INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY RESEARCH AND ANALYSIS

ISSN(print): 2643-9840, ISSN(online): 2643-9875

Volume 09 Issue 09 September 2026

DOI: 10.47191/ijmra/v9-i9-39, Impact Factor: 8.685

Page No. 5943-5957

Religious Trauma and Mental Health: A Systematic Review

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ABSTRACT: Religious trauma is an emerging area of scholarship at the intersection of psychology and mental health. However, the literature field is still underdeveloped and the evidence base fragmented. The present systematic review seeks to consolidate the fragmented conceptualizations and clarify how religious trauma relates to allied constructs such as spiritual abuse and other negative spiritual experiences. Systematic review methodology anchored on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework was used to present a robust and unbiased synthesis of extant knowledge. In total, 137 articles were identified. This comprised 96 articles from Google Scholar, 27 from PubMed, and 14 from Crossref. Rigorous screening processes yielded 13 articles that satisfied the inclusion criteria for review. Results showed that the reviewed studies were undertaken across four geographical regions, with western studies dominating the literature stream. The findings generally converge in showing that religious trauma are associated with psychological, emotional, social, and spiritual harm. It emerges as a global phenomenon whose expression is institutionally, socially, and culturally, constructed. Thus, religious trauma is best conceptualized as a multidimensional and context-dependent phenomenon whose effects on mental health are shaped by a multiplicity of personal and social factors. Specifically, the apparent differences in how religious trauma is conceptualized supports the need for a more integrated theoretical framework capable of linking religious trauma with allied concepts such as spiritual abuse, negative spiritual experiences, and related forms of adversity to explain mental health. To this end, an Integrated Model of Religious Trauma and Coping is proposed. However, the evidence base was susceptible to high risk of bias that undermines its generalizability outside the study contexts. Particularly, the systematic review revealed substantial underrepresentation of Africa, Latin America, and the Middle East in the literature, thus raising questions pertaining to the cross-cultural generalizability of existing studies. Therefore, research extension is much needed outside the western world, especially in Africa where religious trauma is largely undocumented.

KEYWORDS: Mental Health**,** Religious Trauma, Spiritual Trauma, Systematic Review, Integrated Model of Religious Trauma and Coping

I. INTRODUCTION

Religious trauma is an emerging area of scholarship at the intersection of psychology and mental health (Shepley, 2024). However, anyone attempting to make sense of this concept is immediately confronted with definitional conundrums. This is depicted in the divergence of definitions presented and inherent conceptual overlaps. For instance, some studies use the term religious trauma interchangeably with spiritual abuse (Taylor, 2026). However, other scholars agree that the two are close relatives but have conceptual distinctiveness. So what exactly, is religious trauma? The various definitions available conceptualize it as: the emotional, psychological, and social consequences of harmful religious practices, associations, communications, or institutions (Panchuk, 2024), the psychological harm caused by religious messages, stances, and exposures (Johnston, 2021), and the psychological stress emanating from stigmatization by or by being ostracised from religious communities (Herbst, 2025). This means that spiritual abuse can be constructed either as a source or a mechanism of religious trauma and not its synonym. However, there is a convergence of these definitions around the idea that religious or spiritual environments can become sources of psychological harm when beliefs, teachings, authority, or practices are perceived as threatening, coercive, shaming, guilt-tripping, isolating, or denying individual autonomy. Its distinction from other emotional distresses is inherent in its disruption of one's religious or spiritual identity, meaning, or relationship with an established religious identity (Ramler, 2023). Nevertheless, the considerable variations in the definitions – including its depiction by Parker (2020) as a process that undermines an individual's

ability to cope with religious maltreatment – signal that the literature stream is yet to achieve consensus in its operationalization and measurement.

The broad spectrum of evidence points to the growing acknowledgement that religious communities and practices can function not just as sources of identity and psychological support as depicted in coping studies (Fatima et al., 2025; Howie et al., 2024; Rainville, 2018; Thomas et al., 2024) and research on spiritual wellbeing (Richardson et al., 2022; Veronese & Pepe, 2022; Wani et al., 2019) but also as sources of religious trauma. Recent studies reveal that religious trauma is being researched across different populations groups and settings (Perry, 2024; Whitman, 2025). In spite of this expanding literature, the empirical evidence is still relatively small and fragmented. Particularly, there is a shortage of scholarship that consolidate the literature base despite the proliferation of accounts of religious trauma (Farrell, 2025). Recent attempts on this front such as the contributions by Kiley-Morgan (2025) and Saiyad (2026) are few and far between and as such, inadequate for clarifying the apparent conceptual lacuna. This fragmentation undermines efforts to determine the consistency, magnitude, and conditions of the relationship between religious trauma and mental health. This is a problem because the emerging literature frequently associates adverse religious experiences with psychological and emotional consequences including social isolation and diminished psychological functioning. The resulting ambiguity is compounded by the fact that religious trauma can operate through multiple pathways (Marief & Sukmawati, 2025).

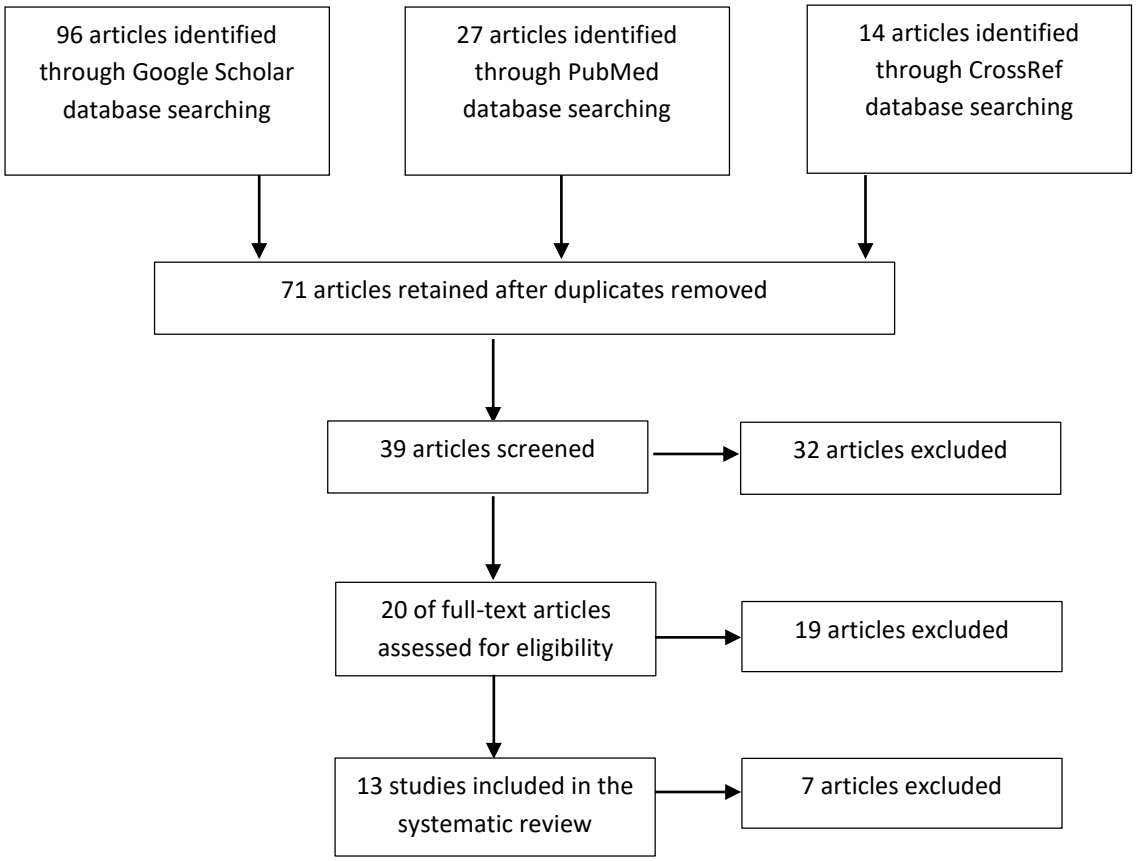
If the fragmented state of knowledge persists, religious trauma may continue to be overlooked or misidentified in mental health assessment and intervention, particularly when psychological distress is embedded within religious beliefs, practices, identities, or communities. Sargon (2026) laments that although religious trauma has moved increasingly into modern trauma scholarship, many mental health professionals remain inadequately equipped to recognize it. This failure may consequently leave affected individuals without appropriately informed psychological or clinical support. It may also perpetuate harmful faith practices where shame, coercion, exclusion, or identity suppression are construed as legitimate spiritual practices rather than potential sources of emotional abuse. Moreover, continuing conceptual inconsistency may hamper the development of valid measures and theoretically coherent models of religious trauma. Without synthesis, researchers and practitioners may continue to treat related but distinct phenomena as interchangeable, thereby limiting the precision with which their relationships with mental health can be understood. Against this backdrop, the present systematic review seeks to consolidate the fragmented conceptualizations and clarify how religious trauma relates to allied constructs such as spiritual abuse and other negative spiritual experiences. This synthesis of the available evidence across different contextual, conceptual, and methodological approaches should facilitate the establishment of consistency and direction of the nexus between religious trauma and mental health and highlight populations and regions where scholarship is still underrepresented for purposes of further research extension.

II. RESEARCH METHODOLOGY

Systematic review methodology anchored on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework was used to present a robust and unbiased synthesis of extant knowledge. This frameworks offers an orderly way of assembling and synthesizing the findings of past studies (Page et al., 2021). By systematically gathering, evaluating, and analysing the body of evidence, a rigorous investigation of current knowledge is achieved, thereby providing a replicable and transparent way of identifying trends, patterns, gaps, and the quality of past studies (Lim et al., 2022). For this purpose, the framework was used to extract relevant literature from open-source databases such as PubMed, CrossRef, and Google Scholar so as to yield a wide-reaching collection of empirical evidence across social, psychological, and religious studies. The PRISMA 2020 underscores the importance of credibility of systematic reviews towards quality assurance of their contribution to scholarship (Page et al., 2021). A key aspect of this is transparency, which is assured by the use of open-source databases due to the unrestricted access to research articles, which promotes verifiability of the studies referenced (Lyon, 2016). The inclusion of three different databases also enhances the chances of exploring diverse publications, hence minimizing publication bias.

The inclusion criteria was all religious trauma studies irrespective of geographical location or branch of knowledge. Eligible articles were those that involved primary research. Thus, no restrictions were put in terms of methodology, as long as the studies were scholarly, peer-reviewed, and published in English language. However, the studies must have been done in the 21st century for relevance. Non-empirical studies as well as studies that were undertaken prior to the year 2000 were excluded. Figure 1 provides a flow diagram demonstrating the identification, screening, eligibility, and inclusion process.

Figure 1 Study Selection Flow Diagram



The combination of key word search used included "Religious Trauma" or "Spiritual Trauma" and "Mental Health" or "Mental Wellbeing" or "Psychological Health" or "Psychological Wellbeing" or "Emotional Health" or "Emotional Wellbeing" The search was carried out in August 2026. In total, 137 articles were identified. This comprised 96 articles from Google Scholar, 27 from PubMed, and 14 from Crossref. After removing duplicates and articles that were not published in English, 71 articles remained. The titles and abstracts of the remaining articles were then screened to weed out theoretical articles and 39 articles were retained. Subsequently, a full-text evaluation of the articles was launched to ascertain their compliance to the pre-defined eligibility criteria. As a result, a further 19 articles that were not focused on mental health or wellbeing were removed. The final screening entailed weeding out studies that were based on anecdotal evidence. This led to the exclusion of a further 7 studies. The entire screening and review process was independently undertaken by the researchers. A total of 13 articles met the conditions set for this systematic review. This was considered adequate given that religious trauma is still an emerging area of scholarship. This is affirmed in a previous systematic review of religious trauma in relation to parental acceptance and support, which reviewed 7 articles (Kiley-Morgan, 2025).

Extracted data included the study demographics such as authors and year of publication, country and broader region of study, target population, variables of focus, research design, methodology, and key research findings. A risk of bias evaluation was then conducted using the PRISMA 2020 checklist (Page et al., 2021). Risks of bias are deviations from the ideal position with respect to the research results. Since none of the studies utilized experimental research design, and none was a longitudinal study, applicable biases were: selection bias which encompass non-response bias, sampling bias, and self-selection bias, and self-report or detection bias. This adhered to the classification scheme used in the Cochrane Collaboration's tool for evaluating risk of bias (Cumpston et al., 2019). Narrative synthesis technique was adopted to map the trends, themes and patterns as well as relationships across the studies. Research results were compared and contrasted based on location of the study, methodology, and conceptual focus.

III. RESULTS

The key characteristics of studies investigating the phenomenon of religious trauma in relation to mental health are summarised in table 1.

Table 1. Study Characteristics

Author & year	Location	Region	Target Population	Variables	Research design	Methodology
Ahmad et al. (2025)	Indonesia	Asia	Muslim women	Religious trauma, religious identity, digital spaces	Qualitative case study	Analysis of approximately 150 units of digital data collected from YouTube and TikTok between 2021–2024, including short videos, comment threads, and public interviews involving Indonesian Muslim diaspora figures
Clemens (2026)	USA	North America	Former Members of the Church of Jesus Christ of Latter-Day Saints Who Identify as a Sexual Minority	Religious trauma	Generic qualitative inquiry	Twelve participants aged 20–74 were interviewed using a semi-structured approach, with inductive analysis used to identify themes
Dille (2023)	USA	North America	Members of the evangelical Christian churches in the Chicago area	Religious trauma, spiritual wounds	Qualitative Phenomeno-logical study	Examined the narratives of three counselors working with clients who experienced religious trauma
Dura-Vila et al. (2013)	Spain	Europe	Catholic contemplative nuns sexually abused by priests	Sexual trauma, religious narrative	Ethnographic methodology	Ethnography involving five Catholic contemplative nuns of the same order belonging to several monasteries.
Dy-Liacco1 and Werdel (2019)	USA	North America	Religiously committed adult volunteers recruited by counselling graduate students at two private U.S. east coast universities	Sense of abandonment, Punishment by God, and Sense of isolation from community Psychological flourishing	Quantitative research design	Data gathered from a cross-sectional sample of 177 participants using validated instruments. Structural equation modelling was used to analyze data
Farrell (2024)	USA	North America	Millennials in evangelical churches	Religious trauma	Phenomeno-logical inquiry	Coded qualitative data gathered in eight interviews from participant
Fredrick et al. (2026)	USA	North America	African American Muslims	Spiritual Abuse, Racial Trauma, & Mental Health	Convergent Parallel Mixed methods design (Spiritual Harm and Abuse Scale)	Questionnaires administered to 127 respondents.

Author & year	Location	Region	Target Population	Variables	Research design	Methodology
					and Racial Trauma Scale.	
Harlow (2024)	USA	North America	Christian adults representing Baptist, Mormon, Evangelical, Anglican, and Pentecostal churches	Spiritual trauma	Qualitative methodology	Five qualitative interviews were conducted
Hollier et al. (2022)	Australia	Oceania	LGBTQIA + people who have spent two or more years in Evangelical church settings.	Spiritual abuse	Qualitative methodology	24 semi-structured interviews
Jones et al. (2022)	Australia	Oceania	Survivors of LGBTQA + change and suppression practices	Religious trauma, moral injury	Qualitative methodology	Qualitative study of the spiritual harms reported in semi-structured interviews of 42 survivors
Mahoney et al. (2010)	USA	North America	Students at Midwestern State University	Spiritual trauma, Parental divorce, Broken vows	Quantitative methodology	274 students at Midwestern state university whose parents had divorced within the past five years and whose general religious involvement and denomination were typical of other American college students
Meyer (2025)	USA	North America	Transgender and gender diverse (TGD) people	Religious trauma, Intrapsychic, Interpersonal, and Spiritual implications	Interpretive phenomen-ological analysis	Six TGD people in the US participated in semi-structured interviews
Yih (2025)	Hong Kong	Asia	Christian women sexual trauma survivors	Spiritual abuse, Mental Health	Qualitative research methodology based on Interpretative Phenomeno-logical Analysis	Snowballing sampling method through the referral of participants who were interviewed to other women survivors

The evidence in Table 1 reveals that the reviewed studies were undertaken across four geographical regions, although the distribution was substantially skewed. North America, represented exclusively by the United States, accounted for 8 of the 13 studies (61.5%). These studies included Fredrick et al. (2026), Clemens (2026), Dille (2023), Farrell (2024), Harlow (2024), Mahoney

et al. (2010), Meyer (2025), and Dy-Liacco and Werdel (2019). Research carried out in Asia accounted for 2 studies (15.4%), conducted in Hong Kong and Indonesia (Ahmad et al., 2025; Yih, 2025), while Oceania accounted for another 2 studies (15.4%), both conducted in Australia (Hollier et al., 2022; Jones et al., 2022). Europe was represented by 1 study (7.7%), conducted in Spain (Littlewood et al., 2013) while none of the studies were conducted in the Middle East, Africa, or South America. Thus, 61.5% of the available evidence originated from North America, compared with 38.5% from Asia, Oceania, and Europe combined. The regional concentration in the United States suggests that the empirical understanding of religious trauma is disproportionately shaped by western conceptualization and experience of religious trauma.

The target populations were very diverse but primarily comprised of individuals who had experienced particular forms of spiritual, sexual, or identity-related religious trauma. The studies targeted African American Muslims (7.7%), Muslim women/diaspora populations (7.7%), Christian women who had survived sexual trauma (7.7%), former members of the Church of Jesus Christ of Latter-day Saints who identified as sexual minorities (7.7%), members of evangelical Christian churches (7.7%), Catholic contemplative nuns who had experienced sexual abuse by priests (7.7%), millennials raised in evangelical churches (7.7%), Christian adults from different denominations (7.7%), LGBTQIA+ individuals exposed to evangelical churches (7.7%), survivors of LGBTQA+ change and suppression practices (7.7%), university students who had experienced parental divorce (7.7%), transgender and gender-diverse individuals (7.7%), and religiously committed adults (7.7%). Although each population accounted for one study, the studies collectively demonstrate that religious trauma has been investigated across different faith contexts, sexual and gender identities, and adverse experiences. These populations were largely niche, characterised by purposively selected survivor groups rather than representative samples of general religious populations. This concentration is especially evident among sexual and gender minorities. As a result, while the literature provides useful insight into the experiences of vulnerable groups, it provides limited evidence concerning the prevalence and mental-health effects of religious trauma among the general population.

The reviewed studies are characterised by substantial variation in the conceptualization and operationalization of religious trauma and its associated outcomes. Religious trauma or closely related constructs constituted a central variable in most studies, including spiritual abuse (Fredrick et al., 2026; Yih, 2025; Hollier et al., 2022), spiritual trauma (Harlow, 2024; Mahoney et al., 2010), negative spiritual experiences (Dy-Liacco & Werdel, 2019), and religious trauma itself (Clemens, 2026; Farrell, 2024; Meyer, 2025). Other studies examined related variables such as racial trauma, religious identity, moral injury, sexual trauma, parental divorce, and spiritual wounds (Ahmad et al., 2025; Fredrick et al., 2026; Jones et al., 2022; Mahoney et al., 2010). Mental-health-related outcomes were explicitly examined in several studies, including psychological distress (Fredrick et al., 2026), mental health and psychological consequences (Yih, 2025; Clemens, 2026), psychological trauma (Hollier et al., 2022), psychological functioning (Dy-Liacco & Werdel, 2019), and negative psychological functioning (Meyer, 2025). The variable distribution shows considerable conceptual heterogeneity. Religious trauma was not consistently as a standardized independent variable. This heterogeneity limits direct comparison across studies and demonstrates the need for greater consistency in the operationalization and measurement of religious trauma.

Methodologically, the literature is largely qualitative, with 10 of the 13 studies (76.9%) employing qualitative designs. The qualitative studies employed interpretative phenomenological analysis (Yih, 2025; Meyer, 2025), generic qualitative inquiry (Clemens, 2026), phenomenological inquiry (Farrell, 2024), ethnography (Littlewood et al., 2013), qualitative case-study methodology (Ahmad et al., 2025), and qualitative interview approaches (Dille, 2023; Harlow, 2024; Hollier et al., 2022; Jones et al., 2022). These studies generally relied on small samples and semi-structured interviews, with sample sizes ranging from 3 counselors in Dille (2023) to 42 survivors in Jones et al. (2022). Quantitative studies were Mahoney et al. (2010), which involved 274 university students, and Dy-Liacco and Werdel (2019), which recruited 177 participants and used structural equation modelling. Fredrick et al. (2026) employed the only mixed-methods design, using questionnaires administered to 127 respondents alongside qualitative inquiry. Thus, the evidence base relies on methods suited to understanding subjective and lived experiences but less suited to estimating population-level associations. The limited number of quantitative and mixed-methods studies restricts the availability of effect estimates and statistical evidence necessary to determine the magnitude of the relationship between religious trauma and mental health.

Across the 13 studies, the findings generally converge in showing that religious trauma are associated with psychological, emotional, social, and spiritual harm. Fredrick et al. (2026) provided the strongest quantitative evidence, reporting a statistically significant model, $F(1, 125) = 198.13$, $p < .001$, $R^2 = .613$, indicating that the model explained 61.3% of the variance. Similarly, Dy-Liacco and Werdel (2019) found a significant negative association between negative spiritual experiences and psychological functioning, $\beta = -.63$, $p < .01$. The qualitative studies consistently reinforced these quantitative findings, reporting psychological consequences (Clemens, 2026; Hollier et al., 2022; Jones et al., 2022; Meyer, 2025). Religious trauma was also found to arise through multiple pathways, including silencing, misuse of Scripture, isolation, identity suppression, homophobia, misogyny, and

deterioration of relationships with religious communities (Ahmad et al., 2025; Harlow, 2024; Jones et al., 2022; Yih, 2025). However, 11 of the 13 studies (84.6%) did not report statistical effect estimates, while only 2 studies (15.4%) provided quantitative effect estimates (Fredrick et al., 2026; Dy-Liacco & Werdel, 2019). Thus, the evidence affirms a consistent link between adverse religious experiences and poorer mental-health outcomes, but the predominance of small qualitative studies and heterogeneous constructs means that the magnitude and generalizability of this relationship remain insufficiently established.

The risk of bias in the reviewed studies was evaluated as shown in Table 2, which presents the risk of bias assessment dimensions. A positive sign (+) indicates high risk of bias, a negative sign (-) denotes a low risk of bias, and a question mark (?) symbolizes unclear risk of bias in line with Drucker et al. (2016). Non-response bias was high for response rates below 50%, sampling bias was high for all non-random samples, self-selection bias was high for convenient samples and online survey-based samples, and self-report bias was high for all non-experimental studies.

Table 2. Risk of Bias Assessment

Source	Non-response bias	Sampling bias	Self-selection bias	Self-report bias
Ahmad et al. (2025)	-	+	+	+
Clemens (2026)	-	+	+	+
Dille (2023)	-	+	+	+
Dura-Vila et al. (2019)	?	+	+	+
Littlewood et al. (2013)	-	+	+	+
Farrell (2024)	-	+	+	+
Fredrick et al. (2026)	?	?	-	+
Harlow (2024)	-	+	+	+
Hollier et al. (2022)	-	+	+	+
Jones et al. (2022)	-	+	+	+
Mahoney et al. (2010)	-	+	+	+
Meyer (2025)	-	+	+	+
Yih (2025)	-	+	+	+

Table 2 shows that the highest risk was found in detection bias, as all 13 studies (100%) relied on self-reported data without experimental designs, leading to consistently high potential self-report bias. Self-selection bias and sampling bias ranked second, with high risk evident in 12 (92%) studies due to the use of non-random and convenient sampling, impacting generalizability. Non-response bias presented the lowest risk overall as 2 out of the 13 studies (15%) indicating unclear risk of bias while none presented non-response bias. Table 3 presents theoretical frameworks underpinning the studies as well as the key findings and limitations of each study.

Table 3 Theoretical Underpinnings and Key Findings

Author & year	Sample Size	Outcome Measure	Theory	Key Findings	Limitations
Ahmad et al. (2025)	150 units of digital data	Religious trauma	Judith Herman's Social Trauma Perspective and Cathy Caruth's Trauma Theory	Religious trauma is largely generated through digitally mediated moral judgment	Religious trauma and its implications on mental health were not quantified
Clemens (2026)	12 participants	Religious trauma	None	Two themes were identified: (a) psychological and emotional consequences, and (b) coping, healing, and resilience	The adoption of pure qualitative methodology limited the measurement of statistical significance.
Dille (2023)	3 counselors	Religious trauma	None	Themes identified included conceptualizing religious trauma and personal	The utilization of the qualitative methods limited the

Author & year	Sample Size	Outcome Measure	Theory	Key Findings	Limitations
				experiences with religious trauma.	generalizability of the results to the study context
Dura-Vila et al. (2013)	5 Catholic nuns	Sexual trauma	None	Trauma was transformed into a symbolic religious narrative that shaped their sense of identity.	The generalizability of the research to other religious contexts is uncertain due to the focus on catholic nuns
Dy-Liacco1 and Werdel (2019)	177 participants	Psychological functioning	None	Psychological functioning was negatively associated with negative spiritual experiences (β= - 0.63, p<.01).	Research quantified the mechanism of cause and effect but did not unmask the lived experiences of the participants.
Farrell (2024)	8 interviewees	Religious trauma	None	Substantial and enduring negative effects associated with their religious upbringing	The effects of religious trauma on mental health was not clarified
Frederick et al. (2026)	127 respondents.	Mental Health	Inter-sectionality-informed Minority Stress Framework	Spiritual abuse and racial trauma are strongly associated with psychological distress and frequently co-occur (F (1,125) = 198.13, $p < .001$, $R^2 = .613$).	The study did not use longitudinal design to establish causal pathways
Harlow (2024)	5 interviews	Spiritual trauma	Trauma Theory	Results revealed themes such as damaging effects of purity culture, homophobia, and misogyny	The themes were not confirmed through inferential analysis
Hollier et al. (2022)	24 interviews	Spiritual abuse	Minority Stress Theory and Micro-aggression Theory	Participants were subject to mischaracterization and viewed as a moral threat, and consequently experienced erasure, social distancing, and suffered psychological trauma	The research targeted a niche population, hence not generalizable to all people
Jones et al. (2022)	42 interviewees	Religious trauma	Moral Injury Framework	Three themes emerged: 1) harm from spiritual practices; 2) harm from impairment of relationship with spiritual community; and 3) harm to spiritual self-concept, meaning and experience.	There was no quantitative confirmation of the themes through statistical analysis
Mahoney et al. (2010)	274 students	Spiritual trauma	Pargament's Theory of Religious/ Spiritual Coping Lazarus and Folkman's Stress-and-Coping Model	Parental divorce can be experienced as a sacred loss and desecration. Such perceptions and feelings reflect a unique and additive dimension of an already intensely stressful experience, rendering it a spiritual trauma. When parental divorce is experienced this way, it may	The research was descriptive, thus there was limited analytical depth

Author & year	Sample Size	Outcome Measure	Theory	Key Findings	Limitations
				trigger painful spiritual struggles.	
Meyer (2025)	6 people	Intra-psychic, Inter-personal, and Spiritual implications	Feminist Standpoint Theory	The findings underscored the 'stickiness' of religious trauma, as negative psychological functioning remained despite distancing from organized religion.	The study focused on niche population that does not represent the typical population
Yih (2025)	8 participants	Mental Health	None	Systemic patterns of spiritual abusive practices revealed in the data have been presented in this article under three themes: silencing, isolation, and abuse of Scripture and "divine position"	The research being a qualitative study, did not measure effect size.

The findings in Table 3 indicate that 7 of the 13 studies (53.8%) were explicitly underpinned by identifiable theoretical frameworks, whereas 6 studies (46.2%) did not specify a theoretical framework. The theoretical approaches were diverse, signaling the interdisciplinary nature of religious trauma studies. The theories included Herman's Social Trauma Perspective and Caruth's Trauma Theory (Ahmad et al., 2025), intersectionality-informed Minority Stress Framework (Frederick et al., 2026) Minority Stress Theory and Microaggression Theory (Hollier et al., 2022), Moral Injury Framework (Jones et al., 2022), Pargament's Theory of Religious/Spiritual Coping and Lazarus and Folkman's Stress-and-Coping Model (Mahoney et al., 2010), Feminist Standpoint Theory (Meyer, 2025), and Trauma Theory (Harlow, 2024). Thus, the theoretical diversity demonstrates that religious trauma has been examined through multiple perspectives, signaling the absence of a single unifying theoretical framework.

Further, that 46.2% of the studies did not identify an explicit theoretical framework represents a significant theoretical gap in the literature. This potentially limits theory development and making it difficult to determine how different conceptualizations of religious trauma relate to one another. Nevertheless, the findings show considerable convergence: religious trauma is associated with psychological and emotional distress, identity disruption, social isolation, impaired relationships with religious communities, and enduring spiritual consequences (Clemens, 2026; Frederick et al., 2026; Hollier et al., 2022; Jones et al., 2022; Meyer, 2025). The few quantitative studies also provide empirical support for this relationship, with Frederick et al. (2026) reporting a significant model, $F(1, 125) = 198.13$, $p < .001$, $R^2 = .613$, and Dy-Liacco and Werdel (2019) reporting a significant negative association between negative spiritual experiences and psychological functioning, $\beta = -.63$, $p < .01$. The results lead to the inference that no single theoretical framework sufficient captures the complexity of religious trauma.

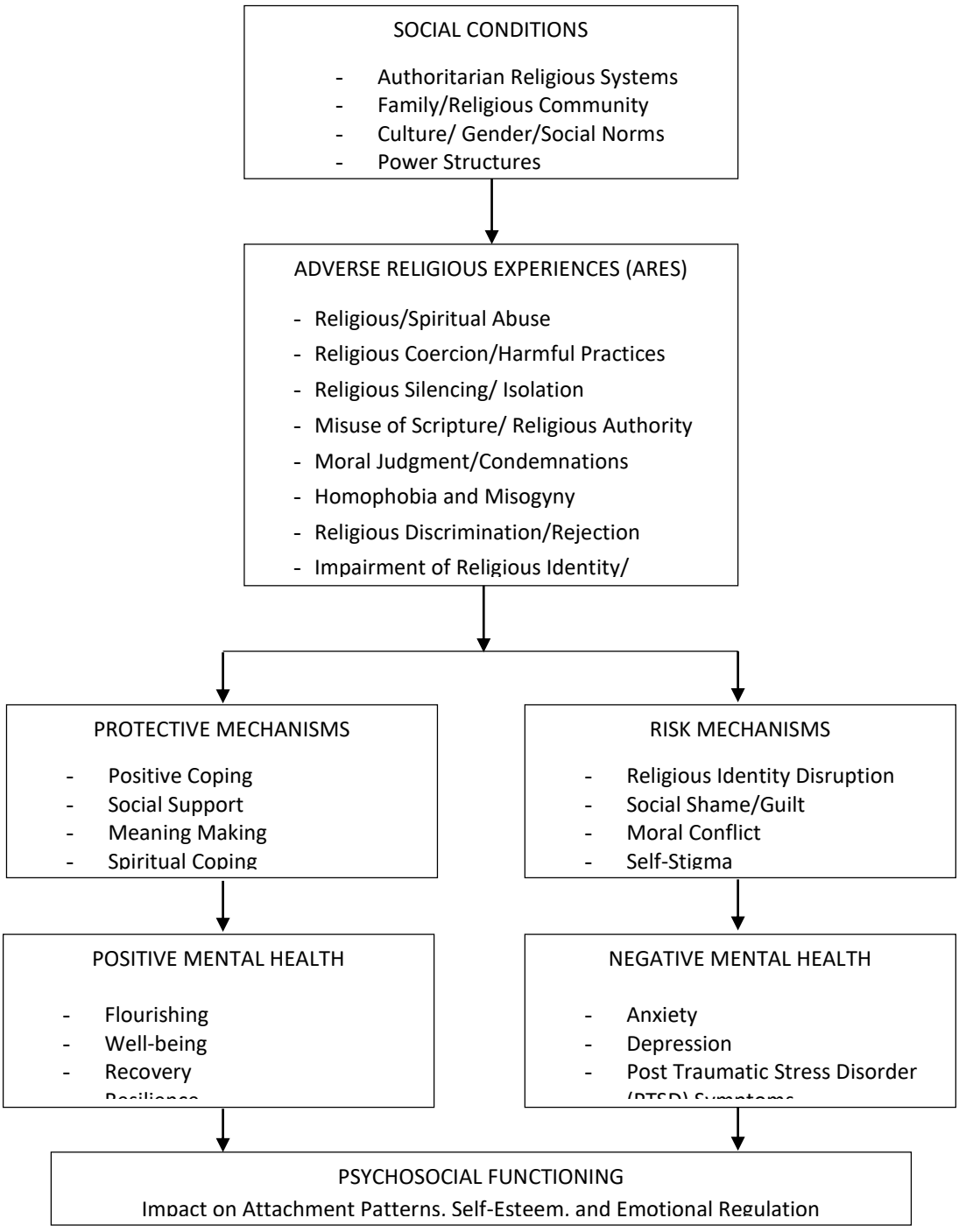
IV. DISCUSSION AND CONCLUSION

This systematic review has revealed both substantial convergence and important methodological divergence in the emerging literature on religious trauma and mental health. The studies generally agree that religious trauma is best understood as a complex, context-dependent phenomenon arising from adverse religious or spiritual experiences (Ahmad et al., 2025; Clemens, 2026; Hollier et al., 2022; Jones et al., 2022; Meyer, 2025). However, the evidence base is geographically concentrated in the western world with particular reference to the United States. The studies also largely focus on marginalized populations, most notably the LGBTQIA+ (Clemens, 2026; Frederick et al., 2026; Hollier et al., 2022; Meyer, 2025). Methodologically, the studies are almost all qualitative (Farrell, 2024; Harlow 2024; Meyer 2025). The quantitative evidence is therefore comparatively limited (Dy-Liacco & Werdel 2019; Fredrick et al., 2026). Therefore, the demonstrated statistical association of religious trauma with mental health is not adequate. Further, the differences in conceptualization of religious trauma suggests that the field lacks a sufficiently integrated theoretical framework (Ahmad et al., 2025; Jones et al., 2022; Mahoney et al., 2010).

From the systematic review, conclusion can be drawn that religious trauma is indeed a global phenomenon whose expression is socially, culturally, and institutionally constructed. Notwithstanding the conceptual diversity, there is no doubt that religious trauma is significantly linked to negative mental health and as such, should be recognized as an important psychological outcome of harmful religious experiences. It can be surmised that religious trauma is best conceptualized as a multidimensional and

context-dependent phenomenon whose effects on mental health are shaped by a multiplicity of personal and social factors. The apparent differences in how religious trauma is conceptualized supports the need for a more integrated theoretical framework capable of linking religious trauma with allied concepts such as spiritual abuse, negative spiritual experiences, and related forms of adversity to explain mental health. Nevertheless, the dispersion of evidence across niche populations and conceptual lenses expose a lack of clarity in the strength and consistency of the association between religious trauma and mental health. Thus, the review supports a model that explains both risk and resilience pathways and recognizes religious trauma as an interaction between adverse religious experiences, individual identity and meaning-making as shown in figure 2. As illustrated in the figure, the proposed model depicts religious trauma as a complex, multi-faceted, and dynamic phenomenon characterized by an interplay of contextual and personal factors that either serve to promote or undermine mental health.

Figure 2 Integrated Model of Religious Trauma and Coping (IMRTC)



Social Conditions

Social conditions are conceptualized as the antecedent factors since they are the context upon which religious trauma is experienced. Authoritarian systems demand total conformity. Independent thought is framed as "sinful," which can lead to Cognitive Dissonance, a state of mental discomfort that, according to the DSM-5 framework, can exacerbate anxiety and depressive symptoms (Panchuk, 2024). The empirical evidence by Yih (2025) suggests that religious leaders and churches used institutional authority, Scripture, and “divine position” to silence, isolate, and coerce victims. Similarly, the research by Hollier et al. (2022) demonstrated how church leaders and evangelical institutions contributed to mischaracterization and social isolation. The use of "hellfire" preaching for instance is a fear-based conditioning that creates a state of chronic hyper-vigilance. This constant state of high arousal is a hallmark of PTSD as defined by the DSM-5 (Exline & Rose, 2022). Spiritual trauma is especially heightened among members of highly controlling religious sects (Harlow, 2024). Such authoritarian systems often discourage contact with the "outside world." If an individual leaves, the community may utilize shunning a practice that can trigger a Major Depressive Episode due to the sudden loss of social support and identity. Further, the research by Ahmad et al. (2025) extended institutional religious authority into digital spaces, where moral judgments are amplified through social media. This is potentially enabled by a lack of oversight that allows abuse to go unchecked, as the leader’s authority is seen as divinely sanctioned, making it difficult for victims to report harm without fear of divine retribution (Perry, 2024).

Religious communities can also exacerbate stigma through exclusion and social distancing, thereby predisposing victims to religious trauma (Hollier et al., 2022). Jones et al. (2022) specifically identified relationship impairment as a key aspect of religious trauma while Dura-Vila et al. (2013) highlighted the role of religious frames in shaping identity among Catholic nuns. The study by Yih (2025) revealed that religious communities often respond to victims through silencing and isolation. In addition, homophobia, misogyny, and purity culture emerged as chronic contributors to spiritual trauma (Harlow, 2024). For instance, religious teachings on gender and sexuality were found to stigmatize LGBTQIA+ people (Ahmad et al., 2025; Frederick et al., 2026). In addition, power imbalance between religious leaders and members perpetuate religious trauma through the overstepping of religious authority by religious leaders (Harlow, 2024).

Adverse Religious Experiences

The model utilizes the term Adverse Religious Experiences (AREs) to represent the spectrum of attitudes and behaviors that predispose individuals to religious trauma. These include: religious/spiritual abuse (Hollier et al., 2022; Yih, 2025), religious coercion/harmful practices including religious silencing/ isolation, misuse of scripture/ religious authority (Dura-Vila et al., 2013), and moral judgment/condemnations (Harlow, 2024; Jones, 2022). These experiences can significantly contribute to psychological distress, particularly anxiety, depression, and trauma-related symptoms. Individuals raised in rigid or fear-based religious environments may internalize beliefs that emphasize punishment, guilt, and moral failure. These beliefs can create chronic anxiety and persistent fear of spiritual consequences. When individuals feel religious standards constantly judge them, they may develop excessive worry, self-criticism, and feelings of inadequacy.

Other manifestations of AREs derived from the empirical findings include homophobia and misogyny, religious discrimination/rejection, impairment of religious identity/ relationships (Amhad et al., 2025; Frederick et al., 2026). Individuals who experience rejection or condemnation from religious communities may develop feelings of sadness, isolation, and hopelessness. When personal identity is strongly connected to religion, conflict with religious teachings can lead to emotional distress and loss of meaning. Religious trauma can also produce symptoms like post-traumatic stress disorder (PTSD). Experiences such as spiritual abuse, fear-based indoctrination, or moral injury can lead to intrusive thoughts, avoidance behaviors, and emotional distress when individuals encounter religious reminders (O’Garo & Koenig, 2023). Moral injury, which occurs when individuals feel they have violated deeply held moral or spiritual beliefs, is increasingly recognized as an important factor in trauma-related psychological symptoms.

A central feature of religious trauma is the development of shame and guilt pathology. Many individuals raised in strict religious systems are taught that certain thoughts, emotions, or behaviors are sinful. Over time, this can lead to internalized shame and a negative self-concept. Unlike healthy guilt, which focuses on behavior, shame affects the individual’s entire sense of identity. Religious trauma may also result in identity confusion or loss of self. Individuals who begin questioning their religious beliefs may struggle to reconstruct their identity outside the religious framework that previously defined their worldview. Narrative-based therapeutic approaches emphasize helping individuals reconstruct personal meaning and develop a coherent identity that integrates spiritual experiences without harmful beliefs (Narcisa, 2025).

Risk and Protective Mechanisms

The model IMRTC introduces two intervening factors namely: protective mechanisms and risk mechanisms. The systematic review advances the argument that positive coping, social support, meaning making, and spiritual coping are among the protective

mechanisms that neutralizes the impact of AREs on mental health. For instance, the study by Clemens (2026) highlighted resilience, coping, and healing among the major themes drawn from respondents' experiences of religious trauma. Similarly, Mahoney et al. (2010), drew from Lazarus and Folkman's Stress-and-Coping Model to demonstrate that people respond to AREs through coping processes and suggested that individuals can appraise AREs as sacred loss or violation, reframing religious isolation as good riddance of the religious institution/community or a path to reclamation of control expressing itself through recovery, wellbeing, and flourishing.

On the other hand, the IMRTC model highlights that risk mechanisms such as religious identity disruption, social shame/guilt, moral conflict, and self-stigma can further exacerbate the negative impact of religious trauma on mental health. The strongest statistical evidence was reported by Frederick et al. (2026) whose inferential analysis revealed that spiritual abuse was strongly linked to psychological distress alongside racial prejudice, $F(1,125) = 198.13$, $p < .001$, $R^2 = .613$. Furthermore, the proposed mechanisms were implied in majority of the qualitative studies (Clemens, 2026; Farrell (2024; Yih (2025).

Psychosocial Functioning

Religious trauma can influence interpersonal relationships and emotional development (Elmore, 2026). Individuals who experienced rigid religious authority may develop insecure attachment patterns, particularly if religious leaders were perceived as controlling or punitive (Chemiak et al., 2021). This can result in difficulty trusting authority figures or forming secure relationships (Saiyad, 2026). Self-esteem is also commonly affected. Internalized beliefs about sinfulness or moral inadequacy may lead individuals to perceive themselves as unworthy or fundamentally flawed (Abdullah, 2026). Over time, this can contribute to persistent low self-worth and negative self-evaluation (Rahmawati & Poerwandari, 2024). Emotional regulation may also be disrupted when individuals are taught to suppress certain emotions, such as anger, doubt, or the urge to question (Bliss, 2025). This suppression can limit emotional awareness and coping abilities, leading to difficulties managing stress and emotional responses (Doll, 2022).

V. IMPLICATIONS

The proposed IMRTC model portends important theoretical, policy, and practice implications. The model proposes an integration of fragmented theories that have characterized religious trauma research such as Trauma Theory, Minority Stress Theory, Moral Injury Framework, and Stress-and-Coping theories to form a unified conceptualization of how AREs impact mental health. The model extends legacy theories by fronting religious trauma as a multifaceted and interactive process as opposed to a solitary psychological outcome. Additionally, it recognizes coping mechanisms and support systems, along with contextual conditions as factors that may generate different pathways toward mental health impairment or flouring. The main contribution of this systematic review to the body of knowledge is its synthesis of the fragmented findings on religious trauma, identifying psychological consequences, and drawing attention to the limited quantitative research and theoretical integration in the field. Thus, the proposed integration should strengthen conceptual clarity and provide a more coherent basis for explaining variations in how individuals experience and respond to religious trauma.

The systematic review has revealed wide geographical gaps, most notably the near total absence of non-western studies. The evidence suggest that Africa, Latin America, and the Middle East suffer from substantial underrepresentation in the literature, thereby raising questions pertaining to the cross-cultural applicability of existing findings. Therefore, research extension is much needed outside the western world, especially in Africa where religious trauma is largely undocumented.

In retrospect, whereas the systematic review based on the PRISMA framework enhanced the credibility of the findings and conclusions drawn, the restriction of the search strategy to English-language and peer-reviewed open-access journal articles introduced database-selection bias. Hence, there is need to treat the findings and conclusions as providing tentative pointers rather than conclusive evidence. Future literature reviews should also expand the scope of databases consulted, including non-English based studies. In addition, because the proposed IMRTC was heavily informed by qualitative studies, future systematic reviews should focus on emergent quantitative evidence and conduct meta-analysis.

Finally, it is instructive to note that the proposed IMRTC itself is a theoretically derived framework that is yet to be subjected to empirical testing. Therefore, there is need for future primary research to validate the framework using sophisticated statistical models such as Structural Equation Modelling (SEM) to confirm causal pathways across the diverse constructs. Such a study should, by extension lead to the development of an empirically valid and reliable IMRTC questionnaire that represents the four principal domains namely: contextual conditions, AREs, Risk and Coping Mechanisms, and Mental Health Outcomes. Exploratory and confirmatory factor analyses will be needed especially to establish the tool's dimensionality.

ACKNOWLEDGMENT

All the authors cited in this study are appreciated for making their articles freely available online.

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