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Childhood Trauma and Resilience:
Towards a Spiritually Focused Cognitive Behavioral Therapy Approach

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ABSTRACT

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Abstract

For many emerging adult childhood trauma survivors (ages 18-25), spirituality can influence the sustainability of resilience in significant ways. A gap exists in the literature regarding the effective integration of spirituality and resilience in therapeutic interventions with this population, particularly among pastoral counseling approaches. This work examines whether or not a Cognitive Behavior Therapy approach highlighting the interaction between spirituality identity development and resilience development enhances survivor resilience. In a pilot study, twenty college students were sequentially assigned to either a treatment group (N=10) or control group (N=10). Treatment group participants received four sessions of an experimental spiritually focused cognitive behavior therapy intervention. Both groups completed pre-test and post-test assessments with the Connor-Davidson Resilience Scale. Research results derived from quantitative and qualitative data analysis. Based upon a univariate analysis of variance, it appears resiliency scores did not differ significantly following the treatment intervention, $p = .55$. Based on the Royal Free Interview for Spiritual and Religious Beliefs instrument, participant perceptions of a spiritual power or force influencing day-to-day life appear significantly different following the treatment intervention $p = .04$ and perceptions of a spiritual power or force enabling them to cope with events in their life appear slightly significant $p = .06$. Qualitative analysis revealed three prominent themes of spirituality that influenced resilience (Beliefs, Practices and Communication) and seven sub-themes (Character of God, Religious Beliefs, Spiritual Beliefs, Relationship to God; Community, Spiritual Disciplines; and Forms of Communicating). In conclusion, religious language, and one's perceived relationship to God during childhood trauma can affect both adaptive and maladaptive coping for survivors. Additionally, the task of identity exploration can amplify evolving theological conflicts in emerging adulthood and influence survivor coping. Emerging adult childhood trauma survivors in this study experienced theological conflicts between the spiritual elements that aided in childhood coping and their present-day spiritual realities.

Keywords:

Resilience, Coping, Childhood Trauma, Childhood Maltreatment, Traumatic Stress, Spirituality, Spiritual Identity, Pastoral Counseling, Pastoral Theology, Late Adolescence, Emerging Adulthood, Young Adulthood, Cognitive Behavioral Therapy

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ABBREVIATIONS

CBT	Cognitive Behavior Therapy
CD-RISC	Connor-Davidson Resilience Scale
CTQ	Childhood Trauma Questionnaire
RFI	Royal Free Interview for Spiritual and Religious Beliefs
SFCBT	Spiritually Focused Cognitive Behavioral Therapy

TABLE OF CONTENTS

Abstract	
Acknowledgments	
Abbreviations	
Introduction: Childhood Maltreatment and Childhood Trauma Overview	1
Emerging Adulthood	5
Nature of the Problem and Basic Assumptions	9
Study Background and Purpose	13
Research Design and Methodology	14
Chapter 1: Childhood Trauma, Resilience, and Spirituality Literature Review	19
Trauma Overview	20
Childhood Trauma	
<i>Social Sciences Literature</i>	22
Interpersonal Childhood Trauma	27
Interpersonal Childhood Trauma and Emerging Adulthood	36
<i>Theology Literature</i>	38
Sin in Context	41
Fragmented Personhood	46
Resilience	
<i>Social Sciences Literature</i>	49
Resilience and Emerging Adulthood	53
<i>Theology Literature</i>	58
The Survivor: Resistance to Violence	58
Spirituality with Emerging Adults	
<i>Social Sciences Literature</i>	61
Spirituality and Resilience	63
<i>Theology Literature</i>	66
Restoration: Finding Meaning and Purpose	66
Emerging Adult Spirituality and Resilience	68

PART I: TREATMENT AND HEALING APPROACHES
Theological and Psychological Perspectives of 'Adaptive' Living

Chapter 2: Theory and Treatment Approaches	78
Cognitive Behavioral Therapy Overview	80
Cognitive Behavioral Therapy with Childhood Trauma Survivors	83
Assessments and Treatment Considerations	85
Cognitive Behavioral Therapy and Resilience	90
Assessments and Treatment Considerations	93
Cognitive Behavioral Therapy with Spiritual/Religious Clients	96
Assessments and Treatment Considerations	106
Chapter 3: Theology and Healing Approaches	112
Theology and Pastoral Counseling Overview	112
Pastoral Theology Research Method	113
Faith Development and Spiritual Identity Development	115
Culture and Emerging Adult Spiritual Development	122
Trauma and Suffering	123
Pastoral Counseling and Reconciliation	126
Pastoral Counseling with Childhood Trauma Survivors during Emerging Adulthood	132
Developing a Pastoral Counseling Approach	134
Eschatological Hope	134
Eschatological Plot	136

PART II: RESEARCH METHODOLOGY
Research, Findings and Discussion

Chapter 4: Methodology	139
Research Design	140
Population Sample	141
Instruments	142
Data Collection	147
Statistical Method	147
Research Design and Procedures	149

Chapter 5: Results	154
Demographic Sample	154
Descriptive Statistics	156
Pre-screen Instruments	156
Presenting Issues	
Gender and Presenting Issues	158
Ethnicity and Presenting Issues	159
Religious/Spiritual Background and Presenting Issues	159
Childhood Trauma Questionnaire	
Gender and Childhood Trauma	164
Ethnicity and Childhood Trauma	165
Religious/Spiritual Background and Childhood Trauma	169
Quantitative Findings	
Results for Research: Question One	171
Results for Research: Question Two	174
Qualitative Findings	
Results for Research: Question Two	175
Results for Research: Question Three	180
Chapter 6: Discussion, Implications, Future Research, and Conclusion	184
Discussion and Implications	189
Goal 1- Spiritual Identity Development and Resilience	191
Christian Theology and Childhood Trauma	193
Christian Theology and Emerging Adult Survivors	195
Case Studies – Spiritual Identity Development	197
Goal 2- Spiritual Elements that Influence Resilience	205
Christian Theology and Survivor Resilience	210
Fragmented-Compartmentalization	214
Goal 3- Towards the Development of an	220
Effective Spiritual Focused Cognitive Behavior Therapy Approach	
Christian Theology and Clinical Practice	222
Future Research	224
Conclusion	226

Index of Tables	230
Appendixes	231
Appendix A – Institutional Review Board Protocol	232
Appendix B – Informed Consent Form	236
Appendix C – Demographic Information Sheet	239
Appendix D – Childhood Trauma Questionnaire (CTQ)	240
Appendix E – Connor-Davidson Resilience Scale (CD-RISC)	241
Appendix F – Modified Royal Free Interview for Spiritual and Religious Beliefs (RFI)	242
Appendix G – Narrative Questionnaire	246
Appendix H – Referral Information	248
Appendix I – Treatment Group Homework – Week 1	249
Appendix J – Treatment Group Homework – Week 2	250
Bibliography	252

INTRODUCTION

Just turning on the news today would draw one's attention to what appears to be a child abuse epidemic in our country. If the parents are not the perpetrators, often the abuse is committed by other authoritarian adults (i.e., coaches, mentors, ministers, family members), who gain and later betray children's trust. The truth is, in 2010 more than 690,000 children in the U.S. and Puerto Rico were substantiated as victims of child maltreatment.¹ Sadly, that statistic does not even include the large number of children with multiple substantiated reports of victimization or whose abuse was unreported. Of those reported, more than 75% have suffered neglect (psychological or physical), about 18% of them physical abuse, and 9% sexual abuse. While the data over the past 5 years shows a decrease in the number of reported victims, these figures reveal a sobering reality about child victimization in this country.

Many of those maltreatment incidents were at the hands of adults designated to protect the victims. Though no current statistics indicate how many of those child victims self-identify as being traumatized by their experiences, it is assumed that a significant number would describe their experiences as traumatic. For those unable to verbalize their experience as traumatic, their stress responses following the incidents may provide evidence of trauma's existence. *Childhood Trauma* can be defined as a stressful event with "traumatogenic qualities, such as feeling threatened, unable to protect oneself, fend

¹ U.S. Department of Health and Human Services, "Child Maltreatment 2010," ed. Administration on Children Administration for Children and Families, Youth and Families, Children's Bureau (Washington, DC2011), 22.

off, or otherwise master a threat, and possibly feeling responsible for its occurrence.”² In the current research, childhood trauma is studied through the lens of childhood abuse (emotional, physical, and sexual) and childhood neglect (emotional, and physical).

Each year more research is added to the study of traumatology regarding the lasting effects of childhood trauma. While emerging research examines how childhood adversity changes brain functioning, much of the research grounding childhood trauma focuses on the developmental implications for adulthood. Developmental researchers have begun to link interpersonal functioning and behavioral responses to maladaptive coping patterns following adverse events in childhood. Psychologically, those studies tie post-traumatic symptomatology to psychological disorders and impaired emotion regulation later in life. Clinically speaking, issues of wellness and hardiness are prominent in the treatment focused research as well as issues of guilt, shame, self-esteem, and depression. Although there is no shortage of research highlighting the detrimental effects of childhood adversity, far fewer studies illuminate the self-protective qualities that follow childhood abuse and neglect, though it is an equally significant topic.

Out of this dearth, the current research study turns its attention to the more positive after-effects of childhood adversity found in survivor resilience. *Resilience* can be defined as “the ability to adapt in positive manifestations following significant adversity or risk.”³ Resilience emanates from one's ability to cope positively with adverse circumstances. Positive coping is typically identified by survivors' ability to excel in

² Martin Drapeau and J. Christopher Perrya, "Childhood Trauma and Adult Interpersonal Functioning: A Study Using the Core Conflictual Relationship Theme Method (CCRT)," *Child Abuse & Neglect* 28(2004): 1050.

³ Emily Crawford, Margaret O'Dougherty Wright, and Ann S. Masten, "Resilience and Spirituality in Youth," in *The Handbook of Spiritual Development in Childhood and Adolescence*, ed. Eugene C. Roehlkepartain (Thousand Oaks, Calif.: Sage Publications, 2006), 356.

some socially recognized arena, despite the trauma experienced. For childhood trauma survivors, resilience may be characterized by the attainment of academic achievement, career accomplishments, or relationship commitment. However, gender and cultural critics might argue that the criteria for resilience need to reflect the context of the survivor.

A great deal of research in the past decade has sought to identify salient factors that contribute to the formation and sustainability of resilience. Across the literature, key factors such as hope, meaning making, sense of purpose, positive mentors and spiritual/religious beliefs have been identified as beneficial to the development of resilience. Spirituality is a major focus of this research. It is regularly cited as an organizing framework used to place boundaries around meaning making following experiences of trauma. Still, the use of spirituality to cope can become a complicated endeavor for survivors, for several reasons. First, how survivors conceptualize and utilize spirituality plays an important role in how they characterize themselves following maltreatment. Depending on their perception of relatedness to a divine other prior to the maltreatment, spirituality could trigger thoughts of punishable condemnation or unconditional acceptance for survivors. Second, spirituality influences how survivors interpret the changes within themselves following the trauma. Their use of spirituality shapes how they engage others, assume responsibility for self and others, perceive themselves as 'good' or 'bad,' and interpret 'before and after' ways of being. Third, spirituality heavily influences the meaning survivors attach to the role or absence of a 'divine other' during the trauma experienced. Each of these functions of spirituality challenge and support survivor resilience. Childhood trauma shakes the early foundations

of ‘meaning making’ (making sense of the trauma) including one’s sense of belonging and connectedness. Survivors who lack a sense of meaning or purpose for their experiences also struggle to feel a sense of belonging and connectedness with others. The next three chapters will discuss the influence of spirituality on resilience in more detail. More specifically, chapter one will provide a review of childhood trauma literature, Resilience Theory, and spiritual identity development theories.

Without question childhood trauma affects many aspects of a child’s life. After the abuse and neglect end, the residual effects motivate how survivors navigate the world. Following trauma survivors are susceptible to elevated anxiety levels often triggered by new situations or relationships that reactivate trauma related anxieties.⁴ The psychological turmoil following maltreatment not only shapes how survivors relate to others (i.e., interpersonal issues), but also how they perceive their self-image, efficacy, and aptitude. Ultimately, survivors learn to respond to life based on the protective coping skills they developed as children. Those protective measures appear more or less adaptive based on social context of the survivor. Further, some survivors continually struggle to distinguish real from perceived threats and thus frequently activate the protective mechanisms that they developed as a child. Depending on the social acceptance of the protective mechanisms that survivors use to cope, they may engage therapeutic services to address functioning issues.

⁴ Stephan Collishaw et al., "Resilience to Adult Psychopathology Following Childhood Maltreatment: Evidence From a Community Sample," *Child Abuse & Neglect* 31, no. 3 (2007): 213.

Emerging Adulthood

Today's adolescent population has more prominence in American culture than their predecessors. They also face a myriad of complex challenges that research has never addressed (i.e. the influence of technology). Before the industrial age, the developmental stage of adolescence did not exist as we know it today. Then, only two developmental stages existed, childhood and adulthood. In contemporary scholarship, the adolescent stage continues to expand and stratify. Some theorists partition adolescence into early, middle and late stages of development, though most theorists refuse to lock human development into exact age groups. Stratifying in this way is a noticeable departure from traditional development theories.

Developmental theorists have shed light on the psychosexual (Freud), psychosocial (Erikson), moral (Kohlberg), relational (Gilligan), social embeddedness (Kegan) and faith (Fowler) factors that influence adolescent development. In traditional stage development theory, the adolescent stage is marked by the quest to form a distinguishable identity. Here, adolescent development is dependent on the completion of certain tasks that signal increased maturity and identity fidelity. Successful task completion (i.e., testing limits, participating in rites of passage, beginning to break dependency ties, and exploring identity) is needed for adolescents to transition into young adulthood. Task accomplishment remains a prominent feature in contemporary human development theories, but the composition of those tasks continues to shift with the changing realities of each generation.

Developmental theories prove especially useful when attempting to frame the maturation challenges and progress for certain groups. However, the presumed universality of developmental theories has become the subject of popular critique. One notable critique involves the shared backgrounds (i.e., gender, race, social class) of the theorists and their research subjects. Early developmental theories based their findings on therapeutic experiences with select groups of European, middle-class, mostly male participants, during the industrial age. Their research was based on samples that had little diversity, in turn limiting the generalizability of their findings. Another critique exposes the tendency of developmental theorists to reduce adolescent developmental tasks to the pursuit of adult freedoms. Stratified theories of adolescent development also account for intra-stage tasks that adolescents encounter. Before reaching adulthood, adolescents face developmental tasks such as forming close friendships, structuring identity (though vaguely), and maintaining rule-abiding conduct.⁵ However, achieving these tasks in modern society may not prepare adolescents to embrace adulthood. This inadequacy is evidenced by a growing trend among young adults to delay traditional adult tasks following adolescence such as forming committed romantic relationships, establishing families, or securing a career. A traditional developmental approach to adolescence does not account for the intra-stage tasks (i.e., peer group social aptitude) that manifest in contemporary adolescences, nor does it account for tasks undirected by the quest for adulthood. These critiques give voice to the importance of developing contextually relevant developmental theories.

⁵ Keith B. Burt and Ann S. Masten, "Development in the Transition to Adulthood: Vulnerabilities and Opportunities," in *Young Adult Mental Health*, ed. Jon E. Grant and Marc N. Potenza (New York: Oxford University Press, 2010), 7.

Traditional development theories could not account for the evolving social dynamics that shape which developmental tasks could be validated within specific cultural, racial, gender, geographical and class distinctions. For example, recent research on contemporary factors that influence adolescent and young adult behavior indicate that not only are young adults delaying the age of their first marriage (until their late twenties) but there is also a significant increase in the childbearing rate among unmarried women.⁶ Therefore, traditional perceptions of young adult goals must be reassessed to account for different contextual realities now present in adolescent and young adult development. This observation points to problems associated with adopting developmental theories unconditionally, particularly when working with adolescents whose contextual reality operates in a state of constant flux. When theories do not consider the contextual limitations or fail to acknowledge researcher bias, there is greater potential for misrepresenting reality. Pamela Cooper-White (2000) points out that texts now considered classics in developmental theory (i.e., the works of Erik Erikson, Robert Kegan, and James Fowler) make no specific mention of trauma or abuse.⁷ Therefore, it is important to state that the intersection of developmental theory and trauma theory has only begun to gain prominence in the literature over the last decade and a half.

Contemporary developmental theorist Jeffrey Arnett has popularized the term 'emerging adulthood' to identify the unique nuances of late stage adolescence (ages 18-25 years old). Conceptually, 'emerging adulthood' is fairly new. The term situates this

⁶ National Adolescent Health Information Center, "Fact Sheet on Demographics: Adolescents & Young Adults," (San Francisco, CA: University of California, 2008), 2.

⁷ Pamela Cooper-White, "Opening the Eyes: Understanding the Impact of Trauma on Development," in *In Her Own Time: Women and Development Issues in Pastoral Care*, ed. Jeanne Stevenson-Moessner (Minneapolis: Fortress Press, 2000), 87.

population between traditional adolescence and young adulthood stages of development and recognizes the widening gap between adolescent experimentation and the adoption of adult roles.⁸ Emerging adulthood (elsewhere identified as late-adolescence or early adulthood) represents an expansion of traditional developmental stage theories. Though sometimes referred to as 'protracted adolescence' by mainstream media, emerging adulthood builds on the experimentation tasks started in adolescence and greatly influences identity stabilization.

Emerging adults live somewhat "in between" several facets of life. Emerging adults are surrounded by expectations placed on them by parents, educators, employers, and peers. Emerging adults in this culture also struggle to be both independent of and interdependent with others in their life. In this stage, goals include accepting responsibility for oneself, making independent decisions, and becoming financially independent. Developmental tasks during this stage are marked by instability, self-focus, and feeling-in-between.⁹ American emerging adults have the privilege and challenge of delaying their launch into adulthood. Delayed launch expands the duration of time emerging adults have to devote to identity exploration, but it also prolongs the acceptance of adult commitments.

This research gives significant focus to the impact childhood trauma has on resilience and human development. In particular, it explores the functions of traumatic response, resilience resources, and spiritual identity in emerging adulthood survivor coping. The pivotal transitions that occur during this developmental stage are fertile

⁸ Jeffrey Jensen Arnett, "Emerging Adulthood: A Theory of Development From the Late Teens Through the Twenties," *American Psychologist* 55(2000): 469.

⁹ *Emerging Adulthood: The Winding Road from the Late Teens through the Twenties* (New York: Oxford University Press, 2004). 48.

ground to contextualize resilience development. There is a call throughout resilience research to study its influence across the lifespan. Furthermore, this population is often studied because they offer researchers a vivid picture of adult trajectories (i.e., lifespan impairment).¹⁰ Relevant research topics include adaptation, adjustment, identity development, ego stability, post-traumatic stress, anxiety and depression disorders, and neurological functioning. This research, however, directed its attention to the effects of childhood trauma and resilience on the lives of emerging adult survivors, with a particular interest in how spiritual identity influenced resilience.

Nature of the Problem and Basic Assumptions

Emerging adults bring their unsuccessful attempts to ‘self-right’ challenging situations into therapy. Spiritual meaning making (i.e., purpose) is a common strategy survivors enlist to resolve complicated feelings. Theologian Emmanuel Lartey provides a grounding definition of spirituality for this work. According to Lartey, “*spirituality* refers to the human capacity for a relationship with self, others, world, God, and that which transcends sensory experience, which is often expressed in the particularities of given historical, spatial and social contexts, and which often leads to specific forms of action in the world.”¹¹ As noted previously, how emerging adults utilize spirituality can also complicate the therapy process. It is likely that counselees may disclose how their spiritual beliefs contribute to or hinder their coping during therapy. Spiritual issues

¹⁰ Vincent J. Felitti et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine* 14, no. 4 (1998): 252.

¹¹ Emmanuel Yartekwei Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed. (London; New York: Jessica Kingsley Publishers, 2003). 140-41.

presented in therapy could conflict with the therapist's own values, and the way the therapist handles the conflict depending on the extent of training (i.e., fears, disappointments, and anger with God). While some therapists (e.g. pastoral counselors) choose to engage spirituality as an asset in finding therapeutic solutions, others resist what they believe to be spirituality's negative influence on positive-growth. Spirituality is a subjective experience that does not lend itself to generalizable objective treatment outcomes. Those therapists unfamiliar with ethical approaches to spiritual issues may subjectively treat counselees out of their own experience. The subjective use of spirituality in treatment remains an issue of competence. While most of mental health professions (i.e., psychiatry, psychology, professional counseling, and social work) now call for therapist competence in spiritual assessment and treatment by recommending specialized training in spirituality, religion, and/or theology, few outside of pastoral counseling require specialized training with spirituality or spiritual issues.¹² This reality continues to find advocacy amongst pastoral counselors who are trained both theologically and psychologically to address such issues. The overarching goal of this research is to expand knowledge in the field on effective and ethical uses of spirituality in therapy. Specifically, this thesis examines whether or not cognitive behavioral therapy highlighting spiritual identity development enhances resilience with emerging adult childhood trauma survivors.

This study is predicated on three assumptions. First, development of resilience relies on survivor meaning making that perceives life as both positive and purposeful.

¹² David R. Brown, Elise P. Johnson, and Mark S. Parrish, "Spirituality Assessments: Limitations and Recommendations," *VISTAS 2007 Online* (2007).

Parker and Lee argue that how survivors interpret their abuse greatly influences the coping strategies they engage. The use of problem-solving and meaning making strategies help survivors develop adaptive coping strategies. In contrast, ‘avoidant’ and ‘emotion-focused’ strategies point to more maladaptive coping linked to greater vulnerability to psychological and physical issues. They suggest that ‘meaning-focused’ coping contributes to the formation of positive coping after trauma. Therefore, “increase[ing] a sense of meaning and purpose in life” helps survivors cope with histories of abuse.¹³

Second, it is assumed that spirituality is an integral factor in resilience development after childhood trauma experiences. Peres et al., have written on the benefits of spirituality and religious belief on resilience after traumatic experiences. Religiousness and spirituality have their foundation in the human quest for meaning. Both provide building blocks for constructing narratives and foster the integration of “traumatic sensorial fragments in a new cognitive synthesis.”¹⁴ Moreover, cognitive synthesis integrated with spiritual beliefs can augment supportive therapy and treatments. Peres et al., (2007) writes, “there is a need for more far-reaching research into the impact of the different forms of religious coping on adjustment to traumatic experiences.”¹⁵ Furthermore, relative to the research that exists, few studies investigate the connection between resilience and spirituality among adult childhood trauma survivors and only a handful study this topic with emerging adults.

¹³ Glennys Parker and Christina Lee, "Relationships Among Abuse Characteristics, Coping Strategies, and Abused Women's Psychological Health: A Path Model," *Journal of Interpersonal Violence* 22, no. 9 (2007): 1186.

¹⁴ Julio Peres et al., "Spirituality and Resilience in Trauma Victims," *Journal of Religion and Health* 46, no. 3 (2007): 343.

¹⁵ *Ibid.*, 345-47.

Third, spiritually enhanced resilience development is instrumental in sustaining and improving positive adaptive behaviors. Though ignored by many therapeutic approaches, spirituality has a powerful influence on positive coping.¹⁶ Crawford, O'Dougherty Wright, and Masten note that in its infancy, resilience research acknowledged spirituality, personal religion, and faith as variables for good outcomes with children who had experienced adversity. Over the years, several other studies emerged asserting spirituality as a protective factor. Protective factors range from the “deeply personal beliefs and feelings to the counseling, rituals, activities, and support provided by organized religions.”¹⁷ Beyond the protective factors of spirituality, there are aspects of spiritual development that shape how survivors engage others. According to Crawford, O'Dougherty Wright, and Masten, spirituality promotes resilience across several life-spheres including attachment relationships, social support, guidelines for conduct, moral values, and transformational opportunities in personal growth. Childhood trauma amplifies attachment and conduct challenges for survivors. This research illuminates the ways in which emerging adult spirituality affects positive coping and relational engagement.

This work directs its attention to the effects of spirituality on survivor resilience and subsequent cognitive structures. Survivor’s cognitive interpretations have direct influence on the ability to cope. After traumatic experiences, resilience emanates from positive meaning making constructed by survivors. Current research links survivor

¹⁶ Kenneth I. Pargament, *The Psychology of Religion and Coping* (New York, London: The Guilford Press, 1997). 137-38.

¹⁷ Crawford, O'Dougherty Wright, and Masten, "Resilience and Spirituality in Youth," 355.

meaning making to a sense of purpose.¹⁸ Concepts of hope and purpose are deeply embedded in spirituality, and thus make spirituality an appropriate framework in this context.

Study Background and Purpose

The current study seeks to determine what effect, if any, incorporating spirituality into cognitive-behavior focused therapy would have on enhancing resilience. The sample population is limited to emerging adults with mild to moderate experiences of childhood trauma. Through a singular lens, this research explores the resources and developmental challenges that manifest following experiences of childhood maltreatment (referred to here as childhood trauma). The study defines childhood trauma as having experienced incidents of childhood abuse (emotional, physical, or sexual abuse) or childhood neglect (emotional or physical neglect). From a broader perspective, this work expands current developmental literature regarding childhood trauma, resilience, and spiritual identity. The triangular focus on all three focal points makes this study different, particularly within the context of contemporary early adulthood. The method used to tackle this complex topic involves an extensive literature review of childhood trauma, resilience, and spiritual identity. In addition to adding knowledge to the field on these topics, the current work furthers the dialogue between theological and psychological approaches to healing. Theology is the study of faith seeking understanding. Theology provided a practical foundation to explore the complexities of developmental suffering and self-

¹⁸ Peres et al., "Spirituality and Resilience in Trauma Victims," 346.

formation, by responding to underlying faith questions that intermingle with survivor resilience.

Before exploring the theological implications, psychological treatment modalities were examined. Cognitive Behavioral Therapy (CBT) approaches have a great deal of supporting research with emerging adults and childhood trauma.¹⁹ CBT models emphasize thought reframing and behavior modification to mold learned responses into more adaptive behavior. CBT approaches lean on a person's ability to identify, reflect on, and choose alternative thoughts thereby changing certain behaviors. Though a great number of research studies have identified CBT as an effective treatment approach for this population, this study seeks to address issues presented by some pastoral counselors who challenge the universality of CBT's mechanistic approach and less thorough approach to symptom relief for mental illness.²⁰ The current research incorporated spirituality and cognitive behavioral therapy, with particular attention to these pastoral counseling considerations.

Research Design and Methodology

This study was designed to investigate a) what influence, if any, spiritual identity development has on enhancing resilience with 18-25 year old childhood trauma survivors

¹⁹ Gretchen M. Thomas, "Cognitive Behavioral Treatment of Traumatized Adults: Exposure Therapy," in *Treatment of Traumatized Adults and Children*, ed. Allen Rubin and David W. Springer (Hoboken, N.J.: John Wiley & Sons, 2009), 37-39.

²⁰ Kirk A. Bingaman, *Treating the New Anxiety: A Cognitive-Theological Approach* (Lanham, Maryland: Jason Aronson, 2007). 11. Clinebell and other pastoral counselors take issue with philosophical assertions that the early behaviorisms focus of cognitive-behavioral therapy presented a very mechanistic style of therapy that targeted symptom relief as the primary goal. Pastoral counselors, who traditionally align their therapeutic approaches with psychodynamic therapies, challenge the assumption that symptom relief is equivalent to permanent psychological and behavioral change.

b) identifiable spiritual elements and themes (i.e., God/Fate, hopelessness, life's purpose, and meaning making) that positively influence coping with childhood trauma survivors and c) effective methods of incorporating spirituality into brief cognitive behavioral therapy. The findings offered two key contributions. First, to lay the foundation for an integrative brief therapeutic intervention that both brings into awareness individual maladaptive coping mechanisms and restructures cognitive coping by illuminating undiscovered (or unacknowledged) resources nestled in survivor spirituality and resiliency. Second, the intervention method was developed to increase anxiety thresholds, augment coping skills, and serve as a foundation for the development of a spiritually focused cognitive behavioral therapy approach for use with emerging adult childhood trauma survivors.

The subjects in this study are college students ages 18-25 years old residing in a large metropolitan city in the southeastern region of the United States. Students were asked to discuss what role, if any, spirituality played in their resilience, and to participate in brief cognitive behavioral therapy sessions that incorporated spiritual elements (i.e., hope, purpose, and meaning making). Students from a private university were recruited using flyers and classroom presentations. All students who met the study criteria had an equal opportunity to be randomly selected to participate in all phases of the study. The study required between 5-6 hours of participant's time and no compensation was given for participation in this study. All participants received referral information for additional therapy services at the beginning and end of the study.

This study utilized a two phase mixed method research approach (quantitative and qualitative methods). Participants who participated in this study completed an Informed

Consent Form and two pre-screen tools, the Demographic Information Sheet and Childhood Trauma Questionnaire (CTQ). Participants who met study criteria were assigned 3-digit code identifiers by the principal investigator, who solely maintained all identifiable data. After the two pre-screen tools were completed, the instruments were scored and reviewed to verify that the participants met study criteria. Students who met study criteria were then entered into phase one of the study.

In phase one, participants completed two assessment instruments, the Connor-Davidson Resilience Scale (CD-RISC) and the Royal Free Interview for Spiritual and Religious Belief (RFI). Ten participants were randomly selected using coded identifiers, from subjects in the sample pool who met the phase one criteria. Those ten participants attended four fifty-minute therapy sessions using a cognitive behavioral therapy approach that incorporated discussion topics from the phase one assessments (CD-RISC and the RFI). Assessments and therapy sessions were held in private counseling office space reserved at a local counseling center. All study subjects were re-tested three weeks after the therapy intervention sessions were complete. In phase two, the ten sample group participants completed a qualitative post-intervention interview designed for this study. The sample group also completed follow up sessions after the study was complete. The follow up interview was analyzed to codify themes relevant to the development of a spiritually focused cognitive behavioral approach.

The approach to therapeutic spiritual integration in this study is drawn from a broad range of evidence-based theories and qualitative findings. The fields of psychiatry, psychology, social psychology, anthropology, and pastoral counseling have produced a wealth of data regarding mental health and positive change (cognitive and behavioral).

Therefore, this study limited its scope to specific lenses of human development, pastoral theology, pastoral counseling and clinical treatment. The diversity of knowledge on this topic is extensive across the academy and clinical practice. The boundaries of this dissertation do not permit the entire scholarship on these topics to be covered comprehensively. Therefore, this study limits its focus to the specific topics of childhood trauma, resilience and spirituality within the context of emerging adult survivors. This work also limits the generalizability of these results to the specified study population.

In summary, this research is timely because the fields of pastoral counseling and professional counseling are beginning to dialogue about the mutual contributions each brings to the process of therapeutic intervention with individuals who exhibit maladaptive trauma responses.²¹ This study is designed to enrich the dialogue between the social sciences and theology by contextualizing an integrative therapeutic approach — grounded in both theological and psychological approaches to healing and mental health. Both pastoral theologians and clinicians are currently exploring how spirituality influences resiliency, but few have researched how both aspects can be integrated for cognitively reframing.²² Currently, there are no other brief cognitive behavioral therapy approaches that incorporate both spiritual identity development and resilience development as reframing resources for therapy with emerging adult childhood trauma survivors. This pilot study resulted in the provisional proposal of an integrative therapeutic intervention that brings into awareness survivor maladaptive coping

²¹ Brown, Johnson, and Parrish, "Spirituality Assessments: Limitations and Recommendations."

²² Kenneth I. Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred* (The Guilford Press, 2007). 272-75.; Jill Snodgrass, "Toward Holistic Care: Integrating Spirituality and Cognitive Behavioral Therapy for Older Adults," *Journal of Religion, Spirituality & Aging* 21, no. no. 3 (2009): 227-28.

mechanisms and cognitive framing by illuminating unacknowledged resources nestled in survivor spirituality and resiliency.

Topics in this dissertation reflect the experiences shared by counselees in my private practice and college counseling setting. In therapy, emerging adults have shared the horrors of their childhood abuse and neglect and their glimmers of hope that fueled their resilience. The prevalence of these experiences have urged me to propose a therapeutic approach that will build on the resources that strengthen their resilience and better orient therapists to help them discover other resources that may enhance their resilience.

This dissertation has two main movements. After the introduction and literature review, *Part I: Treatment and Healing Approaches* are discussed in Chapters 2 and 3. *Part II: Research Methodology and Discussion* are covered in Chapters 4, 5 and 6. The introduction provides a brief overview of the study's purpose, design, and dissertation topics (childhood trauma, resilience, and spirituality) with emerging adult childhood trauma survivors. Chapter 1 provides a thorough literature review of the therapeutic influences of the dissertation topics. Chapter 2 lays the theoretical foundations for a spiritually integrative cognitive behavioral therapy approach. Chapter 3 explores a theological framework for healing work with childhood trauma survivors and outlines pastoral counseling considerations with this population. Chapter 4 details the research method guiding this dissertation and Chapter 5 reveals the results of the research conducted. Lastly, Chapter 6 concludes the dissertation with research implications and suggestions for future research.

CHAPTER 1: LITERATURE REVIEW

Though the concepts and terminology have varied across history, trauma has always existed for humans following unexpected life-threatening events. Tracking a history of trauma would be complicated by the derivations of meaning in different contexts and cultures.²³ Trauma can be a personal or communal experience. In general, the presence of trauma is dependent upon the meaning attached to life-threatening events. Trauma is a personal response to perceived danger. However, one's inability to conceptualize traumatic experiences as traumatic does not invalidate the experience of trauma, especially in cases where traumatic responses are evident. Trauma is a reality in the human experience, but so is humanity's ability to survive traumatic experiences and mobilize internal strengths in resilient ways.

Several fields of study including psychology, sociology, anthropology, public health, criminology, and theology have researched the issue of childhood trauma. Each discipline seeks to understand the factors associated with childhood trauma. Social sciences (i.e., sociology, anthropology, public health, and criminology) have predominately led the way in researching preventative measures.²⁴ This chapter will review the literature of several human science fields as well as the field of theology to provide a landscape for the current research.

²³ Brett D. Thombs et al., "Cultural Sensitivity in Screening Adults for a History of Childhood Abuse: Evidence from a Community Sample," *JGIM: Journal of General Internal Medicine* 22, no. 3 (2007): 368.

²⁴ Dante Cicchetti and W. John Curtis, "Multilevel Perspectives on Pathways to Resilient Functioning," *Development and Psychopathology* 19, no. 03 (2007): 627-28.

The field of pastoral theology has an abundant repository of scholarship, and continues to expand as more culturally diverse reflections and critiques emerge. This work narrows the scope of theological reflection to literature regarding the spiritual development following childhood abuse and neglect. Pastoral theology is “concerned with how theological activity can inform and be informed by practical action in the interests of making an appropriate, effective Christian response in the modern world.”²⁵ Pastoral theology also attends to the “practical Christian pastoral care of individuals and groups.”²⁶ In this chapter, pastoral theology literature will be reviewed with an emphasis on theological approaches to childhood trauma and resilience.

In summary, this chapter will review literature on childhood trauma, resilience and spirituality with emerging adults. This chapter limits its discussion to information found in a review of current social science and theological research regarding childhood trauma, resilience and spirituality. The first section describes the impact of childhood trauma on human development. The second section reviews Resilience Theory and its influence on emerging adults. Lastly, the third section explores how emerging adult spirituality influences resilience and benefits the therapeutic process.

CHILDHOOD TRAUMA, RESILIENCE, AND SPIRITUALITY

TRAUMA OVERVIEW

Definitions of trauma vary enormously. In a broad sense, trauma occurs when persons experience psychological distress triggered by an overwhelming fear of death or

²⁵ James Woodward and Stephen Pattison, *The Blackwell Reader in Pastoral and Practical Theology* (Malden: Blackwell Publishers, 2000). 338.

²⁶ *Ibid.*

dying, or in some cases witnessing a death. The experience of trauma is relative to the individual involved and that individual's sense of helplessness in the event. Surveys conducted nation-wide in community-based centers found that 55%-90% of Americans have experienced at least one traumatic incident.²⁷ Briere and Scott (2006) identify twelve types of major traumatic experiences including Natural Disasters, Mass Interpersonal Violence, Large-Scale Transportation Accidents, House or Other Domestic Fires, Motor Vehicle Accidents, Rape and Sexual Assault, Stranger Physical Assault, Partner Battery, Torture, War, Child Abuse, and Emergency Worker Exposure to Trauma.²⁸ Each type of trauma represents some external person or power acting in a threatening manner unexpectedly. Each type of trauma has the capacity to affect survivors differently and affect different dimensions of a survivors' development.

Several terms have been used to classify trauma. The term "traumatic stress" was prominently used in early trauma research. Traumatic stress describes the impact of sustained traumatic exposure.²⁹ Lenore Terr (1991) who is frequently cited for her contributions to childhood trauma research classifies childhood trauma based on whether it was experienced as a "single blow" or "repeated trauma."³⁰ More recently, the term "complex trauma" has been used to describe "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal

²⁷ Roger D. Fallot and Maxine Harris, "Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol," in *Community Connections* (Washington, D.C.2009).

²⁸ John Briere and Catherine Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment* (Thousand Oaks, Calif.: Sage Publications, 2006). 4-9.

²⁹ Paula P. Schnurr and Bonnie L. Green, *Trauma and Health: Physical Health Consequences of Exposure to Extreme Stress* (Washington, DC: American Psychological Association, 2004).

³⁰ Lenore Terr, *Too Scared to Cry: Psychic Trauma in Childhood* (New York: Harper & Row, 1990).

nature.”³¹ Bessel van der Kolk (2005) argues that complex trauma is a major contributing factor in neurobiological changes that occur after repeated experiences of childhood maltreatment. The Complex Trauma Task force for the National Child Traumatic Stress Network proposes the recognition of a “Developmental Trauma Disorder” in the developmental diagnosis category for the forthcoming DSM-V.³² Based on recent research that indicates the developmental impact of trauma on personality development, psychological wellness and neurological functioning, a “Developmental Trauma Disorder” diagnosis would acknowledge the profound effect of childhood maltreatment on multiple dimensions of functioning. What remains consistent with previous and proposed diagnostic criteria is an underlying emphasis on the developmental disruption of trauma, particularly when that trauma occurs in childhood. The remainder of this chapter will explore current literature on childhood maltreatment, resilience, spirituality/religion and the relationship each has to emerging adults with histories of childhood trauma.

Social Sciences Literature

CHILDHOOD TRAUMA

Thirty years ago, Rizley and Cicchetti (1981) called attention to the complexity of conceptualizing childhood maltreatment. More specifically the effect of childhood maltreatment on human development and the different dimensions of development it

³¹ Ibid.; Bessel A. van der Kolk, "Developmental Trauma Disorder," *Psychiatric Annals* 35, no. 5 (2005): 402.

³² "Developmental Trauma Disorder," 406.

affects.³³ According to English et al., (2005) without Rizley and Cicchetti's call for a conceptualization and taxonomy systems that shifted the way research was conducted, the field would not reliably capture the developmental implications for different dimensions of child maltreatment (i.e., emotional intelligence, impulsivity control, and empathic cognitions). Researchers have since learned that the nature of developmental theory warrants longitudinal as well as inter-dimensional studies on the effects of childhood maltreatment. Different dimensions of maltreatment could lead to different developmental outcomes.

Several factors contribute to the "underlying structure of maltreatment" including the age at first report, frequency, severity, chronicity, duration, and developmental period in which the child experienced the maltreatment. If maltreatment went unaddressed during an early stage of development, researchers believe that later development could be compromised. Cicchetti & Toth's (1995) basic theory argues that maltreatment consequences manifest differently in each survivor as a result of unsuccessful developmental stage negotiation.³⁴ "However, some maltreated children may be resilient despite their experiences."³⁵ Therefore, though childhood maltreatment does have a significant impact on how survivors matriculate through developmental tasks including cognitive and behavioral tasks, resilience is a developmental anomaly following maltreatment.

³³ Ross Rizley and Dante Cicchetti, "Editors' notes," *New Directions for Child and Adolescent Development* 1981, no. 11 (1981). in Diana J. English et al., "Defining Maltreatment Chronicity: Are There Differences in Child Outcomes?," *Child Abuse & Neglect* 29, no. 5 (2005): 576.

³⁴ Dante Cicchetti and S. Toth, "A Developmental Psychopathology Perspective on Child Abuse and Neglect," *Journal of the American Academy of Child and Adolescent Psychiatry* 34, no. 5 (1995).

³⁵ English et al., "Defining Maltreatment Chronicity: Are There Differences in Child Outcomes?," 576.

Not all children who experience abuse and neglect (maltreatment) have the same consequences. Childhood abuse and neglect have long-term effects that worsen mental and physical health.³⁶ Psychiatrists have labeled the clinical after-effects of childhood maltreatment, childhood trauma. The National Center for Chronic Disease Prevention and Health conducted research in conjunction with Kaiser Permanente and over 17,000 participants to study the long-term physical and clinical effects of childhood trauma on adults. This study uses the term *Adverse Childhood Experiences* (ACE) to designate childhood abuse, neglect, and exposure to other traumatic stressors. The study links childhood abuse and neglect with the effects of childhood trauma in adulthood. The ACE study was groundbreaking in many ways but particularly because its participants were more diverse than previous retrospective recall studies. Most of the participants were college-educated, financially solvent individuals ranging in age from 19-60+ years old. Although this study did not test psychological functioning, the study suggests that the short- and long-term outcomes of childhood trauma exposure include a multitude of health and social problems. Participants were surveyed regarding histories of childhood maltreatment and family dysfunction. Participant's responses were scored to assess correlation with their current health status, behaviors and the total amount of their stress during childhood. The study asserted that participants with increased ACE scores had an increased risk for health problems including alcoholism and alcohol abuse, depression, health-related quality of life, obesity, illicit drug use, risk for intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts,

³⁶ Kristen W. Springer et al., "Long-Term Physical and Mental Health Consequences of Childhood Physical Abuse: Results From a Large Population-based Sample of Men and Women," *Child Abuse & Neglect* 31, no. 5 (2007).

unintended pregnancies, early initiation of smoking, early initiation of sexual activity and adolescent pregnancy. These findings are supported by other studies of adult childhood trauma survivors.³⁷ The ACE results have since been used to study health outcomes in chronic disease, reproductive health / sexual behavior, health risk behaviors, mental health, and victimization and perpetration.

Pertinent to this research, the ACE study indicates that 64% of all participants reported having experienced childhood maltreatment. By type, 11% reported emotional abuse, 28% physical abuse, 21% sexual abuse, 10% physical neglect, and 15% emotional neglect.³⁸ The study demographics include 46% male and 54% female participants and the majority of the participants having attended college. Abuse and neglect Definitions for child abuse and neglect vary widely across the literature. This study defines abuse and neglect using composite definitions from the ACE study and the Childhood Trauma Questionnaire. Chart 1.1. lists the definitions of abuse and neglect used in this study.

³⁷ Daniel P. Chapman et al., "Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood," *Journal of Affective Disorders* 82, no. 2 (2004).; Naomi M. Simon et al., "Childhood Maltreatment Linked to Greater Symptom Severity and Poorer Quality of Life and Function in Social Anxiety Disorder," *Depression and Anxiety* 26, no. 11 (2009).; Bernard F. Fuemmeler et al., "Adverse Childhood Events are Associated with Obesity and Disordered Eating: Results From a U.S. Population-based Survey of Young Adults," *Journal of Traumatic Stress* 22, no. 4 (2009).

³⁸ Division of Adult and Community Health, "Data and Statistics: Prevalence of Individual Adverse Childhood Experiences," National Center for Chronic Disease Prevention and Health Promotion, <http://www.cdc.gov/ace/prevalence.htm#ACED>.

Table 1.1 – Abuse and Neglect Definitions

Abuse and Neglect Definitions	
The following categories would have occurred in the survivor’s first 18 years of life.	
Emotional Abuse	Verbal assaults on a child’s sense of worth or well-being, or any humiliating, demeaning, or threatening behavior directed toward a child by an older person. Children facing emotional abuse often experience a parent or older person swearing at them, insulting them, putting them down, or acting in ways that made the children think they might be physically hurt.
Physical Abuse	Bodily assaults on a child by an older person that pose a risk of, or result in injury that may often include pushing, grabbing, slapping, having an object thrown at the child, or hitting the child with a thrown object, any of which injures or leave marks on the child.
Sexual Abuse	Sexual contact or conduct between a child and older person. Explicit coercion is a frequent but not essential feature of these experiences and is perpetrated by an adult or person at least 5 years older than the child. Sexual abuse includes touching, fondling in a sexual way or having a child touch the adults or older person’s body in a sexual way including attempted oral, anal, or vaginal intercourse with them or actually had oral, anal, or vaginal intercourse with the child.
Emotional Neglect	The failure of caretakers to provide a child’s basic psychological and emotional needs, such as love, encouragement, belonging, and support including being made to feel special and loved, and feeling supported and protected by the child’s primary caregivers.
Physical Neglect	The failure of caregivers to provide a child’s basic physical needs, including food, shelter, safety and supervision, and health. Children being physically neglected may report often not having enough to eat (particularly if their caretakers substance abuse interfered with their care), wearing dirty or unmaintained clothing, and possibly have no one to take the child to the doctor in the event of an injury.

Source: Data adapted from the Division of Adult and Community Health, “Data and Statistics: Prevalence of Individual Adverse Childhood Experiences,” National Center for Chronic Disease Prevention and Health Promotion and David P. Bernstein and Laura Fink, *Childhood Trauma Questionnaire: A retrospective self-report manual* (San Antonio, TX: The Psychological Corporation, 1998).

These statistics offer compelling evidence that childhood histories of abuse and neglect not only impact how survivors understand themselves, but also how they function in the world. Some survivors develop symptoms closely aligned with posttraumatic stress syndrome. Research has shown that childhood abuse and neglect can produce long-term psychological distress including an increased likelihood of experiencing sexual or physical assault later in life,³⁹ having less of a sense of empowerment,⁴⁰ vulnerability to

³⁹ Catherine C. Classen, Oxana Gronskaya Paless, and Rashi Aggarwal, "Sexual Revictimization: A Review of the Empirical Literature," *Trauma, Violence & Abuse* 6, no. 2 (2005): 103-29.; Ross Macmillan, "The Life Course Consequences of Abuse, Neglect, and Victimization: Challenges for Theory, Data Collection, and Methodology," *Child Abuse & Neglect* 33, no. 10 (2009).; Cathy Spatz Widom, Sally J.

immature psychological defensive styles,⁴¹ personality disorders,⁴² and psychosis in adulthood.⁴³ In addition, chronic experiences of childhood trauma have a more substantial impact on the developmental process. The *Diagnostic and Statistical Manual-Fourth Edition's (DSM-IV)* field trial studied treatment-seeking traumatized individuals and “found that victims of prolonged interpersonal trauma, particularly trauma early in the life cycle, had a high incidence of problems with (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning.”⁴⁴ For this reason, the current work chose to study mild to moderate experiences of both acute and chronic childhood interpersonal trauma with emerging adults.

Interpersonal Childhood Trauma

Interpersonal trauma is an increasingly popular term associated with the traumatic effects of childhood maltreatment, namely child abuse and neglect. Allen (2005)

Czaja, and Mary Ann Dutton, "Childhood Victimization and Lifetime Revictimization," *Child Abuse & Neglect* 32, no. 8 (2008).; David Finkelhor, Richard K. Ormrod, and Heather A. Turner, "Re-Victimization Patterns in a National Longitudinal Sample of Children and Youth," *Child Abuse & Neglect* 31, no. 5 (2007).

⁴⁰ Victoria L. Banyard and Lindsey E. LaPlant, "Exploring Links Between Childhood Maltreatment and Empowerment," *Journal of Community Psychology* 30, no. 6 (2002).

⁴¹ Ralf Nickel and Ulrich T. Egle, "Psychological Defense Styles, Childhood Adversities and Psychopathology in Adulthood," *Child Abuse & Neglect* 30, no. 2 (2006).

⁴² Theodore P. Beauchaine et al., "Multifinality in the Development of Personality Disorders: A Biology x Sex x Environment Interaction Model of Antisocial and Borderline Traits," *Development and Psychopathology* 21, no. 3 (2009).; Jill Lobbstael, Arnoud Arntz, and David P. Bernstein, "Disentangling the Relationship Between Childhood Maltreatment and Personality Disorders," *Journal of Personality Disorders* 24, no. 3 (2010).

⁴³ John Read et al., "Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psychosocial Model," *Clinical Schizophrenia & Related Psychoses* 2, no. 3 (2008).

⁴⁴ Bessel A. van der Kolk et al., "Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma," *Journal of Traumatic Stress* 18, no. 5 (2005): 389.

categorizes three types of trauma: (1) impersonal trauma, (2) interpersonal trauma and (3) attachment trauma. He describes *impersonal trauma* as an experience that “happens by accident” (e.g., tornados, earthquakes).⁴⁵ On the other end of the spectrum he defines *attachment trauma* as trauma following the assault by someone with whom the survivor had a close emotional connection and some degree of dependence. It would appear that child abuse and neglect would be linked to Allen’s definition of attachment trauma, but his definition of interpersonal trauma more accurately define the concept of abuse and neglect in this study. He defines *interpersonal trauma* as trauma “deliberately inflicted by others, as in an assault.”⁴⁶ His descriptions of attachment trauma and interpersonal trauma overlap somewhat where child abuse and neglect are concerned. Although abuse may be perpetrated by known individuals with whom the child has a close emotional bond and dependency, it may also come at the hands of a distant or unknown individual. By either, the act of abuse is definitely an assault on the child. This work focuses on interpersonal childhood trauma to include abuse and neglect perpetrated by caregivers and other individuals in the child’s life who may exist outside of emotionally close relationships (i.e., causal associations or unfamiliar adults). This would include interactions between the child and authority figures/community members (e.g., coaches, mentors, or ministers).

Allen’s perspective of attachment trauma does offer a useful starting point to explore the developmental interpersonal challenges that survivors may face. According to Allen, childhood trauma occurs in the context of attachment relationships and includes

⁴⁵ Jon G. Allen, *Coping with Trauma: Hope Through Understanding*, 2nd ed. (Washington, DC: American Psychiatric Pub., 2005). 7.

⁴⁶ Ibid.

child abuse, physical abuse, sexual abuse, emotional abuse, and neglect. Childhood trauma can disrupt an individual's capacity to make attachment relationships and renders the individual more vulnerable to later trauma.⁴⁷ He highlights these traumatic experiences because they “hamper our capacity to form secure attachment relationships, and this capacity must be restored.”⁴⁸ Allen suggests that childhood trauma can disrupt an individual's capacity to make attachment relationships and renders an individual more vulnerable to later trauma.⁴⁹ Sanderson (2010) builds on Allen's work by expanding the understanding of interpersonal trauma to also include features that complexify trauma experiences such as prolonged exposure to trauma, multiple types, repeated abuse within relationships, and abuse committed by persons in positions of trust.⁵⁰ Sanderson presents a thicker description of issues surrounding interpersonal trauma than Allen, but she too minimizes her focus to abuse committed within close attachment relationships when the child was dependent on the adult perpetrator.

Interpersonal trauma associated with child abuse carries with it numerous developmental challenges associated with interpersonal functioning and neurologically regulated behavior. Traumatic experiences shape how survivors construct reality.⁵¹ Children might not readily understand abuse and neglect as being traumatic. “It is not until the person is able to understand the meaning of such violations that they can

⁴⁷ Ibid., 26.

⁴⁸ Ibid., 354.

⁴⁹ *Coping with Depression: From Catch-22 to Hope* (Washington, DC: American Psychiatric Pub., 2006). 67-69.

⁵⁰ Christiane Sanderson, *Introduction to Counselling Survivors of Interpersonal Trauma* (London; Philadelphia: Jessica Kingsley Publishers, 2010). 23.

⁵¹ Barbara Rubin Wainrib, *Healing Crisis and Trauma with Body, Mind, and Spirit* (New York: Springer Publishing, 2006). 76-80.

legitimize, and label it as abuse or trauma.”⁵² When children are not able to connect meaning with the violations they experience, the resulting attempts to navigate the after-effects of trauma encounter major challenges.

Judith Herman (1997) writes “to study psychological trauma is to come face to face both with the human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means to bear witness to horrible events.”⁵³ What makes traumatic events so seismic in an individual child’s life is largely influenced by the degree to which that child’s normal ability to adapt is overwhelmed. Herman, renowned for her work with trauma and recovery, would say that traumatic events overwhelm the child’s “ordinary systems of care that [give] a sense of control, connection and meaning.”⁵⁴ Chronic child abuse and neglect force children to adjust to environments that feel consistently threatening and require “constant alertness.”⁵⁵ That sense of always being on alert develops into vigilant scanning skills, often overused to anticipate possible danger. This occurs even when no known danger can be identified. Heightened states of arousal and situation avoidance connected with traumatic responses result in increased startle reactivity (reflex responses to sudden intense stimulus).⁵⁶ Survivors are also susceptible to constant traumatic re-experiencing that can be triggered by certain environments or relationship interactions. The developmental process can be hindered by remaining in environments that disrupt the re-building of trusting relationships, dissociative features in survivors, if survivors construct meaning that

⁵² Sanderson, *Introduction to Counselling Survivors of Interpersonal Trauma*: 24.

⁵³ Judith L. Herman, *Trauma and Recovery* (BasicBooks, 1997). 7.

⁵⁴ *Ibid.*, 34.

⁵⁵ *Ibid.*, 99.

⁵⁶ Tanja Jovanovic et al., "Childhood Abuse is Associated with Increased Startle Reactivity in Adulthood," *Depression and Anxiety* 26, no. 11 (2009).

justifies the abuse or neglect, or survivor attempts to cloak self-blame with social altruism. Herman identifies these ways of being as having a ‘double self.’⁵⁷ By ‘double self,’ she means that the children of abuse perceive themselves to have some ‘inner badness’ but they attempt to be good in hopes of concealing the abuse.

Herman says there are three major forms of adaptation: (1) elaborate dissociative defenses, (2) development of a fragmented identity, and (3) pathological regulation of emotional states.⁵⁸ Childhood experiences of chronic abuse and neglect often lead to fragmented personality organization that prevents the integration of “knowledge, memory, emotional states and bodily experiences” into consciousness.⁵⁹ Fragmented personality development interferes with the formation of identity and the development of a consistent sense of independence. Gaps in identity development and autonomy leave survivors vulnerable to repeated harm from self and others. Although survivors may press as eagerly as their peers towards adulthood, unexpected residuals from trauma may interfere with their adaptation to life as an adult. According to Herman, issues of trust, autonomy and initiative persist as survivor’s approach early adulthood. In early adulthood, survivors encounter particular issues associated with establishing and maintaining independence and intimacy.

Complex interpersonal trauma “is connected with a specific type of bond, mainly a dysfunctional one (ambivalent, avoidant, disorganized, dissociative: Bowlby, 1973)” and usually involves chronic injury or multiple types of abuse.⁶⁰ Repeated betrayals of

⁵⁷ Herman, *Trauma and Recovery*: 103.

⁵⁸ *Ibid.*, 110.

⁵⁹ *Ibid.*, 107.

⁶⁰ Agnieszka Widera-Wysocza, "Interpersonal Trauma as Chronic and Complex," in *Interpersonal Trauma and Its Consequences in Adulthood* (Cambridge Scholars Publisher, 2010), 18.

trust by known persons contribute to the fragmenting of self-structures and a loss of self-agency. As a protective function, children engage defensive structures such as dissociation, splitting or compartmentalizing to manage the oscillating reality of the betrayal and their idealization of the abuser. Following complex interpersonal trauma, children experience self-blame and shame connected with over-exaggerated assumptions of control in the abuse encounter(s) or an overall sense of responsibility for the abuse or neglect. Unaddressed self-blame fosters a sense of being inherently flawed that could affect relationships in an unconstructive manner throughout the life cycle. According to Sanderson (2010), adult survivors report feeling overly responsible for their abuse encounters. They also have a façade of self-sufficiency, invulnerability, fierce independence, and rigid defense systems that oscillate between protective retreating and self-persecution to prevent exposing vulnerability. On the opposite end of the spectrum of traumatic response, survivors also report experiences of intense rage, aggression, and a preoccupation with revenge or retribution.⁶¹ The psychological trauma of child abuse and neglect not only threatens children's way of being in the world, but the effects of abuse and neglect also fuel resulting assumptions of danger in close relationships, especially with authority figures. Counselees who might otherwise be considered socially high functioning (e.g., stable employment, college-level education, socially engaged) might present in therapy with adjustment disorders triggered by a situational crisis that generate intense anxiety and sometimes prompt socially inappropriate behavioral responses.

⁶¹ Martin H. Teicher, "Scars That Won't Heal: The Neurobiology of Child Abuse," *Scientific American* 286, no. 3 (2002). in Sanderson, *Introduction to Counselling Survivors of Interpersonal Trauma*: 107-08.; English et al., "Defining Maltreatment Chronicity: Are There Differences in Child Outcomes?."

Researchers have also noted vulnerabilities in survivor neurological functioning following childhood trauma.

Chronic maltreatment in early life has been linked to increased vulnerabilities in the cognitive, affective, behavioral, physiological, relational, and ‘self-attributional’ domains.⁶² Recent research sheds light on the impact of childhood trauma on development neurological abnormalities. Daniel Siegel (2012) has written extensively on ‘interpersonal neurobiology.’ Interpersonal neurobiology studies “how the mind emerges from the substance of the brain and is shaped by our communication within interpersonal relationships.”⁶³ Siegel’s work asserts that childhood interpersonal trauma alters brain functioning. Right and left brain hemispheres develop sequentially in early childhood. The right hemisphere processes nonverbal information, perceptions of emotion, the regulation of the autonomic nervous system, and social cognitions. In contrast, the left-brain hemisphere processes human linguistics, logic and linear thinking. According to Siegel, “trauma may induce separation of the hemispheres, impairing the capacity to achieve [the] complex, adaptive, self-regulatory states.”⁶⁴ Bessel van der Kolk (2005) indicates that other neurobiological changes occur in children following maltreatment such as issues with emotional regulation, issues with identifying and verbalizing feelings, interruptions in how children integrate sensory information, and how they solidify

⁶² Kristine Jentoft Kinniburgh et al., "Attachment, Self-Regulation, and Competency," *Psychiatric Annals* 35, no. 5 (2005).

⁶³ Daniel J. Siegel, *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are*, 2nd ed. (New York: Guilford Press, 2012). 2.

⁶⁴ Marion Fried Solomon and Daniel J. Siegel, *Healing Trauma: Attachment, Mind, Body, and Brain*, Norton Series on Interpersonal Neurobiology (New York: W.W. Norton, 2003). 15.; Diana Fosha, Daniel J. Siegel, and Marion Fried Solomon, *The Healing Power of Emotion: Affective Neuroscience, Development, and Clinical Practice*, The Norton series on interpersonal neurobiology (New York: W.W. Norton & Co., 2009). 119-23.

emotional and cognitive information.⁶⁵ In addition, childhood abuse and neglect increase vulnerabilities to other neurological issues including the modulation of physiological arousal and the capacity to communicate experiences with descriptive language.

New neurological research is conducted in this field each year. Each new generation of research builds resources that inform therapy and treatment design with survivors. As the field expands and more childhood maltreatment research is conducted on life cycle development, the contributions of neurological development will surely be at the forefront. Yates (2007) studied neurological development following childhood emotional abuse. Childhood emotional abuse affects psychological outcomes and alters neurophysiological stress responses which results in increased susceptibility to stress, anxiety, depression, and other problems of adaptation.⁶⁶ Miller et al., (2009) build on existing research that links childhood adversity to higher risk of adult depression. They found that adult abuse survivors have lower serotonergic system functioning (5-HTT BP_P) that may “represent a biological pathway through which early life stress predisposes to the development of subsequent psychiatric illness, including major depressive disorder.”⁶⁷ Jovanovic and Ressler (2010) focused their work on the neurobiological factors related to fear inhibition following childhood maltreatment. Their work suggests ‘translational methods’ (research analysis methods) enhance fear inhibition and improve

⁶⁵ van der Kolk, "Developmental Trauma Disorder," 406.

⁶⁶ Tuppett M. Yates, "The Developmental Consequences of Child Emotional Abuse: A Neurodevelopmental Perspective," *Journal of Emotional Abuse* 7, no. 2 (2007): 12.

⁶⁷ Jeffrey M. Miller et al., "Reported Childhood Abuse is Associated with Low Serotonin Transporter Binding In Vivo in Major Depressive Disorder," *Synapse* 63, no. 7 (2009): 1-2.

psychiatric outcomes for survivors.⁶⁸ These results highlight just a few of significant neurological issues childhood trauma survivors face over time.

Childhood trauma has lasting characterological effects on survivors. These traumas are compounded by childhood feelings of powerlessness, lack of control, or betrayal when the traumatic event is initiated by an adult that the child perceives to be an authority. In these cases, the child's defenses are rendered inadequate to resist being overpowered by authority-figure privilege. The additional interpersonal conflict of relating to the initiators of the trauma can all but emotionally cripple healthy coping in traumatized children. After traumatic experiences such as these children are often left with feelings of guilt and shame associated with their inability to prevent or stop the incident from happening. Children left in the wake of this type of trauma assume an exaggerated sense of responsibility for the incident and guilt about participating in an inappropriate way. This guilt then shapes how these children develop their defense mechanism for coping with stressful situations. Humans have innate fight or flight response to perceived threat. Just as the physical body has a response to perceived danger, the mind correlates a psychic defense process with the fight or flight response. The mind enlists "defense mechanisms" to manage the anxiety produced by threatening situations.⁶⁹ These defensive mechanisms help individuals to guard against re-experiencing the original pain connected to trauma.

⁶⁸ Tanja Jovanovic and Kerry J. Ressler, "How the Neurocircuitry and Genetics of Fear Inhibition May Inform Our Understanding of PTSD," *American Journal of Psychiatry* 167(2010): 657.

⁶⁹ Sigmund Freud, Josef Breuer, and Nicola Luckhurst, *Studies in Hysteria* (Penguin Books, 2004). 236.

Interpersonal Childhood Trauma and Emerging Adulthood

Emerging adults face many challenges. Emerging Adults in this nation not only face a host of personal obstacles they also contend with societal challenges such as the looming economic recession that affects everything from career outlooks increasing crime rates. For those young adults who are able to navigate the winds of change effectively there is an assumed hope that things will get better in the years to come.

Unfortunately, childhood trauma survivors may not be guaranteed the same hopeful future. Instead of thriving, many of these young adults simply want to survive. These young adults are in pursuit of a light source that though dim, calls them to press forward. In emerging adulthood, societal pressure to define one's self as an adult can elevate already ascending anxiety levels associated with increased responsibilities. Emerging adults are charged with the task of conceptualizing themselves as a productive adult. A task more complicated by past trauma.⁷⁰ For adults with traumatic histories, the simple task of visualizing the future may trigger distress associated with fears of an inescapable future of traumatic re-experiencing. Therefore, the transition to adulthood could bring with it new challenges that amplify other vulnerabilities associated with psychopathology.⁷¹ Vulnerabilities of this magnitude prompt some to search for answers beyond themselves.

For individuals who have experienced childhood trauma, reaching adulthood signifies a relentless determination to cope with the challenges of life. Though some aspects of their coping may be maladaptive (e.g., excessive negative thoughts or

⁷⁰ Burt and Masten, "Development in the Transition to Adulthood: Vulnerabilities and Opportunities," 6.

⁷¹ Scott M. Hyman, Steven N. Gold, and Rajita Sinha, "Coping with Stress and Trauma in Young Adulthood," in *Young Adult Mental Health*, ed. Jon E. Grant and Marc N. Potenza (Oxford ; New York: Oxford University Press, 2010), 153.

interpersonal conflicts), childhood trauma survivors have developed coping strategies that help them to navigate life's developmental and situational transitions in non-debilitating ways. Adulthood however has the potential to mount a major transitional obstacle, perhaps even more challenging than the previous adolescent stage of development. Emerging adults in the United States have a unique privilege and challenge of delaying their launch into mature adulthood.⁷² Perhaps the most significant challenge emerging adults face springs forth from societal pressures to embrace a workable adult identity as it relates to the establishment of independence, career, and nesting.⁷³ In the United States, many emerging adults struggle with the desire for both independence and interdependence. However, they find themselves living in between the dependence of adolescence and the independent responsibilities of adulthood. Living in prolonged ambiguity can lead to a heightened sense of self-fragmentation (i.e., isolation or detachment) and increased anxiousness. This anxiety is further exacerbated when individuals perceive themselves as already having a fragmented sense of self in the aftermath of a traumatic experience. Trauma-related psychological difficulties often influence counselee's interpersonal functioning and expose to developmental delays in select dimensions of their personality (i.e., emotional intelligence, impulsivity control, and empathic cognitions). In general, survivors of childhood maltreatment have challenges in multiple areas of development including interpersonal, cognitive, and behavioral.

⁷² Ibid., 145.

⁷³ Jessica M. Crounce and William R. Corbin, "College and Career," in *Young Adult Mental Health*, ed. Jon E. Grant and Marc N. Potenza (Oxford ; New York: Oxford University Press, 2010), 81.

Theology Literature

CHILD ABUSE AND NEGLECT

Historically, Judeo-Christian communities have placed a high value on protecting its young. The physical, emotional, and psychological vulnerability is recognized across cultures with particular attention given to safeguarding whatever culturally accepted practices of healthy development exist. Though messages and practices conflict at times, Judeo-Christian religions have sacred writings (i.e., Torah, Deuteronomy 6:7; Bible, Matthew 18:10) that encourage child safety precautions. Further, intentional harm to children can carry a sustainable social and legal penalty in many societies if the harmful acts are considered abnormal to appropriate parental or communal discipline. When such an act occurs, witnesses and those made aware of the act then engage some moral ethic to determine justification of action. In these situations, religious influences on moral reasoning play a significant role in ruling on the moral legality of the act.

On the other hand, for some Christians, the Biblical text has also been used as the source of justification for certain forms of child abuse. In the book of Proverbs, four passages speak to the childrearing that appear to justify parental physical abuse:

Proverbs 13:24 - Those who spare the rod hate their children, but those who love them are diligent to discipline them (NRSV)

Proverbs 23:13-14 - Do not withhold discipline from your children; if you beat them with a rod, they will not die. If you beat them with the rod, you will save their lives from Shē'ōl. (NRSV)

Proverbs 29:15 - The rod and reproof give wisdom, but a mother is disgraced by a neglected child. (NRSV)

Proverbs 29:17 - Discipline your children, and they will give you rest; they will give delight to your heart. (NRSV)⁷⁴

In his book *The Child's Song: The Religious Abuse of Children* Donald Capps explores the influence of St. Augustine's childhood beatings at the hands of his teachers as foundational for Augustine's theological legitimization of those actions. Augustine of Hippo was a catholic Bishop of Hippo Regius in the fourth century. His revolutionary writings significantly influenced Western Christianity particularly its scholarship and ecclesial practice.⁷⁵ According to Capps, Augustine saw his parent's choice to allow the strict form of punishment he received at the hands of his teachers as "evidence of their love for God."⁷⁶ Further, Augustine believed that his circumstance was initiated by God and therefore his abuse was predestined to happen. His justification of what would be indentified as abuse today carried substantial weight in the Christian community. By refusing to rebuke of the type of extreme punishment he endured, Augustine undoubtedly lent legitimacy to Christian adults who chose severe forms of punishment for children in their care.

In a recent article titled "Who Spares the Rod? Religious Orientation, Social Conformity, and Child Abuse Potential," Rodriquez and Henderson (2010) investigated connections between parent religiosity and child abuse risk.⁷⁷ Believing that parent religiosity is directly linked to notions of discipline better identified as child abuse,

⁷⁴ Harper Bibles, *NRSV Standard Bible* (New York: HarperCollins Publishers, 2007).

⁷⁵ Justo L. González, *The Early Church to the Dawn of the Reformation*, *The Story of Christianity* (San Francisco: Harper & Row, 1984). 207-11.

⁷⁶ Donald Capps, *The Child's Song: The Religious Abuse of Children* (Louisville: Westminster John Knox Press, 1995). 37.

⁷⁷ Christina M. Rodriguez and Ryan C. Henderson, "Who Spares the Rod? Religious Orientation, Social Conformity, and Child Abuse Potential," *Child Abuse & Neglect* 34(2010).

Rodriguez and Henderson studied 207 Christians who attended church regularly to discover the connection between discipline and abuse, and how that connection influenced behavior. In previous research, religious beliefs that advocate for corporal punishment, underscoring Biblical support, and teaching that espouses the child's responsibility to conform to parental authority were found to be influential in parental child abuse.⁷⁸ Rodriguez and Henderson (2010) found that "greater church attendance was predicted to relate to abuse potential" based on the *Child Abuse Potential Inventory*. Further, participants who interpreted the Bible literally scored at elevated risk of child abuse potential. The elevated scores could be linked to the interpretations of certain Bible passages deemed to encourage a punitive stance toward sinners and contribute to more authoritative parenting styles that emphasize child obedience and the use of corporal punishment.

While Rodriguez and Henderson point to a connection between a subset of religious believers, their study focused on a limited viewpoint of religious contributions to parental attitudes. Of the assessments used to link religiosity, social conformity and child abuse, did not account for theological differences within religious backgrounds that significantly influence believer behavior as well. Their work was not initiated from a theological standpoint. In fact, it ignores theological contributions in its findings. However, their work is helpful in understanding the complexity of the child abuse issue and pastoral theology with religious counselees.

Much of the contemporary theological scholarship that addresses abuse typically focuses on abuse in the form childhood sexual abuse. In recent decades, less attention has

⁷⁸ Ibid.

been given to the issue of physical child abuse. Moreover, very little has been done with emotional abuse or any form of neglect, let alone the theological implications of these specific forms of abuse with adolescents or emerging adults. What does exist in the theological scholarship are contemporary perspectives on the origins of abusive human behavior and the residual effects of abuse on survivor spirituality. Two primary ideas surround the literature on this topic: 1) how does theology inform our understandings of child abuse and 2) what does theological reflection contribute to the survivor of abuse. The next two sections will address these ideas.

Sin in Context

In *Bound to Sin: Abuse, Holocaust and the Christian Doctrine of Sin*, Alistair McFadyen (2000) explores appropriation of ‘sin’ language in contemporary contexts. His work offers a rich dialogue between the classic Doctrine of Sin and present-day pathology (the existence of disease). McFadyen defines *pathology* as “the denial of and opposition to God.”⁷⁹ The term “sin” evokes varied responses in today’s academic dialogues. In academic circles and among some scholars the term sin is greeted with critiques of relevance and suspicion. Here, *sin* is described as “a form of alienation from God.”⁸⁰ McFadyen says that this apprehension is partially due to the de-popularization of sin language in academic discourse, a suspicion of Christian interpretations of sin and a suspicion of sin language as entirely focused on blame and condemnation. However, McFadyen believes that,

⁷⁹ Alistair I. McFadyen, *Bound to Sin: Abuse, Holocaust, and the Christian Doctrine of Sin*, Cambridge studies in Christian doctrine (Cambridge, U.K. ; New York: Cambridge University Press, 2000). 11.

⁸⁰ *Ibid.*, 17.

Speaking of God and world (in its pathological aspects) together is the core function of the language of sin. For sin is an essentially relational language, speaking of pathology with an inbuilt and at least implicit reference to our relation to God. To speak of what damages human beings as sin is to claim that the essential character and defining characteristic of such pathology, however else it may be described and indentified in non-theological languages, is theological: disruption of our proper relation to God. It is of the essence of sin-talk, therefore, that it should function as a *theological* language, and this is the source of its distinctiveness from and irreducibility to other languages through which the pathological may be discerned and described.⁸¹

The sin conversation continues to encounter difficulties associated with cultural situations that influence the nature and sources of what is “sin.” Therefore, McFadyen seeks “to test whether sin holds, not just public meaning, but explanatory and descriptive power in relation to concrete pathologies: sexual abuse of children and the holocaust.”⁸² As such, he utilizes the conversation of ‘sin-talk’ to address the broader question of God and God’s relation to pathology.

McFadyen attempts to destigmatize the use of sin-talk for Christians by explaining the usefulness of a sin doctrine in the therapeutic encounter in the context of concrete pathologies including child sexual abuse and the holocaust. His work too limits his perspective of abuse to a singular form, child sexual abuse. The sin of childhood abuse affects survivors in multiple ways during and long after the abuse events end. McFadyen points out that sin of this type affect the patterns and directions of their spirit, as well as their ‘will’ and how it operates in their life.⁸³ McFadyen takes an unexpected turn in his work when he supposes some activity of will on the part of the victim of child abuse. While he is careful not to assume any causal responsibility on the part of the

⁸¹ Ibid.

⁸² Ibid., 5.

⁸³ Ibid., 114.

victim, he does make reference to a ‘distortion of willing’ that could have surfaced during the abuse and continues to distort ‘patterns and structures of intentionality’ (including ‘willing’) in survivors.

Following McFadyen’s line of understanding, both the abused child and the abuser have some contribution to the abuse or sin act even if they did not will it to happen. However, McFadyen acknowledges feminist critiques that note the perpetrator and the victim do not have equivalent will in the abuse. While acknowledging this critique he does so from a conflictual stance. He concedes that the “perpetrator’s will is not neutral and self-moving...[it] has been predisposed and shaped through processes of male socialization which, it is argued, tend to encourage men to exercise power oppressively (especially over women and children and in the family setting) and to use sex as a means of expressing such power.”⁸⁴ McFadyen, questions the use of the term survivor, primarily because it assumes the agency in victims. For him, to become a survivor requires some agency and willing to *do* the surviving. Therefore, active ‘willing’ exists in children following the abuse events. He chose not to delve into what that conception of that childhood intentionality or ‘willing’ could be in abused children, but he does say, “in practice, the child’s willing is employed in the cause of abuse.”⁸⁵ McFadyen believes that because the child’s own active willing was used against him or her, that the effects of trauma are so long lasting.

Though elaborate, McFadyen’s dialogue of willful activity is disturbing on many levels. First, to concede that children have active will in abuse because they are initially

⁸⁴ Ibid., 122.

⁸⁵ Ibid., 124.

motivated by perpetrator enticements, is to assume that children's "will" is aware of the potential dangers of accepting gifts from perpetrators and made a critical decision based on previously known beliefs of right and wrong in that situation. Second, the structure of intentionality presumes knowledge of other possible options or outcomes, children having never experienced previous encounters of abusive violation, are aware of few options other than compliance with adults in power. Lastly, certain developmental influences (i.e., experiences, socialization, moral character training, and religious education) increase or decrease child vulnerability to perpetrators, particularly based on how they have been conditioned to respond to personal will. McFadyen's work while troubling in some respects illuminates the sin of abuse and the long-term effects that shape how survivors utilize or suppress their will following childhood abuse.

Pastoral theologian James Poling has written a great deal of theological reflection associated with the violence of abuse and its effects on survivors and perpetrators.⁸⁶ Poling investigates the interplay of theological and psychological theories of violence with what he calls an epistemological pastoral theology method. Wherein, Poling focuses on nature of what is experienced, critical theories that identify truth and distortions, and theological assumptions about God that shape perceptions and actions. To contextualize his method, Poling brings attention to the power of evil and the resilience of hope in childhood sexual abuse survivors. Poling offers a contrasting view to McFadyen's will-focused reflection on the sin of abuse. Poling approaches the sin of abuse as an abuse of power.

⁸⁶ James N. Poling, *The Abuse of Power: A Theological Problem* (Abingdon Press, 1991); "Child Sexual Abuse: A Rich Context for Thinking About God, Community, and Ministry," *Journal of Pastoral Care* 42, no. 1 (1988); *Understanding Male Violence: Pastoral Care Issues* (St. Louis, Mo.: Chalice Press, 2003).

In his book *The Abuse of Power: A Theological Problem* (1988), Poling asserts, “children are vulnerable to adult abuse of power because they lack understanding and resources for self-protection.”⁸⁷ Though Poling also limits his discussion here to one form of childhood abuse (sexual abuse), he points to the manipulative use of power as the root of sin in the abuse context. He contends that the overpowering presence of the perpetrator overwhelms children are vulnerable to threats or rewards. In this context, Poling says, “abuse of power for the individual is motivated by fear and by the resulting desire to control the power of life... The power that is intended by God for everyone who lives is used to destroy relationships in exchange for control.”⁸⁸ From Poling’s perspective, systems (e.g., racism) and ideologies (e.g., patriarchy) perpetuate the use of dominant power to control, whereby subjecting the vulnerable among us to abusive conditions. In this way, the abuse of power is evil and a resistance to moving toward communion with self, others, and God. When the evil of abuse is unleashed on children, it interferes with their development and ability to commune with self, others and God. Young children may find it hard to distinguish a perceived world separate from that of their parents or other trusted adults. Therefore, an abuse of power that infiltrates the child’s world could mislead the child to believe that all worlds operate in similar fashion.

⁸⁷ *The Abuse of Power: A Theological Problem*: 23.

⁸⁸ *Ibid.*, 27.

Fragmented Personhood

*Does trauma derail or block development as it might be understood against the backdrop of normative developmental patterns?*⁸⁹

Childhood trauma influences survivor development, if not wholesale development, at least some aspects of personality development. Pastoral theologian Pamela Cooper-White (2000) challenges our belief that childhood trauma derails human development, does not account for the expected resilience of children of abuse to appear to beat the odds and excel in some extraordinary way. Trauma does effect personality development, but perhaps as she suggests, it is more important to focus on the aspects of personality development that are “stunted, missing, or suffering great pain” rather than stay fixated on comprehensive disruption of the developmental process.⁹⁰ From this perspective of development, growth occurs through multiple channels or pathways of development (i.e., interpersonal relating, spirituality). Cooper-White goes on to urge pastoral psychotherapists to “consider multiple areas of growth within the same person and to hold in mind both the person’s areas of strength or even overdeveloped capacities *and* underdeveloped areas of fragility, vulnerability and fear.”⁹¹ Resilience is often times perceived by whether or not childhood trauma survivors excel in some socially acceptable area of development (i.e., academics, community involvement, and church activity). Unfortunately, external behaviors can often mask internal vulnerabilities that surface when the survivor encounters a developmental crisis. This might be recognized when a female sexual abuse survivor is propositioned with dating expectations or

⁸⁹ Cooper-White, "Opening the Eyes: Understanding the Impact of Trauma on Development," 89.

⁹⁰ *Ibid.*, 91.

⁹¹ *Ibid.*, 92.

physical intimacy or when young adult male survivor of physical abuse finds himself in a turbulent romantic relationship that triggers his insecurities and control issues. It is during those moments that survivor resilience comes into question. In light of Cooper-White's challenge to the wholesale derailment of personality development, the true question might be whether resilience is also as partitioned off as personality development is following trauma?

In some ways, childhood trauma contributes to a fragmented sense of self. Identity formation resides in one's sense of self. Having a fragmented sense of self is different than acknowledging multiple pathways to self. Cooper-White would see having a sense of multiplicity of self as being mentally healthy and perhaps a more accurate representation of personality. Unfortunately, childhood trauma "hijacks" a child's healthy development of multiplicity and potentially fosters pathological splitting.⁹² Therefore, therapy with survivors must seek to acknowledge sectors of fragmentation and nurture growth in those areas. Though this current study does not focus its attention on psychodynamic therapy processes aimed at helping individuals work through the original trauma experienced by recalling traumatic memories, it does seek to address present-day "outmoded" or maladaptive survivor coping by drawing on the personal spirituality of childhood trauma survivors.⁹³ It is this researcher's belief that trauma survivors, who experience a sense of fragmentation, also perceive their spirituality as being fragmented. Moreover, what childhood trauma survivors conceptualize as a sense of self-integration

⁹² *Many Voices: Pastoral Psychotherapy in Relational and Theological Perspective* (Minneapolis, MN: Fortress Press, 2007). 114.

⁹³ *Ibid.*, 112-14.

or healthy multiplicity may not be fully inclusive of their spiritually held beliefs and values.

Survivor spirituality also shapes one's sense of self. As with other aspects of development, children of abuse are also vulnerable to spiritual fragmentation. Ryan LaMotte (2002) argues, "the victim of severe trauma alternates between the need to be here in the presence of other human beings and the dissociative isolation of not being here.... Severe trauma, in other words, annihilates faith, creating pockets or fragments of no-faith and non-being."⁹⁴ The tragedy of trauma is that the human psyche and spirit are never left intact as they were prior to the abuse. Perhaps the worst and most significant intrusion of abuse is the attack on spiritual formation. The human spirit influences not only who we become, but also how we relate to self, God and others. According to Cooper-White, "trauma ultimately is a spiritual assault."⁹⁵ An assault of this magnitude tints the lens through which children conceptualize Christian language (i.e., God's love, justice, forgiveness). Certain uses of scripture (i.e., Exodus 20:12 - Honor your father and your mother, so that your days may be long in the land that the Lord your God is giving you) and God-language (i.e., 'respect your elders' or 'obedience is better sacrifice') exacerbate trauma responses as well.⁹⁶ Young children perceive religious ideas quite literally, and follow what they believe to be religious rules as a way to prove to them they are being good or bad (right or wrong). Adolescents gain the ability to add abstract thought to religious ideas and question 'greater good' and 'most appropriate' right

⁹⁴ Ryan LaMotte, "'Where Are You?' Defensive Dissociation and Fragments of Annihilated Faith," *Pastoral Psychology* 50, no. 3 (2002): 173,82.

⁹⁵ Cooper-White, "Opening the Eyes: Understanding the Impact of Trauma on Development," 97.

⁹⁶ Erik H. Erikson, *Identity and the Life Cycle; Selected Papers*, Psychological issues, (New York,: International Universities Press, 1959). 140.

decisions as a product of their maturing insight. Survivors who develop fragmented spirituality might remain locked in the rigidity of absolute right or wrong based religious ideology (from childhood) without developing abstract thoughts about personal spirituality or religious belief that occurs in adolescents and beyond. Cooper-White believes that pastoral counselors are to make visible the abuse and trauma that beset survivors, while offering care and compassion for the horrors they experienced. That visibility may come in the form of advocacy or ecclesial change, but for the sake of healing and justice, it must come.

RESILIENCE

*Resilience is the bridge between illness and wellness –
from emotional distress into emotional health.⁹⁷*

Social Sciences Literature

The formal study of resilience only dates a few decades back. Resilience is defined as a dynamic process of healthy human development growing out of nurturing relationships that support social, academic, and vocational competence and self-righting capacity to spring back from exposure to adversity and other environmental stressors.⁹⁸ Resilience can be identified by the presence of expected psycho-biological and developmental functioning across multiple domains. Resilience however, is different for each person since adverse situations effect each differently. Age, gender, and

⁹⁷ Paul Blenkiron, *Stories and Analogies in Cognitive Behaviour Therapy* (John Wiley & Sons, 2010). 300.

⁹⁸ Dave Capuzzi and Douglas R. Gross, *Youth at Risk: A Prevention Resource for Counselors, Teachers, and Parents*, 5th ed. (Alexandria, VA: American Counseling Association, 2008). 42.

developmental stages are known to affect resilience as well as cultural and historical context. Though resilience is studied across various fields (i.e., social psychology, sociology, psychiatry, nursing), much is still needed to be learned regarding the long-term effects of resilience, particularly the protective functions of resilience.

Emmy Werner, widely accepted as the mother of resilience theory, and her colleagues conducted longitudinal studies of resilience across the human life span. Her work focuses on the human ability to continuously “self-right” or adapt to changing environments.⁹⁹ Werner and Smith later studied the sustainability of resilience as having fixed or concrete qualities. Their findings indicate that individuals who were:

...exposed to adversities in early childhood are not predestined to grow into adults with failed marriages, criminal records, or psychiatric disorder. At each developmental stage, there is an opportunity for protective factors (personal competencies and sources of support) to counterbalance the negative weight exerted by adverse experiences.¹⁰⁰

Individuals have “second chance” opportunities to change during various life transitions.¹⁰¹ These second chance opportunities allow survivors of childhood adversities to rebound in adulthood through outlets (i.e., college, military service, or active participation in church or religious community). Benard (2004) identified protective factors such as caring relationships, opportunities to participate/contribute, and positive resiliency traits as important in fostering resiliency. She identifies four resiliency traits that youth with a positive sense of well-being demonstrate: social competence,

⁹⁹ Emmy E. Werner and Ruth S. Smith, *Vulnerable, But Invincible: A Longitudinal Study of Resilient Children and Youth* (New York: McGraw-Hill, 1982). 36.

¹⁰⁰ *Overcoming the Odds: High Risk Children From Birth to Adulthood* (Ithaca: Cornell University Press, 1992). 280.

¹⁰¹ Capuzzi and Gross, *Youth at Risk: A Prevention Resource for Counselors, Teachers, and Parents*: 40.

problem-solving skills, autonomy, and sense of purpose or future.¹⁰² These traits are significant for thought and behavior based therapeutic approaches and contribute to what Capuzzi and Gross would consider a needed resource.

What makes one childhood survivor more resilient than another? Children are naturally resilient. More so than adults, children are more capable of adapting to new situations using compartmentalization skills structured by dichotomous reasoning. Developmental theorists (e.g., Freud, Piaget, Kohlberg) indicate that children organize their lives in dichotomous frameworks (i.e., good vs. bad, happy vs. sad, right vs. wrong). Dichotomous thinking can deter healthy development for children of abuse and neglect who are prone to sustained compartmentalization throughout the life cycle. Resilient survivors share the ability to detangle trauma experiences from the neurobiological functioning and repressive/avoidant coping styles. Differences in each survivor's psycho-spiritual biological functioning as well as environmental and relational factors contribute to resilience.

Littleton et al., (2007) have distinguished four conceptualizations of coping strategies following trauma as adaptive or maladaptive. They compare and contrast two waves of conceptualization found in the literature: (1) problem-focused versus emotion-focused and (2) approach-focused versus avoidance-focused coping.¹⁰³ Problem-focused coping empowers survivors to make action plans about the original stressor of the trauma. Those action plans might include information gathering and concentrating on resolving the stressor. On the other hand, emotion-focused coping, deemed more adaptive, focuses

¹⁰² Bonnie Benard, *Resiliency: What We Have Learned* (San Francisco, CA: WestEd, 2004). 13.

¹⁰³ Heather Littleton et al., "Trauma Coping Strategies and Psychological Distress: A Meta-Analysis," *Journal of Traumatic Stress* 20, no. 6 (2007).

on managing the emotions related to the known stressor. Managing the emotions linked to the stressor could involve choosing to detach from emotion connected to the stressor, venting, or seeking supportive relationships to share their emotions about the stressor. Similar to problem-focused coping, approach-focused coping can indicate how or whether the survivors focus on the stressor or on their reactions to the stress in ways considered adaptive such as information seeking, plans to resolve the stressor, and seeking emotional support. In contrast, avoidance-focused coping is seen as maladaptive based on the survivor's efforts to avoid the stressor and the individual's own reactions by withdrawing, denying, and detaching from thoughts or feelings related to the trauma. Littleton et al., (2007) found that "results supported a clear, consistent association between reliance on avoidance strategies to cope with trauma and psychological distress."¹⁰⁴ Further, the energy that survivors engaged to maintain ineffective coping strategies increased the survivor's vulnerability to physical and psychological challenges throughout development.

Neuroscience says that sustained exposure to traumatic experience alters the normal patterns of brain development. Research shows that enhanced autobiographical integration of traumatic memories and dissociative experiences increase the likelihood of the developing posttraumatic symptoms.¹⁰⁵ Autobiographical memories are an issue for survivors because they represent an unbroken link between accessing memories associated with trauma events and the biological responses associated with the trauma. In other words, traumatic memories can trigger survivors' re-experiencing sensations similar

¹⁰⁴ Ibid. 977-978, 985.

¹⁰⁵ Tom Smeets et al., "Autobiographical Integration of Trauma Memories and Repressive Coping Predict Post-traumatic Stress Symptoms in Undergraduate Students," *Clinical Psychology & Psychotherapy* 17, no. 3 (2010).

to what they experienced when they were in the initial life-threatening situation that precipitated the trauma. Normal physiological changes also influence how autobiographical information is processed, including traumatic stress responses, emotion regulation, and impulse control. Research has already shown that the advent of puberty has a major effect on neurological development, but Smeets et al., (2010) have tracked the neurological changes in young adulthood as well.¹⁰⁶ They found that anchored traumatic memories exist throughout the domains of functioning, particularly when higher levels of post-traumatic stress were reported. Their work also found that a repressive coping style (a specific combination of low levels of anxiety and high defensiveness) and the ability to suppress emotions enhance resilience in emerging adults. Therefore, resilience is somewhat dependent on the neurological disposition of emerging adults and must be a consideration in therapeutic intervention with this population.

Resilience and Emerging Adulthood

DuMont et al., (2007) provide a thorough review of literature surrounding resilience research. Their study highlights early criterion, issues in naming resilience predictors, and individual and contextual predictors of resilience found in recent literature. Early resilience criterion focused on school performance, avoidance of high-risk behaviors, good sleep quality, absence of depressive symptoms and high self-

¹⁰⁶ Ibid.

esteem.¹⁰⁷ As the resilience research has evolved, attempts to identify predicative resilience factors have faced two hurdles. First, longitudinal studies on resilience, including Werner and Smith's work, were based primarily on small samples that limit the generalizability of the finding. Second, much of the research on the subject of adult survivors of childhood maltreatment focuses on childhood sexual abuse and uses qualitative research. Greater attention needs to be given to research that reflects the trajectories of other dimensions of abuse and neglect across developmental stages.

Though no consensus regarding resilience's predictive factors, DuMont et al., (2007) indicate three individual characteristics and three contextual occurrences found by clinicians in the field of social work to predict resilience in the research.

Individual Characteristics - Resilience Predictors

- Having a significant supportive person in the child's life
- Having a mother (caregiver) show some interest in the child and is emotionally able to respond to the child
- Having high or above average intelligence or cognitive ability
 - Intelligence may have a direct role in resilience or serve as a protective influence illustrated by excelling in other dimensions of life (i.e., school performance or problem solving)

Contextual - Resilience Predictors

- Family setting
- Community (beliefs and support)
- Out-of-home placement (i.e., foster care)

¹⁰⁷ Kimberly A. DuMont, Cathy Spatz Widom, and Sally J. Czaja, "Predictors of Resilience in Abused and Neglected Children Grown-up: The Role of Individual and Neighborhood Characteristics," *Child Abuse & Neglect* 31, no. 3 (2007): 256.

Other predictors of resilience include having a positive and meaningful view of life,¹⁰⁸ and developing a “sense of coherence” that allows survivors to comprehend and make meaningful sense of the trauma, and manage resources to deal with stressors.¹⁰⁹ Resilience research continues to explore the developmental implications for survivors but little research has been dedicated to the stability of resilience across different developmental periods. While some resilience studies have focused on various developmental shifts (e.g., early childhood to school age and school age to adolescence), more needs to be studied regarding the stability of resilience across the developmental shift between adolescence and young adulthood. Further, few studies address the contributing factors and predictors of resilience in different contexts. The current research sought to address these issues.

DuMont et al., (2007) work studied the developmental predictors of resilience in adolescence and young adulthood. They studied 676 children with documented histories of abuse and neglect with survivors from mid-west. They used logistic regressions analysis to track the sample through adolescence and young adulthood. They found that 48% of the adolescents and nearly a third of the young adults were found resilient based on follow up interviews when:

...each respondent was rated as successful or not successful on multiple domains of functioning (the first five domains in adolescence and the full eight domains covering young adulthood): (1) education [dichotomously having graduated or not graduated from high school]; (2) psychiatric disorder; (3) substance abuse; (4) official reports of arrests;

¹⁰⁸ Capuzzi and Gross, *Youth at Risk: A Prevention Resource for Counselors, Teachers, and Parents*: 14.

¹⁰⁹ Based on Antonovsk's concept of “sense of coherence” (SOC). Antonovsk developed SCO based Nazi camp survivor experiences and their abilities to overcome life adversity. SOC has been investigated in over 500 studies. More detailed information for this concept can be found in Peres et al., "Spirituality and Resilience in Trauma Victims," 345-46. and (Lindstrom & Eriksson, 2005; Eriksson & Lindstrom, 2006).

(5) self-reports violent behavior, (6) employment; (7) homelessness; and (8) social activity [includes attending a religious service or prayer group]. These domains were selected to demonstrate evidence of adaptation over time despite a history of abuse or neglect in childhood... Respondents were considered resilient as young adults (age 18 and older) if they had been successful in at least six of the eight domains assessed: graduating from high school, psychiatric disorder, substance abuse or dependence, arrests, self-reported violence, employment, homelessness, and social activity.¹¹⁰

More than half of the study sample found resilient adolescents retained resilience in young adulthood. The two features found to most promote resilience in young adulthood were stressful life events and having a supportive partner. Other indicators of adaptive young adult functioning include gainful employment, military service, and attending college.

Many emerging adults entering college have histories of childhood trauma.¹¹¹ Educational achievement is just one indicator of resilience in childhood trauma survivors, but as western civilization increasingly prioritizes educational achievement over vocational attainment, large segments of the population are flooding to colleges. College matriculation, professional or vocational attainment, and family planning are considered age/stage appropriate strivings for emerging adults. For those who matriculate into college, rigorous schedules, high expectations from peers and authority figures, and unstable social dynamics tax already volatile developmental functioning. Experience of college often exacerbates developmental crises for childhood trauma survivors. Studies have shown difficulties with social and emotional adjustment to be predictors of college

¹¹⁰ DuMont, Widom, and Czaja, "Predictors of Resilience in Abused and Neglected Children Grown-up: The Role of Individual and Neighborhood Characteristics," 259.

¹¹¹ Victoria L. Banyard and Elise N. Cantor, "Adjustment to College Among Trauma Survivors: An Exploratory Study of Resilience," *Journal of College Student Development* 45, no. 2 (2004): 207.

attrition, more so than academic difficulties.¹¹² College adjustment hinges on social life adjustment, forming a support network, and managing new social freedoms as factors of adjustment in college.¹¹³ However, survivors generally have increased likelihood for re-victimization, dropping out of college, depression, and suicide. In addition, childhood sexual abuse survivors in college have been found to score higher on PTSD scales and score lower on well-being measures than students without trauma histories, but in contrast both men and women score higher on emotional coping scales.¹¹⁴ While attending college may present “second chance” opportunities for survivors, this research identifies serious potential challenges. Little research has been dedicated to the role of childhood trauma on the transition to college. LeBlanc, Brabant, and Forsyth (1996) found that attending college had healing qualities for older returning students, but much is still unknown about specific protective enhancements associated with survivors attending college. Based on research with first year college students, Banyard and Canter (2004) found that college may be the first time that survivors come forward to address childhood trauma. Once in college, survivors are able to access a hardier sense of autonomy and choose to seek supportive services and interventions for themselves. Emerging adults who can find meaning in life and construct healthy perspectives of positive reality, are better equipped to cope with difficult circumstances and more equipped to thrive in future endeavors.

¹¹² Laura S. Rodgers and Linda R. Tennison, "A Preliminary Assessment of Adjustment Disorder Among First-year College Students," *Archives of Psychiatric Nursing* 23, no. 3 (2009): 221.

¹¹³ *Ibid.*, 220-21.

¹¹⁴ David Canton-Cortes and Jose Canton, "Coping with Child Sexual Abuse Among College Students and Post-traumatic Stress Disorder: The Role of Continuity of Abuse and Relationship with the Perpetrator," *Child Abuse & Neglect* (2010).; Lynn Rew, Delia Esparza, and Dolores Sands, "A Comparative Study Among College Students of Sexual Abuse in Childhood," *Archives of Psychiatric Nursing* V, no. 6 (December) (1991).

Theology Literature

The Survivor: Resistance to Violence

Much of the stigma surrounding child abuse and neglect derives from its silence in the community (i.e., social, and religious). According to Sarah Rieth (1993), “a child may be shamed into not speaking after the abuser and others, including trusted people to whom the child risks to disclose the abuse, tell the child that she does not know what she is talking about.”¹¹⁵ Survivors in similar predicaments are left to face the trauma of their abuse alone and in silence without comfort of community to support them. Thought to be invisible until some major televised event occurs or public disturbance, child abuse and neglect exist virtually in the shadows of society. Cloaked in secrecy, many survivors suppress their emotional and physical wounds without any acknowledgment from the communities that shape their identity.

James Poling’s work contrasts human suffering and experiences of hope. Cultural critique would add that any understanding of personal experiences by another has embedded language and cultural distortions that may not be accurately interpreted by the researcher. Cultural distortions are likely more evident in systems controlled by secrecy. To that end, Poling asks a provocative question “How can we know the truth in a situation of secrecy and suppression?”¹¹⁶ Poling does not attempt to answer such a

¹¹⁵ Sarah M. Rieth, "Scriptural Reflections on Deafness and Muteness as Embodied in the Healing Journeys of Adult Survivors of Sexual Abuse," *Journal of Pastoral Theology* 3(1993): 40.

¹¹⁶ James Newton Poling, "Hearing the Silenced Voices: The Work of Justice in Pastoral Theology," in *Understanding Male Violence: Pastoral Care Issues* (St. Louis: Chalice Press, 2003). Originally printed as "Hearing the Silenced Voices: The Work of Justice in Pastoral Theology," *Journal of Pastoral Theology*, no. Summer (1991): 13.

poignant question, but he does present a challenge to secrecy in his call to Christian community to resist violence where known.

Poling asserts, “research in pastoral theology is based on a process of deconstructing and reconstructing narratives.”¹¹⁷ He offers three constructive avenues to view pastoral theology with childhood trauma survivors. First, he identifies personal quests or searches that are common in survivors following abuse. Next, he provides a contextualized view of ‘truth’ as it is operationalized in survivor healing. Finally, Poling calls on pastoral counselors and the Christian community to ‘resist the violence’ through reactive and proactive instruments of change.¹¹⁸ Poling provides a useful framework to consider when constructing theological responses to trauma survivors.

According to James Poling, resilient spirits are motivated by searches for self, community, and God. The *search for self*-integrity involves integrating interpersonal dimensions into a resilient sense of self. The self is relational, but abuse damages connectedness with others. Therefore, survivors are searching for healing in their connectedness to self and others. Survivors also *search for community*. In community, survivors seek to reconcile initial fractures in interpersonal relationships. Institutions of power and ideologies that control their contexts play a dominant role in re-forming how survivors relate to others. For survivors, systems that appear to privilege or favor the dominance of abusers (i.e., church, school) reinforce disempowering narratives (i.e., submissive, obedient ‘good girl’) and behavioral control (i.e., socially respectable, conflict avoidant). However, constructing new supportive communities, separate from the

¹¹⁷ "Hearing the Silenced Voices: The Work of Justice in Pastoral Theology," 18.

¹¹⁸ "Toward a Constructive Practical Theology: A Process-Relational Perspective," *International Journal of Practical Theology* 13, no. 2 (2010): 200.

binds of secrecy, survivors can become empowered and stand against the systems that colluded with their abuse. Perhaps most significantly, survivors *search for God* in the midst of their abuse and following in their healing process. In the midst of traumatic events, survivors seek God to overcome the evil present in their lives. After the abuse ends, survivors continue to seek God's love and justice despite what they have endured. Poling notes feminist critiques of constructive theology that reference the image of God as the 'good father.' Such references could become problematic depending on the gender of the perpetrator and survivors' relationship to him, particularly if children of abuse were raised with incongruent messages of God as loving and just, but also capable of wrath and vengeful retaliation. Poling suggests broadening survivors' image of God. To include new symbols of God may give voice to their experience of God and encourage them to speak openly about their suffering. New symbols of God could come in form of supportive community members or God as woman (sharing in suffering). Envisioning God as suffering alongside can aid survivors in reconstructing their image of God and God's liberation.

SPIRITUALITY

In crisis and catastrophe, spirituality is often intertwined in the struggle to comprehend the seemingly incomprehensible and to manage the seemingly unmanageable.¹¹⁹

-- Kenneth Pargament

Social Sciences Literature

The terms *religion* and *spirituality* are often used interchangeably to describe a person's belief system. In general, belief systems have both individual and collective features. Each term however means something entirely different depending on one's experience and conceptual framework. This chapter will discuss how the terms are used sometimes interchangeably and in contrast in the literature on this topic. Spirituality is a huge topic with numerous dimensions to explore. Therefore, this section on spirituality will limit its scope to emerging adult spirituality, and more specifically spirituality in reference to childhood trauma survivor's resilience.

“Spirituality is a topic on which everyone is an expert.”¹²⁰

Spiritual/Religious beliefs play a crucial role in how humans make sense of life events and cope with challenging situations. The terms spirituality and religion are often linked to resilience in research literature. There appears to be no consensus on how the terms are used in research across disciplines, but there are some indications that different terms are used to support certain organizing perspectives (i.e., Judeo-Christian researchers might use the term religion rather than spirituality). Some use the two terms

¹¹⁹ Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*: 3.

¹²⁰ Richard L. Gorsuch and Donald Walker, "Measurement and Research Design in Studying Spiritual Development," in *The Handbook of Spiritual Development in Childhood and Adolescence*, ed. Eugene C. Roehlkepartain (Thousand Oaks, Calif.: Sage Publications, 2006), 101.

interchangeably as different expressions of the same concept,¹²¹ while others contrast the two against each other.¹²² Still others identify the terms in sequential progression,¹²³ or diminish the importance of one.¹²⁴

A few recent studies use the terms spirituality and religiosity (devoutness) to operationalize therapeutic interventions with 'religious clients.'¹²⁵ Spirituality has been studied regarding the risk of perpetrating abuse,¹²⁶ self-regulation and self-control,¹²⁷ depression and hopelessness,¹²⁸ life satisfaction,¹²⁹ health and well-being,¹³⁰ and the changes in spiritual belief following trauma.¹³¹ Consistently, recent human science literature has used generic definitions that either ignores or avoids any religious connection, especially Judeo-Christian religious connections.

¹²¹ Lisa Marin Wexler, Gloria DiFluvio, and Tracey K. Burke, "Resilience and Marginalized Youth: Making a Case for Personal and Collective Meaning-Making as Part of Resilience Research in Public Health," *Social Science & Medicine* 69, no. 4 (2009).

¹²² Ronald Lawson et al., "The Long Term Impact of Child Abuse on Religious Behavior and Spirituality in Men.," *Child Abuse and Neglect* 22, no. 5 (1998).

¹²³ Erik H. Erikson, *Identity and the Life Cycle* (New York: Norton, 1980).

¹²⁴ Jane Dyson, Mark Cobb, and Dawn Forman, "The Meaning of Spirituality a Literature Review," *Journal of Advanced Nursing* 26(1997).

¹²⁵ Harold G. Koenig, Michael E. McCullough, and David B. Larson, *Handbook of Religion and Health* (Oxford University Press, 2001).; Samuel Knapp, John Lemoncelli, and Leon VandeCreek, "Ethical Responses When Patients' Religious Beliefs Appear To Harm Their Well-Being," *Professional Psychology: Research and Practice* 41, no. 5 (2010).

¹²⁶ Christopher W. Dyslin and Cynthia J. Thomsen, "Religiosity and Risk of Perpretrating Child Physical Abuse: An Empirical Investigation," *Journal of Psychology & Theology* 33, no. 4 (2005).

¹²⁷ Michael E. McCullough and Brian L. B. Willoughby, "Religion, Self-Regulation, and Self-Control: Associations, Explanations, and Implications," *Psychological Bulletin: American Psychological Association* 135, no. 1 (2009).

¹²⁸ Patricia E. Murphy et al., "The Relation of Religious Belief and Practices, Depression, and Hopelessness in Persons with Clinical Depression," *Journal of Consulting and Clinical Psychology* 68, no. 6 (2000).

¹²⁹ Keith Zullig, Rose Marie Ward, and Thelma Horn, "The Association Between Perceived Spirituality Religiosity and Life Satisfaction: The Mediating Role of Self-Rated Health," *Social Indicators Research* 79(2006).

¹³⁰ Nan Sook Park et al., "Typologies of Religiousness Spirituality Implications for Health and Well-Being," *Journal of Religion & Health* (2011).

¹³¹ Stacy Smith, "Exploring the Interaction of Trauma and Spirituality," *Traumatology* 10, no. 4 (2004).

Spirituality and Resilience

Having a sense of purposeful living is an important resiliency trait. The Werner and Smith (1982) longitudinal study (mentioned above) followed individuals born into potentially at-risk environments from birth to adulthood. Werner's work indicated that of the individuals they studied (who became relatively adjusted academically and interpersonally) identified spirituality as a meaningful protective factor in their resilience. Although their findings did not indicate that spirituality was a causal factor in resilience, their findings did indicate religiosity as a protective factor may be linked to positive adaptation following adverse childhood events. Their participants reported that their faith belief helped them to believe "that the odds could be overcome." Moreover, a significant portion of their study participants with mental health issues reported some conversion to "fundamentalist religions that assured them salvation, security, and a sense of mission."¹³² Werner and Smith's (1982) work highlighted the long-term contributions of spirituality in the lives of persons who struggle with mental illness. Since their work, resilience research has taken a turn toward clarifying the roles of certain protective factors.

Spirituality has also been studied in connection with several aspects of cognitive coping. This research focuses on spiritual coping, but much of the research in this area uses the terms 'spiritual' and 'religious' interchangeably, although as previously stated they have two clear distinctions for the purpose of this research. Several studies have

¹³² Werner and Smith, *Vulnerable, But Invincible: A Longitudinal Study of Resilient Children and Youth*: 280.

focused on the role spirituality plays as a coping mechanism.¹³³ More recently, research has focused on the significance of religion/spirituality on human growth.

Pargament's research (1997) has been widely influential in understanding how certain spiritual factors such as religious coping methods have been found to predict adjustment more so than non-religious coping strategies.¹³⁴ His work studies the relationship between religious coping and acute stress reduction. He asserts that religion can participate in each domain of coping as well as contribute to the coping process and exists as a product of the coping process.¹³⁵ Though he uses the terms spiritual and religious coping interchangeably at many points in his writing, Pargament limits spirituality or spiritual pursuits to the "search for the sacred," not necessarily including one's present existing connection with transcendent other. Pargament's views of helpful religious coping emanate from his concept of orthodox religious tenets and practices. Pargament (1997) differentiates two forms of religious coping, helpful and harmful. He believes that helpful and harmful religious coping are tied respectively to the positive and negative stress adjustment outcomes.

For Pargament, helpful forms of spiritual coping include having spiritual support (e.g., emotional reassurance, a close spiritual relationship, guidance in problem solving),

¹³³ Danice L. Brown, "African American Resiliency: Examining Racial Socialization and Social Support as Protective Factors," *Journal of Black Psychology* 34, no. 1 (2008): 34-35.; Jungmeen Kim, "The Protective Effects of Religiosity on Maladjustment Among Maltreated and Nonmaltreated Children," *Journal of Child Abuse & Neglect* 32, no. 2008 (2008).; Murphy et al., "The Relation of Religious Belief and Practices, Depression, and Hopelessness in Persons with Clinical Depression."; J. Scott Young, Craig S. Cashwell, and Julia Shcherbakova, "The Moderating Relationship of Spirituality on Negative Life Events and Psychological Adjustment," *Counseling & Values* 45, no. 1 (2000).; Peter C. Hill, "Spiritual Transformation: Forming the Habitual Center of Personal Energy," *Research in the Social Scientific Study of Religion* 13(2002).

¹³⁴ Pargament, *The Psychology of Religion and Coping*.

¹³⁵ Kenneth I. Pargament et al., "God Help Me: (I): Religious Coping Efforts as Predictors of the Outcomes to Significant Negative Life Events," *American Journal of Community Psychology* 18, no. 6 (1990): 95-96.

congregational support and being guided by benevolent religious reframing. As such, 'positive religious coping' is seen here as having a secure sense of God, connection with God and others, and having a personal sense of meaning. On the other hand, his work views harmful forms of spiritual coping as having any anger or discontentment with God or God's possible participation in traumatic experiences. Likewise, Pargament indicates being discontent with one's congregation or using negative reframing about God (e.g., God's Punishment) and indicators of negative coping. Negative religious coping is distinguished by having a more insecure relationship with God through the experiences of anger, discontent and doubt.¹³⁶ Overall, Pargament's work reduces religious coping to positive or negative views of God, which contemporary theologians would argue ignores other realities of healthy spirituality following trauma (suffering).

Though prominent in the field, Pargament's findings have been critiqued by recent researchers who have stressed major concerns that are pertinent to this work. According to La Cour and Hvidt (2010), shortcomings exist in Pargament's religious coping research.¹³⁷ They cite Ganzevoort's (1998) limitations to Pargament's concepts regarding the presumption of stable versus dynamic religious coping and the reductionist view of oversimplifying the field using one coherent dimension of religious coping.¹³⁸ Therefore, future research regarding spiritual coping needs to be careful in its assertions as it distinguishes and delimits the dimensions of spiritual coping.

¹³⁶ Terry Lynn Gall, "Spirituality and Coping with Life Stress Among Adult Survivors of Childhood Sexual Abuse," *Child Abuse & Neglect* 30, no. 7 (2006): 833,38.

¹³⁷ Peter la Cour and Niels C. Hvidt, "Research on Meaning-Making and Health in Secular Society: Secular, Spiritual and Religious Existential Orientations," *Social Science & Medicine* 71, no. 7 (2010): 1297.

¹³⁸ R. Ruard Ganzevoort, "Religious Coping Reconsidered, Part One: An Integrated Approach," *Journal of Psychology and Theology* 26, no. 3 (1998): 261-62.

Theology Literature

Restoration: Finding Meaning and Purpose

Emily Lyon (2010) gives important attention to the spiritual implications of childhood abuse. As stated previously, childhood abuse often leads to fragmented ways of being. Fragmented spiritual identity is perhaps the deepest wound that remains after the abuse or neglect. A person's spiritual identity orients a sense of purpose in the world and their imagination and creativity emanate from within their spirit. Childhood abuse, which Lyon rightfully identifies as 'radical evil,' leaves the spiritual life of children wounded and vulnerable. Abuse assaults a child's ability to trust and depend on others. According to the Lyon, "this secret act steals the child's reality as a sacred being with soul capacities for autonomous thinking, wonder, imagining, creating and growing in relationships with others... made sacred in their creation by God. The attack on a child so that her 'self' becomes a "no-self" is indeed a repudiation of God as creator that can only be understood as radical evil."¹³⁹ The loss of personhood (the autonomy of being a subjective person) alters the spiritual relationship between survivors and the divine. Internalized feelings of 'badness' and being unworthy, unloved and unprotected coupled with being objectified by others creates a disconnection between survivors and God. Theology provides an opening to explore the process of re-connecting for survivors. Lyon says that theology "can address the terrible damage of interpersonal evil ... [has] the potential to bring survivors again to wholeness and thriving. Because the people have

¹³⁹ Emily Lyon, "Spiritual Implications of Interpersonal Abuse: Speaking of the Soul," *Pastoral Psychology* 59(2010): 234.

been wounded by a destructive relationship, all healing approaches must involve reparative relationships.”¹⁴⁰ Pastoral counseling offers a sacred space that facilitates therapeutic healing and reparative relationships.

Theology in the service of pastoral counseling with childhood trauma survivors provides a conduit of shared meaning and language. Theological language such as the terms ‘evil,’ and ‘suffering,’ gives voice to the lived experience that survivors carry in their identity following abuse. Pastoral counseling gives them the space to explore the meaningfulness of those theological constructs in ways that challenge destructive thinking and supports connectedness with God and others. Lyon suggests three useful theological contributions with childhood abuse survivors: 1) redress the survivors’ internal sense of shame, and injustice, 2) restore the relational and creative capacities of the self, and 3) bring to life the emergent qualities of the soul that can lead the survivor to numinous, transcendent and transformative spiritual experience.¹⁴¹ To which, Worthington, Sharp and Lerner (2006) add a fourth consideration: assist survivors in a process of emotional forgiveness that replaces “negative unforgiving emotions with positive other-oriented emotions (like empathy, sympathy, compassion, and love).”¹⁴² However, pastoral theologian Cooper-White would caution against possibly retraumatizing survivors by urging them to forgive their perpetrators prematurely. Cooper-White says, “premature forgiveness may seem to smooth things over temporarily... But it has the effect of driving anger and pain underground where they then

¹⁴⁰ Ibid., 240.

¹⁴¹ Ibid., 241.

¹⁴² Everett L. Worthington, Jr. et al., "Interpersonal Forgiveness as an Example of Loving One's Enemies," *Journal of Psychology and Theology* 34, no. 1 (2006): 33.

fester like a poisonous stream, under our houses and our churches and communities.”¹⁴³

Perhaps, what pastoral counselors offer most in work with survivors is the shared reflection of personal suffering and resurrection (a form of resilience) that exists within their sacred space.

Pastoral counseling also gives survivors a space to lament without being ashamed of their suffering. According to Lyon, “True lament helps us to remember that suffering the deepest pain and agony, even complete despair, is part of our human life and part of the life of Christ to whom we turn for succor.”¹⁴⁴ Following lament, survivors have an opportunity to rebuild a sense of community and connectedness with God through the reparative relationship that begins in pastoral counseling. In pastoral counseling survivors who struggle to see the beauty in themselves, can reclaim their beauty as a divinely created being who was not only created to be beautiful but also created in the image of God’s self. Theology is foundational to the restorative work of pastoral counseling. Further, whether explicitly named or not, theology undergirds all therapeutic work with childhood trauma survivors. Theology gives language to survivors’ spiritual experience as they try to make sense of what has happened to them and who they are in the world.

Emerging Adult Spirituality and Resilience

In her recent work *Almost Christian*, practical theologian Kenda Creasy-Dean says “three out of four American teenagers claim to be Christians, and most are affiliated with a religious organization – but only about half consider it very important, and fewer

¹⁴³ Pamela Cooper-White, *The Cry of Tamar: Violence Against Women and the Church's Response* (Minneapolis, MN: Fortress Press, 1995). 256.

¹⁴⁴ Lyon, "Spiritual Implications of Interpersonal Abuse: Speaking of the Soul," 242.

than half actually practice their faith as a regular part of their lives.”¹⁴⁵ This says three important things. First, 75% percent of the emerging adults in the U.S. have some understanding for the existence of a divine being, a system of belief or how to organize meaning. Second, emerging adults may or may not be using Christianity comprehensively as their primary organizing framework for beliefs. Third, a quarter of U.S. emerging adults may not identify themselves as Christian but they may have some spiritual framework that they understand in contrast to Christianity. An understanding that could become their base for meaning, in which case underlying spiritual values might still apply. In addition to the personal ebbs and flows of faith, extensive experimentation and exploration are considered appropriate stage tasks. Religious experimentation during this stage is expected as well as the wide-ranging rejection of previously held beliefs. Research shows that many will return to their faith foundations when they begin childrearing, but for those who delay family planning the period of exploration may be greatly extended.¹⁴⁶ For these reasons, it is important to explore emerging adult spirituality from a personal perspective.

Spiritual identity development is blossoming as an influential domain of growth. Researchers continue to measure the effects of personal tasks personal tasks in relation to the transcendent other (e.g., God, higher power, universal energy).¹⁴⁷ Spiritual identity development is gaining prominence in research conducted by mental health professionals. Research is growing specifically with regard to identifiable resources present in

¹⁴⁵ Kenda Creasy Dean, *Almost Christian: What the Faith of Our Teenagers is Telling the American Church* (Oxford ; New York: Oxford University Press, 2010). 10.

¹⁴⁶ *Ibid.*, 6.

¹⁴⁷ Janice L. Templeton and Jacquelynne S. Eccles, "The Relation Between Spiritual Development and Identity Processes," in *The Handbook of Spiritual Development in Childhood and Adolescence*, ed. Eugene C. Roehlkepartain (Thousand Oaks, Calif.: Sage Publications, 2006), 257-58.

counselee resilience that benefit the therapeutic process. From this vantage point spiritual identity development is less about merely conceptualizing maturation, but more about ways that identity development has an active role in intervention based therapy. This work provides a particularly supportive foundation for a spiritually focused therapy approach with emerging adult trauma survivors.

Poll and Smith (2003) lay out crucial considerations for operationalizing spiritual identity development into therapy with adults and propose a new developmental stage theory. Their work draws on research pointing to the salient qualities of spirituality that have been observed as beneficial to client outcomes. Studies show that religious counselees benefit from being able to bring their spiritual issues into therapy. Furthermore, some religious persons cannot be effectively treated unless their spirituality is incorporated into the therapy. The incorporation of spiritual identity into therapy promotes and restores psychological health.

This sense of spiritual identity, an individual's belief that she or he is an eternal being and connected to God, is an aspect of human spirituality thought to be effective in protecting and restoring psychological health (Richards & Bergin, 1997)... Previous research has shown that the health-promoting and health-restoring effects of a strong sense of identity are evident throughout the lifespan. In adolescents, healthy identity development may protect against depression (Koteskey, Little, & Matthews, 1991) and encourage optimism and self-esteem (Roberts et al., 1999). Psychological wellbeing is also linked to healthy identity in adults (Pulkkinen & Roenkae, 1994).¹⁴⁸

Little empirical research has investigated the nuances of how spiritual identity development influences psychological health and resilience. However, some studies reveal that spiritual structures have a beneficial influence on identity formation. While no

¹⁴⁸ Justin B. Poll and Timothy B. Smith, "The Spiritual Self: Toward a Conceptualization of Spiritual Identity Development," *Journal of Psychology and Theology* 31(2003): 129.

research has linked the two in a causative manner, it appears that the two intersect at pivotal moments following trauma. In addition, Crawford, O'Dougherty Wright and Masten (2006) note an absence of two important connections in spiritual identity research, namely its connections to biological pathways throughout the life cycle and the influence of cultural differences on protective systems.¹⁴⁹ Templeton and Eccles (2006) indicate that the research is limited with regard to the effects of spiritual identity throughout the life cycle. Research is lacking in “the search, formation, and negotiation of spiritual identities across time, situation, and social contexts [and] with a particular focus on how spiritual identity relates to individuals’ attitudes and behaviors across a range of domains.”¹⁵⁰ This research addresses the known void in the field by contextualizing spiritual identity development and resilience development within a specific stage of development, emerging adulthood.

During the transitional period between adolescence and adulthood, emerging adults also begin to define, shape, and reshape ‘what spirituality is’ for themselves. “College is a critical time when students search for meaning in life and examine their spiritual/religious beliefs and values.”¹⁵¹ Although research shows that religious practices and organized beliefs decline among college students, it cannot be assumed that spirituality declines. Cherry (2002) indicates that college students might be better characterized as “spiritual seekers” who dismantle and reconstruct spiritual realities

¹⁴⁹ Crawford, O'Dougherty Wright, and Masten, "Resilience and Spirituality in Youth," 366-67.

¹⁵⁰ Templeton and Eccles, "The Relation Between Spiritual Development and Identity Processes," 262.

¹⁵¹ Alyssa N. Bryant and Maiko Yasuno, "Understanding the Religious and Spiritual Dimensions of Students' Lives in the First Year of College," *Journal of College Student Development* 44, no. 6 (2003): 726.

during early adulthood without the rigid boundaries of denominational religion.¹⁵²

Studying emerging adult spirituality gives insight into their understanding of connectedness with a greater other and how the formation of that sense of connectedness influenced the protective frameworks they developed following trauma. The essence of this work rests on two profound questions (1) how has spirituality influenced resiliency in childhood trauma survivors and (2) what forms or elements of spirituality have contributed to their enhanced resilience. All studies of this topic share the same limitations as this work. No research method can fully capture the aesthetic and esoteric features embodied in spiritual expression. However, this work attempts to capture written and verbal language that emerging adults use to understand their experience.

Smith (2004) looks at the relationship between psychological trauma and spirituality. Though she uses the terms religion and spirituality interchangeably, her primary focus is on the personal experience of spirituality and its influence on trauma effects. She points out seven effects of trauma on spirituality: (1) the dissolution of trust, (2) idealization of fairness, (3) feelings of emptiness and abandonment, (4) doubt in religious beliefs, (5) pervasive cynicism, (6) guilt and shame, and (7) betrayal.¹⁵³ The majority of which, have been linked to unhealthy psychological adjustment.

On the other hand, research has quantitatively linked spiritual coping to enhanced positive adjustment, the establishment of protective frameworks for understanding and to help counselees derive meaning after adverse experiences. Ano and Vasconcelles (2005) conducted meta-analysis on the links between positive and negative forms of religious

¹⁵² Conrad Cherry, Betty A. DeBerg, and Amanda Porterfield, *Religion on Campus* (Chapel Hill: University of North Carolina Press, 2001). 276.

¹⁵³ Smith, "Exploring the Interaction of Trauma and Spirituality."

coping (Pargament's use of these concepts) and positive and negative psychological adjustment. They found that the 49 studies they reviewed indicated "positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively."¹⁵⁴ Their study discovered useful criteria that support this work particularly associated with positive religious coping and positive psychological adjustment. Below chart 1.2 lists potential positive religious coping strategies that survivors utilize along with positive psychological adjustment outcomes that could become therapeutic elements.

Table 1.2 – Religious and Psychological Adjustment

Positive Religious Coping Strategies	Positive Psychological Adjustment Outcomes
(1) religious purification/ forgiveness	(1) acceptance
(2) religious direction/conversion	(2) emotional well-being
(3) religious helping	(3) general positive outcome
(4) seeking support from clergy/members	(4) happiness
(5) collaborative religious coping	(5) hope
(6) religious focus	(6) life satisfaction
(7) active religious surrender*	(7) optimism
(8) benevolent religious reappraisal	(8) personal adjustment
(9) spiritual connection	(9) personal growth
(10) marking religious boundaries	(10) positive affect
	(11) purpose in life
	(12) recent mental health
	(13) resilience
	(14) satisfaction
	(15) self-esteem
	(16) spiritual growth
	(17) stress-related growth
	(18) quality of life

Source: Gene G. Ano and Erin B. Vasconcelles, "Religious Coping and Psychological Adjustment to Stress:

A Meta-Analysis," *Journal of Clinical Psychology*, 61, no.4 (2005): 464.

*The term surrender here refers to the willing openness to religious doctrine, practices and engagement with a/the Divine other. However, it is necessary to note that the concept of surrendering could hold different meanings for abuse survivors. Reinforcing "surrender" as a positive form of coping could instead reinforce the violation that survivors experienced, especially for those who were coerced into surrendering to the abuse of their perpetrators

¹⁵⁴ Gene G. Ano and Erin B. Vasconcelles, "Religious Coping and Psychological Adjustment to Stress: A Meta-Analysis," *Journal of Clinical Psychology* 61, no. 4 (2005): 461,73.

Though this list of positive forms of religious coping is limited and biased to certain types of spiritual experience, it does offer a foundation for categorizing religious contributions that may be influential in the formation of spiritual identity to varying degrees. Though limited, each form listed could be a significant factor in resilience development and positive adjustment in emerging adults survivors. They offer a scaffolding of healthy coping mechanisms that can be promoted during therapy. Additionally, Southwick, Vythilingam and Charney (2005) point out that religious adolescents and Protestant college students with higher levels of religiosity have been associated with lower levels of depression and suicide, respectively.¹⁵⁵ Therefore, spiritual foundations have protective qualities that help emerging adults defend against problematic mood disturbances.

CHAPTER SUMMARY

Several gaps exist in the literature on this topic, particularly where childhood trauma, resilience, and spirituality intersect with emerging adulthood. Gaps exist in the development of effective treatment approaches that attempt to enhance resiliency through the exploration and incorporation of coping strategies tied to spirituality identity development. This is especially true of the lack of research focused on emerging adulthood spiritual identity development. Another void points to the need for theoretical approaches that seek to discover how spirituality influences survivor interpretations of their trauma, relationship to the perpetrator, relationship to a/the Divine, and relationships

¹⁵⁵ Steven M. Southwick, Meena Vythilingam, and Dennis S. Charney, "The Psychobiology of Depression and Resilience to Stress: Implications for Prevention and Treatment.," *Annual Review of Clinical Psychology* 1(2005): 272-73.

to authority figures and caregivers. As well, there is a need to discover what spiritual elements contributed to the formation of the interpretations they hold.

The current research addresses some questions that remain in the field such as (1) how emerging adults with childhood trauma histories identify their resilience, (2) how emerging adults understand the connection between their resilience and spirituality, and (3) how the incorporation of that understanding influences therapy. This work also lays a foundation for future research to build on this knowledge to advance clinical practice and clinical education. The limitations of this study will be discussed in chapter 6.

Recent childhood trauma research has focused its attention on the developmental implications of childhood maltreatment using primarily retrospective recall approaches to support its assertions. While the debate continues over the reliability of retrospective recall, the fact remains that at least twenty studies from varying disciplines have used this method to retrieve and analyze developmental influences. This study does as well. Three elements of this study build on existing research relevant to emerging adult survivors. First, this study takes into account various types of maltreatment experiences as well as the severity and chronicity of childhood abuse and neglect. The Childhood Trauma Questionnaire (CTQ) was used as a prescreen tool to assess the severity of self-reported childhood trauma. Second, the experimental intervention was designed to test a potential clinical approach and to capture qualitative data regarding (1) survivor trauma contexts, (2) factors they attribute to the maltreatment, and (3) supportive persons or systems following the maltreatment. Finally, the qualitative assessment in this study was designed to acquire survivor feedback regarding the effectiveness of this therapy intervention aimed at enhancing resilience.

Much of the resilience research that emphasizes developmental implications also has a strong emphasis on identifying preventative measures and developing prevention models. This research is not focused on developing a preventative model, but it does recognize that the results can be used to strengthen research already in the field regarding protective factors and coping strategies. The field has called for new research with studies focused on gender and ethnic differences, environmental resources and longitudinal designs. This study does not address those concerns specifically, but it does note the quantitative findings regarding gender and race demographics.

The primary focus of this work involves factors that illuminate and enhance resilience. This is particularly evident in studies of protective factors. Positive coping processes also influence survivor cognitions and behaviors such as self-esteem, self-efficacy, and anxiety management. While the goal of the work is not to identify predictive factors of resilience, it does offer potential considerations and obstacles for therapy with this population. The limited focus on emerging adults will contextualize stage-relevant resilience enhancements and give insight into the impact of childhood trauma on college students and their spirituality.

Much of the early research linking spirituality and resilience has its foundation in Pargament's religious coping research. However, work that is more recent focuses on developmental features that influence coping such as spiritual identity development and ego resiliency development. Pargament's work, though renowned, offers a limited perspective of religious life, practices, and resources. His work lacks specificity regarding gender and cultural differences that influence religious coping. Gender and cultural differences not only shape the "ground" of religious coping, but also the starting point

from which survivors engage religious coping. Further, there is inherent bias in Pargament's attempt to frame religious coping into categories of either positive or negative forms of coping. Beyond the issues of dominance embedded in naming religious expressions as productive or anti-productive to the resilience process, this type of categorization neglects the considerable diversity of religious experience as well as the developmental nuances of spiritual deconstruction and reconstruction throughout the life cycle.

The current study opened itself to diverse spiritual perspectives expressed by survivors with the hopes of capturing relevant spiritual coping mechanisms during this stage. This research uses a mixed-method approach to quantify connections between resilience and spirituality and qualify the role of spirituality in enhancing resilience with this population. The literature in this chapter points to needs for further research regarding treatment approaches aimed at enhanced resilience. Furthermore, there is a call to integrate spirituality resources into healing modalities for survivors. The next two chapters will address this call and explore treatment considerations in more depth.

CHAPTER 2: COGNITIVE BEHAVIOR THEORY AND TREATMENT APPROACHES

No therapist can take away the abuse and force a happy ending. Sometimes what is needed is that we bear witness to the trauma, that we participate in the relationship without trying to deny the pain, without seeking to bandage our own wounds.¹⁵⁶

-- John L. DiMino

This research rests on the foundation of recent theological and theoretical scholarship. Therapeutic intervention becomes a major area of engagement with childhood trauma survivors. Often the effects of childhood maltreatment place survivors at increased risk for developing psychological symptomatology that call for therapeutic intervention. Although there is a great diversity of treatment approaches used with trauma survivors, Cognitive Behavioral Therapy (CBT) approaches have been empirically linked to improved functioning across age groups.¹⁵⁷ Though CBT approaches have been proven effective in the betterment of coping skills, few studies have concentrated on diverse survivor context. Trauma-focused cognitive behavioral therapy does target interventions for work with children and young adolescents, but currently no CBT model exists that targets interventions with emerging adults. In general, CBT models address client issues with recent onset. Approaches involving trauma typically focus on acute issues and not developmental trauma responses, however trauma research regarding Post-Traumatic Stress Disorder (PTSD) treatments note an exception to the guidelines concerning symptom onset. PTSD is just one reality following childhood trauma, but its

¹⁵⁶ John L. DiMino, "A Discussion of Dorianne Laux' The Courage to Heal Metaphor and the Recovery of the Self," *Journal of College Student Psychotherapy* 15, no. 2 (2000).

¹⁵⁷ Thomas, "Cognitive Behavioral Treatment of Traumatized Adults: Exposure Therapy," 31.

symptomatology is well presented by childhood trauma survivors entering therapy. Some trauma survivors who do not meet diagnostic criteria for PTSD may still share key symptoms outlined in the PTSD diagnosis. Therefore, survivors may benefit from a CBT model designed to treat trauma related symptoms regardless of whether those symptoms are acute or developmental.

Cognitive Behavioral Therapy is established on the belief that cognitive reframing, correctives, and the presentation of alternatives influence behavioral changes in a positive manner. Usually seen as a brief therapy approach focused on present-day issues, CBT is often the preferred treatment for individuals who activate “negative statements” or beliefs in response to life events or perceived threats. Absent from the bulk of CBT, is an intentional assessment and inclusion of spiritual identity statements and beliefs that influence coping potentiality. Children, whether or not raised in religious communities, have some concept of spiritual or divine other (person, force, element, or concept).¹⁵⁸ Spirituality is an innate human response to connectedness with a transcendent other and serves as the basis for a sense of meaning and purpose in the world. Based on the frequency, duration, and quality of spiritual or religious exposure, children develop self-statements to accommodate their assumed relationship to a divine other, which influences how they cope with life events. Therefore, a holistic therapeutic approach is needed to assess the significance and influence of spiritual identity when developing intervention.

¹⁵⁸ Karen-Marie Yust, *Nurturing Child and Adolescent Spirituality: Perspectives from the World's Religious traditions* (Lanham, Md.: Rowman & Littlefield Publishers, 2006). 8-9.

COGNITIVE BEHAVIORAL THERAPY

Cognitive Behavioral Therapies share a collaborative history that parallels both cognitive and behavioral theoretical movements in modern clinical psychology. In part, CBT emerged as a response to psychodynamic therapies that focused on unconscious drives rather than cognitive decision-making or behavioral conditioning. Burrhus Frederic (B.F.) Skinner's classical and operant conditioning viewed human behavior as motivated by past experiences. For instance, through his operant conditioning experiments, he theorized that avoidance-behaviors follow unpleasant encounters. Though Skinner's initial use of conditioning theory offers potentially conflicting meanings for childhood trauma experiences (i.e., "a punished person remains 'inclined' to behavior in a punishable way, but he avoids punishment by doing something else instead, possibly nothing more than stubbornly doing nothing"), it is useful in conceptualizing the pattern of responses that follow trauma.¹⁵⁹ Where behavioral therapy most contributes to the current work is in its conceptualization of motivational schema. Motivational schema points to primal inclination humans have to avoid negative experiences. With regard to trauma, that would mean that survivors likely avoid situations or circumstances that could trigger re-experiencing traumatic events or increased anxiety.

From a different but complimentary perspective, Aaron Beck's Cognitive Theory asserts that the situations and events that one encounters become aggrandized based on the meaning and interpretation placed on them.¹⁶⁰ Beck's work laid the foundation for a

¹⁵⁹ Burrhus F. Skinner, *About Behaviorism* (Knopf Doubleday Publishing Group, 2011). 304.

¹⁶⁰ Aaron T. Beck, *Cognitive Therapy of Depression*, The Guilford Clinical Psychology and Psychotherapy Series (New York: Guilford Press, 1979).

cognitive behavioral approach to therapy. Albert Ellis, founder of Rational Emotive Behavior Therapy (REBT), previously labeled Rational Emotive Therapy (RET), added a philosophy orientation to cognitive theory. REBT connected irrational beliefs to unrealistic or absolutistic expressions. Ellis' ABC Model traces symptoms by identifying the (A) activating events (B) irrational belief systems about the event and (C) emotional consequences.¹⁶¹ Ellis developed his theory in response to his clinical work with sexuality and marital counseling. He found that counselee's irrational beliefs about sexuality created sexual problems in their relationship. His theory on irrational beliefs is instrumental in providing a framework for identifying irrational thoughts and the resulting behaviors.

Traditional Cognitive Therapy focused on cognitive schema to understand counselee thought processes. Cognitive schemas are "cognitive structure[s] for screening, coding, and evaluating the stimuli that impinge on the organism."¹⁶² Schemas are the foundation of and holding space for cognitive associations. Therefore, traumatic re-experiencing is not only triggered by other actual life-threatening situations it is also triggered by situations that have associated-meaning for survivors (i.e., such as witnessing abuse or neglect, or encountering objects associated with the abuse or neglect they experienced). Though schema theory was a fundamental element in Cognitive Theory, Riso et al., (2007) indicate that recent theory has followed the clinical practice

¹⁶¹ Keith S. Dobson, *Handbook of Cognitive-Behavioral Therapies*, 3rd ed. (New York: Guilford Press, 2010). 12.

¹⁶² Lawrence P. Riso and American Psychological Association., *Cognitive Schemas and Core Beliefs in Psychological Problems: A Scientist-Practitioner Guide* (Washington, DC: American Psychological Association, 2007). 5.

with a tendency toward short-term models that address automatic thoughts, attributional styles, and intermediate beliefs.

Dobson and Dozois (2010) say, “at their core, CBT’s share three fundamental propositions: 1) cognitive activity affects behavior, 2) cognitive activity may be monitored and altered, 3) desired behavior change may be effected through cognitive change.”¹⁶³ CBT shifted therapeutic goals away from the unconscious focused goals of psychodynamic theories and problem-focused behavioral therapies to laser-focus on specific cognitive and behavioral contributing factors that affect present situations. CBT goals focus primarily on cause and effect interactions within the cognitive-behavioral associations that hinder client functioning. Cognitions and behaviors serve as the indices for change in CBT. However, the weight of each in therapeutic change may vary among counselees. Therapeutic change falls into three classes of CBT: coping skills therapies, problem solving therapies, and cognitive restructuring methods.¹⁶⁴ These classes influence which and to what degree cognitive or behavioral interventions are used to effect change in therapy.

Cognitive Behavioral Therapy filled a void left by behavioral therapies and long-term psychodynamic treatments. By limiting the therapeutic treatment to known issues that did not require a long-term development of insight, therapists could work collaboratively with counselees to address the presenting issues using thought and behavior assessments as well as design action plans for change, that effect counselees actions, and how they interpret their actions.

¹⁶³ Keith S. Dobson and David J. A. Dozois, "Historical and Philosophical Bases of the Cognitive-Behavioral Therapies," in *Handbook of Cognitive-Behavioral Therapies*, ed. Keith S. Dobson (New York: Guilford Press, 2010), 4.

¹⁶⁴ *Ibid.*, 6.

COGNITIVE BEHAVIORAL THERAPY WITH CHILDHOOD TRAUMA SURVIVORS

Therapeutic intervention becomes a major area of engagement with childhood trauma survivors, primarily because the effects of maltreatment place survivors at increased risk of developing adjustment issues deemed pathological. Clinical presentations of childhood trauma often involve PTSD symptoms, but other clinically relevant issues include depression, anxiety, and adjustment and personality disorders. Several treatment approaches that address clinical issues with childhood trauma survivors also identify enhanced resilience as the primary goal of treatment.

Two particularly popular approaches are Solution-Focused Brief Therapy (SFBT) and CBT. Two underlying assumptions motivate these approaches. Each has a short-term approach to address present-day issues for trauma survivors. The primary differences lie in their philosophical orientation towards treatment. Solution-focused treatments tend to focus on an individual's assets for change whereas cognitive behavioral treatments focus on deficit reduction. A Solution-Focused approach offers an individual the opportunity to focus specifically on identifiable concerns and work toward achievable goals with the therapist. The focus is on the individual's strengths and successes rather than challenges and maladaptive behaviors. While aspects of a strengths-building therapy approach may be an asset to this population, a treatment approach that seeks to understand how childhood trauma survivors have interpreted the world is also needed. Additionally, it is important to understand how those interpretations contribute to the coping structures that exacerbate transitional or situational crises and clinically significant mental health

episodes. Cognitive behavioral approaches call on both the individual and therapist to work collaboratively toward thought and behavioral modification. Cognitive Behavioral Therapy approaches have been statistically proven to be effective in evidence-based studies to improve coping skills.¹⁶⁵ Several uses of CBT remain unexplored, particularly with the emerging adult childhood trauma survivors.

Dobson and Dozois (2010) however, argue that CBT does not include models that target memories of “long-past” traumatic events because therapies that focus solely on cognitive approaches are not cognitive-behavioral frameworks.¹⁶⁶ In contrast to Dobson and Dozois’ (2010) assertion, Möller and Steel (2002) identify several CBT focused studies with adult survivors of childhood trauma.¹⁶⁷ Jehu, Klassen, and Gazan (1985) identified distorted beliefs connected to guilt, low self-esteem, and sadness that showed clinical and statistical improvement with cognitive restructuring and alleviated the accompanying mood states. Smucker, et al., (1995) proposed combining imagery rescripting with cognitive restructuring to alter the pathological schemas connected to survivor interpretations of the traumatic event. Similarly, Echeburua, et al., (1997) conducted a comparison study of psychological treatment modalities with chronic PTSD patients who had histories of childhood trauma. The study used cognitive restructuring

¹⁶⁵ Allen Rubin and David W. Springer, *Treatment of Traumatized Adults and Children* (Hoboken, N.J.: John Wiley & Sons, 2009). 80-81.

¹⁶⁶ Dobson and Dozois, "Historical and Philosophical Bases of the Cognitive-Behavioral Therapies," 7.

¹⁶⁷ André T. Möller and Henry R. Steel, "Clinically Significant Change After Cognitive Restructuring for Adult Survivors of Childhood Sexual Abuse," *Journal of Rational-Emotive & Cognitive-Behavior Therapy* 20, no. 1 (2002): 50. Möller and Steel (2002) identify the following works as presedenct studies using cognitive behavior therpay approaches with childhood trauma survivors. Carole Klassen and Marjorie Gazan, "Cognitive Restructuring of Distorted Beliefs Associated With Childhood Sexual Abuse," *Journal of Social Work & Human Sexuality* 4, no. 1-2 (1986); Mervin R. Smucker et al., "Imagery Rescripting: A New Treatment for Survivors of Childhood Sexual Abuse Suffering from Posttraumatic Stress," *Journal of Cognitive Psychotherapy* 9, no. 1 (1995); Enrique Echeburua et al., "Psychological Treatment of Chronic Posttraumatic Stress Disorder in Victims of Sexual Aggression," *Behavior Modification* 21, no. 4 (1997).

and progressive relation training modalities. Their results showed higher post-treatment success rates on measures with patients who received cognitive restructuring treatment. Despite these early connections found between CBT and the alleviation of symptoms, CBT research has ignored the contribution of personal spirituality in cognitive restructuring and reframing.

Assessments and Treatment Considerations with Childhood Trauma Survivors

Research designed to assess the effects of childhood abuse and neglect has steadily increased globally. The issue of gathering child abuse and neglect evidence complicates traditional measurement of the phenomenon. Consistently, two ethical approaches have surfaced with regard to childhood trauma research practices. First, known child abuse and neglect survivors are generally researched in controlled settings with safeguards in place to protect the children from further harm. Second, a great number of researchers are drawing on the “retrospective recall” of childhood abuse and neglect survivors in adulthood to illuminate the developmental effects of trauma.¹⁶⁸ This longitudinal development focus has become the backbone in childhood trauma theory. Despite the reliability critiques of retrospective memory, research “suggests that memories for childhood events are often verified when corroborative evidence is available, particularly in the case of events that are unusual, unexpected, or consequential, such as traumatic experiences.”¹⁶⁹ On the other hand, researchers must

¹⁶⁸ David M. Fergusson, L. John Horwood, and Lianne J. Woodward, "The Stability of Child Abuse Reports: A Longitudinal Study of the Reporting Behaviour of Young Adults," *Psychological Medicine* 30, no. 03 (2000): 529-30.

¹⁶⁹ David P. Bernstein and Laura Fink, *Childhood Trauma Questionnaire: A Retrospective Self-Report Manual* (San Antonio, TX: The Psychological Corporation, 1998). 4.

recognize and acknowledge the sample group and research design limitations when working with this population. Since much of childhood maltreatment goes unreported, the research conducted will never be fully representative or generalizable of the true population studied. With an unknown quantity of the population inaccessible during childhood, researchers turned to adult survivors who have more autonomy to share their experiences.

Bernstein and Fink (1998) indicate early childhood trauma assessments were often one-question assessments with direct questions about childhood abuse. As assessments improved, two new features arose. First, initial assessments focused primarily on physical and sexual abuse. Others have now expanded measures to include questions regarding emotional maltreatment and dimensions of childhood trauma including emotional abuse, physical neglect, and emotional neglect. Second, prior to the mid-90's most measures treated abuse as an "all or none" event without measuring for chronicity, severity and duration. As mentioned previously, complex childhood trauma research continues to evolve as new dynamics are studied and the field expands. As new research enters the field of complex childhood trauma, assessment instruments will also continue to evolve.

Rubin and Springer (2009) argue that it is crucial to assess emerging adults who have trauma-related difficulties for developmental gaps and deficits that might exist in individual adaptive skills, particularly those with histories of childhood abuse.¹⁷⁰ As a result, therapy with this population needs to acknowledge the successful navigation of some developmental tasks and identify tasks that might need remediation. A number of

¹⁷⁰ Rubin and Springer, *Treatment of Traumatized Adults and Children*.

emerging adults enter therapy with histories of childhood trauma, though many identify present day issues as their motivating factor for engaging therapy (i.e., anxiety, depression, interpersonal issues). Some emerging adult survivors present with issues triggered by developmental or transitional crises, but more often they present with situational crises that have triggered traumatic re-experiencing challenges. Their challenges are usually compounded and influenced by how they have interpreted their personhood (e.g. “I’m always going to be screwed up,” or “I just can’t get right” negative self-talk).¹⁷¹ Distorted cognitions, emotional dysregulation, impulse control, interpersonal issues, and wounded spirits are just some of the underlying issues emerging adult survivors present in therapy.

Several therapeutic factors and challenges need to be considered when working with interpersonal childhood trauma survivors. As noted previously, the neurological abnormalities that follow childhood trauma experiences alter survivor outcomes in therapy. Increased difficulties with articulating feelings, thoughts, and experiences, issues with modulating physiological arousal as well as decreased serotonin levels are important neurological factors that can be a challenge throughout the therapeutic process. Sanderson (2010) adds relational challenges as another obstacle that survivors bring into the therapeutic relationship. Histories of abuse and neglect complicate how adult survivors interpret relational cues and how they engage the trust building process. Three primary challenges include (1) a fear of dependency on the therapist, centered on expectations of being abused by another trusted person, (2) a need to constantly test the

¹⁷¹ Anne-Laura van Harmelen et al., "Child Abuse and Negative Explicit and Automatic Self-Associations: The Cognitive Scars of Emotional Maltreatment," *Behaviour Research and Therapy* 48, no. 6 (2010): 487.

therapist's investment level and constancy, and (3) some survivors maintain a submissive and biddable demeanor with the therapist in an attempt to appease the therapist.¹⁷² Other challenges include a degree of depersonalization or dissociation with trauma memories and others in their life, multi-layered compartmentalization regarding a sense of self and identity, and oscillation between closeness and retreating in the therapeutic encounter.

Treating survivors of childhood trauma during emergent adulthood often involves attending to an array of diagnostic symptoms (e.g., anxiety, depression, anger management, suicidal ideation, substance abuse) or the interpersonal conflicts that they present as primary issues. Understanding the role of childhood trauma in stage development is imperative for therapists working with emerging adults. By the time survivors reach adulthood they would have endured extended periods of powerlessness where they felt they had no control over their circumstances. Therefore, one major goal of therapy might involve restoring a sense of power and control. This could help to build therapeutic alliance, and normalize and validate the survivor's reactions to current and past events. van der Kolk (2005) adds the need to "establish safety and competence, deal with traumatic reenactments, and [address] integration and master[y] of the body and mind."¹⁷³ Although, some stress responses (coping strategies) are identified as maladaptive, understanding the development of those stress responses contextualizes the need and use of such mechanisms. One challenge in treating childhood trauma survivors involves core issues of longing for but fearing safe and intimate relationships with

¹⁷² Sanderson, *Introduction to Counselling Survivors of Interpersonal Trauma*: 114.

¹⁷³ van der Kolk, "Developmental Trauma Disorder," 407.

individuals who care about their well-being.¹⁷⁴ Other challenges stem from the pervasiveness of distress that survivors experience, particularly during developmental transitions. Using cognitive behavioral approaches, therapists typically treat trauma-related cognitive disturbances by exploring the details of the traumatic events and the surrounding circumstances. This is done to draw out the assumptions, beliefs, and perceptions situated in the meaning making following the events. Ultimately, therapy with emerging adult childhood trauma survivors rests on four key goals: restoring safety and control, establishing trust, helping survivors to reconnect with self and others, and learning to live more authentically.

Psychoanalytic therapists would emphasize additional treatment considerations related to transference and countertransference issues with childhood trauma survivors. Davies and Frawley (1994) point to the impact of childhood trauma, particularly sexual abuse, to the development of therapeutic relationship with survivors. Davies and Frawley (1994) identify four specific complications to consider 1) the degree to which a client's unorganized, unsymbolized experiences frighten or confuse counselees as they emerge during treatment, 2) the potential use of dissociation as coping skill, defense, and vehicle of communication, 3) defensive structures common to abuse survivors (e.g., splitting, denial, acting out, omnipotence, projective identification), and 4) countertransference reactions based on personal attitudes or experiences of the clinician as well as the counselees perceived transference of the therapists role.¹⁷⁵ When these considerations are acknowledged in the therapeutic encounter counselees can feel empowered by the

¹⁷⁴ Eliana Gil, *Working with Children to Heal Interpersonal Trauma: The Power of Play* (New York: Guilford Press, 2010). 7.

¹⁷⁵ Jody Messler Davies and Mary Gail Frawley, *Treating The Adult Survivor Of Childhood Sexual Abuse: A Psychoanalytic Perspective* (Basic Books, 1994). 149-66.

validation of their past and present experience. Likewise, therapeutic interventions with childhood trauma counselees should be intentional to explore client projections onto the therapist that might interfere with the therapeutic alliance. Pastoral counselors in particular, should address any projections that liken their role in the therapeutic encounter to that of God or Higher Power.

COGNITIVE BEHAVIORAL THERAPY AND RESILIENCE

Resilience comprises a set of flexible cognitive, behavioural and emotional responses to acute or chronic adversities which can be unusual or commonplace. These responses can be learned and are within the grasp of everyone; resilience is not a rare quality given to a chosen few. While many factors affect the development of resilience, the most important one is the attitude you adopt to deal with adversity. Therefore attitude (meaning) is the heart of resilience.¹⁷⁶

According to Blenkiron (2010), CBT is on the cusp of its fourth generation or wave of theoretical orientation. In brief summary, the first generation of CBT resisted its psychoanalytic roots and chose to confront known fears rather than talk about their unconscious roots. The focus began with the uniting of cognitive schema theory, rational thinking and behavior reactions to help counselees learn “by doing, through reward and punishment.”¹⁷⁷ The second generation broadened its view to acknowledge the influence of personal worldviews on individual reactions (e.g., how one views the world, effects how they react to certain things). The focus turned to “thinking, doing and testing out beliefs.”¹⁷⁸ The third generation appears to have made perhaps the most significant shifts in CBT. Theorists in what is assumed to be the third generation of CBT began

¹⁷⁶ Michael Neenan, *Developing Resilience: A Cognitive-Behavioural Approach* (London; New York: Routledge, 2009). 17.

¹⁷⁷ Blenkiron, *Stories and Analogies in Cognitive Behaviour Therapy*: 279.

¹⁷⁸ Ibid.

experimenting with alternative ideas including those with influences from Eastern thought and practice. Emphases took new direction such as “being kind to yourself (compassionate mind training), addressing deeply held beliefs (schema therapy) or managing opposing emotions within relationships (dialectical behaviour therapy).”¹⁷⁹ In the third generation, the goal shifted from changing thoughts to changing feelings. This shift turns towards changing how counsees relate to thoughts and feelings that arise. Rather than avoidance, the focus became the observing the presence of negative thoughts, accepting that the thoughts will exist, and choosing to continue to move toward the intended goal (i.e., “I don’t think I can do this, but I’m going to keep trying to reach my goal despite my fears”). Another significant turn involved a departure from merely focusing on distress relief (or symptom relief) toward an emphasis on building resilience and positive qualities. In doing so, CBT somewhat returned to its roots “help[ing] people learn new ways to cope with old problems.”¹⁸⁰ The fourth generation of CBT is on the horizon and much of how it will reshape the theory is still unknown. However, Blenkiron (2010) suggests some shifts might include reengaging the CBT theoretical base in light of recent developments in the research. That reengaging process might include embracing authentic counselee experiences, relying more on individual narratives and less on formulaic practices, and an increased emphasis on the therapeutic relationship and its influence on the change. The fourth generation appears to be more aligned with positive psychology and strength-based models than any generation before.

¹⁷⁹ Ibid.

¹⁸⁰ Ibid., 280.

In fact, Padesky, et al., (2011) call for a strength-focused approach to how CBT cases are conceptualized and focused on building resilience. While positive psychology theories appear ahistorical to CBT theories, fourth generation CBT in some ways is returning to its roots. Padesky, et al., assert that CBT's continued emphasis has been to encourage counselees to become their own therapist as they are capable of applying both cognitive and behavioral skills as needed. This view of resilience, they argue, has been the foundation for CBT from the beginning. Beck's (1979) words convey the same message:

The patient needs to acquire specialized knowledge, experience, and skill in dealing with certain types of problems; therapy is a training period in which the patient will learn more effective ways to handle these problems. The patient is not asked or expected to gain complete mastery or skills in therapy: The emphasis instead is on growth and development. The patient will have ample time after therapy to improve on these cognitive and behavioral coping skills.¹⁸¹

Cognitive Behavioral Therapy has a clear history of improving cognitive and behavioral skills drawn from counselee strengths. However, these strengths have not always been explicitly linked to resilience enhancement, though positive coping has been a consistent “intended outcome” of treatment. The emphasis on counselee strengths may also influence how counselees perceive the therapy process. Counselees who initially perceive therapy to be an overwhelming experience might become less overwhelmed if they can conceptualize the therapeutic process as being more about “what is right with them” than “what led them to seek help.”¹⁸² Highlighting counselee strengths and cognitive distortions offer counselees broader parameters to address varying degrees of

¹⁸¹ Beck, *Cognitive Therapy of Depression*: 425. in Christine A. Padesky, Willem Kuyken, and Robert Dudley, *Collaborative Case Conceptualization: Working Effectively with Clients in Cognitive-Behavioral Therapy* (New York: Guilford Publications, Incorporated, 2011). 55.

¹⁸² *Collaborative Case Conceptualization: Working Effectively with Clients in Cognitive-Behavioral Therapy*: 55.

distress in therapy, which in turn, could increase the variety of pathways that lead to the change counselees seek.

Assessments and Treatment Considerations for Resilience

As mentioned in previous chapters, resilience involves one's ability to 'bounce back' from adversity. It harnesses the collection of internal and external resources that propel a person toward healthy functioning and facilitates growth. Follette and Ruzek (2006) point out the clinical distinction between resilience and recovery. Recovery is the remittance of PTSD or subclinical stress reactions that become less evident over the course of months. Resilience on the other hand, can be distinguished by "low initial and continuing levels of trauma reactions."¹⁸³ There is a concerted effort among therapists to avoid labeling acute trauma stress reactions as pathology. Depending on how resilience is interpreted, it may cloak ongoing traumatic stress otherwise labeled as pathology, especially as time lapses from the initial traumatic event. Though research is still scarce in the field regarding the efficacy of CBT with survivor resilience, Follette and Ruzek (2006) cite Ursano's (2003) suggestion that therapists could understand their role as helping survivors identify and manage self-regulation obstacles.

Zarb (2007) acknowledges the lifespan issues connected to resilience and thus proposes a Developmental CBT model that is derived from the areas of developmental psychology and developmental psychopathology. Developmental pathways suppose pathology as a developmental deviation, and argues that the longer maladaptive pathways

¹⁸³ Victoria M. Follette and Josef I. Ruzek, *Cognitive-Behavioral Therapies for Trauma*, 2nd ed. (New York: Guilford Press, 2006). 453.

are followed the less likely positive adaption is reclaimed. But change is possible throughout the lifecycle. Vehicles such as therapy and life transitions offer different entry points of change. For Zarb (2007) resilience represents the appearance of good adaptation despite high-risk exposure to developmental threats. Therapeutically, developmental CBT conceptualizes resilience as “evolving through the successive adaptations of individuals in their environment.”¹⁸⁴ The components of developmental resilience are still being researched to discover additional uses and influence CBT.

Interest in the development and enhancement of resilience led Southwick et al., (2011) to undertake a comprehensive study of recent published literature. Their research gathered information from studies designed to enhance constructs and factors related to resilience such as hardiness, stress inoculation, and self-efficacy. They found psychosocial factors also have a protective role in resilience including:

realistic optimism and positive emotions, active problem-focused coping, high levels of positive social support, altruism, religious/spiritual practices [emphasis added], attention to physical health and exercise, cognitive flexibility (e.g. cognitive reappraisal, acceptance, positive explanatory style), disciplined focus on skill development, commitment to a valued cause or purpose, and the capacity to extract meaning from adverse situations and from life in general (Southwick, 2005).¹⁸⁵

Though little empirical research has focused on enhancing resilience as a preventative intervention against the development of psychopathology, more research is emerging on treatment interventions aimed at enhancing resilience.

Southwick et al., (2011) identify two earlier studies that used CBT elements to enhance resilience by focusing on perceptions of social support and learned optimism.

¹⁸⁴ Janet M. Zarb, *Developmental Cognitive Behavioral Therapy with Adults* (Routledge, 2007). 9.

¹⁸⁵ Steven M. Southwick et al., *Resilience and Mental Health: Challenges Across the Lifespan* (Cambridge University Press, 2011). 289.

Brand et al., (1995) sought to enhance perceived social support with 51 community residents. The counselees were given 13-week group psychoeducation sessions that focused on social skills and cognitive reframing. Particular attention was given to helping counselees identify personal positive qualities, correcting cognitive distortions, re-conceptualizing relationships with family members, negative cognitive biases, and how counselees interpreted supportive behaviors. Brand et al., (1995) work resulted in improved social competence based on increases in perceived social support. This was possibly due to improved self-esteem in the counselees. Seligman et al., (1999) studied learned optimism as a prevention against increased anxiety and depression symptoms. They conducted an experimental study with 231 college students who scored in low percentiles on the Attributional Style Questionnaire, meaning they scored in the “most pessimistic explanatory style.” The experimental group received 8-week prevention workshops focused on CBT topics. The cognitive topics and training included cognitive theory of change and identification of automatic negative thoughts, while the behavioral topics and training focused on activation techniques such as assertiveness training, interpersonal and creative problem-solving skills. Students were assessed multiple times over a three-year period and again at 6-30 months following the study. The experimental group reported fewer symptoms of anxiety and depression than the control group, and improvements in hopefulness and dysfunctional attitudes.

The interventions discovered in Southwick et al., (2011) research were based primarily on psychoeducation and cognitive-behavioral therapies and included individual, family and community intervention models. They also note that the literature primarily denotes fostering resilience in individual interventions and enhancing resilience in family

or community interventions. According to Southwick et al., “interventions designed to enhance resilience can be targeted at preventing risk factors; bolstering resources; developing skills; supporting cultural, religious and spiritual rituals; promoting organizations that focus on developing competence; limiting stressful/traumatic exposure; and providing rapid evidence-based treatment for traumatized individuals.”¹⁸⁶ While research regarding enhancing resilience is steadily increasing, there is still a call to study this topic with a wider range of populations. This work addresses that void. To date, no studies outside of the current study use CBT to enhance resilience with emerging adult childhood trauma survivors utilizing spiritual resources discovery as an intervention for enhanced resilience.

COGNITIVE BEHAVIORAL THERAPY WITH SPIRITUAL/RELIGIOUS CLIENTS

Absent from the bulk of CBT models is an intentional assessment and inclusion of spiritual identity and spiritual beliefs that influence coping. Whether raised in religious communities or not, survivors often have some concept of spiritual or divine other (i.e., transcendent other, spirit, element, or concept) from their exposure to others, school or media.¹⁸⁷ Based on the frequency, duration, and quality of spiritual or religious exposure, children develop self-statements to accommodate their assumed relationship to a divine other. Therefore, holistic therapeutic approaches (i.e., bio-spiritual-psychosocial) need to determine the significance and influence of spiritual identity when developing an intervention.

¹⁸⁶ Ibid., 302.

¹⁸⁷ Templeton and Eccles, "The Relation Between Spiritual Development and Identity Processes," 258.

Spirituality, particularly religious expressions of spirituality, has endured a love/hate relationship with therapists since the twentieth century. Some factions embrace the resources and meaning found in spiritual life, while others often more vocally reject any beneficial uses of spirituality. This is more so in insight-focused therapies that rely on rational and empirical validity of treatment components. Perhaps ignited by Freud's (1928) argument that religion (spirituality assumed as synonymous) promoted neurotic defenses,¹⁸⁸ clinicians were placed in an antagonist position against spirituality as an essential component of growth.

Later, Albert Ellis, a self-described atheist and REBT theorist, referred to religion as an emotionally unhealthy irrational belief. Ellis suggests that REBT has been influenced by Christian philosophy particularly the "viewpoint of condemning the sin but forgiving the sinner," but he also believed that "the less religious [patients] are, the more emotionally healthy they will tend to be."¹⁸⁹ In his later years, Ellis softened his objections to religion. In his words, "for almost 40 years I have known many therapists, including members of the clergy, who nicely combine REBT teachings with religious teachings and have no difficulty doing so."¹⁹⁰ Although, Ellis held on to his atheistic

¹⁸⁸ Sigmund Freud, *The Future of An Illusion*, The International Psycho-Analytical Library (New York: H. Liveright, 1928).

¹⁸⁹ Albert Ellis and Windy Dryden, *The Practice of Rational Emotive Behavior Therapy* (New York: Springer Publishing Company, 1997). 3.; Albert Ellis, "Psychotherapy and Atheistic Values: A Response to A. E. Bergin's "Psychotherapy and Religious Values."," *Journal of Consulting and Clinical Psychology* 48, no. 5 (1980): 637.

¹⁹⁰ "Irrational beliefs" statement from John Swinton and Harriet Mowat, *Practical Theology and Qualitative Research* (London: SCM Press, 2006).; emotionally unhealthy concept from Ellis, "Psychotherapy and Atheistic Values: A Response to A. E. Bergin's "Psychotherapy and Religious Values."," 637.; use of religion in REBT from "Can Rational Emotive Behavior Therapy (REBT) Be Effectively Used with People Who Have Devout Beliefs in God and Religion?," *Professional Psychology: Research and Practice* 31, no. 1 (2000): 29.

beliefs, he acknowledged the benefits of his theory in addressing religious problems conceptually.

By 1994 the American Psychiatric Association had identified “Religious and Spiritual Problem” as a diagnostic category (V62.89) in the *Diagnostic and Statistical Manual-Fourth Edition* (DSM-IV). V-codes are classified as “other conditions that may be a focus of clinical attention.”¹⁹¹ Spirituality and spiritual influence is still underrepresented in “all [therapy] phases: diagnosis, conceptualization, prevention and treatment.”¹⁹² While, placement in the DSM-IV was a significant step in therapeutic inclusion, it gave clinicians license to interpret clinically relevant religious and spiritual beliefs and determine appropriate treatment approaches based on those factors, regardless of training, specialty, or competence.

Recent research integrating the therapeutic use of spirituality, outside of pastoral counseling, has focused heavily on therapeutic interventions with ‘religious or spiritual clients.’ The majority of research integrating spirituality into therapeutic practice has been from a Christian perspective. Three notable published works include Pecheur and Edwards (1984) that compares ‘secular’ and religious versions of Cognitive Therapy with college students, Propst et al., (1992) that compares the efficacy of religious and non religious CBT, and Hawkins et al., (1999) focuses their research on secular versus Christian inpatient CBT programs.¹⁹³ Each study used religious content as a therapeutic

¹⁹¹ American Psychiatric Association Task Force on DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th ed. (Washington, DC: American Psychiatric Association, 1994). 695.

¹⁹² Stacey Scott et al., "Religious Issues in Diagnosis: The V-Code and Beyond," *Mental Health, Religion & Culture* 6, no. 2 (2003): 161.

¹⁹³ David R. Pecheur and Keith J. Edwards, "A Comparison of Secular and Religious Versions of Cognitive Therapy with Depressed Christian College Students," *Journal of Psychology and Theology* 12, no. 1 (1984).; L. Rebecca Propst and R. Ostrom, "Comparative Efficacy of Religious and Nonreligious

intervention. All three studies were found to be effective with religious counselees and to reduce diagnostic symptoms.

Other integrative approaches have attempted to operationalize religious or spiritually influenced CBT. Pastoral theologian Kirk Bingaman in *Treating the New Anxiety: A Cognitive-Theological Approach* (2007) reveals significant theological considerations when attempting to address learned behavioral responses with counselees using cognitive-focused therapeutic approaches. Though his work focuses more on anxiety rather than post-traumatic stress, Bingaman's background in theology, pastoral counseling, and mental health counseling gives him a unique perspective of the potential intersection of theological constructs and cognitive theory. Though many pastoral counselors have found resonance with psychodynamic therapy to address issues of personhood and personality disorders, Bingaman suggests that the pastoral counselors should not easily dismiss the empirical evidence that supports cognitive behavior therapies that treat clinical issues such as anxiety. According to Bingaman, "if CBT is the treatment of choice when it comes to anxiety, then along with addressing beliefs about self, others, worry, and problem solving is the need to identify and address the anxious client's ontological beliefs, views, and images about God and ultimate reality."¹⁹⁴ He calls on all psychotherapists to first explore their own theological beliefs to avoid imposing their beliefs onto counselees. Then, with intentionality, therapists are to make a safe place for counselees to reflect on and examine their core beliefs in relation

Cognitive-Behavioral Therapy for the Treatment of Clinical Depression in Religious Individuals," *Journal of Consulting & Clinical Psychology* 60, no. 1 (1992).; Rebecca S. Hawkins, Tan Siang-Yang, and Anne A. Turk, "Secular Versus Christian Inpatient Cognitive-Behavioral Therapy Programs: Impact on Depression and Spiritual Well-Being," *Journal of Psychology and Theology* 27, no. 4 (1999).

¹⁹⁴ Bingaman, *Treating the New Anxiety: A Cognitive-Theological Approach*: 11.

to present day issues. This approach to theological inclusion echoes recent research done in the field by non-pastoral counselors as well.

Australian psychiatrists D'Souza and Rodrigo (2004) outline a Spiritually Augmented Cognitive Behavioral Therapy (SACBT) as an adjunct therapy for inpatient individuals with depression and psychosis diagnoses. Developed by a multidisciplinary professional team at the University of Sydney's Centre for Excellence in Remote and Rural Psychological Medicine, SACBT focuses on integrating existential issues into meaning-based therapeutic intervention. It uses a phase treatment plan to achieve meaning and purpose 1) examine the life inevitabilities (i.e., life and death), 2) let go of one's fear and turmoil, 3) examine one's lifestyle and life aspects that avoid confronting mortality, 4) seek divine purpose after examining and accepting life's inevitabilities, and 5) seek meaning for each day. SACBT has an emphasis on respecting counselee belief systems and spiritual practices. Beliefs and practices are incorporated into cognitive (i.e., acceptance, hope, achieving meaning, purpose and forgiveness) and behavioral (i.e., relaxation, meditation, prayer/ritual exercises, and record keeping) components of therapy. SACBT is individual therapy intended to be practiced at a counselee's bedside or in a 'healing environment such as a quiet room, a non-denominational prayer room or the chapel. SACBT addresses topics of existential meaning and empowerment. According to D'Souza and Rodrigo, "what is new in the therapy is the focus on meaning, purpose and connectedness, in the context of the patient's belief system."¹⁹⁵ SACBT has been proven

¹⁹⁵ Russell F. D'Souza and Angelo Rodrigo, "Spiritually Augmented Cognitive Behavioural Therapy," *Australasian Psychiatry* 12, no. 2 (2004): 150.

to reduce symptoms (i.e., hopelessness, despair, depression), improve quality of life and lower relapse occurrences.

Tan and Johnson (2005) propose a Spiritually Oriented Cognitive-Behavioral Therapy (SOCBT) that blends counselee religious beliefs with CBT assessments and interventions. The focus of SOCBT is inclusion of direct religious and biblical influence with religious counsees. They believe that CBT is well suited for religious counsees or clients with problems related to religion or spirituality because CBT is belief oriented and emphasizes foundational core beliefs, focuses on teaching and education (i.e., homework assignments involving scripture reading or religiously integrated activities), and an emphasis on modifying and transforming beliefs to achieve growth and change. Spiritually Oriented Cognitive-Behavioral Therapy psychotherapists utilize specific interventions such as “cognitive disputation using scriptural or other religious evidence to combat or argue against irrational and self-defeating beliefs (beliefs that are nearly always counter to the tenets of one’s own faith), use of religious imagery to decrease anxiety or heighten comfort, and [the] use of scripture reading or prayer in session or as adjuncts to other cognitive homework.”¹⁹⁶ Therefore, in SOCBT therapists are capable of shifting between psychological interventions and spiritual counseling during sessions by discerning which approach to therapy is beneficial as needed. Tan and Johnson’s (2005) SOCBT model is based primarily on Judeo-Christian references, but they note that their approach to cognitive distortions could be applied to other religions (i.e., Buddhism or Islam, here referred to as ‘a Muslim approach’). Therapeutic success with CBT is

¹⁹⁶ Siang-Yang Tan and W. Brad Johnson, "Spiritually Oriented Cognitive-Behavioral Therapy," in *Spiritually Oriented Psychotherapy*, ed. Len Sperry and Edward P. Shafranske (Washington, DC US: American Psychological Association, 2005), 81.

attained by establishing collaborative therapeutic relationships, having sound case conceptualizations, and the selection and application of appropriate techniques. SOCBT adds the willingness “to accommodate and explicitly integrate religious practices, beliefs, and scriptural material into traditional cognitive-behavioral techniques” given the potential benefit to consenting counsees.¹⁹⁷ There is also a focus on therapist competence relating to religious and spiritual beliefs and practices. They call for therapists to ethically attend to counselee’s religious beliefs in a sensitive manner without trivializing counselee beliefs (regardless of the therapist’s personal beliefs) and to avoid confronting or disputing client’s fundamental beliefs. However, Tan and Johnson refer to SOCBT’s research outcomes (i.e., ‘shown to be effective with depressed religious clients’), but their article does not supply research findings specific to their model of SOCBT. Instead, they cite 10 studies (6 Christian CBT and 4 Muslim CBT) to support efficacy of SOCBT, but no direct research regarding their approach.

Lastly, Hodge and Bonifas (2010) studied the efficacy of a Spiritually Modified Cognitive Behavioral Therapy (SMCBT) model. From the field of social work, SMCBT was conceptualized from various research sources focused on integrating spirituality into therapeutic intervention. Aligned closely with traditional CBT goals to cognitively restructure irrational thought, SMCBT incorporates counselee’s spiritual narratives into traditional CBT to modify negative self-statements and construct healthier self-statements. It uses a “three-step process that can be summarized via the following rubrics: understanding the therapeutic concept, ensuring cultural congruence, and repackaging the

¹⁹⁷ Ibid., 84.

therapeutic concept.”¹⁹⁸ Though no direct outcome research has been conducting using SMCBT, it cites previous research studies accommodating spirituality as basis for efficacy. Spiritually Modified Cognitive Behavioral Therapy is well suited for counselees that identify religiosity as central to their lives, particularly older adults with depressive symptoms. In SMCBT, cognitive distortions are disputed (i.e., unrealistic expectations, overgeneralizations, and negative attributions) and behavior modification (i.e., ‘clients who pray or meditate regularly can be encouraged to incorporate such statements into their spiritual routines’) guide therapeutic intervention. Hodge and Bonifas (2010) include general ethical considerations for SMCBT that include acquiring informed consent before engaging spirituality in therapy, collaborations with clergy and spirituality specialists, cultural competence with different spiritual experiences, and familiarity with various common religious beliefs and practices and an empathic approach toward those religious beliefs and practices. Ultimately, Hodge and Bonifas (2010) propose that further research validating this model will indicate its therapeutic efficacy with faster recovery, improved treatment adherence, lower post treatment relapse, and reduced treatment disparity.

Spiritually Augmented Cognitive Behavioral Therapy, Spiritually Oriented Cognitive-Behavioral Therapy, and Spiritually Modified Cognitive Behavioral Therapy are fairly representative of current literature on spiritually accommodated cognitive behavior therapies. They represent common strengths and challenges to consider when conceptualizing spiritually focused cognitive behavioral therapy. All three models

¹⁹⁸ David R. Hodge and Robin P. Bonifas, "Using Spiritually Modified Cognitive Behavioral Therapy to Help Clients Wrestling with Depression: A Promising Intervention for Some Older Adults," *Journal of Religion & Spirituality in Social Work: Social Thought* 29, no. 3 (2010): 194.

indicate the intent to respect the spiritual beliefs and practices of spiritual and religious counselees. However, these three share limitations regarding age/stage appropriate modifications, developmental trauma considerations, and limited perspectives of spiritual and religious competence needed for therapists. Another key limitation of both SOCBT and SMCBT involves the strict focus on religious frameworks with the assumption that religion and spirituality are synonymous terms and experiences.

Specifically, SACBT's strength rests in its attempt to respectfully embrace counselee meaning making as a therapeutic resource without attempting to label beliefs and practices as irrational. The strengths based approach to spiritual expression is in line with contemporary CBT orientation that draws on positive resources to empower counselees. Further, the SACBT is designed to address issues of perceived suffering and trauma. Though primarily studied with inpatient psychiatric counselees, this approach offers a generic framework for CBT models that centralize spirituality, rather than relegate it to a tertiary status. Limitations are evident in the lack of age, ethnicity, cultural and diagnostic diversity. Additionally, no theological framework is considered, which could present an issue for counselees who encounter theological conflicts that influence meaning making. On the other hand, SOCBT relies heavily on religious tenets, despite the diversity of spiritual expressions that exists among counselees. Spiritually Oriented Cognitive-Behavioral Therapy does acknowledge the serious need for spiritual and religious competence of its therapists, but engagement with religious 'problems' may be limited when therapists encounter inter-religious diversity outside of the therapist's religious framework. The potential for religious bias could interfere with how cognitive distortions are interpreted. Further, the over emphasis on irrational beliefs without

significant attempts to emphasize counselee strengths bring into question how culturally competent SOCBT can be with diverse populations. The greatest strength of SMCBT is its intentionality in soliciting counselee's spiritual narratives. Culturally, that offers inclusive invitations to diverse perspectives of healthy and optimal functioning. The intentional observation of diverse realities such as gender, ethnicity and religious belief, show a definite effort to comply with ethical standards of clinical practice. Most pertinent to this research is an ethical objective to refer to and collaborate with clergy and spiritual specialists when working with spiritual counsees. A significant issue with SMCBT is its limited outcome research and age/stage diverse research.

Spiritually Focused Cognitive Behavioral Therapy (SFCBT) attempts to draw from the strengths and challenges of these three models to lay a foundation for a spiritually inclusive therapy model. SFCBT seeks to respect counselee beliefs and practices, embrace a therapeutic openness to meaning making, emphasize counselee strengths, hold true to religious and spiritual guidance, assist in clinical outcomes, and solicit the personal narratives to inform spiritually relevant cognitive restructuring. SFCBT unites theories that seek to empower counsees to become their own therapists. Therapists using SFCBT recognize and acknowledge the common limitations of brief therapies, and therefore inform counsees that it focuses primarily on present-day issues. However, SFCBT may serve well as a bridge to deeper healing with long-term therapies for populations that are initially attracted to short-term action oriented approaches. Ultimately, SFCBT centralizes personal spirituality as the basis for holistic therapeutic intervention with individuals who acknowledge spiritual influence in their lives.

Assessments and Treatment Considerations with Spiritual/Religious Emerging Adults

Emerging adult research is relatively sparse beyond issues of severe mental illness. The field of pastoral counseling is just beginning to focus its attention on counseling practices with this population. However, counselors in higher education have added at least 40 articles on counseling practices with emerging adults in the last five years, and a few studies are pertinent to this research. Therefore, this section on therapeutic assessment and treatment will focus heavily on the literature involving college students, who typically fit into the age parameters of emerging adulthood.

Kellems et al., (2010) surveyed 220 university counselors about the influence of religion/spirituality in therapy. At least 200 of them reported recent contact with college students having issues related to their religious/spiritual beliefs. Common issues included questioning their childhood beliefs, exploring new religious/spiritual beliefs and using their spirituality as a resource for strength. The study intended to obtain “descriptive information about therapy involving RS [religious/spiritual] issues” and “to examine the relationship between similarity of therapist-client RS and [the] therapy process.”¹⁹⁹ They identified nine ways that spiritual issues were evident in therapy which are 1) incongruence between beliefs and sexual behaviors, 2) abandonment of family’s religious/spiritual traditions, 3) use of religiousness/spirituality as a source of strength, 4) exploration and defining of religious/spiritual beliefs, 5) viewed issues through a religious/spiritual perspective, 6) influence of religiousness/spirituality on peer or romantic relationships, 7) clients’ negative religious/spiritual experiences, 8) discussion

¹⁹⁹ Ian S. Kellems et al., "Working With Clients Who Have Religious/Spiritual Issues: A Survey of University Counseling Center Therapists," *Journal of College Student Psychotherapy* 24, no. 2 (2010): 140.

of grief, and 9) increase in religiousness/spirituality, respectively. Of those counselees reporting spirituality as a source of strength, therapists said that clients

“incorporated God into [their] understanding of how to handle life stressors,” “used prayer as a form of coping,” “used biblical and religious references as ways to counter negative automatic thoughts contributing to anxiety,” and “conceptualized problems from a religious perspective.”²⁰⁰

Counselees who entered therapy specifically to address spiritual exploration issues, noted questions regarding what their religion means to them at the heart of their struggle. Other therapists mention how “therapy often involves theological and philosophical pondering, exploring her [counselees] relationship with God, understanding the teachings of her faith, and deciding how she would like to internalize these teachings.”²⁰¹ Therefore, spirituality research with this population adds to the diversity of literature in the field, particularly with students in different contexts.

Perhaps more alarming are the therapists’ views in this study about their preparedness to address spirituality in therapy. The therapist’s own religious/spiritual background made a difference in how they address religiousness/spirituality with students. Some felt differences in personal values added a “wide space for acceptance,” while therapists who shared religious/spiritual beliefs with students “made this kind of work with the client natural.” Therapists, by majority, agreed that differences and similarities made the therapeutic relationship stronger depending on therapeutic approach used.

As for interventions, Kellems et al., (2010) also surveyed college therapists about the use of religious/spiritual assessments, but of the 15 inventories surveyed, there was

²⁰⁰ Ibid., 148.

²⁰¹ Ibid.

minimal use found. Some therapists added interventions such as consultation/referral to religious/spiritual leaders, exploring alternative approaches to religious/spiritual thought, using literature with a religious/spiritual focus, and confronting the client's religious/spiritual beliefs. As for training, 76% indicated they had read about working with religious/spiritual issues, 56% had consulted supervision on the topic, 46% participated in continuing education courses related to religiousness/spirituality, and only 23% had taken graduate coursework in religion/spirituality. Toward the issue of competence, referrals to spiritual/religious leaders are most appropriate for therapists without extensive training in spirituality or religion. Furthermore, without theological training, it is inappropriate for therapists to confront religious or spiritual beliefs and constitutes unethical practice.

Therapists typically treat trauma-related cognitive disturbances by exploring the details of the traumatic events and the surrounding circumstances to draw out the assumptions, beliefs, and perceptions situated in the meaning making following the events. Related to the scope of this work, Gelea (2008) studied the potential effects of child abuse history on emerging adult survivor 'psycho-spiritual' status. Though studied specifically with Maltese college students, his work found a link between child abuse and present-day trauma experiences. Further, his work points to spiritual resources as possible treatment options with child abuse survivors. Previous research found that although child abuse survivors may distrust God and believe that God allowed the abuse, they still sought a spiritual dimension in their lives. In fact, Gelea's results indicate that the abuse they suffered had no direct impact on their spirituality, but that their spirituality had a direct impact on their positive affect. Therapy with child trauma survivors seeks "to

promote self-forgiveness, forgiveness of their perpetrators, and in helping them to grow in self-esteem and respect, and [to] build trusting relationships, especially if the abuse occurred by a trusted adult.”²⁰² Therapeutic intervention with adults who have experienced childhood multi-type or chronic abuse focuses on establishing a safe therapeutic relationship. This study sought to further how therapy with childhood trauma survivors could be expanded to include an emphasis on spirituality and spiritual identity in an effective and ethical treatment approach with emerging adults.

CHAPTER SUMMARY

There are a number of effective treatment approaches with childhood trauma survivors. Empirically speaking, Cognitive Behavioral Therapy has been repeatedly linked to its positive effect on survivor resilience. In addition, research supports the use of CBT with adolescents and emerging adults because it addresses not only thought processes but also behavioral responses that influence adult maturity. Childhood trauma survivors benefit from the examination of cognitive responses, irrational beliefs, and assumptions that develop following trauma.

Historically, therapists have been hesitant to incorporate spirituality into therapy with survivors. The practice of avoiding spiritual realities limits the potential growth for counselees. In some cases, particularly with trauma survivors, avoiding spirituality in therapy is borderline negligent considering the likelihood that survivor spirituality has a

²⁰² Michael Galea, "The Impact of Child Abuse on the Psycho-Spiritual and Religious Status of Maltese College Students," *Pastoral Psychology* 2008, no. 57 (2008): 157.

major impact on their beliefs and assumptions about themselves and their behaviors. This chapter reviewed three therapy approaches that attempt to incorporate spirituality.

Spiritually Augmented Cognitive Behavioral Therapy (SACBT), Spiritually Oriented Cognitive-Behavioral Therapy (SOCBT) and Spiritually Modified Cognitive Behavioral Therapy (SMCBT) make an effort to acknowledge the spiritual background of counselees with intentional focus on spiritual inclusiveness. There are however, significant challenges with each approach when trying to apply them to therapeutic interventions with emerging adult childhood trauma survivors. As treatment models, SACBT, SOCBT, and SMCBT have noticeable limitations with regard to their application across age, ethnicity, cultural and diverse diagnostic dynamics. Further, these models do not address or understates the embedded danger of inappropriately imposing religious bias on survivors using their model. To fill in the gap left by these theories, this dissertation proposes the development of a new therapy approach, Spiritually Focused Cognitive Behavioral Therapy (SFCBT).

The development of a Spiritually Focused Cognitive Behavioral Therapy was conceived out of a need to address diversity concerns within the treatment population: age, gender, spiritual reality, and psychopathology. SFCBT would not only respect spiritual beliefs and practices, but also explore the development of the client's meaning making process as it relates to spirituality, self, and others. A SFCBT approach would respect the diversity of spiritual formation and approaches spiritual maturity with a positive regard for transitional growth. Ultimately, SFCBT seeks to become a holistic therapeutic intervention that embraces spiritual resources and empowers spiritual reflection in the service of enhancing resilience. The next chapter will discuss the

theological foundations of a Spiritually Focused Cognitive Behavioral Therapy approach with emerging childhood trauma survivors.

CHAPTER 3: THEOLOGY AND HEALING APPROACHES

I've experienced that faith can become quite the roller coaster for a survivor, depending on how much the struggle to reconcile abuse is present pertaining to different life stages (or faith development). I've found myself a willing or unwilling dance partner with God, based on how well I understand the moves (circumstances), the Mover (God), or the willingness on my part to move period (depression, exhaustion, confusion). I think this is pretty standard to many on the faith journey. It just happens that mine (like many) is a struggle from childhood on and I've accepted and lost faith at various times in my life as my outlook relates to issues of theodicy (coupled with personality), questioning the nature of God from the age of 5.²⁰³

– Nicole Moody
(Childhood Trauma Survivor and Seminary Graduate)

THEOLOGY AND PASTORAL COUNSELING

This chapter delves into the complex process of meaning making for emerging adult childhood trauma survivors, particularly those who have beliefs rooted in or intermingled with Christian theology. As stated in Chapter 1, emerging adulthood extends the period of identity exploration, including spiritual identity exploration. For those emerging adults who have shared histories of Christianity and childhood trauma, contemporary theological approaches may offer inroads to healing their traumatic wounds. In essence, theology is the study of faithful people seeking understanding. Therefore, theology is grounded in the quest for understanding meanings and practices that nurture growth. This chapter examines relevant theological understanding around the topic of suffering and resilience as it relates to childhood trauma survivors. Rather than

²⁰³ This quote is extracted from an email conversation with Nicole Moody regarding her personal theological and psychological integration process following childhood trauma. Ms. Moody is a seminary graduate and soon to be published author.

attempting to offer survivors a framework to understand the abuse and neglect they experienced, the focus here is on the resilience and thriving that follows.

This chapter begins with an overview of pastoral theology and the theological method utilized in this work. The next section addresses relevant influences from faith development and spiritual identity development. Following the development section, this chapter explores the ways in which childhood trauma influences spiritual identity development with emerging adults. Finally, the chapter ends with pastoral counseling approaches that facilitate reconciliation with survivors.

Pastoral Theology Research Method

During the twentieth century, the field of pastoral theology experienced significant methodological shifts. The prominence of behavioral science that gained early popularity across all academia in the early 1900's soon attracted the attention of pastoral practitioners as well. Theologians, particularly pastoral theologians and practical theologians, began to integrate psychological premises and theories into pastoral care and counseling methods and practices. By the 1960's, theologians such as Paul Tillich ignited dialogues regarding the use of theological and non-theological sources of meaning in modern pastoral methodology.²⁰⁴ Controversy over the suitability of psychological theory as a grounding for theological method ensued. Some theologians expressed concern that pastoral care and pastoral counseling had reached a point of becoming too reliant on other disciplines (i.e., psychology, sociology, anthropology) to shape theological method. By the 1990's another shift began. In an attempt to reclaim the primacy of theology as the

²⁰⁴ Woodward and Pattison, *The Blackwell Reader in Pastoral and Practical Theology*: 65.

initiating point of pastoral methodology, theologians began to scrutinize psychological thought for its unacknowledged theological underpinnings. That last, and most current, shift attempted to reassert theology as the primary foundational element for pastoral methodology.

David Tracy developed a method of “Revised Critical Correlation.” His revised critical correlation method both built upon and served as a critique of Paul Tillich’s correlation method. Tillich’s systematic theology model is an explanation of the contents of the Christian faith and experience with an apologetic approach. Tillich’s correlation method relied on the Bible, Church history, the history of religion and culture as valid sources for methodology.²⁰⁵ Common human experience posed life’s big questions; theology provided the answers. Tracy’s model on the other hand, asserted two primary sources as mutually influential forces for theological reflection: Christian text (scripture and tradition) and common human experience (values, understandings, ethical judgments).²⁰⁶ Though similar to Tillich’s method, Tracy’s model provides a fully correlational and mutually critical method of engaging both faith and experience as fully authoritative for theological reflection and praxis.

For Tracy, “theology is the mutually critical correlation of the interpreted theory and praxis of the Christian faith with the interpreted theory and praxis of the contemporary situation.”²⁰⁷ His goals developed around two primary assumptions (1) the need of theology to engage increasing pluralism and (2) a need to develop genuinely public theology. His theology calls for a theological approach that opens itself to mutual

²⁰⁵ Paul Tillich and F. Forrester Church, *The Essential Tillich* (University of Chicago Press, 1999). 84-85.

²⁰⁶ David Tracy, *Blessed Rage for Order* (Chicago: University of Chicago Press, 1996). 64-66.

²⁰⁷ “Foundations of Practical Theology,” in *Practical Theology*, ed. Don Browning (San Francisco: Harper and Row, 1983), 76.

critique and mutual methodological examination with non-theological sources. For Tracy, both the human experience and the Christian message could create and answer questions of human situation. His approach implies that public discourse must occur and be inclusive of other fields besides theology.

Tracy advocates for a methodology that develops critical criteria for correlating the questions and answers found in both the Christian message and situation. In Tracy's methodology, the Christian texts are investigated to discover historical and hermeneutical elements found in the faith such as "significant gesturers, symbols, and actions of the various Christian traditions."²⁰⁸ The goal of the investigation is to discover 'common human experience and language' sources that theologians may reference in interdisciplinary dialogues. The methodology then, draws out the phenomenological aspects of 'Religious Dimensions' that intersect with contemporary science. The current research builds on a modified revised correlation approach to pastoral praxis. Most relevant, the acknowledgment of a known situation (i.e., emerging adult childhood trauma survivor coping) that has been approached using public discourse with other disciplines (i.e., psychology and sociology) and lived experience (i.e., the spiritual identity development components of resilience) toward constructing a pastoral theological approach to this population of individuals.

Faith Development and Spiritual Identity Development

The term *spiritual identity* is not synonymous with popular understandings of religious identity. Popular Christian writing in recent years has connected the notion of

²⁰⁸ *Blessed Rage for Order*: 49.

growing spiritually with observing religious piety, doctrine, and traditional practices.

However, spiritual identity and religious identity can be distinctly separate aspects of knowing. Religious identity can be defined as “a collective identity... an organized system of beliefs, practices, rituals, and symbols designated to facilitate closeness to the sacred, foster an understanding of one’s relationship and responsibility to others.”²⁰⁹

Whereas spiritual identity is personally constructed based on spiritual characteristics that are “unique to the individual rather than shared with a group and ... not associated directly with feelings of belonging to a valued religious group.”²¹⁰ Spiritual identity development with emerging adult survivors may have both personal and collective elements that facilitate personal connectedness to God and others.

Spiritual development can be defined as “a process of growing the intrinsic human capacity for self-transcendence, in which the self is embedded in something greater than the self, including the sacred.”²¹¹ From this perspective, spiritual development is a personal process of awareness, belief and conceptualization of sacredness or holiness. Spiritual development emerges from individual reflection and inquiry. The procurement of personal transcendence (an experience that is presumably beyond the limits of human conceptualization) for many is an obscure destination. Yet, humans seek to connect with some greater existence external to their own. Whether or not individuals acknowledge the search for a greater other, it appears that the search is a feature of the human experience, even if the notion of a greater other seems incomprehensible at times. Some seek a relationship with a transcendent other to help cope with life issues. Others attempt to

²⁰⁹ Templeton and Eccles, "The Relation Between Spiritual Development and Identity Processes," 253.

²¹⁰ Ibid.

²¹¹ Ibid., 255.

obtain personal transcendence through their faith, causes, careers, or relationships, apart from religion. Thus, it is common for individuals to seek some level of transcendence in their lives, sometimes without ever understanding or naming what they seek to attain.

Spiritual identity development is defined as a personal developmental process whereby individuals understand themselves in relation to their awareness of or comprehension of a sense of connectedness with a divine other. Further, personal identity here is distinguished from collective identity (identity found in connection to a religious body, group, or organization). Spiritual identity is personal whereas religious identity exists within a larger faith community identity and is constructed collectively. Several elements influence this personal concept of spiritual identity development.

Spiritual identity development offers a unique perspective of how emerging adults understand themselves in relationship to others and the world with which they interact. Foundationally, spiritual identity is rooted in having a sense of meaning and purpose connected to human existing. The pursuit of life meaning or purpose can motivate or demotivate an individual's thoughts, feelings, and behaviors. This process of shaping identity is complex, and draws on social, career, educational, spiritual, familial, and cultural experiences.

Why explore spiritual identity development? Spiritual development has been explored for centuries in various religious and faith contexts. There has long been a fascination with the process of enlightenment or transcendence among 'holy men' and other seekers in search of a deeper connection with the divine. The prospect of achieving a deeper connection with a transcendent other motivates individuals to expand their conceptualization of spirituality and its transformative potential. Whether in the

monasticism of the 4th century or in communal cell groups of the emergent church in the 21st century, the pursuit of spiritual maturity continues to inspire individuals of all ages, races, cultures, and faith traditions.

James Fowler, prominent Faith Development theorist, sought to explain how individuals develop and progress in specific aspects of their personality throughout the lifespan. Fowler broadly defines faith “a person’s or group’s way of moving into the force field of life. It is our way of finding coherence in and giving meaning to the multiple forces and relations that make up our lives. Faith is a person’s way of seeing him- or herself in relation to others against a background of shared meaning and purpose.”²¹² Though he interchanges his use of the term faith with spirituality, Fowler’s definition leans more towards an individual’s shared meaning and shared relationship with the Divine/Transcendent Other which is a slightly more communal view of spirituality than the individualistic operation of spirituality defined in this dissertation. For Fowler, faith/spiritual development occurs through a five-stage process. Each stage is delineated by cognitive development, psychosocial development, age correlations, and Fowler’s perspective of faith potentialities.²¹³ Fowler’s third faith development stage Synthetic-Conventional is initiated with the onset of puberty and the ability to perceive abstract thoughts, a skill which matures in emerging adulthood. During this stage, emerging adults become more aware of personal values and normative images. Though an organized value system may not yet exist, emerging adults begin the process of investigating the normative images of their childhoods in the service of declaring what

²¹² James W. Fowler, *Stages of Faith: The Psychology of Human Development and the Quest for Meaning* (San Francisco: Harper & Row, 1981). 4.

²¹³ Jean Piaget, *The Child's Conception of Geometry* (London: Routledge and Paul, 1960).; Klassen and Gazan, "Cognitive Restructuring of Distorted Beliefs Associated With Childhood Sexual Abuse."

would remain normative for them. Also during this stage, adolescents “construct social relations as extensions of interpersonal relationships.”²¹⁴ Fowler believes that emerging adults hunger for a God who deeply “knows, accepts, and confirms” their sense of self.

In contrast to Fowler’s view of a semi-delineated faith development process, other scholars (e.g. Edward Piper) assert that understanding the process of spiritual identity development is difficult to conceive as a universally identifiable process.²¹⁵ Further, the process of spiritual identity development is often unclear even to the individual pursuing maturation. Therefore, the personal nature of spirituality and its influence on individual identity must be understood contextually. Furthermore, the process of understanding spiritual identity development must acknowledge that individuals may have some concept of a sacred-other without connecting spirituality to a religious meaning. Because spiritual identity develops within personal contexts of meaning making, it is impossible with any certainty to generalize the process of spiritual development, even within certain parameters of shared age and cultural practice. In their work, *Soul Searching: The Religious and Spiritual Lives of American Teenagers*, Christian Smith and Melinda Denton (2005) explore how religion influences adolescent moral reasoning, risk behaviors, character, and spiritual seeking. Based on the results of his National Study of Youth and Religion, Smith reports,

²¹⁴ Fowler, *Stages of Faith: The Psychology of Human Development and the Quest for Meaning*: 46.

²¹⁵ Edward Piper, "Faith Development: A Critique of Fowler's Model and a Proposed Alternative," *A Publication of Meadville Lombard Theological School* 3, no. 1 (2002).

Most U.S. teens have a difficult to impossible time explaining what they believe, what it means, and what the implications of their beliefs are for their lives...religion seems very much a part of the lives of many U.S. teenagers, but for most of them it is in ways that seem quite unfocused, implicit, in the background, just a part of the furniture.²¹⁶

Individual meaning making is connected to numerous factors of interpretation and experience. As discussed previously, religious identity develops communally and collectively. Spiritual identity though, does not necessary develop out of an awareness of religious symbolism or practices. Spiritual identity can develop outside of a religious context if one attributes a sense of holiness or sacredness to some irreligious external otherness (i.e., fate, destiny). For example, persons who have not encountered organized religion, still may sense that there is something or someone greater than themselves that has the potential to influence destiny in their world, (some higher power or guiding force). It could be said then that for those persons spiritual awareness exists. Spiritual awareness is foundational for an understanding of self in relation to a “greater external other,” as well as the being foundational for the existence of spiritual identity development. Recurring reflection on individual connectedness with ‘otherness’ can shape individual concepts of spiritual identity, regardless of whether that relationship is explicitly named or not. Therefore, the process of spiritual identity development can and does exist outside of religious influences. That being said, individuals may be aware of the existence of a spiritual development process in their lives, but may not be able to distinguish clearly how that process is operating in their lives or how their lives are being shaped by that process.

²¹⁶ Christian Smith and Melinda Lundquist Denton, *Soul Searching: The Religious and Spiritual Lives of American Teenagers* (Oxford; New York: Oxford University Press, 2005). 262.

In *Positive Youth Development & Spirituality: from Theory to Research*, Richard Lerner, Robert Roeser, and Erin Phelps illuminate the challenges associated identifying developmental factors that signal positive spiritual identity development. For Lerner, et al., (2008) assessing spiritual identity development requires an understanding of the details of context, circumstance, thought, and imagery that influence an individual (or individual's) conceptualization. These details shape whether spirituality would support moral life or not in the long-term or short-term. The greatest challenge to designating what signals positive spiritual identity development is the question of how individuals interpret transcendence and its operation in one's life. Moreover, how an individual "develops [these] convictions while dealing with ambiguity" demonstrates the complexity of that person's maturation process.²¹⁷ Emerging adulthood is a particularly crucial period of self-questioning that shapes how one handles the ambiguous transition spaces in life based on the convictions they develop.

The desire and attainment of a deeper spiritual connection would influence life and connectedness to others. If identity development represents the quest to know one's self, then spiritual identity development signifies the quest to know one's self in connectedness to greater otherness and other humans. Spiritual development makes visible a clearer perspective of self in relation to others and a connectedness to others through spiritual pathways. The shared experience of spiritual awaking has the potential to connect individuals without encountering the obstacles of religious difference. Spiritual maturity in this sense embraces a common journey shared by all individuals.

²¹⁷ Richard M. Lerner, Robert W. Roeser, and Erin Phelps, *Positive Youth Development & Spirituality: From Theory to Research* (West Conshohocken, Pa.: Templeton Foundation Press, 2008).

Moreover, individuals share this journey with a transcendental hope of destiny for all humans. The awareness and exploration of guaranteed interconnectedness can offer needed reassurance for emerging adults who struggle to feel connected with others and with themselves.

Culture and Spiritual Development in Emerging Adulthood

Spiritual identity is situated within culture and ethnicity. As a female African American, middle-class, Baptist youth minister, pastoral counselor, and professional counselor, I recognize and acknowledge that my perspectives of reality have been shaped by my experiences in the world. Each person regardless of cultural background has unique gifts and challenges, but that in some way mirrors the gifts and challenges present in others.²¹⁸ According to Emmanuel Lartey (2003), “every human person is in certain respects 1. like all others 2. like some others 3. like no other.”²¹⁹ In essence, no human can escape every woe that besets humanity. However, it is how we interpret challenging experiences that determines the degree of disruption in our lives. Our spirituality identity has as much to with our cultural context as our personal disposition does. Like other aspects of identity, spiritual identity develops within contextual parameters.

Cultural and ethnic experiences have significant influence on one’s process and understanding of spiritual identity. For example, African Americans like other groups of individuals with shared histories of systemic oppression and dehumanization, draw close to faith systems. Individual and collective faith beliefs help survivors to make sense of

²¹⁸ Ca Trice B. Glenn, "Health Day (Focus on Mental Health)," ed. The African American Lectionary, *Lectionary Commentaries* (<http://www.theafricanamericanlectionary.org/>, Spring 2012).

²¹⁹ Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*: 34.

life tragedies, facilitate hope, and build safe spaces for expression and relationship. Exploring African American religious practices offers theologians and therapists a different lens with which to view how the communal process influences spiritual identity. African American faith traditions in most cases are rooted in African religious traditions. Interconnectedness, tacit knowing, otherworldly encounters, and intuitive observations are commonly accepted elements of spiritual experiences within the African American religious experience.²²⁰ As this example demonstrates, it is important to acknowledge the cultural influences that shape the survivor's spiritual identity. Further, any contextual study of the spiritual identity development needs to investigate the role of cultural and ethnic factors play in survivor spirituality, and how their contexts have contributed to their concepts of restorative spirituality.

TRAUMA AND SUFFERING

In his article "My Father's House" Shannon Hodges (2004) gives a reflective account of an adult survivor of child abuse and the internal faith struggles following the abuse.²²¹ Hodges, who became a college counselor, offers personal reflections that recount the trauma of abuse at the hands of his father prior to age five. His father beat him mercilessly when he was unable to master the dexterity of tying his shoelaces. After which, he and his siblings were sent away to grandparents. He like many trauma survivors, lived through terrifying abuse by dissociating during the event, having

²²⁰ The concepts mentioned in this statement appear in various terms discussed by authors whose work focuses on African American religious experience. Authors previously cited in this work include: Jacqueline S. Mattis and Carolyn R. Watson, "Religion and Spirituality," in *Handbook of African American Psychology*, ed. Helen A. Nevelle, Brendesha M. Tynes, and Shawn O. Utsey (Thousand Oaks, California: Sage Publications, 2009), 91-102.

²²¹ Shannon Hodges, "My Father's House," *The Journal of Pastoral Care & Counseling* 58, no. 4 (2004).

somewhat of an out of body experience to shield themselves from the direct impact of the abuse. He vacillated between feelings ranging from rage to pity with his mother who stood aside and allowed the abuse to continue at the hands of his father. He, like his counselees, also wondered “Why the abuse was happening to me” and “Should I forgive them?”²²² Between his story and his college student counselees’ experiences, Hodges identifies the grief associated with a lost childhood and the loss of a parent-child relationship that never existed.

Having participated in the healing of his counselees, he shares that intrusive memories can appear throughout life even when survivors assume that the issues of trauma were resolved. Hodges sheds light on what adult survivors face as their attempt to heal from trauma they experienced. His father, nearing death, contacted him seeking reconciliation, but failed to take responsibility for his abusive actions. For Hodges, his father’s attempts resurfaced confusion and brought up feelings of anger and shame. Survivors share feelings of self-blame for the abuse that happened and shame connected to their inability to prevent what happened. Later, feelings of self-blame may morph into self-judgment as survivors question how they handled the abusive situation while it was occurring and afterwards.

Ultimately, Hodges chose not to visit his father before his death. For Hodges, liberation came in choosing his own emotional health over being present with his father who chose not to acknowledge responsibility for the abuse that happened. Hodges says that friends and relatives questioned his actions with religious cliché’s such as “Honor your Father” without understanding the full dynamics of the relationships between

²²² Cherry, DeBerg, and Porterfield, *Religion on Campus*.

himself and his father. All too often, the faith community seeks to resolve issues of parent-adult child conflict using well-intentioned cliché's without exploring the complexities of the relationships involved. In doing so, the issues become distractions that can be overcome by choosing to forgive and forget. Hodges gives one example of spiritual health in that he acknowledges that his issues with his father were not resolved, but that he could forgive his father for what he had done. What appears most healthy is his choice to forgive while still holding the abuser accountable for the actions he committed.

Hodges' account brings theological issues to the surface. For centuries, theologians have struggled to articulate God's role in human suffering. Augustine addressed God's role using an assertion that the original sin of Adam entrapped humanity in a state of sin from birth, with existence of suffering as an outgrowth of humanity's sinful nature. Still questions of theodicy (suffering) remained. Does God cause or allow human suffering, and if either how does that participation in suffering represent God's love. Theologians have studied God's role in suffering from multiple positions on the participatory spectrum. Perspectives about the existence of suffering range from it being the result of judgment for sinful behavior to suffering being an instigator of behavioral change (motivation for change). In the postmodern era, other theologians have begun to analyze the need and appropriateness of offering answers to these questions. To that point, twentieth century theologians such as Jürgen Moltmann turned the focus of theodicy toward an understanding of God's solidarity with humans in suffering.²²³ With

²²³ Jürgen Moltmann, *The Crucified God: The Cross of Christ as the Foundation and Criticism of Christian Theology* (Minneapolis: Fortress Press, 1993). 25.

this reorienting, the study of God's role in suffering, shifted to the study of God's choice to walk alongside humans in suffering. Beyond questions of theodicy, pastoral theologians are concerned with understanding the role of faith in the lives of the wounded. Childhood abuse however, does not fit neatly at either end of this spectrum. The abuse of a child, even if labeled as corporal punishment, is not the result of any sin on the child's part. Very much to the contrary, the act of violence and assault against the child rests solely with the adult perpetrator. Resilience following abuse often gets mingled with assumptions that the suffering had to happen to ignite change or bring some attribute to optimization in the survivor's life. Viewpoints such as these negate the extreme impact of the suffering experienced and the devastation that follows. By reducing the suffering to its presumed purposeful end, the survivor's torment is dismissed for the sake of happy endings. As stated in chapter one, the process of lamentation has an important contribution to the healing process for survivors.

PASTORAL COUNSELING AND RECONCILIATION

The discipline of pastoral counseling specializes in exploring the internal processes of connectedness between individuals and the divine. According to Cooper-White (2007) "all forms of pastoral care and counseling are intended to foster growth, healing, and empowerment for just and loving engagement with the world"²²⁴ One guiding belief of pastoral counseling suggests that optimized engagement with one's true self radiates from one's reception to being enduringly connected with other humans and with the divine. In therapy, having a deeper awareness of being divinely connected to all

²²⁴ Cooper-White, *Many Voices: Pastoral Psychotherapy in Relational and Theological Perspective*. 5.

others may serve as an entry point into a sense of belongingness for individuals who feel isolated. Pastoral counseling can help give recognition to each person's divinely created self. Such recognition has the potential to nurture a divinely intertwined sense of self. Advocating for a more reflective awareness of spiritual identity has the potential to nurture a deeper sense of connectedness for individuals who struggle interpersonally with those they engage.²²⁵ Spiritual identity is defined by an individual's personal reflection about the role of spirituality in his or her life and that may or may not include a collective religious identity. Spirituality identity is grounded in one's personal beliefs, behaviors, and values concerning the transcendent.²²⁶ Obtaining a deeper sense of life's meaning and connectedness also has the potential to reshape behavioral responses to interpersonal conflict.

Aimed at providing holistic care (body, mind, and spirit) for individuals, pastoral counselors engage depth-therapies that seek to uncover and understand the root elements of change. This research distinguishes the prominence holistic therapy essentials such as a sense of connectedness between body, mind, and spirit, connectedness with others and with the divine in the therapeutic encounter. Like other approaches, it uses meaning making as a framework for understanding life situations, but unlike other approaches this research integrates meaning making found in resiliency and spiritual identity development using pastoral theology as a conduit for reframing. Those essentials are found consistently in traditional pastoral counseling approaches. The current research

²²⁵ Poll and Smith, "The Spiritual Self: Toward a Conceptualization of Spiritual Identity Development," 129.

²²⁶ Templeton and Eccles, "The Relation Between Spiritual Development and Identity Processes," 254.

suggests that those essentials can also be used effectively in therapy with emerging adults, particularly with childhood trauma survivors.

Pastoral counselors often encounter individuals who struggle with adjustment challenges in life. Wayne Oates (1982) asserts that pastors are to “teach people in their search for the meaning of their past histories, the nature of their calling in life, and the quality of hope that endows their ultimate concerns.”²²⁷ While some transitions are expected outgrowths of development, other transitions represent an unexpected upheaval in the perceived normalcy of life. It is at those times when individuals question and seek intervention from a divine source. Sudden or rapid change can trigger individuals to engage learned defensive mechanisms to fend off the mounting anxiety of unexpected threat. When humans perceive a situation as threatening, crisis-like responses are triggered, particularly in individuals with histories of traumatic experience. Once engaged in the process of threat elimination, individuals may re-experience intense traumatic threat responses such as anxiety, depression, hyper-vigilance, and sleep disturbance that can influence their thoughts, feelings and behaviors, as well as their interactions with others. Further, when traumatic responses reemerge, difficulties surface with regard to self-identity, self-concept, and impairments in social and occupational functioning.²²⁸ Re-experiencing traumatic threats can also increase symptomatology for anxiety disorders, depression disorders and post-traumatic stress disorder. This research sought to study the particular resources that childhood trauma survivors identified as contributory to their resilience, with particular attention to how those individuals understood the

²²⁷ Wayne Edward Oates, *The Christian Pastor*, 3rd ed. (Philadelphia: Westminster Press, 1982). 22.

²²⁸ Jon G. Allen, *Coping with Trauma: A Guide to Self-Understanding* (Washington, DC: American Psychiatric Press, 1995). 198-99.

influence of divine/transcendent other(s), existential purpose, and adaptive meaning making in their positive coping.

For nearly a century, pastoral counselors have developed integrative practices uniting theological discourse and “preconscious, conscious, and unconscious” oriented therapeutic interventions.²²⁹ Howard Stone says that “currently, two forms of pastoral counseling are practiced: a brief, time-limited form that is problem-solving or solution-focused, and a long-term form that is often psychoanalytically-oriented that focuses on personality change.”²³⁰ Psychodynamic theories including Object Relations theory, have served as foundational elements for a significant number of modern pastoral counseling approaches. However, pastoral counselors face two key challenges when relying too heavily on a psychodynamic orientation toward therapy. First, though brief psychodynamic therapy approaches exist, less empirical support is available to substantiate their use with diverse populations, and with some trauma-related presenting issues.²³¹ Further, the field of pastoral counseling has conducted minimal research toward developing effective brief therapy approaches for therapy with adolescents, and emerging adults. Robert Dykstra (1997) and Wade Rowatt (1989) have done some work in this area, but pastoral counselors have published little in the last decade to further

²²⁹ Cooper-White, *Many Voices: Pastoral Psychotherapy in Relational and Theological Perspective*: 3-9.

²³⁰ Howard W. Stone, "Pastoral Counseling and the Changing Times," *Journal of Pastoral Care* 53(1999). In Len Sperry, "Integrating Spiritual Direction Functions in the Practice of Psychotherapy," *Journal of Psychology and Theology* 31, no. 1 (2003): 4.

²³¹ Bessel A. van der Kolk and Alexander C. McFarlane, "The Black Hole of Trauma," in *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, ed. Bessel A. van der Kolk, Alexander C. McFarlane, and Lars Weisaeth (New York: Guilford Press, 2007), 7,12.

therapeutic approaches with this population.²³² Kenda Creasy Dean (1998, 2001, 2010) continues to expand theological perspectives for work with adolescents and young adults, but her work focuses primarily on church-based ministry intervention, not pastoral counseling.²³³

Second, the proliferation of managed care's fiscal influence on the counseling profession has triggered sweeping changes in the delivery of therapeutic treatment in the United States. Changes in insurance coverage have significantly altered the volume of people entering therapy, duration of therapeutic intervention, what issues are considered valid, what treatment entails, what degree of treatment is sufficient, and how treatment outcomes are measured. Ultimately, those changes significantly shifted how and to whom the counseling profession offers therapy. Pastoral counselors who largely operate in private practice settings are also amongst those feeling the therapeutic shift. In addition to the strivings of managed care, counselees have begun to enter therapy with action-oriented mentalities seeking immediate personal change.²³⁴ While counselee impatience is not a new phenomenon, it continues to motivate counselees to seek out therapeutic interventions that meet their perceived need, even if this need is simply symptom relief.

Traditionally, psychodynamic approaches by design are long-term in-depth engagements that generally require a substantial time commitment by counselees to the

²³² Robert C. Dykstra, *Counseling Troubled Youth* (Louisville, Ky.: Westminster John Knox Press, 1997).; Wade Rowatt, *Pastoral Care with Adolescents in Crisis* (Louisville, Ky.: Westminster/J. Knox Press, 1989).

²³³ Kenda Creasy Dean and Ron Foster, *The Godbearing Life: The Art of Soul Tending for Youth Ministry* (Nashville: Upper Room Books, 1998).; Kenda Creasy Dean, Chap Clark, and Dave Rahn, *Starting Right: Thinking Theologically About Youth Ministry* (Grand Rapids, Mich.: Youth Specialties/Zondervan Pub. House, 2001).; Dean, *Almost Christian: What the Faith of Our Teenagers is Telling the American Church*.

²³⁴ Ivan J. Miller, "Time-Limited Brief Therapy Has Gone Too Far: The Result is Invisible Rationing," *Professional Psychology: Research and Practice* 27, no. 6 (1996): 567.

therapeutic process. Widespread acceptance of brief therapy interventions have not only influenced the canvas of the therapeutic landscape today, but also which therapists find themselves selected to deliver those services to new therapy seekers. This shift in therapeutic orientation should compel all therapists, including pastoral counselors, to explore effective brief therapy strategies that meet counselee needs without betraying therapist's core values. This research sought to develop a therapeutic intervention approach informed by pastoral counseling principles, but also integrative of brief therapy approaches. Chapter 2 has a more detailed discussion of brief therapy models with potential within this population.

The interpersonal dynamics present in counselor-counselee relationships play a significant role in how counsees perceive, receive, and respond to therapist's assessment. Pastoral counselors recognize the powerful influence of divine representation that could be present in therapeutic encounters with clergy psychotherapist. This interpersonal engagement not only influences the assessment process, but also the therapeutic potential in ways that need to be examined in more detail with this population, particularly where questions of divine love and sovereignty meet lived-experiences of abuse and suffering. In general, therapeutic intervention with adults who have experienced childhood abuse focuses on establishing a therapeutic relationship, establishing safety, assessing of strengths and challenges, formulating behavioral conceptualization, interpersonal skills training using psychoeducation, and problem solving.²³⁵ It could be argued that pastoral counseling is the most appropriate therapy for

²³⁵ Charles R. Figley, *Brief Treatments for the Traumatized: A Project of the Green Cross Foundation, Contributions in Psychology* (Westport, Conn.: Greenwood Press, 2002). 74-82.

this population because it not only offers a safe space for counselees to process emotional, cognitive and spiritual material, but it also offers an additional insight into meaning making that does not exist in traditional psychotherapy treatment.

Pastoral Counseling with Childhood Trauma Survivors during Emerging Adulthood

Few research studies exist that address methods for incorporating potential spiritual resources into therapeutic interventions to bolster resilience, particularly with emerging adults. However, this work begins to address said methodology in a pastoral counseling framework that demonstrates the willingness to engage human suffering and influence Christian responses to those experiences. What follows are methodological considerations for developing a spiritually focused therapy approach aimed at enhancing resilience in emerging adults.

Connor and Davidson (2003) studied “the relationship between spirituality, resilience, anger and health status, and posttraumatic symptom severity in trauma survivors.”²³⁶ Their research suggests that spirituality or belief in a higher power often occurs to assist violent trauma survivors a with a vehicle for coping with the trauma. Terry Lynn Gall (2006) approaches resilience and spirituality from a different perspective. Gall studied the role of spiritual coping with adult childhood trauma survivors and found that childhood sexual abuse survivors with adult distress were linked to negative forms of spiritual coping whereas positive forms of spiritual coping were related to less distress. Gall indicated that spiritual coping could predict and play a

²³⁶ Kathryn M. Connor and Jonathan R.T. Davidson, "Development of a New Resilience Scale: The Connor-Davidson Resilience Scale (CD-RISC)," *Journal of Depression and Anxiety* 18(2003): 487.

positive or negative role with current distress in adult childhood trauma survivors, more so than the roles of demographics or severity of abuse. Michael Galea (2008), similarly studied the impact of childhood trauma on the psycho-spiritual and religious status of young adults. His work investigates the effects of child abuse histories on college students. His results suggest that abuse not only influences survivor's tendencies toward being withdrawn and detached, but that it also "adversely impacts one's spirituality and religiosity... shown through anger at God for letting the abuse happen, and low church attendance."²³⁷ Thus, it is important for mental health professional to assess what role spirituality and religiosity play in alleviating distress and enhancing positive coping. His work further supports the foundational inquiry in this study in that he adds:

Spirituality may serve as an additional therapeutic resource for intervention by counselors. They could use timely interventions in helping abuse victims to promote self-forgiveness, forgiveness of their perpetrators, and in helping them to grow in self-esteem and respect, and build trusting relationships, especially if the abuse occurred by a trusted adult.²³⁸

Several studies have focused on the spirituality or religious impact on mental health.²³⁹ Likewise, a few resiliency studies have focused on children and mid-life adults.²⁴⁰ However, it is important that resilience and the influence of spirituality be examined at various developmental levels. No study or therapeutic intervention to date has targeted both resilience and spiritual identity development in emerging adults toward the development of a spiritually focused brief cognitive behavioral therapeutic approach.

²³⁷ Galea, "The Impact of Child Abuse on the Psycho-Spiritual and Religious Status of Maltese College Students," 156.

²³⁸ Ibid., 157.

²³⁹ la Cour and Hvidt, "Research on Meaning-Making and Health in Secular Society: Secular, Spiritual and Religious Existential Orientations," 1292-93.

²⁴⁰ Collishaw et al., "Resilience to Adult Psychopathology Following Childhood Maltreatment: Evidence From a Community Sample," 213-14.

Developing a Pastoral Counseling Approach with Emerging Adult Survivors

To develop a pastoral counseling approach for use with emerging adult childhood trauma survivors, constructive elements were drawn from Edward Wimberly's notion of "Eschatological Plot" and Robert Dykstra's notion of "Eschatological Hope." Each of these approaches offers unique perspectives of theodicy and suffering, resiliency and God's connection to the believer. From these approaches, it is hoped that an approach might be developed that utilizes hope to empower rather than encumber resilience development for childhood trauma survivors.

Eschatological Hope

Some Christian scholars turn to answers found in the potentialities and challenges of eschatological hope (i.e. hope that Christ can and will re-enter the world and effect change) to address the spiritual fragmentations that occur after childhood trauma.²⁴¹ Theologically speaking, eschatology represents the study of things to come. For early Christian disciples, the anticipation centered on Christ's impending return to the earth. That return would signal promised change for themselves and their world. Generations of disciples later, much of the discussion of eschatology is relegated to doctrines of last things and the end times for the world, but its early embrace represented much more for the disciples who viewed eschatology as a prism used to see their future selves. Robert Dykstra (1997) builds on Jürgen Moltmann's reassertion of eschatology as a foundational tenet of Christian hope. Dykstra uses this understanding of hopeful potential to discuss

²⁴¹ Dykstra, *Counseling Troubled Youth*: 88-89.

the hopeful coming of a transformative self for troubled youth. Dykstra suggests that eschatology in relation to self identity springs hopeful in the notion that one's identity is not tied to present circumstances or life experiences, but to "what is not yet, what is future, what is hoped for, what is coming, [rather] than to what is past or not even present."²⁴² An anticipated eschatological self as Dykstra sees it, is a self that is no longer a prisoner to its developmental past but instead a self with a promised future from an external source.

This positive view of an eschatological *coming* to oneself, offers firm foundation for a pastoral theological approach used with trauma survivors. With this understanding, past circumstances and ways of being do not bind an individual to a life controlled by past events, but rather releases that individual to claim the self that is "somehow beyond and simultaneously, mysteriously, within oneself."²⁴³ There are considerable benefits and challenges associated with advancing eschatological hope (i.e. hope that Christ can and will re-enter the world and effect change). Elaine Brown Crawford (2002) points out that eschatological hope as espoused by Jürgen Moltmann (which Dykstra builds on), has hidden cultural and social functions that could be construed as oppressive.²⁴⁴ The action of hoping can be used as a tool for advancement (motivation) or decline (denial). Crawford makes note of the ways that suffering people that clung to protective 'hoping' for survival, but in reality that hope kept them powerless in situations of oppression such as slavery. The hope for something better can sometimes disable the initiative needed to empower persons to make radical change.

²⁴² Ibid., 15.

²⁴³ Ibid., 16.

²⁴⁴ A. Elaine Brown Crawford, *Hope in the Holler: A Womanist Theology* (Louisville, Ky.: Westminster John Knox Press, 2002). 13-15.

From a different perspective, Andrew Lester (1995) says, “hope in the Judeo-Christian tradition is rooted in the character of God, the Creator and Redeemer of the universe...Our hope is in our relationship with this trustworthy God whose character is marked by a faithful, steadfast love for us.”²⁴⁵ That love does not require Christians to remain in circumstances that disrupt the process of growth God intends for us. A relational view of hope then can serve as an empowering agent to resist the things that come up against that relationship of love and faithfulness between an individual and God. By this reasoning, eschatological hope can serve as a reminder of the relational commitment between a survivor and God, as well as empower survivors by reaffirming God’s solidarity in their suffering.

Eschatological Plot

Edward Wimberly points to the influence of God’s presence in an eschatological plot (i.e. God at work in life’s narrative) in the lives of humans. This dissertation draws on both of these approaches for useful perspectives in constructing a treatment approach.

Wimberly’s notion of an eschatological plot offers a narrative framework of one’s call to participate in life and in God’s unfolding story in the world. Wimberly draws on a belief that God is present during and suffering is “working out healing, wholeness, and liberation on behalf of others.”²⁴⁶ The eschatological plot emphasizes God’s healing presence despite suffering and pain. His model does not seek to minimize suffering or oppression, but rather to ensure that despite suffering and oppression people see

²⁴⁵ Andrew D. Lester, *Hope in Pastoral Care and Counseling* (Louisville, Ky.: Westminster John Knox Press, 1995). 65.

²⁴⁶ Edward P. Wimberly, *African American Pastoral Care*, Rev. ed. (Nashville: Abingdon Press, 2008). 47.

purposeful directions in life. From this perspective, each life is significant in God's unfolding story in the world and thus as life continues each story changes and individuals find that they have value and their life has intentional direction. This research works toward developing a pastoral counseling approach that incorporates a trauma survivor's experiences of a transcendent other, existential sense of purpose and meaning making. Aspects of this approach were constructed using elements of the eschatological hope, which promises positive self-transformation and the eschatological plots that empower individuals to redirect the story of their life. These two perspectives along with the data from this research study serves as a foundation for a pastoral counseling approach for use with emerging adult childhood trauma survivors.

The primary means of healing in pastoral counseling is through a cognitive reframing of the counselee's current situation and adoption of new strategies for coping, although some focus may be given to antecedents in the counselee's early life. Pastoral counseling, then – including cognitive, cognitive-behavioral, Solution-Focused, Rational Emotive, and many contemporary narrative approaches – tends to focus on the present and future rather than past emotional events, and works through various methods of reframing negative perspectives or meanings to events in order to arrive at solutions to problems identified by counselees.²⁴⁷

Wimberly's discussion of eschatological plots sets the stage for action planning. Often survivors find themselves stuck in survival patterns of behavior. Heightened arousal and anxiety make it difficult for survivors to be at ease in the world. When survival is the focus of life, survivors often choose not to reflect on painful memories. Helping counselees to situate their experiences within blocks or frames of time could

²⁴⁷ Cooper-White, *Many Voices: Pastoral Psychotherapy in Relational and Theological Perspective*.7.

prompt them to broaden their reflection of life to include ways of being before and after the experience. Reflecting in this way could pave the way toward spiritual reconciliation.

CHAPTER SUMMARY

This research is timely because the fields of pastoral care and counseling and professional counseling are beginning to dialogue about the mutual contribution that each field brings to the process of therapeutic intervention with individuals exhibiting maladaptive trauma responses. This research expands the exploration by contextualizing an integrative therapeutic approach that is grounded in both theological and psychological approaches to mental healing and health. Both theological scholars and psychological clinicians are currently investigating how spirituality influences resiliency, but few are researching how these two aspects of health can be used with integrative intentionality for cognitive reframing. This research seeks to develop an integrative therapeutic intervention that both brings into awareness individual maladaptive coping mechanism and build on or reframe coping structures by illuminating undiscovered or unacknowledged resources nestled in one's spiritual identity and resiliency traits. This intervention hopes to increase anxiety thresholds and augment coping skills, thus, enhancing individual capacity for a more holistic understanding of identity.

CHAPTER 4: METHODOLOGY

This study explored what effect a Spiritually Focused Cognitive Behavioral Therapy approach would have on enhancing resilience with emerging adult childhood trauma survivors. This research was timely because the fields of pastoral counseling and professional counseling are beginning to dialogue about the mutual contribution that each field brings to the process of therapeutic intervention with individuals who exhibit maladaptive trauma responses. This research study hopes to enrich the dialogue by contextualizing an integrative therapeutic approach that was grounded in both theological and psychological approaches to healing and health. Both theological scholars and psychological clinicians are currently investigating how spirituality influences resiliency, but few are researching how these two aspects of health can be used with integrative intentionality for cognitively reframing challenging experiences or situations.

The nature of the subject matter in this study (e.g., Childhood Trauma) could have caused uncomfortable memories, flashbacks, or emotional responses to occur during this research study. Reflecting on childhood trauma through the lenses of childhood abuse and neglect could have triggered emotional or mental distress for subjects, though not the intent of this study. Procedures were put in place to address mental or emotional distress that might have emerged during study. Referral information was provided for participants with contact a list of local mental health professionals. This list was provided to participants multiple times throughout the research process and included mental health

providers with varying fee structures. At intake and during the treatment intervention, participants were encouraged and instructed to stop what they were doing if they felt distress. None of the participants in this study expressed distress during the research or during follow-up. The researcher who is a Licensed Professional Counselor conducted the assessments and treatment interventions.

This study begins to lay the groundwork for future research with this subject. The findings serve as foundation for the development of an integrative therapeutic intervention that both brings into awareness individual maladaptive coping mechanisms and restructures cognitive coping by illuminating undiscovered or unacknowledged resources nestled in people's spiritual identity and other resiliency traits. The interventions used in this study are aimed at increasing anxiety thresholds, augmenting coping skills, and serving as a foundation for the development of a spiritually focused cognitive behavioral therapy approach for use with young adult childhood trauma survivors.

Research Design

This research was a pilot study. The study was designed to answer three research questions: a) what influence, if any, spiritual identity development has on enhancing resilience within childhood traumas, b) identifiable spiritual elements and themes (i.e., God/Fate, hopelessness, life's purpose, and meaning making) that positively influence coping with childhood trauma survivors, and c) an effective method of incorporating spirituality into a brief cognitive behavioral therapy approach. The research context was limited to emerging adult college students with histories of childhood trauma. As a pilot

study, certain limitations exist that prevent generalizable results including the limited duration of the therapy intervention used in the study and the small sample size of study participants. However, the results lay the foundation for the development of a larger study with this population and this intervention.

The research was conducted using a sequential phase mixed method research approach utilizing quantitative and qualitative research methods. The research design followed a sequential explanatory design wherein the qualitative analysis was used to build on the quantitative findings.²⁴⁸ The quantitative research method used a pre-test and post-test control group experimental design. Recognizing that the qualitative analysis could potentially reveal embedded information that may be different or more in-depth than the quantitative measures alone, a narrative questionnaire followed the quantitative post-test process. Below is specific information regarding the study, including the sample population, data collection and statistical analysis methods and the detailed research design procedures.

Population and Sampling

Undergraduate college students were recruited using a convenience sample for this study. Students were recruited from Theology, Psychology, Sociology, and Religion classes from a 26,000 student public two-year community college and a 7,000 student private four-year university in a large southeastern metropolitan city in the United States. To participate in the study, students responded to flyers or class presentations by

²⁴⁸ John W. Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 3rd ed. (Thousand Oaks, California: Sage Publications, 2009). 211.

contacting the researcher. The study criteria limited participation to 18-25 year old college students with a childhood history of abuse (physical, sexual, and/or emotional) or neglect (physical and/or emotional). Additional criteria included a willingness to discuss their concept of spirituality and how it developed, a willingness to complete 3 assessment instruments twice, and a willingness to participate in four brief therapy sessions to discuss childhood experiences and spirituality. Volunteers were informed of exclusion criteria through the recruitment material and prescreen process. The three exclusion criteria identified were: (1) outside of the age range, (2) refusal to discuss their personal childhood trauma, resilience, and spirituality and (3) scoring in the 'severe/extreme history of abuse' category of childhood trauma. Volunteers excluded from the study after the prescreen measures were referred to community mental health providers. The study protocol was approved by the Institutional Review Boards of both colleges and all subjects provided informed consent (see IRB Approval Letters in Appendix A).

Instruments

Participants completed two prescreen instruments, the Demographic Information Sheet and Childhood Trauma Questionnaire (CTQ) prior to entering the study.

Participants that met study criteria were placed in the study. Once in the study, all participants completed the study instruments, the Connor-Davidson Resilience Scale (CD-RISC) and the Royal Free Interview for Spiritual and Religious Beliefs (RFI). The researcher in this study has adapted the RFI to address language and religious differences in the American context. Both instruments were administered twice (pre-test, post-test

method). The intervention therapy sessions were not scripted. At the completion of the intervention experimental group participants completed a qualitative post-test interview (Narrative Questionnaire). Instrument details follow.

Demographic Information Sheet

The demographic information sheet was designed for this study. Participants were asked to provide contact information and identified personal demographics, including marital status, race/ethnicity, sex, age, religious/spiritual background, education level, employment status. Additionally, participants were asked to disclose the reason for choosing to participate in the study. Also as a part of the initial intake, students were asked to identify presenting ‘relevant concerns’ that were current issues for them. The relevant concerns listed include, but are not limited to, symptoms of anxiety/nervousness, depression, emptiness, guilt, and panic attacks.

Childhood Trauma Questionnaire

The Childhood Trauma Questionnaire developed by David Bernstein and Laura Fink (1998) was used to assess adolescents and adults with histories of childhood trauma.²⁴⁹ It was a 28-item standardized retrospective self-report questionnaire used as an abuse and trauma measure. Bernstein, Jelly, and Handlesman (1997) used the instrument in a study with 92 college students with Cronbach’s alpha reliabilities ranging between .60-.92 across the five sub-scales.

²⁴⁹ Bernstein and Fink, *Childhood Trauma Questionnaire: A Retrospective Self-Report Manual*.

The instrument measures the severity of an individual's experience of childhood trauma using five subscales that consists of five items corresponding to Emotional Abuse, Emotional Neglect, Physical Abuse, Physical Neglect and Sexual Abuse. The instrument has three additional subjective items on a Minimization-Denial scale to discover potential response bias or if subjects have attempted to underreport/minimize their childhood experiences. Individuals indicate responses based on memories of "when subject were growing up" to respond to the questionnaire items. On the Likert scale responses range from "never" = 1 to "very often" =5. For example, a question might ask participants to respond to the statement "When I was growing up...People in my family called me things like 'stupid' 'lazy' or 'ugly'." The items were designed to obtain reliable recall of childhood histories of abuse and neglect using objective non-evaluative terms. The CTQ takes approximately 5 minutes for subjects to complete.

Connor-Davidson Resilience Scale

The Connor-Davidson Resilience Scale (CD-RISC) measures stress coping ability. Connor and Davidson's (2003) scale assesses resilience using a 25-item instrument with each item rated on a 5-point scale (0-4) with higher scores reflecting greater resilience. The CD-RISC was based on characteristics found in resilient people per the findings of Kobasa (1979), Rutter, 1985, and Lyons, 1991. Connor and Davidson's (2003) goal was "to develop a valid and reliable measure to quantify resilience, to establish reference values for resilience in the general population and in clinical samples, and to assess the modifiability of resilience in

response to pharmacologic treatment in a clinical population.”²⁵⁰ The CD-RISC sample population included non-help seeking community members, psychiatric outpatients, and patients with generalized anxiety and PTSD diagnoses. The CD-RISC has reliability of .89 for the full scale based on Cronbach’s alpha. Increased CD-RISC scores correlate proportionately with overall clinical global improvement. The scale demonstrates that resilience was modifiable and can improve with treatment. Greater CD-RISC scores correspond with higher levels of global improvement.

Royal Free Interview for Spiritual and Religious Beliefs

King, Speck, and Thomas (2001) developed the Royal Free Interview for Spiritual and Religious Beliefs (RFI) to measure emotional and cognitive experiences of faith and spiritual belief systems.²⁵¹ It was an 18-item self-report questionnaire aimed at measuring spiritual experiences in addition to faith or intellectual assent. The instrument was studied with three groups: hospital employees, non-treatment seeking community participants in London and Southampton, and members of a fundamentalist Christian church in London. The spiritual scale for the test group had good internal consistency. Cronbach's alpha for the first two groups was .89, and .74 for the third group. Despite RFI’s development in England and its homogenous demographic sample (predominately

²⁵⁰ Connor and Davidson, "Development of a New Resilience Scale: The Connor-Davidson Resilience Scale (CD-RISC)," 77-78.

²⁵¹ Michael King, Peter Speck, and Angela Thomas, "The Royal Free Interview for Spiritual and Religious Beliefs: Development and Validation of a Self-Report Version," *Psychological Medicine* 31(2001): 1016.

white middle-aged, middle-to-upper class married women), aspects of the assessment may be relevant for United States participants in this study (i.e., distinctions between spiritual and religious expression). The RFI assessment used in this study has been adapted to address religious and spiritual diversity in the United States. RFI modifications focus primarily on descriptive language for religious identifiers and denominations/sects categorizations. Similarly, other researchers adapted the RFI to better suit their research populations including Mitchell and Romans (2003) who studied the Religious and Spiritual Beliefs of patients with Bipolar Disorder diagnosis in New Zealand and Sapountzi-Krepia et al., (2005) who adapted the RFI for Greek populations with a younger mean age (26.73 years old).²⁵² Their subjects were mostly single/unmarried college students.

Narrative Questionnaire

The Narrative Questionnaire was designed for this study to assess the effectiveness of the therapy intervention. It was a qualitative interview that prompted experimental group participants to detail their personal experience during the therapeutic encounter. Experimental group participants commented upon the most and least helpful elements in the therapy encounter, the unexpected or anxiety producing elements, and any personal changes they identified as resulting from their participation in therapy. Suggestions or recommendations

²⁵² Logan Mitchell and Sarah Romans, "Spiritual Beliefs in Bipolar Affective Disorder: Their Relevance for Illness Management," *Journal of Affective Disorders* 75, no. 3 (2003). and Despina Sapountzi-Krepia et al., "Validation and Test-Retest Reliability of the Royal Free Interview for Spiritual and Religious Beliefs When Adapted to a Greek Population," *Annals of General Psychiatry* 4, no. 1 (2005).

were also retrieved. There are seven open-ended questions on the Narrative Questionnaire. Qualitative analysis was used to identify cogent themes in the collective responses.

Data Collection

Data were collected using quantitative *personality inventories* (questionnaires) and qualitative *standardized open-ended interview*. Quantitative questionnaires “provide good measures of many characteristics of people” and qualitative interviews are useful in “measuring attitudes and most other content of interest.”²⁵³ The mixed method approach capitalizes on the strengths of both to data collection methods. The data in this study were collected sequentially QUEST-QUAN → INT-QUAL. In this study, quantitative data were collected using the Demographic Information Sheet, Childhood Trauma Questionnaire, Connor-Davidson Resilience Scale and The Royal Free Interview for Spiritual and Religious Beliefs. The qualitative data were collected using the Narrative Questionnaire. Quantitative data provides broad ranging information, while the qualitative data provides more in depth information supported by the quantitative information.

Statistical Method

The quantitative data in this study were analyzed using inferential statistical test using analysis of variance. The univariate analysis of variance was used to analyze

²⁵³ Charles Teddlie and Abbas Tashakkori, *Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences* (Los Angeles: SAGE, 2009). 239.

categorical variables (e.g., resilience and religious/spiritual beliefs) and correlation with the continuous measure of age. Descriptive statistics were used to characterize assessment scores in the sample by gender, age, ethnicity, religious/spiritual background and presenting issue.

The qualitative data were analyzed using an inductive data analysis which employs a phenomenological research approach. Phenomenological research seeks to discover shared meaning among a group of people, particularly those who have shared experiences.²⁵⁴ A phenomenological approach to data allows the researcher to illuminate the relevance of theoretical elements in light of the lived experiences among the test population.

Qualitative data were used to analyze beneficial and ineffectual elements of the therapeutic intervention, as revealed during the intervention session dialogues and by the Narrative Questionnaire following the intervention. Qualitative data were coded into category themes and subthemes.²⁵⁵ Those categories were then analyzed for the meaning in the themes. NVivo10 qualitative data management software was used to facilitate coding of both approaches and to develop the main themes and subthemes. The themes and subthemes discovered in the qualitative data follow in the next section.

²⁵⁴ John W. Creswell, *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*, 2nd ed. (Thousand Oaks: Sage Publications, 2007). 57.

²⁵⁵ Swinton and Mowat, *Practical Theology and Qualitative Research*: 175-78.

Research Design and Procedures

As stated earlier in this section, this study was developed using a mixed-method two phase sequential research design with both quantitative and qualitative results. In phase one quantitative measures in the form of assessment instruments were administered. In the second phase, participants completed a written narrative to elaborate on the quantitative results. Power calculations were determined by significance level α based on an anticipated $N=30$.²⁵⁶ The study did not achieve the anticipated n . Instead, the study sample was $N=20$. Although the study did not reach desired sample size to achieve the power calculation threshold for $\alpha = .05$, significance was still reflected in the study.

Sample subjects were assigned numerical identifiers by the researcher to enhance the confidentiality of the records. The coded identifiers, a 3-digit numerical code, were used to identify all records, assessments, and notes. For randomization purposes, ten subjects were assigned sequentially to participate in the experimental group from the sample pool list of identifiers and the next ten subjects were assigned to the control group. The experimental group received the therapeutic intervention. There was no subject attrition or replacement in this study. The 10 subjects assigned to the experimental group were scheduled for four therapy intervention sessions. Assessments and interventions were conducted in counseling offices on or near each campus.

After completing the Informed Consent form, study volunteers completed two pre-screen tools, a Demographic Information Sheet and the Childhood Trauma Questionnaire (CTQ). These two tools take approximately 10 minutes to complete.

²⁵⁶ Geoffrey Keppel, *Design and Analysis: A Researcher's Handbook*, 3rd ed. (Englewood Cliffs, N.J.: Prentice Hall, 1991). 71-72.

Subjects then received a debriefing session and assessment for risk prior to having the CTQ instrument scored. If no imminent risk was present, subjects were instructed to complete the Connor-Davidson Resilience Scale (CD-RISC) and the Royal Free Interview for Spiritual and Religious Beliefs (RFI) instruments. The CD-RISC and RFI take approximately 10-15 each to complete. After the experimental group participants completed the intervention phase of the quantitative research. The experimental group subjects participated in 4 50-minute sessions of Spiritually Focused Cognitive Behavioral Therapy (intervention). The treatment sessions were conducted on a weekly basis. Participants were assigned homework at the end of each session and given handouts to log their responses. The treatment protocol for each treatment group session is listed below (see table 4.1). The therapy session intervention discussed the subject's childhood trauma experience, understanding of resiliency factors (positive coping), and spiritual resources (i.e., hope, purpose, and meaning making).

Participants met with a specific researcher for the duration of the treatment. The researcher has training in adolescent and college student therapeutic practices, as well as in pastoral counseling. Following the completion of the treatment group interventions all study subjects were readministered the CD-RISC and RFI assessments (pre-test/post-test). Following the post-test of the CD-RISC and RFI assessments, were administered the Narrative Questionnaire. All participants were given community mental health contacts following the completion of the post-test and debriefing meeting. Approximately a month later, study subjects received a follow-up session to discuss the effects of the study and risk-assessment of functioning.

Table 4.1 – Treatment Session Goals, Intervention and Homework Assignments

Session - 1
Goals
<ol style="list-style-type: none"> 1. Assessment of Current Presenting Issues 2. History of Childhood Trauma 3. History of Spiritual Development
Interventions
<ol style="list-style-type: none"> 1. Assess for threat, self-harm and psycho-social functioning
Homework
<ol style="list-style-type: none"> 1. Keep a log of negative-thoughts/self-statements: - the time, the event, what you were thinking, what you were feeling, your statement or reactions, how your spirituality does or does not influence your statement or reaction
Session - 2
Goals
<ol style="list-style-type: none"> 1. Review Week 1 homework – triggers, thoughts, behaviors, and spiritual influences 2. Discuss Spiritual Resources in conjunction with Resilience Scale (CD-RISC) items 3. Discuss Spiritual Resources in conjunction with (RFI) items 4. Where has spirituality been absent?
Interventions
<ol style="list-style-type: none"> 1. Discuss: <ul style="list-style-type: none"> • What are your personal spiritual beliefs • What shaped your spirituality? • If relevant, what makes spiritual disciplines (i.e. prayer, mediation, ritual, reading sacred texts) and the practice of your faith significant to you? • If your spirituality has helped you to cope with life events, how has it helped? Past and present. • Has there been a spirituality experience that adds meaning to your experiences? 2. Discuss: the relationship between presenting issues and spirituality with particular emphasis on the relevance of the following items from the RFI. <ul style="list-style-type: none"> • Adaptability, God can help, Things happen for a reason, Perseverance, Think of yourself as a “strong person,” Strong sense of purpose
Homework
<ol style="list-style-type: none"> 1. Keeps a log of how you attempted to reframe the negative thoughts/statements using the resources we discuss? the time, the event, what you were thinking, your statement or reactions, how you reframed the thought
Session - 3
Goals

-
1. Review Week 2 homework – triggers, reframes, spiritual influences
 2. Discuss history of childhood abuse or neglect and its effect on current behaviors, emotions, and thoughts. How did those experience shape who you have become?
 3. Discuss the history of spiritual development and how it affects current behaviors, emotions, and thoughts. How did those experience shape who you have become?

Interventions

-
1. Risk assessment
 2. Process on-going reflections:
 - Explore the childhood trauma experiences and developmental impact based on responses to the CTQ assessment. What do those responses mean for you. How have those experiences shaped who you have become?

Homework

-
1. Reflect on how the childhood experiences of abuse and/or neglect have influenced or been influenced by their spirituality.
-

Session - 4

Goals

-
1. Termination
 - Review of session 3 homework
 - Final discussion of resilience attributes
 - Review of the therapeutic process
 - Referrals
 - Schedule follow-up session in 3 -4 weeks

Interventions

-
1. Resource discovery: To what do you attribute your ability to excel in spite of your childhood experiences?

Homework

-
1. Continue to practice the process of acknowledging negative thinking and self-statements, choosing to use positive reframing to gain a broader perspective of the life's issues, and searching your spiritual meaning making for connection points to help you navigate challenging situations.
-

Follow-Up

Goals

-
1. Completion of the CD-RISC, RFI, and Narrative Questionnaire
 2. Debriefing

CHAPTER SUMMARY

In summary, this study seeks answers to three questions. First, does spirituality influence resilience enhancement for emerging adult childhood trauma survivors? Secondly, what elements of spirituality positively influence resilience, and lastly, what elements do emerging adult childhood trauma survivors indicate as effective in the development of a brief therapy approach with this population? To retrieve results for these questions, twenty participants were recruited who had histories of childhood trauma and who were suitable to participate in assessment instruments, treatment interventions, and/or post-intervention interviews, based on an initial risk assessment. Selected participants were sequentially assigned to two experimental groups (treatment group and control group). Following the completion of treatment intervention sessions participants post-tested on the previous assessments to complete the study. During the study, participants were repeatedly assessed for risk and suitability for continuing in the study. There were no harmful risks reported by participants. The quantitative and qualitative data results of the study were analyzed using SPSS and NVIVO10 software. The results of the study are found in chapter 5.

CHAPTER 5: RESULTS

This chapter will present the research findings of the current study. The chapter begins with demographic information about the sample population. The next two sections discuss the quantitative and qualitative data results in conjunction with the research goals. The quantitative data section will provide an analysis of the descriptive statistics and tables derived from the quantitative data, including the results for research question 1 and 2. The qualitative data section will reveal themes and sub-themes derived from the treatment interventions and post-intervention instruments. The chapter concludes with a summary of both quantitative and qualitative findings of this study.

Demographics of Sample

College students (n=20) who self-reported having a history of childhood trauma participated in the study. Twenty college students participated in the treatment and control groups. Participants either attended a two year community college (n=15) or a four-year private university (n=5). The mean age was 21.35 years old with a standard deviation of 2.254. The study sample consisted of 70 percent (n=14) female and 30 percent (n= 6) male participants. Participants in the study identified their ethnicity as Caucasian (30%, n=6), African American/Black (60%, n=12), Caribbean (5%, n=1) and African (5%, n=1). Regarding religious/spiritual background, 65 percent (n=13) reported

their background as Christian, 15 percent (n=3) Muslim, 5 percent (n=1) Jewish, and 15 percent (n=3) other.

Participation rate was over 100% of volunteers who responded for the study. The treatment group and control groups were assigned by sequential assignment where the first ten participants who met study criteria were assigned to the treatment group and the next ten participants were assigned to the control group. Table 5.1 reveals the sample demographics per group assignment.

Table 5.1 Demographic description of the participants

Variables		Treatment Cohort <i>n</i> = 10		Control Cohort <i>n</i> = 10	
		N	%	N	%
Age	Mean age (SD)	21.7		21.0	
	Min-Max	18-25		18-25	
Gender	Female	7	70%	7	70%
	Male	3	30%	3	30%
Ethnicity	African American/Black	5	50%	7	70%
	Caucasian	4	40%	2	20%
	Caribbean	1	10%	0	0%
	African	0	0%	1	10%
Education Status	Associate/Undergraduate Student	9	90%	10	100%
	Master's Student	1	10%	0	0%
Religious/Spiritual Background	Christian	6	60%	7	70%
	Jewish	1	10%	0	0%
	Muslim	1	10%	2	20%
	Other	2	20%	1	10%
	No Religious/Spiritual Background	0	0%	0	0%

Descriptive Statistics

Pre-screen Instruments

Presenting Issues. Participants completed two pre-screen instruments prior to participating in the study. First, participants completed a self-reported presenting issues form to identify any current thoughts, behavior, family, and relationship, or work/school issues (See APPENDIX C). The high frequencies of presenting issues are displayed below (see tables 5.2 and 5.3, respectively). Table 5.2 displays the most frequent presenting issues for participants by group (i.e., treatment vs. control group). In the treatment group, the most frequent presenting issues were anxiety/nervousness (80%), childhood issues (80%), stress (70%), problems with parents (60%), career concerns (60%), failure (50%), procrastination (50%), and excessive worry/fear (50%). Conversely, the most frequent presenting issues for the control group were distractibility (30%), sudden mood changes (30%), procrastination (30%), anxiety/nervousness (20%), stress (20%), and anger/frustration (20%).

Table 5.2 Highest frequency of self-reported presenting issues per Treatment Group and Control Group

Variable	Gender	
	Treatment Group (n=10)	Control Group (n=10)
	%	%
Thoughts		
Anxiety/Nervousness	80	20
Stress	70	20
Anger/Frustration	40	20
Failure	50	10
Attention/Distractibility	30	30
Excessive Worry / Fear	50	20
Guilt	30	10
Perfectionism	40	20
Self-esteem	30	20
Sudden Mood Changes	30	30
Behaviors		
Eating Problems / Overeating	40	20
Procrastination	50	20
Smoking	20	10
Isolation	20	10
Sleep Difficulty	50	--
Family & Relationships		
Childhood Issues	80	20
Problems with Parents	60	10
Interpersonal Conflict	40	--
Parenting	30	--
Friendships	40	--
Work/School		
Procrastination	50	30
Career concerns	60	20
Performance	20	20
School Problems	40	20
Tardiness	20	--

Gender and Presenting Issues

Table 5.3 presents the most frequently reported presenting issues by gender, ethnicity, and religious/spiritual background. By gender, participants reported presenting issues related to thoughts, behaviors, relationships, and work/school issues. Fourteen females and six males reported presenting issues. In relation to gender, females in the study frequently reported thought-related presenting issues associated with anxiety/nervousness (42.9%), stress (50.0%), and anger/frustration (21.4%). Similarly, males in the study frequently reported anxiety/nervousness (66.7%), stress (33.3%), and anger/frustration (50.0%). Related to behavioral presenting issues, females more frequently reported eating problems/overeating (35.7%), procrastination (35.7%) and sleep difficulty than other behavioral issues. Males reported procrastination (33.3%), smoking (33.3%), and isolation (33.3%) more frequently than other behavioral issues. Relevant to this study, over half of the females (57.1%) reported current problems with childhood issues, while 33.3 percent of male reported childhood issues as a current problem. Females (42.9%) reported problems with parents more often than males (16.7%). However, males (33.3%) reported issues with friendships more often than females (14.3%). Some females (42.9%) and males (33.3%) in this study reported procrastination in their work/school. A little more than one third of the females in this study (35.7%) reported career concerns as a presenting issue, while half of the males (50.0%) identified career concerns as an issue.

Ethnicity and Presenting Issues

Four ethnic groups were represented in the study. The two predominant ethnic groups represented in the study were African Americans/Blacks (n = 12) and Caucasians (n = 6). In the category of thought-related presenting issues, African American/Black participants reported consistent frequencies of anxiety/nervousness (33.3%), stress (33.3%), anger/frustration (33.3%), and attention/distractibility (33.3%). On the other hand, the majority of the Caucasian participants reported anxiety/nervousness (83.3%), stress (66.7%), and perfectionism (50.0%) as current presenting issues. Regarding presenting behaviors, African American/Black participants (41.7%) reported eating problems/overeating (41.7%) and procrastination (41.7%) as current issues. Similarly, Caucasian participants reported eating problems/overeating (33.3%) and procrastination (33.3%) more often as behavior-related issues. Childhood issues remained a prominent presenting issue with each ethnic group as with gender. African American/Black (41.7%) and Caucasian participants (66.7%) reported childhood issues as a current problems, as well as problems with parents for (25.0%) and (50.0%), respectively. Finally, half of the African American/Black participants reported procrastination (50.0%) and career concerns (50.0%) related work/school issues in the as presenting issues, while Caucasian participants reported procrastination (33.3%) and performance (33.3%), as work/school related presenting issues.

Religious/Spiritual Background and Presenting Issues

Three religious/spiritual groups were predominantly represented in this study, Christian (n = 13), Muslim (n = 3) and other religious/spiritual backgrounds (n = 3).

When it comes to thought-related presenting issues, Christians (53.8%) and other (66.7%) religious/spiritual background participants most frequently reported the issue of anxiety/nervousness. Frequently, Christian (46.2%), Muslim (33.3%) and other (33.3%) religious/spiritual background participants reported stress as a presenting issue. Christian (30.8%), Muslim (66.7%) and other religious/spiritual background (33.3%) participants also reported eating problems/ overeating as presenting issues. Likewise, Christians (30.8%), Muslims (33.3%) and other religious/spiritual backgrounds (33.3%) reported behavior-related issues such as procrastination with consistent frequency. To be expected Christian participants (46.2%), Muslims (67.7%), and other religious/spiritual backgrounds (33.3%) reported having current problems with childhood issues. Christians (46.2%) and participants with other religious/spiritual backgrounds (33.3%) also reported problems with parents as current issues. Some Christian (30.8%) and Muslim (66.7%) participants reported procrastination related to work/school as a presenting issue. Finally, nearly half of the Christian participants (46.2%) identified career concerns as presenting issues, while fewer participants with other religious/spiritual backgrounds (33.3%) reported career concerns as presenting issues.

Table 5.3 Highest frequency of self-reported presenting issues by participant gender, ethnicity and religious/spiritual background

Variable	Gender		Ethnicity		Religious/Spiritual Background			
	Female (n=14)	Male (n=6)	African American/ Black (n=12)	Caucasian (n=6)	Christian (n=13)	Muslim (n=3)	Jewish (n=1)	Other (n=3)
	%	%	%	%	%	%	%	%
Thoughts								
Anxiety/Nervousness	42.9	66.7	33.3	83.3	53.8	--	100	66.7
Stress	50.0	33.3	33.3	66.7	46.2	33.3	100	33.3
Anger/Frustration	21.4	50.0	33.3	16.7	23.1	33.3	100	33.3
Failure	35.7	16.7	25.0	33.3	30.8	33.3	--	33.3
Attention/Distractibility	28.6	33.3	33.3	33.3	30.8	33.3	100	--
Excessive Worry / Fear	28.6	16.7	25.0	33.3	23.1	33.3	100	33.3
Guilt	14.3	33.3	8.3	33.3	23.1	--	100	--
Perfectionism	28.6	33.3	16.7	50.0	23.1	33.3	100	33.3
Self-esteem	28.6	16.7	25.0	33.3	15.4	33.3	100	33.3
Sudden Mood Changes	28.6	33.3	25.0	33.3	38.5	33.3	--	--
Behaviors								
Eating Problems / Overeating	35.7	--	41.7	33.3	30.8	66.7	--	33.3
Procrastination	35.7	33.3	41.7	33.3	30.8	33.3	100	33.3
Smoking	7.1	33.3	--	33.3	15.4	0.0	100	--
Isolation	7.1	33.3	8.3	16.7	7.7	33.3	100	--
Sleep Difficulty	28.6	16.7	25.0	16.7	30.8	33.3	--	--
Family & Relationships								
Childhood Issues	57.1	33.3	41.7	66.7	46.2	67.7	100	33.3
Problems with Parents	42.9	16.7	25.0	50.0	46.2	--	--	33.3
Interpersonal Conflict	21.4	16.7	25.0	16.7	7.7	33.3	100	33.3
Parenting	14.3	16.7	16.7	--	15.4	33.3	--	--
Friendships	14.3	33.3	8.3	33.3	23.1	--	100	--
Work/School								
Procrastination	42.9	33.3	50.0	33.3	30.8	66.7	100	33.3
Career concerns	35.7	50.0	50.0	16.7	46.2	--	100	33.3
Performance	28.6	--	16.7	33.3	23.1	33.3	--	--
School Problems	28.6	16.7	33.3	16.7	30.8	33.3	--	--
Tardiness	7.1	16.7	8.3	--	15.4	--	--	--

Childhood Trauma Questionnaire. Secondly, participants completed the Childhood Trauma Questionnaire (CTQ), which identified the level of severity of childhood trauma experiences based on five categories of abuse and neglect. They are physical neglect, emotional neglect, physical abuse, sexual abuse or emotional abuse. The CTQ responses to these five categories ranged in scores in each category delineating trauma severity: none/minimal, low, moderate, or severe. The results of the CTQ are presented below (see tables 5.4 and 5.5, respectively).

Table 5.4 - Childhood Trauma per Treatment Group and Control Group

	Classifications								
	None (or Minimal)		Low (to Moderate)		Moderate (to Severe)		Severe (to Extreme)		
	N	%	N	%	N	%	N	%	
Emotional Abuse									
Treatment Group	0	--	0	--	6	60	4	40	
Control Group	5	50	2	20	2	20	1	10	
Sexual Abuse									
Treatment Group	4	40	1	10	0	--	5	50	
Control Group	6	60	2	20	0	--	2	20	
Physical Abuse									
Treatment Group	5	50	3	30	0	--	2	20	
Control Group	5	50	5	50	0	--	0	--	
Emotional Neglect									
Treatment Group	1	10	4	40	2	20	3	30	
Control Group	6	60	2	20	1	10	1	10	
Physical Neglect									
Treatment Group	6	60	2	20	0	--	2	20	
Control Group	7	70	3	30	0	--	0	--	

Table 5.4 reveals the levels of childhood trauma by treatment group (n = 10) and control group (n = 10). Of the treatment, group participants, six (60%) report moderate levels of emotional abuse and four report severe levels (40%). Five treatment group

participants (50%) report no to low sexual abuse and 5 (50%) reported severe histories sexual abuse. The treatment group had eight participants (80%) to report none to low levels of physical abuse and two participants (20%) to report severe physical abuse. The treatment group was split equally, five participants (50%) reported none to low emotional neglect, and five participants (50%) reported moderate to severe emotional neglect. As for physical neglect, eight treatment group participants (80%) reported none to low levels and two (20%) reported severe physical abuse.

Participants all had moderate to severe levels of abuse and neglect. Seven control group participants (70%) reported none to low levels of emotional abuse, but three participants (30%) reported moderate to severe emotional abuse. Eight control group participants (80%) reported none to low levels of sexual abuse, but two participants (20%) reported severe levels. Regarding emotional neglect, eight participants (80%) reported none to low levels, but two participants (20%) report moderate to severe levels of emotional neglect. All ten control group participants (100%) reported none to low levels of physical abuse and physical neglect.

Table 5.5 - Childhood Trauma Questionnaire Results Chi-Square Test with Gender

	Chi-Square Value	Sig.	Childhood Trauma Level							
			None (or Minimal)		Low (to Moderate)		Moderate (to Severe)		Severe (to Extreme)	
			F	M	F	M	F	M	F	M
			% of N		% of N		% of N		% of N	
Emotional Abuse	.556	.907	28.6	16.7	28.6	33.3	21.4	16.7	21.4	33.3
Sexual Abuse	.635	.888	50.0	50.0	14.3	16.7	7.1	16.7	28.6	16.7
Physical Abuse	5.714	.057	85.6	66.7	--	33.3	14.3	--	--	--
Emotional Neglect	5.658	.130	35.7	16.7	35.7	33.3	21.4	--	7.1	50.0
Physical Neglect	9.414	.009**	85.7	16.7	7.1	66.7	7.1	16.7	--	--

* $p \leq .05$ Statistically Significant Difference

** $p \leq .01$ Statistically Significant Difference

Gender and Childhood Trauma

A Chi Square test was performed to determine if males and females were distributed differently across the physical neglect. The test indicated a significant difference, $\chi^2(1) = 9.41$, $p = .01$. The results trend toward none to low experiences of physical neglect among females and low to moderate experiences among males. A Chi Square test was also performed to determine if males and females were distributed differently across the emotional abuse. The test failed to indicate a significant difference, $\chi^2(1) = .56$, $p = .91$ (an alpha level of .05 was adopted for this and all subsequent statistical tests). Chi Square tests likewise failed to indicate a significant difference in by gender across sexual abuse ($\chi^2(1) = .64$, $p = .89$), physical abuse ($\chi^2(1) = 5.71$, $p = .06$), and emotional neglect ($\chi^2(1) = 5.66$, $p = .13$).

Female and male participants in this study reported similar results (percentages) regarding childhood traumatic experiences from emotional abuse. Of the participants that

reported childhood emotional abuse eight females reported none (4 = 28.6%) to low (4 = 28.6%) levels, while three (21.4%) reported a moderate level and three (21.4%) a severe level. Three of the six males in the study reported none to low (3 = 50.0%) levels of emotional abuse however, three males reported moderate to severe experiences of childhood emotional abuse. Related to childhood sexual abuse trauma, nine female study participants reported none (7 = 50.0%) to low (2 = 14.3%) levels of sexual abuse, while the other five participants reported moderate (1 = 7.1%) to severe (4 = 28.6%) levels of sexual abuse. Similarly, the more than half of the male participants (3 = 66.7%) reported no sexual abuse to low levels (16.7%) of abuse. One male participant each reported moderate (16.7%) and severe sexual abuse (16.7%). On the topic of physical abuse, the majority of female participants reported none (12 = 85.6%) and two female participants reported a severe level (14.3%). On the other hand, all six of the male participants reported none (4 = 66.7%) to low levels (2 = 33.3%) of physical abuse. As for experiences of childhood trauma from emotional neglect, 10 female participants reported none (5 = 35.7%) to low levels (5 = 35.7%) of neglect. Three females (21.4%) reported moderate emotional neglect, and one reported a severe level (7.1%) of neglect. Three of the male participants (50%) reported severe emotional neglect. One male participants (16.7%) reported no emotional neglect, and two (33.3%) reported a low level of emotional neglect. A large number of the female participants reported none (12 = 85.7%) to low levels (1 = 7.1%) of physical neglect in childhood, with one female participant (1 = 7.1%) reporting moderate physical neglect. Likewise, the majority of the male participants reported none (1 = 16.7%) to low levels (4 = 66.7%) physical neglect. One male participant (1 = 16.7%) reported a severe level of physical neglect.

Table 5.6 - Childhood Trauma Questionnaire Results Chi-Square Test with Ethnicity

	Chi-Square Value	Sig.	Childhood Trauma Level			
			None (or Minimal)	Low (to Moderate)	Moderate (to Severe)	Severe (to Extreme)
			% of N	% of N	% of N	% of N
Emotional Abuse	16.958	.049*				
African			--	--	100.0	--
African-American/Black			41.7	41.7	--	16.7
Caribbean			--	--	--	100.0
Caucasian			--	50.0	16.7	33.3
Sexual Abuse	7.333	.602				
African			100.0	--	--	--
African-American/Black			50.0	16.7	--	33.3
Caribbean			100.0	--	--	--
Caucasian			33.3	16.7	33.3	16.7
Physical Abuse	11.875	.065				
African			--	100.0	--	--
African-American/Black			83.3	--	16.7	--
Caribbean			100	--	--	--
Caucasian			83.3	16.7	--	--
Emotional Neglect	19.107	.024*				
African			--	--	--	100.0
African-American/Black			50.0	25.0	16.7	8.3
Caribbean			--	--	--	100.0
Caucasian			--	--	83.3	16.7
Physical Neglect	18.538	.005**				
African			--	100.0	--	--
African-American/Black			91.7	8.3	--	--
Caribbean			--	--	100.0	--
Caucasian			33.3	50.0	16.7	--

* $p \leq .05$ Statistically Significant Difference

** $p \leq .01$ Statistically Significant Difference

Ethnicity and Childhood Trauma

A Chi Square test was performed to determine if African Americans/Blacks, Caucasians, Africans, and Caribbeans were distributed differently across the emotional abuse. The test indicated a significant difference, $\chi^2 (1) = 16.96$, $p = .05$. Chi Square test

also indicated a significant difference across emotional neglect ($\chi^2(1) = 19.11, p = .02$), and physical neglect ($\chi^2(1) = 18.54, p = .01$). The results trend toward none to low experiences of emotional abuse, emotional neglect and physical neglect among African American participants. In contrast, Caucasian participant results trend toward low to severe experiences of emotional abuse and moderate to severe experiences of emotional neglect. Test results for Caucasian participants trend toward none to moderate experiences of physical neglect. Chi Square test by ethnicity failed to indicate a significant difference across the sexual abuse, $\chi^2(1) = 7.33, p = .60$ and physical abuse, $\chi^2(1) = 11.88, p = .07$.

Relative to the African American/Black participants in the study, ten reported none (5 = 41.7%) to low (5 = 41.7%) levels of childhood emotional abuse. Two African American/Black participants (16.7%) reported severe abuse. The half of the Caucasian participants (3 = 50%) reported low levels of childhood emotional abuse, but one Caucasian participant (1 = 16.7%) reported moderate levels of abuse, and two reported severe (33.3%) abuse. In addition, the sole African participant (1 = 16.7%) reported moderate emotional abuse, while the sole Caribbean participant reported a severe level of abuse. Regarding childhood sexual abuse, eight African American/Black participants reported none (6 = 50%) to low (2 = 16.7%) levels of abuse and four African American/Black participants (33.3%) reported a severe level of abuse. Three Caucasian participants reported none (2 = 33.3%) to low (1 = 16.7%) levels of sexual abuse, two Caucasian participants (33.3%) reported moderate abuse, and one reported severe abuse. Both the African and Caribbean participants reported no sexual abuse. Ten African American/Black participants reported no (10 = 83.3%) physical abuse. Two African

American/Black participants (16.7%) reported moderate physical abuse. In contrast, all six Caucasian participants reported none (5 = 83.3%) to low (1 = 16.7%) levels of physical abuse. Caucasian participants reported no moderate or severe levels of physical abuse. The African participant (1 = 16.7%) reported a low level of physical abuse, while the Caribbean participant reported no physical abuse. Nine of the African American/Black participants reported none (6 = 50%) to low (3 = 25%) levels of emotional neglect. Two African American/Black participants reported moderate emotional neglect (16.7%) and one reported severe (8.3%) emotional neglect in childhood. Five Caucasian participants reported moderate (5 = 83.3%) levels of emotional neglect. One Caucasian participant reported severe emotional neglect. Both the African and Caribbean participant reported severe emotional neglect during childhood. As it relates to physical neglect childhood experiences, twelve African American/Black participants reported none (11 = 91.7%) to low (1 = 8.3%) levels of physical neglect. None of the African American/Black participants reported moderate or severe physical neglect. Four of the Caucasian participants reported none (2 = 33.3%) to low (3 = 50%) levels of physical neglect, while one Caucasian participant (16.7%) reported severe physical neglect. The African participant reported a low level of physical neglect, while the Caribbean participant reported a moderate level of physical neglect.

Table 5.7 - Childhood Trauma Questionnaire Results Chi-Square Test with Spiritual/Religious Background

	Chi-Square Value	Sig.	Childhood Trauma Level			
			None (or Minimal)	Low (to Moderate)	Moderate (to Severe)	Severe (to Extreme)
			% of N	% of N	% of N	% of N
Emotional Abuse	8.513	.483				
Christian			30.8	46.2	7.7	15.4
Jewish			--	100.0	--	--
Muslim			33.3	33.3	--	33.3
Other			--	--	33.3	66.7
Sexual Abuse	9.726	.373				
Christian			61.5	15.4	7.7	15.4
Jewish			--	--	100.0	--
Muslim			33.3	33.3	--	33.3
Other			33.3	--	33.3	33.3
Physical Abuse	14.615	.023*				
Christian			92.3	--	7.7	--
Jewish			100.0	--	--	--
Muslim			66.7	--	33.3	--
Other			33.3	66.7	--	--
Emotional Neglect	9.817	.366				
Christian			38.5	15.4	7.7	38.5
Jewish			--	--	100.0	--
Muslim			33.3	33.3	33.3	--
Other			--	--	33.3	66.7
Physical Neglect	10.962	.090				
Christian			76.9	7.7	15.4	--
Jewish			--	100.0	--	--
Muslim			100.0	--	--	--
Other			100.0	--	--	--

* $p \leq .05$ Statistically Significant Difference

Religious/Spiritual Background and Childhood Trauma

A Chi Square test to determine if Christians, Muslims, Jews, and participants of other religious/spiritual backgrounds were distributed differently across the physical abuse indicated a significant difference, $\chi^2 (1) = 14.62$, $p = .02$. The results trend toward

none to low experiences of physical abuse among Christians and other religious/spiritual backgrounds, but none to moderate among Muslim participants. The Chi Square tests by religious/spiritual background across emotional abuse ($\chi^2(1) = 8.51, p = .48$), sexual abuse ($\chi^2(1) = 9.72, p = .37$), emotional neglect ($\chi^2(1) = 9.82, p = .37$), and physical neglect ($\chi^2(1) = 10.96, p = .09$) failed to indicate a significant difference.

Christianity was the most prominently represented religious/spiritual group in this study. Related to childhood emotional abuse, ten Christian participants reported none (4 = 30.8%) to low (6 = 46.2%) levels of abuse. One Christian participant reported a moderate level (7.7%) of emotional abuse and two reported severe (15.4%) abuse. One of the three Muslim participants (33.3%) reported no emotional abuse, one (33.3%) reported low levels of abuse, and one (33.3%) reported severe abuse. The sole Jewish participant reported a low level of emotional abuse. Three participants with while three participants that identified as having other religious/spiritual backgrounds reported moderate (1 = 33.3%) to severe (2 = 66.7%) emotional abuse. Ten Christian participants reported none (8 = 61.5%) to low (2 = 15.4%) levels of sexual abuse in childhood. One Christian (7.7%) reported moderate sexual abuse, and two Christians (15.4%) reported severe sexual abuse. One Muslim participant reported no childhood sexual abuse, one reported a low level of abuse, and one reported a severe level of abuse. The Jewish participant reported moderate childhood sexual abuse. One of the participants with other religious/spiritual backgrounds reported no sexual abuse (33.3%) and two reported moderate (33.3%) to severe (3.3%) abuse. With regard to physical abuse, twelve Christian participants reported no (12= 92.3%) level of abuse. One Christian reported moderate physical abuse. Similarly, two Muslim participants (66.7%) reported no

physical abuse, and one reported a severe level of physical abuse. The Jewish participant reported no physical abuse. The participants with other religious/spiritual backgrounds reported none (1 = 33.3%) to low (2 = 66.7%) levels of abuse. Seven Christian participants reported none (5 = 38.5%) to low (2 = 15.4%) levels of emotional neglect, while one Christian (7.7%) reported moderate emotional neglect, and five Christians (38.5%) reported severe emotional neglect. One Muslim participant reported no emotional neglect, one reported low neglect, and one reported moderate neglect. The one Jewish participant reported moderate emotional neglect and the participants with other religious/spiritual backgrounds reported moderate (1 = 33.3%) to severe (2 = 66.7%) emotional neglect. Lastly, eleven Christian participants reported none (10 = 76.9%) to low (1 = 7.7%) levels of childhood physical neglect. Two Christian participants reported moderate (15.4%) physical neglect. With similar responses, all three Muslim participants reported no physical neglect. The Jewish participant reported a low level of physical neglect. The three participants with other religious/spiritual backgrounds reported no physical neglect.

Quantitative Findings

Results for Research: Question One

The first research question sought to investigate what influence, if any, spiritual identity development had on enhancing resilience with childhood trauma survivors. To answer this question, participants in both the treatment and control groups completed pre-test and post-test assessments with the Connor-Davidson Resilience Scale. Difference

scores between the first and second assessments were calculated for both groups and a univariate analysis of variance (ANOVA) was used to compare difference scores between the treatment and control groups (see table 5.6 for ANOVA results). Based upon analyses, it appears resiliency scores were not found to differ as a function of the intervention, $F(1, 18) = .380, p = .55$. That is, resiliency difference scores from first assessment and second assessment did not significantly differ between the treatment group ($M = .50; SD = 11.29$) and control group ($M = 3.90; SD = 13.31$).

Additional analyses were conducted to compare treatment and control groups on four individual questions from the resiliency scale. Question three of the resiliency scale asked subjects to report the relevance of the statement 'Sometimes God can help' with day-to-day life. A univariate ANOVA was conducted to compare difference scores between the treatment and control groups on question three. The results indicated that testing time difference scores varied as a function of treatment, $F(1, 18) = .497, p = .37$. That is, resiliency differences scores on question three between testing times one and two did not significantly differ between the treatment group ($M = -.10; SD = 1.20$) and control group ($M = .30; SD = 1.38$). Question nine of the resiliency scale asked subjects to report the personal relevance of the statement 'Things happen for a reason.' A univariate ANOVA was conducted to compare difference scores between the treatment and control groups on question nine. The results indicated that testing time difference scores varied as a function of treatment, $F(1, 18) = .871, p = .36$. That is, resiliency differences scores on question nine between testing times one and two did not significantly differ between the treatment group ($M = 1.40; SD = .97$) and control group ($M = -.10; SD = .32$). Question twelve of the resiliency scale asked subjects to report any personal resonance with the

statement ‘When things look hopeless, I don’t give up.’ A univariate ANOVA was conducted to compare difference scores between the treatment and control group on question twelve. The results indicated that testing time difference scores varied as a function of treatment, $F(1, 18) = 1.108$, $p = .31$. That is, resiliency differences scores on question twelve between testing times one and two did not significantly differ between the treatment group ($M = .10$; $SD = .87$) and control group ($M = -.30$; $SD = .82$). Question twenty-one of the resiliency scale asked subjects to report the personal significance of the statement ‘Strong sense of purpose.’ A univariate ANOVA was conducted to compare difference scores between the treatment and control groups on question twenty-one. The results indicated that testing time difference scores varied as a function of treatment, $F(1, 18) = .847$, $p = .37$. That is, resiliency differences scores on question twenty-one between testing times one and two did not significantly differ between the treatment group ($M = .30$; $SD = 1.34$) and control group ($M = -.10$; $SD = .32$). Based on the results of the analyses, the null hypotheses for research question one failed to be rejected.

Table 5.8 - ANOVA: The Effects of Treatment on Change in Resiliency Scores

	SS	df	MS	F	p	partial <i>eta</i> ²
Total Score	57.80	1	57.80	.380	.55	.021
Question #3: Sometimes God and Help	.80	1	.80	.497	.49	.027
Question #9: Things happen for a reason	.45	1	.45	.871	.36	.046
Question #12: When things look hopeless, I don’t give up	.80	1	.80	1.108	.31	.058
Question #21: Strong sense of purpose	.80	1	.80	.847	.37	.045

Results for Research: Question Two

The second research question drew on both quantitative and qualitative results from the Royal Free Interview for Spiritual and Religious Beliefs (RFI) to discover identifiable spiritual elements and themes that positively influence coping with childhood trauma survivors. Three quantitative questions (items 7, 8, 9) and two qualitative questions (items 7b, 12b) were analyzed to identify meaningful spiritual elements for childhood trauma survivors.

A univariate ANOVA was conducted to compare difference scores between the treatment and control groups on questions 7, 8, and 9 from the instrument (see table 5.7 for ANOVA results). Question seven asked about importance of the practice of spiritual beliefs. The ANOVA results indicated that testing before and after scores did not vary significantly as a function of treatment, $F(1, 18) = .103, p = .75$. That is, resiliency differences scores on question seven between testing times one and two did not significantly differ between the treatment group ($M = -.60; SD = 3.92$) and control group ($M = .20; SD = .42$). Question eight asked about belief in a spiritual power or force other than yourself that can *influence* what happens to you in our day-to-day life. The ANOVA results indicated that testing before and after scores did vary significantly as a function of treatment, $F(1, 18) = 4.716, p = .04$. That is, resiliency differences scores on question eight between testing times one and two did significantly differ between the treatment group ($M = -1.90; SD = 3.07$) and control group ($M = .70; SD = 2.21$). The results suggest that study participants experienced a significant difference in how they acknowledge or

recognize a spiritual force or power at work in the day-to-day events they encounter. Question nine asked about belief in a spiritual power or force other than yourself that enables you to *cope* personally with events in your life. The ANOVA results indicated that testing time difference scores varied as a function of treatment, $F(1, 18) = 4.048$, $p = .06$. That is, resiliency differences scores on question nine between testing times one and two did not significantly differ between the treatment group ($M = -1.00$; $SD = 1.87$) and control group ($M = 1.20$; $SD = 2.90$).

Table 5.9 - ANOVA: The Effects of Treatment on Change in Spiritual and Religious Beliefs

	SS	df	MS	F	p	partial η^2
Question #7: Importance of spiritual practices	.80	1	.80	.103	.75	.006
Question #8: Spiritual influence on day-to-day life*	33.80	1	33.80	4.716	.04*	.208
Question #9: Spiritual influence on coping	24.20	1	24.20	4.048	.06	.184

* $p \leq .05$ Statistically Significant Difference

Qualitative Findings

Results for Research: Question Two

The qualitative data in this study was retrieved through three tools of inquiry: The Royal Free Interview for Spiritual and Religious Beliefs (RFI) assessment, therapy intervention sessions transcribed verbatim from audio recordings, and a Narrative Questionnaire administered post-intervention. The data were analyzed using two theoretical approaches to qualitative results. To emphasize the meaning of shared

experiences of emerging adult childhood trauma survivors, a phenomenological approach was used to analyze the RFI data. The RFI offers contextual elements that connect survivor experiences.

The second research goal of this study sought to discover what identifiable spiritual elements and themes positively influence coping with childhood trauma survivors would emerge among emerging adult childhood trauma survivors. All study participants completed The Royal Free Interview for Spiritual and Religious Beliefs (RFI) at pre-test/post-test assessments. The responses items 2, 7b, and 12b were open-ended questions regarding their personal religious/spiritual beliefs, spiritual/religious practices, and communication with God/Higher Power, respectively. Nvivo10 software was used to identify coded themes and subthemes in the data. Table 5.8 provides categorical data of the spiritual elements that participants identified as influential in positive coping.

Table 5.10 - Spiritual Elements that Influence Positive Coping

Category	
Beliefs	Item #2: Religious and/or Spiritual Beliefs (quotes)
Nature / Character of 'God'	Transcendent God; Immanent God; Loving and merciful God; God is in control of the world; Living God; God is a good God; Directs my life; God will not/never put more on me that they can bear; God will not bring me to a situation that God is not going to bring me through; Doesn't give me more than I can handle
Religious Beliefs	Jesus Christ (son of God; died on a cross; his message; died for our sins; everlasting life); The Triune nature of one God; The Bible is true; Life was pre-destined; Human imperfection; striving for perfection; Human beings sent to earth to fulfill a purpose for God; Making sure one's thoughts, words and actions are 'right'; Seeking God on a personal level; Belief is a way of life, it's who you are, how you act; Religious belief allows me to better cope with my past; Prayer changes everything
Spiritual Beliefs	Belief in a higher power; God created the world and its inhabitants; God as motivating force (a piece of the puzzle, left humanity to survive and thrive); A vital energy that is sometimes thought of as god; Higher spirit which guides reality; A creator that connects to each other and everything; The universe functions through a balance and without it there is destruction; Synchronistic events (Jungian sense) reveal greater order connecting all things
Relationship to 'God'	Fear no one but God; Trust God to protect; Trust God to provide for you; Look to God in a time of need; Worship God; Talk to God regularly; God is the head of my life; Life events happen at the perfect time that cannot be explained by anything but the work of GOD; Keep faith and everything will work out for the best
Practices	Item #7b: Importance of Practicing Beliefs (quotes)
Community	Attending church; Attending Musjids, Attending Shabbat
Spiritual Disciplines	Prayer (alone and in community); Worship (alone and in community); Ritualized Worship; Church services; Reading the Bible; Bible Study/Class; Yoga; Personal reflection; Meditation
Communication	Item #12b: Ways of Communicating with a God / Higher Power (quotes)
Forms of Communicating	Prayer, Forms of Prayer (Salat or Dua) Worship; Writing; Interactive psychic communication; Patience; Meditation; Speaking to or Commenting on the Universe; Breathing Techniques; Talking to God; Thought

*Note: Comments are verbatim quotations from study participants

The third goal of the research study hypothesized an effective method of incorporating spirituality into a brief cognitive behavioral therapy model. The outline of the therapeutic protocol is specified in chapter 4 in the research design and procedures section. The qualitative data collected to address this goal were retrieved from the treatment group responses during the therapy intervention and post-intervention narrative questionnaire. Nvivo10 software was used to identify frequency and coded themes in the data. Table 5.9 illuminates the frequency of interpersonal, spiritual/religious, and coping functions that influence the therapeutic process with emerging adult childhood trauma survivors.

Table 5.11 – Treatment Group Dynamics		
Rank	Functioning Factors	<i>F</i>
Interpersonal Functioning		
References		
1	Issues with Parents -'Mother' (141), 'Father' (57), 'Parents' (28)	226
2	Issues with Family	114
3	Issues with People in General	100
4	Issues with Dating or Significant Other	59
5	Issues with Friends	49
Spiritual / Religious Functioning		
1	Right Behavior - Being 'Right' or 'Wrong'	158
2	Meaning	102
3	Religion	51
4	God	28
5	Belief	24
6	Church	24
7	Faith	16
8	Spiritual	15
9	Connected	10
10	Hope	8
Coping (Barriers and Aids)		
1	Engaging in Sexual Acts	77
2	Life	67
3	Needs	51
4	Self-image (looks, shape, etc.)	32
5	Money	31
6	Problems	24
7	Control	15
8	Comfort	15
9	Moving/Unstable	14
10	Trust	14

Similarly, table 5.10 ranks the top (frequency) thought, emotion, and behavior considerations that influenced the therapeutic process with the treatment group.

Table 5.12 – Therapeutic Considerations Presented by the Treatment Group

Rank	Therapeutic Factors: Thought, Emotion and Behavior Considerations	<i>F</i>
1	Excessive focus on the intentions of others	134
2	Frequent Experiences of Anger / Frustration	92
3	Substance Abuse or Dependence	63
4	Anxiety	56
5	Alcohol Abuse or Dependence	53
6	Seeking Love	45
7	Ruminating on childhood memories	44
8	Sleep Disturbance	25
9	Aggression	23
10	Processing experiences	19
11	Combating Negative Thoughts	7
12	Withdrawal	7
13	Desire for Peace	5
14	Self-harm / Cutting	4
15	Maintaining Positive Thoughts	3

Results for Research: Question Three

Following the treatment intervention, each participant completed a post-intervention Narrative Questionnaire. The questionnaire included seven open-ended items that query the effectiveness of the elements hypothesized in this research toward the development of a spiritually focused cognitive behavioral therapy approach. Nvivo10 software was used to identify coded themes and subthemes in the data. Table 5.11 illustrates the thematic responses from the Narrative Questionnaire.

Table 5.13 – Narrative Questionnaire – Post-Intervention Treatment Group Responses

Theme	Narrative Questionnaire Responses (quote excerpts)
Question 1: Most helpful and useful intervention elements	
Talk therapy	Talking in general (helps); someone who you can talk to; fear of judgment; talking things out
Nonbiased Therapist	Ability to share my thoughts with someone was encouraging; someone whose opinion was unbiased; researcher diagnosis
Therapeutic Elements	Identifying the root causes of negative thoughts; identifying the underlying theme; helpful ideas; reflection on my childhood experience and its connection to my spirituality; reframing negative thoughts; anger journal homework and follow-up processing (i.e. reactions, actions, decision making)
Symptom Relief	Felt a sense of relief; able to focus on the present and not hold such much weight on my shoulders; focus with positivity to changes instead of feeling overwhelmed; want to continue as I find out more about myself; surprised by my own responses; It was time to open up and disclose my personal indiscretions of thought; everything has been taken into perspective and will be applied as needed; held so many negative experiences inside that I welcomed the therapy; helped me open up a little more
Question 2: Least helpful and useful intervention elements	
Therapeutic Elements	The overall sort of "lack" of what to do after some situation; reframing has limitations – then actions are needed at some point
Spiritual Elements	Discussing spiritual beliefs (1)
Question 3: Most unexpected or surprising intervention elements	
Talking about the childhood trauma	How easily I shared my past and present dilemma. That really surprised me because I rarely share my thoughts; I knew we were going to talk about everything even the stuff that I didn't want to discuss; very surprised when I realized that it was just us having regular conversation. It was very relaxed and I didn't feel pressured to open up. It went at whatever pace I wanted.
Therapeutic Elements	The CBT elements surprised me. I had never practiced this before
Therapist Insights	The researcher put an unexpected hole in my logic
Question 4: Most uncomfortable or fearful intervention elements	
Talking about the childhood trauma	Out loud made me VERY uncomfortable; talking about a troubled past is not comfortable; discussing my early childhood experience; certain topics made me uncomfortable
Talking about who I have become	Coming clean about my inner desires made me feel uncomfortable. Having to take responsibility for being content because I am avoiding the issues. The thought of living as who I dream about made me fearful; now I see how deeply connected my early childhood experience is to who I am today

Question 5: Changes in thought process following the intervention	
Therapeutic Elements	Reframing, [to] continue working on my own resolution
Negative Thinking	Working to keep from indulging in negative thoughts
The Impact of Childhood Trauma	I have changed how I understand my childhood experience. I now see how deeply connected it is to who I am today; I have realized that still waters run deep. I will now begin to think about things more thoroughly and try & understand where the root lies
Enhanced Resources	Positive Coping - I can handle stressful situations a bit more positively. While it hurts to go through stressful situations, it hurts more to stay negatively in that place. It is better to move forward with a plan and cope. Patience - Be more patient Self-love - Don't let other people use me; love self first Managing emotions - Take everything that the therapist and I talk about and try to come up w/ways to control feelings; if I feel I can't I take it upon myself to think of solutions and just by talking a weight is lifted off my shoulders Openness - I learned that opening up isn't a bad thing; plenty of benefits emotionally in the long run; I seem more open to counselors now than I was beforehand

Question 6: Changes in behaviors following the intervention	
Negative Thoughts	Trying to stop negative thoughts
Seek Therapy	I think I might try to connect with someone who can help me, where I wouldn't have before.
Sexuality	I have thought more positively about my sexuality
The Future	I am more positive about my future prospects. I cannot let the actions or words of other people dictate my mood and actions. While it may be easier said than done, it is a work in progress. Every day I become closer to being the whole person that I envision.
Processing	Some things can't be changed overnight; addressing that there is a problem and ways to fix it; is the first step to changing those behaviors.
Openness	I have become a little more open with my feelings amongst my peers

Question 7: Changes in thoughts or experiences of spirituality following the intervention	
Spiritual reflection	In knowing that there are all these things and people that get under my skin, I know that I should just pray about it and call on the help of God to keep me sane. I also have to remember to "let go and let God" in certain situations that I can't control.
New Spiritual Insight	When I first started therapy, I was trapped in confusion because I thought I had to be dependent on God to thrive. I believe in God but on an independent level. God is powerful in creation. I am important in being that creation. It is up to me to make positive life choices and surround myself with positive people to reach that powerful destination; more grateful for my faith; more grounded and light; my mind is definitely more open
No Change	Two responses

*Note: Comments are verbatim quotations from study participants

CHAPTER SUMMARY

This chapter discussed the quantitative and qualitative findings of the Childhood Trauma and Resilience pilot study. Data were gathered through measurement instruments, therapeutic intervention, and a post-intervention questionnaire.

The quantitative data were analyzed to determine if a statistical significance existed to support the spiritually focused CBT treatment following the experimental intervention with participants. No significant statistical significance was found across the instruments, with the exception of a slight significance found in treatment group responses to whether a spiritual power or force other than themselves could influence what happens in their day-to-day life, $p = .04$.

The qualitative data were retrieved from written and verbal responses (audio transcribed) regarding the essence, development, and practice of their spiritual beliefs. Prominent themes were revealed that indicate the meaningfulness of their spiritual experience on coping and day-to-day functioning such as having community, regular communication with spiritual power, and spiritual disciplines. Additionally, the qualitative data revealed factors that could contribute to the effectiveness of a spiritually focused therapeutic intervention with this population, including retrospective reflection, nonjudgmental presence, and an openness to spiritual exploration processes. These results are discussed in more detail in chapter 6.

CHAPTER 6: DISCUSSION AND FUTURE RESEARCH

It could be argued, that this generation is more aware of psychological jargon than any other generation in US history. In fact, due to the plethora of media outlets today the average person is inundated with information regarding psychological issues. Whether it is the proliferation of self-help books or the numerous dialogues about mental health via television, radio, or internet the average person has access to more mental health information now than ever before. Over the last four decades, references to psychological jargon and talk-therapy have almost become everyday vernacular in popular culture. As such, we are raising a generation of psychologically aware children, for whom therapy is seen as a common occurrence. Research has indicated that almost 2.9 million children and adolescents between the ages of 4-17 years old are treated for therapeutic issues each year in the United States.²⁵⁷ Perhaps the population most affected by this trend has been the last few generations of adolescents who constantly find themselves on a quest for self-discovery. What makes this statistic significant for pastoral counselors is the comparative fact that nearly 70% of American adolescents have also had exposure to religious youth groups whose teachings usually emphasize strict adherence to particular faith beliefs.²⁵⁸ This combination of developmental factors makes it imperative for pastoral counselors to equip themselves with tools that help engage adolescents and

²⁵⁷ Gloria A. Simpson et al., "Use of Mental Health Services in the Past 12 Months by Children Aged 4-17 Years: United States, 2005-2006," in *NCHS Data Brief*, ed. National Center for Health Statistics (Hyattsville, MD2008), 3.

²⁵⁸ Smith and Denton, *Soul Searching: The Religious and Spiritual Lives of American Teenagers*: 51-53.

emerging adults more effectively. Particularly, for those who seek to explore possible interpretive conflicts that arise in their quest for understanding.

The manifestation of new freedoms can be both exciting and scary for emerging adults. As in other stages of development, emerging adults attempt to understand themselves in contrast and comparison to their peers. Often this is done in an attempt to fit into groups or cliques that they feel represent positive aspects of themselves. Similarly, emerging adulthood is a time of great introspective growth. During this stage, individuals gain new abstract thinking skills, learn to understand interpersonal relationships in different ways, hone their ability to analyze life experiences, and explore personal values and beliefs. It is not unusual for emerging adults during this stage to experiment with different identities in the search for a clearer understanding of their authentic self. Amidst the myriad of transitional elements, emerging adult survivors of childhood trauma face additional developmental obstacles based on residual effects of abuse and neglect.

The popularization of therapeutic intervention is beginning to combat negative stigmas attached to psychological treatment. Across cultural and socio-economic barriers, more people are seeking counseling to address issues that previously would have gone untreated. Emerging adults are a growing group involved in that trend. Emerging adults find in the counseling process, a confidential space to explore the new awakenings and process the challenging issues of their past, sometimes it is a past that they were not able to share with anyone prior to therapy.

As stated in the introduction, many cases of childhood abuse and neglect go unreported or undetected every year. For the majority of the participants in this study,

their abuse and neglect went unreported as well. In fact, only two participants had their abuse or neglect reported. Those two reports resulted in protective custody placement by state officials. It is likely that many of the emerging adults with histories of childhood abuse or neglect will not have an opportunity to address their abuse or neglect until their first therapy encounter. Scores of emerging adults, who were previously intimidated into silence as a child, now reach out for therapeutic vehicles to talk about their abuse and neglect experiences. It is during this stage that emerging adults feel empowered to mobilize their independence to address the issues of their childhood. Pastoral counseling could offer a unique space for survivors not only to explore the implications of their past, but also help them to embrace a holistic view of their true selves.

Developing resilience following childhood trauma is understandably a complicated process. How we understand and identify resilience however has undergone significant critique. Cultural critiques in particular would argue against adequacy of any theory of resilience that does not address embedded biases toward certain cultural realities. In other words, anytime a dominant culture assumes the right to label reality for another culture, there is an increased likelihood of misrepresentation, missing information, and erroneous labeling for that cultural reality. This is also the case when it comes to labeling the features that qualify as resilient functioning or positive coping for childhood trauma survivors.

Survivors enlist a variety of coping mechanisms to protect them from perceived external and internal threats. In general, coping mechanisms that appear to conform to social norms are often deemed more resilient than coping strategies that are perceived inappropriate functioning by governmental agencies, educational institutions or the legal

system. This research supports Tummala-Narra's (2007) claims that an individual's ability to cope with trauma depends on both life circumstances and developmental stage. This research acknowledged cultural influences by attempting to understand the importance of identifying survivor adaptation within the context of their cultural background. For example, personal autonomy and achievement are valued as ideals for resilience in the US and western cultures, but other cultural expressions might prioritize collective orientation or familial interdependence as ideal resilience.²⁵⁹ This research highlights the need for additional research in this area that is intended to broaden its perspectives of culturally relevant adaptability. In doing so, more survivors might feel empowered by the validation of their survival skills that could potentially be affirmed as positive coping skills given the cultural vantage point in which they were developed.

Resilience in the context of this study focused on the ability to demonstrate positive coping following adverse childhood experiences which is evident by categorical attributes identified within the Connor-Davidson Resilience Scale (CD-RISC). The CD-RISC identifies commitment, recognition of limits to control, engaging the support of others, close, secure attachment to others, personal or collective goals, self-efficacy, strengthening effect of stress, past successes, realistic sense of control/having choices, sense of humor, action oriented approach, patience, tolerance of negative affect, adaptability to change, optimism, and faith as attributes of resilience.²⁶⁰ Resilience, as seen from this perspective is limited to a socially accepted lens of appropriate functioning

²⁵⁹ Pratyusha Tummala-Narra, "Conceptualizing Trauma and Resilience Across Diverse Contexts: A Multicultural Perspective," *Journal of Aggression, Maltreatment & Trauma* 14, no. 1/2 (2007): 36-37; Wexler, DiFluvio, and Burke, "Resilience and Marginalized Youth: Making a Case for Personal and Collective Meaning-Making as Part of Resilience Research in Public Health."

²⁶⁰ Connor and Davidson, "Development of a New Resilience Scale: The Connor-Davidson Resilience Scale (CD-RISC)," 77.

that is not inclusive of all societal realities. However, I acknowledge the potential for misrepresentation associated with generalizing functionality using such limited parameters.

The motivation for this research came from my therapeutic encounters with emerging adult childhood trauma survivors, both in private pastoral counseling practice and college counseling of students. I noticed a trend of students entering therapy, many for the first time with histories of moderate to severe childhood abuse or neglect. Regardless of the setting, their personal spirituality and spiritual journey invariably entered the conversation. Often times their religious or spiritual background served as a backdrop to their current dilemmas. Whether they were rejecting the teachings of their childhood or experiencing shame or guilt at their inability to hold fast to the ideal set forth by their religion, their spirituality informed their coping strategies. What was clear in all cases was that an honest discussion about their spiritual influences and transition process was important in understanding their current dilemmas and resilience. Another major consideration for this study was the need for a spiritually focused brief therapy approach that would be effective with this population.

As stated in early chapters, evidence-based research supports Cognitive Behavioral Therapy (CBT) as an effective brief therapy with adolescents, emerging adults, and adult childhood trauma survivors. However, no CBT model existed that both addressed present-day challenges and incorporated therapy interventions that address the spiritual challenges of childhood trauma survivors and the developmental stage challenges of emerging adulthood. Therefore, this pilot study is important because it not only studies the development of spirituality with these survivors. It also studies the

therapeutic influence of their present-day spirituality on coping towards developing a spiritually focused cognitive behavioral therapy approach.

This study sought to illuminate the effects of childhood trauma on the psychological and spiritual functioning in the lives of emerging adult survivors. The three goals of this study were to investigate a) what influence, if any, spiritual identity development has on enhancing resilience with 18-25 year old childhood trauma survivors, b) identifiable spiritual elements and themes that positively influence coping with childhood trauma survivors and c) effective methods of incorporating spirituality into brief cognitive behavioral therapy. This last chapter offers an interpretive discussion of the study results, pastoral counseling implications, study limitations, and recommendations for future research. The chapter begins with a discussion of the findings and implications for each of the three goals. Next, study limitations and future research considerations are identified. Finally, the chapter concludes with a summary of factors that influence clinical practice, particularly pastoral counseling with this population.

Discussion and Implications

The findings of this study offered three key clinical and theological contributions. First, the current study revealed factors that influence resilience enhancement that are connected to spiritual identity development for emerging adult survivors. Second, the study identified elements of resilience development that illuminate maladaptive coping mechanisms and other coping resources left unexplored within survivors' spirituality. Third, the study proposed the development of an effective therapy intervention with this

population that would lay the foundation for a spiritually focused cognitive behavioral therapy approach.

The theological implications of this study are addressed using a Revised Correlation Theory method. Revised Correlation Theory is essentially a method of theological inquiry that brings into dialogue Christian theology (i.e., Christian texts, tradition, and language) and other sources of meaning making such as psychology or sociology to enrich the knowledge and practice of both. In this dissertation, the topics of childhood abuse and neglect, human development, and resilience served as dialogical intersecting points between the theological and clinical approaches to meaning for childhood trauma survivors. Theology in the service of pastoral counseling with childhood trauma survivors has the potential to provide a conduit of shared meaning and language. The qualitative research in this dissertation illuminated the influence of spiritual meaning making with psychological functioning. Study subjects presented meaningful theological constructs based on their Christian traditions and language and those constructs were then reflected upon using psychological theories of trauma, emerging adulthood, and resilience. The results of this dissertation highlight points of connection and disconnection between the two sources of meaning (theological and clinical).

In this chapter, the findings are discussed congruently with the three goals of the study. Following a general discussion of each goal, clinical and theological implications are explored as they relate to the goal. The chapter concludes with future research considerations.

Goal 1: *Spiritual Identity Development and Resilience*

The heart of the first goal sought to better understand the connection between spiritual identity development, and resiliency. Acknowledging the burgeoning sources of research that support such a connection, this study narrowed its exploration to the emerging adulthood stage of development, with a particular emphasis on survivors who had experienced histories of childhood abuse and/or neglect. One's spiritual identity development influences day-to-day functioning. This is noticeable most often through one's intrapersonal and interpersonal interactions. The first goal of the study used a quantifiable research approach to determine if the exploration of spiritual identity resources had any statistically significant impact on resilience with this population. Alone, the quantitative results of the Connor-Davidson Resilience Scale (CD-RISC) instrument imply that the therapeutic intervention used to discover survivor resources associated with spiritual identity development was not an effective method of enhancing resilience. However, when asked if spirituality influenced their day-to-day life, a slightly significant statistical difference occurred among survivor responses following the therapeutic intervention. Therefore, the use of the therapeutic intervention had some effect on survivor's beliefs that spiritual forces or powers are at work in their day-to-day life (see table 5.7).

The CD-RISC scores were used to analyze enhanced resilience with survivors. The research results showed no significant statistical difference in resilience scores from the pre-test to the post-test, however the qualitative data somewhat conflicts with the quantitative data. When asked what changes occurred in their thoughts, behaviors and

spirituality as a result of the treatment intervention, participants identified enhanced coping resources such as positive coping (e.g., “I can handle stressful situations a bit more positively”), patience (e.g., “Be more patient”), self-love (e.g., “Don't let other people use me” “Love self first”), managing emotions (e.g., “Take everything that the therapist and I talk about and try to come up w/ways to control feelings”), and openness (e.g., “I learned that opening up isn't a bad thing”). Study design and researcher-subject factors might have contributed to the low statistical significance on the CD-RISC. First, this study was designed as a pilot study and therefore the low number of participants (n=20) hindered the ability to obtain statistically significant data results. Second, maladaptive coping mechanisms common to survivors (i.e., *apprehensive subject role*, the need for the approval of authority figures or people pleasing) may have compromised instrument scores their self-report on the instruments.²⁶¹ Although the CD-RISC has good reliability statistics with regard to identifying resilience strengths, the scale was used in a slightly different way in this study to assess changes in resiliency. Using CD-RISC in that way might have affected the results of resilience scores post-intervention. The quantitative results that followed the second administration of the instrument were incongruent with the qualitative responses from the subjects. In fact, the study subjects were able to identify specific elements and outcomes that enhanced their resilience following the intervention (see table 5.11). Future research aimed at enhancing resilience using a similar therapeutic intervention should design or secure other instruments to gather data on enhanced resilience post-intervention. The next two sections provide

²⁶¹ Frederick J. Gravetter and Lori-Ann B. Forzano, *Research Methods for the Behavioral Sciences* (Cengage Learning, 2011). 100.

reflections on the theological implications of childhood trauma and emerging adult survivors that influence spiritual identity development and resilience.

Christian Theology and Childhood Trauma

Assimilating. Child abuse and neglect often are hidden under the cloak of secrecy. Considered a hidden shame, this type of trauma affects many children in our country and crosses geography, socioeconomic strata, cultural difference, and religious background barriers. As such, the majority of the Christian survivors in this study reported that only they, their perpetrators, and maybe a parent knew about their abuse and neglect. Moreover, most of them had never spoken to another adult about their experiences and only a handful had received any counseling prior to the study. Those who had received counseling did so as a result of being placed in child protective services (foster care) or after having had a mental health crises that required immediate attention.

The secrecy surrounding their abuse and neglect limited the support they received from their religious communities. One unfortunate result of this secrecy is that it leaves children without support for their suffering within their faith community. Perhaps the greatest strength of being a part of a faith community is that it provides a shared space to give and receive support during challenging times. Children of abuse and neglect not only have to continue functioning without that support but they are also left to interpret the meaning of their suffering without the benefit of having relevant guidance from their faith communities. Though the survivors in this study periodically participated in a faith community, they did so without the benefit of receiving Christian support that specifically addressed their needs.

Survivors took for themselves theological language (i.e., “God won’t put more on you than you can bear”) to interpret their trauma. Certain faith statements based on biblical principles are recited among Christians within their faith communities to encourage endurance, empowerment and spiritual maturity, as well as instruction and comfort for Christians facing a troubling situation. However, because these messages often come from sermons, teachings or good-intentioned Christians these statements may not be intended to address abuse and neglect specifically. Messages like these can become challenging for survivors because they are not directly applied to the suffering of childhood trauma and do not account for God’s role in the abuse or neglect. Further, statements such as “God won’t bring you to something that he won’t bring you through” imply that God plans for a child to suffer abuse or neglect so that God would assist them through the abuse or neglect to make them a better person. Alternate statements also emphasize the omnipotence of God but perhaps unintentionally imply the bad things that happen in life are the result of either inappropriate behavior on the part of the sufferer or as a part of God’s plan to prepare them for some good/better outcome to come in the future.

It is obvious that statements such as these can be a significant comfort for some troubled Christians. However, for childhood abuse and neglect survivors these statements could have devastating effects on how they interpret their experiences and relationship with God. Rarely do abuse survivors hear statements from the church that are specific to their God’s role in their experience. For the survivors in this study, there were no teachings or sermons about how to handle abuse or neglect, nor were there any Christians who asked them about abuse or neglect. Instead, they left their faith communities just as

they came, trying to make sense of their experiences. What resulted was an assimilation of messages (Christian language) that were seemingly meaningful for others as a way to deal with troubling situations. They were left to assume that these messages, that held so much meaning for others Christians, applied to all suffering, regardless of the degree of devastation.

Christian Theology and Emerging Adult Survivors

Exploring. Emerging adults are on a quest for independence and empowerment across all of the spheres of life. For many, this period in life marks the first time they felt fully in control of how they understand and operate in the world. A major part of newfound control at their discretion is the control they now have over defining their spirituality. In childhood, their families of origin and faith communities heavily influenced what shape their spirituality took. Emerging adulthood opens up the opportunity for them to define their unique spiritual reality on their own terms. All of the emerging adults in this study were choosing to explore new knowledge and understanding of spirituality during this stage. That exploration process for some meant rejecting previously held Christian beliefs/spiritual frameworks all together while others were in the process of adding or exchanging elements of their Christian beliefs/spiritual frameworks for newly discovered elements. The majority of the subjects admitted that they were not practicing the beliefs of their childhood with any consistency but that those foundational beliefs were still meaningful to some degree. Some expressed guilt around not practicing their beliefs as often as they felt they “should,” but they adamantly expressed that the absence of their practices did not mean that there was an absence of

spirituality. In fact, for them, spirituality was often discussed and reflected on with friends and peers who share diverse perspectives of spiritual reality. Childhood trauma survivors in this study continuously described themselves as “open” to different perspectives of spirituality and resistant to viewing any one religion as completely authoritative including the religion of their childhood. The majority of the survivors had read the sacred texts of multiple religions, taken religion classes, and worshiped in multiple religious settings. The diversity of their experiences informs the spiritual reality that they currently hold.

In chapter 3, two theological frameworks (Eschatological hope and Eschatological plot) were presented as potentially meaningful approaches to pastoral counseling with struggling survivors. At the center of both models is the focus on God’s participation in the transformative process of humans. Eschatological hope draws on the Christian belief that better things are to come for believers who anticipate God’s movement in their lives. That movement promises to be not only transformative but also enriching. Similarly, an eschatological plot perspective allows Christians to track God’s transformative movements in their lives through revelations found in their personal narratives. Within each personal plot or narratives, survivors may find encouragement rooted in the experiences that emphasize God’s healing presence. The spiritual identity journeys revealed in this study demonstrate how the concepts of eschatological hope and plots could be useful reflective tools in pastoral counseling with this population. The following cases illustrate this point.

Case Studies – Spiritual Identity Development

Spiritual identity is shaped by the meanings we attach to religious and spiritual experiences. As to be expected, the participants in this study had diverse experiences that shaped their spiritual identity development. Four of those spiritual journeys are presented below to illuminate ways in which their spiritual identity development influenced their resilience. The stories of Jessica, Beth, Trevor and Matthew highlight particular challenges and strengths that could impact therapy with this population. The following case material appears for the first time in this chapter. The inclusion here is simply to illuminate the discussion points.

Case 1 - Jessica

Jessica is a 23-year-old African American female from a large urban city in the southeast. She reports incidents of severe childhood sexual and physical abuse. She was raised as a Christian with some Muslim influences from her father. She entered the foster care system at age 12. Between age 12 and 18 she was placed in Juvenile Detention centers multiple times, ran away from foster homes multiple times, worked as an exotic dancer, and was a prostitute. She has a strained relationship with her family and their religious beliefs.

“They raised me as a Christian. We always used to go to church [on] my dad’s side [and] my mom’s side. We always went to church, I can truthfully say that. My dad is not a Christian but his family is so when I was with them we pretty much went to church and when I was with my mom, we always went to church. That being said, I think the only thing that got my dad to stop smoking crack was the whole Malcolm X Muslim thing, because for a while he really used to be like that. I’ve always felt disconnected around [my family]. Why? probably because for one my grandfather and my grandmother, [my mother’s] parents are preachers but they weren’t always preachers... and the way that they act. It’s like, my mom [and her] two sisters and everybody acts different when they are around grandma and pawpaw. My dad said [grandma and pawpaw] used to smoke pot, drink like freaking I don’t know what. My dad said they went from one extreme to the next extreme. My mom got pregnant when she was 15. Around that time when my mom got pregnant, [that] was when pawpaw thought he was a preacher and his calling and all that crap. And so, they made my mom carry that baby, and they

made her give that baby up when she had the baby. Like some color purple stuff...So she's screwed up and her mom and dad are all like 'cling to your wives and cling to your husbands,' forget about the kids. It's like they pretend to be something that they're not and I refuse to be something that I'm not. I feel like we should just be ourselves. There's no reason why we should have to be somebody different. We're family, why do we have to act like that? You know what I mean. It's not even a respect level, people are literally scared to be themselves around grandma and pawpaw."

Jessica reports that her current beliefs are difficult to articulate. She continues to explore new expressions of spirituality.

"Because I was raised Christian, I don't really connect with any beliefs. I would just say that I'm spiritual. I know that there is a God, I believe in God. I would say I know that God died on the cross for us but then I've read the Koran too. When I was out there doing my own thing, I used to go to Jumu'ah, go to the Musjid, do all that stuff. So really I don't know. I don't know which one because even when I went to bible study the other day with my granddaddy, some of the stuff he said I remember hearing in the Koran. I don't know, I really haven't sat down and really said which one it is but I would say that it's more Christian than Muslim. Because, it just is I guess. But then I don't really think it matters what God you believe in because everybody has their own different God and this person believes in this God and I believe in my God and each one of our gods when we pray our prayers come true. So it shouldn't matter what we call him or what it is as long as we, everyone has their own commandments and their own individual bible and it's the same. So when it comes to that kind of stuff I really don't know what to say. I just say hey, I know he's God, lord, savior, all that stuff. Really, that stuff is too complicated. I figure as long as I just recognize and know that I'll be okay."

In this first case, it is not difficult to imagine how complicated engaging spirituality might be during therapy with Jessica. Moreover, there are real significant issues that might arise during pastoral counseling with Jessica. It is highly possible that countertransference issues associated with power dynamic could interfere with the pastoral counseling encounter particularly if those issues are not openly discussed in the therapy. In general, pastoral counselors face idealization or devaluation by counsees who either idealize or devalue clergy. In Jessica's case, clergy are not to be trusted and are often judgmental, critical, and intolerant. Therefore, pastoral counseling with similar

counselees would benefit from acknowledging countertransference issues that arise, even in the midst of a CBT therapy session. In addition, Jessica demonstrates how spiritual influences do not necessarily follow a consistent track from childhood through adolescence for childhood trauma survivors. Her family and detention center peers exposed her to several religious traditions. Her experiences contribute to her openness to different spiritual realities. She appears to embrace a complex view of spirituality and the importance of searching for personal answers without dismissing the realities of others. Openness could be a beneficial strength to explore moving forward in her resilience as she continues to search for meaning for her experiences.

Case 2 - Beth

Beth is a 25-year-old Caucasian female raised in the suburbs of a large urban city in the southeast. She reports severe physical neglect and moderate emotional neglect in childhood. Her parents abused alcohol regularly. Her mother was less functional than her father who maintained two jobs throughout her childhood. She reports that her mother often neglected her needs and the two had volatile emotional interactions. Her family was not religious, but around age 11 she started attending a local Methodist church with a friend.

“I was preparing to be confirmed in the Methodist church with a friend from down the street. I loved it, until my family moved to another city. [Then] I had a really bad experience when I was about 13 years old. I started attending a Methodist church in the new city but the pastor pulled me aside after about 3 months and said, ‘Your parents don’t attend?’ I said yeah, they aren’t religious. The pastor told me that I needed a guardian or sponsor, because people were uncomfortable about me attending the church without a parent. He said it was ‘unseemingly’ for me to attend church without a parent or supervisor. My next-door neighbors attended the church and I asked them if they wanted to be my supervisors and they said no. So I said fine, and I stopped going and didn’t want anything to do with Christianity for like five years. This is not how Jesus would act. After that event with the pastor, I spent all of high school trying out a lot of different faiths (e.g. Buddhism, Hinduism, and Islam). I wanted to be Jewish. I read a book about every type of religion I could get my hands on except Christianity. Senior year of high school I went to catholic mass with a friend and

loved it. That was my way back into Christianity. I was old enough to recognize that they made a mistake. Church became a place of peace and comfort, my oasis in the middle of the week (especially catholic mass). I remember feeling like I was a part of a community and a profound sense of peace and comfort. I loved church so much because it was a place I wasn't in charge. It wasn't hectic like school and wasn't work like theater and home was tedious and at church I wasn't responsible for anything, just responsible for being. It's quiet, peaceful, not responsible for anything just sitting in the presence of God. That was nourishing. I was really interested in becoming a part of what I thought was a peaceful community."

Beth currently is completing a seminary degree and preparing for ordination into Christian ministry. Spirituality has influenced how she copes with life's challenges and understands her sense of purpose.

"I want to trust that God had a plan and that God led me to seminary and figured it out from there 'I believe that God doesn't drive a parked car and that I need to be doing my end of the work.' I'm comfortable with being different, almost like the sense of being a missionary. It's something that I've wrestled with but I feel like I've come out on the other side of by going back and doing that."

Beth's spiritual formation has followed several paths and taken many turns.

Ultimately, she finds herself now committed to a life of spiritual observance. Her story does not begin with a spiritual influence in the home. Instead, Beth sought out what became spiritually relevant for her without the aid of her family's support. Her path has been significantly influenced by experiential approaches to meaning making and securing a sense of community. She found meaning for life in having a sense of purpose. Along the way, she faced a spiritual injury that could have detoured her spiritual journey, but instead it impassioned her to continue searching. She recounts finding and losing new communities along her journey. Pastoral counseling has an opportunity to represent a holding community that will help her to embrace her whole self, including the diversity within her spiritual beliefs, without encountering rejection.

Case 3 - Trevor

Trevor is a 20-year-old African American male from the Caribbean. Trevor reports severe childhood emotional neglect and minimal incidents of other forms of abuse or neglect. However, Trevor's responses on the Childhood Trauma Questionnaire suggest that he may be underreporting other forms of abuse or neglect. His family was "super religious" as he grew up and they were very active in church administration. In addition to attending regular church services with his family, Trevor attended Catholic school growing up. The combination of these two experiences triggered a theological conflict in Trevor's spiritual development.

"I went to Catholic school growing up [from a young age]. It was very awkward because I didn't attend a catholic church. I went to regular church. So like, I would go to mass all week and then go to a different church on Sunday. It was basically like teaching two different things and things that are important are different across the board, so there was a lot of confusion for me growing up. I think that's where I started to question a lot of my religious views. All my peers in class would participate in mass, but my mom told me that I didn't have to participate, I was like 'is what they are doing wrong? or is what is what I'm doing right?' That was the question in my mind. Even though I question religion a lot growing up, I was still religious up until the age of like twelve. Like I listened to gospel music, because that's the path I was going into. I didn't really see anything else. So I feel like I had a good foundation with the rights and the wrongs of the world. I've seen how just within those churches, sometimes it seems manipulative. I'm not saying that religion is manipulative but just within the context of the churches [my family] attend. That kind of like pushed me away from it. After all that stuff started happening I just kind of strayed away from religion as a whole. And then we came here [to the United States] and we just stopped going to church because we were trying to get settled in and really didn't know people. I just kind of use my own thoughts and ideas and knowledge to resolve issues and help move forward with things. Not saying that I don't believe in God. I very much believe in God but not religion. All of that didn't get washed away it just turned into knowledge instead of what I based my life on."

Today, Trevor is on a spiritual quest to get answers even though he is not exactly sure what his questions are. He continues to take religion courses in college although his major is graphics design and he describes his spirituality as the acquisition of knowledge.

"Religion really interest me, so when I started college I started taking a lot of religion classes and like going through the history in the books on different religions and I think that's where everything really just kind of went out the

window. Cause I'm pretty good with logic, so when I'm seeing all these things and I'm being told all these things, I'm like man created religion. Man didn't create God but God created man. Man makes mistakes and men are greedy, men do whatever so in the time when all these religions started my mind [questions] what was their real intention? Where they trying to create something to get to another spiritual level or were they trying to constrain the people's thoughts and abilities. And I just continue taking the religion classes. I keep learning more. I would say I want to search for an answer, but I don't really know what the answer is. it just interest me because it's just something that is accepted. Like you are just born into this world and if you're born into a religious family, then that's what they taught you and you just learn to take it as what it is. Like you just take the bible for face value. Instead of it being teachings and lessons, it's Word. Everything is taken very literal, and that's not how I take it. I try not to just take what they are saying and just apply it to the world. I just feel like there are a lot of misunderstandings that have arisen throughout time and I would love to find that answer but it keeps me thinking."

In Trevor's case, the tension of theological conflict in his childhood continues to interfere with his spiritual coping. For Trevor, he received too much of what he felt were too many contradicting beliefs to find spirituality helpful in coping with his trauma. As a result, He has distrust for organized religions and spiritual practices associated with organized religion. Trevor only trusts his own logic and knowledge building. Self-reliance is what he understands as the goal of being spiritual. His thirst for knowledge is an identifiable strength. He continues to seek new ways to understand spirituality. When describing his spirituality at this time, he is inclusive of different spiritual realities that offer him useful meaning making elements. The intentional emphasis on spiritual inclusivity in pastoral counseling could help Trevor by providing him a nurturing space to both process the theological conflicts of his childhood and operationalize resources found in his new spiritual perspective.

Case 4 - Matthew

Matthew is a 23-year-old Caucasian male with a history of severe emotional and physical neglect. He grew up in a rural town in a southern state alone with his mother who suffered from untreated schizophrenia (paranoid type). His mother's family attended a local Baptist church that he and his mother attended sporadically until he was six years old. When he was six-years-old his mother informed her family and church that she was a lesbian. His mother soon decided to leave that church. After which, his mother started to explore other spiritual practices (i.e. reading auras) and he says her spiritual practices began to complicate their lives.

“When her spirituality went from kind of a normal spirituality to like keeping her from working, keeping her from everyday things. It became obsessive for her. That's kind of where I put that line between me and an all knowing, all aware God. My mom tried to have a secular house for me where I could go and you know find out whatever I wanted to find out. We didn't attend any particular church or anything, and my mom kind of went off on her own little metaphysical thing which led to the end and her delusions.”

When Matthew was 15 years old his mother had a delusion that Matthew became a divine God. Recognizing that his mother's delusions were unmanageable, he reported her to child protective services so that he would be removed from the home and taken into protective custody. He spent the next few years moving between different foster care homes until he aged out of the system at 18-years-old. While in foster care, he began selling and abusing drugs. After a near death car accident when he was 20 years old, Matthew entered Alcoholics Anonymous. He now has two years of sobriety.

“Spirituality to me just means how you cope with what you can't explain. What we don't know. It's hard for me to believe in a God in the standard terms of there's an all mighty deity somewhere sitting on a cloud watching what we do and either has your back or doesn't. I mean I believe that everything in existence is connected and that what I do affects others and that if I do well I will receive good things and that. But I just believe that if we say that there is an all mighty deity that it takes away from just how amazing and how random everything just kind of worked out. And I'm okay with the idea that maybe I don't have an eternal life, my personality won't forever be sealed in a soul but I confident in the fact that whatever I'm made of will still be here when I cease to live. That's what I can allow myself to work with and really feel comfortable with. When I started to believe that there wasn't an almighty being and that everything is essentially just what it is and essentially one big entity, it made me, it's easier for me because I don't believe that there is anyone who could have looked out for me or who did look out for me, more like on an individual level. I feel like I don't spend my time...where I do allow myself to go on the spiritual side. I don't spend it pleading for help or anything like that. It's more like... at the beginning we were

only guaranteed conception and death and everything in between that is essentially a miracle and as much as I tell myself that, I make myself remember that it's just a blessing that I get to be a part of it. That helps me and if that doesn't help me and then I just say the serenity prayer over and over again and I just point out what I can't help."

Matthew's spiritual identity grew out of a resistance to organized religion and certain spiritual expressions. In part, the dynamics of his family life created a space for him to develop his own awareness of spirituality. However, his mother's mental illness imposed a spiritual reality on him that felt unsafe. He believes that his spiritual awakening came during a drug-induced high. After which, he felt empowered to define spirituality on his own terms. He believes that his spiritual reality has helped him to navigate Alcoholics Anonymous and drug addiction. His spirituality does not involve a deity, but it helps him to cope with challenging situations. Pastoral counseling with Matthew could help him identify salient elements of his spirituality that formed in response to his childhood experiences and process any unresolved grieving around the ways in which religion and spirituality influenced an unsafe environment for him as a child.

In summary, the stories of Jessica, Beth, Trevor and Matthew give therapists a dynamic view of the meaningfulness and complexities associated with spirituality for some survivors. It is clear that spiritual identity development has a significant impact on the context for resilience in emerging adult childhood trauma survivors. The research supports claims by Templeton and Eccles (2006) that people who clung to some sense of self-transcendence to survive their ordeal or trauma connect to some sense of being "embedded in something greater than oneself".²⁶² Spirituality takes many shapes

²⁶² Templeton and Eccles, "The Relation Between Spiritual Development and Identity Processes," 255.

throughout life. What appears to be the gyroscope at the center of the spiritual transformation is one's capacity to understand themselves in relationship to God. Whether or not that viewpoint is seen as good or bad, close or distant it is the ability to recognize the existence of a greater other that survivors carry with them throughout. Through this research, survivors offered a glimpse into the contours of that relationship at this point in their spiritual identity journey.

Goal 2- Spiritual Elements that Influence Resilience

The second goal of the study sought to identify spiritual elements and qualitative themes that have positive influences on childhood trauma survivors' coping skills. This study, unlike most other studies in this area had a particular focus on spiritual elements identified as positive by emerging adult survivors. Quantitative and qualitative data were gathered to address this goal. The Royal Free Interview for Spiritual and Religious Beliefs (RFI) instrument asked participants to disclose their personal beliefs about spirituality and religion on an 18-item assessment with both Likert scale and open-ended questions. Three qualitative responses provided data to support the second goal of the study. Participants were asked to explain the form that their religious and/or spiritual beliefs have taken as well as the importance of practicing those beliefs and methods of communicating with a spiritual power or force. Although all participants provided an explanation of their religious and/or spiritual beliefs, not all participants chose to disclose spiritual practices or ways of communicating with spiritual powers. Despite the diversity of religious backgrounds (i.e., different religions, different denominations) in this study, a

few of the same spiritual practices and ways of communicating were reported frequently (see table 5.8).

The responses explaining religious/spiritual beliefs were categorized into four sub-themes: the nature/character of 'God,' Religious Beliefs, Spiritual Beliefs, and Relationship to 'God.' A distinction was made between religious beliefs and spiritual beliefs based on whether or not specific language was associated with an identifiable religious orthodoxy. Christians predominantly represented in the religious beliefs, nature/character of 'God,' and relationship to 'God' sub-categories, followed by Muslim respondents. The data of participants who listed themselves as having 'other' religious/spiritual beliefs heavily influenced spiritual beliefs sub-category. The Nature/Character of 'God' and Relationship to 'God' sub-categories were reiterated during the therapy intervention frame how childhood trauma survivors made sense of God's role or lack of role in their trauma. The nature of God is described as 'loving and merciful,' 'in control,' 'good,' 'directs one's life,' and 'preventer of placing an unbearable burden on person.' Similarly, the relationship to 'God' is described using terms such as 'fear,' 'trust,' 'worship,' and 'head (e.g., head of my life).' Both categories emphasize the authoritarian aspects of God as supreme power. However, little is noted about an empathizing, caring, emotionally connected, or compassionate God, unless those characteristics are implied through God's choice to prevent unbearable circumstances. The beliefs identified are weighed heavily on God's omnipotence and use of power in human lives. It appears, based on the results of post-intervention assessment that those views have been maintained for the majority of the participants. In contrast, the spiritual beliefs sub-category emphasized the influence of higher power in creation, but several

participants believed that the role of a higher power lessened in prominence after creation. For these participants, God as a higher power ‘guides reality,’ is a ‘motivating force,’ and ‘connects to each person and everything.’ Spirituality through this lens focuses on the creative role of a higher power in designing humanity and everything around humanity. Therefore, God does not take on a person relationship with humans, nor influence specific activities in the lives of humans, where the higher power is somewhat like a conduit that connects things (i.e., by motivating, through energy, and providing balance). In therapy the participants who identified themselves as spiritual, often emphasized self-reliance and self-initiative as manifestations of their spiritual awakening.

Regarding spiritual practices, the two prominent sub-categories were community and spiritual disciplines. Community engagement was a fairly important spiritual practice to the participants. Although, most of them acknowledged that they had not been regular attendees to community functions (i.e., church, Musjids, Shabbat services) while in college. They indicated a disconnect with the worship communities of their childhood and challenges in finding a new worship community that felt comfortable to them, particularly as their religious and spiritual views were in flux and shifting. The responses regarding spiritual disciplines identified individual and corporate behaviors such as prayer, worship services, reading the Bible, going to a Bible study class, yoga, and meditation/reflection. The inclusion of private and corporate activities suggests that the participants in this study find it meaningful to connect and search for truths independently, but also find it meaningful to participate in collective efforts toward the same goal. Therefore, pastoral counseling could offer them an opportunity to connect and

search in an intimate environment that represents both their personal quest and corporate interaction.

Lastly, only one sub-category represented the ways in which participants communicated with God/ Higher Power. The forms of communicating sub-category shows the diversity of the spiritual experiences among the study population, which listed 10 forms of communication. The most frequent response was prayer, whether a specific form of prayer such as Salat or unspecified prayer (e.g., talking to God or the universe). Other approaches included writing, breathing techniques, and meditation. Communication methods emphasized either the practice of engaging in private dialogue with God or achieving an inner sense of connectedness with God. During therapy sessions, several participants pointed to their increased use of prayer to help them make it through difficult situations. They use prayer when seeking direction and as a protective agent that helps them to cope with life stressors.

As for meaning making, of the emerging adults in this study some chose to cling to certain traditional doctrines they were taught in childhood, reject certain doctrines, or search for new spiritual frameworks all together. While the majority of the group cites beliefs, practices and communication methods passed down by relatives or mentors, those same participants acknowledge a noticeable inconsistency of their current beliefs, practices, and communication with God. Some are now challenging previously held beliefs based on new experiences and knowledge that they have learned. While others are resistant to explore their beliefs because they consider it to be a complicated endeavor to extract what they were taught from what they might believe based on their experiences. In the case of study participant Renee, her traditional views provide great comfort and her

help to cope with current stressors. Her case illustrates the powerful connection that can exist between emerging adult survivors and spiritual coping.

Renee

Renee is a 21-year-old African American female from an urban city in the southeast. She reports having low incidents of childhood physical abuse or neglect, but severe incidents of sexual abuse and emotional abuse and neglect. She says her mother raised her Baptist and that they attended church services often. She has issues with self-esteem and her body image. She reports that her spirituality helps her think positively and avoid downfalls.

“Prayer and being spiritually connected to a higher being, I think is what ultimately helps me to get through tough situations. I pray and that helps because with prayer it’s just releasing what I feel my anxiety is coming from or pray about something that I am unsure of, so prayer really helps me and reading the bible. Certain scriptures, that really helps me. I think [that] ultimately we choose certain things [and] certain things that we choose have pros and cons. Our consequences are the result of what we choose and I think everything happens for a reason because certain things kind of happen and you realize that maybe that was for the best. I think all of us have a purpose and it’s up to us to determine that purpose and with everything that choose comes consequences, so I think in a way that God kind of makes it better so we would experience more pro’s than the con’s necessarily. [Being spiritual means] being at peace with your surroundings and being content with who you are and what you have. It means like putting God first in your life could kind of help you with a lot of things that come as temptations or come as downfalls for you. I think that ultimately we are not in control of the world. God is in control and I think that we are just in control of our actions. That means a lot to me because that’s all I really knew growing up. So, I think not being at peace with yourself it can cause your downfall and not living in harmony can cause your downfall. You have to humble yourself to a certain extent to where nothing doesn’t bother you. The way I pictured it is like maybe this will help me become one with myself, with my mind, body and spirit. But the mind body and spirit has a lot to do with your actions and how you react to certain things and how you kind of succumb to certain circumstances, how you come to terms with certain circumstances.”

Christian Theology and Survivor Resilience

Reconciling. It is difficult to find a direct correlation to the process of resilience in Christian theology. In its simplest form, resilience is the process of coping with adversity in a positive way. While there are many references in the sacred text to positive outcomes following challenging situations, I am unaware of any passages that directly speak to the process of coping following trauma. One might look to certain narratives in the biblical text that describe the spiritual elements that helped persons to transition from one situation to another. Examples such as Samson using ‘prayer’ to regain his strength and defend God’s honor, Joseph’s ‘faith’ that helped him overcome the adversity of slavery, and Ruth’s ‘obedience’ that made it possible for her and Naomi to survive in a new land, shed light on some of the spiritual elements that can contribute to resilience for religious people. Despite the absence of direct passages that refer to process of coping following trauma, these examples and others indicate that spiritual elements found in the biblical texts function similarly to other elements of resilience.

Though resilience deals specifically with the positive coping of survivors following adversity, some elements of resilience can have both positive and negative effects on survivor functioning. The Christian participants in this study identified some Christian language as meaningful in their coping process. However, the Christian language (messages, phrases or statements) identified had both positive (beneficial) and negative (challenging) effects on their spiritual identity development. Phrases such as “God won’t give you more than you can bear” and “God won’t bring you to something that God won’t bring you through” had a mixed effect on survivor resilience. Positively, these messages gave survivors some sense of meaning for the experiences they endured.

As mentioned previously, statements such as these may be intentioned phrases meant to encourage hope between fellow religious followers. From a positive perspective, the messages imply that good things will follow the tragedy that survivors experience and that they should be hopeful about the future. They also convey God's promise of a better life in the future than the present life they are experiencing. These messages suggest that there is some plan or organization behind what is happening in their life and that God is orchestrating a good ending for them. Survivors in this study found those beliefs helpful to the extent that they could believe that something good would come out of their suffering. However, potential challenges arise when survivors encounter questions about God's role in the suffering experienced.

The unintentional implication of statements such as these is that God participated with intentionality in their suffering. When asked where her childhood trauma and her understanding of God intersect, one survivor resisted reflecting on the connection because it was too difficult to contemplate what God's role was in her abuse. Instead, she recited her faith statement ("I guess we can't know the mind of God") to resolve any internal conflict she was experiencing.²⁶³ Future research should investigate how survivors use these messages as defensive structures to keep unwanted reflections or insights that feel threatening at bay.

²⁶³ Mattis and Watson, "Religion and Spirituality," 96-98. Mattis and Watson (2009) identify several factors that influence religious meaning making for African Americans. Those factors include linking personal plights to the plights of characters religious texts to adversity, linking their optimism to attributes of God (e.g., reporting greater wellbeing because they believe that there is a divine purpose for the negative events that occur in their lives), and the influence of religious beliefs on how they construct, understand and experience their social identities. Meaning making can become challenging when religious people hold a punitive view of God and interpret life events as punishment for violations against God. This view of their relationship to God then links arbitrary events to God's judgment on them, possibly fostering painful despair without a perceivable end.

In Quesha's case, the messages that she internalized as a child now trigger a theological conflict for her as a young adult questioning her sexuality. She not only questions how she should relate to God but whether or not to continue a relationship with God since she is questioning her sexuality as a result of her childhood sexual abuse.

Quesha is a 23-year-old African American female from an urban city in the southeast. She reports childhood incidents of severe sexual and emotional abuse (by both a male and female relative) and minimal to low levels of other types of abuse or neglect. She was raised Baptist but she says that her family did not attend church services regularly. She says they primarily went to church on religious holidays (i.e. Christmas, Easter, etc.). She is now questioning her beliefs as questions surface within herself about her sexuality.

“That's where religion comes in [deciding what to do about my sexuality]. That is also at the back of my mind because I don't know ... I have all these boyfriends...now that I have all these questions...I don't know. I've never read the bible front to back but pieces here and there. So I don't really know how it addresses sexuality. And then when I hear people say it's wrong... it's not what God intended... that first confuses me because God created everything so he knows what's happening so if God created everything then how could it be wrong... so if it's wrong... it's circular reasoning, it's circular reasoning... so that I believe in God, but if God would punish someone... its more so about why would God punish... basically the bible says as long as you repent and acknowledge his son you're okay with God. But then it's like you can do whatever you want to do because as long as you represent... I don't know...just everything seems like contradictory to me and I can't deal with that...to me it either is or it's not. So that frustrates me now and I don't know what to do with it, I really don't. And it's like if God would really punish me for thinking the way I think as a result of living on the earth and being influenced by the earth cause that's all there is...you're either here or you're dead...the thought of someone going to hell for something like this...it makes me mad. Like not even for myself but the thought of someone being punished for something that's really out of their hands, out of their control. And I don't know how or what to believe, cause everyone's tied religion to their own version of what's right and what's wrong. And at what point do I say well...I don't know how far to go back because I wasn't there when God was here or Jesus was here. I don't know...what do I follow. Which is why I don't know what to do with it.”

Quesha's case and others, reveal an interesting connection between survivors and the Christian language that they appropriated to cope with their childhood trauma. Repeatedly survivors recited Christian phrases that have provided meaning for them after trauma they experienced. As mentioned previously in this chapter, the secrecy of trauma prevented survivors from receiving direct guidance concerning their trauma from religious sources. Therefore, the connections between their experience and religious resources were largely linked through their own meaning making skills. It is also important to note the cognitive developmental stage that survivors were in during their process of meaning making following the trauma. It appears in their responses that certain Christian messages or phrases were applied as rationale for the trauma. These messages in time became fixed responses layered over all future situations that triggered traumatic stress. The direct connection that these messages have to the trauma experience appears to interfere when survivors attempt to reflect on the appropriateness of these messages as rationale for current situations. Some survivors in this study displaced subtle resistance when prompted to explore meaning of phrases such as "God will not put more on me that I can bear" in light of current realities such as an emotionally abusive relationship or chronic panic attacks. Though many choose to explore various aspects of spirituality and religious life during this phase, it appears that childhood trauma survivors may resist exploring those interpretations that are closely tied to their spiritual coping, thus hindering some aspects of their spiritual maturity.

Fragmented-Compartmentalization

It is common for adults to compartmentalize different aspects of their identity into the roles they play in the world. Human identity is shaped by the various roles we play such as that of a parent, friend, co-worker, neighbor, etc. For many adults personal spirituality is integrated into a number of these roles. Spirituality is also integrated into emerging adult identity roles as well. Each of these psychological compartments of identity are comprised of separate fragments of experiences and meaning that come together to shape how we understand ourselves in the context of that role. Childhood trauma survivors, by in large are susceptible to psychological compartmentalization as a defensive structure following trauma. As a result, survivors may experience delays in identity development that lead to interpersonal challenges.

This research seems to support other research that childhood trauma survivors have widespread fragmentation within these compartments. What this research adds is a unique perspective of survivor fragmentation through the lens of spiritual fragmenting. This research supports the work of Peres et al., (2007) that calls for clinicians to help trauma counselees build personal spiritual narratives to facilitate the integration of traumatic sensory fragments into new cognitive synthesis. Participant's spiritual narratives in this study point to a compartmentalized function of spirituality that allows them to process certain aspects of spirituality while leaving other aspects undisturbed and intact. In therapy that may be visible by the stark contrast between aspects of spirituality that seem to be budding with new insights versus other areas that appear to be avoided or unaddressed since childhood. Therefore, it may be a useful to process expressions of spirituality with this population to discover which spiritual frameworks are fluid or fixed.

Another possibility therapists should consider is the purpose for the attachment that survivors have to certain spiritual messages. Some messages are adopted as absolute meaning for survivors. If the role of these messages is to guard against traumatic stress, then survivors would likely resist spiritual exploration in that compartment. Ultimately, the use of these messages as inflexible defense mechanisms could interfere with spiritual recovery and reconciliation for survivors, which in turn would have a negative impact on their ability to cope with current feelings, thoughts, and behaviors. These messages then operate in their lives as concrete explanations for the existence of all suffering. This mode of coping can become challenging for survivors when the limitations of these messages become apparent or when the messages are used to justify remaining in unhealthy situations.

This study appears to have identified layered defensive mechanisms among emerging adult childhood trauma survivors that would indicate not only compartmentalized functioning, but also significant fragmenting occurring within established compartments. I conceptualize this process as fragmented-compartmentalization. *Fragmented-compartmentalization* can be defined as inner separateness and disintegration of meaning making elements within cognitive compartments of identity formation, relatedness to others or self-efficacy. In a nutshell, cognitive fragments shaped by experiences exist within sectors of our lives that operate exclusively of other fragments. From this research, spiritual fragments appear to function within several cognitive compartments for survivors. However there are some spiritual fragments that are fixed and unmovable pieces of meaning making which appear not to be connected with any other developing fragments. These particular spiritual fragments

appear to be fixed as and protected by defensive structures connected to the trauma they experienced.

Developmental theorists believe that childhood is a stage of cognitive development when thought processes function in a concrete dichotomy, black or white, right or wrong. Work with the survivors in this study suggests that the childhood trauma influenced the concretizing of certain messages for survivors. Those messages continue to remain fixed, despite abstract thinking in other areas of spirituality because those messages are now directly linked with the trauma itself and thus it would feel threatening to the survivors to revisit those messages of spiritual reality for additional reflection. This appears evident when emerging adult survivors can speak broadly about the new perspectives that they have discovered but are resistant to explore or adjust their perspectives of meaning making about God's participation in the abuse they experienced. Once survivors concretize these messages they are not open for debate or future explanation. Survivors re-purposed these statements to become all-inclusive explanations that resolve any conflicts or questions that arise about the abuse, thus prohibiting future exploration of meaning. These statements become all-inclusive answers for all questions about suffering including whether or not they will recover from the trauma and why the abuse happened to them. The problem is that these statements hinder growth because they obstruct deeper reflection, insight, and new understanding, which leaves the survivor, stuck with the concrete interpretation of childhood.

Emerging adults in this study, as in previous research, compartmentalize aspects of cognitive processes such as the role of student versus the role of

girlfriend/boyfriend.²⁶⁴ Each role can cross the boundary lines of another despite contrasting ways of functioning and responding to the world. One unique feature of emerging adulthood is the intentional blending of divergent identities in an effort to advance the exploration process (e.g., joining a student fraternity/ sorority or becoming a student activist). It is stage appropriate for emerging adults to attempt to bring together fragmented meaning making within their cognitive compartments. Spirituality may complicate this process for emerging adult survivors. While survivors may be prepared at this stage to identify clear boundaries around the functional roles of their identity (i.e., student, girlfriend/boyfriend, adult child), placing a boundary around the role of spirituality within each of those compartments becomes more challenging when there are fragments of spirituality that survivors resist exploring. More specially, survivors in this study demonstrated a resistance to address how their spirituality has and continues to influence their role development following childhood trauma experiences. When prompted to reflect on the integration of spirituality and development, survivors in the study chose either to resist reflection by clinging to fixed messages that gave them meaning as a child or by rejecting any notion of God's influence based on their current anti-theistic beliefs. Survivors explained with great detail other elements of their evolving spiritual awareness, the resistance mentioned here only appeared when survivors were prompted to discuss the intersection or integration of the spirituality and development following the trauma. Perhaps this process of fragmented-compartmentalization is more recognizable during this stage of development because it becomes easier for therapists to

²⁶⁴ Read et al., "Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psycho-Social Model," 246. Susan J. McAlpine and Allison Shanks, "Self-Concept and Attributions About Other Women in Women With a History of Childhood Sexual Abuse," *Journal of Clinical Psychology and Psychotherapy* 17(2010): 198.

notice fixed objects among moveable objects. Moving forward, future research could add insight into the impact of exploring these fixed spiritual elements during this developmental stage for childhood trauma survivors in this stage.

Pastoral counseling has an opportunity to be extremely useful to emerging adult survivors who are seekers of greater spiritual understanding. The presence of a pastoral counselor during this period could both simplify and complicate a survivor's ability to process trauma related spiritual injury. At this pivotal stage of development where spiritual exploration and rejection are regular occurrences, pastoral counseling is uniquely equipped to provide a safe space and provides support that encourages the process of exploration without dismissing its formative influences. The opportunity to process a new spiritual awakening in a theologically aware environment gives survivors an opportunity to grapple with the challenging ontological and theological interpretations of their trauma with a non-judgmental representative of the spiritual struggles they face.

This study also reveals three important considerations for pastoral counselors working with emerging adult childhood trauma survivors. First, emerging adulthood is a stage of great transition and as such, pastoral counselors need to approach the therapeutic encounter with an expectation of religious and spiritual instability. Regardless of childhood upbringing, previous activity in religious/spiritual practices or statements of beliefs, it should be understood that assumptions cannot be made about shared beliefs or relevant theological constructs (e.g., God is good). Emerging adults have and continue to evolve in their spiritual worldview. That process should be acknowledged and affirmed.

Second, survivors may carry the notion of being a burden into therapy that might need to be addressed early in the therapeutic alliance, particularly in pastoral counseling.

Pastoral counselors regardless of intent are seen as representatives of God. Childhood trauma survivors often have unprocessed feelings about their relationship with God and God's intentions toward them. 'Being a burden' was a common theme reported by participants in this study. Participants felt undesirable in the world and disposable by others, as such they have become hypersensitive to perceived rejection. For these participants becoming a burden to others will lead to rejection. Therefore, it becomes difficult for them to 'burden' others with their issues or needs, particularly God (or God's representative) as not to find themselves rejected by God. This may be represented by them withholding information about their true spiritual beliefs, spiritual injury, anger with God, spiritual resistance, behavioral acting out (e.g., sexuality, risk-taking, self-harm), or cognitions (e.g., 'impure thoughts'). The intentional withholding of significant information could initially hinder the therapeutic process unless acknowledged and addressed early in the process.

Third, as one might expect, cultural difference plays a major role in how religious and spiritual coping are interlocked with resilience. Context is everything with childhood trauma survivors. Cultural experiences such as those of African Americans or Caucasians raised in the south are likely to have been heavily influenced by religious traditions. However, in the African American community religious affiliation is not only connected to one's individual spiritual beliefs but community belonging and social empowerment. Therefore, it is important to assess the degree to which religious influences have been used to interpret the survivor's trauma experience and proof of resilience. It cannot be assumed that the goals of the religious influences that the survivor has encountered were focused on empowerment or self-acceptance. In fact, several participants indicated

repeated messages that supported the abuser or justified the abuse using religious language (e.g., ‘God never puts more on you than you can bear,’ ‘Everything happens for a reason,’ ‘God is just making me stronger,’ ‘I wouldn’t be who I am today if that hadn’t happened to me’).

Goal 3- Towards the Development of an Effective Spiritual Focused Cognitive Behavioral Therapy Approach

The third goal of this study focused on identifying therapeutic elements that would support the development of an effective method of incorporating spirituality in a brief therapy with emerging adult childhood trauma survivors. In particular, the goal sought to test the effectiveness of a therapeutic approach that emphasized the influences of spiritual identity and resilience with this population. This pilot study lays the foundation for the forthcoming development of a spiritually focused cognitive behavioral therapy approach. Such a approach would draw on the potential resources and strengths found in the spiritual development and resilience experiences of survivors, while combating residual negative thinking that impacts positive growth. Trauma related negative thinking interferes with interpersonal and academic/professional functioning. A spiritually focused cognitive behavioral therapy approach to pastoral counseling would emphasize the spiritual beliefs, practices, and communication methods that emerging adult survivors identify as meaningful and effective in their positive coping.

A Spiritually Focused Cognitive Behavioral Therapy (SFCBT) approach would draw on the strengths and challenges of survivor resilience. SFCBT is rooted in a healthy respect for the beliefs and spiritual practices of survivors. This approach affirms the

process of meaning making that has propelled survivors to their present reality. There is an emphasis on embracing the characterological strengths by soliciting the development of those strengths through personal narratives. Those narratives in turn inform the process of cognitive restructuring in a spiritually relevant way. A SFCBT approach seeks to empower counselees to honor their process of survival and discovery. The ultimate hope of a SFCBT approach is its potential use as a bridge to deeper healing and long-term mental health for populations that would benefit from short-term action oriented therapy prior to engaging more depth long-term treatment approaches.

The efficacy of the therapeutic intervention was evaluated using a qualitative post-intervention interview, the Narrative Questionnaire. Participants were asked to respond to seven open-ended items (see table 5.11). The questions asked about the most/least helpful elements, unexpected/uncomfortable elements, and cognitive, behavioral, and spiritual changes following the study. According to the qualitative results sub-categories, participants identified the rudimentary agents of therapeutic change most useful: talk therapy, nonbiased therapist, symptom relief and particular therapeutic elements. More relevant to this study were the comments regarding the therapeutic elements that included reframing and journaling homework. The reframing technique was used during sessions to challenge negative thinking and deepen psycho-spiritual insight. The journaling homework encouraged participants to track their negative thinking experiences and the cognitive, behavioral, and spiritual effects of the negative thinking. In therapy, participants affirmed the usefulness of identifying negative thinking and its connection to childhood experiences. In contrast to the usefulness of the reframing and journaling elements, one participant reported frustration with the 'lack' of action-oriented

advice they believed was necessary to address negative thinking moving forward, and another participant said that the discussions about spiritual beliefs were least helpful for them.

Christian Theology and Clinical Practice

For emerging adults, being able to discuss their spirituality in therapy helps in several ways. First, it gives them a safe space to process another aspect of their personal exploration in similar ways that they would process their decision making skills, coping strategies and interpersonal skills. Here they have an opportunity to process the meaning of how their spirituality is shifting and the factors that are contributing to that shifting in a nonjudgmental space in the context of understanding the ways that it is affecting their decision making skill, coping strategies and interpersonal skills with self, others and God. Pastoral counselors need to recognize the significance of these conversations with emerging adults. It is important for pastoral counselors as well as pastoral care practitioners to understand the benefits of this explorative process of transitional reality for emerging adults. Everyone's spiritual reality and conditioning is unique based on not only what that emerging adult has been exposed to but how they have interpreted it and what meaning it has for them. Ultimately, it is important to learn if and how their current beliefs are in concert with or contrast to those childhood beliefs. Therefore, it is important to understand how they are being used.

Cognitive Behavioral Therapy (CBT) utilizes developmental histories to contextualize present day issues with counselees. Therefore, the inclusion of spiritual history assessments is key in contextualizing counselees' present-day spiritual realities.

Their current religious/spiritual critiques have likely emerged either in concert with or in contrast to their childhood rearing experiences of religion and spirituality. Therefore, spirituality history assessments are important with this population first to understand the parameters and contributing factors of reality that shape this transitional period.

Emerging adulthood is a period of great awakening. There are new experiences they are being exposed to so there is more information to process than before. They likely grew up in somewhat of an isolated space or framework but now they have access to more diverse realities of spirituality. Second, it is developmentally on target to seek out new meaning, new understanding and new insight. Part of that is to be different from the parents that they had (differentiation) or their family of origin and part is to take some self-control, some empowerment to define their unique identity. Third, it is important to remember their spiritual identity and spiritual beliefs are still in flux. From an onlooker's perspective, emerging adult spirituality may seem like a hodgepodge of adopted spiritual elements, but during this exploration process their spirituality feels no less meaningful or valid for them. This is a period of fluidity in thought and opinions. There are many different thoughts and opinions floating around their environment, but their engagement with these thoughts and opinions can become solidified during this phase. Therefore, it is important to acknowledge the significance of their current spiritual reality. Although they may not be consistently practicing any particular spirituality or religious acts at this point in their development, existential questions (e.g., "who am I?") are intersecting many spheres of their life, and for many of them spirituality has a front and center position in defining the answers to those questions.

Whether any particular acts or spiritual disciplines are in place or not, it is important to remember that assessments (history and current formation) are important and that those assessments need to gather both spiritual formation as it developed, and the ways in which that formation has shaped current spiritual reality today. Further, it is important for therapists to remember the potential fluidity of spiritual reality in this stage of development. The transitional nature of spirituality makes it likely to shift over the course of treatment as new reflections and interpretations come into awareness. Pastoral counselors should be intentional to ask in what ways their spirituality is shifting from their childhood or previous understanding of spirituality with a sense of curious positive-regard. Additionally, survivors will likely be helped by frequent opportunities to articulate how their spiritual awareness is shifting and operating in their day-to-day lives.

Future Research

Moving forward, there are several factors that could be considered for future research of this topic. First, the study limited the population focus to a specific developmental stage within certain parameters. A large contingent of developmental theorists believes that stages or phases of development cannot be locked into rigid chronological age brackets. Therefore, future research that seeks to capture a fuller representation of emerging adult spirituality and resilience might need to consider a wider age range. To that point, research shows that there is a significant void in developmental research across most all stages of development with regard to the intersection of spirituality and resilience following childhood trauma. Therefore, future research should consider incorporating other stages of development going forward.

Second, college students were the only participants recruited for this study.

Research does indicate academic achievement as an identifiable factor in emerging adult resilience. However, other non-college experiences could be studied as well to include emerging adults in the workforce, military or stay-at-home parents. In addition, this study was conducted in a major urban city where a significant percentage of the population attends post-high school education. This reality may not be consistent with more rural or suburban environments. Additional research should include other geographic regions to compile a more diverse sample of participants.

Third, future research could benefit from a treatment model that explicitly addresses theological conflicts. During the course of the treatment intervention with participants in this study, theological elements were addressed as they arose. Going forward, the research design could embed discussion points based on the theological conflicts previously discovered among survivors. Those theological conflicts include topics such as guilt, shame, things happening for a reason, having a sense of purpose because of or despite the childhood trauma, or reconciliation. In addition, pastoral counselors recognize perhaps more than other therapists that their role as representatives of religious communities influences the therapeutic encounter in helpful or challenging ways. Future research could include in its design appropriate acknowledgement of potential interpersonal factors that impact the therapy.

Lastly, this was a pilot study and by design, the sample population was small but robust enough to retrieve valuable qualitative data. The point of such a design ensures that the serious nature of the topic could be addressed with as little potential harm to the subject group as possible. Based on the results of this study, several design factors need

to be considered prior to enlarging the sample population including: a) other methods of recruiting that are reliant on self-reporting to obtain subjects, b) the possibility of compensating research subjects to encourage reluctant participants to come forward, c) plans to address therapeutic issues with study subjects prior to, during and after the study to include periodic follow up therapy sessions over a course of years, and d) plans to expand the therapeutic treatment plan to meet between 8-12 sessions to more effectively address the therapeutic needs of participants. Another major consideration for future research would be the intentional recruiting of underrepresented populations. In this study participants who met the study criteria were accepted into the study as volunteers. As a result, some racial and religious backgrounds demographics were disproportionately represented. If future researchers plan to recruit large samples it will be important to intentionally recruit underrepresented groups (i.e., races, ethnic backgrounds, and religious/spiritual backgrounds). Moving forward, a larger sample could provide generalizable findings that reveal additional spiritual, developmental, and resiliency elements that influence the lives of childhood trauma survivors.

DISSERTATION CONCLUSION

The question at the heart of the dissertation asks how a person's spirituality helps them to cope with life's atrocities, especially when those traumatic experiences happen during in childhood. As a pastoral counselor, I often encounter individuals at various stages of life who have faced what seem to be unbearable circumstances. Yet, it seems equally miraculous that they mobilized internal and/or external resources that help them to not only survive their ordeal but also thrive in some ways in spite of it. In part, the

research at the center of this dissertation seeks to find answers regarding the influence of spirituality in the process of resilience. Further, as a practicing therapist and pastoral theologian this work also provides a useful vehicle to strengthen research in the both the fields of theology and clinical practice regarding our treatment with this population.

Conceptually, the three goals of this research followed a pragmatic train of thought. First, the research sought to understand if merely exploring the spiritual identity development journey of the childhood trauma survivors would have any significant impact on enhancing their resilience. While the results statistically did not prove that the intervention method used would enhance resilience, survivors reported personal benefits from the inclusion of their spiritual journey in the therapy encounter. The second goal simply sought to understand better what spiritual elements survivors identified as contributory to their resilience. Here, survivor responses ranged from those that align with traditional religious beliefs to newly constructed spiritual realities that blend elements from several different sources to address personal issues with organized religion. Perhaps what was most surprising about this portion of the research was the depth to which survivors had engaged the exploration process through deep reflection, experimentation with different faiths, interfaith dialogues, and taking religion courses. Lastly, the research suggested that a therapy approach with the aim of testing the effectiveness of spiritually focused cognitive behavioral therapy with childhood trauma survivors could benefit this population. The majority of the treatment group participants found the inclusion of spiritual identity development narratives, cognitive reframing, journaling, and active reflection effective in alleviating their symptoms to some degree,

but research that is more intensive needs to be conducted to support the use of this approach across different developmental stages.

In addition to the research goals, there were other professional benefits discovered during the process of this research. The findings offer therapists and clergy additional insight into the connection between spirituality and resilience. The qualitative data reveals protective factors (e.g., fragmented-compartmentalization, dissociation) and relational strengths (e.g., relationship to God or the Divine) that impact the effectiveness of treatment with this population. One direct benefit is gaining a contextual understanding of how these strengths and challenges influence childhood trauma survivors at different stages of development. For example, this research showed that spiritual exploration is not only appropriate but important during emerging adulthood, therefore therapists' competency should include the ability to acknowledge and affirm this process of meaning making by helping survivors to incorporate their new spiritual realities into their identity formation and resist the inclination to leave certain fragments unprocessed. Ultimately, this research will enhance my empathic connection with childhood trauma survivors going forward, which in turn will strengthen the therapeutic alliance and facilitate growth with counselees.

This dissertation began with the alarming statistics associated with reported and unreported child abuse and neglect in this country. Though the focus of this work was not expressly preventative, any approach aimed at addressing survivors inadvertently has some effect upon the deterrence of other acts of abuse or neglect. This work begins the dialogue of theological and psychological meaning making in the emerging adult survivor context. It is my hope that others will take up this important topic and add to the

dialogue from different vantage points. In the end, emerging adult survivors will be better supported in their journey toward healing.

INDEX OF TABLES

Chapter 1 – Literature Review

Table 1.1 – Abuse and Neglect Definitions	26
Table 1.2 – Religious and Psychological Adjustment	73

Chapter 4 - Methodology

Table 4.1 – Treatment Session Goals, Intervention and Homework Assignments	151
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Chapter 5 – Results

Table 5.1 – Demographic description of the participants	155
Table 5.2 – Highest frequency of self-reported presenting issues per Treatment Group and Control Group	157
Table 5.3 – Highest frequency of self-reported presenting issues by participant gender, ethnicity and religious/spiritual background	161
Table 5.4 – Childhood Trauma per Treatment Group and Control Group	162
Table 5.5 – Childhood Trauma Questionnaire Results Chi-Square Test by Gender	164
Table 5.6 – Childhood Trauma Questionnaire Results Chi-Square Test by Ethnicity	166
Table 5.7 – Childhood Trauma Questionnaire Results Chi-Square Test by Religious/Spiritual Background	169
Table 5.8 – ANOVA: The Effects of Treatment on Change in Resiliency Scores	173
Table 5.9 – ANOVA: The Effects of Treatment on Change in Spiritual/Religious Beliefs	175
Table 5.10 – Spiritual Elements that Influence Positive Coping	177
Table 5.11 – Treatment Group Dynamics	179
Table 5.12 – Therapeutic Considerations Presented by the Treatment Group	180
Table 5.13 – Narrative Questionnaire – Post-Intervention Treatment Group Responses	181

APPENDIXES

Appendix A – Institutional Review Board Protocol

Appendix B – Informed Consent Form

Appendix C – Demographic Information Sheet

Appendix D – Childhood Trauma Questionnaire (CTQ)

Appendix E – Connor-Davidson Resilience Scale (CD-RISC)

Appendix F – Modified Royal Free Interview for Spiritual
and Religious Beliefs (RFI)

Appendix G – Narrative Questionnaire

Appendix H – Referral Information

Appendix I – Treatment Group Homework – Week 1

Appendix J – Treatment Group Homework – Week 2

Appendix A – Institutional Review Board Protocol

STUDY BACKGROUND

This study explores what effect a spiritually focused cognitive behavioral therapy approach would have on enhancing resilience with young adult childhood trauma survivors. This research is timely because the fields of pastoral counseling and professional counseling are beginning to dialogue about the mutual contribution that each field brings to the process of therapeutic intervention with individuals who exhibit maladaptive trauma responses. This research study hopes to enrich the dialogue by contextualizing an integrative therapeutic approach that is grounded in both theological and psychological approaches to healing and health. Both theological scholars and psychological clinicians are currently investigating how spirituality influences resiliency, but few are researching how these two aspects of health can be used with integrative intentionality for cognitively reframing .

This study is designed to learn more about a) what influence, if any, spiritual identity development has on positive coping with childhood trauma survivors b) identifiable spiritual elements and themes (i.e., God/Fate, hopelessness, life's purpose, and meaning making) that positively influence coping with childhood trauma survivors and c) effective methods of incorporating spirituality into brief therapy models. This study is a pilot study. Therefore, the researcher acknowledges the statistical limitations of the study based on the intervention duration and small sample size. This study is intended to lay the groundwork for future research with this subject. The findings will serve as foundation for the development of an integrative therapeutic intervention that both brings into awareness individual maladaptive coping mechanisms and restructures cognitive coping by illuminating undiscovered or unacknowledged resources nestled in one's spiritual identity and other resiliency traits. The interventions used in this study are aimed at increasing anxiety thresholds, augmenting coping skills, and serving as a foundation for the development of a spiritually focused cognitive behavioral therapy model for use with young adult childhood trauma survivors.

RESEARCH DESIGN

Sample

The subjects in this study are college students who reside in a large metropolitan city (Atlanta, GA) in the southeastern region of the United States. Inclusion criteria require individuals to be between 18-25 years old, have experienced mild to moderate childhood abuse or neglect (between 1-4 incidents), have a willingness to discuss their concept of spirituality and how it developed, a willingness to complete 3 assessment instruments twice, and a willingness to participate in four brief therapy sessions to discuss childhood experiences and spirituality. Individuals who self-report severe childhood trauma experiences on the pre-screen tools will be excluded from this study, because the intervention used is not suitable for the treatment of severe traumatic response. Individuals excluded from the study will be referred to community therapy resources. The researcher acknowledges that the nature of the subject matter, location of research, and characteristics of the researcher may influence the demographics of persons who respond or volunteer for this research. Therefore, research subject variables include age, race (this study may draw a predominance of African American subjects), and gender (this study may draw a predominance of females).

Setting and Recruitment

The research location for this study is limited to a two-year college, Georgia Perimeter College, Atlanta, GA, and a four-year university, Emory University, Atlanta, GA. Assessments and therapy sessions will be held in private counseling office space that has been reserved on the Georgia Perimeter College, Decatur campus, and at the Care and Counseling Center of Georgia, near Emory University.

Recruitment will be conducted using printed recruitment flyers that will be distributed on each college's campus. Classroom presentations may also be used to recruit students. When presented in class, the recruitment classroom presentation script or the recruitment flyer will be read. Volunteers who meet the study criteria from these two locations have an equal opportunity to participate in all phases of this study.

Procedures

This research will be conducted using a sequential phase mixed method research approach utilizing quantitative and qualitative research methods. The research design will follow a sequential explanatory design wherein the qualitative analysis will be used to build on the quantitative findings. The quantitative research method will use a pre-test and post-test control group experimental design. Recognizing that the qualitative analysis could potentially reveal embedded information that may be different or more in-depth than the quantitative measures alone, a narrative questionnaire will follow the quantitative post-test process.

In this design, the intervention will only be provided for the experimental group. In phase one, quantitative data in the form of assessment instruments will be administered. In the second phase, participants will complete a written narrative to elaborate on the quantitative results. The study sample is limited to $N=100$. Sample subjects will be assigned numerical identifiers by the researcher. The coded identifiers, a 5-digit numerical code, will be used to identify all records, assessments and notes. From the sample pool list of identifiers, ten subjects will be selected by designating every third coded identifier into the experimental group until ten subjects have been designated. In the event that one or more subjects leave the experimental group, replacements will be selected using the same method. The ten subjects designated from the sample population will be scheduled for four therapy intervention sessions. The research procedure follows.

After completing the Informed Consent form, subjects will be asked to complete two pre-screen tools, a Demographic Information Sheet and the Childhood Trauma Questionnaire (CTQ). Once the two forms have been completed, the researcher will collect the materials and debrief subjects regarding any mental or emotional distress related to the pre-screen tools. After which, subjects will receive contact information for local counseling professionals, regardless of whether or not the subjects meet the study criteria. Thirty subjects who meet the study criteria become the study sample group and will receive phase one study instructions. The researcher will schedule sample subjects to complete the Connor-Davidson Resilience Scale (CD-RISC) and the Royal Free Interview for Spiritual and Religious Beliefs (RFI) instruments. In this study, sample subjects will be asked to complete these instruments twice, once at the beginning of the study and then again approximately two months later, after the scheduled therapy intervention sessions have ended. Based on their pre-selected responses to the (CD-RISC) and (RFI) instruments, ten subjects will be designated as the experimental group and will receive four spiritually focused cognitive behavioral therapy intervention sessions. The therapy sessions will discuss the subject's childhood trauma experience, understanding of resiliency factors (positive coping), and spiritual resources (i.e., hope, purpose, and meaning making). Ca Trice Glenn, a Licensed Professional Counselor (GA License Number-LPC006136), will conduct the therapy sessions.

Measures

The total time commitment for this study is between 5-6 hours. That timeframe is based on completing, the Demographic Information Sheet (5 minutes), Childhood Trauma Questionnaire (5 minutes), Connor-Davidson Resilience Scale (15 minutes, completed twice), the Royal Free Interview for Spiritual and Religious Beliefs (15 minutes, completed twice), four Cognitive Behavioral Therapy sessions (50 minutes each, totaling 4 hours), and the Narrative Questionnaire (10 minutes). The pre-screen tools, the Demographic Information Sheet and CTQ, will be administered to subjects after completing the Informed Consent Form (see sample forms attached). Subjects who score within the mild-moderate severity range on the CTQ will be included in the sample group pool. From the sample group, subjects may be randomly selected to participate in the experimental intervention.

Childhood Trauma Questionnaire (CTQ)

The Childhood Trauma Questionnaire developed by David Bernstein and Laura Fink identifies adolescent and adult individuals with histories of trauma. It is a 28-item standardized retrospective self-report questionnaire used as an abuse and trauma measure. The instrument measures the severity of an individual's experience of childhood trauma using five subscales of five items regarding: Emotional Abuse, Emotional Neglect, Physical Abuse, Physical Neglect and Sexual

Abuse. The instrument has three additional subjective items on a Minimization-Denial scale to discover potential response bias or subjects attempts to underreport/minimize their childhood experiences. Individuals will be asked to reflect on memories of “when subject were growing up” to respond to the questionnaire items. A Likert scale is used to measure severity. On the Likert scale subject responses range from “never” = 1 to “very often” =5. The CTQ takes approximately 5 minutes for subjects to complete.

Study subjects will be administered the Connor-Davidson Resilience Scale (CD-RISC) and the Royal Free Interview for Spiritual and Religious Beliefs (RFI), sequentially.

Connor-Davidson Resilience Scale (CD-RISC)

The CD-RISC measures stress coping ability. This scale assesses resilience using a 25-item instrument with each item rated on a 5-point scale (0-4) with higher scores reflecting greater resilience. Increase in CD-RISC scores will be noted in proportion to overall clinical global improvement. The scale demonstrates that resilience is modifiable and can improve with treatment, with greater improvement corresponding to higher levels of global improvement.

Royal Free Interview for Spiritual and Religious Beliefs (RFI)

The Royal Free Interview was designed to measure religious and spiritual belief. It is a self-report questionnaire and measures of spiritual experiences in addition to faith or intellectual assent. The instrument is an 18-item questionnaire to assess the nature of spiritual experiences and their relationship to beliefs and strength of beliefs.

Risks to Subjects

The nature of the subject matter in this study may cause uncomfortable memories, flashbacks, or emotional responses to occur when discussed during the assessments or therapy sessions. Reflecting on childhood trauma through the lenses of childhood abuse and neglect could trigger emotional or mental distress for subjects who participate in this study, though not the intent of this study. Should mental or emotional distress emerge while completing any study related materials or interventions, subjects will be instructed to stop what they are doing, speak with the researcher regarding the distress and follow up with a counseling referral. A Licensed Professional Counselor will be conducting the assessments and the therapy sessions for this study. If subjects would prefer to speak with a different professional, they will be given a list of local therapy referrals.

Benefits to Subject or Future Benefits

Subjects will receive a clinical assessment and four therapy sessions with a Licensed Professional Counselor at no cost through their participation in this study. The study results may be used to help counselors, educators, and non-profit workers seeking effective brief holistic therapy approaches (body, mind, and spirit) that will benefit young adults who experience anxiety, depression, or post-traumatic stress disorder symptomatology triggered by childhood trauma.

Data Analysis

Quantitative data will be analyzed using inferential statistical test using *t* tests or analysis of variance. Qualitative data will be analyzed using an inductive data analysis in a phenomenological research approach. This qualitative research data will then be analyzed for coding thematic data statements, the generation of meaning units, and the development of essence statements.

TRAINING

The principal investigator/researcher, Ca Trice Glenn, is a Licensed Professional Counselor (GA-LPC006136). Training specialties include marriage and family therapy, spiritual/theological issues, adolescent therapy, adjustment disorders, anxiety disorders, depression disorders, anger management and

crisis intervention. Certifications include Anger Management, Crisis Intervention, Domestic Violence Advocate, and Level II Chaplain. Additionally, Ms. Glenn is employed as a Personal counselor at Georgia Perimeter College to college students and a Pastoral Counselor for the Care and Counseling Center of Georgia.

PLANS FOR DATA MANAGEMENT AND MONITORING

Study data to include notes, forms, audio recordings, written assessments, transcripts, and evaluations will be maintained in a locked storage box, in the sole possession of Ca Trice Glenn. After the study is complete, paper and audio files will be kept securely in a locked environment up to five years, and then destroyed.

CONFIDENTIALITY

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at subject's study records. These offices include the Emory Institutional Review Board and the Emory Office of Research Compliance. Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than subject's name will be used on study records wherever possible. Subject's name and other facts that might point to subject will not appear when we present this study or publish its results. Any subject, who discloses acts of child or elder abuse, or an intent to do immediate harm to oneself or another person, will be reported to law officials or reported to protective services.

INFORMED CONSENT

See attached

PLANS TO INFORM SUBJECTS OF NEW FINDINGS

It is possible that the researcher will learn something new during the study about the risks of being in this study. If this happens, subjects will be informed of any new potential risk. Then subjects can decide if they want to continue with this study or not. Subjects may be asked to sign a new consent form that includes the new information if subject decide to stay in the study.

References

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Appendix B – Informed Consent Form

Emory University

Consent to be a Research Subject

Title: Childhood Trauma and Resiliency: Toward the Development of a Spiritually-Focused Cognitive Behavioral Therapy Model

Principal Investigator: Ca Trice Glenn, M.S., M.Div., LPC, (Th.D. Candidate) (404) 636-1457, Extension 502

Research Supervisor: Dr. Emmanuel Lartey, (404) 727-6594

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.

Before making your decision:

Please carefully read this form or have it read to you

Please ask questions about anything that is not clear

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form, you will not give up any legal rights.

Study Overview

The purpose of this study is to determine what affect, if any, incorporating spirituality into cognitive-behavioral focused talk therapy has on resilience (positive coping) with young adults who have experienced mild to moderate severity incidents of childhood trauma. This current research defines childhood trauma as having experienced incidents of childhood abuse (emotional, physical, or sexual abuse) or childhood neglect (emotional or physical neglect). This study is designed to learn more about: a) what influence, if any, spiritual identity development has on positive coping with childhood trauma survivors b) identifiable spiritual elements and themes that positively influence coping with childhood trauma survivors c) effective methods of incorporating spirituality into brief therapy models.

Procedures

After completing an Informed Consent form, you will be asked to complete a Demographic Information Sheet and the Childhood Trauma Questionnaire (CTQ). Once the two forms have been completed, the researcher will collect the materials and debrief you regarding any mental or emotional distress related to the pre-screen tools. After which, you will receive contact information for local counseling professionals, regardless of whether or not the you meet the study criteria. If you meet the study criteria, the researcher will provide you with scheduling information to complete the two other written assessments, the Connor-Davidson Resilience Scale (CD-RISC) and the Royal Free Interview for Spiritual and Religious Beliefs (RFI). You will be asked to complete these assessments twice, at the beginning of the study and approximately two months later, at the end of the study.

After completing the (CD-RISC) and (RFI) assessments, that take approximately fifteen minutes each to complete, you may be randomly selected to participate in four fifty-minute therapy sessions based on your responses to certain items on the (CD-RISC) and (RFI) assessments. Counseling sessions will be held in private counseling office space at the Care and Counseling Center of Georgia, near Emory University. The four sessions of therapy will discuss your childhood trauma experience, understanding of resiliency factors

(positive coping), and spiritual resources. The therapeutic sessions will be conducted by Ca Trice Glenn, a Licensed Professional Counselor (GA License Number-LPC006136) and will be audio recorded. Audio recordings will not include any notation of your name and will be stored using the coded identifiers indicated in the confidentiality statement. Should you experience any mental or emotional distress while completing any study related materials or therapy, you should stop what you are doing, and speak with the researcher regarding a counseling referral. If you are selected for the four therapy sessions, this consent form will be reviewed with you at the beginning of each session to ensure that your rights to decline or discontinue are reiterated. You will also receive debriefing with each therapy session and with the three-week follow-up session. Additionally, counseling referral information will also be available at the beginning and end of each session. Further, you will be contacted for a follow-up within one week after your study participation and again at three week intervals.

Risks and Discomforts

The nature of the subject matter in this study may cause uncomfortable memories, flashbacks, or emotional responses to occur when discussed during the assessments or therapy sessions. Reflecting on childhood trauma through the lenses of childhood abuse and neglect could trigger emotional or mental distress for subjects who participate in this study, though not the intent of this study. Should mental or emotional distress emerge while completing any study related materials or interventions, you will be instructed to stop what they are doing, speak with the researcher regarding the distress and follow up with a counseling referral. A Licensed Professional Counselor will be conducting the assessments and the therapy sessions for this study. If you would prefer to speak with a different professional, you will be given a list of local therapy referrals.

New Information

It is possible that the researcher will learn something new during the study about the risks of being in this study. If this happens, you will be informed of any new potential risk. Then you can decide if you want to continue to be in this study or not. You may be asked to sign a new consent form that includes the new information if you decide to stay in the study.

Benefits

You will receive a clinical assessment and four therapy sessions with a Licensed Professional Counselor at no cost through your participation in this study. The study results may be used to help counselors, educators, and non-profit workers seeking effective brief holistic therapy approaches (body, mind, and spirit) that will benefit young adults who experience anxiety, depression, or post-traumatic stress disorder symptomatology triggered by childhood trauma.

Compensation

You will not be offered payment for being in this study.

Other Options Outside this Study

If you decide not to enter this study, there is counseling available to you outside of this research. There are other private and community based counseling services that can address any therapeutic needs you have regarding childhood abuse or neglect. We will discuss these with you. You do not have to be in this study to be treated for mental or emotional issues OR for referrals to therapeutic services.

Confidentiality

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Emory Institutional Review Board and the Emory Office of Research Compliance. Emory will keep any research records we create private to the extent we are required to do so by law. A study number (coded identifier) rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.

Voluntary Participation and Withdrawal from the Study

Choosing to participate in or decline this study has no effect on your academic standing or the potential college/university services available to you. You have the right to leave a study at any time without penalty. You may refuse to do any procedures you do not feel comfortable with, or answer any questions that you do not wish to answer. If you choose to discontinue participation in this study, you may request that your assessment results be returned to you.

The researchers also have the right to stop your participation in this study without your consent if:
 They believe it is in your best interest;
 You were to object to any future changes that may be made in the study plan;
 You discontinue participate in study requirements
 or for any other reason.

Contact Information

Contact Ca Trice Glenn at (404) 636-1457, Extension 502:
 if you have any questions about this study or your part in it,
 if you feel you have had a research-related distress, or
 if you have questions, concerns or complaints about the research

Contact the Emory University Institutional Review Board at (404) 712-0720 or irb@emory.edu:
 if you have questions about your rights as a research participant.
 if you have questions, concerns or complaints about the research.
 You may also let the IRB know about your experience as a research participant through our Research Participant Survey at <http://www.surveymonkey.com/s/6ZDMW75>.

Consent

Please, print your name and sign below if you agree to be in this study. By signing this consent form, you will not give up any of your legal rights. We will give you a copy of the signed consent, to keep.

 Name of Subject

 Signature of Subject

 Date Time

 Signature of Person Conducting Informed Consent Discussion

 Date Time

Appendix C – Demographic Information Sheet

Demographic Information Sheet

Name: Last: _____ First: _____ MI: _____

Physical Address: _____ City: _____

State: _____ Zip: _____ Age: _____ Sex: _____

Email Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How would you describe yourself? (Check one or more)

Single Married Living with another
 Divorced Widowed Separated

How would you describe yourself? (Check one)

Caucasian/White African American/Black Asian/Pacific Islander
 Caribbean African Hispanic Latino Arab
 Multiracial Other: (please specify) _____

What is your religious/spiritual background? (Check one)

No religious/spiritual background Jewish Muslim
 Christian Buddhist Hindu
 Other (please specify) _____

What is your highest level of education? (Check one)

Middle school High School Some College
 College Degree Master's Degree Doctorate

Are you? (Check all that apply)

Student Employed Military Unemployed

COUNSELING CONCERNS

What would you like to see happen as a result of participating in this research study?

Appendix D –Childhood Trauma Questionnaire (CTQ)

The Childhood Trauma Questionnaire: A Retrospective Self-Report (CTQ), Author(s): David P. Bernstein and Laura Fink is copyright protected. Contact PsychCorp, Pearson Education, Inc.

Appendix E –Connor-Davidson Resilience Scale (CD-RISC)

How have you felt over the past month?	Not True at All	Rarely True	Sometimes True	Often True	Nearly True All the Time
1. Able to adapt to change	0	1	2	3	4
2. Close and secure relationships	0	1	2	3	4
3 Sometimes God can help	0	1	2	3	4
4. Can deal with whatever comes	0	1	2	3	4
5. Past success gives confidence for new challenge	0	1	2	3	4
6. See the humorous side of things	0	1	2	3	4
7. Coping with stress strengthens	0	1	2	3	4
8. Tend to bounce back after illness or hardship	0	1	2	3	4
9. Things happen for a reason	0	1	2	3	4
10. Best effort no matter what	0	1	2	3	4
11. You can achieve your goals	0	1	2	3	4
12. When things look hopeless, I don't give up	0	1	2	3	4
13. Know where to turn for help	0	1	2	3	4
14. Under pressure, focus and think clearly	0	1	2	3	4
15. Prefer to take the lead in problem solving	0	1	2	3	4
16. Not easily discouraged by failure	0	1	2	3	4
17. Think of self as strong person	0	1	2	3	4
18. Make unpopular or difficult decisions	0	1	2	3	4
19. Can handle unpleasant feelings	0	1	2	3	4
20. Have to act on a hunch	0	1	2	3	4
21. Strong sense of purpose	0	1	2	3	4
22. In control of your life	0	1	2	3	4
23. I like challenges	0	1	2	3	4
24. You work to attain your goals	0	1	2	3	4
25. Pride in your achievements	0	1	2	3	4

Appendix F – Modified Royal Free Interview for Spiritual and Religious Beliefs

Royal Free Interview for Spiritual and Religious Beliefs (RFI)

This questionnaire concerns your beliefs and views about life.

We are now going to ask you some questions about your religious and spiritual beliefs. Please try to answer them even if you have little interest in religion.

In using the word *religion*, we mean the actual practice of a faith, e.g. going to a temple, mosque, church or synagogue. Some people do not follow a specific religion but do have *spiritual* beliefs or experiences. For example, they may believe that there is some power or force other than themselves that might influence their life. Some people think of this as God or gods, others do not. Some people make sense of their lives without any religious or spiritual belief.

1. Therefore, would you say that you have a *religious* or *spiritual* understanding of your life?
(Please check one or more.)

- Religious Religious and spiritual
 Spiritual Neither religious nor spiritual

If you have NEVER had a RELIGIOUS or SPIRITUAL BELIEF, please go to Question 13.
Otherwise, PLEASE TRY TO ANSWER THE FOLLOWING QUESTIONS:

2. Can you explain briefly what form your *religious* or *spiritual* belief has taken?

(See Last Sheet to Write More)

3. Some people hold strongly to their views and others do not. How strongly do you hold to your religious / spiritual view of life? Place an X beside the number that best describes your view.

Weakly Held View	0	1	2	3	4	5	6	7	8	9	10	Strongly Held View
---------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

4. Do you have a specific religion?

- No religious/spiritual background (go to question 8)
 Christian Jewish Buddhist Muslim Hindu
 Other (please specify) _____

5. Can you give more detail? (e.g. denomination, sect)

(See Last Sheet to Write More)

Proceed to page 2

Royal Free Interview for Spiritual and Religious Beliefs (Page 2)

6. Do any of the following play a part in your belief? For example, you might pray or meditate alone or with other people. (Check as many choices as applies to you.)

Prayer people	<input type="checkbox"/> Alone	<input type="checkbox"/> With other
Ritual or Ceremony people (e.g. washing before prayer, a religious service)	<input type="checkbox"/> Alone	<input type="checkbox"/> With other
Meditation people	<input type="checkbox"/> Alone	<input type="checkbox"/> With other
Reading and study people	<input type="checkbox"/> Alone	<input type="checkbox"/> With other
Contact with religious leader people	<input type="checkbox"/> Alone	<input type="checkbox"/> With other
None of the above	<input type="checkbox"/>	

7. How important to you is the practice of your belief (e.g., private meditation, religious services) in your day-to-day life? Place an X beside the number that best describes your view.

Not Necessary 0 1 2 3 4 5 6 7 8 9 10 Essential

You can explain further if you would like to:

(See Last Sheet to Write More)

8. Do you believe in a spiritual power or force other than yourself that can *influence* what happens to you in our day-to-day life? Place an X beside the number that best describes your view.

No Influence 0 1 2 3 4 5 6 7 8 9 10 Strong Influence

9. Do you believe in a spiritual power or force other than yourself that enables you to *cope* personally with events in your life? Place an X beside the number that best describes your view.

No Help 0 1 2 3 4 5 6 7 8 9 10 A Great Help

10. Do you believe in a spiritual power or force other than yourself that influences world affairs (e.g., wars)? Place an X beside the number that best describes your view.

No Influence 0 1 2 3 4 5 6 7 8 9 10 Strong Influence

THANK YOU VERY MUCH FOR TAKING PART IN THIS QUESTIONNAIRE
Please Continue Your Answers Below:

2. _____

5. _____

7. _____

12. _____

13. _____

15. _____

17. _____

18. _____

Appendix G – Narrative Questionnaire

Narrative Questionnaire

Please take some time to share your thoughts about the therapy session you received for this research study.

1. What elements of the therapy were most helpful and useful for you?

2. What elements of the therapy were least helpful and useful for you?

3. Were there any elements of the therapy that were unexpected or surprised you?

4. Were there any elements of the therapy that made you uncomfortable or fearful?

5. What, if anything, has changed in the way you think about things after the therapy?

6. What, if any, behaviors have you changed after the therapy?

7. What, if anything, has changed in the way you think about or experience your spirituality?

Appendix H – Referral Information

COMMUNITY REFERRAL RESOURCES CONTACT INFORMATION

Student Mental Health Counseling Referrals

Emory University Student Counseling Center – 404.727.7450

<http://studenthealth.emory.edu>

1462 Clifton Road, Suite 235, Atlanta, GA

Other after hours resources include:

HELPLINE: 404-727-HELP, 7 Days a week 9PM to Midnight.

In case of an emergency the Police should be called by dialing 911

Georgia Perimeter College Personal Counseling Services – 770.278.1300

<http://personalcounseling.gpc.edu>

Alpharetta Center - Building AA, Room 1430 – 678.240.6174

Clarkston Campus - Building CN, Room 1548 – 678.891.3315

Decatur Campus – Building SA, Room 2140 – 678.891.2346

Dunwoody Campus - Building NB, Room 1306 – 770.274.5166

Newton Campus - Building 2N, Room 2306 – 770.278.1286

Spiritual / Pastoral Counseling Referrals

Care and Counseling Center of Georgia – 404.636.1457, Ext. 406

1814 Clairmont Road, Atlanta, GA 30033

Crisis Referrals

Georgia Crisis & Access Line (Behavioral Health Link) – 1.800.715.4225

<http://www.mygal.com>

County Mental Health Referrals

Cobb County Community Service Board – 770.422.0202

Crisis Stabilization Unit, 5400 South Cobb Drive, Smyrna, GA 30080

Alternate Phone: 404.794.4857

Fulton County Department of Behavioral Health – 404.613.3675

99 Jesse Hill Jr. Drive, Atlanta, GA 30303

DeKalb County Community Service Board – 404.892.4646

455 Winn Way, Decatur, GA 30030

Gwinnett County Community Service Board – 770.962.5544

175 Gwinnett Drive, Lawrenceville, GA 30046

Appendix I – Treatment Group Homework – Week 1

Session 1 Homework: Log of Negative Thinking and Self-Statements

The triggering event:	Time of day:
What you were thinking?	What you were feeling?
Your statement or reactions:	Whether or not your spirituality influences your statement or reaction. If so, how?

The triggering event:	Time of day:
What you were thinking?	What you were feeling?
Your statement or reactions:	Whether or not your spirituality influences your statement or reaction. If so, how?

Appendix I – Treatment Group Homework – Week 2

Session 2 Homework: Log of Negative Thinking Reframes

The triggering event:	Your statement or reactions:
What you were thinking?	What you were feeling?
How did you reframe your statement?	Whether or not your spirituality influences your reframing statement. If so, how?

The triggering event:	Your statement or reactions:
What you were thinking?	What you were feeling?
How did you reframe your statement?	Whether or not your spirituality influences your reframing statement. If so, how?

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