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Editorial

Beyond the Artificial Separation: Integrating Spirituality into Trauma Counseling

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A combat veteran presents for clinical evaluation, describing nightmares persisting eighteen years post-deployment. The clinical presentation is not fear-conditioned hypervigilance but moral distress: guilt over actions taken - and not taken - during deployment. Standard prolonged exposure therapy has reduced his physiological arousal, yet the core pathology remains untouched. "I don't recognize who I became over there", he reports. "And I don't know if I can ever be forgiven". His symptomatology meets DSM-5-TR criteria for PTSD, but the deeper wound is moral: a rupture in his relationship with his own conscience, his community, and whatever he once understood as sacred [1]. This is not an outlier presentation. It is, increasingly, what the field is being asked to treat. And it demands that clinicians reckon with a dimension of suffering that our dominant treatment paradigms were not designed to address.

The evidence is accumulating that something essential has been missing from trauma care. Approximately 40% of individuals with PTSD do not respond adequately to first-line evidence-based interventions, a treatment gap that has persisted despite advances in trauma-focused therapies [2]. These authors argue that the gap reflects, in part, the limitations of fear-based models that fail to capture the full complexity of posttraumatic suffering. When trauma severs a person's sense of meaning, purpose, and belonging - what many would call the spiritual dimension of human experience - interventions focused solely on fear extinction and cognitive restructuring may leave the deepest wounds untouched. The question facing the field is no longer whether spirituality matters in trauma recovery, but how to address it ethically, rigorously, and within the bounds of evidence-based practice.

The clinical case for spiritual integration

The concept of moral injury has moved from the margins to the mainstream of trauma discourse. First articulated by Litz and colleagues [3] in their seminal work with war veterans, moral injury describes the psychological, social, and spiritual distress that follows from perpetrating, failing to prevent, or witnessing acts that violate deeply held moral beliefs. Unlike the fear-based architecture of PTSD, moral injury is fundamentally about trust and sacred relationships - "the loss of safe connection with self, society, God/Divine/a Higher Power" [4]. This is not a niche concern. Litz and colleagues [5] have established that moral injury represents a distinct syndrome with measurable prevalence among U.S. veterans, and Harris and colleagues [6] have documented that moral injury syndrome substantially reduces resilience, diminishes responsiveness to psychotherapy, and increases suicide risk.

The DSM-5-TR recognizes Z codes for religious/spiritual problems. This official acknowledgment signals that the clinical establishment now recognizes what practitioners and patients have long reported: that some wounds are spiritual in nature and require spiritually informed responses.

The connection between spiritual struggles and clinical outcomes extends beyond moral injury. Kim and colleagues [7] found that spiritual struggles function as an independent contributor to suicide risk among post-9/11 veterans, above and beyond the effects of trauma exposure itself. Captari and colleagues [8] documented that trauma survivors' spiritual struggles - experiences of divine abandonment, anger at God, or loss of religious meaning - are significantly linked to mental health symptoms and diminished well-being. These findings carry a clear clinical implication: when spiritual disruption goes unaddressed, it does not remain neutral. It actively perpetuates suffering and undermines recovery.

The evidence landscape: Promise and gaps

The practice-based evidence for spiritually integrated psychotherapy has grown substantially. Captari, Sandage, and Vandiver [9] synthesized findings from 35 studies across six clinical domains, including trauma, and identified best practices for spiritually integrated care. Harris and colleagues [10] reviewed spiritually integrated interventions specifically for PTSD and moral injury, finding a growing but still limited evidence base. Wortmann and colleagues [11] provided clinical guidance for addressing the spiritual features of war-related moral injury, and Pernicano, Wortmann, and Haynes [12] described a psychospiritual group intervention co-led by a mental-health-trained chaplain and a mental health provider - a practical model for spiritual-clinical collaboration that moves veterans from trauma-focused processing toward a restorative self-view.

Yet the field must be honest about what remains unknown. The evidence base is characterized by practice-based studies, clinical case series, and small pilot trials. Large-scale randomized controlled trials of spiritually integrated trauma interventions remain scarce. Clinicians are increasingly integrating spiritual resources into trauma care because their patients demand it and their clinical experience supports it, but the rigorous outcome data that would move these approaches from promising to established is still being built. Williamson and colleagues [13], reviewing the moral injury intervention literature, reached the same conclusion: research is growing, but evidence for specific interventions remains limited.

This gap should not be mistaken for absence of effect. It reflects, rather, the relative youth of the field and the methodological challenges inherent in studying interventions that are, by design, individualized to each patient's spiritual framework. A spiritually integrated cognitive processing therapy protocol for a Catholic veteran will look different from one designed for a Buddhist survivor of interpersonal trauma - and both should look different from an intervention for a patient who identifies as spiritual but not religious. Cobbina and Boynton [14] have recently proposed a spiritually integrated cognitive processing therapy model for interpersonal trauma survivors that explicitly targets posttraumatic growth, and Fortuna and colleagues [15] demonstrated the integration of spirituality into mindfulness-based CBT for PTSD with Latinx unaccompanied immigrant children. These efforts represent the kind of culturally grounded, spiritually informed work the field needs - and the kind that demands more systematic evaluation.

A framework for integration: Disruption, integration, reconnection

The forthcoming volume "Reclaiming Wholeness: A Spiritual Framework for Trauma and Social Reconnection" [16] proposes a three-part clinical framework designed to address the spiritual dimension of trauma within evidence-based practice. The framework is not a replacement for established trauma treatments but a scaffold for weaving spiritual resources into existing modalities - cognitive processing therapy, prolonged exposure, EMDR, and others - in a manner that is clinically rigorous and ethically sound.

The first phase, Disruption, involves recognizing and assessing the spiritual impact of trauma. Trauma fragments what the framework terms "spiritual identity" - the core assumptions about a benevolent world, a trustworthy self, and meaningful connection to something larger than the individual. The framework distinguishes moral injury (distress from violating moral beliefs) from spiritual injury (loss of connection to the sacred or transcendent) and warns against spiritual bypassing - the use of spiritual beliefs to avoid painful emotional processing, a maladaptive coping pattern that can masquerade as resilience. Assessment in this phase is explicitly non-impositional: the clinician's task is to understand the patient's spiritual landscape, not to map it onto any particular tradition. Language matters here. The

framework recommends "spiritual disruption" over "spiritual crisis" to reduce pathologizing, and it emphasizes dynamic consent - the understanding that a patient can decline to discuss spiritual topics in any session, regardless of prior engagement.

The second phase, Integration, operationalizes the clinical workflow. Spiritual assessment is embedded within standard intake and screening, with careful attention to the distinction between inherited religious traditions and currently held beliefs. Resource mapping identifies protective spiritual resources - rituals, community ties, sacred practices - that can be mobilized as therapeutic tools. The framework provides step-by-step guidance from intake through assessment, plan formulation, intervention, and follow-up, with the principle that rituals and spiritual practices must emerge from the patient's own meaning system rather than being imposed by the clinician.

The third phase, Reconnection, addresses what may be the most neglected dimension of trauma recovery: the restoration of belonging. Individual healing, the framework argues, is incomplete without community restoration. This phase encompasses relational witnessing, posttraumatic growth, and the bridging of individual clinical work with community partnerships - faith communities, NGOs, and peer support networks. It also addresses the reality of spiritual abuse, drawing on emerging work by Kalvari [17] on pathways from spiritual abuse to spiritual repair, and it provides guidance for safeguarding patients who have been harmed within religious contexts.

Ethical integration, not imposition

The ethical architecture of spiritually integrated trauma care deserves as much attention as the clinical techniques. The field has moved decisively past the question of whether spirituality belongs in the consulting room. The contemporary question is how to integrate it without imposing it. Six principles anchor the framework's ethical approach: non-imposition (the therapist's beliefs are never the standard), dynamic consent (ongoing, revocable at any session), scope demarcation (psychological processing of spiritual issues, not spiritual direction), referral readiness (vetted clergy or chaplains for specialized spiritual support), cultural responsiveness (tools adapted to the patient's specific context), and validating ambivalence (doubt and anger toward the divine are treated as protective responses, not pathological symptoms).

These principles reflect a broader shift in the field. The clinician's role in spiritually integrated trauma work is not that of priest, chaplain, or spiritual director. It is that of witness - someone who can hold space for a patient's ambivalence, doubt, and anger without rushing to resolve it, and who can help the patient mobilize their own spiritual resources in service of healing. This is a clinical skill, not a theological one, and it belongs within the scope of competent psychotherapy when practiced with appropriate training and ethical safeguards.

A call to the field

The integration of spirituality into trauma counseling stands at a pivotal moment. The DSM-5-TR's recognition by a Z code inclusion, the growing practice-based evidence for spiritually integrated interventions, and the persistent 40% nonresponse rate to first-line trauma treatments together create both an imperative and an opportunity. The imperative is clinical: patients are presenting with spiritual wounds, and the field must develop the competence to address them. The opportunity is scientific: a research agenda that rigorously evaluates spiritually integrated approaches - through randomized controlled trials, dismantling studies, and comparative effectiveness research - could significantly expand the reach of trauma care.

Several specific directions warrant attention. First, the field needs treatment manuals and protocols for spiritually integrated trauma interventions that can be tested across diverse populations and settings. Second, training curricula for graduate programs and continuing education must include competencies in spiritual assessment, ethical integration, and scope demarcation. Third, partnerships between mental health clinicians and chaplains, clergy, and spiritual care providers - modeled on the collaborative approach described by

Pernicano and colleagues [12] - should be studied and scaled. Fourth, outcome measures must capture not only symptom reduction but also the dimensions of recovery that spiritually integrated approaches target: meaning-making, posttraumatic growth, forgiveness, and the restoration of belonging.

The artificial separation of neurobiological, psychological, and spiritual dimensions in conventional trauma care has contributed to suboptimal outcomes for too many patients [2]. Reclaiming wholeness - the title of the framework proposed here - is not a metaphor. It is a clinical objective. The evidence base, while still developing, points clearly in one direction: when clinicians attend to the spiritual dimension of trauma with the same rigor and ethical care they bring to the psychological and biological dimensions, patients have access to a fuller recovery. The field's task now is to build the science that matches the clinical need.

Bibliography

1. Koenig HG., *et al*. "Moral injury in the DSM-5-TR: Syndrome spectrum vs. categorical disorder". *Journal of Religion and Health* 65.2 (2026): 1205-1220.

2. Burback L., *et al*. "Evolving psychotherapeutic approaches for PTSD: Beyond the fear-based model". *Psychiatry and Clinical Psychopharmacology* 35.1 (2025): S152-S167.

3. Litz BT., *et al*. "Moral injury and moral repair in war veterans: A preliminary model and intervention strategy". *Clinical Psychology Review* 29.8 (2009): 695-707.

4. DeMarco MJ. "6-Fold path to self-forgiveness: An interdisciplinary model for the treatment of moral injury with intervention strategies for clinicians". *Frontiers in Psychology* 15 (2024): 1437070.

5. Litz BT., *et al*. "The prevalence of moral distress and moral injury among U.S. veterans". *Journal of Psychiatric Research* 189 (2025): 435-444.

6. Harris JI., *et al*. "Implementing a multi-disciplinary, evidence-based resilience intervention for moral injury syndrome: Systemic barriers and facilitators". *Behavioral Sciences* 14.4 (2024): 281.

7. Kim E., *et al*. "Beyond trauma: The influence of spiritual struggles on suicide risk in post-9/11 veterans". *Psychological Trauma* 18.3 (2026): 587-591.

8. Captari LE., *et al*. "Trauma survivors' spiritual struggles and the anger of hope: A practice-based clinical study examining links with mental health symptoms and well-being". *Spirituality in Clinical Practice* 11.3 (2024): 235-249.

9. Captari LE., *et al*. "Spiritually integrated psychotherapies in real-world clinical practice: Synthesizing the literature to identify best practices and future research directions". *Psychotherapy* 59.3 (2022): 307-320.

10. Harris J., *et al*. "Spiritually integrated interventions for PTSD and moral injury: A review". *Current Treatment Options in Psychiatry* 8.4 (2021): 1-17.

11. Wortmann J., *et al*. "Spiritual features of war-related moral injury: A primer for clinicians". *Spirituality in Clinical Practice* 4.4 (2017): 249-261.

12. Pernicano P., *et al*. "Acceptance and forgiveness therapy for veterans with moral injury: Spiritual and psychological collaboration in group treatment". *Journal of Health Care Chaplaincy* 28.1 (2022): S57-S78.

13. Williamson V., *et al*. "Moral injury prevention and intervention". *European Journal of Psychotraumatology* 16.1 (2025): 2567721.

14. Cobbina M and Boynton H. "Considerations for spiritually integrated cognitive processing therapy (SICPT) for PTSD and posttraumatic growth in survivors of interpersonal trauma". *Journal of Religion and Health* 65.3 (2025): 3137-3152.

15. Fortuna L., *et al*. "Integrating spirituality and religious beliefs in a mindfulness based cognitive behavioral therapy for PTSD with Latinx unaccompanied immigrant children". *Journal of Child and Adolescent Trauma* 16.3 (2023): 481-494.

16. Shea C. "Reclaiming wholeness: A spiritual framework for trauma and social reconnection". Lifesjourney Life Coaching, LLC. [Forthcoming - pre-sale] (in press).

17. Kalvari L. "From spiritual abuse to spiritual repair: A trauma-attentive, theologically grounded pathway for religious survivors". *Pastoral Psychology* 75 (2026): 597-619.

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