# Mental health and quality of life among Veterans: The role of prayer/mediation and faith in God/higher power

by

Jennifer Switzer

A.A.S., Lake Area Technical College, 2014
B.S., Kansas State University, 2020
M.S., Kansas State University, 2022

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Human Sciences
College of Health and Human Sciences

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2025

# Abstract

The aim of this study is to better understand the role of spirituality in reducing the adverse effects of mental health conditions on Veterans' quality of life. The study explored which aspects of spirituality – rituals or faith in God/Higher Power – were associated with mental health conditions and if spirituality mediated the relationship between mental health conditions and Veterans' quality of life. Participants included 1048 military Veterans in the U.S. Structural equation modeling was utilized to test the proposed mediation model. The results indicated that depression and anxiety were correlated with less engagement in prayer/meditation and greater faith in God/Higher Power. Trauma was correlated with more engagement in prayer/meditation and greater faith in God/Higher Power. Suicidal risk was correlated with greater faith in God/Higher Power. Results of indirect effects suggested that prayer/meditation had the potential to reduce the adverse effects of trauma but not depression or anxiety on quality of life. No indirect effects were found for faith in God/Higher Power. The results have implications for clinical practice and future research.

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Approved by:

Major Professor
Joyce Baptist

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# Dedication

This journey is dedicated with deepest gratitude and love to those who have supported me throughout this process. All novels have key characters, so thank you for being mine.

To my wonderful spouse, TJ, your patience, encouragement, and belief in me made this achievement possible. Thank you for being my rock through every late night, changing of schedules, and venting sessions.

To my children, Isaac, Noah, and Raelynn, your hugs and curiosity reminded me of why I live and enjoy life. You were my inspiration to never stop achieving dreams.

To my friends and family, thank you for allowing me the space to crack jokes and converse about the path I was on. I appreciate the support you provided me.

To my military family, without my experiences with you, I would not know what resilience looked like. Thank you for being the backbone of my research.

And to my major professor, Dr. Joyce Baptist, there are not enough words to describe how much I appreciate the unwavering guidance, mentorship, and belief in me that you provided. I am forever grateful for your wisdom and support. This work is as much yours as it is mine.

# Chapter 1 - Introduction

As of 2023, the United States is home to over 18 million Veterans (Department of Veteran Affairs, 2025), each carrying a unique story of service and sacrifice. The stories of war and deployment often leave not only physical but also emotional reminders that can be manifested as mental health struggles. It is estimated that close to 7% of Veterans will experience posttraumatic stress disorder (PTSD) in their life in comparison to 6% of non-Veterans; of this group, female Veterans will be twice as likely to present with mental health conditions compared to male Veterans (Department of Veterans Affairs, 2025). Veterans with anxiety are almost double the non-Veteran population (Macdonald-Gagnon et al., 2024), and suicide rates among Veterans average 17.5 per day (Zardetto, 2025).

Veterans who were exposed to heavy combat are particularly vulnerable. Australian Veterans who served in the Korean War reported poorer quality of life compared to non-Veteran peers (Ikin et al., 2009). Among post-9/11 Veterans, higher PTSD and depression severity were linked to increased odds of life dissatisfaction and deployed and battle-injured service members experienced declines in mental and physical health and quality of life (Bernstein, 2022). When PTSD and depression co-occurred, the decline was steeper, with one study noting effect sizes of 1.49 for mental health and 1.03 for cognitive functioning, and overall quality of life reducing by 0.84 (Nichter et al., 2019).

Religious practices can provide a sense of purpose, community, and a framework for understanding life events, through multiple domains, including spirituality, that in turn can enhance overall satisfaction with life (Rojas & Watkins-Fassler, 2022). Numerous religious traditions share transcendent experiences and the pursuit of meaning and purpose, giving them

rich spiritual dimensions (Hill & Pargament, 2003). The term "spirituality" will be used throughout this study to refer to the spiritual component of religiosity.

Engaging in spiritual activities can also be a primary preventive function concerning emotional distress and outcomes related to mental health and well-being (Levin, 2010). Research has shown that among female Veterans receiving ambulatory care, spiritual rituals (such as the frequency of worship), spiritual coping (such as feeling connected to a transcendent force), and general spirituality are associated with better mental health (e.g., Chang et al., 2001). For Latinx female Veterans and survivors of sexual assault in particular, spiritual rituals mitigated the effects of anxiety and depression, fostering adaptive trauma processing and enhanced quality of life. Quality of life is the subjective sense of one's own well-being and contentment with life as it is influenced by the satisfaction of basic human needs like freedom, security, and affection (Costanza, 2008).

The positive impact of spirituality was also reported by female Veterans who served in Iraq and Afghanistan, but not by male Veterans. In fact, coping with stress using spirituality was related to poorer physical health for male Veterans (Park et al., 2021), suggesting spirituality may be a double-edged sword. For instance, spiritual struggles (e.g., doubting one’s God) were found to predict increased pain for male Veterans (Park et al. 2021). This was also found among Croatian Veterans, whereby negative spiritual coping (e.g., negative appraisals of God’s power) and struggles were linked to increased symptoms of posttraumatic stress (PTS), depression, and hopelessness (Mihaljević, 2012). Prayer too emerged as a double-edged sword. U.S. Veterans of the Iraq and Afghanistan conflicts. Prayer for help decreased PTS and depressive symptoms during the Iraq and Afghanistan conflicts, while avoidant prayer increased depression (Tait, 2016).

While Veterans' military experiences cannot be changed, interventions aimed at preventing further decline in mental health and quality of life can decrease healthcare utilization and mortality (Singh, 2005), offering significant future health cost benefits. Knowing what aspects of spirituality play a role in helping to mitigate the negative effects of mental health on Veterans' quality of life can help with developing programs to promote Veteran mental health. Research examines how specific aspects of spirituality, such as rituals including prayer and worship attendance, and connectedness with a transcendent force influence mental health, and in turn, the quality of life, is scarce and inconsistent. In other words, there is a lack of research exploring how prayer/meditation and faith in God/Higher Power influence aspects of mental well-being and how these relationships contribute to Veterans' quality of life. Understanding how various aspects of spirituality enhance Veterans' quality of life can contribute to the development of targeted interventions aimed at improving their overall quality of life.

Further, while a growing body of research has examined how spirituality influences mental health outcomes, comparatively fewer studies have investigated whether pre-existing mental health conditions shape spiritual engagement. For example, depressive symptoms, particularly those involving social withdrawal, may hinder participation in communal spiritual practices, thereby limiting the potential benefits of spiritual involvement for mental well-being (Fried et al., 2016). This study was designed to address this paucity in the literature by examining the extent to which prayer/meditation and faith in God/Higher Power mediate the relationship between mental health conditions and quality of life among Veterans in the U.S. Using the Vulnerability-Stress-Adaptation (VSA) model as a guiding framework, it investigates how quality of life is shaped by the interaction of long-term vulnerabilities (e.g., mental health condition), stressful situations (e.g., military service), and adaptive mechanisms (e.g.,

spirituality). By clarifying these pathways, the study aims to inform the development of targeted spiritual interventions that promote resilience and improve the quality of lives of our Veterans.

# Chapter 2 - Literature Review

## Vulnerability Stress Adaptation Model

Throughout a lifetime, individuals encounter numerous events and interactions that shape their understanding and responses to future experiences. These experiences contribute to the development of coping mechanisms and adaptive behaviors. For soldiers, it is inevitable that they will face added layers of stress during their military service. These stressors can range from the rigors of training and deployment to the challenges of reintegration into civilian life. Such experiences can foster adaptive responses to stressors, helping soldiers build resilience and coping strategies. The Vulnerability-Stress-Adaptation (VSA; Karney & Bradbury, 1995) model, developed for marital relationships, is a framework that can help better understand Veterans' experiences. According to the VSA model, outcomes in relationships and individual well-being are influenced by three key factors: enduring strengths and vulnerabilities, stressful events, and adaptive processes (see Figure 1).

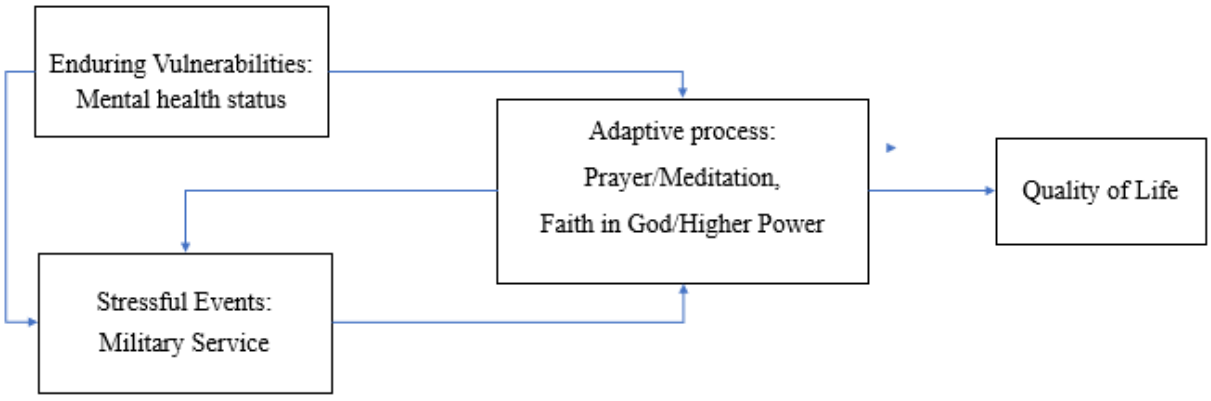


**Figure 1. Application of the Vulnerability-Stress-Adaptation framework to Veterans' Quality of Life**

Enduring strengths and vulnerabilities are stable characteristics that individuals bring into their experiences. For Veterans this can include gender, state of mental health, and history of trauma, which can significantly impact how they handle stress. Stressful events and circumstances are the external pressures and challenges that individuals encounter. For Veterans, this can include experiences during military service, and the process of adjusting to civilian life. Each of these events can introduce significant stress and require adaptive responses. Adaptive processes are the ways in which individuals manage and respond to stressors. For Veterans, this could include behavioral skills, and spiritual beliefs that can help Veterans navigate stress. By examining these factors, the VSA model helps researchers and practitioners understand the complex interplay between personal characteristics, external stressors, and adaptive behaviors. This understanding can inform interventions and support systems designed to enhance the well-being and quality of life for Veterans.

## Mental Health and Spirituality

Jeff Levin's (2010) model of religiosity highlights the intricate relationship between spirituality and mental health, proposing multiple pathways through which spirituality may influence mental health, including ideational (belief), ritualistic (behavior), and social (belonging) (Levin & Chatters, 1998). This influence can be both positive and negative. Spirituality can provide mental models for appraising life events and self-regulating thoughts, promoting healthier coping strategies and resilience (James & Wells, 2003). Spiritual teachings and practices, such as prayer and rituals, shape perceptions and responses to life situations, offering a sense of community, purpose, and hope. These practices help manage stress and maintain mental health by fostering a strong support network and providing a safe space for expressing emotions.

Spiritual involvement often enhances social support by providing a group setting where individuals can speak about their concerns without fearing social reproach (Hassner, 2016). Spiritual communities foster a sense of belonging and mutual aid (Weber & Pargament, 2014), which are crucial for managing stress and which are essential for stress management and mental health maintenance (Ellison & Henderson, 2011). Research has indicated that participation in church activities, meditation, or prayer can reduce PTSD symptoms, especially in Veterans (Currier, 2015). Further, spiritual services were linked to a lower likelihood of suicidal ideation among Veterans with PTSD (Kopacz et al., 2016).

Transpersonal theory views spiritual experiences as transcending the individual, aiding in processing difficult events (McCormick & Wellings, 2004). Among Croatian War Veterans with PTSD, suicidality was inversely correlated with intrinsic religiosity and spiritual well-being. Veterans who felt close to God and satisfied with their relationship with God were the least likely to attempt suicide (Mihaljević et al., 2011). However, viewing God as cruel was linked with recent suicide ideation, PTSD, and major depressive disorder (Currier et al., 2020). Similarly, negative spiritual coping (e.g., feeling punished or abandoned by God) and problems with forgiveness were significantly associated with increased suicide risk, even after controlling for demographic factors, combat exposure, and PTSD severity (Kopacz et al., 2016).

When spirituality is pursued as an introspective and compassionate endeavor rather than in a rigid manner, it improves resilience and personal well-being (Dubey et al., 2024). Structured doctrine practices based on fear and dogma can exacerbate stress and guilt, particularly in punitive spiritual settings. Additionally, using spirituality as a way to avoid or put off dealing with psychological problems can cause a detachment from reality (Walach, 2021). The nature and quality of spiritual involvement appear more important than mere affiliation for mental

health impacts (Marks, 2005; Ellison & Levin, 1998). The depth of one's spiritual engagement and the personal significance of spiritual practices play a crucial role in determining mental health benefits. Positive spiritual coping, including forgiveness, consistently correlates with lower PTSD symptoms, reduced depression, and diminished suicide risk. In one sample of 788 Veterans, these associations were held even when differences in combat exposure moderated the benefits of spiritual engagement (Currier et al., 2014). In contrast, negative spiritual coping and strain relate to elevated PTSD and depressive symptoms (Currier et al., 2015). Further, service attendance appeared to buffer mental illness among combat Veterans, while studies of non-combat Veterans showed that stronger spiritual well-being was linked to less alcohol abuse and fewer symptoms of personality disorders (Smith MacDonald, 2017).

Spirituality has been linked to PTSD, suicide, depression, anger, aggression, anxiety, and other mental health outcomes for Veterans, according to a systemic review of 43 studies (Smith-MacDonald, 2017). Positive spiritual coping was associated with lower PTSD symptoms, reduced depression, and diminished suicide risk, even when differences in combat exposure were considered. Regular attendance at spiritual services and engagement with spiritual communities are linked to better mental health outcomes among Veterans (Rogers, 2020). Among Veterans with recent deployments or combat exposure, prayer coping and overall spiritual involvement relate to lower levels of PTSD symptoms, depressive symptoms, and moral injury (Koenig, 2018).

Combat-related trauma can significantly disrupt core beliefs and spiritual frameworks, often giving rise to moral injury—defined as a violation of deeply held moral convictions—which may lead to spiritual distress and impaired psychological functioning (Wortman et al., 2017). This unique spiritual challenge faced by military personnel underscores the need for

spiritually oriented psychotherapy tailored to address both existential and clinical concerns (Foy & Drescher, 2015). Currier et al. (2016) extends this perspective by revealing that forgiveness, a key spiritual construct, mediates the relationship between spirituality and quality of life among veterans with PTSD, suggesting that spiritual growth and the ability to reconcile inner conflict through forgiveness may promote post-traumatic recovery. However, spiritual struggle does not always accompany moral transgression. Ames et al. (2019) found that moral injury was linked to suicidal risk independently of spiritual distress, suggesting that spirituality, while potentially therapeutic, may not be sufficient in mitigating all the adverse effects of moral injury.

## Veterans' Mental Health and Quality of Life

Extensive research on Veterans consistently demonstrates that mental health conditions such as PTSD, depression, anxiety, and suicidal risk are strongly associated with significant impairments in several areas of quality of life. PTSD has been linked to markedly lower overall quality of life, with large effect sizes reported for mental health functioning, social relationships, and general well-being, as well as a substantial negative association with physical health (Nichter et al., 2019). Depression similarly contributes to diminished mental and physical health outcomes, reduced occupational functioning, and lower life satisfaction (Richardson et al., 2008; Schnurr & Lunney, 2011). Generalized anxiety disorder has been associated with moderate declines in quality of life, affecting both mental health and physical domains (Cully et al., 2006; Mittal et al., 2006). Furthermore, suicide risk—especially when comorbid with PTSD or alcohol use disorder—has been shown to exacerbate these impairments, compounding the challenges Veterans face in maintaining overall well-being.

The impact of these conditions is even more pronounced among certain subgroups. Female Veterans with a history of military sexual trauma report disproportionately higher rates of PTSD and depression, along with significantly lower quality of life (Suris et al., 2007). Social support, a critical buffer against emotional distress, is often compromised in Veterans with elevated mental health symptoms. Proescher et al. (2022) found that post-9/11 Veterans experiencing mental health struggles frequently encounter barriers to forming and maintaining strong social networks, which are essential for emotional resilience and recovery. Harbertson et al. (2023) further confirmed that both depression and PTSD are significant predictors of reduced health-related quality of life in a large, diverse sample of military personnel. Collectively, these findings reflect the multifaceted and often compounding effects of mental health conditions on Veterans' quality of life.

Positive spiritual coping strategies are linked to reduced hopelessness (Mihaljević et al., 2012), fewer PTSD and depressive symptoms (Tait et al., 2016), and higher overall quality of life (Fadilpašić et al., 2017). Intrinsic religiosity may also buffer the relationship between PTSD symptoms and suicide risk (Orak et al., 2023). However, not all spiritual engagement is beneficial: private prayer has been associated with increased pain in minority Veterans, and spiritual coping has predicted poorer physical quality of life for men with combat experience (Park et al., 2021). While spiritual engagement, especially communal and positive coping practices, can support mental health and quality of life, its benefits are not universal. The impact of spirituality varies significantly depending on the Veteran's background, type of spiritual practice, and whether they have experienced combat.

## Purpose of the Study

The aim of this study is to better understand the role of spirituality in reducing the adverse effects of mental health conditions on Veterans' quality of life. Specifically, the study explored which aspects of spirituality – rituals or faith in God/Higher Power – are associated with mental health conditions, and if spirituality mediates the relationship between mental health conditions and Veterans' quality of life. To our knowledge, this is the first study to systematically examine these spiritual dimensions as mediators of mental health and quality of life.

The following hypotheses were tested and shown in Figure 2. However, given the inconsistency of findings in the existing literature, no directional hypothesis was proposed regarding the association between veterans' mental health conditions and engagement in prayer/meditation and faith in God/Higher Power, nor for the mediation analysis.

H1: Veterans' mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) are associated with prayer/meditation.

H2: Veterans' mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) are associated with their faith in God/Higher Power.

H3: Prayer/meditation mediates the relationship between mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) and quality of life.

H4: Faith in God/Higher Power mediates the relationship between mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) and quality of life.

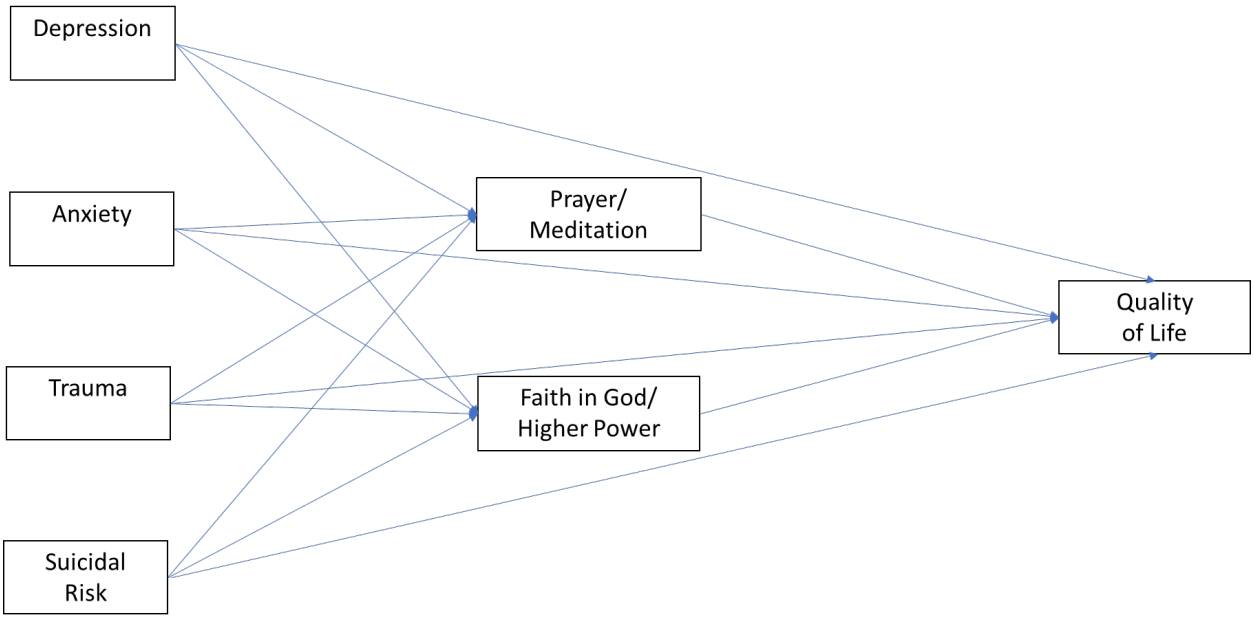


Figure 2. Mediation Model of Depression, Anxiety, Trauma and Suicide Risk on Quality of Life Through Prayer/Meditation and Faith in God/Higher Power

# Chapter 3 - Method

## Design

The study utilized a cross-sectional mediation model design to examine the indirect effects of mental health conditions, specifically depression, anxiety, trauma, and suicidal risk, on quality of life through prayer/meditation and faith in God/Higher Power.

## Participants

Participants included 1048 Veterans who served in the U.S. military. The average age of participants was 39.90 years (*SD* = 11.83). Participants included 848 men and 199 women, and 694 had been deployed at least once. The average years of service was 7.62 years (SD = 6.15). See Table 1 for detailed demographics.

Table 1. Demographics *(N* = 1048)

| Variable | Frequency | Percentage | Missing |
|---|---|---|---|
| **Gender** | | | .1% |
| Male | 848 | 80.9% | |
| Female | 1993 | 19.0% | |
| **Race** | | | - |
| White | 626 | 59.7% | |
| Non-White | | | |
| Black/African American | 195 | 18.6% | |
| Hispanic/Latin/Mexican | 164 | 15.6% | |
| Native American Indian | 4 | 0.4% | |
| Asian/ Hawaiian/Pacific Islander | 22 | 2.1% | |
| Mixed Race | 30 | 2.9% | |
| Other | 7 | 0.7% | |
| **Employment** | | | 3.1% |
| Full-time | 531 | 50.7% | |
| Part-time | 82 | 7.8% | |
| Temporary | 10 | 1.0% | |
| Unemployed | 191 | 18.2% | |
| Disabled | 147 | 14.0% | |
| Retired | 55 | 5.3% | |
| **Relationship Status** | | | 2.7% |
| Single | 188 | 18.0% | |
| Committed Relationship | 154 | 14.7% | |
| Married | 502 | 47.9% | |
| Separated | 56 | 5.3% | |
| Divorced | 120 | 11.5% | |
| **Rank** | | | 10% |
| E1 to E3 | 167 | 16.0% | |
| E4 to E6 | 685 | 65.5% | |
| E7 to E9 | 57 | 5.4% | |
| CW2 and CW4 | 4 | 0.4% | |
| O1 to O3 | 13 | 1.3% | |
| O4 to O6 | 17 | 1.7% | |
| **Income** | | | - |
| Less than $25,000 | 542 | 51.7% | |
| $25,001 - $50,000 | 232 | 22.1% | |
| $50,001 -$75,000 | 152 | 14.5% | |
| $75,001 - $100,000 | 66 | 6.3% | |
| $100,001 - $125,000 | 25 | 2.4% | |
| $125,001 - $150,000 | 12 | 1.1% | |
| More than $150,000 | 19 | 1.8% | |

## Data

This study utilized secondary data from a study conducted by the University of Texas Health Science Center (IRB #HSC-SPH-20-1264). Access to the data was granted by a OneTribe Foundation Researcher who manages the dataset. The original sample size consisted of over 2,000 participants, of which 1,048 met the inclusion criteria for this study, which were: 1) U.S. Veterans, and 2) at least 18 years of age.

This cross-sectional data was collected at one time point between 2015 and 2021 by a nonprofit organization that served Veterans, first responders, frontline healthcare workers, and their families at the client's first appointment with the intake manager before being assigned to a therapist. Participants were asked to complete self-report surveys as part of the intake process to seek services at the nonprofit organization. The data was collected from self-report surveys completed at the participants' therapy intake session. These surveys included demographic questions and standardized assessments. This study was approved by Kansas State University (IRB #11559).

## Measures

The following measures were used to test the variables in the model presented in Figure 2.

### *Quality of life*

Quality of life was measured using the 16-item Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-SF; Endicott et al., 1993). The questionnaire assesses quality of life in several domains. Participants were asked questions about general activities they may have done over the past week. Specifically, participants were asked how

satisfied they were with their: “physical health,” “ability to function in daily life,” and “overall sense of well-being.” Participants responded using a Likert scale of 1 = very poor to 5 = very good. Scores across all items were summed, with higher scores indicating higher quality of life. The reliability and validity of this scale have been demonstrated for numerous psychiatric conditions, and it has been used as a measure of quality of life in more than 100 peer-reviewed publications (Mick et al., 2008). Studies have demonstrated that it has strong internal consistency, test-retest reliability, and content validity. The Cronbach’s alpha for this study was .91, indicating high internal consistency.

### *Spirituality*

Spirituality was measured using two items from the Response to Stressful Experiences Scale (RSES-22; Johnson et al., 2011). Participants were asked to rate the degree they used spirituality to manage stress. RSES4 measured prayer/meditation: “During or after life’s most stressful events, I tend to pray or meditate” and RSES20 measured faith in God/Higher Power: “During or after life’s most stressful events, I tend to lean on my faith in God or higher power”. Participants responded using a Likert scale of 0 = never true to 4 = always true.

### *Depression*

The Beck Depression Inventory-II (BDI-II; Beck et al., 1996) was used to assess the severity of depression. The BDI-II consists of 21 items, each corresponding to a specific symptom of depression, such as sadness, loss of interest, and changes in sleep patterns. Participants were asked to rate each item on a 4-point Likert scale ranging from 0 (no symptom) to 3 (severe symptom), based on how they had been feeling over the past two weeks. Total scores range from 0 to 63, with higher scores indicating greater severity of depressive symptoms.

The BDI-II has demonstrated strong psychometric properties, including high internal consistency (Cronbach's alpha coefficients typically exceeding 0.90), and good convergent validity with other measures of depression (Beck et al., 1996). The BDI-II is validated across various populations and has been shown to have strong convergent validity with other measures of depression (von Glischinski et al., 2019). In the current study, the BDI was used both as a continuous variable to assess symptom severity. The Cronbach's alpha for this study was .96, indicating high internal consistency.

### *Anxiety*

Anxiety symptoms were measured using the Beck Anxiety Inventory (BAI; Beck et al., 1988), a 21-item self-report questionnaire developed to assess the severity of anxiety in adults and adolescents. Each item describes a common symptom of anxiety (e.g., numbness, fear of the worst happening, inability to relax), and participants are asked to rate how much they have been bothered by each symptom over the past week. Responses are recorded on a 4-point Likert scale, ranging from 0 ("Not at all") to 3 ("Severely—it bothered me a lot"), yielding a total score between 0 and 63. Higher scores indicate greater levels of anxiety. The BAI has demonstrated strong psychometric properties, including high internal consistency (Cronbach's alpha coefficients typically exceeding 0.90, Beck et al., 1988) and good discriminant validity, particularly in distinguishing anxiety from depression. In this study, the BAI was used as a continuous variable to assess the severity of anxiety symptoms. The BAI is validated across various populations has shown strong convergent validity with other measures of anxiety, such as the Hamilton Anxiety Rating Scale (Beck et al., 1988). The Cronbach's alpha for this study was .90, indicating high internal consistency.

### *Trauma*

The DSM-V symptoms of post-traumatic stress disorder (PTSD) were measured using the 20-item PTSD Checklist 5 (PCL-5; Weathers et al., 2013). Participants were asked about stressful experiences in the past month. Sample items included “Repeated, disturbing, and unwanted memories of the stressful experience,” “Feeling distant or cut off from other people,” and “Taking too many risks or doing things that could cause you harm.” Participants responded using a 5-point Likert scale of 0 = not at all to 4 = extremely. Scores across all items were summed, with higher scores indicating higher levels of PTSD. The PCL-5 scores correlate well with other measures of PTSD, such as the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), distinguish between individuals with and without PTSD, and have shown high internal consistency, with a Cronbach's alpha typically above 0.90 (Weathers et al., 2013). The Cronbach’s alpha for this study was .95, indicating high internal consistency.

### *Suicidal Risk*

Suicidal risk was measured using the 4-item Suicide Behaviors Questionnaire-Revised scale (SBQ-R; Osman et al., 2001). The SBQ-R assesses lifetime history of thoughts/attempts, threat to attempt, thoughts of telling others they would attempt, and thoughts of suicide in the last year. Participants responded using a 5- or 6-point Likert scale for each item. For instance, “How often have you thought about killing yourself in the past year?” Responses ranged from 0 = never to 5 = very often (five or more times). Scores across all items were summed, with higher scores indicating higher risk of suicidality. The SBQ-R scores correlate significantly with other measures of suicidal ideation and behavior, such as the Beck Scale for Suicide Ideation and the Adult Suicidal Ideation Questionnaire, and differentiates between individuals with and without a

history of suicidal behavior (Osman et al., 2001). Further, the SBQ-R has shown high internal consistency, with a Cronbach's alpha of .87 in clinical samples. The Cronbach's alpha for this study was .84, indicating high internal consistency.

### *Control Variables*

The confounding effects of the following variables on mental health, spirituality and quality of life were examined before including them as control variables in the proposed mediation model. Combat exposure was considered because studies consistently found that combat exposure was associated with higher rates of mental health conditions and lower quality of life (Brajkovic et al., 2018). Gender was another variable considered because studies found that female Veterans with serious mental illness scored substantially lower on quality of life compared to male Veterans (Teh et al., 2008). Female Veterans were also found to report higher incidence of depression compared to male Veterans (Street et al., 2013). Rank was another variable considered because studies reported that mental health outcomes and quality of life after service differed by military rank with enlisted and junior personnel often reporting higher rates of depression, anxiety, and PTSD and lower quality of life compared to officers (Merians et al., 2022; Vogt et al., 2019).

## Data Analysis

### *Preliminary Analysis*

Preliminary analysis was completed using SPSS v29 (IBM Corporation, 2023). Data was examined for completeness and normality (i.e., skewness and kurtosis). Acceptable levels of skewness and kurtosis are between –1 and +1 and –2 and +2, respectively (Kline, 2011). Independent sample t-tests were used to compare the variable means for combat versus non-

combat Veterans and gender. Bivariate correlations will be used to examine the relationships among the variables.

### *Structural Equation Modeling*

The proposed mediation model in Figure 2, was tested with structural equation modeling using MPlus v8.4 (Muthen & Muthen, 1998-2023) and maximum likelihood estimation. Full information maximum likelihood estimation was used to estimate missing values. The evidence of acceptable fit between the hypothesized model and the observed data was assessed using multiple fit indices, including a non-significant Chi-square, Comparative Fit Index (CFI) and Tucker Lewis Index (TLI) values of above .95, and Root Mean Square Error of Approximation (RMSEA) of below .08 (Hu & Bentler, 1999).

To test the mediation hypothesis, the significance of the indirect effect of the independent variables (depression, anxiety, trauma, and suicidal risk) on quality of life through prayer/meditation and faith in God/Higher Power. The significance of the indirect effect was assessed using bootstrapping procedures with 5,000 bootstrap samples. Bootstrapping is a non-parametric resampling method that provides confidence intervals for indirect effects, enhancing the robustness of mediation analysis (Preacher & Hayes, 2008).

# Chapter 4 - Results

## Preliminary Analysis

Prior to analysis, data was tested for normality. Skewness ranged between -.28 and .91 and kurtosis ranged between –1.33 and -.01, indicating that the data was normally distributed. Intercorrelations (Table 2) indicated significant negative relationships between quality of life and trauma ($r$ = -.48, $p$ < .001) and suicidal risk ($r$ = -.30, $p$ < .001). As trauma or suicidal risk increased, the lower the quality of life reported by Veterans. It appeared that trauma and suicide risk had more bearing on quality of life than other mental health conditions, namely depression and anxiety.

Table 2. Intercorrelations of Study Variables

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| 1. Quality of Life | - | | | | | | | | |
| 2. Prayer/ Meditation | .11*** | - | | | | | | | |
| 3. Faith in God/ Higher Power | .11*** | .98*** | - | | | | | | |
| 4. Depression | .31*** | .62*** | .62*** | - | | | | | |
| 5. Anxiety | .33*** | .62*** | .61*** | .92*** | - | | | | |
| 6. Trauma | -.03 | .13*** | .12*** | .20*** | .19*** | - | | | |
| 7. Suicidal Risk | .14*** | .81*** | .80*** | .49*** | .49*** | .01 | - | | |
| 8. Gender | -.06 | .01 | .01 | -.03 | -.03 | -.03 | -.01 | - | |
| 9. Rank | -.05 | .06*** | .05** | .02 | .01 | .10*** | .10*** | -.02 | - |
| *M* | 48.29 | 2.00 | 2.08 | 13.35 | 12.33 | 40.95 | 6.25 | | |
| *SD* | 12.55 | 1.41 | 1.46 | 7.32 | 6.13 | 20.16 | 3.64 | | |
| Range | 16-78 | 0-4 | 0-4 | 0-27 | 0-21 | 0-80 | 0-17 | 0-1 | 1-6 |
| Missingness | 77.8% | 44.1% | 43.9% | 31.7% | 30.9% | 20.9% | 46.9% | .1% | 10% |

Note. *$p$ < .05. **$p$ < .01. ***$p$ < .001. Gender: 0 = Men, 1 = Women. Rank: 1 to 6 from enlisted to officers.

Results further indicated a negative relationship between prayer/meditation and suicidal risk ($r$ = -.16, $p$ < .001). Conversely, faith in God/Higher Power was negatively related to suicidal risk ($r$ = -.09, $p$ = .04) and depression ($r$ = -.26, $p$ = .03). It appeared that for Veterans, increased participation in prayer/meditation corresponded to lower suicidal risk while believing more in faith in God/Higher Power corresponded to lower depression and suicidal risk.

As expected, depression was positively related to anxiety ($r$ =.73, $p$ < .001), and trauma was positively related to depression ($r$ =.73, $p$ < .001), anxiety ($r$ = .68, $p$ < .001), and suicidal risk ($r$ = .38, $p$ < .001). Suicidal risk, however, was not significantly related to either depression ($r$ = .25, $p$ =ns), or anxiety ($r$ = .07, $p$ = ns). These results suggest that for Veterans, suicidal risk may be more aligned with experiences of trauma than depression or anxiety. Higher ranking among participants was positively related to faith in God/Higher Power ($r$ = .09, $p$ =.04), and negatively related to trauma ($r$ = -.09, $p$ = .02), suicidal risk ($r$ = -.10, $p$ = .03). These results suggested that the higher the rank of Veterans, the more they believed in God/Higher Power and the lower their reports of trauma and suicidal risk.

Examination of group differences across genders using $t$-tests found significant differences in only suicidal risk, $t$(555) = -1.59, $p$ = .018, with women reporting higher rates of suicide risk ($N$ = 116, $M$ = 6.73, $SD$ = 4.11), compared to men ($N$ = 441, $M$ = 6.13, $SD$ = 3.50). No significant differences were found across genders for quality of life, spirituality, and other mental health conditions. Further, there were no significant differences between deployed and non-deployed Veterans across quality of life, spirituality, and mental health conditions. Given these results, only gender and rank were included as control variables in the proposed model.

**Structural Equation Modeling**

The structural equation modelling fit indices suggested that the data fit the model in Figure 3. Fit indices: $x^2(6) = 32.19$, $p < .001$, RMSEA = 0.09, ($p = .01$, 90%CI: .06, .12), CFI = .99, TFI = .97, SRMR = 0.004. Chi-square is sensitive to sample size such that with larger sample size, even a small discrepancy between observed and expected covariance matrices can become statistically significant. Chi-square divided by the *df* of less than 5 are considered acceptable (Hu & Bentler, 1999). In this sample, 32.19/6 is less than 5, hence the model is acceptable. Although RMSEA indicates mediocre fit, both CFI and TLI of > .95 suggest an excellent fit between the model and the data (Hu & Bentler, 1999). The structural equation modeling results are presented in Figure 3 (standardized results) and Table 3 (unstandardized results).

Table 3. Unstandardized Path Analysis Results Illustrating the Effects of Depression, Anxiety, Trauma and Suicide Risk on Quality of Life Through Prayer/Meditation and Faith in God/Higher Power.

| **Paths** | *B* | S.E. | 95% CI | $R^2$ |
|---|---|---|---|---|
| **Paths to Quality of Life:** | | | | .14*** |
| Prayer/Meditation | -.48* | .24 | -.79,-.20 | |
| Faith in God/Higher Power | .17 | .23 | -.08,.47 | |
| Depression | .14 | .09 | -.01,.29 | |
| Anxiety | .39*** | .09 | .24,.54 | |
| Trauma | -.08** | .03 | -.13,-.04 | |
| Suicidal Risk | .15** | .05 | .07,.24 | |
| Gender | -.84 | 4.9 | -1.03,10.46 | |
| Rank | -.06 | .06 | -.17,.02 | |
| **Paths to Prayer/Meditation:** | | | | .73*** |
| Depression | .14** | .05 | .06,.22 | |
| Anxiety | .15** | .05 | .07,.24 | |
| Trauma | .05** | .02 | .03,.08 | |
| Suicidal Risk | .63*** | .03 | .58,.68 | |
| **Paths to Faith in God/Higher** | | | | .71*** |
| **Power:** | .22*** | .05 | .14,.31 | |
| Depression | .07 | .05 | -.02,.14 | |
| Anxiety | .05** | .025 | .02,.07 | |
| Trauma | .62*** | .03 | .58,.68 | |
| Suicide Risk | | | | |

Note. Gender 0 = Male, 1 = Female. Rank: 1 to 6 from enlisted to officers.

*p < .05. **p < .01. ***p < .001. Model fit, x2(12) = 35.75, p = .0004, RMSEA = 0.04, CFI = .996, TLI = .992, SRMR = 0.029.

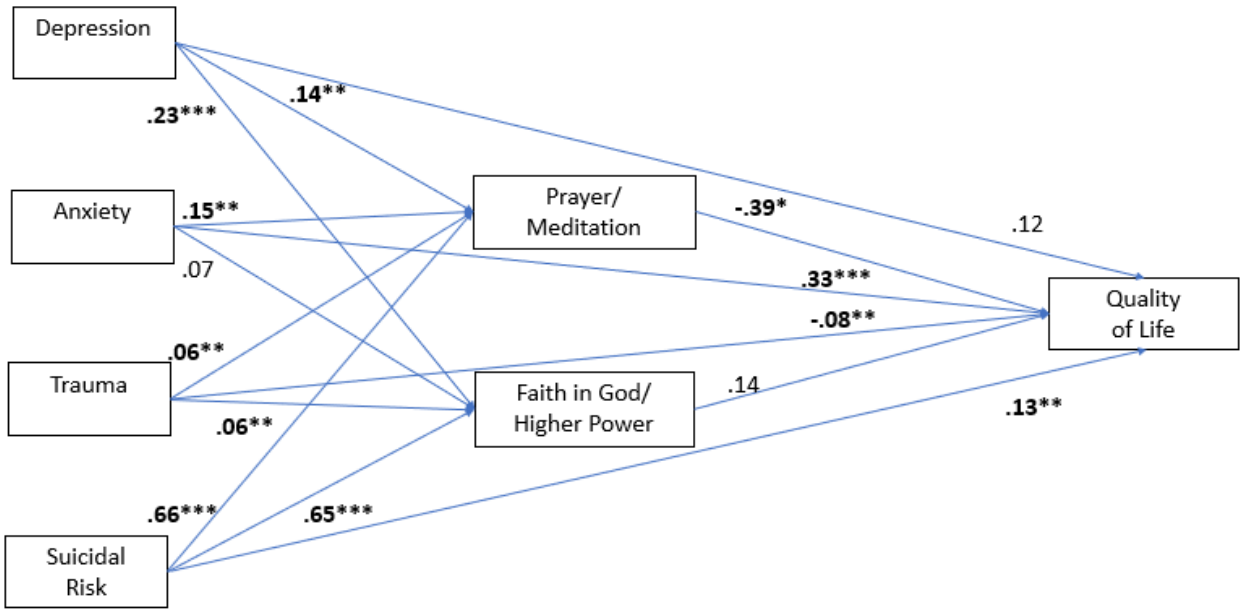


Figure 3. Standardized Mediation Model Illustrating the Effects of Depression, Anxiety, Trauma and Suicide Risk on Quality of Life Through Prayer/Meditation and Faith in God/Higher Power

H1: Veterans' mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) are associated with their engagement in prayer/meditation.

H1 was partially supported. The standardized results indicated that depression and anxiety were negatively associated with prayer/meditation ($\beta$ = -.19, $p$ < .001 and $\beta$ = -.20, $p$ < .001 respectively), while trauma was positively related to prayer/meditation ($\beta$ = .62, $p$ < .001). Suicidal risk was not associated with prayer/meditation. These results indicated that predispositions to depression, anxiety, and trauma, but not suicidal risk, were was associated with engagement in prayer/meditation.

H2: Veterans' mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) are associated with faith in God/Higher Power.

H2 was fully supported. The standardized results indicated that depression ($\beta$ = .13, $p$ = .03), anxiety ($\beta$ = .13, $p$ = .04), trauma ($\beta$ = .30, $p$ < .001), and suicidal risk ($\beta$ = .30, $p$ < .001) were positively associated with faith in God/Higher Power. These results suggested that there is a positive relationship between being predisposed to depression, anxiety, trauma, and suicidal risk and believing in God/Higher Power.

Table 4. Unstandardized Coefficients of Indirect Effects from Depression, Anxiety and Trauma to Quality of Life Through Prayer/Meditation, and Faith in God/Higher Power.

| Indirect Path | β | SE | 95%CI |
|---|---|---|---|
| **Depression → Prayer/Meditation → Quality of Life** | **-.07** | **.04** | **-.15, -.03** |
| **Anxiety → Prayer/Meditation → Quality of Life** | **-.07** | **.04** | **-.16, -.02** |
| **Trauma → Prayer/Meditation → Quality of Life** | **-.03** | **.01** | **-.05,-.01** |
| **Suicidal Risk → Prayer/Meditation → Quality of Life** | **-.30** | **.15** | **-.50, -.13** |
| Depression → Faith in God/Higher Power → Quality of Life | .04 | .05 | -.02, .11 |
| Anxiety → Faith in God/Higher Power → Quality of Life | .01 | .02 | -.003, .06 |
| Trauma → Faith in God/Higher Power → Quality of Life | .01 | .01 | -.002, .03 |
| Suicidal Risk → Faith in God/Higher Power → Quality of Life | .10 | .15 | -.005, .30 |

H3: Prayer/meditation mediates the relationship between mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) and quality of life.

H3 was partially supported. Standardized path coefficients (Table 4) demonstrated that prayer/meditation mediated the relationship between depression ($\beta$ = -.18, $SE$ = .05, $p$ < .001)

and quality of life, and anxiety (β = -.19, SE = .04, p < .001) and quality of life. These results indicate that as depression or anxiety increased among Veterans, their engagement in prayer/meditation diminished, which subsequently resulted in a decline in their quality of life. In contrast, Veterans' trauma ($\beta$ = .60, SE = .06, $p$ < .001) had a positive impact on quality of life through prayer/meditation. Higher levels of trauma corresponded to increased engagement in prayer/meditation, which enhanced quality of life. However, spiritual ritual did not serve as a mediator between suicidal risk and quality of life.

H4: Faith in God/Higher Power mediates the relationship between mental health conditions (i.e., depression, anxiety, trauma, and suicidal risk) and quality of life.

H4 was not supported. Standardized path coefficients (Table 4) demonstrated that faith in God/Higher Power did not mediate the relationship between depression, anxiety, trauma, and suicide risk and quality of life. Although all four mental health states were positively related to faith in God/Higher Power, this relationship did not influence Veterans' quality of life.

# Chapter 5 - Discussion

This study examined the relationship between depression, anxiety, trauma, and suicidal risk with prayer/meditation and faith in God/Higher Power and the quality of life among 1048 military Veterans in the U.S. It further examined the mediating role of prayer/meditation and faith in God/Higher Power in the relationship between depression, anxiety, trauma and suicidal risk, and quality of life.

The results of this study reinforce existing research on the relationship between mental health and quality of life among Veterans, while also contributing novel insights into the roles of prayer/meditation and faith in God/Higher Power. Specifically, the study highlights how prayer/meditation may serve as a behavioral mechanism that mediates the effects of certain mental health conditions, and while faith in God/Higher Power may coexist with distress, it does not necessarily buffer its impact on overall well-being. Internal beliefs alone may not be sufficient to improve quality of life without corresponding behavioral or social support mechanisms.

**Prayer/meditation**

Based on the results, prayer/meditation appears to be negatively influenced by mental health outcomes such as depression and anxiety that are associated with a decline in overall quality of life. One explanation is that depression often presents with symptoms like social withdrawal, fatigue, and diminished motivation, which in turn can intensify distress and functional impairment (Fried et al., 2016). As a result, Veterans experiencing these symptoms may be less inclined or able to participate in communal spiritual practices, such as attending services, engaging in prayer, or taking part in other faith-based activities. Social avoidance is

also a common feature of anxiety disorders (Heuer et al., 2007). Vietnam Veterans with PTSD often experience elevated social anxiety, avoidance, detachment, and a persistent expectation of invalidation by others (Hofmann, Litz, & Weathers, 2003). These symptoms can hinder Veterans' ability to seek out and engage with spiritual communities for support.

The Vulnerability-Stress-Adaptation (VSA; Karney & Bradbury, 1995) model provides a useful framework for interpreting these patterns. According to the VSA model, individuals' long-term well-being is shaped by the interaction between enduring vulnerabilities (e.g., trauma history, mental health conditions), external stressors (e.g., military service), and adaptive processes (e.g., spirituality, coping strategies). In this context, prayer/meditation may serve as an adaptive process that helps buffer the effects of stress from military service, but only when individuals are emotionally and socially able to access and engage in them. Veterans with depression or anxiety may be less able to activate this coping resource due to their symptoms, limiting the protective effects of prayer/meditation on quality of life.

In contrast, the results suggest that Veterans heightened trauma is associated with them engaging in more prayer/meditation. Veterans with PTSD, particularly those grappling with moral injury, may actively seek prayer/meditation as a form of spiritual healing. Moral injury, often characterized by guilt, shame, and existential distress stemming from perceived violations of moral or ethical codes during service, can prompt a search for forgiveness, meaning, and reconciliation (Thomas et al., 2022). Prayer/meditation may offer a structured path toward spiritual restoration. As Park et al. (2021) noted, these practices can help Veterans navigate the emotional and moral challenges of combat, while Koenig and Zaben (2021) highlight how spiritual traditions frame moral transgressions as "missing the mark," offering pathways for redemption and peace.

The results on suicidal risk and prayer/meditation are contrary to existing literature. A meta-analysis by Poorolajal et al. (2022) found an inverse relationship between spirituality and suicidal behavior, suggesting that spirituality can serve as a protective factor. One key aspect may be attending spiritual services, which provide emotional uplift, social connection, and reinforcement of positive values (Idler et al., 2009). Yet, individuals at elevated suicide risk, especially those with co-occurring depression or PTSD, may withdraw from these rituals due to symptoms like hopelessness or isolation, limiting their access to these protective benefits. Furthermore, many spiritual traditions explicitly condemn suicide, which may intensify feelings of guilt or spiritual failure in those struggling with suicidal ideation (Gearing & Alonzo, 2018).

This distinction between external spiritual behaviors and internalized beliefs is central to Levin's theory of religiosity, which emphasizes that religiosity is multidimensional -- encompassing behavioral, cognitive, emotional, and social components (2010). While participation in rituals may offer structure and community, the protective factors most consistently associated with reduced suicide risk, such as hope, purpose, and belief in the sanctity of life, are more closely tied to internalized spiritual beliefs (U.S. Department of Veterans Affairs, 2024). These internal convictions may serve as cognitive and emotional buffers against suicidal ideation, even when outward spiritual behaviors are absent.

**Faith in God/Higher Power**

The findings that higher levels of mental health challenges, such as depression, anxiety, trauma, and suicidal ideation, are associated with stronger faith in God/Higher Power can be meaningfully interpreted through the VSA model (Karney & Bradbury, 1995) and Levin's (2010) multidimensional model of religiosity. These frameworks provide insight into why

Veterans may turn to God/Higher Power during emotional distress and why such beliefs, while meaningful, may not always translate into improved quality of life.

In this context, faith in God/Higher Power functions as an adaptive process, a cognitive and emotional strategy that Veterans may use to manage the emotional impact of their vulnerabilities and stressors. For example, Veterans facing depression may experience a loss of meaning or purpose, prompting them to seek existential grounding through spiritual beliefs (U.S. Department of Veterans Affairs, n.d.; Steen et al., 2024). Similarly, anxiety—particularly death-related anxiety common among military personnel—may be buffered by a belief in God/Higher Power or spiritual continuity (Piotrowski et al., 2020).

However, the study found that while transcendence was positively associated with mental health symptoms, it did not mediate the relationship between those symptoms and quality of life. This means that on their own, internal belief systems may not be sufficient to improve well-being. The VSA model helps to explain this by suggesting that adaptive processes must be supported by contextual and behavioral factors to be effective. Without partaking in religious rituals, community support, or other behavioral reinforcement, transcendence may only provide existential contentment, not measurable improvements needed to enhance life satisfaction.

This interpretation is further supported by Levin's (2010) model of religiosity. The current findings suggest that Veterans exhibit strong ideational spirituality or deep faith in God/Higher Power but may lack corresponding ritualistic or social engagement. Levin's framework posits that the full benefits of spirituality emerge when all three dimensions are integrated. For instance, faith in God/Higher Power may provide meaning, but participation in communal worship or prayer/meditation may be necessary to translate that meaning into improved emotional and social functioning. The protective role of belief-based spirituality is

further supported by a meta-analysis cited by the U.S. Department of Veterans Affairs (2024), which found a 69% reduction in suicide deaths associated with spiritual beliefs and practices. Notably, belief-based dimensions had a stronger protective effect than ritual behaviors, yet the findings also imply that belief alone may not be sufficient for broader quality-of-life outcomes. This aligns with the idea that faith in God/Higher Power may serve as a mental health anchor, helping Veterans make sense of trauma (Russano et al., 2017) and regulate emotions during distress (Verhaeghen, 2019), but may require behavioral and social reinforcement to impact overall well-being.

In summary, the VSA model and Levin's religiosity framework together suggest that while faith in God/Higher Power is a valuable coping resource for Veterans facing emotional distress, its effectiveness in improving quality of life depends on the broader context of behavioral engagement and social support. Integrating prayer/meditation may be essential for translating spiritual meaning into sustained emotional resilience and quality of life.

**Limitations**

The results of this study must be interpreted while considering its limitations. First, all the participants were drawn from a single geographic region within the U.S.,.S. and as a result, the findings may not be generalizable to populations in other regions, particularly when considering regional differences in access to services and resources. Additionally, the data was gathered through self-report measures administered at a single point in time. This cross-sectional approach limits the ability to capture changes in participants' perceptions or behaviors over time and may not accurately reflect their long-term experiences. Other limitations include the 1-item measurement for prayer/meditation and faith in God/Higher Power that does not capture the full dimension of the construct. Further, missing data was estimated using maximum likelihood that

assumes that data are missing at random. If the data are not missing according to these assumptions, the estimates can be biased.

## Clinical Implications

These findings carry several important implications for healthcare organizations, particularly those serving Veteran populations. Integrating spiritual screenings alongside standard mental health assessments could help providers identify Veterans who may benefit from faith-based support systems. Understanding a Veteran's spiritual preferences can inform referrals to chaplaincy services or community-based spiritual organizations, fostering a more comprehensive approach to care. The VA Chaplain Service, for example, plays a vital role in offering spiritual care tailored to Veterans' individual needs, regardless of spiritual affiliation (U.S. Department of Veterans Affairs, n.d.). Professionals working within spiritual institutions—such as pastors, chaplains, or lay leaders—may also benefit from understanding the mental health challenges Veterans face. These leaders often serve in informal counseling roles and may be uniquely positioned to encourage engagement in prayer/meditation, which, as this study suggests, can positively influence mental health and quality of life. Given the importance of structure and routine in military culture, healthcare and spiritual leaders alike should consider how prayer/meditation can be integrated into broader wellness strategies. Promoting structured spiritual practices may serve as a proactive measure to support emotional resilience and emotional well-being among Veterans. Further, interventions that combine spiritual support with behavioral or clinical strategies to improve quality of life may provide a more holistic approach of care for Veterans.

## Future Research

Building on the findings of this study, several avenues for future research are worth exploring. One promising direction involves examining differences in spiritual engagement and mental health outcomes based on military rank. This study included fewer officers than enlisted personnel, yet these groups often experience distinct roles, responsibilities, and stress exposures. Investigating how these differences influence spiritual coping and quality of life could yield valuable insights. Future research should explore how different dimensions of spirituality—such as intrinsic religiosity, moral beliefs, or spiritual struggle—interact with mental health and quality of life. Additionally, the development and validation of a standalone scale specifically designed to measure prayer/meditation and faith in God/Higher Power would significantly strengthen future research. Such a tool would allow for more precise assessment of these constructs and their unique contributions to mental health. Recognizing that prayer/meditation and faith in God/Higher Power may influence well-being in diverse ways, a more nuanced and comprehensive survey instrument could better capture these dynamics and inform tailored interventions. Last, comparative studies across different spiritual traditions could deepen our understanding of how specific beliefs and practices relate to mental health and quality of life, offering culturally sensitive insights for both clinical and community-based support.

## Conclusion

This study emphasizes the complex role that spirituality plays in U.S. Veterans' mental health and general quality of life. Only prayer/meditation showed a mediating effect on quality of life, even though both practice and belief in God/High Power (transcendence) were linked to mental health issues. Although significant, internal beliefs by themselves did not result in increased life satisfaction. These results imply that behavioral manifestations of spirituality, like meditation and prayer, may provide protective advantages, especially in reducing the negative

consequences of trauma and the risk of suicide. It is essential for both behavioral health professionals and spiritual leaders who work with Veterans to recognize the relevance of these dimensions of spirituality. A more holistic understanding of the protective factors associated with spirituality may inform proactive strategies to support Veterans at increased risk for mental health challenges.

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