The Principle and Practice of Faith Based Techniques in Trauma Therapy

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The area of trauma has been well researched, depicting long-term consequences to a trauma survivor's physical and psychological health, as seen through higher rates of mental illness and comorbid disorders, as well as a predisposition to illness, disease, and autoimmune disorders (Batten, Aslan, Maciejewski, & Mazure, 2004; Gall, Baque, Damasceno-Scot, & Vardy, 2007; Krejci et al., 2004; Lubin, 2007; Lundqvist, Svedin, Hansson, & Broman, 2006; Peres, Moreira-Almeida, Naswello, & Koenig, 2007; Sareen et al., 2007; Walker et al., 2009; Wright et al., 2007). Unfortunately, the association between trauma and the spirit has fashioned far less research, and the research available is ambiguous at best. For instance, the majority of research related to trauma and spirituality show survivors end up with a distorted view of God and stunted spiritual growth as a result of rumination, distrust, and negative religious coping mechanism (Ahrens, Abeling, Ahmad, & Hinman, 2010; Falsetti, Resick, & Davis, 2003; Gall et al., 2007; Turell & Thomas, 2002; Walker, Reid, O'Neill, & Brown, 2009). At the same time, these studies also demonstrate that those who have an active spiritual life are buffered from trauma and better able to create meaning from their trauma, which lowers depression and anxiety levels and increases well-being (Ahrens et al., 2010; Bryant-Davis et al., 2012; Connor et al., 2003; Decker, 1993; Gall, 2006; Gall et al., 2007; Krejci et al., 2004; Murray-Swank & Pargament 2005; Wright et al., 2007). But the ambiguity does not stop there, as a handful of studies question the effectiveness of religious coping and demonstrate mixed results or maladjusted results for those who incorporate spirituality into their healing (Chen & Koenig, 2006; Oaksford & Frude, 2003).

This ambiguity related to trauma and spirituality extends into the field of practice, as positive religious coping mechanisms (i.e. a trusting relationship with God) increase a trauma survivor's ability to heal from the trauma, yet research demonstrates the majority of trauma survivors reject God due to feelings of betrayal and anger (Ahrens et al., 2010; Burkett, 2004; Krejci et al., 2004; Wright et al., 2007). In addition, the majority of therapy clients demonstrate a greater concern for spiritual and religious matters than those in the psychology field, where the majority of therapists avoid spiritual concepts under the belief that they are personal and separate from psychological health, a concept that does not align with the research (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Cornish & Wade, 2010; Pargament, 1997; Young, Cashwell, Wiggins-Frame, & Belaire, 2002).

The American Psychological Association (APA) and the Council for Accreditation of Counselling and Related Education Programs (CACREP), recognizing the research related to spirituality, trauma, and well-being, have begun to incorporate religion and spirituality into their clinician training programs as a section of multi-cultural counseling. Yet, this attempt has not overcome the culture of psychology that implies spiritual matters do not belong in the counseling room, as graduating therapists continue to feel ill-equipped to integrate such matters into their therapy for fear of violating ethical statutes (Brawer et al., 2002; Briggs & Rayle, 2005; Schulte et al., 2002; Shaw et al., 2012; Smith, 2004; Vogel et al., 2013; Young et al., 2002). This is an interesting and concerning realization as the majority of Americans identify with a Christian denomination and consider their religion an important aspect of their lives, and ethical guidelines state therapists are to adhere to the multicultural (including spiritual and religious) needs of their client (Cornish & Wade, 2010; Cragun & Friedlander, 2012; Knabb, 2012).

Therefore, therapists need to have an understanding of how to address the holistic impact trauma has on a client in order to ethically incorporate spirituality within therapy. Currently, the majority of research that addresses spirituality within the therapy room has focused on coping mechanisms, often combining positive and negative coping mechanisms together. This grouping may have led to the ambiguity that is seen in the research, as positive religious coping mechanisms create positive outcomes, while negative religious coping mechanisms create negative outcomes. Furthermore, research in trauma is clear that a person's belief system is impacted following a trauma, requiring more than coping mechanisms to address the negative spiritual impact.

The Current Study

Given the gaps in the literature and the spiritual impact of trauma, the purpose of this study was to identify biblical principles that bridge the gap between trauma and Christ and identify how these principles become therapeutic interventions. In contrast to the current literature, the present study focused on licensed therapists who work primarily with trauma and integrate biblical principles into therapy, narrowing the scope to one religion, Christianity. This study also focused on biblical principles used as therapeutic interventions rather than coping mechanisms to identify what is working in the field of practice. The research questions were: 1. What biblical principles are helpful/needed when working with trauma clients? 2. How are these principles integrated into therapy through therapeutic interventions?

Yin's qualitative case study design was used, utilizing a holistic single case study design through a bounded system. The bounded system was defined as licensed therapists who work primarily with trauma clients and integrate biblical principles into their practice, and this

approach provided an opportunity to incorporate exploratory and explanatory questions related to trauma, spirituality, and therapy.

Participants were gathered utilizing the American Association of Christian Counselors and Christian Association for Psychological Studies, as well as social media and snowballing. Sixteen licensed mental health professionals, four men and 12 women, from all over the world participated in in-depth interviews, conducted over phone or Skype, and recorded for transcription and accuracy. Each participant was asked to include standard documentation, such as treatment plans, assessments, or progress measures, and outside experts were used to evaluate themes, safeguarding meaning and increasing validity and reliability.

Data Analysis Process

Themes collected from the memos were used to identify initial categories in the analysis phase, and then a theoretical ground up approach was used as transcriptions were narrowed into questions and answers, and further narrowed into categories. Themes and patterns were identified through the use of literature and professional experience and member checking was utilized to verify interpretations. Three subject matter experts – two therapists and one pastor – were also incorporated to verify themes and interpretations.

The cumulative categories were further divided into subcategories in order to gain a better understanding, re-sent to the subject matter experts to verify accuracy, and modified as directed. Data patterns were matched with prior predictions and research, which continued to narrow the categories. The final phase originated meaning from themes, where specific principles and interventions were identified, creating a catalyst for therapeutic implementation and future research.

The Findings – Biblical Principles in Healing Trauma

Table 1

Categories

<table>
<tr><th colspan="5">Research Question #1

What Christian principles are helpful/ needed when working with trauma clients?</th><th colspan="5">Research Question #2

How are these Christian principles integrated into therapy through therapeutic interventions?</th></tr>
<tr><td rowspan="2">Primary Issues

(16/16)</td><td>Control (5/16)</td><td>Trust (7/16)</td><td colspan="2">World View (16/16)</td><td rowspan="2">Integrating Views Before & After

(16/16)</td><td colspan="2">Intrinsic vs. Extrinsic (7/16)</td><td colspan="2">Identifying & Realigning Distortion (16/16)</td></tr>
<tr><td>Comorbid Disorders (4/16)</td><td>Family Systems (5/16)</td><td colspan="2">Trauma Symptoms (16/16)
➔ Previous Trauma (6/16)</td><td colspan="2">Cognitive Integration (6/16)</td><td colspan="2">Meaning Making (8/16)</td></tr>
<tr><td rowspan="2">Biblical Principles

(16/16)</td><td>Character of God (16/16)</td><td>Hope (10/16)</td><td>Grace / Mercy (8/16)</td><td>Faith (7/16)</td><td rowspan="2">Therapeutic Interventions

(16/16)</td><td>Relationship Building (10/16)</td><td>Prayer (8/16)</td><td>Psychological Education (6/16)</td><td>Story Telling (16/16)</td></tr>
<tr><td>Forgiveness (9/16)</td><td>Purpose (16/16)</td><td>Sin/ Sin Nature (5/16)</td><td>Scripture (16/16)</td><td>Secular Theories (16/16)</td><td>Addressing Impact (14/16)</td><td>Forgiveness (4/16)</td><td>Reframe / Meaning Making (14/16)</td></tr>
<tr><td rowspan="2">Necessity of Biblical Principles

(16/16)</td><td>Buffer (5/16)</td><td>Anchor / Foundation (16/16)</td><td colspan="2" rowspan="2">Blueprint in Addressing Issues (11/16)</td><td rowspan="2">Different Spiritual Backgrounds

(16/16)</td><td colspan="2" rowspan="2">Same Approach (3/16)</td><td colspan="2" rowspan="2">Different Approach (13/16)</td></tr>
<tr><td>Holistic (8/16)</td><td>Holy Spirit (11/16)</td></tr>
<tr><td rowspan="2">Spirituality

(16/16)</td><td colspan="2" rowspan="2">Foundation (11/16)</td><td colspan="2" rowspan="2">Both – Foundation & Coping (5/16)</td><td rowspan="2">Promoting Implementation (16/16)</td><td colspan="2">Education (15/16)</td><td colspan="2">Supervision / Consultation (5/16)</td></tr>
<tr><td colspan="2">Spiritual Growth of Therapist (6/16)</td><td colspan="2">Self Reflection (7/16)</td></tr>
</table>

Note. The numbers in parenthesis represent the number of participants that used each technique. For example, all 16 participants used Biblical Principles when working with trauma clients.

Primary Issues Related to Trauma

In order to address what biblical principles and coordinating interventions need to be used with trauma, the primary issues related to trauma needed to be specified. Worldview, trauma symptoms, trust, control, family systems, and comorbid disorders were the six categories that emerged. Worldview referred to the client's view of God, self, and others and encompassed the client's questions, distortions, and skewed identity following a trauma. Trust related to the client's inability to trust following a trauma, in relation to others as well as self, and also encompassed fears – fear of more trauma as well as a general fear of the world/life. The inability to trust was closely related to control, where the inability to stop the trauma combined with trauma symptoms reiterates the loss of control, while intensifying a need for control.

The category of control began to bring some dichotomies to the surface of which faith based therapists need to be aware. For instance, many participants indicated that the Christian faith is based on a concept of giving up control, yet taking away control from a trauma victim can re-traumatize them. Another participant pointed out that control is simply an illusion and discussed the importance of helping clients realize this, allowing them to shift perspective to a higher truth that God loves them, is sovereign, and has not finished their story.

Only a handful of participants specified family systems, which may reflect a lack of training for those who were not trained in Marriage and Family. Those who mentioned family systems pointed out the importance of gaining background information related to belief system, unhealthy attachments, coping mechanisms, and survival techniques. Similarly, although the majority of participants mentioned Post Traumatic Stress Disorder, only a few mentioned comorbid disorders, an area highly referenced in the literature. The areas that were mentioned by

participants were depression, anxiety, paranoia, dissociative identity disorder, eating disorders, and substance abuse.

Biblical Principles Used

The participants discussed many biblical principles that are needed when working with trauma clients, including the characteristics of God, scripture, purpose, hope, forgiveness, grace and mercy, faith, and sin/sin nature. The characteristics of God, such as Healer, Love, Unmoving, Consistent, Friend, Good, and Sovereign, were mentioned in addressing the distorted beliefs brought out by the trauma, as well as the implementation of specific scripture, such as Psalm 23, Romans 8:28, Jeremiah 29:11, and Job.

Grace and mercy were referred to as gifts given by God of which the client can choose to accept or reject. Participants stated these concepts help to accept difficult concepts related to the trauma, such as God's presence during the trauma ("Where was He?"), sanctification, and personal responsibility related to regretful decisions stemming from distorted worldviews. The principle of faith was also mentioned to fight fear and create a buffer for clients who can ask, "What did I learn in the past about God and what does God say about who I am and what happened to me?"

God's purpose and the concept of forgiveness were two more complex principles mentioned. Forgiveness encompassed God's forgiveness for all mankind to demonstrate it is given and not deserved or earned; the ability to forgive oneself or the perpetrator in order to move past the trauma; or helping clients understand the difference between forgiveness and reconciliation. Participants also stressed that forgiveness cannot be addressed too soon in the

healing process and mentioned the harm that is often done within the Christian realm when forgiveness is pushed before the trauma has been processed and distorted views realigned.

In relation to God's purpose, participants stated this was often skewed by clients and needed to be realigned with scripture, especially in deciphering suffering for righteousness, suffering as a result of personal choice, and suffering due to free will and sin. Sin and sin nature were mentioned to stress the role of freewill and help the client understand God's character within the context of a sinful world and free will.

The Necessity of Biblical Principles

When participants were asked why biblical principles were needed in therapy, the areas of a buffer, anchor/foundation, and blueprint were mentioned, in addition to a holistic approach and the incorporation of the Holy Spirit for wisdom and discernment. The participants pointed out that the Bible not only creates an anchor or foundation of absolute truths by which the distorted views can be measured, but also creates a blueprint, as many of the primary issues mentioned when dealing with trauma correspond with the biblical principles listed by participants.

The concept of a buffer, or protective quality, was also mentioned by participants and lines up with the literature, however, the participants of this study went a step further in stating it was an existing relationship with Christ that creates a buffer when trauma hits. These participants stated an existing faith provides healthy coping skills, hope, and perspective, where the client can look back over past experiences and incorporate what they know to be true about God, His presence and follow-through, and who they are in Christ.

Spirituality – Coping versus Foundation

Citing the literature, where spiritual concepts are primarily addressed through coping, the participants of this study were asked whether the biblical principles mentioned are used as a foundation of therapy through interventions or as a coping skill. The overwhelming response was that biblical principles must be used as a foundation and intervention within the therapeutic process. In response to coping, some participants interpreted a negative meaning, or the negative religious coping mentioned in literature, stating spirituality and religion can become a Band-Aid and is no different than other means of distractions, such as alcohol and drugs. Other participants interpreted the concept of coping mechanisms as a positive tool used between sessions to reinforce healing, pointing out the importance of using biblical principles to address both surface and root issues simultaneously.

The Findings - Biblical Principles as Interventions

Integrating Views Before and After Trauma

In looking at the trauma literature, one area that stands out is the ability to integrate worldviews before and after the trauma. In relation to this, participants noted the necessity of identifying the client's belief system early in the therapy process in order to have a starting point for integrating views. Along the same lines, the concept of intrinsic/internal belief system, such as a relationship with Christ, versus an extrinsic or external belief system based on actions or rituals was mentioned, noting that the intrinsic faith is what actually creates the buffer for trauma, and the extrinsic faith often requires longer therapy in order to address negative religious coping mechanisms and distorted beliefs.

Once the belief system and distortions have been identified and the therapist has gained an understanding of the client's worldview before and after the trauma, a grieving process may

occur, where the client grieves the "safe understanding of God they had." Through this process, distorted views can be realigned and cognitive integration can begin to occur so that the trauma "is no longer a defining factor" but gets absorbed into the rest of the life experiences. With cognitive integration also comes meaning making, which is highlighted in the literature as a necessity to post traumatic growth and an area where biblical principles provide a source of hope that good and a purpose will come from their pain.

Therapeutic Interventions

Walking with a trauma survivor through the healing process can be a long and arduous journey, and participants in the study referenced a variety of strategies. Storytelling through scripture and Bible stories was reported in order to relate to a client's struggle, bring perspective, and align distortions. The necessity of psychological theories was mentioned, especially incorporating Cognitive Behavioral Therapy and Narrative Therapy, and specific techniques such as grounding techniques, guided imagery, exposure, and coping skills. This also leads into the other areas that need to be addressed, such as anger, grief, boundaries, and identity, as well as the importance of incorporating psycho-education. Forgiveness was mentioned as a tool to release the client from the control of the perpetrator and meaning making referenced a way to establish hope and gauge healing.

Interestingly, while most participants considered relationship building a given in the therapeutic process, several specifically addressed the importance of relationship building with trauma survivors, especially in relation to trust, safety, compassion, and meeting clients in their place of need. The concept of prayer was mentioned as an intervention, both covert (before, between, or silently during session) or overt (in sessions with clients), where participants

mentioned the positive impact of using prayer to reflect rather than react to trauma symptoms and the ability to separate themselves from the trauma and its impact, placing it back on God. In contrast, one participant stated she specifically did not pray with clients, stating this was a difference in pastoral versus professional counseling.

Different Spiritual Backgrounds

All participants were asked how they approach clients from differing spiritual backgrounds. Although initially some stated they did change their approach, in actuality they only changed their starting point and terminology, but maintained the biblical foundation of their personal belief system. Though "biblical" terms were not used with some clients, they all clarified the same goal of drawing clients closer to Christ in a way that could be heard by the client.

Promoting Implementation

Participants were asked what was needed for therapists who have not been trained to integrate biblical principles into their practice. Education, supervision/consultation, and spiritual growth of the therapist were referenced, as some participants pointed out that a person cannot give away what he or she does not possess. Self-reflection and/or personal therapy was mentioned in order for therapists to work through their own trauma and have an understanding of their personal view of Christ and theology of suffering.

Implications for Practice

Biblical Principles Used with Trauma – Conclusions and Implications

Primary Issues Related to Trauma. The primary issues that were identified by participants of this study line up the literature (Connor et al., 2003; Gall et al., 2007; Ganje-Fling

& McCarthy, 1996; Krejci et al., 2004; Lubin, 2007; Lundqvist et al., 2006; Peres et al., 2007; Schaefer & Schaefer, 2012; Turell & Thomas, 2002; Walker et al., 2009; Wright et al., 2007), depicting a wide array of areas that need to be addressed, many of which cannot be adequately addressed without a spiritual component. The concern is the lack of integration between the psychological and biblical arenas, where the majority of "secular" therapists are not integrating or do not feel equipped to integrate spiritual or religious concepts (Brawer et al., 2002; Briggs & Rayle, 2005; Cornish & Wade, 2010; Schulte et al., 2002; Shaw et al. 2012; Smith, 2004; Vogel et al., 2013, Young et al., 2002), and the church has substituted trained therapists with programs or ministers who only incorporate the Bible and leave out research based approaches to therapy. As a result, there is a concern as to whose needs are being met in both approaches, that of the client incorporating what research has deemed necessary, or the ideology of the counselor. The participants in this study continually expressed concern for both extremes, reiterating the Bible is full of psychology and that Christians have no need to be afraid of psychological theory or science, while also expressing concern for the lack of spiritual awareness among secular colleagues. The conclusion is that trauma requires an integrated approach, where empirical approaches to trauma are intertwined with the biblical truths of the Bible, thus treating the entire impact of the trauma.

Biblical Principles Used. Identifying which biblical principles are needed and used when working with trauma is an area that is waiting to be explored, as the majority of research that does exist has combined all forms of spirituality and religion. In contrast, this study began identifying specific biblical principles, many of which align with traumatic issues already verified in the literature, that can be used to address distortions, anger, and God-questions. This

meets a very specific need among trauma clients and therapists and bridges a gap in the literature, where coping mechanisms are the primary source of spiritual integration, leaving therapists and clients to either minimize or ignore the spiritual impact.

The Necessity of Biblical Principles. Spirituality as a buffer for trauma is an area that has been supported by the research (Ahrens, et al., 2010; Gall et al, 2007; Krejcie et al., 2004), and the participants of this study went further stating it was a relationship with Christ, intrinsic faith, that created the buffer. This implies that religion and spirituality protect people from the realities of life, despite the current political notion that people must be protected from religion. This raises concerns in regards to society bowing under political pressure that blatantly goes against research, and requires thoughtful consideration as to how biblical concepts can be implemented in a helpful, rather than harmful or aggressive, manner.

This is also an important concept for the church and parents to recognize, as an accurate view of God and intimate relationship with Him creates a buffer for trauma. Bad things happen to good people, even children, but if a child is taught a developmentally appropriate view of who God is (i.e. helping a child to understand God's presence and protection, even when bad things happen) and establishes an identity based on who they are in Christ rather than good behavior or accomplishments, they will be better prepared to deal with the disappointments and traumas of life.

Also mentioned was the anchor and foundation that biblical principles provide, where an absolute truth provides a measuring stick and the authority by which distortions can be measured and realigned. This is an area that contrasts with the literature, where all forms of spirituality and religion have been combined, leaving dichotomous views to stand side by side in an arena of no

absolute truth. However, if there is no absolute truth then there is no basis for identifying or realigning distorted beliefs about self, God, or the world, leaving the therapist as the only form of authority, and a shaky foundation for a client who is already battling so many issues related to trust and vulnerability. The lack of research in this area may stem from the hesitancy to declare an absolute truth in an attempt to be all encompassing.

Spirituality – Coping or Foundation. Spirituality as a coping versus a foundation was the primary area that contrasted with the literature, where the majority of the literature focuses on spirituality as a coping mechanism (Ahrens et al., 2010; Dutton & Karakanta, 2013; Gall, 2006; Gall et al., 2007; Leavell et al., 2012; Oaksford & Frude, 2003; O'Grady, et al, 2012; Pargament, 1997; Pargament et al., 1999; Perrott et al., 1998; Snow et al., 2011; Tran et al., 2012; Wright et al., 2007), yet every participant in this study relied on biblical principles as the foundation of their therapeutic approach, demonstrating a deficiency related to biblical concepts in the literature. Furthermore, one participant specifically stated she had not seen anything, in research or trainings, addressing the questions that were being asked during the interview, which may relate to the general lack of training and ethical concerns related to spirituality and religion in the therapy room.

Biblical Principles as Interventions: Conclusions and Implications

Integrating Views Before and After Trauma. All the participants discussed the importance of assessing the trauma client's spiritual background and belief system during the beginning stages of therapy in order to establish a starting point for working through distorted views; yet as one participant pointed out, this is something that is rarely done in secular therapy, where spiritual matters are considered less important and left in the hands of the client. The

concern with this status quo is the spiritual impact of trauma, supported in the literature and this study, where anger and questions about God abound, as well as the research demonstrating clients rely on the therapist to guide the therapy process (Cragun & Friedlander, 2012; Knox et al., 2005). Therefore, the culture of psychology needs to progress towards the needs of the client, addressing the spiritual impact of trauma and incorporating the cultural/spiritual concepts.

The intrinsic and extrinsic faith system was another area discussed by participants, where the participants pointed out it is the relationship with Christ that actually serves as the buffer, a view that distinguishes itself from the literature and may speak to the ambiguity that persists in the literature. The current literature demonstrates mixed results, where some studies show an intrinsic faith creates the buffer (Smith, McCullough, & Poll, 2003), while others show the extrinsic qualities also produce a buffer (Tran et al., 2012), but these variables distinguishing the intrinsic and extrinsic faith may still need to be defined (Smith et al., 2003). One quality that does stand out is the motivation. Tran et al. (2012) found the motivation behind the extrinsic faith was important, which speaks to the client relying on positive versus negative religious coping mechanisms.

An interesting reality that came to light while analyzing the data was the actual process of walking trauma clients through addressing, reframing, integrating, and ultimately finding meaning from their trauma, steps that are specified individually in the literature as necessary for healing and well-being. However, this study brought these qualities together in a comprehensive approach, addressing Decker's (1993) concerns that the pulling away from God relates to the trauma survivor's interpretation of the trauma, the impact on the belief system, and the inability to integrate the trauma.

Therapeutic Interventions. As expected, the participants of this study frequently combined psychological theories and faith based approaches, using Bible stories, scriptures, and prayer to address common themes in therapy, and thus creating an integrated approach where psychology and the Bible work together. This means that therapists who use this approach must be adept in the Bible, trauma, and therapeutic approaches proven effective with trauma, and then be able to effectively and accurately implement these concepts in therapy. Yet, while this approach may require extended hours of education and understanding, it does have its rewards, as biblical principles supply the therapist with additional tools that work directly with the trauma issues that need to be addressed in therapy, and those that are often left undone. For instance, prayer as a reflective tool to reduce triggers, the Bible as a foundation for restructuring belief systems, God's view of mankind's worth to externalize problems, and general biblical principles to address trauma related roadblocks such as trust, control, and evil. The ability to integrate faith-based approaches with psychological theory provides an edge in therapy, a holistic approach, where clients have the opportunity to truly find freedom and healing.

In this respect, the literature is replete with the importance of meaning making following a trauma (Gall et al., 2007; Pargament et al., 1999; Wright et al., 2007) and this is an area where the biblical principles most thrive. The principles of faith, grace, and mercy, where a loving God who is omnipresent and has a plan and purpose for one's life provides a catalyst for meaning making and hope for the future. This concept of hope is an important one. Suicide research shows that hope (or the lack thereof), as opposed to the current negative state, is the greatest predictor of suicide or suicide prevention (Pompili, 2010). While meaning making can be found

outside of faith, the biblical principles supply a belief system created on a foundation of truth that meaning can and will come from the trauma and their suffering is not in vain.

Forgiveness. Forgiveness is a popular concept in Christian circles but one that should be handled with care when working with trauma clients. Kennedy (2002) spoke harshly against the concept of forgiveness stating it is a form of social control that protects the powerful and blames the victim. The research, however, demonstrates positive outcomes, mentally and physically, for those who are able to forgive (Langman & Chung, 2013; Lawler, Karremans, Scott, Edlis-Matityahou, & Edwards, 2008), even though it can negatively impact the client if not approached correctly (Lander, 2012). How to appropriately incorporate forgiveness arose during the interviews with participants, when it was postulated that the faith-based approach provides an understanding that forgiveness releases the trauma client from the perpetrators' power yet does not absolve them from guilt. Furthermore, participants reiterated the timing and placement, asserting that motives should be assessed when there is a push for forgiveness. This uncertainty related to implementation may be the reason for the gap between research and practice, even in the faith-based arena, as only nine of the 16 participants addressed this as an intervention in therapy.

Different Spiritual Backgrounds. This category brought to light some interesting ramifications of the therapist's belief system, as all participants approached clients from their personal faith based belief system, despite the belief system of the client. This stresses the importance of including the therapist's belief system in the informed consent, along with the therapist's view of how his or her belief system impacts the therapeutic approach. One

participant in this study pointed out the danger of a therapist who believes his or her Christian views can be left out of the therapy room under the auspices that biases could be ignored, which applies to atheist and agnostic therapists, as well. Although it is the norm to leave one's belief outside the therapy room, in doing so, there remains an undercurrent of beliefs and biases that impact the therapeutic process.

On the other hand, this realization also points out the fact that therapists can implement faith-based approaches with clients of all backgrounds and do so in a safe and ethical manner. Each participant was adamant about meeting clients where they were in their faith journey, but just as adamant about not leaving them there, describing how biblical concepts related to their struggles could be slowly introduced as a possible solution, while respecting the client's acceptance or rejection of these ideas. However, in order to do this, the therapy room must first be a safe place where questions and anger towards God can be acknowledged without fear of reproof; and in order to provide such an environment the therapist must first have a healthy and secure view of God so that the client is free to express and explore God without pressure from the therapist, understanding it is not the therapist's responsibility to change the client's mind, but rather the work of the Holy Spirit.

Promoting Implementation. The majority of responses received from participants in this area were logical recommendations for learning a new therapeutic approach, i.e. training, books, consultation/supervision, and personal growth. However, a distinct quality mentioned by participants was the need for the therapist to have a growing personal relationship with Christ. This drastically sets faith-based therapists apart from secular therapists, noting that the majority of those in the psychology field are less religious. This is not only a question for therapists and

clients of differing belief systems, but also differing faith maturity levels. This highlights a concern regarding how to bridge this chasm, especially in a field where religion is seen as a crutch rather than a lifesaver.

Where Do We Go From Here?

The purpose of this study was to open the door to the spiritual impact of trauma and lay the groundwork for future research in the hopes of bridging the gap between psychology and the church. In response, more research related to the implementation of biblical principles within the therapeutic process is needed, separating these from coping mechanisms and dividing out religions to study separately, providing the opportunity to compare the effectiveness across multiple religions. In addition, more research related to how secular counselors address the distortions of God following a trauma would help broaden the ways these issues can be accurately, safely, and effectively addressed in therapy.

This leads to the concept of posttraumatic growth, where research shows religious/ spiritual concepts contribute to healing, yet few trauma survivors are able to do this, signifying the need for more research to promote this aspect of healing. Information can be taken from this study to create conclusions that would help solidify ways to implement posttraumatic growth. Finally, the concepts of spirituality as a buffer and forgiveness in the therapeutic process created more questions than answers and highlighted the ambiguity that currently exists. More research needs to be done to determine the aspects of spirituality/religion that create the buffer so these can be used in a helpful manner, and studies related to faith based versus secular approaches on forgiveness and where forgiveness falls in the therapeutic process would help gain a better understanding of its role in healing.

References

Ahrens, C. E., Abeling, S., Ahmad, S., & Hinman, J. (2010). Spirituality and well-being: The relationship between religious coping and recovery from sexual assault. *Journal of Interpersonal Violence, 25*(7)*,* 1242-1263. doi: 10.1177/ 0886260509340533

Batten, S. V., Aslan, M., Maciejewski, P. K., & Mazure, C. M. (2004). Childhood maltreatment as a risk factor for adult cardiovascular disease and depression. *Journal of Clinical Psychiatry*, *65*, 249-254.

Bowlby, J. (1982). *Attachment* (vol. 1): *Attachment and loss* (2nd ed.). New York, NY: Basic Books.

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice, 33*(2), 203-206.

Briggs, M. K., & Rayle, A. D. (2005). Incorporating spiritualty into core counseling courses: Ideas for classroom application. *Counseling and Values, 50*, 63-75.

Bryant-Davis, T., Ellis, M. U., Burke-Manyark, E., Moon, N., Counts, P. A., & Anderson, G. (2012). Religiosity, spirituality, and trauma recovery in the lives of children and adolescents. *Professional Psychology: Research and Practice, 43*(4), 306-314.

Chen, Y. Y., & Koenig, H. G. (2006). Traumatic stress and religion: Is there a relationship? A review of empirical findings. *Journal of Religion and Health, 45*(3), 371-381.

Connor, K. M., Davidson, J. R. T., & Lee, L. (2003). Spirituality, resilience, and anger in survivors of violent trauma: A community survey. *Journal of Traumatic Stress, 16*(5), 487-494.

Cook, A. Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). *Complex trauma in children and adolescents; White paper from the National Child Traumatic Stress Network Complex Trauma Task Force*. Retrieved from http://www.nctsnet.org

Cornish, M. A., & Wade, N. G. (2010). Spirituality and religion in group counseling: A literature review with practice guidelines. *Professional Psychology: Research and Practice, 41*(5), 398-404.

Cragun, C. L., & Friedlander, M. L. (2012). Experiences of Christian clients in secular psychotherapy: A mixed methods investigation. *Journal of Counseling Psychology, 59*(3), 379-391.

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed). Thousand Oaks, CA: Sage Publications.

Decker, L. R. (1993). Beliefs, post-traumatic stress disorder, and mysticism. *Journal of Humanistic Psychology, 33*(15), 15-32.

Gall, T. L. (2006). Spirituality and coping with life stress among adult survivors of childhood sexual abuse. *Child Abuse & Neglect, 30,* 829-844.

Gall, T. L., Basque, V., Damasceno-Scott, M., Vardy, G. (2007). Spirituality and the current adjustment of adult survivors of childhood sexual abuse. *Journal for the Scientific Study of Religion 46*(1), 101-117.

Hall, T. W., Fujikawa, A., Halcrow, S. R., & Hill, P. C. (2009). Attachment to God and implicit spirituality: Clarifying correspondence and compensation models. *Journal of Psychology and Theology, 37*(4), 227-244.

Kennedy, M. (2000). Christianity and child sexual abuse – the survivors' voice leading to change. *Child Abuse Review, 9,* 124-141.

Kilpatrick, D. G., & Saunders, B. E. (1999). *Prevalence and consequences of child victimization: Results from the National Survey of Adolescents, final report (revised).* National Crime Victims Research and Treatment Center, Medical University of South Carolina. Retrieved from http://www.childrescuebill.org/ societypays/nsa fnl rpt. rev.pdf

Knabb, J. J. (2012). Centering prayer as an alternative to mindfulness-based cognitive therapy for depression relapse prevention. *Journal of Religious Health, 51,* 908-951.

Krejci, M. J., Thompson, K. M., Simonich, H., Crosby, R. D., Donaldson, M. A., Wonderlich, S. A., & Mitchell, J. E. (2004). Sexual trauma, spirituality, and psychotherapy. *Journal of Child Sexual Abuse, 13*(2), 85-103.

Lander, I. (2012). Towards the incorporation of forgiveness therapy in healing the complex trauma of parental incarceration. *Child and Adolescent Social Work Journal, 29*, 1-19.

Langman, L. & Chung, M. C. (2013). The relationship between forgiveness, spirituality, traumatic guilt and posttraumatic stress disorder (PTSD) among people with addiction. *Psychiatric Quarterly, 84*, 11-26.

Lawler-Row, K. A., Karremans, J. C., Scott, C., Edlis-Matityahou, M. & Edwards, L. (2008). Forgiveness, physiological reactivity and health: The role of anger. *International Journal of Psychophysiology, 68*(1), 51-58.

Lubin, H. (2007). Group and individual therapy for childhood sexual abuse survivors. *International Journal of Group Psychotherapy, 57*(2), 257-262.

Lundqvist, G., Svedin, C. G., Hanssson, K., & Broman, I. (2006). Group therapy for women sexually abused as children. *Journal of Interpersonal Violence, 21*(12), 1665-1677.

Maltby, L. W., & Hall, T. W. (2012). Trauma, attachment, and spirituality: A case study. *Journal of Psychology and Theology, 40*(4), 302-312.

Murray-Swank, N. A., & Pargament, K. I. (2005). God, where are you?: Evaluating a spiritually integrated intervention for sexual abuse. *Mental Health, Religion, & Culture, 8*(3), 191-203.

National Child Traumatic Stress Network (n.d.). *Early childhood trauma.* Retrieved from http://www.nctsnet.org

Oaksford, K., & Frude, N. (2003). The process of coping following child sexual abuse: A qualitative study. *Journal of child Sexual Abuse, 12*(2), 41-72.

Pargement, K. I. (1997). *The psychology of religion and coping.* New York, NY: Guilford Press.

Peres, J. F. P., Moreira-Almeida, A., Nasello, A. G., & Koenig, H. G. (2007). Spirituality and resilience in trauma victims. *Journal of Religion and Health, 46*(3), 343-350.

Sareen, J., Cox, B. J., Stein, M. B., Afifi, T. O., Fleet, C., & Asmundson, G. J. (2007). Physical and mental comorbidity, disability, and suicidal behavior associated with posttraumatic stress disorder in a large community sample. *Psychosomatic Medicine, 69*(3), 242-248.

Schulte, D. L., Skinner, T. A., & Claibom, C. D. (2002). Religious and spiritual issues in counseling psychology training. *The Counseling Psychologist, 30*, 118-134.

Shaw, B. M., Bayne, H., & Lorelle, S. (2012). A constructivist perspective for integrating spirituality into counselor training. *Counselor Education & Supervision, 51,* 270-280.

Smith, C. (2004). Incorporating faith, spirituality, and religion into college counseling and student affairs graduate programs. *The College of Student Affairs Journal, 23*(2), 208-212.

Substance Abuse and Mental Health Services (SAMHSA) (n.d.). *Trauma.* Retrieved from http://www.integration.samhsa.gov/clinical-practice/trauma#RESOURCES

Turell, S. C., & Thomas, C. R. (2002). Where was God? Utilizing spirituality with Christian survivors of sexual abuse. *Women & Therapy, 24*(3-4), 133-147.

U.S. Department of Veteran Affairs (2014). *PTSD: National Center for PTSD.* Retrieved from http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp

Vogel, M. J., McMinn, M. R., Peterson, M. A., & Gathercoal, K. A. (2013). Examining religion and spirituality as diversity training: A multidimensional look at training in the American Psychological Association. *Professional Psychology: Research and Practice, 44*(3), 158-167.

Walker, D. F., Reid, H. W., O'Neill, T., & Brown, L. (2009). Changes in personal religion/ spirituality during and after childhood abuse: A review and synthesis. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(2), 130-145.

Wright, M. O., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence, 22,* 597-608. doi: 10.1007/s10896-007-9111-1

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Young, J. S., Cashwell, C., Wiggins-Frame, M., & Belaire, C. (2002). Spiritual and religious competencies: A national survey of CACREP-accredited programs. *Counseling and Values, 47*(1), 22-33.