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Spiritually Integrated Care for Veteran Trauma Survivors: A Quantitative Analysis

by

Krystle Englund, BSW, LSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to determine if spiritually integrated care positively changed symptoms of Posttraumatic Stress Disorder and spiritual distress in veterans. This quantitative study used secondary data ($n = 138$) from a sample of veterans identified by the Minneapolis Veteran Affairs Health Care System. Instruments used in the study were the Posttraumatic Stress Disorder Checklist and the Religious and Spiritual Struggles Scale. The findings from this study included a decrease in spiritual distress following a spiritually integrated intervention. Veterans who participated in an 8-session group intervention known as Building Spiritual Strength self-reported less distress with a Higher Power following the conclusion of the study. Additional findings included positive correlations between Posttraumatic Stress Disorder symptoms (re-experiencing, avoidance, and hypervigilance), and subscale scores on the Religious and Spiritual Struggles Scale. Implications for social work practice and the implications for research are discussed in this research study.

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Spiritually Integrated Care for Veteran Trauma Survivors: A Qualitative Analysis

Introduction

During combat, service members are exposed to situations that may come into conflict with their spiritual and moral beliefs. Service members are often required to perform duties that may conflict with their spiritual beliefs and challenge their morals, such as acts of violence against others, killing, witnessing death, and other atrocities. Moral injury is a term used to address how veterans' spirituality or morals can be impacted by trauma (Litz et al., 2009). Moral injury and all that it encompasses can be a rather nuanced topic, particularly when considering exposure-based and environmental-based traumas (Litz et al., 2009). Additionally, moral injury as it occurs within the veteran population—which differs greatly compared to non-veterans—due to exposure to combat, killing or witnessing death, or orders given during combat-specific situations which may conflict with one's morals (Drescher et al., 2011).

War-related trauma may change service members' subsequent lives in numerous ways. Those who have experienced spiritually traumatic events express symptoms of shame and guilt as well as Posttraumatic Stress Disorder symptoms such as avoidance, hypervigilance and re-experiencing an event (Litz et al., 2009). Morally injurious events can change service members' lives. Exposure to the event impacts a person's morals, making them question their actions and feelings (Maguen & Litz, 2016). Other symptoms of moral injury include social withdrawal, legal problems, loss of trust, spiritual conflict, loss of meaning, loss of caring, depression, anxiety, and loss of self (Drescher et al., 2011).

Spirituality in veterans can be a positive attribute when encountering a spiritually distressing traumatic event. In veterans with a strong sense of spirituality, they may turn to their Higher Power following a traumatic event to help them process in a healthy way, or they could question why a Higher Power would allow such events to occur (Drescher & Foy, 2008). When moral injury is present, veterans' beliefs in the face of trauma may change spiritually in one of four ways: loss of faith, negative spiritual coping, feelings of guilt, and lack of forgiveness (Foy & Drescher, 2015).

Three main interventions have been identified that have been used to support veterans who have experienced/are experiencing spiritual distress due to traumatic event(s). The first intervention is Adaptive Disclosure, a therapeutic method targeted for active duty service members that focuses on processing the morally or spiritually injurious event without shame or guilt (Gray et al., 2012; Steenkamp et al., 2011). The second is Building Spiritual Strength, an eight-session group-based treatment intervention that focuses upon addressing spiritual conflicts that have occurred, and developing greater spiritual resilience (Harris et al., 2011). The third is the Spirituality and Trauma model, which targets moral injury and spirituality for service members diagnosed with posttraumatic stress disorder within residential treatment settings. The focus of this intervention is to gain comfort in talking about the traumatic event and to increase healthy spirituality (Foy & Drescher, 2015).

In the process of attempting to target morally and spiritually injurious events, it can be helpful for providers to understand several types of barriers that might come up within treatment contexts. Veterans' experiences of shame and guilt, ruptures that may take place in the therapeutic alliance, and conflicts that arise among therapists in relation

to their beliefs and values are three common examples of such treatment barriers. One main barrier is that a veteran or service member often has shame or guilt from experiencing the event, and are uncomfortable sharing their experience with others. An important factor in treating someone with a moral injury is to build a therapeutic relationship allowing the veteran or service member to be open and feel safe disclosing an event they experienced. Another barrier is the clinician's countertransference if they do not build a strong sense of self-reflection. If a clinician experiences countertransference when working with a veteran with spiritual distress, they may change their body language or give other cues that cause the veteran to limit their account of the event due to feelings of guilt or shame not addressed by the clinician (Litz et al., 2009).

While there are several barriers to working with veterans with spiritual distress, social workers can have a positive impact on treating service members who have experienced morally injurious events. It is important for the social worker to develop rapport with the veteran and create an environment free of judgment. This will allow the veteran to discuss what occurred and thoughts surrounding the event. Because of the possible guilt or shame a service member may have due to the event, social workers need to have an awareness of their beliefs and values, and how it could affect their work with the veterans they are serving. Social workers need to have knowledge of how trauma impacts the lives of individuals, and how to practice with a trauma-informed lens. Practicing from a trauma-informed lens allows a practitioner to explore trauma while also assessing the areas of the awareness of the trauma, safety, and control while using a strength-based approach (Hopper, Bassuk, & Olivet, 2009).

Spiritually integrated care is an uncommon practice within the mental health field, and it could affect the way a veteran processes their traumatic event and the meaning behind it. The purpose of this study is to determine if spiritually integrated group therapy has a positive change in self-reported spiritual distress in veterans with a diagnosis of Posttraumatic Stress Disorder.

Literature Review

The literature review is divided into three primary sections. First, common terms used throughout the literature review are introduced that are relevant to this research. Second, 10 relevant empirical studies will be analyzed and connected to the research as a secondary data analysis are summarized. Third, an overview of moral injury, combat exposure, and spirituality research are discussed and then connected to this secondary quantitative data analysis of using spiritually integrated care to treat spiritual distress encountered by veterans.

Definition of Terms

In this section, definitions that are relevant to moral injury, posttraumatic stress disorder, spirituality in veterans, and an introduction to military specific concepts are introduced.

Definitions of relevance to spirituality in veterans. Spirituality is assessed in service members for three main reasons. The first is to determine if a service member is fit for duty, which includes a comprehensive exam including fitness, mental health, and spiritual health. The second reason is that spirituality can also help with cohesion in a service member's unit and help provide a coping mechanism for experiencing a traumatic event (Hufford, Fritts, & Rhodes, 2010). Finally, when a service member experiences a traumatic event, they may question why a Higher Power would allow such an event to occur, thus causing a negative impact on their spirituality (Dresher & Foy, 2008).

From a theoretical perspective, Foy and Drescher (2015) identify four main areas of negative spiritual impact related to combat trauma: loss of faith, negative religious coping, guilt, and lack of forgiveness. When a service member experiences a traumatic

event that they cannot fit into their cognitive schema it may cause a loss of faith as a result and they may question their Higher Power. A service member may express anger with their Higher Power as a coping mechanism. They may also experience conflict with clergy when a spiritually distressing event occurs. When a service member plays a role in a traumatic event, they may experience guilt due to another service member perishing in combat, or if they felt they could have performed differently to change the outcome of the event. For service members with spiritual distress, they may struggle with forgiving themselves, others or their Higher Power which can lead to more symptoms of trauma. (Foy & Drescher, 2015).

Definitions of relevance to moral injury. Moral injury is a relatively new term; however, service members have experienced moral conflicts for many years. Fontana, Rosenheck, and Brett (1992) conducted a quantitative research study to determine the relationship between war zone stressors and posttraumatic stress disorder symptomology. This study specifically looks at killing and failing to prevent death as factors contributing to symptoms of posttraumatic stress disorder (Fontana, Rosenheck, & Brett, 1992). Shay (1991) first discussed the concept of how combat exposure can cause moral injury, and question what is right in a service member's life.

The working definition of moral injury is “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness” (Litz et al., 2009, p. 700). Moral injury can occur in a service member due to the nature of their mission, their rank structure and other factors relating to their military career. At times during a deployment, service members may need to be more aggressive than their training taught them, and may violate the rules of engagement

to protect themselves and their fellow troops (Drescher, et al., 2011). Soldiers have been taught moral disengagement during their basic training to help them become more lethal (Antal & Winings, 2015), however many do experience morally injurious events including killing, witnessing killing, or obeying commands of senior ranking service members (Litz et al., 2009).

Moral injury does not have a classification in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5); however, it can at times be similar to the diagnosis of posttraumatic stress disorder due to the symptoms experienced, such as intrusion and avoidance (American Psychiatric Association [APA], 2013). Symptoms of moral injury include social withdrawal, legal problems, loss of trust, spiritual conflict, loss of meaning, loss of caring, depression, anxiety, guilt, shame, and loss of self (Drescher et al., 2011). If a service member has not had prior experience with a similar trauma, they could have difficulty processing the morally injurious event and could experience memory intrusions (Litz et al., 2009). Because there is not a specific moral injury diagnosis, there is a possibility of missing it while assessing a service member's mental health. The implications of not having a specific moral injury diagnosis will be discussed later in this research.

Four major areas of morally injurious events which can occur in the military include acts involving civilians, disproportionate violence, betrayal and between rank violence. Betrayal takes many forms, including failure to live up to a service member's moral standards, betrayal by civilians, and betrayal by peers. Violence can happen in many situations, including mistreatment of enemy combatants, or revenge due to a fellow service member being injured or killed in combat. During combat, civilians may be

assaulted or have their personal property damaged. Within the military, violence can be experienced or witnessed through occurrences of friendly fire or military sexual trauma. (Drescher et al., 2011).

Definitions of relevance to Posttraumatic Stress Disorder. Posttraumatic Stress Disorder (PTSD) is defined as having experienced a life-threatening trauma that causes a significant distress in a person's life, whether the traumatic event was experienced directly, or indirectly because of the account of the traumatic event (APA, 2013). Eight criterion must be met for the diagnosis of PTSD: (1) Exposure to actual or threatened death, serious injury, or sexual violence; (2) presence of one or more intrusion symptoms associated with the traumatic event; (3) persistent avoidance of stimuli associated with the event; (4) negative alterations in cognitions and mood associated with the traumatic event; (5) marked alterations in arousal and reactivity associated with the traumatic event; (6) duration of the disturbance that is longer than one month; (7) disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning; and, (8) the disturbance is not attributable to the physiological effects of a substance or another medical condition (APA, 2013). Posttraumatic Stress Disorder has varying prevalence among combat veterans in different war eras; post-9/11 veterans experience PTSD at a rate of 11-20%, while Gulf War era veterans experience PTSD at a rate of 12%. Vietnam era veterans have the highest prevalence of PTSD at 15%, and approximately 30% of Vietnam era veterans have experienced PTSD at some point in their lifetime (National Center for PTSD, 2016).

A Review of Relevant Empirical Studies

Research relevant to types of traumatic events. The following research studies target how traumatic events can be categorized as well as their impact on a service member's mental health, suicidal ideation, and other symptomology due to combat.

In one study, Stein et al. (2012) conducted a quantitative study to identify and categorize different types of traumatic events and their impact on service members. Categories included: Life Threat to Self, Life Threat to Others, Aftermath of Violence, Traumatic Loss, Moral Injury by Self, and Moral Injury by others. In a sample of active duty service members ($n = 119$) at Fort Hood, Texas, participants were assessed based on their traumatic events and placed in the categories mentioned above. One traumatic event could fall into more than one category. Life Threat to Self includes traumatic events that caused a service member to feel their life was threatened in some way. Examples include receiving enemy fire and experiencing military sexual trauma, among others. Life Threat to Others explored traumatic events that occurred to others and had a negative effect on a service member. Examples of life threat to others may include witnessing death, hearing of a traumatic event, or encountering threats of death. The Aftermath of Violence included exposure to the outcomes of combat, including mangled and dead bodies, destroyed buildings, injured service members or civilians. The Traumatic Loss category included watching a death or hearing of a death of a service member. Lastly, morally injurious traumatic events were categorized into two categories: Moral Injury by Self, and Moral Injury by Others. Internalizing morally injurious events could include killing others, preventing death, giving orders to fire, or rape. Externalizing morally injurious events could include witnessing atrocities such as witnessing a rape, seeing dead bodies,

and being betrayed by another service member. The study concludes that there was a correlation between the moral injury categories and posttraumatic symptoms. If a service member's trauma experience was categorized in one of the moral injury categories, they were likely to have symptoms of re-experiencing the event (Stein et al., 2012).

In another study on quantitative research with Vietnam era veterans ($n = 1,709$), Fontana, Rosenheck, and Brett (1992) identified and categorized traumatic events and service members' roles in the events. Roles were assigned based on the service member's part in the traumatic event: Target, Observer, Agent, and Failure. Three main variables were identified in this study: combat exposure, witnessing abusive violence and participating in abusive violence. Approximately one-third of the sample participated in abusive violence, while 39% witnessed abusive violence. These variables fit into the four roles that service members participate in combat. The role of Target consisted of being a target in combat and the role of Observer consisted of observing killing when in combat. The role of Agent consisted of attempting to or killing others and is broken down into three categories: guilt over killing others, guilt over the enjoyment of killing others, and guilt or self-loathing over participating in atrocities. The fourth role of Failure consisted of having failed at preventing death or injuries, and is broken down into four categories: guilt over failing to fulfill duties or responsibilities; feeling inadequate to effectively treat or save the wounded; grief or anger over the death of a fellow service member; and guilt over accidentally contributing to the death of a service member or another American. The role of failure has similar situations to that of a morally injurious event and scored higher for suicide and PTSD (Fontana et al., 1992). Although moral injury was not specifically

identified in this study, the roles of Observer, Agent and Failure were roles that could have had symptoms of moral injury.

Additional quantitative research with Gulf War veterans ($n = 317$) evaluated deployment experiences and mental health symptoms. Maguen et al. (2011) surveyed Gulf War veterans on their exposure to danger, witnessing killing, exposure to death or dying, and killing. Results found that 46% of veterans reported feeling at danger during their deployment, 42% were exposed to death and dying, 19% saw a service member killed in action, and 11% report killing an enemy. The sample also scored high for mental health symptoms: 30% for posttraumatic stress symptomology and 45% for depression (Maguen, Vogt, King, L., King, D., & Litz, 2011).

In their research, Maguen et al. (2011) conducted similar study that examined mental health and combat exposure as a risk factor in suicidal ideation among Iraq War veterans ($n = 2,854$). The data for the study was collected via post-deployment screenings. The purpose of the study was to determine if combat exposure and mental health symptoms were risk factors of suicidal ideation. The study measured combat exposure, PTSD screening, depression screening, alcohol use, suicidal ideation, and psychiatric history. Results of the study were that 2.8% had thoughts of self-harm or suicidal ideation. There was a correlation between past killing and suicidal ideation which was mediated by symptoms of depression and PTSD ($p = .01$; Maguen, et al., 2011). This study fits with moral injury research because it includes combat exposure, killing, and suicidal ideation, which are factors for moral injury.

Other quantitative research by Tripp et al. (2016) investigated an association between the act of killing and suicidal ideation. Operation Iraqi Freedom (OIF; 2003 –

2010) and Operation Enduring Freedom (OEF; 2001 – 2014) veterans ($n = 68$) were sampled from a Veteran Affairs (VA) Medical Center and invited to participate in an alcohol intervention study. Most veterans were first time users of VA Health Care services. The study measured combat exposure, combat-related PTSD, depression, alcohol use, and misuse. Combat exposure measures included questions about firing a weapon and killing. Fifty-seven percent of the sample met criteria for PTSD, and there was a relationship between having suicidal ideation and believing someone was killed. Limitations of this study were the inclusion criteria requiring an alcohol use disorder, the suicidal ideation assessment was one question, and a small sample size (Tripp, McDevitt-Murphy, & Henschel, 2016).

Research that examines the impact of trauma on spirituality. Spirituality can have an impact on how a person processes a traumatic event. Spiritual professionals such as chaplains or ministers can utilize confession as a way for veterans to process morally injurious events in a safe, non-judgmental way (Antal & Winings, 2015). Service members experiencing combat may experience either a positive or negative change in their spirituality.

Tait et al. (2016) conducted qualitative research that examined associations between prayer and mental health symptoms, which included trauma. Veterans who had returned from combat in Operation Iraqi Freedom (OIF; 2003 – 2010) or Operating Enduring Freedom (OEF; 2001 – 2014) missions within the past six months were surveyed ($n = 110$). Veterans were recruited via telephone and postal mail. Results from this study found that 110 veterans experienced at least one traumatic event while deployed. There was an association between the urge to disclose the trauma and the

prayer coping variables of provides acceptance ($p < .001$), provides calm and focus ($p < .001$), provides assistance ($p < .001$), and deferring/avoiding prayer ($p = .013$; Tait, Currier, & Harris, 2016). Results from Tait and colleagues study are relevant to the current study in that spirituality has an impact on the disclosure of trauma, and likely moral injury.

Additional research by Kopacz, Currier, Drescher & Pigeon (2016) found that difficulty with forgiveness was correlated with suicide risk. This quantitative study sampled veterans ($n = 472$) on an inpatient PTSD unit measured religiousness, spirituality, and PTSD symptoms. Findings included less suicidal ideation in veterans engaged in spiritual practices or attending church ($p = .008$). Results from this study are relevant to the current study in that spirituality has implications on suicidal ideation and risk factors.

Holland et al. (2014) conducted qualitative research to determine if a service member's spirituality was impacted by experiencing a morally injurious event and finding the meaning behind the event. Several tools were administered to veterans ($n = 140$) from a community college in Southern California. Results found were that veterans with more combat exposure had more morally injurious experiences ($ps < .01$). Veterans were unable to make meaning of the morally injurious event and had a negative religious coping ($p < .01$) in response to the event. However, veterans who practiced spirituality daily had positive religious coping and scored high on forgiveness ($p < .01$; Holland, Malott, & Currier, 2014).

In another study, Kuile and Ehring (2014) conducted qualitative research to help predict a change in a service member's spirituality due to trauma. A sample of trauma

survivors ($n = 293$) was surveyed via web-based survey, in which they were asked questions about their traumatic experience and their spiritual beliefs measured at pre-trauma and post-trauma stages. Study participants reported a decrease in spiritual activities between pre-trauma and post-trauma ($p < .001$). Close to one-quarter of those surveyed reported a decrease in spiritual beliefs after the trauma, and 19.4% reported an increase in spiritual beliefs after the trauma. Kuile and Ehring (2014) identified that those who attended more religious activities before the trauma were more likely to decrease their participation in activities after the trauma. There was a negative relationship between negative changes in spiritual beliefs and increased symptoms of PTSD ($p = .003$); however, there was no relationship between PTSD symptoms and changes in religious activities ($p = .14$; Kuile & Ehring, 2014).

A study by Fontana and Rosenheck (2004) researched changes in the strength of spirituality of veterans receiving treatment for PTSD. The targeted sample was veterans accessing outpatient services ($n = 554$) and inpatient services ($n = 831$) for PTSD from the Department of Veteran Affairs Health Care System. Data from outpatient veterans was collected from September 1989 to December 1991; data from inpatient veterans was collected from November 1991 to January 1994. Ninety-four percent of veterans in the study were diagnosed with PTSD; 95% of participants were Vietnam era veterans, and 5% were World War II era veterans. Much of the sample (89%) identified as being raised Christian, 37.6% Catholic, and 51.5% as Protestants. Six and a half percent were raised in another religion, and 4.3% responded they were not raised in any religion. Results from this study showed those with weakened faith and feelings of guilt accessed VA programming more frequently. Veterans who witnessed death or failed to prevent death

reported a weakening in their faith after separating from the military, and increased use in mental health services. (Fontana & Rosenheck, 2004).

Spirituality may play an important role in the treatment of PTSD. In a cross-lagged study by Currier, Holland, and Drescher (2015), veterans ($n = 532$) participating in a residential treatment program for PTSD were assessed for their ability to forgive themselves, their practice of prayer or meditation, and their exposure to stressors. At intake, veterans' symptoms of PTSD were associated with their baseline level of spirituality. However, at the end, there was data showing that if a veteran had improved their spirituality, they were likely to have fewer symptoms of PTSD. Veterans who reported practicing spirituality daily such as prayer or meditation had improvements in their PTSD symptoms at the end of the study (Currier et al., 2015).

The practice of mindfulness paired with deep breathing and yoga can ease symptoms of PTSD such as experiencing intrusive thoughts. Mindfulness during meditation helps to allow the intrusive thoughts to present, be acknowledged and dissipate. Regarding the symptom of avoidance, veterans who have regular spiritual practice at a place of worship may find themselves relying on their place of worship to avoid outside factors. (Sherman, Harris, & Erbes, 2015).

Research that examines spiritually integrated interventions. There are two main spiritually integrated interventions in the treatment of trauma: Building Spiritual Strength; and Spirituality and Trauma. The first of these interventions, Building Spiritual Strength (BSS), is focused on spiritually integrated interventions in veterans or service members who are managing PTSD and moral injury. This is an eight-session group based intervention that targets spiritual distress while being inclusive of all spiritual

denominations. The group works on identifying spiritual conflicts that cause distress in life and focuses on increasing spiritual strengths (Harris et al., 2011). The effectiveness of this group intervention has been tested by Harris and colleagues (2011). Results found that the intervention helped to reduce symptoms of PTSD, and clinically significant results were found between the treatment group and the control group. BSS is a less stigmatizing option for mental health treatment because it focuses on building spiritual strength as a way to decrease symptoms of PTSD (Harris et al., 2011).

The second intervention, Spirituality and Trauma group module (ST), is focused on a residential treatment setting for veterans diagnosed with combat related PTSD (Foy & Drescher, 2015). The goals of ST are to discuss healthy spirituality and become comfortable discussing the meaning of a traumatic event. There are several themes in ST, which include: defining spirituality broadly; building connections; enhancing spiritual practices; addressing the “why” question; considering forgiveness of self and others; defining and living out personal values; and restoring or finding meaning in life (Foy et al., 2015). There has not yet been research published on the effectiveness of this treatment modality.

Using a multidisciplinary team, including a chaplain, could prove beneficial in the treatment of PTSD, as chaplains have an important role in providing care in a variety of ways. Chaplains are utilized in the military and offer less stigma than a mental health practitioner. An additional focus could be to utilize a spiritual framework combined with an evidence-based practice, such as Prolonged Exposure or Cognitive Processing Therapy (Currier, Holland, & Drescher, 2015).

Conceptual Framework

Theoretical Lens

Meaning Making Systems are a way in which people makes sense of their beliefs and values in different systems, such as within oneself, within the community, and within the larger world (Park, Currier, Harris, & Slattery, 2017). People experience a lot of different events throughout their life and to help make sense of the events, they may rely on their spirituality to determine their feelings about the event. A person may attribute positive or negative outcomes to their Higher Power's plan to help make meaning of a traumatic event. Trauma may inhibit the ability to assimilate a traumatic event with experiences they've had in the past. When a person experiences trauma, it may cause them to question their past experiences and beliefs to help make meaning of the situation (Park et al., 2017).

The Park et al. theory fits in very well when studying veterans with posttraumatic stress disorder and their views of their higher power. Veterans are often asked to perform duties that are outside of their familiarity with their environment, culture, or life history. At times, veterans can be in life or death situations that require immediate decisions. Veterans may deal with the outcome of making life or death decision many years later. This framework supports clinicians in targeting the distressing experiences and helping veterans make sense of the traumatic event.

Global Meaning and Situational Meaning

Global meaning encompasses a person's worldview as part of their belief system, family values, environment, and culture. When an event occurs, a person may use these factors to identify how the event can fit into their schemas or past experiences (Park et al., 2017). A person's spiritual beliefs may be formed by their global beliefs, culture,

environment, and familial structure. Global meaning may help a person identify traits or beliefs as positive or negative in another person, and spirituality or belief in a higher power may play an important role in a person’s schema (Park et al., 2017).

The meaning making model suggests that the person uses their global and personal beliefs to rationalize situational events. Spirituality can have an influence on a situational meaning because it may help a person assimilate their experience and attribute the outcome to their Higher Power. Situations may also be understood differently by different people based on their spiritual beliefs. (Park et al., 2017). As viewed in Figure 1, if characteristics of the traumatic event are aligned with what the person identifies as a traumatic event and is consistent with their global meaning, no distress should occur. If the traumatic event is not consistent with a person’s global meaning, it causes distress and questioning of global beliefs, which may lead to changing the meaning of the trauma or a person’s beliefs or perceptions.

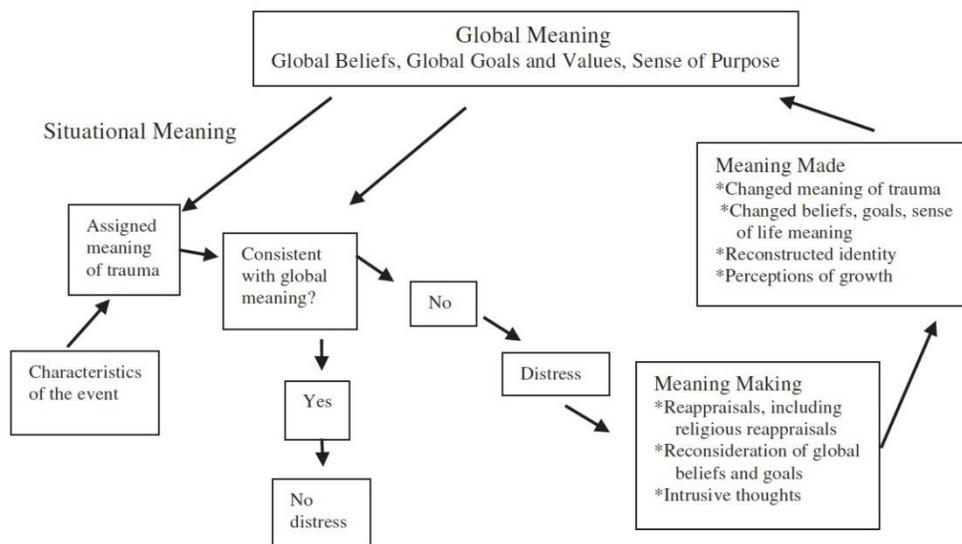


Figure 1. Reciprocal Meaning Making Model. (Park, Currier, Harris, & Slattery, 2017).

Personal Lens

This research is of importance to me because of my friends, family, and colleagues who have made the commitment to serve their country by enlisting in the military. My grandfather served in the Army for many years, and my cousin served two tours of duty in Iraq and Afghanistan. As a family member of a deployed service member, I cherished the moments my cousin called me from overseas and the experiences he shared, but I also witnessed changes in his mental health after being deployed.

Professional Lens

Working with the veteran population for several years has allowed me to understand the complexities of trauma some veterans have experienced as well as the struggles they continue to have due to their trauma. Many veterans have complex needs, and mental health is a top concern for veterans who are dealing with many stressors such as income, housing, and substance use. From professional experience, when a veteran who has experienced homelessness obtains housing, they begin to operate outside of constant crisis mode and often can begin engaging with programming to help target their mental health symptoms or begin to look at the reasons behind their substance use.

Methods

Study Design and Rationale

In this study, quantitative data from the Minneapolis Veteran's Affairs (VA) Health Care System was collected. Then, a secondary data analysis was conducted. Data was collected at three points in time: at intake, after eight weeks in the group, and two months after the group ended. This researcher identified the following hypotheses: In veteran trauma survivors, scores on all subscales of the Religious and Spiritual Struggles Scale (RSSS) will correlate positively with Posttraumatic Stress Disorder (PTSD) symptoms. A second hypothesis identified by this researcher was: When comparing veterans in spiritually integrated therapy versus conventional therapy, those in the spiritually integrated group will report significantly less distress in relationship with a Higher Power than those in the conventional therapy intervention.

Sample

Veterans accessing the Minneapolis VA Health Care System were recruited from multiple sources, including the mental health providers at the medical center, Army National Guard, Beyond the Yellow Ribbon, Vets Centers, County Veteran Service Officers, and other veteran organizations. Veterans who were interested in participating in a larger study of spiritually integrated care were asked to contact the study's team to complete an initial telephone screening to determine if they were suitable for the study. During the brief telephone screening, veterans were given information on informed consent and asked questions to help determine whether they understood the parameters for participation in the research study.

Inclusion criteria encompassed veterans who were at least 18 years of age, and veterans who met the DSM-IV criteria for PTSD or subthreshold PTSD. For veterans on

psychiatric medications, medication stability for a minimum eight weeks was an additional inclusion criterion. Veterans were excluded from the research sample if they met DSM-IV criteria for a substance use disorder, bipolar disorder, schizophrenia, or other psychotic disorder. Veterans with a moderate or severe traumatic brain injury or major cognitive impairment were also excluded from the sample. Additionally, veterans who were deemed high risk for suicidality or homicidality with a plan or intent were excluded from the sample due their need for more immediate crisis care. Veterans who met the inclusion criteria and chose to participate in the study were randomly divided into two groups; the intervention group would receive the Building Spiritual Strength intervention (BSS), and the control group would receive the Present Centered Group Therapy (PCTG) intervention.

Data Collection

In the original study, the participants came in for an interview with the research team, gave consent and completed both an interview and self-report instruments assessing PTSD, depression, and several types of spiritual distress. For this secondary analysis study, the Religious and Spiritual Struggles scale and the PTSD Checklist were analyzed.

Instruments

Several instruments were used to gather data for this study. The RSSS is a tool used to collect data on religious and spiritual struggles including religious doubt, questions about a participant's relationship with God, emotions toward God, meaning in life and other variables (Exline, Grubbs, Pargament, & Yali, 2014). The data in this research project focused on the data from the RSSS. The variable 'Divine' focused on questions about the participant's view of how their Higher Power had let them down or

abandoned them during the event, or questioned their Higher Power's love. The variable 'Demonic' focused on questions about the participant's view that the event was attributed to something that the devil had done instead of their Higher Power. The variable 'Interpersonal' focused on questions about the participant's views of relationships with other spiritual/religious people and feeling rejected or misunderstood by them. The variable 'Moral' focused on questions about the veteran's morals and congruence with their actions. The variable 'Ultimate Meaning' focused on questions about the participant questioning their purpose and meaning in life and whether they make a difference in the world. The variable 'Doubt' questioned a participant's spiritual/religious beliefs and if they were correct.

One inclusion criteria of this study were that veterans meet the criteria for PTSD or subthreshold PTSD. The PTSD checklist, commonly referred to as the PCL, was given to veterans at the time of intake into the study. The PCL is an assessment completed by the patient to help the practitioner assess the severity of the PTSD symptoms (Weathers, Litz, Herman, Huska, & Keane, 1993). Variables from the PCL that were analyzed are: Reexperience (Rexpert) which tested a participant's re-experiencing of their trauma; Avoidance (Avoid), which tested a participant's avoidance of discussing their trauma; Hypervigilance (Hypervigt), which focused on symptoms of hypervigilance in participants; and PCLTTL which looked at a participant's total score on the PTSD Checklist.

Risks and Ethical Concerns

The Minneapolis VA Health Care System's Institutional Review Board approved the original research. All data used in this research was provided to this researcher with

all identifying information removed. The initial study was assessed to have a greater than minimal risk and identified the following risk factors: Audio or video recording kept secured when not being assessed in the study; use of private records to determine their history of treatment, and self-report surveys from participants that include personal information about their feelings and behavior. The support groups discussed stressors, feelings of distress and symptoms related to their PTSD diagnosis; however, participants were informed they did not need to discuss anything that they chose not to answer. Participants were informed that group leaders might discuss their lack of answering questions or participating in the group to determine the effectiveness of the group process.

Social risks for participation in this study may have included a stigma of participating in a group and being identified as having a mental health diagnosis. Groups were held in the community and not at the Minneapolis VA Health Care System to help reduce the possibility of stigma. To ensure further anonymity, groups were identified as support groups rather than psychotherapy groups. Economic risks included the cost of traveling to the support group, as well as the possibility of missing work to attend the group. Veterans were compensated for their participation in the study in accordance with the VA Health Care System's guidelines. Legal risks included screening questions asking about legal concerns or illegal substance use; however, all information was kept confidential.

To help minimize the risks, the study staff attempted to schedule group times that were convenient for the participants, and locate them close to their homes. All data was

stored in locked cabinets or encrypted password files, and group leaders discussed the importance of confidentiality with all group members.

Sample Description

This study had a sample size of 138 veterans divided into two groups: the control group that received the Present Centered Group Therapy modality ($n = 67$), and the group that received the Building Spiritual Strength intervention ($n = 71$). The mean age for the control group was 55.87, while the mean age for the intervention group was 58.26. Three race categories were identified within the whole sample group: White ($n=115$, 83%), Black ($n=10$, 7%), and Other ($n=13$, 9%). Because the intervention was spiritually focused, the participants identified their religious affiliation at intake. Much of the sample identified as Protestant ($n = 74$, 54%), other identified religious affiliations included Catholic ($n = 25$, 18%), None ($n = 22$, 16%), Other ($n = 12$, 9%), Agnostic ($n = 4$, 3%), or Jewish ($n = 1$, 1%). A complete table of descriptive statistics can be found in Table 1.

Table 1.
Descriptive Statistics of Present Centered Group Therapy and Building Spiritual Strength groups.

<u>Variable</u>	<u>Total (138) n (%)</u>	<u>PCGT (67) n (%)</u>	<u>BSS (71) n (%)</u>
Male	105 (76%)	52 (78%)	53 (75%)
Female	33 (24%)	15 (22%)	18 (25%)
Age – mean (SD)	57 (13.67)	55.87 (14.50)	58.26 (12.86)
Race			
White	115 (83%)	57 (85%)	58(82%)
Black	10 (7%)	2 (3%)	8 (11%)
Other	13 (9%)	8 (12%)	5 (7%)
Religious affiliation			
Protestant	74 (54%)	35 (52%)	39 (55%)
Catholic	25 (18%)	14 (21%)	11 (15%)
Jewish	1 (1%)	1 (1%)	0 (0%)
Agnostic	4 (3%)	2 (3%)	2 (3%)
None	22 (16%)	10 (15%)	12 (17%)
Other	12 (9%)	5 (7%)	7 (10%)

Note. PCGT = Present Centered Group Therapy; BSS = Building Spiritual Strength; SD = Standard Deviation.

Additional information gathered before the beginning of the study to control for variables included receiving one on one therapy independent of the study if veterans were prescribed and taking psychotropic medications, and the average number of group sessions the study participants completed. As viewed in Table 2, 43% of veterans were using psychotropic medication ($n = 105$), and 29% ($n = 71$) were receiving other psychotherapy at the time of intake. Both the control group and the intervention group in this study were scheduled for eight sessions. The mean number of sessions completed was 4.64 (sd 3.33) for the complete sample; with a mean of 4.78 (sd 3.34) for the control group and 4.52 (sd 3.33) for the intervention group.

Table 2.
Additional Factors Included in the Research Sample Groups.

<u>Variable</u>	<u>Total (138) n (%)</u>	<u>PCGT (67) n (%)</u>	<u>BSS (71) n (%)</u>
Using psychotropic medication	105 (43%)	46 (69%)	58 (82%)
Other psychotherapy	71 (29%)	33 (49%)	37 (52%)
Total sessions completed (sd)	4.64 (3.33)	4.78 (3.34)	4.52 (3.33)

Note. PCGT = Present Centered Group Therapy; BSS = Building Spiritual Strength; sd = Standard Deviation.

Findings

Several tests were administered to research the two hypotheses set by this researcher: (1) There will be positive correlations between posttraumatic stress disorder symptoms and Religious and Spiritual Struggles subscale scores; and (2) veterans who participate in the Building Spiritual Strength intervention will report significantly less distress with a Higher Power following program completion. Correlation testing, hypothesis testing, and analysis of covariance (ANCOVA) tests were conducted on the sample. Correlations between the Religious and Spiritual Struggle scale variables and the PTSD checklist found two strong correlations, nine moderately strong correlations, and three weak correlations. Additionally, the ANCOVA test found that those participants who were in the intervention group had self-reported less spiritual distress immediately following the completion of the study. This section highlights findings pertaining to three overarching themes: (1) PTSD-specific themes (types of trauma; PCL scores at intake); (2) spiritual distress-related responses (including avoidance, re-experiencing, hypervigilance, PTSD checklist scores, and changes in spiritual distress); (3) and variances in RSSS scores between the control group and the treatment group.

PTSD-Specific Themes

Types of trauma. At the time of intake, veterans disclosed the type of trauma that was causing the most distress in their life. As viewed in Table 3, most veterans identified combat trauma ($n = 90$, 65%), followed by sexual trauma ($n = 21$, 15%). Other types of trauma identified were accident ($n = 7$, 5%), other ($n = 7$, 5%), life-threatening illness or injury ($n = 6$, 4%), physical assault ($n = 4$, 3%), and adverse childhood experiences ($n = 3$, 2%).

PTSD Checklist scores. Both groups were asked to complete the PTSD Checklist (PCL) at intake, after completion of the study and during a follow-up two months after the study ended. As viewed in Table 3, the mean score at program entry for the entire sample was 55.81, with a standard deviation of 11.95. The PCL scores range from 17-85; the higher the number, the more severe the symptoms experienced by the participant. Participants in the control group scored a mean of 54.87 at intake, while participants in the intervention group scored 58.20.

Table 3.
Type of Trauma Experienced by Participants.

<u>Variable</u>	<u>Total (138) n (%)</u>	<u>PCGT (67) n (%)</u>	<u>BSS (71) n (%)</u>
Combat	90 (65%)	42 (63%)	48 (68%)
Sexual trauma	21 (15%)	13 (19%)	8 (11%)
Accident	7 (5%)	5 (6%)	3 (4%)
Other	7 (5%)	4 (6%)	3 (4%)
Life-threatening illness/injury	6 (4%)	2 (3%)	4 (6%)
Physical assault	4 (3%)	2 (3%)	2 (3%)
Adverse childhood experiences	3 (2%)	0 (0%)	3 (4%)
PCL (SD)	55.81 (11.95)	54.87 (11.18)	58.20 (11.26)

Note. PCGT= Present Centered Group Therapy, BSS = Building Spiritual Strength, PCL = PTSD Checklist, SD = Standard Deviation.

Participants were also asked to complete the RSSS at the beginning of the study, immediately following the completion of the study, and two months following the ending of the study. For this research, only the initial RSSS scores were used.

Table 4.
Mean Religious and Spiritual Struggle Scale Scores for Participants at Study Intake.

<u>Variable</u>	<u>Total (138) (SD)</u>	<u>PCGT (67) (SD)</u>	<u>BSS (71) (SD)</u>
Divine	9.39 (4.79)	8.51 (4.00)	10.02 (5.69)
Demonic	7.11 (4.19)	6.78 (4.16)	7.67 (4.34)
Interpersonal	9.61 (4.69)	9.71 (4.78)	9.44 (4.28)
Moral	10.03 (4.48)	9.82 (4.37)	10.63 (4.85)
Ultimate meaning	9.84 (4.85)	9.88 (4.78)	9.84 (5.07)
Doubt	9.18 (4.56)	9.45 (4.10)	8.86 (5.11)

Note. PCGT = Present Centered Group Therapy; BSS = Building Spiritual Strength; SD = Standard Deviation.

Spiritual Distress-Specific Themes

Avoidance. As viewed in Table 5, Ultimate Meaning had a strong correlation with the symptom of Avoidance ($r = .568$). Participants who self-reported experiencing the symptom of avoidance also scored high in questioning their purpose in life, felt their life didn't matter or questioned whether they would make a difference in the world. The RSSS variable Moral had a moderate correlation with the PCL symptom of avoidance ($r = .383$). This may be interpreted as those who reported symptoms of avoidance also struggled with avoiding thinking about the moral conflict of their trauma.

Re-experiencing. As viewed in Table 5, a moderate correlation was found between the symptom of Re-experiencing and the RSSS variable Moral ($r = .402$). Participants who reported the symptom of re-experiencing their trauma also had a moral conflict associated with their traumatic experience. A moderate correlation was found between the symptom of re-experiencing and the RSSS scale variable of Ultimate Meaning ($r = .397$). This may be interpreted as participants who were having difficulty identifying their purpose or if their life mattered also self-reported symptoms of re-experiencing their trauma.

Hypervigilance. As viewed in Table 5, the Moral variable from the RSSS was moderately correlated with the symptom of hypervigilance ($r = .375$). This can be interpreted as those who self-reported the symptom of hypervigilance also reported moral conflict with their traumatic experience. There was a moderate correlation between the symptom of hypervigilance and the RSSS variable Divine ($r = .334$). This may mean that participants who had negative feelings about their Higher Power such as abandonment, anger, or punishment may have reported a heightened awareness of their surroundings. A moderate correlation was found between the symptom of hypervigilance and the RSSS scale variable Ultimate Meaning ($r = .372$). This may be interpreted that those participants who had difficulty identifying their true meaning in life may also have experienced symptoms of hypervigilance.

PTSD Checklist Scores in relation to spiritual distress. As viewed in Table 5, Ultimate Meaning had a strong correlation with the total PCL score ($r = .557$). This can be interpreted as those who self-reported higher scores on the PCL also scored high in questioning their purpose in life, felt their life didn't matter, or questioned whether they would make a difference in the world. The Religious and Spiritual Struggles scale variable Moral had a moderate correlation with the total PCL score ($r = .466$). This can be interpreted as those who self-reported high scores on the PCL also had a moral struggle with the trauma they experienced. A moderate correlation was found between the PCL checklist total and the RSSS variable Divine ($r = .350$). This may be interpreted as the participants who scored high on their PCL total also self-reported negative feelings about their Higher Power.

Table 5.
Correlations Between Religious and Spiritual Struggles Subscales and PTSD Checklist Scores at Baseline.

	Rexpert1	Avoidt1	Hypervigt1	PCLTTLt1
DivineT1	.242*	.290*	.334**	.350**
DemonicT1	.236*	.165*	.235*	.248*
InterpersonalT1	.063	.059	.135	.103
MoralT1	.402**	.383**	.375**	.466**
UltMeaningT1	.397**	.568***	.372**	.557***
DoubtT1	.161*	.332**	.221*	.299*

Note. $n = 133$; * denotes $r < 0.3$ **, weak correlation; denotes $r = 0.3 < 0.5$, moderate correlation; *** denotes $0.5 < r$ strong correlation; Rexpert1 = PTSD Checklist variable Re-experiencing; Avoidt1 = PTSD Checklist variable Avoidance; Hypervigt1 = PTSD Checklist variable Hypervigilance; PCLTTLt1 = PTSD Checklist total at baseline.

Variance between Present Centered Group Therapy and Building Spiritual

Strength in PTSD Checklist Scores

To establish any statistically significant differences in variance between the two subsamples and indicate validity of the study, a Levene's Test was used. The findings reported no significant differences in variance in all variables across sample groups. An independent samples t-test was used to compare the baseline scores on the PTSD Checklist variable Re-experience in the control group, PCGT and the intervention group BSS. As viewed in Tables 6 and 7, there was no significant difference in the scores for PCGT ($M=15.90$, $SD=3.91$) and BSS ($M = 16.76$, $SD = 4.06$) conditions; $t(124)=-1.12$, $p = .22$. The results show there was no significant difference in the sample groups reports of re-experiencing at program intake. An independent samples test was used to compare the PCL checklist variable Avoidance in the PCGT group and the BSS group. As viewed in Tables 6 and 7, there was no significant variance in the scores for PCGT ($M=22.45$, $SD=5.71$) and BSS ($M=23.65$, $SD=5.38$) conditions; $t(124)=-1.21$, $p=.22$. These results show there was no significant difference in the sample groups reports of the symptom

avoidance at program intake. Additional independent sample tests were done on the variables Hypervigilance and the PCL checklist total. Tests found no significant difference in conditions for the Hypervigilance variable, PCGT (M=16.67, SD=3.94), and BSS (M=17.78, SD=3.98) conditions; $t(124)=-1.56$, $p=.12$. Tests found no significant difference in the conditions for the PCL checklist total, PCGT (M=54.86, SD=11.18), and BSS (M=58.20, SD=11.26) conditions; $t(122)=-1.65$, $p=.10$.

Table 6.
Variance Testing of PTSD Checklist Variables for Sample Groups.

	<u>t</u>	<u>df</u>	<u>Sig. (2-tailed)</u>	<u>Mean difference</u>
Rexpert1				
Equal variances assumed	-1.21	124	.22	-.86
Equal variances not assumed	-1.21	123.99	.22	-.86
Avoidt1				
Equal variances assumed	-1.21	124	.22	-1.20
Equal variances not assumed	-1.21	122.94	.22	-1.20
Hypervigt1				
Equal variances assumed	-1.56	124	.12	-1.10
Equal variances not assumed	-1.56	123.93	.12	-1.10
PCLTTLt1				
Equal variances assumed	-1.65	122	.10	-3.33
Equal variances not assumed	-1.65	121.59	.10	-3.33

Note. df = Degrees of Freedom; Rexpert1 = PTSD Checklist variable Re-experiencing; Avoidt1 = PTSD Checklist variable Avoidance; Hypervigt1 = PTSD Checklist variable Hypervigilance; PCLTTLt1 = PTSD Checklist scores at baseline.

Table 7.
Independent Samples Test for PTSD Checklist Variables.

	<u>Condition</u>	<u>n</u>	<u>Mean</u>	<u>Std. Deviation</u>	<u>Std. Error Mean</u>
Rexpert1	0	62	15.90	3.91	.49
	1	64	16.76	4.06	.50
Avoidt1	0	62	22.45	5.71	.72
	1	64	23.65	5.38	.67
Hypervigt1	0	62	16.67	3.94	.50
	1	64	17.78	3.98	.49
PCLTTLt1	0	60	54.86	11.18	1.44
	1	64	58.20	11.26	1.40

Note. Condition 0 = Present Centered Group Therapy; Condition 1 = Building Spiritual Strength; Rexpert1 = PTSD Checklist variable Re-experiencing; Avoidt1 = PTSD Checklist variable Avoidance; Hypervigt1 = PTSD Checklist variable Hypervigilance; PCLTTLt1 = PTSD Checklist total at baseline.

Variance between Present Centered Group Therapy and Building Spiritual

Strength in Religious and Spiritual Struggle Scale Scores

To establish any statistically significant differences in variance between the two subsamples and indicate validity of the study, a Levene's Test was used. The findings reported no significant differences in all variables across sample groups. An independent samples test was used to compare the Divine variable in the control group which received PCGT, and the intervention group which received BSS. As viewed in Tables 8 and 9, there was no significant difference in the scores for PCGT (M=8.51, SD=4.00) and BSS (M=10.02, SD=5.69) conditions; $t(86)=-1.44$, $p=.15$. These results show there were no significant difference between groups' self-report on the Divine variable at study intake. The RSSS Demonic variable was compared between the PCGT group (M=6.77, SD=4.16) and the BSS group (M=7.67, SD=4.34) conditions; $t(86)=-1.43$, $p=.15$. These

results show there were no significant difference between groups' self-report on the RISSS for the Demonic variable at study intake.

The RISSS Interpersonal variable was compared between the PCGT group (M=9.71, SD=4.58) and the BSS group (M=9.44, SD=4.28) conditions; $t(86)=-.28$, $p=.77$. This also shows no significant difference between groups' reporting on the Interpersonal variable at study intake. The RISSS Moral variable was compared between the PCGT group (M=9.81, SD=4.37), and the BSS group (M=10.62, SD=4.84) conditions; $t(85)=-.81$, $p=.41$. These results show there were no significant differences between groups' self-report at study intake. The RISSS Ultimate Meaning variable was compared between the PCGT group (M=9.88, SD=4.78), and the BSS group (M=9.83, SD=5.06) conditions; $t(84)=0.44$, $p=.96$. The RISSS Doubt variable was compared between the PCGT group (M=9.45, SD=4.10), and the BSS group (M=8.86, SD=5.10) conditions; $t(85)=.59$, $p=.55$. This result determined no significant difference between groups for the variable Doubt at study intake.

Table 8.
Variance testing of Religious and Spiritual Struggles Scale Variables for Sample Groups

	<u>t</u>	<u>df</u>	<u>Sig (2-tailed)</u>	<u>Mean difference</u>
DivineT1				
Equal variances assumed	-1.44	86	.15	-1.51
Equal variances not assumed	-1.43	75.07	.15	-1.51
DemonicT1				
Equal variances assumed	-.98	86	.32	-.89
Equal variances not assumed	-.98	85.33	.32	-.89
InterpersonalT1				
Equal variances assumed	.28	86	.77	.26
Equal variances not assumed	.28	85.96	.77	.26
MoralT1				
Equal variances assumed	-.81	85	.41	-.80
Equal variances not assumed	-.81	83.68	.41	-.80
UltMeaningT1				
Equal variances assumed	.04	84	.96	.04
Equal variances not assumed	.04	83.72	.96	.04
DoubtT1				
Equal variances assumed	.59	85	.55	.59
Equal variances not assumed	.59	80.41	.55	.59

Note. df = Degrees of Freedom; DivineT1 = Religious and Spiritual Struggles Scale (RSSS) variable Divine at baseline; DemonicT1 = RSSS variable Demonic score at baseline; InterpersonalT1 = RSSS variable Interpersonal at baseline; MoralT1 = RSSS variable Moral at baseline; UltMeaningT1 = RSSS variable Ultimate Meaning at baseline; DoubtT1 = RSSS variable Doubt at baseline.

Table 9.
Independent Samples Test for Religious and Spiritual Struggles Scale Variables.

	<u>Condition</u>	<u>n</u>	<u>Mean</u>	<u>Std. Deviation</u>	<u>Std. Error Mean</u>
DivineT1	0	45	8.51	4.00	.59
	1	43	10.02	5.69	.86
DemonicT1	0	45	6.77	4.16	.62
	1	43	7.67	4.34	.66
InterpersonalT1	0	45	9.71	4.58	.68
	1	43	9.44	4.28	.65
MoralT1	0	44	9.81	4.37	.65
	1	43	10.62	4.84	.73
UltMeaningT1	0	43	9.88	4.78	.72
	1	43	9.83	5.06	.77
DoubtT1	0	44	9.45	4.10	.61
	1	43	8.86	5.10	.77

Note. Condition 0 = Present Centered Group Therapy; Condition 1 = Building Spiritual Strength; DivineT1 = Religious and Spiritual Struggle Scale (RSSS) variable Divine; DemonicT1 = RSSS variable Demonic; MoralT1 = RSSS variable Moral; UltMeaningT1 = RSSS variable Ultimate Meaning; DoubtT1 = RSSS variable Doubt.

Changes in Spiritual Distress Following Completion of Study

To test the hypothesis comparing veteran's spiritual distress in relationship with a Higher Power, an analysis of covariance (ANCOVA) was used. The dependent variable was the endpoint measure of distress in relationship with Higher Power (DivineT2), and the independent variable was the condition, or which group the veterans were placed in. The covariates included the baseline PTSD scores from the PCL and the baseline score of the distress in relationship to a Higher Power (Divine). The alpha was set at .05. As

viewed in Table 10, the condition variable was statistically significant ($p = .050$) which supports the hypothesis that participants in the spiritually integrated intervention reported less distress with their Higher Power following the intervention. Note in Table 11, that after controlling for the baseline PTSD symptoms and the Time 1 score on the Divine subscale of the RSSS, that the confidence interval for the control group reflects much more spiritual distress than that for the Building Spiritual Strength group.

Table 10.
Analysis of Covariance at Study Completion.

<u>Variable</u>	<u>F</u>	<u>p</u>
Corrected Model	10.934	< .001*
Intercept	.164	.687
DivineT1Ex	15.721	< .001*
PCLTTLt1	3.296	.075
Cond	4.007	.050*

Note. ANCOVA = Analysis of covariance; PCL = PTSD Checklist; degrees of freedom = 1 for all variables; * $p < .05$; DivineT1Ex = Religious and Spiritual Struggle Scale variable Divine score at baseline; Cond = Condition.

Table 11.
Estimated Marginal Means for Divine Variable at Study Completion.

<u>Variable</u>	<u>Mean</u>	<u>SE</u>	<u>95% Confidence Interval</u>	
			<u>Lower Bound</u>	<u>Upper Bound</u>
Control Group	1.869a	.145	1.57	2.15
Intervention Group	1.463a	.140	1.18	1.74

Note. Covariates appearing in the model are evaluated at the following values: DivineT1Ex = 1.75, PCLTTLt1 = 56.27.

Discussion

This research was conducted to determine if utilizing a spiritually integrated practice would have a positive impact on veterans with spiritual distress and trauma. The data analyzed in this study was taken from a larger study conducted at the Minneapolis VA Health Care System. Variables analyzed in this study included: PCL scores, spiritual distress measures, and demographics of participants. In this section, three overarching themes discussed in relation to existing empirical literature are: (1) PTSD-specific themes (types of trauma; PCL scores at intake); (2) spiritual distress-related responses (including avoidance, re-experiencing, hypervigilance, PTSD checklist scores, and changes in spiritual distress); (3) and variances (between Present Centered Group Therapy and Building Spiritual Strength in Religious and Spiritual Struggle Scale Scores).

PTSD-Specific Themes

Trauma types. The research of trauma types was partially supported in the literature. The current research study found trauma outside of the military, including childhood trauma, assault, and accident or injury, while research literature focused on trauma experienced in the military. Stein et al. (2012) developed a system to categorize traumatic events experienced by service members, within the scope of their military career. The categories encompassed many different types of traumatic events; all focused on combat. The sample in the current study identified combat trauma as the main type of trauma experienced (65%), followed by sexual trauma (15%). The findings of non-military trauma can contribute to widening the research scope for treating a service member for trauma experienced outside of their military experience.

PTSD Checklist Scores. This research study found a strong correlation between a participant's PTSD Checklist (PCL) score and the variable ultimate meaning. This may mean that those who scored high on the PCL also questioned their purpose in life or felt their life did not matter due to the spiritual distress they have experienced. The results found in this research may help contribute to the deeper understanding behind spiritual distress and PTSD symptomology. This researcher's hypothesis of participants having a positive correlation between PTSD symptoms and spiritual distress was supported in the findings and will be discussed within each PTSD symptom including avoidance, re-experiencing, and hypervigilance.

Spiritual Distress-Specific Themes

Avoidance. Spiritual distress in relationship to the symptom of avoidance was supported in the research literature. Stein and colleagues (2012) categorized traumatic events and found that service members who experienced moral conflict had symptoms of Posttraumatic Stress Disorder (Stein, et al., 2012). Kuile and Ehring (2014) found that after a traumatic event, a veteran attended fewer spiritual activities than prior to the traumatic event (Kuile & Ehring, 2014). The current research study found a strong correlation between the symptom of avoidance and a person's struggle with finding their ultimate meaning, purpose in life, or if they questioned whether they would make a difference in the world. There was a moderate correlation between avoidance and moral distress, which can be interpreted as those who reported the symptom of avoidance also struggled with the moral conflict of their trauma. The current research will contribute to a greater understanding of using a spiritually integrated method to treat moral conflict and avoidance in relationship to PTSD.

Re-experiencing. Spiritual distress in relation to re-experiencing an event was supported in the literature. In Stein and colleagues (2012) research on developing categories for traumatic events, it was found that the more categories a traumatic event was categorized in, the higher likelihood of re-experiencing a traumatic event (Stein, et al., 2012). In Fontana, Rosenheck, and Brett's (1992) study found three main variables, including combat exposure, which included killing, witnessing killing or failing to prevent death while in combat. For the service members who were categorized in the 'combat' category had more symptoms of intrusive thoughts (Fontana et al., 1992). Additionally, Sherman and colleagues (2015) found that practicing mindfulness was beneficial in the treatment of intrusive thoughts. The current research study found a moderate correlation between the symptom of re-experiencing and moral conflict, as well as ultimate meaning. The current research findings of correlations between re-experiencing an event and having moral conflict can help contribute to a greater understanding of using a spiritually integrated method to treat the symptoms of PTSD.

Hypervigilance. Spiritual distress in relation to hypervigilance was supported in the research literature. Fontana et al. (1992) found that those who witnessed a traumatic event had a high rate of hyperarousal as a symptom of Posttraumatic Stress Disorder. Those who were a target of a traumatic event had hypervigilance as a prominent symptom of PTSD (Fontana et al., 1992). The current research study found a moderate correlation between the symptom of hypervigilance and moral conflict. Additionally, a moderate correlation was found between hypervigilance and the variable divine. This can be interpreted as participants who self-reported the symptom of hypervigilance also reported difficulty with negative feelings for their Higher Power, including abandonment,

anger or punishment. The findings in the current study can contribute to research focused on understanding the spiritual distress encountered by veterans with Posttraumatic Stress Disorder symptomology.

Changes in spiritual distress following completion of the study. This researcher's hypothesis of those participants who receive the intervention would report less distress with a Higher Power was supported in the findings. Decreases in spiritual distress following a spiritually integrated treatment was also supported in the research literature. In a study by Currier, Holland, and Drescher (2015), veterans were assessed for changes in spirituality following an inpatient treatment program. Findings from this study support the current study's findings in that those who practiced spirituality reported improvements in their PTSD symptoms at the end of the study (Currier, et al., 2015). The current study found that there was a significant decrease in spiritual distress in relationship to a Higher Power following the Building Spiritual Strength intervention. Fontana and Rosenheck (2004) found that veterans who experienced a spiritually distressing event had a weakened faith and utilized mental health services more following their separation from the military (Fontana & Rosenheck, 2004). The current research contributes to a greater understanding of how focusing treatment on spiritual distress related to a traumatic event can lessen symptoms of PTSD.

Strengths of this Study

Three strengths of this study are (1) recruitment strategies, (2) the sample being representative of the greater Minnesota veteran population, and (3) the study was a randomized, controlled trial. First, recruitment for the original study was spread throughout the veteran community, including Beyond the Yellow Ribbon events, at local

Vet Centers, through County Veteran Service Officers, within the VA Medical Center, and through other veteran community providers. This is a strength of the research because the recruitment net was cast wide to attract veterans who may not access the VA Medical Center for services and instead remain in the community.

A second strength of this study was that the population sampled was representative of the general veteran population of Minnesota. In the study sample, seven percent of the sample identified their race as African American, while statistics show that as of 2014, approximately three percent of the veteran population identified as African American in Minnesota. In the study sample, 83% of the sample identified as Caucasian, while in the state of Minnesota 93% of the veterans identified as Caucasian (National Center for Veterans Analysis and Statistics, 2016). A third strength of this study was that it was a randomized controlled trial.

Limitations of this Study

Two limitations of this study are (1) data collection was limited to the Minnesota area, and (2) the sample was predominantly Christian, Caucasian males. The first limitation of this research study was that data collection was kept within the state of Minnesota, specifically within the metropolitan area. This is a limitation because the results could have been different if the study was replicated at other VA locations throughout the United States to determine if the location had an impact on a person's spiritual distress. Because there is not an active duty military base in Minnesota, the composition of the sample may have been different in a state with an active duty base (California, Georgia, Kentucky, Texas, etc.). As the study was completed only in Minnesota, the findings should not be generalized for the larger veteran population.

A second limitation of the original study was that the sample was comprised of predominantly Christian, Caucasian males and cannot be generalized to the larger populations.

Implications for Social Work Practice

Based on findings from this study, there are two important implications for social work practice. These two implications are (1) for social workers to learn more about a person's spirituality, including any distress or spiritual practices they use, and (2) utilizing a holistic approach in assessment, to include spirituality in the assessment. The first implication for social workers is to use an all-encompassing approach to practice. By looking at all aspects of a person's life, social work practice can begin to understand the functioning level of each person and focus on their strengths. When learning about a person's spiritual practices, a social worker can draw on the spiritual strengths as an approach for treatment. This study has shown that by building a person's spiritual strengths, their PTSD symptoms may decrease. If a person had spiritual distress because of trauma they had encountered, a social worker might be able to use a spiritually informed therapy to help relieve the distress and refocus their thoughts on the trauma.

There is no specific diagnosis or specifier in the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition, so a service member with a moral or spiritual injury may not be discovered during a routine diagnostic assessment. For this reason, it is important to assess spirituality when conducting a biopsychosocial assessment.

A second implication for social work practice is for social workers to use sufficient time to assess a person's spirituality and spiritual practices. When social workers are completing their biopsychosocial assessments, it may be beneficial to give

more time to assess a person's spirituality and spiritual practices as a part of their treatment plan. The use of a multidisciplinary team may also benefit a client who is resistant to engaging with mental health professionals and who may want to seek services from a chaplain or spiritual advisor.

Implications for Research

There are two spiritually focused interventions for veterans with trauma and spiritual distress. The BSS intervention allowed for veterans to identify spiritual conflicts that are causing distress and focus to increase their spirituality. The effectiveness of the study showed that those who participated in the intervention had a reduction in PTSD symptoms (Harris et al., 2011). The current research study found a significant decrease in spiritual distress following the BSS intervention.

The second spiritually focused intervention is the Spirituality and Trauma group module. The group therapy modality focused solely on veterans with combat trauma. The ST module allows for a greater understanding of finding meaning in life, forgiving self and others, and enhancing spiritual practices (Foy & Drescher, 2015).

By participating in a spiritually integrated treatment, a veteran may begin to process their spiritual distress and gain a greater understanding of the trauma they experienced. If a veteran can resolve their spiritual distress, they may have a stronger relationship with their Higher Power, and experience less symptoms of PTSD.

Conclusion

Research shows that veterans can experience spiritual distress due to a traumatic event that has occurred in their life. Fontana and Rosenheck (2004) found that veterans with spiritual distress had an increase in mental health services as a result of their traumatic event (Fontana & Rosenheck, 2015). Social workers should practice a comprehensive approach when conducting biopsychosocial assessments on veterans with trauma because they may experience spiritual distress as a complication of the trauma they experienced. Kuile and Ehring (2014) found that approximately one-quarter of veterans in their study reported decreased spirituality following a traumatic event (Kopacz et al., 2016). This research helps clinicians identify the need for spiritually integrated programming to assist veterans with increasing their spiritual practices as a coping skill for their trauma.

Sherman and colleagues (2015) reported that practicing mindfulness and deep breathing during meditation and yoga practice allowed veterans to process intrusive thoughts in a positive way (Sherman et al., 2015). This research gives clinicians a variety of options to practice trauma treatment outside of the typical office setting that may be less stigmatizing, and which would allow veterans to be open about their traumatic experience.

Findings of the current study show a decrease in spiritual distress following the completion of the 8-session Building Spiritual Strength intervention. Veterans self-reported less struggle with their Higher Power at the completion of the study. The current study found positive correlations with the PTSD symptoms avoidance, hypervigilance,

and re-experiencing and the Religious and Spiritual Struggles subscales of divine, moral, and ultimate meaning at study baseline.

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