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Developing a Trauma Oriented Spiritual Care Framework through the Compassionate Spiritual Governance Theory Based on the Sound Heart Model: An Expanded Multi Grounded Theory Study

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Abstract

Introduction: Trauma surgery prioritizes physiological stabilization and survival, however, severe trauma triggers spiritual distress, moral injury, and religious struggles. Holistic trauma care must address shattered beliefs and spiritual crisis by integrating structured spiritual healthcare frameworks into trauma systems. To address this gap, the present study introduces two trauma relevant constructs: (1) The Sound Heart Model (SHM) as a theistic and clinically adaptable spiritual care framework that emphasizes compassionate therapeutic communication by spiritual care providers as mentors and includes three core dimensions:-knowledge enhancement, -meaning making in the relationship with God, self, people, and nature, -and spiritual motivation; and (2) the Compassionate Spiritual Governance Theory, as a multi level system for organizing spiritual healthcare across clinical, familial, professional, and policy settings. This study aimed to develop a trauma oriented spiritual care framework through the Compassionate Spiritual Governance Theory based on the SHM using an Expanded Multi Grounded Theory (MGT Extended) approach.

Materials and Methods: An Expanded Multi Grounded Theory design incorporating with the Field informed Integrative Comparative Analysis (FICA) method was used. Empirical grounding was achieved through field observations, clinical notes, and expert interviews with trauma clinicians. Theoretical grounding incorporated scientific literature on trauma, spiritual distress, and coping, along with conceptual elements from Islamic and comparative spiritual traditions. Internal and rational grounding were performed through iterative model consolidation and the Rational Grounding Cycle. All analyses followed MGT procedures (open–axial–selective coding, conceptual integration, and multi layer triangulation). The validity of the framework was examined at the content level (expert confirmation), structural level (coherence and operationalizability), adaptive level (conformity with clinical evidence), and theoretical level (critical comparison with existing models). Reliability was also explained through inter rater agreement, stability of discourse analysis, and reproducibility of the inference pathway.

Results: Comprehensive trauma treatment requires cultural awareness. Social discourses framing suffering as divine punishment act as destructive social determinants of spiritual health (DSDSH), fostering negative images of God, insecure attachment to God, and shattered beliefs about God, self, others, and the world. Spiritual insecurity manifests as loneliness, helplessness, despair, and loss of meaning, leading to fear, grief, diminished self compassion, social withdrawal, and maladaptive coping. The proposed framework involves spiritual communication to build trust and security, reconstruct beliefs and restore meaning, develop secure attachment to God and supportive resources, and strengthen coping capacity and motivation for self care. It also allows culturally sensitive adaptation for patients and survivors with non religious worldviews.

Conclusion: This culturally informed, and clinically adaptable framework by strengthening meaning-making, spiritual security, and compassionate support can enhance spiritual health, coping capacity, and overall recovery in trauma settings.

Key words: Critical Care, Pastoral Care, Psychological Distress, Spirituality, Wounds and Injuries

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Introduction

Trauma, as a health system problem, is the second leading cause of fatal injuries in developing countries (1). It results from acute exposure to unbearable amounts of heat, mechanical energy, electricity, chemicals, and radioactive substances (2). Exposure to events such as accidents (vehicle accidents and falls from heights), interpersonal violence (sexual and physical assault, child neglect, child abuse, and domestic violence), natural disasters (earthquakes and floods), serious injuries, war-related experiences, and threat of death can cause psychological trauma (3). According to global statistics, everyone experiences at least one traumatic event in their lifetime. Approximately two-thirds of children and adolescents under the age of 18 experience adverse childhood experiences (3). It is estimated that by 2030, road traffic injuries will be the fifth leading cause of death in the world (4). Although there are no accurate statistics on the prevalence of trauma in Iran, studies show that trauma is most common in young people under the age of 40 due to vehicle accidents, fights, and falls from heights (1).

An event, is a potentially damaging phenomenon beyond the "normal course of life". It will be considered as a traumatic event if it negatively changes the definition of the individual's identity and disrupts the ability to cope with the situation (5). Janoff-Bulman (1989) believed that, the traumatic events can disrupt three basic assumptions of victims and survivors about themselves and the world. Assumptions such as: "The world and people are benevolent", "The world is meaningful, logical and predictable. The coincidence between an individual and their outcomes is observable", and "I deserve good outcomes in life. I have the ability to control the outcomes"(6). These implicit assumptions are derived from lived experience. They form the basis of individuals' well-being and "sense of relative invulnerability." They are a guide for navigating "everyday life." As the basic assumptions of trauma victims and survivors are shattered, their ability to adapt is impaired (5).

Hurst R, Kannangara (2022) believe that trauma triggers the "grief process" and causes denial, anger, bargaining, and depression (7), and leads to severe mental health disorders such as post-traumatic stress disorder (PTSD), anxiety, depression, and physical health disorders in the victim and family (8). The PTSD, through re-experiencing the traumatic event, creates symptoms such as severe, chronic anxiety accompanied by nightmares, increased arousal, and decreased social interactions. It negatively affects the daily living of victims for long periods of time, placing them 2 to 5 times more at risk of suicidal thoughts, suicide attempts, and death from suicide than the general population (9).

A study by Leo et al. showed that traumatic experiences can have the opposite effect of strengthening or weakening spiritual beliefs (10). Van et al. showed that traumatic experiences can lead to the deepening of spirituality in the form of: positive religious openness, readiness to face existential questions, religious participation, intrinsic religiosity, which is useful in people's coping with trauma, and post-traumatic growth (PTG) (11). Unlike Janoff-Bulman (1989), Tedeschi and Calhoun (2004) believed that all people after a traumatic event, often develop their beliefs about themselves, others, and the world unconsciously in order to survive and restore balance to their lives. Following the development of these beliefs, individuals experience positive personal and psychological changes, which lead to improved functioning in five domains and result in PTG (12). As victims' spiritual beliefs deepen, their life priorities and relationships with others change, and they experience increased feelings of inner strength and appreciation for life. They provide a framework for a new identity, sense of competence, ability to solve challenges, embrace new experiences, and find meaning in life. These perceived changes in self, relationships with others, and philosophy of life provide the basis for progress, finding a sense of meaning, growth and flourishing (13). The confrontation of these two different discourses on trauma requires hermeneutic precision and community-oriented attention. Health system personnel in each country must be able to manage trauma based on the discourse of their society (14).

Although studies have identified religion and spirituality as facilitators of PTG, searching for meaning, purpose, and connection to a higher power can increase feelings of empowerment and healing (15), and trauma can draw victims' attention to religion. Religiosity, as a powerful resource with a solid intellectual organization and a strong worldview, can protect the victim from psycho-spiritual distress, and promote adaptation to the situation (16). Although the existing research highlights the role of spirituality in PTG, clinical interventions often focus on psychological interventions. The literature review does not reveal

practical strategies for "reconstructing the shattered assumptions of victims." Strategies for transforming damaged beliefs, spiritual distress, and rumination into acceptance and adaptation have received less attention (5). Studies do not provide an integrated framework of cognitive, spiritual, and cultural factors. They do not address the impact of the difference between the victim's reading of the traumatic event and the social reading of it (17). It is unclear what interventions can be implemented to facilitate adaptation in the group of trauma victims who are suffering from "the Shattered Assumptions" rumination, and spiritual distress.

To address this conceptual and practical gap within trauma care systems, the present study introduces two trauma related constructs. The first is the Sound Heart Model (SHM), a theologically grounded and spirituality oriented framework with clinical adaptability that emphasizes compassionate therapeutic presence (18). This model facilitates the reconstruction of shattered beliefs, the restoration of meaning, and the strengthening of adaptive capacity in trauma victims and survivors. It focuses on three core dimensions—enhancing spiritual knowledge, meaning making in one's relationship with God, self, others, and nature, and cultivating spiritual motivation—thereby defining a "sound heart" as the foundation of psychological, moral, and existential resilience (19). The second construct is the Compassionate Spiritual Governance Theory, designed not merely for spiritual care but for promoting spiritual health and spiritual security across individual, family, clinical/professional, and policy levels. Grounded in divine mercy and compassion (20). This theory challenges and corrects maladaptive interpretations of traumatic events—interpretations that often construe trauma as "punishment" or "retribution for sin." Instead, it conceptualizes adversity as a divine test and an opportunity for spiritual growth, thereby facilitating meaning reconstruction, identity repair, and the reduction of existential distress. The theory also attends to the distinction between an individual survivor's interpretation of trauma and the broader social reading of the event, offering a mechanism to harmonize these layers of meaning within cultural contexts and thereby support adaptive recovery (21).

Given the gap in understanding the relationship between spirituality and trauma, the current study aimed to develop a trauma oriented spiritual care framework through the Compassionate Spiritual Governance Theory based on the SHM using an Expanded Multi Grounded Theory (MGT Extended) approach.

Materials and Methods

Study Design

The present study employed the Expanded Multi Grounded Theory (MGT-Extended) methodology to develop a trauma-informed spiritual care framework grounded in the theory of Compassionate Spiritual Governance and the SHM (22). This methodological approach integrates three types of grounding—empirical grounding, theoretical grounding, and internal grounding—along with an additional grounding process known as the Rational Grounding Cycle (TRG) (21)—to construct complex, multi-source theoretical models. Within this study, the constructs of spiritual personality, spiritual pathology, spiritual distress, and spiritual restoration were analyzed in the context of trauma and organized within a clinically applicable framework. The research process involved the collection of empirical data, comparative theoretical analysis, integrative synthesis of findings, Qur'anic–rational reconstruction of the model, and final validation of the proposed framework (Table 1).

Data Sources and Participants

1- Empirical Grounding: Empirical data were obtained from trauma patients (acute and post-acute phases), family members of victims, ICU nurses, trauma surgeons, and spiritual care providers. A purposive sampling strategy was used, with data collection continuing until conceptual saturation was achieved. Semi-structured interviews (30–60 minutes each), participant observation in emergency departments and intensive care units, and the review of clinical reports documenting spiritual distress, meaning crises, and spiritual struggle were utilized.

Data Collection Procedures

Data collection proceeded through three primary channels:

- **Semi-structured interviews:** Focusing on experiences of spiritual distress, attempts at meaning reconstruction, and spiritual needs following trauma. Sample interview questions included: *"What psychological or spiritual impact has this traumatic event had on you?"*, *"Aside from physical injuries, are you experiencing any other forms of distress?"*, *"What strategies have you used to cope with or alleviate this distress?"*, and *"How has this*

event affected your relationship with yourself, others, or God?"

- **Participant observation:** In Emergency Department and ICU settings, with attention to behavioral and emotional manifestations of spiritual suffering.
- **Clinical document analysis:** Examining medical and psychosocial reports describing spiritual pathology, religious-spiritual struggles, or impairment of meaning-making.

All interviews were audio-recorded and transcribed verbatim. In addition, field notes from observations were systematically documented.

Data Analysis

The collected data were analyzed through open, axial, and selective coding, resulting in the extraction of primary empirical concepts related to spiritual pathology, spiritual personality, trauma-related spiritual distress, and pathways of spiritual restoration.

2- Theoretical Grounding**:** To strengthen theoretical grounding, an analytical–conceptual literature review was conducted, incorporating:

- The SHM
- Theories of spiritual personality and spiritual pathology
- Trauma psychology, coping, and resilience frameworks
- Islamic theological sources addressing suffering, compassion, hope, patience, and acceptance of destiny.

This phase enabled the identification of supporting theoretical categories, conceptual gaps, and areas requiring refinement (Table 2).

3. Internal Grounding

Empirical and theoretical findings were then integrated into a coherent internal structure. This process led to:

- A preliminary model of trauma-related spiritual pathology
- Identification of causal pathways of spiritual restoration
- Clarification of how spiritual personality moderates distress and facilitates post-traumatic transformation (Figure 1).

These insights informed the initial formulation of the Trauma-Informed Spiritual Care Framework (Table 3) (20).

4. Rational Grounding Cycle (TRG)

The TRG process was longitudinal and iterative, drawing on Qur'anic principles and rational analysis. It involved three steps:

1. Extraction of Qur'anic-rational principles concerning suffering, patience, hope, and tranquility of the heart.
2. Alignment of these principles with empirical findings.
3. Rational inference and reformulation of propositions to harmonize empirical data, scientific knowledge, and scriptural insights for refinement and enhancement of the trauma-informed spiritual care model.

This cycle ensured contextual validity, conceptual coherence, and fidelity to integrative epistemological foundations. Qur'anic insights were incorporated through discourse analysis and adherence to 14 principles of textual interpretation (22).

Table 1 illustrates how the Compassionate Spiritual Governance theory was developed through the Multi-Grounded Theory (MGT) approach and demonstrates its applicability as a validated framework for integrating spiritual care into the management of trauma victims and survivors.

Table 1. Stages of the Developed Multi-Grounded Theory Method**.**

Main Stages of the Study	Research Activities
Problem Identification	**Central research question**: Within the framework of the Compassionate Spiritual Governance theory based on the SHM, what mechanisms are required to reduce spiritual distress and enhance spiritual resilience among trauma survivors and victims' families?"
Empirical Grounding	Examination of the role of social determinants of spiritual health (SDSH) through in-depth interviews for: • Identifying (SDSH) and their role as causal factors • Identifying contextual facilitators and negative intervening factors influencing the core phenomenon • Understanding how SDSH generate insecure attachment to God • Extracting spiritual needs and patterns of spiritual distress among trauma survivors and their families
Structured Narrative Review	A narrative–analytical review of literature on trauma, spiritual health, trauma psychology, coping models, and Islamic sources (2000–2026), conducted to critically examine existing theories, extract key conceptual constructs, and compare frameworks of spiritual training. -Studies were retrieved from Scopus, Web of Science, PubMed, CINAHL, Psych INFO, SID, Magi ran (2000–2026). -Influential classical sources were included when necessary. Languages: Persian, English, and Arabic (for exegetical sources). **Inclusion criteria:** • Conceptual relevance to spiritual health • Presence of clear theoretical or methodological framework • Scientific credibility. This review was non-systematic, aiming to trace conceptual evolution rather than quantitatively synthesize evidence (Table 2).
Initial Concept Generation	Extraction of primary concepts-spiritual suffering, meaning conflict, crisis meaning-making, spiritual resilience- and development of intermediate theories including: • Theory of Spiritual Personality • Theory of Spiritual Pathology. Initial intervention proposals were developed through a comparative analysis of key concepts and SDSH.

Theoretical Grounding	Comparing and aligning field concepts with Islamic sources, the SHM, crisis nursing models, and health education models. • Explaining the role of spiritual interventions as protective factors within the diathesis–stress model.
Development of Strategies	Developing practical steps for implementing spiritual health care: a) Compassionate spiritual communication by mentors b) Therapeutic content including: • Spiritual knowledge enhancement • Meaning-making in relation to God, self, people, and nature • Strengthening emotion-focused and problem-focused coping • Spiritual motivation Five operational strategies and associated performance indicators were developed.
Multi-level Theory Construction	Designing the final four-level of Compassionate Spiritual Governance: • Individual level (spiritual self-care) • Family level (transmission of spiritual beliefs) • Expert and social role-model level (spiritual supervision) • Macro-policy level (modifying SDSH) Integration of findings from the previous stage with the SHM to build structural coherence.
Internal Grounding & Validation	Stabilizing causal relationships among constructs; integrating theoretical elements; designing the initial "Trauma-oriented Spiritual Care Framework." • Review by trauma and psychiatry specialists • Evaluation in ten academic theories-critique and theory-building forums in both seminary and university settings. Expert feedback used to: • Assess coherence, logic, and clarity of the theoretical structure • Examine relationships among constructs (peer review) • Conduct triangulation with religious, philosophical, and scientific literature • Document the full analytical path (audit trail) to enhance research trustworthiness

Final Theorizing & Reporting	Integrating all four types of grounding (empirical, theoretical, internal, rational); formulating final theoretical propositions Outputs: • Spiritual health service competency questionnaire • Spiritual mentoring questionnaire • Predictive questionnaire of spiritual health based on SDSH • Development of educational and policy intervention packages • Dissemination of results and knowledge-translation workshops
Stabilization and Validation	Review by trauma and surgery specialists; alignment with evidence; triangulation; finalization of the trauma-oriented spiritual care framework.

Table 2. Databases and Criteria for Source Selection.

Database	Keywords	Operators	Limits	Purpose
Scopus	"Spiritual Health", "Spiritual Distress", Trauma, "Critical Care", "Spiritual Care"	AND / OR	2000–2024	Identification of spiritual care frameworks in crisis and trauma contexts
PubMed	Spirituality, Health Assessment, Trauma, Spiritual Care	AND	English, 2000–2024	Focus on spiritual distress and spiritual assessment among critically ill patients
Web of Science	"Spiritual Care Model", Trauma, Clinical Practice	AND	2000–2024	Identification of adaptable models in clinical environments
SID	Spiritual Health, Spiritual Care, Trauma	AND	Persian, 2000–2024	Relevant Persian-language sources
Magi ran	Spiritual Distress, Spiritual Care	AND	Persian, 2000–2024	Analytical and empirical Persian articles

Note: This review did **not** constitute a PRISMA-based systematic review but a purposive, theory-driven conceptual synthesis appropriate for MGT-Extended.

Table 3. Spiritual Interventions to Transform Traumatic Experiences into Spiritual Experiences.

Spiritual pathology	Home work	Session title	Session objectives	Art therapy
Shattered hypotheses due to the severity of the trauma or social determinants of spiritual health	My sufferings, how do I adapt to my sufferings	Establishing spiritual communication (With compassion and unconditional acceptance for gaining trust)	Rebuilding Destroyed Beliefs: - The world is a place of divine testing - Suffering is not divine punishment. -There is wisdom in hardships - Hardships are for God's friends - Man is not subject to "forced fate" - Man's power to control events is limited - Prayer changes destinies - God's love includes everyone	- Using: Film therapy, story therapy, reviewing memories, reading poetry to express emotions
"Grief process" due to spiritual insecurity	Positive aspects of the disease:	Spiritual education (with paying attention to the positive aspects of the events based on duality)	Reflection on Trauma Process: -Explaining the causes of trauma, methods of treatment and care, -Clarifying the reason for life's suffering -Developing courage, optimism, hope, positive thinking	- Using: Educational films and software, stories, puppet shows, animation
"Meaninglessness" due to spiritual distress	Enjoying the present moment:	Skill training (to develop a connection with nature)	Enjoying the blessings of the universe, - paying attention to the melody of the universe's creatures, -using the beauty of nature	- Using: drawing, painting, coloring, poetry, pottery, puppet shows, memoirs
"Lack of self-compassion" due to suffering and pain	What are my honors in life?	Skill training (to develop spiritual self-awareness and sense of self-compassion)	Strengthening Self-compassion, -Preparing the victims to pay attention to their own suffering and try to reduce it - Helping the victims to become aware of their feelings of helplessness, fear, threat, sadness, and emotional states -Helping the victims to recognize spirituality as a factor in gaining strength	- Using: story writing, role playing, storytelling, painting, photography
"Shame or social isolation" due to inability to self-care	Letters of gratitude and appreciation	Skill training (to develop social communication)	-Attracting social support from relatives and friends, -creating an inner desire to develop social relationships, -Advising benevolence and charity	- Using: email, social networks, drawing, coloring, stories, memories poetry to express gratitude

"Disappointment from God's mercy" due to negative perception of God and insecure anxious-avoidant attachment to God	God's miracles in my life (a letter to God)	Skill training (to develop a connection with God)	Strengthening hope in God's mercy -Strengthening a positive perception of God and secure attachment to God, -Helping the victims to feel at peace in God's shelter	- Attending a mosque or shrine, participating in congregational prayers, calligraphy, decoration, mosaic
"Maladaptation" due to spiritual crisis	My abilities	Adaptation (to cope)	Teaching adaptation methods; -Strengthening problem-oriented and emotion-oriented adaptation to trauma	-Using: Film therapy, video games, performances
"Unmotivated" due to learned helplessness	Love gives me the ability (I can)	Motivation (For strengthening self-efficacy)	-Identifying, confirming, and acknowledging victims' values -Helping to acquire an inner desire to change one's behavior and spiritual states	- Creating a favorite work of art

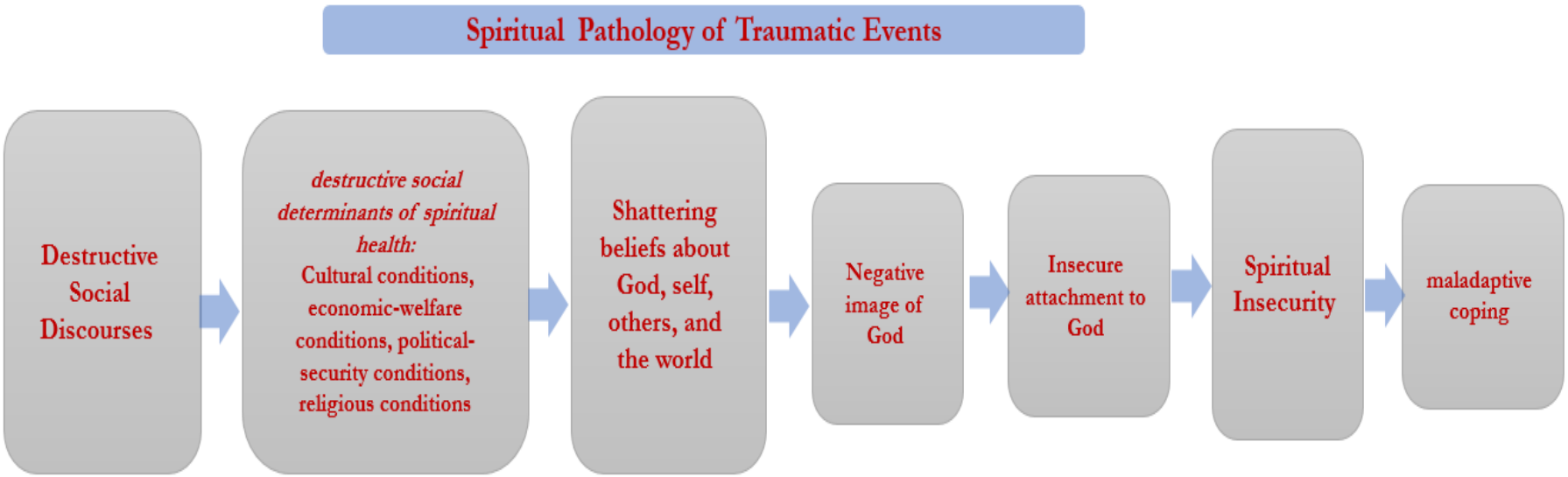

Figure 1. Social discourses framing suffering as divine punishment act as destructive social determinants of spiritual health, fostering negative images of God and insecure attachment patterns and shattering beliefs about God, self, others, and the world. Spiritual insecurity manifests as loneliness, helplessness, despair, loss of meaning, leading to maladaptive coping.

Integrative Conceptual Synthesis (FICA Framework)

To integrate the multi-level findings within MGT-Extended, the Field-Informed Integrative Comparative Analysis (FICA) method was applied.

This framework combines:

- Comparative theory analysis
- Narrative thematic synthesis
- Interdisciplinary synthesis (e.g., medicine, trauma psychology, spirituality studies, applied theology).

These analytical processes enabled the consolidation of constructs into a unified conceptual model.

The objective of this approach is to combine established analytical methods to evaluate competing theories and derive reliable and practically applicable theoretical propositions. The FICA framework was applied to integrate field data derived from the SHM with scientific theories across empirical, theoretical, and intervention levels (23, 24).

Validation and Trustworthiness

Validity was assessed through:

- **Content validity:** Expert review panels consisting of trauma surgeons, psychiatrists, and spirituality scholars
- **Structural validity:** Integration of concepts into coherent and operational constructs
- **Comparative validity:** Alignment with existing theoretical frameworks and clinical evidence
- **Theoretical validity:** Triangulation across religious, philosophical, empirical, and clinical sources

Reliability was enhanced through inter-reviewer agreement, stability of discourse analysis and concept extraction, and the replicability and traceability of the analytical path (audit trail) (25).

Results

Model Construction

Through iterative synthesis, a four-level model of Compassionate Spiritual Governance was developed:

1. **Individual Level:** Spiritual self-care and meaning-making
2. **Family Level:** Transmission and stabilization of spiritual beliefs
3. **Professional Level:** Spiritual care and clinical role-modeling
4. **Macro-Policy Level:** Modification of SDSH

Practical trauma-informed spiritual care strategies were formulated, including compassionate therapeutic communication, spiritual knowledge enhancement, meaning-making processes, and strengthening both emotion-focused and problem-focused coping.

Table 3 and Figure 1 show that SDSH creates spiritual crisis and threatens the spiritual security by shattering spiritual beliefs. Loss of meaning of life due to spiritual insecurity (feeling of loneliness and helplessness) causes spiritual health disorders (despair of God's mercy, lack of self-compassion, and social isolation), and disturbance in adaptation and motivation.

Table 4 exhibits the differences in the treatment of traumatic events in various contemporary approaches.

Discussion

The findings of the present study showed that spirituality has a hermeneutic effect on trauma. Based on the "social reading of religion", it can have dual and contradictory effects on victims and survivors. In each society, the type of reading of religion and the causes of suffering and life events creates a positive or negative image of God and a secure or insecure attachment to God. This is consistent with the findings of Asadzandi and Seyed Kalal on the role of social customs in creating insecure attachment to God. They argue that introducing the suffering of life as punishment for sins, by cutting off secure attachment to God, causes spiritual distress and ineffectiveness of the meaning of life (26). Social reading of religion in the form of SDSH (cultural-religious conditions, behavior of spiritual role models, spiritual upbringing methods, content of spiritual education) affects individuals' interpretation of the spiritual causes of trauma (27). A positive image of God (presenting God as a kind and compassionate creator) that strengthens a secure attachment to God, gives a positive meaning to unpleasant life events and strengthens spiritual beliefs (21). On the contrary, negative image of God (as a "vengeful tyrant" who is in wait to punish sinners), by an insecure attachment to God (avoidant or anxious), causes a feeling of spiritual insecurity and helplessness in victims (28). This is consistent with Janoff-Bulman's findings in "theory of

shattered assumptions" that trauma can challenge an individual's basic assumptions about the world (6). In a study by Leo et al., trauma was found to decrease spiritual beliefs in some individuals while strengthening spirituality in some others (10). In another study by Chan et al., it was shown that survivors of natural disasters may either face a spiritual crisis or achieve "spiritual reconstruction" through prayer and religious rituals (29). In the present study, the empirical data and conceptual synthesis jointly showed that the social reading of religion functions as a major determinant of whether trauma leads to "spiritual insecurity" or to "spiritual reconstruction." This dual pathway, mediated through the victim's image of God and type of spiritual attachment, constitutes one of the key original contributions of this research and extends existing trauma-spirituality models by demonstrating the way cultural-religious environments shape meaning-making at the earliest stages of post-trauma adjustment.

Therefore, in the first step of spiritual interventions, spiritual caregivers should establish a safe and reliable therapeutic relationship aimed at gaining trust, offering unconditional acceptance, and avoiding any judgment (30). This is because the victim's sense of security enables the discovery and expression of traumatic experiences (31). Consistent with the results of the present research, Parayil considers a safe therapeutic relationship as the first key element of trauma-based counseling, and emphasizes understanding trauma by educating clients about its effects on the mind and body, thereby reducing feelings of shame or isolation (32). The findings of this study highlight victims who experienced negative or punitive religious interpretations showed heightened spiritual avoidance, self-blame, and inability to express their distress unless a secure, compassionate therapeutic relationship was first established. This is the second major finding derived from our empirical data, clarifying why spiritual security must precede spiritual interventions.

For implementing therapeutic content (e.g., spiritual enrichment, skills training, and motivation), it is essential to pay attention to cultural differences. This is because an individual's appraisal of trauma affects the perception of the suffering of traumatic experiences. It is essential to correct social misreading with spiritual education (deliberate rumination) (15). Eames and O'Connor examined the role of repetitive thinking and spirituality in PTSD. They reported that spirituality moderated the relationship between deliberate rumination and PTG. Individuals with stronger spiritual beliefs showed more PTG. Spirituality enhances cognitive processes leading to growth (33). Hansen, in "Trauma-informed Spiritual Care," recommends that spiritual caregivers create safety, facilitate meaning-making, and promote survivor connection (34). This is consistent with the findings of the present study.

The third step, "meaning-making," focuses on the positive aspects of the problems based on ambivalence. The victims' questions about meaning should be answered using spiritual narratives and prophetic experiences (35). O'Donnell (2022) considered the reconstruction of narratives and finding meaning and purpose as facilitating factors of PTG (5). Resick in "Cognitive Processing Therapy" (CPT) emphasizes the changing negative thinking patterns and dysfunctional beliefs resulting from traumatic experiences for the recovery from trauma and effective management of PTSD symptoms (aggressive memories, increased irritability, emotional numbness and avoidance behaviors). Because trauma distorts the individual's cognitive processes and leads to the development of dysfunctional beliefs about oneself and the world. Based on the principles of "Cognitive-Behavioral Therapy" (CBT), which emphasizes that our thoughts, feelings and behaviors are intricately connected, focusing on the cognitive distortions of trauma that result in feelings of hopelessness, guilt, and helplessness. Therefore, changing dysfunctional thought patterns can reconstruct victims' experiences (36). CPT includes:

1- Educating clients about PTSD, understanding the complex relationship between thoughts, feelings, and behaviors as foundational knowledge,

2- Cognitive restructuring to identify and challenge negative thoughts and beliefs through "Socratic questioning" and the use of thought records and replacing them with more balanced and rational perspectives,

3- Emotional processing to confront emotions through writing detailed descriptions of the traumatic event and exploring related emotions,

4- Developing coping skills to manage symptoms, includes relaxation techniques, mindfulness and self-compassion exercises, changing mental imagery.

Clients who visualize the traumatic event and

actively change its narrative can regain power over the trauma narrative, develop a more coherent and deeper understanding of their experiences, reduce the associated emotional distress, and thereby manage challenges while strengthening their sense of resilience (37).

In the fourth step, "spiritual coping," skills are used to strengthen connections with God, self, people, and nature. Self-compassion, forgiveness, and kindness to people and universe are strengthened (28). Parayil/trauma-based counseling uses techniques, such as talk therapy, CBT, and eye movement desensitization and reprocessing to process and integrate traumatic memories and teach healthy coping mechanisms, and uses techniques, such as mindfulness, meditation, and prayer to enhance resilience (32).

Bu hake recommends integrating faith-based approaches into CBT for mental health by:

1- Mindfulness and meditation for self-connection, emotional regulation, and stress reduction,
2- Prayer and reflection on spiritual teachings for meaning-making,
3- Social support through spiritual communities to foster a sense of belonging and shared purpose,
4- Exploration of meaning and purpose to repair the person's challenged worldview,
5- Seeking help from spiritual counselors or clergy to heal the victim's beliefs,
6- In some ways, this study is consistent with present study (38).

The integration of spirituality into CPT, titled Spiritual Integrated Cognitive Processing Therapy (SICPT), was developed by Pearce et al. (2018) to target moral harm. The approach used spiritual interventions such as prayer to strengthen clients' sense of connection to a higher power. Pearce et al. (2018) reported that this approach effectively reduced PTSD symptoms in former military personnel ($p<0.05$) (37). In Iran, a study by Mousavi and Vatankhah (2023) on women with breast cancer showed that SICPT by:

1- Cognitive restructuring (identifying and changing dysfunctional and negative beliefs),
2- Spiritual practices (using prayer, meditation, and communication with God),
3- Writing experiences (to process one's feelings and beliefs),
4- Socratic questioning (to guide clients to self-awareness and change negative beliefs),
5- Psychological education (about the connection between thoughts, feelings, and behaviors), was able to significantly increase PTG (39).

Although SICPT incorporates spirituality into CPT, the SHM developed in this study differs in several key respects:

(1) It is not an adaptation of CPT, but a spirituality-first framework centered on spiritual personality, spiritual pathology, and secure attachment to God.
(2) SHM addresses social-religious determinants of spiritual distress, an area not explicitly covered in SICPT.
(3) SHM provides a four-level governance model (individual, family, professional, and policy), whereas SICPT is exclusively a psychotherapeutic intervention.

These distinctions highlight the added conceptual and clinical value of SHM beyond existing spiritually integrated trauma therapies.

The final stage will occur when the traumatic experience is integrated into a spiritual narrative and strengthens resilience. Love and secure attachment to God help this transformation by providing motivation and increasing adaptability. This love and gratitude prepare the individual to accept the current situation and strive to improve it. It makes life's suffering meaningful and bearable and motivates the search for meaning in life (40). Rahimi and Heydarzadeh (2022) also proposed a positive psychology-based PTG model for cancer survivors that identified six components: psychological capital, self-compassion, meaning in life, spirituality, gratitude, and love. Spirituality played a central role in this model and facilitated meaning-making (41). In the current study, narrative reconstruction and shifts in God-image were identified as the most decisive mechanisms through which victims progressed from "spiritual insecurity" to "spiritual reconstruction." Which represents another novel contribution of this research to the trauma-spirituality field.

The present research was developed within a theistic spiritual framework; therefore, its applicability may be limited for individuals who identify as atheists and do not adopt a spiritually-oriented worldview. In addition, the study relied primarily on existing literature and conceptual synthesis rather than primary empirical data. No quantitative data were generated, and no statistical analyses were conducted. The study represents a

theory-building design focused on conceptual development and validation. The proposed trauma-informed spiritual care model has not yet been tested in a clinical trial and should, therefore, be regarded as a theoretically grounded model rather than an empirically evaluated intervention.

Future research should examine the model through longitudinal randomized controlled trials to evaluate its long-term effectiveness. Testing the framework among specific populations (e.g., children, adolescents, and ethnic minorities) is recommended to assess broader applicability. Cross-cultural studies are also needed to refine the model and explore its adaptability across diverse spiritual and cultural contexts.

Table 4. Comparing the SHM with Contemporary Approaches in Trauma Treatment

Domain	Sound Heart Model (SHM)	Post-Traumatic Growth (PTG)	Trauma-Based Counseling	Cognitive Processing Therapy (CPT)	Spiritual Integrated CPT (SICPT)	Trauma-Informed Care (TIC)	Trauma-and Violence-Informed Care (TVIC)
View of Spiritual	A breakdown of spiritual trust and beliefs caused by suffering; leads to spiritual insecurity, despair, and existential distress	Trauma can catalyze spiritual questioning that leads to spiritual growth	Often acknowledged but typically addressed indirectly through emotional and cognitive work	May involve distorted cognitions with spiritual themes, but does not explicitly define "spiritual trauma"	Recognizes spiritual trauma as part of broader traumatic disruptions; integrates faith in healing	Acknowledges trauma broadly, including spiritual impacts, but does not directly define spiritual trauma	Considers how systemic violence and oppression (e.g. religious discrimination) cause spiritual suffering
Core Spiritual	- Negative image of God - Insecure attachment to God - Loss of meaning and hope - Spiritual isolation	- Spiritual disruption reframed as a potential catalyst for transformation	- Emotional wounds often include spiritual confusion - Loss of existential meaning	- Maladaptive cognitions may include guilt, self-blame, or distorted religious beliefs	- Faith struggles, anger at God, shattered beliefs are directly addressed	- Spiritual wounds considered within a holistic trauma response	- Cultural/religious oppression considered key in marginalization and spiritual breakdown
Primary Goal of	Restore spiritual security, rebuild meaning, strengthen attachment to God, self, others, and nature	Meaning-making, existential reconstruction, and spiritual maturation	Reduce distress and restore functioning, occasionally including spiritual coping	Cognitive reappraisal and emotional regulation	Combine faith-based practices with CBT to restore spiritual coherence	Promote safety, trust, and empowerment, indirectly supporting spiritual well-being	Address social injustice and structural causes of trauma, including spiritual invalidation
Spiritual Interventions	1. Establish spiritual trust 2. Rebuild shattered beliefs 3. Develop secure spiritual attachments 4. Enhance spiritual coping & motivation	Reflection, gratitude, spiritual narrative reconstruction	May include prayer, spiritual dialogue, meaning-making as client-centered tools	Does not use spiritual interventions by default	Prayer, scripture, forgiveness, spiritual journaling	Incorporates spirituality if relevant to client's identity	Validates spiritual experiences, addresses intergenerational/spiritual oppression
Image of God / Divine Reconnection	Central focus: healing distorted images of God and establishing secure divine attachment	Not always God-specific, but encourages spiritual openness and gratitude	May be explored if relevant to client's distress	Occasionally addressed if beliefs interfere with recovery	Direct integration of God's image and divine trust into cognitive healing	Supports client-led exploration of divine trust	Frames religious wounding within cultural power structures

Cultural Sensitivity	High: rooted in understanding diverse theological and cultural constructs of suffering	Moderate to high depending on client-led meaning-making	Moderate: depends on therapist's framework	Low to moderate unless spiritual themes emerge	High: includes client's spiritual worldview and practices	Moderate: prioritizes emotional safety but spiritual elements are client-driven	High: explicitly incorporates intersectionality and cultural-spiritual trauma
Outcomes Related to	Psychological peace, spiritual resilience, reconnection with divine, self, others, and world	Spiritual growth, increased appreciation of life, deeper relationships	Relief of emotional/spiritual pain, better adjustment	Reduction in PTSD symptoms; potential relief of spiritually rooted guilt/shame	enhanced faith-based resilience	Trust restoration, empowerment, spiritual expression if relevant	Restoration of agency, healing from religious/cultural oppression, meaning reintegration
Empirical Support	Emerging; supported by qualitative clinical applications and alignment with SDSH	Strong empirical support across trauma populations	Strong clinical use; varied empirical focus on spiritual factors	Strong evidence for PTSD treatment efficacy	Preliminary evidence supports use in faith-based populations	Widely accepted in trauma care, esp. in behavioral health	Growing evidence, especially in marginalized populations

Conclusion

Spirituality serves as a critical resource for trauma recovery, yet its efficacy is contingent upon the SDSH. The present study demonstrates that by treating spiritual insecurity and negative God-images, traumatic experiences can be transformed into opportunities for spiritual growth. This transformation is operationalized through the four-step protocol of the SHM:

1. **Establishing Spiritual Security:** Prioritizing a non-judgmental, compassionate therapeutic relationship to facilitate a secure attachment to God and the caregiver.
2. **Spiritual Education and Awareness:** Correcting social misreading of religion and punitive interpretations of trauma through deliberate spiritual rumination.
3. **Meaning-Making and Narrative Reconstruction:** Utilizing spiritual narratives and prophetic experiences to find purpose within suffering.
4. **Strengthening Spiritual Coping:** Enhancing resilience through forgiveness, gratitude, and deep connection with the Creator, self, and society.

The SHM provides a culturally sensitive framework that bridges empirical evidence with religious insights.

The findings of this study indicate that integrating spirituality into trauma-focused therapy, as conceptualized in the SHM, offers several important clinical applications. In this model, reductions in trauma-related distress are facilitated through strengthening secure attachment to God, correcting maladaptive spiritual appraisals, and supporting constructive meaning-making processes. These mechanisms suggest that SHM may contribute to reducing post-traumatic symptoms, fostering PTG, and improving emotional regulation. The SHM also provides practical guidance for incorporating spiritual coping practices, such as forgiveness, gratitude, and compassion-based reflection, into the trauma-recovery process. Furthermore, because SHM defines spirituality in a structured, culturally sensitive, and clinically applicable manner, it may enhance treatment responsiveness and acceptability among clients for whom spirituality is an important resource. Overall, the present research offers a framework that clinicians can use to address the spiritual dimensions of trauma, serving as a valuable adjunct to existing trauma-focused therapeutic approaches.

Ethics Approval and Consent to Participate

This study is derived from the research project entitled: “Needs Assessment, Situational Analysis, and Development Methods of Spiritual Counseling in Hospitals Based on the Sound Heart Model” approved by the Ethics Committee of Baqiyatallah University of Medical Sciences under the Ethical Code: IR.BMSU.REC.1404.162. Researchers were required to adhere to the ethical principles of the Declaration of Helsinki, including:

- Honesty in data collection, analysis, and reporting
- Protection of confidentiality and privacy of information
- Respect for participants’ rights
- Assurance that no psychological or spiritual harm would be inflicted upon patients

Consent for Publication

Not applicable.

Data Availability Statement

All data generated or analyzed during this study are included in this published article. No additional datasets were generated.

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Authors’ Contribution

M.A. conceptualization, methodology, data curation, writing – original draft, writing – review & editing **A.SK.** study consultation, writing – review & editing. All Authors read and approved the final manuscript.

Conflict of Interest

The authors declare no conflicts of interest related to this study.

Declaration of Generative Artificial Intelligence (AI) in Scientific Writing

The authors declare that generative artificial intelligence tools were used solely for language editing and improvement of grammar and clarity.

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