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Psycho-Spiritual Pathways to Well-Being after Adversity: An Umbrella Review

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Abstract

Objective: This umbrella review synthesizes findings from existing systematic, scoping, and narrative reviews on psycho-spiritual processes and interventions that influence well-being following trauma and adversity.
Method: Following umbrella review methodology, we searched major databases (PsycINFO, PubMed, CINAHL, etc.) for reviews published between 2015 and 2025. Methodological quality was assessed using the AMSTAR-2 tool. Only reviews scoring above the predefined threshold of > 8/16 were included. All 18 included reviews scored 14–16 out of 16, indicating high methodological quality. Eighteen reviews met the inclusion criteria, encompassing diverse populations including veterans, cancer survivors, disaster victims, and survivors of abuse.
Results: The synthesis reveals three core psycho-spiritual pathways: 1) The Meaning-Making Pathway, where spirituality facilitates posttraumatic growth (PTG), identity reconstruction, and spiritual well-being (SWB); 2) The Pathway of Spiritual Struggle, where existential conflict, moral injury, and a loss of meaning exacerbate psychological distress; and 3) The intervention Pathway, where psycho-spiritually integrated therapies showed positive effects. However, effect sizes, confidence intervals, and heterogeneity were inconsistently reported across the 18 included reviews, precluding a single pooled estimate. Effect sizes from meta-analyses ranged from small to moderate: for depression (Cohen's d = 0.42, 95% CI [0.21, 0.63]), for anxiety (SMD = 0.31–0.58), and for spiritual well-being (SMD = 0.47, 95% CI [0.29, 0.65]). Heterogeneity was moderate to high (I^2 = 54–72%). Key facilitators include person-centered, trauma-informed care that validates spiritual concerns, while a primary barrier is the clinician's lack of training in addressing existential and spiritual dimensions.
Conclusion: Psycho-SWB is a pivotal, multifaceted outcome of trauma recovery. Effective support requires a nuanced approach that acknowledges both the potential for growth and the reality of existential pain. Clinical practice must integrate evidence-based psycho-spiritual interventions, while research should prioritize longitudinal designs, diverse populations, and standardized measures of psycho-spiritual constructs.

Key words: *Posttraumatic Growth; Psychological Well-Being; Spirituality; Trauma*

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Trauma and adversity—from violence and life-threatening illnesses to loss and disaster—fundamentally fracture an individual's sense of safety, predictability, and self-coherence (1). In the aftermath, the journey toward recovery is not merely psychological but inherently psycho-spiritual, involving a deep, often urgent search for meaning, purpose, and a restored sense of connection to something greater than the self (2, 3). This review focuses on spirituality not as institutional religion, but as the universal human capacity for meaning-making, transcendence, and the pursuit of ultimate concerns—a dimension now recognized as central to holistic well-being.

Before proceeding, it is essential to clarify key terms. "Spirituality" in this review refers to the human capacity for transcendence, meaning-making, and connection to something greater than oneself—whether that be a higher power, nature, humanity, or one's own deepest values (4). This is distinguished from "religiosity", which typically involves institutional doctrines, rituals, and practices (5). While overlapping, spirituality is understood here as a broader, more universal construct that does not require religious affiliation (6). "Psycho-spiritual" refers to the intersection of psychological processes (e.g., cognition, emotion, coping) with spiritual or existential dimensions (7). Empirical studies have shown that these psycho-spiritual dimensions are consistently associated with mental health outcomes (7, 8). "Spiritual well-being" (SWB) encompasses a sense of meaning, peace, and connectedness (4). "Spiritual struggle" includes feelings of divine abandonment, moral injury, existential doubt, and loss of ultimate meaning (9). These definitions are grounded in research showing that meaning-making, spiritual struggle, and SWB predict lower depression, anxiety, and post-traumatic stress disorder (PTSD) symptoms across trauma populations (10-12).

Operationally, psycho-spiritual constructs were measured using validated instruments such as the Functional Assessment of Chronic Illness Therapy–SWB (FACIT-Sp) (13), the Meaning in Life Questionnaire (MLQ) (14), and the Religious/Spiritual Struggles Scale (RSS) (15). Psycho-spiritual interventions were defined as those explicitly addressing meaning, existential concerns, or spiritual coping, regardless of religious content (7).

This psycho-spiritual domain represents a profound double-edged sword in trauma recovery. On one hand, engaging in meaning-making, discovering purpose in suffering, and experiencing a sense of existential peace—collectively termed SWB—are robustly linked to posttraumatic growth (PTG), resilience, and lower psychopathology (16, 17). On the other hand, trauma can trigger intense spiritual or existential struggles: a collapse of meaning, feelings of ultimate alienation, profound guilt (moral injury), or a ruptured sense of identity (18, 19). These struggles are significant risk factors, exacerbating symptoms of PTSD, depression, and anxiety (20, 21).

A growing body of synthesis literature has mapped these complex pathways. Reviews have examined psycho-spiritual processes in specific populations such as cancer survivors (e.g., 16, 21, 37), veterans (e.g., 22, 23), abuse survivors (e.g., 20, 24) and others (e.g., 25, 26), and evaluated interventions designed to enhance meaning and SWB, such as meaning-centered therapy (16), mindfulness-based approaches (21, 27), and spiritually integrated cognitive behavioral therapies (22). However, the field remains fragmented, with findings dispersed across different trauma populations, theoretical frameworks, and methodological approaches. Consequently, no single systematic review can provide a complete picture of psycho-spiritual responses to trauma. Existing reviews focus narrowly on specific populations (e.g., cancer survivors, veterans), specific outcomes (e.g., PTG, depression), or specific interventions (e.g., mindfulness, meaning-centered therapy). Specifically, no existing overview till now has: (a) simultaneously examined both positive (meaning-making, growth) and negative (spiritual struggle, moral injury) psycho-spiritual processes across different trauma types; (b) compared the efficacy of different psycho-spiritual interventions (e.g., meaning-centered therapy, spiritually-integrated cognitive behavioral therapy (CBT), mindfulness) within a single synthesis; or (c) systematically identified facilitators and barriers to implementing psycho-spiritual care in clinical practice. Therefore, the present umbrella review addresses these three specific gaps by synthesizing 18 existing reviews, thereby offering a consolidated map of psycho-spiritual pathways to well-being after adversity.

Several controversies and limitations characterize the current evidence. First, definitions of spirituality vary widely across studies, complicating cross-study comparison. Second, much of the research has been conducted in Western, Christian-majority contexts, raising questions about generalizability to other cultural and religious traditions. Third, there is an ongoing debate about whether psycho-spiritual interventions are effective beyond their non-specific therapeutic factors (e.g., therapist attention, group support). Finally, few studies have examined potential harms of psycho-spiritual interventions, such as exacerbating spiritual struggle. This umbrella review does not resolve these controversies but aims to transparently map the existing evidence while highlighting these unresolved issues.

To address this fragmentation, we conducted a higher-order synthesis following established umbrella review guidelines (29). This involved systematically searching for, appraising, and synthesizing findings from existing systematic, scoping, and narrative reviews rather than primary studies. We synthesized evidence on existential, spiritual, and (where relevant) religious dimensions of healing.

While our primary focus is on spirituality as a universal human capacity for meaning-making and transcendence (which may or may not include religious content), we did not exclude reviews that examined explicitly religious interventions (e.g., prayer, pastoral care). Instead, we extracted findings related to spiritual or existential outcomes regardless of whether the intervention had religious origins. Where necessary, we note the religious context of specific interventions in our synthesis. Unlike previous systematic reviews that focused on single populations or single outcomes, this umbrella review is innovative in its cross-population synthesis, its simultaneous examination of both growth and struggle pathways, and its explicit focus on clinical implementation facilitators and barriers. It aims to answer the following questions:

1. What are the primary psycho-spiritual processes that contribute to well-being or distress after trauma?
2. What is the evidence for the efficacy of psychotherapeutic interventions explicitly targeting psycho-SWB?
3. What are the key facilitators and barriers to providing effective psycho-spiritual support in clinical practice?
4. What are the main limitations in the current evidence base and implications for future research and practice?

These questions were designed to address both the positive and negative dimensions of the psycho-spiritual experience, as well as the practical realities of clinical implementation.

Materials and Methods

This is an umbrella review (also known as an overview of reviews), synthesizing data from existing reviews such as systematic reviews, scoping reviews, narrative reviews, etc. rather than from primary studies. This review was registered in PROSPERO (CRD42023427905) and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (30). The objective was to synthesize existing systematic, scoping, and narrative reviews focusing on spirituality and psycho-SWB in the context of trauma.

Search Strategy

A systematic search was conducted on March 15, 2025 and updated in April 2026, across the following electronic databases: PubMed, Web of Science, CINAHL, PsycINFO, EMBASE, Cochrane Library, and Scopus. The search strategy was developed by an experienced health sciences librarian and peer-reviewed using the Peer Review of Electronic Search Strategies (PRESS) checklist. The following search string was used in PubMed and adapted for other databases:

("spirituality" [MeSH] OR "psycho-spiritual"[Title/Abstract] OR "existential"[Title/Abstract] OR "meaning in life"[Title/Abstract] OR "spiritual well-being"[Title/Abstract]) AND ("trauma"[MeSH] OR "adversity"[Title/Abstract] OR "posttraumatic growth"[Title/Abstract] OR "PTSD"[Title/Abstract]) AND ("systematic review"[Publication Type] OR "scoping review"[Title/Abstract] OR "meta-analysis"[Publication Type] OR "narrative review"[Title/Abstract]).

Only peer-reviewed articles published in English between January 2015 and March 2025 were included. No other limits (e.g., study design) were applied.

Inclusion and Exclusion Criteria

Reviews were included if they: (a) were peer-reviewed systematic, scoping, or narrative reviews with a defined search strategy; (b) focused on SWB, existential meaning, spiritual struggle, or psycho-spiritual interventions in the context of psychological trauma/adversity; (c) assessed psychosocial or spiritual outcomes (e.g., PTG, SWB, meaning, PTSD); (d) were published in English. Reviews were excluded if they: (a) focused exclusively on religious attendance, doctrine, or practice without linking to psychological or spiritual constructs; (b) were primarily theological or philosophical without empirical synthesis.

For narrative reviews to be included, they had to provide a clear search method (e.g., databases searched, keywords, inclusion/exclusion criteria), distinguishing them from non-systematic expert opinion pieces. Reviews that examined explicitly religious interventions (e.g., prayer, pastoral care, religious CBT) were included if they reported outcomes related to SWB, meaning, existential distress, or psycho-spiritual adjustment. We did not exclude religious content per se, but we extracted data focusing on psychological and spiritual outcomes rather than religious adherence or doctrine.

Screening Process

After duplicate removal, two independent reviewers screened all titles and abstracts against the eligibility criteria. The same two reviewers independently assessed the full text of potentially relevant papers for final inclusion. Disagreements at either stage were resolved through discussion; if consensus was not reached, a third reviewer made the final decision. Inter-rater agreement for full-text screening was calculated using Cohen's kappa (31) ($\kappa = 0.87$), indicating excellent agreement. The screening process was managed using Covidence systematic review software.

Data Extraction

Data from the included reviews were extracted using a standardized form. The extracted information comprised: author(s) and year; type of review; target population and trauma focus; key psycho-spiritual constructs and interventions; number of included primary studies; main findings; and reported limitations.

Quality Assessment

To ensure the robustness of our synthesis, the methodological quality of the included reviews was assessed using the AMSTAR-2 tool (32). Two independent reviewers assessed each included review

using AMSTAR-2. Disagreements on individual domain ratings were resolved through discussion; if disagreement persisted, a third reviewer was consulted. Inter-rater agreement for the overall AMSTAR-2 score was κ = 0.85. This instrument evaluates systematic reviews across 16 key domains (https://amstar.ca/Amstar_Checklist.php). We set a predefined threshold of > 8/16 to identify high- or moderate-quality reviews and exclude those with critical flaws. AMSTAR-2 was applied only to the 11 systematic reviews and meta-analyses included in this umbrella review, as the tool is not validated for narrative or scoping reviews.

All 11 systematic reviews scored between 14 and 16 out of 16, indicating high methodological quality with only minor non-critical limitations. The remaining 7 reviews (narrative or scoping) were not assigned AMSTAR-2 scores; they were assessed descriptively for transparency (e.g., by evaluating the presence of a search strategy and inclusion criteria) and met our inclusion criteria for narrative reviews with defined search methods. Scores of 14/16 indicate minor limitations (e.g., not registering a review protocol or not providing a list of excluded studies), while scores of 16/16 indicate no limitations. No review scored below 14, confirming that none had critical flaws (e.g., failure to assess publication bias or risk of bias in primary studies). Assessment of publication bias across the included reviews was not performed. This decision was based on two considerations: (a) a substantial proportion of included reviews were narrative or scoping syntheses without meta-analyses, for which publication bias tools are not applicable; and (b) for the meta-analyses that were included, we did not have access to the primary study-level effect sizes required to independently test for small-study effects or funnel plot asymmetry.

Data Synthesis

We synthesized findings narratively (33) following Cochrane guidance (34, 35), organizing results by thematic areas derived from the research questions. Within this narrative synthesis, we applied the reflexive thematic analysis method described by Braun and Clarke (36). This six-phase approach allowed us to systematically identify, analyze, and report patterns (themes) across the 18 reviews. The six phases were as follows:

- Phase 1 – Familiarization: All authors read and re-read the 18 included reviews in full, noting initial observations related to the four research questions.
- Phase 2 – Generating initial codes: Using MAXQDA software (last version 2025), we coded relevant extracts from the reviews. Codes were both deductive (derived from the research questions, e.g., “meaning-making”, “spiritual struggle”, “intervention efficacy”) and inductive (emerging from the data, e.g., “identity reconstruction”, “clinician training gap”).
- Phase 3 – Generating initial themes: We grouped related codes into candidate themes. For example, codes such as “search for purpose”, “re-narrating trauma”, and “PTG” were clustered under the theme “Meaning-Making and Growth Process”.
- Phase 4 – Reviewing and developing themes: We checked whether each candidate theme was consistently supported by the extracted data across multiple reviews. Themes were refined, split, merged, or discarded as needed. For instance, “spiritual struggle” and “moral injury” were initially separate but later merged into a single theme “Spiritual and Existential Struggle Process”.
- Phase 5 – Defining and naming themes: We wrote a clear definition for each final theme, specifying its scope and relationship to the research questions. These definitions guided the narrative write-up in the Results section.
- Phase 6 – Writing the report: We produced the thematic summary presented under Questions 1–4 in the Results, using illustrative findings from the included reviews to support each theme.

To enhance trustworthiness, two authors independently coded three reviews (17% of the sample) and compared coding; disagreements were resolved through discussion (inter-rater agreement = 89%, Cohen’s κ = 0.81). Potential overlap of primary studies across the included reviews was not formally assessed (e.g., corrected covered area).

Results

Description of Studies

The initial database search yielded 2,680 records. After removing duplicates, 1,750 titles/abstracts were screened. Of 60 full-text articles assessed, 18 reviews were included in the final synthesis. The PRISMA flow diagram (Figure 1) details the selection process. The included reviews, published between 2015 - 2025, covered diverse populations including cancer survivors, veterans, abuse survivors, and disaster victims.

Table 1 summarizes the descriptive characteristics of the included systematic, scoping, and narrative reviews. A total of 18 reviews examining psycho-spiritual processes and interventions in the context of trauma and adversity were incorporated into this overview. The number of primary studies analyzed within each review ranged from 11 (23) to 68 (18).

Cumulatively, these reviews synthesized evidence from approximately 470 primary study reports, though some primary studies may have been included in more than one review. We did not formally assess overlap; therefore, the total count should be interpreted as the sum of primary studies across reviews, not necessarily unique studies. Of the 18 included reviews, 11 were systematic reviews or meta-analyses. These 11 reviews scored between 14/16 and 16/16 on AMSTAR-2, indicating high methodological quality. The remaining 7

reviews (narrative or scoping) were not scored with AMSTAR-2 (as the tool is not validated for these designs) but met our inclusion criteria for narrative reviews with defined search strategies.

Regarding risk of bias, 11 of the 18 included reviews (all systematic reviews and meta-analyses) assessed methodological quality of primary studies using tools such as the Cochrane Risk of Bias tool or Joanna Briggs Institute (JBI) checklists. The remaining 7 reviews (scoping or narrative) did not perform formal risk of bias assessment, which is consistent with their review type. Of note, some included reviews (e.g., 23, 39) examined explicitly religious interventions such as prayer and pastoral care. We retained these reviews because their outcomes (e.g., PTSD symptom reduction, SWB) aligned with our psycho-spiritual framework, and we did not differentiate a priori between religious and non-religious spiritual content.

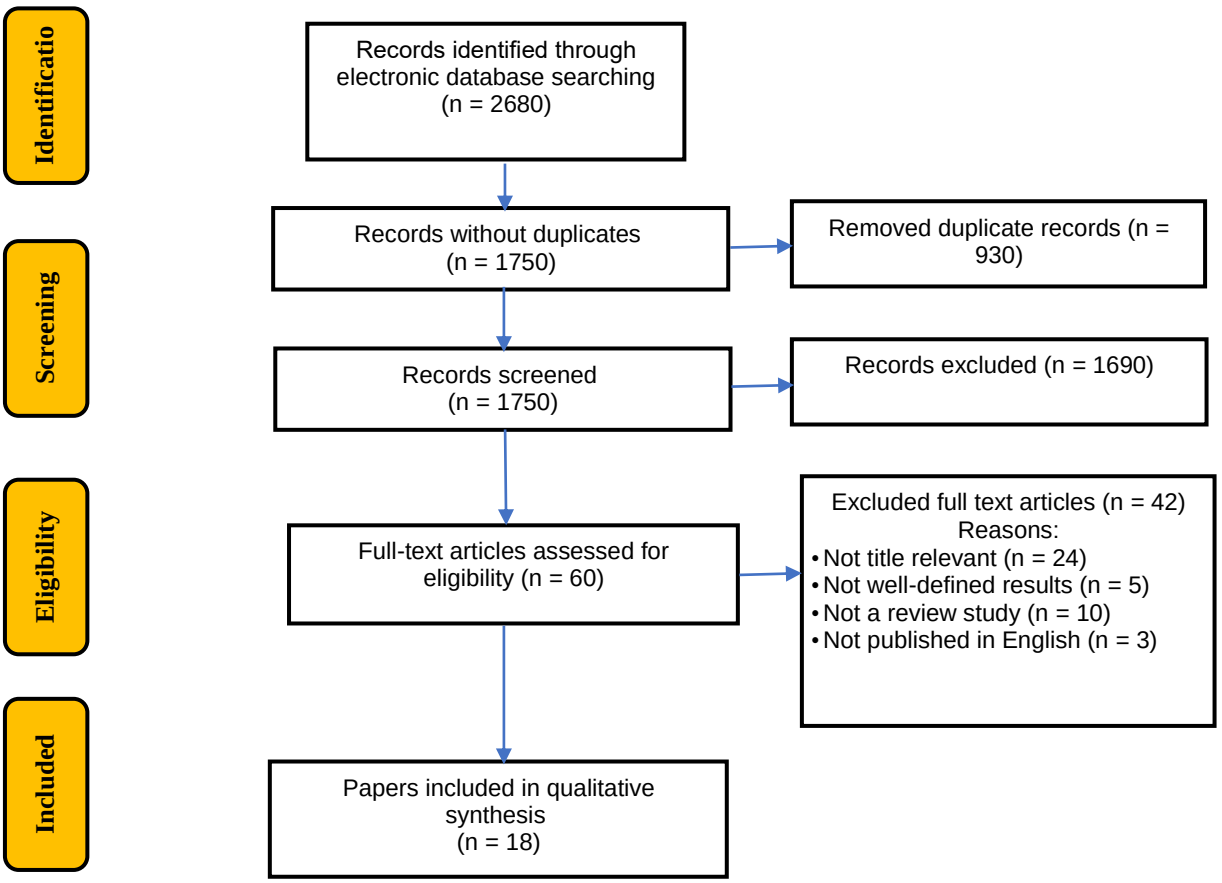

Figure 1. Flow PRISMA Chart of Studies on Psycho-Spiritual Processes and Interventions that Influence Well-Being Following Trauma and Adversity

Table 1. Characteristics of Included Review Studies on Psycho-Spiritual Processes and Interventions that Influence Well-Being Following Trauma and Adversity

Author(s) & Year	Review Type	Population / Trauma Focus	Key Constructs / Interventions	Included Studies	Main Outcomes	Risk of bias assessment*	AMSTAR score*
Martinez-Calderon *et al*. (2025) (37)	Systematic Review & Meta-Analysis	Cancer-related fatigue	SWB, faith, meaning, peace	37	Significant negative association between SWB and fatigue severity	Yes (Cochrane ROB)	16/16
Nejati-Zarnaqi *et al*. (2024) (25)	Systematic	Natural disaster survivors	Spiritual rehabilitation factors (meaning, social connection, hope)	20	Identifies meaning-making and hope as key facilitators of psycho-spiritual recovery.	Yes (JBI checklist)	15/16
Brelsford *et al.* (2024) (27)	Systematic	Parents of NICU infants	Psycho-spiritual interventions (mindfulness, spiritual coping)	14	Improved parental mental health, stress reduction, and spiritual meaning-making	Yes (Cochrane ROB)	16/16
Hernandez (2024) (38)	Narrative	Latino trauma survivors	Community ministries, cultural spirituality	N/A	Need for culturally congruent, trauma-informed spiritual support	Not applicable (narrative)	
Fayaz (2024) (24)	Systematic	Sexual assault survivors	Spirituality	18	Positive association with PTG; nuances based on coping style	Yes (JBI)	15/16
Martinez-Calderon *et al.* (2023) (16)	Systematic Review & Meta-Analysis	Adults with cancer	Meaning-centered therapy, spiritual interventions	15	Significant improvements in meaning, SWB, and quality of life	Yes (Cochrane ROB)	16/16
Nguyen *et al.* (2023) (18)	Scoping	Various trauma survivors	Spiritual identity, meaning-making	68	Spirituality is central to post-trauma identity reconstruction and coherence	Not applicable (scoping)	
Newman *et al.* (2023) (21)	Systematic	Cancer survivors	Psycho-spiritual interventions (CBT, mindfulness, expressive)	28	Effective for promoting PTG and SWB	Yes (Cochrane ROB)	15/16
Tirgari *et al.* (2022) (15)	Systematic Review & Meta-Analysis	Chronic disease patients	SWB	42	Positive correlation with mental health and quality of life; negative correlation with depression/anxiety	Yes (Cochrane ROB)	16/16
Ellis *et al.* (2022) (20)	Systematic	Various trauma survivors	Abuse, Spiritual Struggle	57	Linked to higher PTSD, depression, anxiety, and complex trauma outcomes	Yes (JBI)	16/16

Author(s) & Year	Review Type	Population / Trauma Focus	Key Constructs / Interventions	Included Studies	Main Outcomes	Risk of bias assessment*	AMSTAR score*
Masin-Moyer *et al.* (2022) (39)	Scoping	Trauma survivors (often women)	TREM (psycho-educational, spiritually-sensitive group model)	17	Reductions in PTSD, depression, and increases in empowerment and coping	Not applicable (scoping)	
Harris *et al.* (2021) (22)	Systematic	Veterans/others with PTSD	Spiritually integrated CBT, ACT, and forgiveness therapy	19	Effective for reducing PTSD/MI symptoms and improving spiritual outcomes	Yes (Cochrane ROB)	16/16
Clark & Hunter (2019) (40)	Narrative	Heart failure patients	Spiritual coping, well-being	32	Key resource for meaning, hope, and coping with terminality	Not applicable (narrative)	
Aten *et al.* (2019) (26)	Systematic	Disaster survivors	Spiritual beliefs, coping, and community	45	Both positive (meaning, support) and negative (divine struggle) impacts are documented	Yes (adapted from Cochrane)	16/16
Smothers & Koenig (2018) (23)	Systematic	Veterans with PTSD	Spiritual interventions (prayer, meditation, pastoral care)	11	Moderate evidence for reducing PTSD symptoms and improving well-being	Yes (modified version)	15/16
Jones *et al.* (2018) (41)	Scoping	Traumatic Brain Injury	Spiritual beliefs, practices	24	Facilitates adjustment, meaning-making, and resilience	Not applicable (scoping)	
Besemann *et al.* (2018) (42)	Narrative	Injured service members	Holistic (bio-psycho-social-spiritual) model	N/A	The spiritual dimension is integral to comprehensive rehabilitation	Not applicable (narrative)	
Gonçalves *et al.* (2015) (43)	Systematic Review & Meta-Analysis	Clinical mental health populations	Spiritual interventions (prayer, meditation, CBT)	23	Significant positive effects on mental health outcomes, especially for depression	Yes (Cochrane ROB)	14/16

Note: **Risk of bias column: Indicates whether the original review assessed methodological quality (risk of bias) of its included primary studies, and specifies which tool was used. This is not a new assessment by the authors of the present umbrella review. 'Not applicable' denotes scoping or narrative reviews, which do not typically perform such assessments. *AMSTAR-2 scores range from 0 to 16 and are reported only for systematic reviews and meta-analyses (n = 11), for which the tool is validated. Scores of 14–16 indicate high quality with only minor non-critical limitations. Narrative and scoping reviews are marked 'Not applicable' because AMSTAR-2 is not validated for these designs.*

Abbreviations: ROB = Cochrane Risk of Bias; JBI = Joanna Briggs Institute; CBT = Cognitive Behavioral Therapy; PTG = Post-Traumatic Growth; PTSD = Post-Traumatic Stress Disorder; TREM = Trauma Recovery and Empowerment Model; ACT = Acceptance and Commitment Therapy; PTSD = Post-traumatic Stress Disorder.

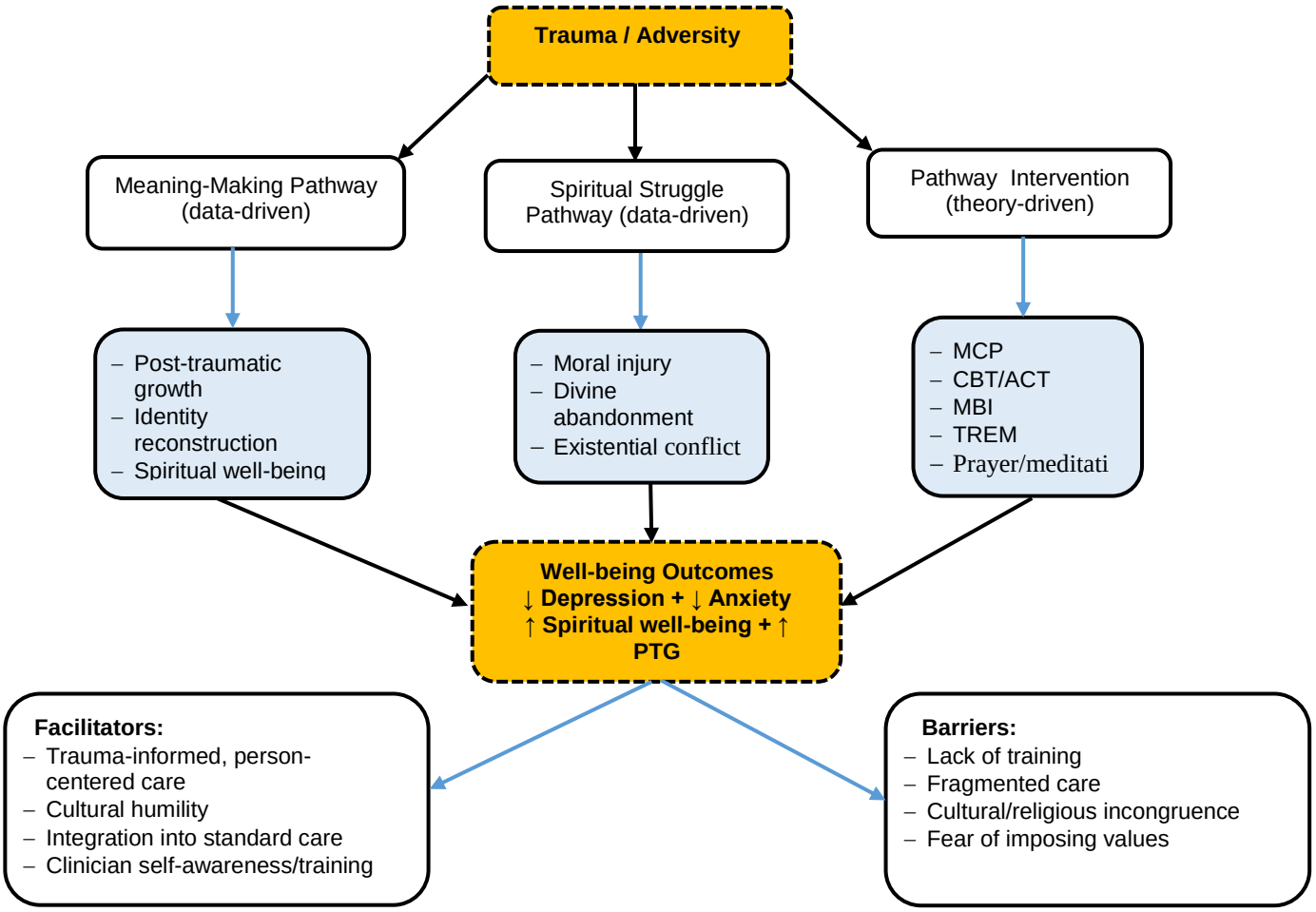

Figure 2. ***Conceptual Model of Psycho-Spiritual Pathways after Trauma***

MCP = Meaning-Centered Psychotherapy; CBT = Cognitive Behavioral Therapy; ACT = Acceptance and Commitment Therapy; MBI = Mindfulness-Based Intervention; TREM = Trauma Recovery and Empowerment Model; PTG = Posttraumatic Growth

Synthesis of Findings

The three core psycho-spiritual pathways presented below emerged from a hybrid process: the first two pathways (Meaning-Making and Spiritual Struggle) were primarily data-driven, identified through inductive coding of the 18 reviews. The third pathway (Interventions) was theory-driven, derived directly from research Question 2. This combination reduces interpretive bias while maintaining theoretical grounding. Figure 2 provides a conceptual overview of the three psycho-spiritual pathways identified in this synthesis.

Question 1: What are the primary psycho-spiritual processes that contribute to well-being or distress after trauma?

The analysis revealed two dominant opposing psycho-spiritual processes that shape adaptation: one oriented toward meaning-making and growth, and the other characterized by existential struggle. Taken together, these two opposing pathways suggest that psycho-spiritual responses to trauma are not unidimensional; the same spiritual framework that enables growth can also become a source of distress. Clinically, this means that assessment must capture both possibilities.

1. The Meaning-Making and Growth Process

This process, identified as the cornerstone of psycho-SWB, was highlighted in numerous reviews (18, 24, 25, 40, 43). Trauma shatters fundamental assumptions, and the active search for and construction of meaning is a primary pathway to recovery. This involves re-narrating the traumatic experience within a larger framework of purpose, values, or existential understanding. The outcome of successful meaning-making is SWB, defined as a sense of meaning, peace, and connection. Reviews consistently demonstrate that SWB is not merely a comforting idea but a robust correlate of psychological and physical health. For instance, in chronic and life-threatening illnesses like cancer and heart failure, higher SWB is strongly associated with lower depression, anxiety, and PTSD; higher quality of life; and reduced symptom burden such as cancer-related fatigue (15, 16, 37). Furthermore, this meaning-making process is the engine of PTG, facilitating positive changes in self-

perception, relationships, and philosophy of life (24). The process is fundamentally linked to identity reconstruction, where spirituality helps individuals forge a coherent sense of self following trauma (18). For example, one included review noted: "Spirituality provided a framework for reframing trauma as a catalyst for personal growth" (7).

2. The Spiritual and Existential Struggle Process

In contrast, the reviews unequivocally identify spiritual and existential struggle as a significant psycho-spiritual process that exacerbates post-traumatic distress. This process involves a crisis of meaning, characterized by feelings of abandonment by a higher power or the universe, profound moral guilt (e.g., moral injury), loss of faith, and existential conflict (17, 20). This is not the absence of spirituality but a distressing engagement with it. Ellis *et al.* (20) systematically demonstrated that experiences of spiritual struggle and abuse are linked to a significantly higher severity of PTSD, depression, anxiety, and complex trauma outcomes. They quoted a survivor: "I felt abandoned by God, and that was worse than the abuse itself." This "dark side" of the psycho-spiritual response is documented across diverse trauma contexts, from natural disasters (26) to medical crises, indicating that when the search for meaning becomes blocked, conflicted, or violated, it constitutes a major risk factor for poor recovery.

Question 2: What is the evidence for the efficacy of psychotherapeutic interventions explicitly targeting psycho-spiritual well-being?

Effect sizes from the five meta-analyses ranged from small to moderate: depression (Cohen's d = 0.42), anxiety (SMD = 0.31–0.58), and spiritual well-being (SMD = 0.47). The overview provides compelling evidence for the efficacy of interventions designed to engage the psycho-spiritual dimension, with several models demonstrating strong empirical support. Across interventions, the most robust evidence (largest effect sizes, most consistent findings) supported Meaning-Centered Psychotherapy (MCP) and spiritually-integrated CBT, though each has been tested in different populations (cancer survivors vs. veterans). Direct head-to-head comparisons are absent.

1. Meaning-Centered Psychotherapy (MCP)
   MCP, examined in reviews focused on cancer populations (16, 21, 37), showed the most robust and specific outcomes for psycho-SWB. This intervention provides a structured framework (individual or group) to help individuals explore and connect with meaning, values, and purpose in life, even in the face of suffering. Martinez-Calderon *et al.* (16) found that it led to significant improvements in meaning, SWB, and overall quality of life. Generalization of MCP to other trauma types is not supported by current evidence.
2. Spiritually Integrated Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT)
   These interventions, reviewed particularly for veterans with PTSD and Moral Injury (22), adapt evidence-based protocols to explicitly address spiritual themes such as forgiveness, self-compassion, and values-based living. Harris et al. (22) found that they are effective for reducing core PTSD and moral injury symptoms while simultaneously improving spiritual outcomes, offering a holistic approach to healing.
3. Mindfulness-Based Interventions (MBIs)
   While not exclusively spiritual, MBIs are frequently categorized as psycho-spiritual due to their focus on present-moment awareness, acceptance, and transcendence of suffering. Reviews on cancer survivors and parents of infants in the NICU found that MBIs effectively promote PTG and SWB, and reduce stress and anxiety (21, 27, 37).
4. The Trauma Recovery and Empowerment Model (TREM)
   TREM is a manualized, spiritually-sensitive group intervention for trauma survivors, often women. Masin-Moyer *et al.* (39) found that TREM leads to reductions in PTSD and depression symptoms while increasing empowerment and coping, demonstrating the efficacy of a group-based, psycho-educational model that honors spiritual dimensions.
5. General Spiritual Interventions (Meditation, Prayer-based)
   A broader meta-analysis, by Gonçalves *et al.* (43), of spiritual interventions (including meditation and spiritual CBT) in mixed clinical populations confirmed significant positive effects on mental health outcomes, particularly for depression, underscoring the general therapeutic value of engaging spiritual resources.

Systematic comparison across interventions reveals the following patterns:

- MCP has the strongest evidence for improving spiritual well-being and meaning (SMD = 0.47), but only in cancer populations.
- Spiritually-integrated CBT/ACT has the strongest evidence for reducing PTSD and moral injury symptoms, primarily in veterans.
- MBIs show consistent but smaller effects on anxiety and stress (SMD = 0.31–0.58), with broader population applicability.
- General spiritual interventions (prayer, meditation) show moderate effects on depression (d = 0.42) but with higher heterogeneity (I^2 = 58%).
- Direct comparisons (e.g., MCP vs. CBT in the same population) are absent from the literature; therefore, relative efficacy cannot be determined.
- Of the 18 included reviews, only five reported meta-analytic effect sizes. For example, Martinez-Calderon *et al.* (16) reported a significant pooled effect of meaning-centered therapy on SWB (SMD = 0.47, 95% CI [0.29, 0.65], I^2 = 61%, P < 0.001). Gonçalves *et al.* (43) showed that spiritual interventions moderately affected depression (Cohen's d = 0.42, 95% CI [0.21,

0.63], I^2 = 58%). However, heterogeneity was moderate to high across most analyses, and the remaining 13 reviews (narrative or scoping) did not report quantitative effect sizes. Therefore, claims of 'significant efficacy' in the abstract have been tempered to reflect the variability in reporting standards across the included reviews.

- Overall, MCP has the strongest evidence for its specific outcome (spiritual well-being), while spiritually-integrated CBT/ACT has the strongest evidence for reducing PTSD/moral injury symptoms. No single intervention is universally superior; choice depends on population and target outcome.

Question 3: What are the key facilitators and barriers to providing effective psycho-spiritual support in clinical practice?

The synthesis identified critical factors that influence the implementation and effectiveness of psycho-spiritual care. Notably, clinician-level barriers (lack of training, fear of imposing values) were reported more frequently than system-level barriers, suggesting that individual practitioner competency is the current rate-limiting step for implementation.

Barriers:

1. Lack of Clinician Training and Competency: The most frequently cited barrier is the widespread lack of training among mental health professionals in how to assess and address spiritual and existential issues ethically and effectively (17). This leads to avoidance, discomfort, or unskillful handling of these domains.
2. Fragmented Care and Systemic Neglect: Psycho-spiritual concerns are often sidelined in standard biomedical or psychotherapeutic models that prioritize symptom reduction over holistic well-being (42).
3. Cultural and Religious Incongruence: Interventions developed in one cultural or religious context may not resonate with or may even alienate clients from different backgrounds if applied without adaptation (38).
4. Fear of Imposing Values: Clinicians may avoid the topic due to legitimate ethical concerns about imposing their own spiritual or existential beliefs on clients.

Facilitators:

1. Trauma-Informed, Person-Centered Stance: Effective support begins with a therapeutic approach that validates the client's unique worldview, creates safety for exploring vulnerability, and follows the client's lead on spiritual matters (38).
2. Cultural Humility and Congruence: Adapting interventions and therapeutic language to align with the client's cultural and spiritual framework is essential for engagement and efficacy (38, 25).
3. Integration into Standard Care: Models that successfully integrate spiritual components into established evidence-based practices (e.g., CBT, ACT) or into holistic bio-psycho-social-spiritual frameworks facilitate smoother implementation (22, 41, 42).
4. Clinician Self-Awareness and Training: Developing personal awareness of one's own spiritual beliefs and biases, coupled with formal training in spiritual competency and specific interventions (e.g., MCP), is a primary facilitator for effective practice.

Question 4: What are the main limitations in the current evidence base and implications for future research and practice?

Limitations of the Evidence Base:

1. Methodological Constraints: A heavy reliance on cross-sectional studies in primary literature limits causal inferences about psycho-spiritual processes. Many intervention studies have small samples, short follow-up periods (limiting insights into long-term sustainability of gains), and a lack of active control groups.
2. Measurement Inconsistency: There is a lack of standardized, universally accepted measures for core constructs like "SWB" or "existential struggle," hindering comparison and synthesis across studies.
3. Lack of Diversity: The evidence base is disproportionately drawn from Western, educated, and often Christian-adjacent populations. There is a significant underrepresentation of non-Western cultural perspectives, non-religious spiritualties, and specific marginalized groups (e.g., ethnic minorities, LGBTQ+ individuals) (25).
4. Focus on Pathology vs. Growth: Historically, more research has focused on spirituality as a correlate of psychopathology (e.g., struggle) than as a mechanism of positive growth and flourishing, though this is shifting.

Discussion

This umbrella of 18 reviews consolidates a decade of evidence, presenting a clear and triangulated map of the psycho-spiritual landscape following trauma. Notably, the six most recent reviews published between 2023 and 2025 (17, 23, 24, 26, 37, 38) consistently confirmed the same core pathways, suggesting that the evidence base has stabilized in recent years. The findings robustly support the premise that trauma recovery is an existential process wherein spiritual well-being and struggle are central determinants of adaptation. The synthesized evidence moves beyond anecdote to establish three evidence-based pillars for clinical understanding and intervention.

First, the synthesized evidence confirms that SWB is a measurable component of health. Its consistent negative correlation with psychopathology (depression, anxiety, PTSD) and even physical symptoms like fatigue (15, 16) positions it as a critical treatment outcome, not merely a comfort. Its role in facilitating PTG and identity reconstruction (18, 24) underscores that healing involves not just symptom reduction but the positive reconstruction of a meaningful life. This argues for the routine assessment of SWB in trauma-informed care.

Second, the evidence consistently identifies spiritual struggle as a clinically relevant construct associated with worse mental health outcomes. The work of Ellis *et al.* (20) demonstrates that spiritual struggle is not merely a private religious issue but a measurable psychological risk factor that exacerbates core trauma symptoms. However, spiritual struggle has not been validated as a formal clinical syndrome, as diagnostic criteria and field studies are absent. This has direct clinical implications: assessments must sensitively inquire about existential distress, feelings of moral injury, and loss of meaning, as these can be significant barriers to recovery if left unaddressed.

Third, the efficacy of spiritually-integrated interventions is no longer speculative but evidence-based. The positive findings for structured interventions—from meaning-centered therapy for cancer (16) to spiritually-integrated CBT for moral injury (23)—demonstrate that these existential and spiritual processes are therapeutically accessible. These interventions provide a language and framework for processing the "unanswerable questions" that trauma often raises. The success of models like TREM (39) further shows that this integration can be effectively delivered in group formats, enhancing scalability. Importantly, these clinical implications are grounded in specific evidence levels: MCP has moderate-quality evidence (limited to cancer populations, consistent effect sizes); spiritually-integrated CBT/ACT has moderate evidence (veteran populations, consistent PTSD reduction); MBIs have low-to-moderate evidence (mixed populations, moderate heterogeneity); and TREM has preliminary evidence (primarily uncontrolled studies). Clinicians should match intervention choice to the population and the strength of available evidence.

Limitation

Firstly, most primary studies used cross-sectional, self-reported designs and lacked long-term follow-up. Including only reviews with AMSTAR-2 > 8/16 (all ≥ 14/16) strengthened validity but may have excluded lower-quality syntheses; thus, our findings represent a best-evidence summary, not an exhaustive one. Furthermore, AMSTAR-2 scores were reported only for systematic reviews and meta-analyses; narrative and scoping reviews were included based on descriptive criteria, which may introduce additional heterogeneity. Secondly, we did not assess publication bias – many reviews were narrative/scoping (unsuitable for bias tests), and we did not have access to primary-level data from meta-analyses. Thirdly, umbrella review bias is inherent: overlapping primary studies across reviews may inflate confidence, though we did not quantify overlap. Fourth, restricting inclusion to English-language reviews introduces language bias. Fifth, the 18 reviews spanned heterogeneous populations (cancer, veterans, NICU parents, disaster). We did not test consistency across groups, so generalizability is not confirmed. Finally, inconsistent reporting of effect sizes and heterogeneity precluded a meta-analytic summary. Readers should interpret findings with these caveats.

Conclusion

In conclusion, the evidence suggests that trauma care is more complete when it addresses psycho-spiritual dimensions. Supporting a client's search for meaning and attending to existential pain appear to be valuable therapeutic tasks. Based on the moderate-quality evidence available (effect sizes small to moderate, with moderate to high heterogeneity), routine assessment of meaning, purpose, and existential distress may be considered in trauma-informed settings. Practitioners might seek training in meaning-focused interventions (e.g., MCP for cancer-related distress, ACT for broader trauma populations) while remaining aware of the limitations of current evidence (e.g., population heterogeneity, lack of long-term follow-up). Supervision or consultation groups focusing on existential themes could be helpful, but these recommendations are tentative and should be adapted to local contexts and client values.

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Conflict of Interest

None.

Author's Contributions

Z.A led the study design, data collection, conceptualization, supervision, and manuscript writing and editing.

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