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Spiritually integrated care for PTSD: A randomized controlled trial of "Building Spiritual Strength"

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ABSTRACT

Previous literature documents important cross-sectional and longitudinal relationships between spiritual distress and posttraumatic stress disorder (PTSD) outcomes. This study tests the efficacy of a spiritually integrated intervention "Building Spiritual Strength" (BSS) that can be delivered by trained chaplains. The intervention addresses spiritual concerns expressed by trauma survivors, including concerns in relationship with a Higher Power, difficulty with forgiveness, and theodicy. In a randomized controlled trial with blinded assessment, veterans were randomized to engage in a BSS condition (n = 71) or Present Centered Group Therapy (PCGT; control) condition (n = 67) with assessments at baseline, posttreatment, and a two-month follow up. Both groups showed similar, statistically significant reductions in symptoms of PTSD as measured by the Clinician Administered PTSD Scale (CAPS). BSS was shown to be more effective than PCGT in treating distress in relationship with a Higher Power. This was the second clinical trial of BSS with promising results and highlights the need for further study in psychospiritual interventions. More research is warranted on BSS being offered by non-specialized chaplains and on the application of BSS in suicide prevention.

1. Introduction

The research literature on spirituality and trauma evidences important relationships between spiritual distress and clinical outcomes among trauma survivors in both cross-sectional and longitudinal studies (Currier et al., 2014, 2015; Harris et al., 2008, 2012; Ogden et al., 2011). Cross-lag analysis shows that among veterans in intensive treatment for PTSD, levels of spiritual functioning before treatment predicted improvements in PTSD symptoms, which suggests that spiritual distress may be an etiological factor in posttraumatic recovery (Currier et al., 2015). The literature on spiritual distress and combat also includes theoretical concerns that the complex moral environments that can characterize war-zone deployments may overwhelm individuals whose psychospiritual development is in comparatively concrete stages (Harris et al., 2015; Nash and Litz, 2013). Namely, when confronted with morally ambiguous situations that lead service members to act in ways that violate their previous sacred beliefs and values, they can experience distressing thoughts and emotions related to religious faith and/or spirituality, sometimes described as moral injury (Litz et al., 2009).

Theory related to spiritual coping suggests that when confronted with threat or loss, individuals respond with spiritual coping; if coping does not alleviate distress, spiritual struggle ensues (Murray-Swank and Pargament, 2011). Spiritual struggle may be resolved either as a transformative process resulting in spiritual growth, or a disengagement process resulting in spiritual disintegration (Murray-Swank and Pargament, 2011). Research documenting cross-sectional, longitudinal, and cross-lag relationships between spiritual distress and more severe and persistent symptoms of PTSD is consistent with this theory (Bryan et al., 2017; Fontana and Rosenheck, 2004; Harris et al., 2008, 2012; Currier et al., 2015). The relevance of spiritual distress in PTSD discussed above has been recognized in the *Diagnostic and Statistical Manual-5 (DSM-5;* 2013), which now identifies guilt as a symptom of PTSD. Spiritual distress involves a broad constellation of concerns such as guilt and shame, including problems forgiving self and others, self-loathing, poor self-care, alienation from a Spiritual Universe/Higher

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Power construct, alienation from a faith community, and loss of purpose or meaning (Bryan et al., 2014, 2015; Gray et al., 2012; Maguen et al., 2011). Across studies, results indicate that spiritual distress, such as disruption in a relationship with a Higher Power, feeling ostracized or judged by a faith community, high levels of guilt or shame, or feeling that one is being punished by a Higher Power or karmic force, has been associated with higher levels of PTSD symptoms, and a more severe, longer course of PTSD over time (Currier et al., 2014, 2015; Harris et al., 2008, 2012; Ogden et al., 2011). Evidence that potentially spiritually challenging events, such as killing in combat, and subsequent spiritual distress, are uniquely related to worse suicidal ideation and risk for substantially worse mental health outcomes is mounting (Harris et al., 2014; Kopacz et al., 2016a; Maguen et al., 2011). Given the growing body of research relating to spiritual coping, spiritual distress, and mental health outcomes among trauma survivors, especially among veterans, it would make sense to test models of spiritually integrated care for PTSD in this population.

1.1. The intervention: Building Spiritual Strength

BSS (Harris et al., 2011) is a manualized, spiritually integrated, group counseling intervention designed to reduce symptoms of PTSD by facilitating resolution of spiritual distress, thus helping individuals make new, more adaptive, and global meanings of traumatic experiences. The program was designed to be accessible and respectful to participants from any religious or non-religious identification. Training for group facilitators and participants prohibits proselytizing or evangelizing in group contexts. The intervention was designed to be led by either mental health providers with training, experience, or supervision in spiritually integrated care, or chaplains/clergy/pastoral counselors with specialized mental health training, Clinical Pastoral Education or similar training, or other specific training in mental health counseling.

In a previous, pilot randomized controlled trial of BSS, as compared to a wait-list group, BSS participants evidenced statistically significant reductions in PTSD symptoms (Harris et al., 2011). Participants were veterans who met criteria for PTSD diagnoses based on their score on the PTSD Checklist (PCL-C). The average age of participants was 45 years, and the average level of education was 15 years. The group was primarily comprised by Caucasian males who identified with a Christian denomination. The mean difference in PTSD Checklist scores between the treatment and wait-list groups was 12.23, which exceeds the 10-point margin for clinically significant change on that instrument. The effect size was in the medium range ($d = 0.67$). The pre- post- effect size for the wait-list condition was $d = 0.01$, and the pre- post-effect size for the BSS condition was $d = 2.30$. After treatment, 69% of the control group were still above the cutoff score for PTSD, while 46% of the treatment group remained above cutoff. When members of the wait-list group were subsequently enrolled in the intervention, their rates of symptom reduction as compared to their wait-list baseline were similar (Harris et al., 2011).

The goal of the present study was to conduct a larger randomized clinical trial of BSS, using an active control group (PCGT), rather than a wait-list control. Secondary goals were to expand knowledge of BSS outcomes to variables specifically relevant to spiritual distress. Hypotheses were as follows:

H1. Veterans randomized to BSS will experience greater reduction in PTSD symptoms than those randomized to PCGT.

H2. Veterans randomized to BSS will report greater reduction of spiritual distress than veterans randomized to PCGT.

2. Methods

2.1. Participants

Participants were recruited through fliers, newsletter announcements, and letters to veterans who had received services for PTSD within the VA system, including those served at two large VA Medical Centers and four Community Based Outpatient Centers. The vast majority of respondents indicated that they contacted study staff in response to a letter sent to them by the study team. Inclusion criteria included a) status as a veteran or active duty service member, b) competence to consent to research, c) Clinician Administered PTSD Scale scores consistent with a diagnosis of PTSD or subthreshold PTSD as defined by *DSM-IV* or the Blanchard et al. (1996a) definition of subthreshold PTSD (see below), and d) stability on any psychotropic medications for eight weeks prior to enrollment. Exclusion criteria included a) imminent or severe risk of harm to self or others, b) levels of substance abuse that would interfere with treatment, and c) acute psychosis. All procedures for the study were reviewed and approved by the Institutional Review Board.

A total of 138 veterans participated in the study. The average age was 58.33 (range = 18–76; $SD = 13.00$). Sixty-five percent were Vietnam cohort veterans, 14% were Operation Enduring Freedom/ Operation Iraqi Freedom cohort veterans, 7% were Gulf War veterans, and the remainder were from other periods. The sample was 14% female, 70% Caucasian, 8% African-American, 3% Hispanic, 1% each for Asian, Native American, and Multiracial, and 17% unreported ethnicities. Reported religious affiliations included: Protestant ($n = 84$), Catholic ($n = 38$), Spiritual but not religious ($n = 13$), Agnostic ($n = 5$), Jewish ($n = 2$), Sufi ($n = 1$), Shinto ($n = 1$), and Native American Spiritualty ($n = 1$). Note that some participants reported multiple affiliations. Sixty-seven veterans were randomized to PCGT, and 71 were randomized to BSS. See Table 1 for detailed sample description.

2.2. Procedures

Based on a power analysis using effect sizes derived from the pilot study, the planned sample size was 150 participants. Participants were recruited from April 2014 through April 2016. Data collection was stopped at 138 because the team came to the end of the funded period for study implementation before attaining 150 participants. Veterans interested in participating in the study were asked to call the study coordinator and initially complete a telephone screening for inclusion/ exclusion criteria. Those who appeared to meet criteria based on a very brief telephone screening were invited to an informed consent and baseline screening interview including structured interviews to assess for PTSD and exclusionary conditions, as well as demographics, and self-report measures of PTSD symptoms and spiritual distress (See Fig. 1 for Screening and Randomization data). Outcomes were collected using interview and self-report measures at the end of the eight weeks of intervention, and again using self-report measures only at a two-month follow-up after the intervention had ended. Interview assessments were conducted by a Master's level independent evaluator who was blind to treatment condition and supervised by a similarly blinded study co-investigator. Interviews and implementation of groups took place in community and faith group settings, such as inter-faith centers and churches that defined services to veterans as part of their mission. Veterans were randomized to conditions based on a randomization table developed by the study statistician before recruitment began, and were informed of their treatment condition only after eligibility for enrollment and baseline assessment data were collected.

Both groups were led by chaplains who had additional qualifications in mental health. The demographic and training descriptions of the study chaplains are as follows: Chaplain One was a Caucasian male, held Master's degrees in Divinity and Marriage and Family Therapy, affiliated with the United Church of Christ, and also functioned as an Army Reserve Chaplain. Chaplain Two was a Caucasian female, held a bachelor's degree in Youth Ministry and a Master's degree in Marriage and Family Therapy, had no military affiliation, and practiced as a non-denominational Christian. Chaplain Three was a Caucasian male, held

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