRocca-Pitts, 2015). The advantage of these instruments is that they allow for the collection of the relevant information in a brief time period, however, they are not without limitations. First, when used too clinically, they can make the carer appear impersonal and unsympathetic. Second, Australian spirituality tends to be private, personal, and individualistic (Tacey, 1995, p. 126), it is only spoken about with reticence (Bouma, 2006, pp. 2, 33), it is “without dogma” (Frame, 2009, p. 76), and it is quite secular in form (Williams, 2015, p. 8).

Moreover, many Australians are “disconnected from their spiritual selves” (Tacey, 2004, p. 30). As a consequence, the language of faith used in these tools, while meaningful in other cultural contexts, is foreign to many Australians. Therefore, time constraints permitting, it can be more constructive simply to *listen for the indicators of the loss of meaning, control, and connection*, identified above, as a client tells their story in their own way and test the validity of these observations with the client.

Fourth, the goals of spiritual trauma care are threefold.

a. Meaning and purpose

The first is to assist the individual to regain a sense of meaning or purpose through:

- the *affirmation* of fundamental goals and core beliefs;
- the *assimilation* of experiences into a “meaningful pattern” or “coherent narrative frame” provided by those existing beliefs and spanning their remembered past, present experience, and desired future; and
- the *orientation* of events and activities towards a purpose thereby giving them value as steps towards a desired outcome or better future and in doing so providing an *explanation* or answer for the seemingly inexplicable.

Almost any positive action taken to strengthen fundamental goals and core beliefs and bolster self-esteem will make the individual less prone to exhibiting anxiety-related behaviours in response to threats.

b. Control and self-efficacy

The second is to provide access to the information and resources necessary for the exercise of some degree of control, either directly or indirectly, over the consequences of a traumatic event, thereby minimizing uncertainty about the outcome and enabling the individual to choose a beneficial course of action and have confidence in the efficacy of that course of action to achieve their desired outcome. Actions might include:

- Recognising and accepting the *limits of personal agency*;
- Fostering reliance on *benign external sources of control* to overcome these limitations;
- Encouraging *hope and self-acceptance*;
- Providing a *secure and stable sanctuary* from which to operate;
- Facilitating *benefit finding* by the reframing of personal challenges as opportunities for growth; and

- Identifying other *compensatory responses* that might allow for the regaining some measure of indirect control over the individual's circumstances.

Almost any action to regain a measure of control, regardless of whether or not it is effective, will have the effect of decreasing the stressfulness of the situation.

c. Connection

The third is to aid the individual in restoring, maintaining, or creating, positive supportive relationships with peers, friends, family, or a higher power to facilitate each of the above.

9. Conclusion

Spirituality is an information processing system that operates in concert with a number of other information processing systems in the human brain. As a universal aspect of the human condition, spiritual issues are an inescapable part of the experience of trauma, indeed, coping with the experience of trauma can be thought of as “a spiritual process” (Adams, 1995, p. 201). Spiritual concerns fall naturally into three broad categories: first meaning, purpose, direction, and value; second, self-efficacy and control; and third, connectedness. Spiritual distress results when any of these needs are unmet.

Meaning is the universal, existential need to make sense of life experiences, traumatic or otherwise, by incorporating them into a coherent narrative frame. *Control* is the need to minimize uncertainty about the outcome of life events, predict beneficial courses of action, have confidence in the efficacy of one's chosen course of action to achieve the desired outcome, exercise some degree of control, either directly or indirectly, over events, and have access to the information and resources/spiritual resources necessary to make and implement decisions to realise purpose-oriented goals. *Connection* is the need to maintain positive supportive relationships with peers, friends, family, or a higher power, have continuity of relationships, even in the midst of chaos, and know that there are external sources of strength they can draw on. Together these provide a conceptual framework that explains spiritual distress and spiritual resilience and can inform and direct spiritual trauma care. Spiritual trauma care is the process of assisting a trauma affected individual to engage their personal spiritual information processing system.

The foundations of this process are recognition, respect, and understanding. We *recognise* that spirituality is a universal part of the human condition, that spiritual issues are an inescapable component of the experience of trauma, and that individuals, knowingly or unknowingly, do use spiritual forms of coping and

problem solving in the face of adversity. We demonstrate a genuine *respect* for each individual's deeply held spiritual beliefs and practices, irrespective of whether or not we agree with them. We make a concerted effort to *understand* how these spiritual/religious beliefs and practices have found expression in the individual's pre-trauma, peri-trauma, and post-trauma experience. Within this context, we can assist the individual to recover a sense of meaning and purpose; we can provide access to the information and resources necessary for the exercise of some degree of control, either directly or indirectly, over the consequences of a traumatic event, thereby minimizing uncertainty about the outcome and enabling the individual to choose a beneficial course of action and have confidence in the efficacy of that course of action to achieve their desired outcome; and we can assist the individual in restoring, maintaining, or creating, positive supportive relationships with peers, friends, family, or a higher power.

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