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Does Participation in Christian Faith Affect the Healing Process of Female African American Childhood Sexual Abuse Survivors

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DOES PARTICIPATION IN CHRISTIAN FAITH AFFECT THE HEALING PROCESS OF FEMALE, AFRICAN AMERICAN CHILDHOOD SEXUAL ABUSE SURVIVORS

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Dissertation Approval

This is to certify that the thesis presented to us by Tamika A. Thomas on the 27 day of May, 2010, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Abstract

Childhood sexual abuse (CSA) is often associated with devastating effects that are long-lasting and pervasive in nature. Though the sequelae vary from survivor to survivor, difficulties typically manifest psychologically, interpersonally, behaviorally, and in physical health problems. While there are many articles in the CSA literature on coping strategies and various treatment modalities, literature on the efficacy of treatment for this population is limited. Further absent from the CSA literature is an understanding of the impact that participation in religious activities has on the healing process within this population. The purpose of this qualitative study was to explore the impact that participation in Christian faith has on the healing process among female, African American, CSA survivors. The results suggested that participants found involvement in Christian faith activities to be a beneficial factor in their healing process, and that healing from CSA is a transitional process that is facilitated through a relationship with God and an understanding of His characteristics and promises. The implications of this study can be useful in clinical psychological practice with other CSA survivors of the Christian faith.

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"I can do all things through Christ which strengtheneth me."

Philippians 4:13

Chapter 1

Introduction

Statement of the problem.

Childhood sexual abuse (CSA) is often a traumatic event that has long reaching effects in the lives of its survivors. It is estimated that there are 39 million survivors of CSA in the United States (Abel, et al., 1987). Though the sequelae vary from survivor to survivor, difficulties typically manifest psychologically, interpersonally, behaviorally, and in physical health problems. Psychologically, survivors of CSA are more likely to experience post traumatic stress disorder (PTSD), major depressive disorder, and other psychiatric disorders than non victims (Finkelhor, 1990). They tend to be sexually promiscuous, report more substance abuse problems, and lack trust, which inhibits their ability to establish and maintain healthy interpersonal relationships and attachments (House, 2006). Compounding the long-term negative impact, the guilt, shame, and silence associated with CSA often prevent many survivors from disclosing their abuse and seeking treatment. Though there are many articles in the CSA literature on coping strategies and various treatment modalities, literature on the efficacy of treatment for this population is limited. Further absent from the CSA literature is an understanding of the impact that participation in religious activities has on the healing process within this population.

Purpose of the study.

The purpose of the present study was to explore the impact that participation in Christian faith has on the healing process among female, African American CSA survivors. The present study examined CSA survivors' understanding of how participation in religious activities, membership in community, and relationship with God impacted their healing process. The subsequent literature review describes CSA, its sequelae, and empirically supported treatments. The historical and current role of the African American church in the lives of its members is also explored.

This study met multicultural goals in two ways. First, the study created a space for African American women to provide their perspective on the impact that participation in Christian faith has had on their healing process. The study addressed a sample of the population that is underrepresented in research studies. The sample population was selected because of the social-cultural history of African Americans and Protestant Christianity (Mattis, 2000) and statistics that suggested that women are more likely than men to be sexually abused before age 18 (Finkelhor, 1990). The information learned from this qualitative study will hopefully create an opportunity for future research with African Americans and people of other cultures and religions as it is replicated to test generalizability.

The diversity and multiculturalism goal is also met because this study examined the role of Christian faith on the healing process. Developing a deeper understanding of this process may help increase the efficacy of future treatment of people who participate

in religious activities and present for treatment by integrating their religious beliefs into existing empirically supported treatment modalities.

Chapter 2

Review of the Literature

Childhood sexual abuse

Prevalence and incidence of childhood sexual abuse.

According to Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, and Murphy (1987), there are an estimated 39 million survivors of childhood sexual abuse survivors (CSA) in the United States. As reported in a national sexual abuse survey conducted by Finkelhor, Hotaling, and Smith (1990), 27% of adult women and 16% of adult men disclosed a history of CSA. In 1990, Finkelhor reported that 1 in 4 girls and 1 in 6 boys are sexually abused before age of 18. A report published by the World Health Organization (2002) suggested that CSA affects nearly 800 million people worldwide. More recently, Freyd, Putnam, Lyon, Becker-Blease, Cheit, Siegel, and Pezdek (2005) reported that approximately 20% of women and 5% to 10% of men worldwide report a history of CSA.

While these statistics are overwhelming, the prevalence among CSA studies vary for different reasons. First, there is no consensus about the definition of CSA, so the meaning varies from study to study (Paolucci, Genius, & Violato, 2001). There is additionally no consistency in data collection, measurement, and reporting of the incidence of CSA from state to state (Jones-Johnson, 2008). Lastly, CSA often goes unreported. In their 1998 study, Holmes and Slap found that 71% of adolescents and 77% of men never disclosed that they had been victims of CSA. Some explanations for this

include shame, self-blame, embarrassment, uncertainty about how others might respond to disclosure (Bonanno, et al., 2007), and male fear of homosexual stigmatization (Holmes & Slap, 1998). In spite of the variability in prevalence, the reported incidence of CSA is truly disturbing.

Definition of childhood sexual abuse.

As previously stated, the definition and prevalence of CSA vary across studies. Many states define CSA as sexual activity by an adult age 18 and over with a child under age 18 for the purpose of sexual gratification for the adult (Green, 1993). CSA entails a variety of behaviors that involve contact and noncontact abuse. Contact abuse includes fondling breasts or genitals, oral genital sex (licking, kissing, sucking or biting), penetration of either the vagina or anus with fingers, objects, or penis, prostitution, and the creation of child pornography. Contact abuse can occur by forcing or coercing the child to perform these acts or by the adult performing these acts on the child. Noncontact abuse includes inappropriate sexual talk, exhibitionism, voyeurism, and watching pornography. CSA can also be defined in terms of the victim's relationship with the perpetrator. Incest or intrafamilial sexual abuse usually refers to abuse among family members. This type of abuse includes nuclear and extended family living in and outside of the victim's home (Burkhardt & Rotatori, 1995). Extrafamilial sexual abuse includes perpetrators outside of the victim's family, such as a family friend or stranger. Boys typically experience extrafamilial abuse, while girls typically experience incest or intrafamilial abuse (Finkelhor, 1990). When compared to boys, girls are also more likely to be revictimized later in life (Finkelhor, 1990; Finkelhor et al., 1990).

Effects of childhood sexual abuse on the victim.

While some research suggests that the traumatic effects of CSA are highly overstated (Chiswick, 1983; Sandfort, Brongersma, & van Naerssen, 1990), a significant body of research has found CSA to have significant, pervasive negative effects on the lives of its survivors. Difficulties most commonly reported by CSA survivors include PTSD, depression, sexual maladjustment, interpersonal problems, and prostitution (Carver, Stalker, Stewart, & Abraham, 1989; Jones-Johnson, 2008; Paolucci et al., 2001). Other research suggests that CSA interferes with regional brain development and has physical consequences that may persist throughout adulthood (Anderson, et al., 2008; Johnson, 2004). Although CSA sequelae vary from survivor to survivor, it tends to have negative residual effects that profoundly impact many aspects of psychosocial development.

Brain development. According to a study conducted by Anderson et al. (2008), CSA has enduring adverse effects on brain development, with some regions being more susceptible to damage during sensitive periods than others. The study further suggested that the level of morphological change in brain formation is typically associated with early onset abuse, abuse duration, and stress. Using volumetric MRI scans from 26 women with repeated episodes of CSA, this study found that abuse occurring between ages 3 and 5 and 11 and 13 resulted in the reduction of hippocampal volume. Reduced hippocampal volume has been associated with memory problems and unipolar depression (Videbech & Ravnkilde, 2004). Abuse occurring between ages 9 and 10 was found to effect corpus callosum development, which is associated with axonal loss and damage to

white matter (Paul et al., 2008). Sexual abuse occurring between ages 14 and 16 affected frontal cortex development. Damage to this area interferes with the ability to integrate and regulate emotional responses with executive functions. Although the study attempted to control for other factors that could have attributed to morphological brain changes (i.e., motor vehicle accidents, past or present substance abuse, premature birth), the findings of this study were limited because of the small number of subjects who experienced sexual abuse during each stage.

Psychological sequelae. Research has shown that CSA victims are two times more likely to develop psychiatric disorders than to non victims (Finkelhor, 1990). Disorders most commonly associated with CSA include posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and Somatoform disorders. PTSD is a common reaction to very stressful or traumatic events. These events can be experienced directly or indirectly. Symptoms associated with PTSD include reliving the trauma through intrusive memories, nightmares, and flashbacks, avoidance of people, places and things, and physical signs of stress such as difficulty sleeping, hypervigilance, and irritability (American Psychiatric Association (APA), 2000). MDD is typically characterized by a variety of symptoms, such as sadness, loss of energy, loss of interest in activities, loss of weight and appetite, difficulty concentrating and making decisions, withdrawal, self-criticism, feelings of hopelessness, and suicidal thinking. These symptoms can vary from mild to severe (APA, 2000).

Somatoform disorders include a series of disorders in which physical symptoms suggest that a medical condition is present, but the symptoms are not fully explained by a

medical condition. The following are somatoform disorders: somatization disorder (combination of pain, gastrointestinal, pseudoneurological symptoms), conversion disorder (unexplained symptoms that affect sensory motor functioning), pain disorder (pain is the predominant symptom), hypochondriasis (preoccupation with having a serious disease); and body dysmorphic disorder (preoccupation with imagined or exaggerated defects in physical appearance) (APA, 2000). The above-mentioned disorders have been known to cause significant impairment in affect, cognition, and physical functioning in many CSA survivors (Rosenthal, Rasmussen-Hall, Palm, Batten, & Follette, 2005).

Some research suggests that the severity of symptoms and development of full disorders is associated with the period over which the abuse occurred, type of abuse (contact or noncontact), and the victim's relationship to the perpetrator (Finkelhor & Browne, 1985; Kendall-Tackett, Williams, & Finkelhor, 1993; Sirles, Smith, & Kusama, 1989;). For many CSA survivors, symptoms occurring shortly after the incidents of CSA often include fear, sleep problems, distractedness, depression, PTSD-like symptoms, low self-esteem, drug use, sexual problems, suicidal ideation, anxiety, anger, and dissociation (Finkelhor, 1990; Paolucci et al., 2001). Although some psychological sequelae either remit (with or without appropriate treatment) or never meet the full criteria for the diagnosis of a psychiatric disorder, (Johnson, 2004) some survivors experience the effects long into adulthood. In many cases, these effects include the development of psychiatric disorders, sexual problems, difficulties in interpersonal relationships, and distorted attitudes and beliefs regarding self-esteem, self-worth, and how survivors get what they need from the world around them (Beitchman et al., 1992; Cohen & Hien, 2006;

Finkelhor, 1990; Ginzburg et al, 2006; Johnson, Sheahan & Chard, 2003; Luterek, Harb, Heimberg, & Marx, 2004; Steel, Sanna, Hammond, Whipple & Cross, 2004). Finkelhor et al. (1989) also found that CSA survivors tend to have higher rates of marital disruption and lower levels of religious participation than their non abused counterparts.

Behavioral sequelae. In addition to the negative life challenges that arise from the psychological sequelae associated with CSA, the behavioral aftermath is equally devastating. Behavioral sequelae that tend to manifest as a result of CSA include the externalization of coping strategies, such as participation in self-destructive acts (i.e., aggressiveness, delinquent criminal behaviors, and substance abuse) (Johnson et al., 2003; Paolucci et al., 2001). Substance abuse is often a self-medicating response that helps numb the emotional affect in many survivors (Kilpatrick et al., 2003). Research also suggests that some CSA survivors tend to develop maladaptive sexual attitudes and behaviors, such as prostitution, sexual promiscuity, unprotected sex, and multiple sex partners (Arriola, Louden, Doldren & Fortenberry, 2005; Beitchman et al., 1992; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996). These maladaptive sexual practices may also increase the probability of medical consequences that include all or any combination of positive HIV status, other sexually transmitted diseases, or pregnancy (Johnson, 2004).

Interpersonal sequelae. Research suggests that the long-term consequences of CSA also affect interpersonal functioning and the survivor's ability to maintain healthy relationships (Harter, Alexander, & Niemeyer, 1988; Jehu, Klassen, & Gazan, 1986; Kessler & Goff, 2006). CSA survivors tend to have difficulties forming trusting

relationships (Elliot, 1994) and often experience feelings of guilt, shame, helplessness, and vulnerability, which impair judgment and complicate social adjustment (Paivio & Patterson, 1999). They may also face interpersonal challenges within their parenting relationships. In an effort to prevent intergenerational abuse, some CSA survivors are more hypervigilant than their nonabused counterparts (Lev-Wiesel, 2006), which could lead to strain in the parent-child relationship. Research also indicates that difficulties in interpersonal functioning also interfere with the development of the therapeutic alliance (Paivio & Patterson, 1999). Though three different categories of sequelae have been identified, it is important to note that some survivors may experience symptomatology from more than one category at the same time.

Coping strategies. According to Lazarus and Folkman (1984), coping is defined as changes in cognitions and behaviors aimed at managing internal or external demands that are perceived (by the person) to be too difficult to handle. Their transactional model of coping is based on cognitive appraisals that intervene between stressful encounter and reaction to the encounter. These appraisals occur through use of primary and secondary appraisals and reappraisals of internal or external demands before a reaction is made. During primary appraisal, events are placed in one of the following three categories: irrelevant, benign-positive, and stressful. Irrelevant appraisals have no effect on the person's well-being. Benign-positive appraisals evoke pleasurable emotions, and stressful appraisals take account of harm, loss, threat, and challenge. Secondary appraisals seek to determine what can be done to mediate the stressful event. During secondary appraisal, outcome expectancy and efficacy expectation are considered.

Reappraisals occur when the environment provides alternate information. This appraisal could result in a change of response to the situation by adding or removing pressure.

Research suggests that CSA survivors tend to utilize a variety of coping strategies on the approach-avoidance continuum to manage the sequelae associated with their victimization (Marivate & Madu, 2007; Roth & Cohen, 1986). In 1996, Coffey, Leitenberg, Henning, Turner, and Bennett conducted a study to examine the types of coping strategies most often used by adult survivors of CSA. Their findings suggested that adult CSA survivors generally utilize avoidant strategies to cope with memories of their abuse. Avoidant coping strategies tend to temporarily minimize the emotional impact of CSA and prevent survivors from losing control, but they often result in psychological distress and poor long-term adjustment. Emotion-focused coping is on the avoidance end of the continuum. It is associated with controlling the emotional responses associated with the abuse. Survivors may utilize this coping strategy if they do not feel capable of changing their emotional or behavioral state or if they feel they lack the internal resources necessary to deal with the demand the situation requires. Substance use, wishful thinking, fantasizing, and distraction are examples of strategies used to protect survivors from being overwhelmed (Johnson et al., 2003; Steel et al., 2004).

Approach coping strategies generally result in the survivor taking action to remedy maladaptive cognitive, behavioral, emotional, spiritual, and interpersonal functioning. Approach strategies evoke intense emotions by exposing the survivor to the negative thoughts, emotions, and behaviors associated with CSA. Approach strategies include problem solving, seeking social support, and taking advantage of opportunities to

gain more control over the situation. These strategies tend to lead to appropriate affective release and better long-term adjustment (Marivate & Madu, 2007; Roth & Cohen, 1986). Within the problem-solving approach, survivors believe that cognitive, behavioral, and interpersonal change is possible and seek to use or expand their resources to facilitate the change (Steel et al., 2004). Cognitive coping is another approach strategy that typically results in the remediation of the negative sequelae associated with CSA (Marivate & Madu, 2007). This form of coping may entail restructuring thoughts about one's self, others, the world, and the abusive act or utilizing spiritual coping. Spiritual coping can be seen as the survivor's attempt to make meaning of the abuse by seeking guidance and strength from God (Krejci et al., 2004; Pargament et al., 1990; Smith & Kelly, 2001). This can include participation in religious activities such as private and/or group prayer, Bible study, and support from the faith community (Knapik, Martsolf, & Draucker, 2008; Oaksford & Frude, 2003; Pargament, Smith, Koenig, & Perez, 1998). Appropriate use of spiritual coping tends to lead to acceptance, personal growth, and a sense of resolution of the abuse (Gall, Basque, Damasceno-Scott, & Vardy, 2007).

Behavioral coping often employs a combination of approach and avoidant strategies to manage the far-reaching effects of CSA. This coping style entails seeking professional help, talking to family and friends, and the use of activities to keep the mind busy (Marivate & Madu, 2007). While all three of these strategies can aid in coping with CSA, the latter could become pathological if it is used too often or in isolation. The variability in severity and symptoms of abuse among survivors makes identifying one side of the continuum as better than the other problematic because there are times when both approach and avoidant strategies are needed.

*Treatment for CSA survivor*s. Research suggests that effective treatment for CSA survivors should be conducted in a manner that recognizes the vulnerability of this population, while facilitating an atmosphere that is conducive to disclosure, growth, and the reduction of the negative sequelae that often occur (Kessler & Goff, 2006). While there is research that found some CSA survivors to be asymptomatic (Jones-Johnson, 2008; Mannarino & Cohen, 1986), a substantial body of empirical research suggests that CSA has far-reaching effects that negatively impact psychological, emotional, behavioral, and interpersonal functioning (Arriola et al., 2005; Beitchman et al., 1992; Elliot, 1994; Finkelhor, 1990; Finkelhor & Browne, 1985; Harter, Alexander, & Niemeyer, 1988; Jehu et al., 1986; Kendall-Tackett et al., 1993; Kessler & Goff, 2006; Lev-Wiesel, 2006; Paivio & Patterson, 1999; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996; Sirles, Smith, & Kusama, 1989). As previously noted, experiencing CSA tends to lead to feelings of isolation, stigmatization, and disturbances in many survivors' ability to modulate emotions (Johnson et al., 2003), which adversely affects interpersonal functioning and challenges the alliance between the client and therapist (Luterek et al., 2004). Effective treatment for many CSA survivors will address the negative psychological and behavioral sequelae related to the abuse in a supportive environment. Over the last two decades, empirical studies have found different theoretical approaches to be effective in treating CSA survivors (Martsolf & Draucker, 2005).

Emotion-focused therapy. According to Greenberg and Foerster (1996), emotion-focused therapy (EFT) is a form of psychotherapy that emphasizes the role of emotion in functioning and therapeutic change by integrating emotion and experiential theory. Within the context of a supportive therapeutic relationship, EFT uses exposure-based

techniques to address PTSD symptomatology. Similar to emotional processing (Foa, Rothbaum, Riggs, & Murdock, 1991), EFT postulates that trauma memories must be accessed before they can be modified. Exploring previously inhibited adaptive emotions accesses these memories. During sessions, CSA survivors modify memories and feelings associated with their trauma by incorporating new information. Research has found EFT to be effective in treating adult survivors of child abuse and other psychiatric disorders (Johnson, 1998; MacIntosh & Johnson, 2008; Paivio & Greenberg, 1995). In 2008, Greenberg, Warwar, and Malcolm found EFT to be more efficacious than psychoeducation in a sample of 46 clients assessed as having unsettled, interpersonal, emotional trauma. The study examined portions of the emotional process by exploring the role of forgiveness in resolving interpersonal injuries. The results indicated that EFT was significantly more efficacious than psychoeducation on measures of forgiveness, letting go, depression, global symptoms, and key target complaints at pretest, posttest and 3-month follow-up. Paivio and Patterson (1999) also found EFT to be effective in treating a sample of 33 adult survivors of child abuse (sexual, physical, and emotional). After 20 sessions, their sample showed significant improvements on trauma-related symptoms, psychiatric symptoms, social functioning, and trauma resolution. Limitations of this study include reliance on self-report, exclusion of data from participants who did complete treatment, and sample homogeneity. Similarly, Paivio and Nieuwenhuis (2001) also reported EFT to be effective in treating adult survivors of child abuse and adults with other psychiatric disorders. These gains were maintained at the 9-month follow-up.

Cognitive analytic therapy. More than two decades ago, cognitive analytic therapy (CAT) emerged as a promising treatment for CSA survivors (Ryle, 1990). CAT

is an integration of psychoanalytic and cognitive behavioral psychology that seeks to assist clients in shifting dysfunctional thoughts, behaviors, and interpersonal patterns to more adaptive patterns and functioning (Llewelyn, 2002). CAT utilizes cognitive, behavioral, and psychodynamic techniques to help reformulate maladaptive patterns of behavior. When used with CSA survivors, CAT links current interpersonal patterns and difficulties to past abusive relationships (Ryle & Fawkes, 2007). In 1994, Clarke and Llewelyn found CAT to be effective in reducing psychiatric symptoms in a sample of seven women with histories of CSA. After 16 weeks of treatment, most women reported significant increases in self-esteem and decreases in self-abusive behaviors and maladaptive cognitions. Although some women maintained their therapeutic progress at the 3-month follow-up, many women continued to experience difficulty with maladaptive cognitions about men when the study was complete. Findings of this study were limited by the sample size. Although empirical evidence on the effectiveness of CAT is scant, preliminary studies have yielded some promising results (Brockman, Poynton, Ryle & Watson, 1987; Ryle, 1990).

Group therapy. Research has found group treatment to be an effective form of therapy for adult survivors of CSA (Bagley and Ramsey, 1986; Bagley & Young, 1998). Group treatment is thought to be an appropriate modality because it effectively neutralizes the survivors' sense of betrayal, powerlessness, and stigmatization (Carver et al., 1989). This occurs as a result of creating a safe space for CSA survivors to disclose their traumatic experiences and through the normalizing of the traumatic event by other members of the group with similar experiences. More specifically, group therapy provides participants with a sense of cohesiveness and support through difficult phases of

therapy and the social and interpersonal problems that often occur as a result of CSA (Callahan, Price, & Hilsenroth, 2004; Ryan, Nitsun, Gilbert & Mason, 2005;). A 1998 study (Longstreth, Mason, Schreiber, & Tsao-Wei) found group psychotherapy facilitated by clinical social workers to be effective in reducing psychological and somatic symptomatology in a sample of 19 women with CSA histories. This 16-week study addressed maladaptive psychological, behavioral, interpersonal, and emotional functioning. Participants showed significant improvement on all global indices of the Symptom Checklist–90–R (Derogatis, 1977) at posttest and 1-year follow-up. Global indices of the Symptom Checklist–90–R are comprised of the Global Severity Index (designed to measure overall psychological distress), Positive Symptom Distress Index (designed to measure the intensity of symptoms), and the Positive Symptom Total (number of self-reported symptoms).

Similarly, Ryan, Nitsun, Gilbert, and Mason (2005) found group therapy to be an effective form of treatment for adult CSA survivors. After 12 weeks of group therapy, participants in their study showed statistically and clinically significant improvements on general psychological symptomatology measured by the Brief Symptom Inventory (Derogatis, 1993), the Beck Depression Inventory (Beck & Steer, 1987), the Belief Inventory (Jehu, 1988), and the Self Concept Questionnaire (Robson, 1989). Therapeutic gains were maintained at the 4- and 8-month follow-ups. Other studies have also found group therapy to be effective in reducing psychiatric distress in various populations (Chard, 2005; Kriedler, Einsporn, Zupancic, & Masterson, 1999; Lubin, 2005; Lubin, Loris, Burt, & Johnson, 1998).

Cognitive behavior therapy. Research suggests that cognitive behavior therapy (CBT) is effective in treating many psychiatric disorders (Martsolf & Draucker, 2005; Otto, et al., 1993; Rush, Beck, Kovacs, & Hollon, 1977; Sensky, et al., 2000). CBT postulates that thoughts and beliefs significantly influence feelings and behaviors. Over the course of treatment, CBT seeks to identify, challenge, and change maladaptive thoughts and behaviors through a variety of techniques. The CBT family of therapies includes rational-emotive behavior therapy, rational behavior therapy, rational living therapy, cognitive therapy, and dialectic behavior therapy. CBT's dedication to restructuring irrational, dysfunctional, and distorted thoughts makes it a good fit to address the feelings of guilt, shame, and low self-esteem that often occur as a result of CSA.

According to Deblinger, McLeer, and Henry (1990), CBT was effective in treating a sample of sexually abused children with PTSD. After 12 weeks of treatment, participants in this study showed significant improvement across all categories of PTSD (reexperiencing, avoidance, and hyperarousal) and depression, as measured by the State–Trait Anxiety Inventory (Spielberger, 1973) and the Children's Depression Inventory (Kovacs & Beck, 1977). In 2005, McDonagh et al. reported that CBT was significantly more effective than person-centered therapy and a wait list control group in reducing symptoms of PTSD in a sample of adult female CSA survivors. After 14 weeks of treatment, symptom reduction was evident on the State–Trait Anxiety Inventory (Spielberger, Gorusch, & Lushene, 1970), Traumatic Stress Institute Beliefs Scale (Pearlman, 2001), Dissociative Experiences Scale (Carlson, Putnam, Ross, Torem, Coons, & Dill, 1993), State–Trait Anger Expression Inventory (Spielberger, 1988), Beck

Depression Inventory (Beck & Steer, 1987), Quality of Life Inventory (Frisch, Cornell, Villanueva, & Retzlaff, 1992), and the Clinician Administered PTSD Scale (Weathers, Keane, & Davidson, 2001). At the 3- and 6-month follow-ups, remission of PTSD symptomatology and reductions in trauma-related cognitive distortions and anxiety symptom severity were maintained.

Similarly, a study conducted by Lubin et al. (1998) showed significant improvement on measures of PTSD and other psychiatric symptoms after 16 weeks of trauma-focused cognitive-behavioral group therapy. Although significant reductions in PTSD sypmtomatology (reexperiencing, avoidance, hyperarousal) and depression were maintained at the 6-month follow-up, the study was limited because there were no comparison or control groups. Moller and Steel (2002) also found cognitive restructuring based on rational-emotive behavior therapy to be effective in significantly reducing depression, anxiety, and anger in a sample of adults with CSA histories after 10 weeks of treatment and an 8-week follow-up. Cognitive restructuring for guilt and self-esteem did not, however, meet the level of statistical significance within this study. Findings of this study were limited due to small sample size. Jehu et al. (1985) reported clinically and statistically significant improvements in mood states and distorted beliefs after a cognitive restructuring intervention, as well. Jacobs (2002) found the role-play technique to be effective in challenging and changing beliefs and instilling hope in two adolescent CSA survivors, and Echeburua, de Corral, Zubizaretta, and Sarasua (1997) demonstrated the effectiveness of combining cognitive restructuring with self-exposure in a sample of 20 adults with chronic PTSD.

Cognitive processing therapy for sexual abuse. Cognitive processing therapy for sexual abuse (CPT-SA) is a cognitive behavioral treatment for adults with CSA histories that incorporates information processing with trauma and developmental theories. The therapeutic process is a combination of group and individual therapy that takes place over a period of 17 weeks. CPT-SA addresses the function that cognitions, attachment, and development play in the creation and maintenance of symptoms associated with CSA (Chard, Weaver, & Resick, 1997). In this study conducted by Chard, Bennett, and Resick (1997), 15 adult women with CSA histories showed significant improvement on the Modified PTSD Symptom Scale–SR (Resick, Falsetti, Resnick, & Kilpatrick, 1991), Clinician Administered PTSD Symptom Scale (Blake et al., 1990), Symptom Checklist–90–R (Derogatis, 1977), and the Beck Depression Inventory (Beck & Steer, 1987).

Similarly, Resick, Nishith, and Griffin (2003) reported significant improvement in PTSD and depression symptomatology, as measured by the Trauma Symptom Inventory (Briere, 1996), in a sample of adult females with CSA histories. Chard (2005) reported significant clinical and statistical improvement on symptom measures of PTSD, depression, and dissociation in a sample of 30 women with CSA histories after 17 weeks of CPT-SA. Treatment gains were maintained at 3-month and 1-year follow-ups. House (2006) also found a modified version of CPT-SA to be effective in reducing PTSD and depression symptoms. The modified version reduced the number of individual sessions from nine to four and increased the number of group sessions by adding four skills training sessions. After 20 weeks of treatment, participants in this pilot study showed reduction in PTSD symptoms, as measured by the Modified PTSD Symptom Scale–SR (Resick et al., 1991), and depression symptoms, as measured by the Beck Depression

Inventory–II (Beck, Steer, & Brown, 1996). Other studies using eclectic treatment methods were also found to be effective for treating CSA survivors (Martsolf & Draucker, 2005; Sultan & Long, 1998).

In sum, as previously mentioned, CSA is a worldwide epidemic that tends to negatively impact the psychological, behavioral, and interpersonal functioning of many survivors. Difficulties commonly reported from a large portion of CSA survivors include a combination of various psychological complaints that could lead to the development of psychiatric disorders, sexual maladjustment, and interpersonal problems that compromise their ability to form intimate relationships. The above-mentioned professional treatments used for this population typically target trauma, affect, and maladaptive cognitions. Although many studies have been conducted to test the generalizability of various treatment modalities, longitudinal studies to determine clinical significance are still needed. There is also a need for more research to examine variables that may serve as protective factors against the negative effects of CSA (Gall et al., 2007; Cohen, 2008; Jones-Johnson, 2008; Martens, 2007; Miller, Cardona, & Hardin, 2007).

Religion.

Prior to the last two decades, religiosity and spirituality were almost taboo topics in the arena of psychological research and literature, due partially to the difficulty of operationally defining these constructs (Levin & Vanderpool, 1987; Newlin, Knafl & D'Eramo-Melkus, 2002; Taylor, Thornton, & Chatters, 1987;). Religiosity is widely viewed as the practice of a shared set of beliefs or rituals associated with God or gods, while spirituality is often associated with acknowledgement of a supernatural,

transcendent force that permeates all areas of life. It is also explained as an inner sense of a power greater than self (Ellison & George, 1994; Mattis & Jagers, 2001). Behaviors that typically are under the rubric of religiosity include attending worship service and other religious activities in adherence with denominational doctrines, whereas faith, hope, and love are characteristics that can be associated with spirituality (Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1998). Religiosity is, therefore, more behaviorally based, and spirituality is more cognitively and emotionally based (Seeman & McEwen, 1996). Though there are still variations in the definitions of these phenomena, it is clear that the ambiguity that once surrounded these constructs has all but dissipated as mental health professionals and their medical counterparts move toward understanding the benefits of religiosity as it relates to the overall health of their clients (Levin & Vanderpool, 1987). Possible reasons for this surging interest may include the efforts of the mental health and medical professions to treat the whole person or their desire to understand how these phenomena interact in the lives of the populations they serve. Although a growing body of research suggests that religion and religious activities are beneficial to the overall health and well-being of believers (Hill & Pargament, 2003; Koenig, 2008), there is still a need for more empirical studies to further our understanding of how religion impacts the lives of believers.

Religiosity has been reported to play an important role in the lives and culture of African Americans (Taylor & Chatters, 1986), as it may in the lives and cultures of other ethnic groups. Research suggests that African Americans tend to have a high level of religious involvement (Chatters, Taylor, & Lincoln, 1999; Levin & Taylor, 1993; Levin, Taylor, & Chatters, 1994). The relationship between the African American community

and the Black church was born through a history of slavery and oppression. In accordance with Lincoln and Mamiya (1990), the Black church is being defined as independent, African American controlled denominations that were founded after the Free African Society of 1787. The Black church was and continues to be a source of inspiration, information, and resource for many African Americans (Holt, Kyles, Wiehagen, & Casey, 2003). Cooper-Lewter and Mitchell (1986) suggest that African Americans in the Black church use a set of core religious beliefs that helped them survive and adapt through slavery, oppression, and hardship. Those beliefs are: God is omnipotent, fair, just, forgiving and merciful; God has a plan for all His children; God will not burden His children with more than they can bear; and God is all knowing. They further suggest that these core beliefs contribute to the emotional and spiritual health of many African Americans.

African Americans and Protestant Christianity.

Religiousness and spirituality have always been a prominent component of African American culture (Gonnerman, Lutz, Yehieli & Meisinger, 2008; Mattis, 2000; Taylor et al., 1989). Historically, African American participation in religious activities provided solace and hope during great adversities such as slavery, Jim Crow, discrimination, and racism (Morris & Robinson, 1996; Newlin et al., 2002). This rich religious tradition of community and belief in God's mighty power, passed down from one generation to the next, continues to be the source of guidance and peace for many African Americans. Though many once assumed that the relationship between Africans and Protestant Christianity began with slavery (Raboteau, 1978), it was formed and

nurtured on the continent of Africa before the first slave ship reached America.

Slavery. Although many Africans enjoyed freedom and prominent lifestyles prior to the start of the trans-Atlantic slave trade, these liberties were removed upon their arrival in the Americas (Franklin & Moss, 1994). In spite of the fact that many slave owners inappropriately interpreted and used Biblical scriptures to justify slavery, slaves learned to use the appropriate form of biblical interpretation to develop a relationship with God (Osborne, 2006). During slavery, religion provided a refuge from the daily atrocities witnessed and experienced by slaves. Instead of being overcome by the rape, violence, brutality, and dehumanization that was commonplace, many slaves used religion as a coping strategy by focusing on the hope of liberation promised in the Bible (Vlach, 1993).

Between 1619 and the early 1700s, many slaves participated in slave religion, a combination of Christianity and other African religions, because their masters prohibited them from practicing Christianity (Genovese, 1972). To the chagrin of some slave masters, many slaves were converted to Christianity by the early 1800s through the efforts of the Society for the Propagation of the Gospel in Foreign Parts (SPG) and the Great Awakening (Encyclopedia of African Culture and History, 1996). Not long after the Great Awakening, the invisible institution (secret prayer and worship away from their masters) was formulated.

Within the invisible institution, slaves assumed leadership roles that included preaching, teaching the gospel of Jesus, counseling, and ensuring that the physical needs of slaves were met (Encyclopedia of African Culture and History, 1996; Genovese,

1972). During this time, many slaves began to equate themselves with the Hebrews in the book of Exodus (Holy Bible) who were delivered from the harsh hand of their oppressors. They began to focus on liberation, believing that God would deliver them as He did the Hebrews (Vlach, 1993). Then, in 1863, their prayers appeared to be answered by the Emancipation Proclamation.

After the Emancipation Proclamation, ex-slaves continued to be mistreated and discriminated against in the South. With their newfound freedom and support from northern missionaries, Black churches and schools were established in many southern states (Encyclopedia of African Culture and History, 1996). Though different religious ideologies about worshipping God became apparent among African Americans after slavery, their collective focus to meet the needs of their community, attain justice, and equal rights were central themes of the early Black church (Cone, 1997; Hill, 1990; Morris & Robinson, 1996; Raboteau, 1994). Hopes of equality continued to be the driving force of the Black church after emancipation and throughout much of the 20th century.

The civil rights movement. During the height of the civil rights movement, many African American Christians were criticized by some for participating in what was seen as a White man's religion (Cone, 1997; Smallwood, West, & Keyes, 1998). They were accused of supporting a religion that promoted forgiveness, turning the other cheek, and loving those who were persecuting African Americans at a time when overt racism and oppression were the norm. In an effort to provide educational insight on Africa's rich

history with Christianity prior to the institution of American slavery, Dr. John Mbiti wrote books about ancient African religions, which included Christianity (Mbiti, 1970).

Mbiti accurately asserted that ancient Christianity was practiced on the continent of Africa, specifically Egypt and Northern Africa, before it made its way to Europe (1970). By the start of the 17th century, Africa's first Christian church, the Ethiopian Coptic Church (based on the belief in and teachings of Jesus Christ), was a thriving national church found in every region of the country. The book of Acts (Holy Bible) also documents the involvement of Africans from Cyrene and Ethiopia as a part of the congregation of believers in Jesus Christ and preachers of the gospel in the first century.

Black theology of liberation. Throughout the 1950s and 1960s, disdain toward the Black church began to rise. Some accused the church of failing to appropriately respond to the brutality and dehumanization that African Americans experienced on a daily basis (Haley, 1964). Others considered the church to be a powerful institution capable of bringing about change (McKinney, 1971). During their lifetimes, Dr. Martin Luther King, Jr. and Malcolm X gave their voices and service to opposing strategies for obtaining justice and equal rights for African Americans. In his 1969 book *Black Theology and Black Power,* Dr. James Cone synthesized their ideologies into what is now known as the black theology of liberation movement (BTLM). BTLM merged basic Christian principles (equality and justice for all) with the Black Power movement's struggle to liberate African Americans from the physical and psychological aftermath of slavery. BTLM sought to heighten the awareness of the inconsistency between the

teachings of Jesus Christ and the way African Americans had been (and were being) treated by White America (Cone, 1999).

Throughout the tension between the two camps and Cone's development of BTLM, the Black church continued to promote Christians ideals. The church provided services to meet the sociocultural and political needs of the African American community (Hill, 1990; Morris & Robinson, 1996), and provided its members with a sense of autonomy and leadership not typically found in the world outside of its walls (Boyd-Franklin, 1989; Moore, 1991). Much like the slave religion of the 17th century, many contemporary Black churches continue to positively impact the African American community by addressing their spiritual, physical, and psychological needs (Lincoln & Mamiya, 1990).

Religion and treatment. Historically, religion and spirituality were largely absent from psychological research and mainstream treatment (Turrell & Thomas, 2001). As previously mentioned, reasons for the absence in empirical studies may have included problems with construct definition (Newlin et al., 2002), while the absence in therapeutic settings may have been attributed to minimal (or no) discussion around religious issues in clinical training programs (Walker, Gorsuch, & Tan, 2004). Research also indicated that clinician participation in religious and spiritual activities has an influence on use of religion in therapeutic settings (Fosarelli, 2008; Walker et al., 2004). Clinicians who frequently participate in religious and spiritual activities are more likely to incorporate the patient's religious and spiritual beliefs into treatment than those who do not. The above-named factors may have resulted in clinicians being unprepared or unsure of the

appropriateness of using religious teachings and spirituality in treatment. Although many clinicians recognize the need to treat patients holistically to help facilitate behavioral change, use of religion and spirituality in therapeutic settings was an art that lay dormant for many years.

In recent decades, research has found religion to be a significant positive coping strategy in the areas of physical and mental health outcomes, social support, and overall quality of life (Ardelt, Ai, & Eichenberger, 2008; Ellison & Levin, 1998; Holt, Llewelyn & Rathweg, 2005; Levin & Chatters, 2008; Mullen, 1990; Zullig, Ward, & Horn, 2006). Although research to further our understanding about the ways in which religion and spirituality positively affect physical and mental health outcomes is still needed (Davidson, 2008; Hill & Pargament, 2003), general consensuses on religious dimensions thought to be beneficial have been identified. A working group commissioned by the National Institute on Aging and the Fetzer Institute (1997) identified 10 dimensions, but empirical research typically investigates the following four dimensions: (a) public participation (attendance at religious services and related activities, e.g., study groups), (b) religious affiliation (major religious groups and/or specific denominations), (c) private religious practices (e.g., prayer, meditation, reading religious materials), and (d) religious coping (the extent to which individuals turn to religion when coping with problems) (George, Ellison, & Larson, 2002).

Religion and physical health. Over the past few decades, there has been a steady increase in research on the empirical association between religion and health outcomes (Masters, 2007). Various studies document positive outcomes, such as hopeful state of

mind, positive coping with long-term illness, community support, and other physical health benefits (Ellison & Levin, 1998; Holt et al., 2005; Levin & Chatters, 2008; Mullen, 1990; Zullig et al., 2006), while others suggest that religion is negatively linked to health because it can lead to negative emotions and increased suffering (Curlin et al., 2007; Jarvis & Northcott, 1987). This can occur when patients neglect treatment recommendations by assigning responsibility for their care to a higher being or when they view illness as abandonment by God (Turrell & Thomas, 2001). There have also been studies that report no connection (Atchley, 1997; Blazer & Palmore, 1976). Despite differing opinions, most studies report a positive relationship between religion and health. In response to growing empirical support, several professional medical organizations support physician training that incorporates religion and health (Puchalski & Romer, 2000).

According to a study conducted by Ferraro and Koch (1994), religious practices had a significant positive influence on the health of African Americans in a nationwide study of individual religiosity and the social organization of religion by race. In this study, data from the American Changing Lives survey of 1986 were analyzed to determine the effect of religious social support on health. Although it was hypothesized that social support would have a greater effect on the health of African American participants, no such interaction was found. The results did, however, find that Black adults were more likely than their White counterparts to use religion as a coping strategy when faced with health problems. Limitations of this study included lack of follow-up due to use of archival data and difficulty distinguishing social support from religious social support.

Simon, Crowther, and Higgerson (2007) also reported use of spiritual coping to be significantly beneficial to most women in a sample of 18 African American participants diagnosed with breast cancer. This study was designed to understand the role of spirituality throughout the four-phase breast cancer model developed by Holland and Christ. Even though most participants identified spirituality as a positive resource throughout all phases of their illness, during active treatment (phase two) and recurrence (the return of cancer) (phase four), spirituality was acknowledged as a more significant factor. It is, however, important to note that the findings of this study were based on self-report, and no follow-up was included.

Similarly, a qualitative study conducted by Ardelt et al.(2008) with 10 men and women cancer survivors and six seriously ill nursing home residents reported religion and spirituality to be a source of emotional healing. Members of the sample reported experiencing a sense of control over their lives as a result of their relationship with God after being diagnosed with their illness. Other research also indicated positive associations between prayer and perception of health and well being (Johnson, Williams, & Bromley, 1986) and church attendance and improved health (Zuckerman, Kasl, & Ostfeld, 1984).

Religion and mental health. Research indicates that religiosity and religious coping have a positive impact on physical, mental, and spiritual health (James & Wells, 2003; Trice & Bjorck, 2006). In addition to inducing positive mental states that may serve as a mediator between religiosity and mental health (Holt et al., 2005), religiosity has also been reported to protect against depression, suicide, anxiety, alienation, and

loneliness (Maddi, Brow, Khoshaba, & Vaitkus, 2006). In 2005, Levin, Chatters, and Taylor discussed positive changes that occurred as a result of research on the association between religion and mental health. In addition to being more inclusive of African Americans as participants in research studies, religious or spiritual problems were included as a source of psychological distress in the DSM–IV–TR. There has also been an increase in research on the salutary impact of religion. They further report that religion typically has a protective effect on mortality, morbidity, and overall psychological distress among African Americans (Levin, Chatters, & Taylor, 2005).

Although mental health clinicians have generally avoided discussing from religion and spirituality (Hill & Pargament, 2003), the American Psychological Association (2002) recognizes both constructs as important facets of diversity training. It is, therefore, ethically imperative for clinicians to inquire about their patients' religious and spiritual beliefs to provide culturally competent care (Sue & Sue, 1999). To facilitate understanding and increase the likelihood of incorporating religion and spirituality consistently as a component of culturally competent practice, research has begun and must continue to be conducted in this area.

According to Ai, Dunkle, Peterson, and Bolling (1998), private prayer was found to be a predictor of lower levels of depression and psychological distress in a sample of 40- to 80-year-old patients. One month following cardiac surgery, patients with higher levels of depression were more likely use private prayer as a coping strategy to reduce psychological distress than those with lower levels of depression. Although prayer was reported to be less common at the 12-month follow-up, the findings of this study are

consistent with literature that suggests that prayer is frequently used as a coping strategy during times of adversity. Limitations of this study included no baseline data on level of depression and its retrospective design.

A study conducted by Acklin, Brown, and Mauger (1983) indicated that church attendance was associated with positive coping and psychological well-being in a sample of patients being treated for various types of cancer. When compared to patients with non-life-threatening illness, cancer patients who attended church were more likely to report reductions in withdrawal and social isolation and decreased feelings of anger and hostility. Though not the focus of this study, religious social support has been reported to positively influence physical and mental health outcomes (Holt et al., 2005). This study was limited by a lack of baseline data and follow up.

In 1985, Gary conducted a study to provide information on the correlation between demographic factors, stressful life events, sociocultural patterns, and depressive symptoms. He found that lower levels of depression (measured by Center for Epidemiological Studies–Depression Scale) were associated with higher degrees of religiosity in a sample of noninstitutionalized African American men. Similarly, Nooney and Woodrum (2002) indicated that frequent church attendance and prayer were positively associated with religious coping in a sample of religiously affiliated participants. They additionally reported that persons with positive coping styles and social support reported lower levels of depression. While this study provided significant information about individual and institutional religiousness as it relates to mental health

outcomes, it was limited because the authors used archival cross-sectional data to test causal hypotheses.

CSA and religious coping.

Though there are many studies that indicate a positive relationship between religion and physical and mental health outcomes (Ardelt et al., 2008; Ellison & Levin, 1998; Levin & Chatters, 2008; Mullen, 1990; Holt et al., 2005; Zullig et al., 2006), there is still a sizable gap in the literature on the effects of religion as it relates to the treatment of CSA survivors (Knapik et al., 2008). Similar to the research on physical and mental health outcomes, empirical evidence shows both positive and negative associations between CSA survivorship, religious activity, and spirituality. Some studies indicate positive forms of spiritual coping (i.e., increase in religious activities and spirituality, spiritual support, and asking God for help to surrender negative emotion) (Gall, 2006; Krejci et al., 2004; Oaksford & Frude, 2003) as it relates CSA. Others indicate negative forms of spiritual coping, such as distancing oneself from God and religion, spiritual distress, and less religious activity as it relates to CSA (Finkelhor et al., 1990; Ganzevoort, 2002; Hall, 1995). Positive religious coping can be an added benefit that positively influences recovery by lowering levels of psychological distress in CSA survivors (Gall, 2006; Kennedy, Davis, & Taylor, 1998), while negative religious coping can impede the therapeutic process and healing (Gall, 2006).

In 1990, Pargament et al. found religion to be an effective coping strategy that significantly reduced distress when participants were faced with negative life events. Although this study was limited by its cross-sectional design and inability to determine

whether the findings were the result of religious coping alone or social resources (i.e., mental health, personality, and social network) brought to bear on the negative event, the findings highlighted the need for clinicians to develop an understanding of the role that religion plays in coping. It also references the benefit of collaboration with religious communities.

While the need for more longitudinal studies still exists, there is a great deal of empirical evidence that demonstrates the efficacy of religious activities and religious coping as they relate to adversity and physical and mental health outcomes. From this body of research, suggestions that may help clinicians improve culturally competent care have been made. In addition to incorporating religion and spirituality into clinical training course work, mental health providers would also benefit from assessing each patient's level of religiosity and spirituality when treatment is initiated. Collaboration and consultation with religious leaders and communities might also be useful.

Development of research question.

CSA is a devastating occurrence that affects more the 800 million people worldwide. Many people who experience CSA must cope with negative sequelae that affect psychological, behavioral, and interpersonal functioning. There is abundant literature that expounds on the pervasive impact that the guilt, shame, and silence often associated with CSA have on survivors, but there is still regarding need for research on the efficacy of treatment for this population (Martsolf & Draucker, 2005).

Further absent from the CSA literature is an understanding of the impact that participation in religious activities has on the healing process within this population. The current study was generated in response to empirical evidence that indicates a significant positive relationship between many African Americans and the Black church and the efficacy of religiosity and spirituality as they relate to physical and mental health outcomes and overall quality of life.

The current study addresses the question Does participation in Christian faith affect the healing process of female, African American childhood sexual abuse survivors? It examines the impact that participation in Christian faith has on the healing process of a sample of female, African American CSA survivors who participated in the Sexual Abuse Survivors ministry at a church in the Northeast region of the United States.

Chapter 3

Method

Design and design justification.

This study utilized a qualitative research methodology, specifically grounded theory, as a means of developing a rich understanding of the impact that Christian faith has on the healing process in female, African American CSA survivors. According to Kazdin (2003), qualitative research is a methodology that attempts to make meaning of or interpret a subject's experience with phenomena through use of multiple approaches that may include interviews, conversations, and photographs. Grounded theory involves an inductive process that generates theory from the data collected (Glaser, 1998).

According to Strauss and Corbin (1998), grounded theory is a process that produces information about individual experiences with a social-cultural phenomenon. They further describe grounded theory as a method of collecting and analyzing data with the goal of arriving at a place of understanding subjective experiences.

This study also employed Strauss and Corbin's approach to qualitative research in the following way. First, data was collected from participants through semistructured interviews. During the interviews, field notes on participants' affect and reactions to questions were documented. This information was later incorporated into the data analysis process by the coding team. Next, a team of coders consisting of the investigator and two graduate students analyzed and interpreted the interviews to identify convergent and divergent themes among the participants. This process was accomplished through

use of the flip-flop technique, constant comparisons, and open and axial coding. The flip-flop technique was used to turn a concept inside out to consider alternative perspectives of the participants' experience. Constant comparison entailed comparing incidents in an effort to classify the data. Open and axial coding was used to identify and categorize data and to identify causal relationships between categories respectively. Then the information was synthesized to evaluate the meaningfulness of the patterns that were identified. This process was facilitated by combining the findings of the coding team. A qualitative methodology was selected with the hope of creating insight into a phenomenon that is largely absent from the CSA literature. This study generated knowledge about the relationship between Christian faith and the healing process as it relates the CSA, which may later be used to augment treatment with CSA survivors who participate in religious activities.

Participants.

Participants in the present study included 10 female, African American CSA survivors between the ages of 18 and 65 years old who had at least one incident of child sexual abuse before their 18th birthday. Child sexual abuse is being defined as contact and non contact sexual activity with a child under age 18 by an adult over age 18. Participants were recruited through a Sexual Abuse Survivors' ministry (SAS) at a church in the Northeast region of the United States. SAS is a ministry that provides support to male and female CSA survivors. The ministry meets for seven 2-hour sessions over a period of two and a half months. During this time, the ministry, led by five facilitators, provides a safe place for men and women to share their story of abuse while working

toward forgiveness (of self and others), self-esteem and self-worth, and the reclamation of their best life by focusing on Godly principles and biblical truths. This population was chosen for this study due to the homogeneity of their beliefs and the rich history of African Americans with Protestant Christianity. Using a homogenous sample aided in the development of a richer understanding of the processes that helped facilitate change among this specific sample of CSA survivors.

Inclusion and exclusion criteria.

Inclusion criteria included being African American, female, between 18 and 65 years of age, self-identification as a survivor of childhood sexual abuse, and sexual abuse occurring prior to their 18th birthday. They had to have attended the Sexual Abuse Survivors ministry at the church. Exclusion criteria included age below 18-years and not having attended the SAS ministry.

Measures.

Demographic sheet.

The demographic sheet was used to collect identifying information on potential study participants. Information collected included the following: name, sex, age, marital status, and church affiliation. It was also used to identify the prior treatment for CSA. The demographic questionnaire can be found in Appendix A.

Posttraumatic Cognitions Inventory (PTCI).

The PTCI is a brief instrument used to assess negative cognitions about self, the world and self-blame as they relate to PTSD symptomatology. The PTCI uses a Likert type scale ranging from 1 (totally disagree) to 7 (totally agree) to assess the level of negative trauma related appraisal. The PTCI can found in Appendix B.

Brief Multidimensional Measurement of Religiousness/Spirituality.

As a result of a growing body of literature that suggests that religiousness and spirituality may enhance physical and mental health outcomes (Ellison, 1991; Levin 1996; Wallace & Williams, 1997; Williams, Larson, Buckler, Heckmann & Pyle, 1991); the Fetzer Institute supported a collaboration between the National Institute on Aging (NIA) and part of the National Institutes of Health (NIH) to identify and isolate dimensions of religiousness and spirituality responsible for these outcomes. The Brief Multidimensional Measure of Religiousness/Spirituality: 1999 (BMMR) is the result of that collaboration. The BMMR, a shorter version of the Multidimensional Measurement of Religiousness/Spirituality, is organized into the following 11 domains: daily spiritual experiences, values, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history, commitment, organizational religiousness and religious preference. The BMMR was embedded in the 1997-1998 General Social Survey (GSS), a random survey of the national Data Program for the Social Sciences. The GSS is used to gather and circulate data about trends, attitudes, and behaviors in contemporary American society. The 1997-1998 version of the survey used the BMMR and another religious measure to help develop a better understanding of the

relationship between religion, spirituality, and health. The BMMR was found to be appropriately valid and reliable. The BMMR can be found in Appendix C.

Semistructured interview questions.

The semistructured interview, Appendix D, consisted of nine questions. This 90-minute interview was designed to elicit information on the participants' beliefs about God, relationship with God, and the church before, during, and after CSA, their experience with CSA, and how that experience changed how they felt about themselves. The interview also inquired about other coping mechanisms outside of their Christian faith used to help them cope with their CSA experiences. The nine questions were developed as a means of gathering this information with the intention of gaining insight into the impact that Christian faith has on the healing process of female, African-American CSA survivors.

Definition of Constructs.

1. *Participation*: attending church service, studying the Bible, private and public prayer, and involvement in ministry.
2. *Christian* faith: being sure of what we hope for and certain of what we do not see (Hebrews 11:1, Holy Bible, New International Version). Christian faith is also the belief in forgiveness, redemption, and transformation powers of God in the triune form.
3. *Childhood sexual abuse*: contact (fondling of breasts or genitals, oral genital sex, penetration of either the vagina or anus with fingers, objects, or penis,

> creating pornography) and noncontact (inappropriate sexual talk, exhibitionism, voyeurism, watching pornography) sexual activity by an adult age 18 and over with a child under age 18 for the purpose of sexual gratification for the adult.

Procedures.

Participants were recruited for this study by fliers posted in the room where the SAS ministry meets. The flier informed potential participants that a study was being conducted to investigate the impact that participation in Christian faith has on the healing process in female, African American CSA survivors. Interested individuals contacted the investigator by telephone. During this conversation, interested individuals were provided an overview of informed consent. They were provided with information on what participation in the study would entail, the procedure the study would follow, potential risk of changes to their psychological state after participating in the study, and limits of confidentiality. Individuals who wished to continue scheduled an interview. The interviews took place at the church. Participants were also given the opportunity to select another location for their interview. Prior to the start of the interview, the full informed consent document was reviewed and signed, and the limits of confidentiality were explained. Participants chose pseudonyms and the interview began.

The interviewing process lasted approximately 90 minutes. After the interview, participants completed the demographic questionnaire, the BMMR, and the PTCI. After coding the measures with the pseudonym chosen by the participant, participants were debriefed on the interviewing process. At this time, the investigator informed them that

the findings of the study would be made available to them if they wished to have a copy. If participants requested or were assessed to be in need of therapeutic intervention, they were referred for counseling to Women Organized Against Rape (WOAR). If they decided to participate in counseling through WOAR, they were asked to sign a release of information form. The referral to WOAR was made by the investigator. If participants were assessed to be in need of immediate services, they were referred to crisis intervention.

After the interview, all signed consent documents and standardized measures were placed in a locked file cabinet. Audiotapes were stored and locked until transcription took place. The audio recordings were transcribed by the investigator and immediately erased following transcription. The electronic version of the pseudonym-encrypted transcripts was password protected on a removable disk. Transcripts were delivered to the coding team of three doctoral level graduate students. Each transcript was individually analyzed and interpreted by each student through use of various grounded theory techniques (i.e., the flip-flop technique, constant comparisons, and open and axial coding). The coding team met on a biweekly basis to identify themes and subcategories until consensus and saturation were reached. After the transcripts were thoroughly analyzed, the results were written.

Potential risks and benefits.

Potential risk to participants.

Discussing thoughts, feelings, and behaviors associated with CSA may increase feelings of sadness and anger and generate painful memories of the trauma, including but not limited to anxiety and physical symptoms. Prior to the start of the study, the investigator contacted WOAR to establish counseling services for study participants. WOAR's services were offered to all study participants who expressed or were assessed to be in need of therapeutic intervention. Participants in need of immediate care were referred to crisis intervention.

Potential benefits to others.

In addition to generating knowledge that may help increase the efficacy of treatment for CSA survivors who subscribe to the Christian faith, this study might also increase the likelihood of future research with other underrepresented populations when it is replicated to test generalizability to other religions and cultures. Additionally, participants may have benefited from participating in this study by sharing their experiences with other survivors. The sharing of their experiences may help other survivors who share their religious beliefs to overcome similar challenges associated with CSA.

Chapter 4

Results

This chapter will give an account of the experiences of the 10 participants as they relate to faith, childhood sexual abuse (CSA), and the healing process. The qualitative analysis that follows is categorized according to participant responses made on standardized measures, a demographic questionnaire, and themes extracted from participant responses during semistructured interviews. Results relating to this study will be divided into three sections: Participants, Standardized Measures, and Themes.

Participants.

This study was conducted to find out how participation in Christian faith affects the healing process in female, African American childhood sexual abuse survivors. The 10 participants in this study were members of a sexual abuse survivors' ministry from a church in the Northeast region of the United States. All participants were female, African American, self-defined survivors of childhood sexual abuse occurring before age 18. Participants' ages ranged from 23 to 53 years, with a mean age of 39.7 (SD = 10.9). Sixty percent of the sample participants were married, 30% were single, and 10% were divorced. All participants identified themselves as Christians of the Baptist denomination. Demographic information describing this sample is found in Table 1. An overview of each participant's experience with CSA is found in Table 2. Below are participant descriptions coded with each participant's chosen pseudonym.

Participant Descriptions.

Ashyleigh is 23 years old and single. Ashyleigh has been attending church since she was a small child. She currently attends worship services on a weekly basis and regularly engages in group and private prayer and Bible study. Additionally, she is involved in three ministries at her church. Ashyleigh experienced intrafamilial and extrafamilial CSA: two single incidents of CSA and a third incident of abuse that lasted for 3 years. The abuse occurred at ages 4, 8 through 12, and 17. There were multiple abusers.

Atiya is 53 years old and divorced. Atiya has attended church all her life. Prior to becoming Baptist, she was a Christian of the Lutheran denomination. Atiya attends worship services and group Bible study on a weekly basis. She also frequently involves herself in private and group prayer and bible study. Additionally, she is involved in two ministries at her church. Atiya experienced four incidents of both intrafamilial and extrafamilial CSA, which included two single incidents of abuse, a third incident of abuse that occurred infrequently over a period of time, and a fourth incident of abuse that lasted for over 4 years. All instances of abuse took place at ages 8 and 16. There were multiple abusers.

Black Beauty is 44 years old and single. Black Beauty is a lifelong member of the Baptist church she currently belongs. She attends worship services and participates in public and private Bible study on a weekly basis. She is involved in three ministries at her church and regularly engages in private and group prayer. Black Beauty experienced extrafamilial CSA one time. The abuse took place at age 10.

Grace is 44 years old and married. She was baptized at age 5 and regularly attended church all her life. Grace attends worship services and group Bible study once a

week. She also engages in private Bible study and group and private prayer daily. Grace is involved in three ministries at her church. Her experience with CSA includes extrafamilial abuse that occurred over the course of 2 days. The abuse took place at age 17. There was one abuser.

Lucy is 52 years old and married. She has attended church all her life. Lucy currently attends worship services twice a week. She engages in group Bible study weekly, private Bible and group prayer on a daily basis, and private prayer multiple times a day. She is also involved in four ministries at her church. Lucy experienced intrafamilial abuse over a period of 2 years beginning at age 8. There was one abuser.

Married is 51 years old and married. Married began attending church at a young age. Married participates in worship services, group Bible study and group prayer on a weekly basis. Additionally, she participates in private Bible study daily and private prayer multiple times a day. Married is involved in three ministries at her church. She experienced intrafamilial CSA for 3 years. The abuse began at age 14. There were multiple abusers.

Mercedes is 37 years old and married. She has attended church regularly throughout her life. Mercedes attends worship services once a week. She frequently engages in private and group prayer and Bible study. She is additionally involved in three ministries at her church. Mercedes experienced intrafamilial CSA for 7 years. The abuse began at age 7. There was one abuser.

Revelation is 25 years old and married. She is a lifelong churchgoer. She participates in worship services and group Bible study on a weekly basis. She also engages in group and private prayer daily and private Bible study several days a week.

Revelation is involved in two ministries at her church. Her experience with CSA was extrafamilial. The abuse began at age 13 and took place for 2 years. There was one abuser.

Tiny is 25 years old and married. She was not raised in church. She joined the church when she was 24 years old. Tiny attends worship services and participates in group prayer once a week. She engages in private prayer multiple times a day. She also participates in group and private Bible study on a monthly basis. Tiny is involved in four ministries at her church. She experienced intrafamilial CSA for a period of 7 years. The abuse began at age 7. There were two abusers.

Victoria is 31 years old and single. She began attending church at a young age. She attends worship services and engages in private and group Bible study, and group prayer on a weekly basis. She also engages in private prayer on a daily basis. Victoria is involved in four ministries at her church. She experienced intrafamilial CSA that lasted for a period of 2 years. The abuse began at age 8. There was one abuser.

Table 1

Demographic Characteristics

Pseudonym	Age	Marital Status	Religious Affiliation
Ashyleigh	23	Single	Christian-Baptist
Atiya	53	Divorced	Christian-Baptist
Black Beauty	44	Single	Christian-Baptist
Grace	44	Married	Christian-Baptist
Lucy	52	Married	Christian-Baptist
Married	51	Married	Christian-Baptist
Mercedes	37	Married	Christian-Baptist
Revelation	25	Married	Christian-Baptist
Tiny	37	Married	Christian-Baptist
Victoria	31	Single	Christian-Baptist

Table 2

Experience of Childhood Sexual Abuse

Pseudonym	Age of Onset	Duration	Type	Number of Abusers
Ashyleigh	4 years	Other*	Both**	3
Atiya	8 years	Other*	Both**	4
Black Beauty	10 years	Once	Extrafamilial	1
Grace	17 years	2 days	Extrafamilial	1
Lucy	8 years	2 years	Intrafamilial	1
Married	14 years	3 years	Intrafamilial	2
Mercedes	7 years	7 years	Intrafamilial	1
Revelation	13 years	2 years	Extrafamilial	1
Tiny	7 years	7 years	Intrafamilial	2
Victoria	8 years	2 years	Intrafamilial	1

*Other = Ashyleigh experienced two single incidents of abuse, and a third incident that lasted 3 years. Atiya experienced two single incidents of abuse, a third that occurred infrequently over a period of time, and a fourth that lasted 4 years.

*Both = intrafamilial and extrafamilial childhood sexual abuse.

Standardized Measures.

BMMR: 1999.

The BMMR identifies nine dimensions of religiousness and spirituality that have been found to significantly impact physical and mental health outcomes. The nine identified dimensions are: daily spiritual experiences, values/beliefs, forgiveness, private religious practices, religious and spiritual coping, religious support, religious/spiritual history, and commitment. Also included in the measure is a section that identifies religious preference and an overall ranking of religiousness and spirituality. This section of the results will briefly explore the nine dimensions by identifying what each area intends to assess and participant responses to the statements for each dimension.

Daily spiritual experiences. This domain intends to measure participants' perceptions about their interactions and involvement with God in daily life. The central focus of this section of the BMMR is spirituality. The daily spiritual experiences domain consists of six statements that require a Likert-scale response from the following options: 1 (many times a day), 2 (every day), 3 (most days), 4 (some days), 5 (once in a while), and 6 (never or almost never). Statements within this domain, participants' responses, and the mean and standard deviation for each statement are presented in Table 3.

Table 3

Participant Responses for the Daily Spiritual Experiences Domain of the BMMR

Pseudonym	S1 *M* = 1.5 *SD* = 0.71	S2 *M* = 1.8 *SD* = 1.1	S3 *M* = 2.3 *SD* = 1.1	S4 *M* = 1.2 *SD* = 0.63	S5 *M* = 1.7 *SD* = 0.82	S6 *M* = 2.8 *SD* = 1.6
Ashyleigh	2	4	4	1	3	6
Atiya	1	1	3	1	2	4
Black Beauty	1	1	1	1	1	1
Grace	1	1	1	1	1	1
Lucy	1	2	3	1	2	1
Married	1	1	2	1	1	3
Mercedes	2	3	1	3	3	3
Revelation	2	1	2	1	2	3
Tiny	3	3	3	1	1	4
Victoria	1	1	3	1	1	2

Note. Statements from the daily spiritual experiences domain (S means statement):

S1. I feel God's presence.

S2. I find strength and comfort in my religion.

S3. I feel deep inner peace or harmony.

S4. I desire to be closer to or in union with God.

S5. I feel God's love for me, directly or through others.

S6. I am spiritually touched by the beauty of creation.

Values/Beliefs. The values/beliefs domain is intended to assess the influence of faith in the participants' daily lives. This domain measures the extent to which participants' behavior is reflective of their faith or religion. The two statements within the values/beliefs domain are measured by a Likert scale with the following options: 1 (strongly agree), 2 (Agree), 3 (disagree), and 4 (strongly disagree). Table 4 presents statements within this domain, participants' responses, and the mean and standard deviation for each statement.

Table 4

Participant Responses for the Values/Beliefs Domain of the BMMR

Pseudonym	S7 *M* = 1 *SD* = 0	S8 *M* = 1.6 *SD* = 0.69
Ashyleigh	1	2
Atiya	1	1
Black Beauty	1	1
Grace	1	1
Lucy	1	1
Married	1	2
Mercedes	1	2
Revelation	1	1
Tiny	1	2
Victoria	1	3

Note. Statements from the values/beliefs domain.

S7. I believe in a God who watches over me.

S8. I feel a deep sense of responsibility for reducing pain and suffering in the world.

Forgiveness. This domain contains items that intend to assess the level of participants' forgiveness of self and others. It also assesses their beliefs about

forgiveness by God. The forgiveness domain consists of three statements and uses a Likert scale with the following options: 1 (always or almost always), 2 (often), 3 (seldom), and 4 (never). Table 5 illustrates statements within this domain, participants' responses, and the mean and standard deviation for each statement in the forgiveness domain.

Table 5

Participant Responses for the Forgiveness Domain of the BMMR

	S9	S10	S11
	M = 1.5	*M* = 1.4	*M* = 1.1
Pseudonym	*SD* = 0.70	*SD* = 0.51	*SD* = 0.31
Ashyleigh	2	1	1
Atiya	2	1	1
Black Beauty	1	2	1
Grace	1	1	1
Lucy	1	1	1
Married	2	2	1
Mercedes	1	1	1
Revelation	3	2	2
Tiny	1	2	1
Victoria	1	1	1

Note. Statements from the forgiveness domain.

S9. I have forgiven myself for things that I have done wrong.

S10. I have forgiven those who hurt me.

S11. I know God forgives me.

Private religious practices. The private religious practices domain is designed to assess participants' involvement in nonorganizational religious practices (practices that

take place outside of organized religion setting). This domain consists of five questions that seek to develop an understanding of how often private religious practices occur. Statements 12 through 15 use a Likert scale consisting of the following eight options: 1 (more than once a day), 2 (once a day), 3 (a few times a week), 4 (once a week), 5 (a few times a month), 7 (less than once a month), and 8 (Never). Question 16 uses a Likert scale that contains the following options: 1 (at all meals), 2 (once a day), 3 (at least once a week), 4 (only on special occasions), and 5 (never). Table 6 illustrates questions within this domain, participants' responses, and the mean and standard deviation for each statement in the private religious practices domain.

Table 6

Participant Responses for the Private Religious Practices Domain of the BMMR

	Q12	Q13	Q14	Q15	Q16
	M = 1.1	*M* = 2.7	*M* = 3.4	*M* = 2	*M* = 1.2
Pseudonym	*SD* = 0.31	*SD* = 1.70	*SD* = 2.31	*SD* = 0.81	*SD* = 0.42
Ashyleigh	1	3	3	3	2
Atiya	1	2	3	2	1
Black Beauty	1	2	4	2	1
Grace	1	1	7	1	1
Lucy	2	3	1	1	1
Married	1	1	1	1	1
Mercedes	1	3	7	2	1
Revelation	1	3	1	3	2
Tiny	1	2	5	2	1
Victoria	1	7	2	3	1

Note. Questions from the private religious practices domain.

Q12. How often do you pray privately in places other than at churches or synagogue?

Q13. Within your religious or spiritual tradition, how often do you meditate?

Q14. How often do you watch or listen to religious programs on TV or Radio?

Q15. How often do you read the Bible or other religious literature?

Q16. How often are prayers or grace said before or after meals in your home?

Religious and spiritual coping. The religious and spiritual coping domain assesses participants' patterns of religious and spiritual coping with stressful events. The seven statements within this domain use a Likert scale with the following options: 1 (a great deal), 2 (quite a bit), 3 (somewhat), and 4 (not at all). Table 7 illustrates statements within this domain, participants' responses, and the mean and standard deviation to responses in the religious and spiritual coping domain.

Table 7

Participant Responses for the Religious and Spiritual Coping Domain of the BMMR

Pseudonym	S 17 *M* = 1.7 *SD* = 0.94	S 18 *M* = 2.1 *SD* = 1.28	S 19 *M* = 1.1 *SD* = 0.31	S 20 *M* = 3.7 *SD* = 0.48	S 21 *M* = 3.8 *SD* = 0.42	S 22 *M* = 3.1 *SD* = 0.87	S 23 *M* = 1.1 *SD* = 0.31
Ashyleigh	4	3	2	4	4	3	1
Atiya	2	1	1	3	3	3	2
Black Beauty	1	3	1	4	4	4	1
Grace	1	1	1	4	4	1	1
Lucy	2	4	1	4	4	4	1
Married	2	1	1	4	4	4	1
Mercedes	1	1	1	4	4	3	1
Revelation	1	1	1	3	4	3	1
Tiny	1	4	1	4	4	3	1
Victoria	2	2	1	3	3	3	1

Note. Statements from the religious and spiritual coping domain.

S17. I think about how my life is part of a larger spiritual force.

S18. I work together with God as partners.

S19. I look to God for strength, support, and guidance.

S20. I feel God is punishing me for my sins or lack of spirituality.

S21. I wonder whether God has abandoned me.

S22. I try to make sense of the situation and decide what to do without relying on God.

S23. To what extent is your religion involved in understanding or dealing with stressful situations in any way?

Religious support. The religious support domain seeks to assess aspects of participants' social relationships within their place of worship. This domain contains four questions with the following Likert scale options: 1 (a great deal), 2 (some), 3 (a little), and 4 (none). Table 8 illustrates questions within this domain, participants' responses, and the mean and standard deviation to questions in the religious support domain.

Table 8

Participant Responses for the Religious Support Domain of the BMMR

Pseudonym	Q24 *M* = 1.4 *SD* = 0.69	Q25 *M* = 1.3 *SD* = 0.67	Q26 *M* = 2.9 *SD* = 0.87	Q27 *M* = 2.9 *SD* = 0.87
Ashyleigh	3	3	2	1
Atiya	2	1	3	3
Black Beauty	1	1	1	3
Grace	1	1	4	3
Lucy	2	2	3	3
Married	1	1	4	3
Mercedes	1	1	3	2
Revelation	1	1	3	4
Tiny	1	1	3	4
Victoria	1	1	3	3

Note. Questions from the religious support domain.

Q24. If you were ill, how much would the people in your congregation help you out?

Q25. If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?

Q26. How often do the people in your congregation make too many demands on you?

Q27. How often are the people in your congregation critical of you and the things you do?

Religious /Spiritual history. This domain seeks to assess participants' religious/spiritual history over the course of their life. The three questions in this domain require a yes/no response and also provide a space for participants to give ages for yes responses. Table 9 illustrates questions and participants' responses in the religious/spiritual history domain.

Table 9

Participant Responses for the Religious/Spiritual History Domain of the BMMR

Pseudonym	Q28 Yes or No	Age for yes responses	Q29 Yes or No	Age for yes responses	Q30 Yes or No	Age for yes responses
Ashyleigh	Yes	14	Yes	21	Yes	22
Atiya	Yes	47	Yes	44	Yes	37
Black Beauty	Yes	41	Yes	41	Yes	30
Grace	Yes	5	Yes	5	No	
Lucy	Yes	40	Yes	42	Yes	DR*
Married	Yes	42	Yes	42	No	
Mercedes	Yes	7	Yes	35	No	
Revelation	Yes	19	Yes	Throughout the years	Yes	Years ago
Tiny	Yes	24	Yes	31	No	
Victoria	Yes	NG**	Yes	28	Yes	14

Note. Questions from the religious/spiritual history domain.

Q28. Did you ever have a religious or spiritual experience that changed life?

Q29. Have you ever had a significant gain in your faith?

Q30. Have you ever had a significant loss in your faith?

*DR = Don't remember.

**NG = None given.

Commitment. The commitment domain intends to assess the importance of and commitment to participants' religious/spiritual beliefs. This domain uses a Likert scale to assess the individual's ability to carry religious beliefs into other areas of their life. The scale consists of the following options: 1 (strongly agree), 2 (agree), 3 (disagree), and 4 (strongly disagree). The commitment domain also requests information on financial contribution and the average number of hours spent weekly on religious or spiritual activities. Table 10 illustrates questions and participants' responses to this domain.

Table 10

Participant Responses for the Commitment Domain of the BMMR

	Q31	Q32	Q33
	$M = 1.2$		
Pseudonym	$SD = 0.42$		
Ashyleigh	2	$1,300 yearly	6 hours
Atiya	1	$4,000 yearly	7-5 hours
Black Beauty	1	Refused to answer	8-10 hours
Grace	1	$7.00 monthly	15 hours
Lucy	1	$300 monthly	25 hours
Married	1	$450 monthly	5-10 hours
Mercedes	1	$180 monthly	7 hours
Revelation	1	10%	15 hours
Tiny	2	10%	6 hours
Victoria	1	No Response	12-15 hours

Note. Questions from the commitment domain.

Q31. I try hard to carry my religious beliefs over into all my other dealings in life.

Q32. During the last year about how much was the average monthly contribution of your household to your congregation or to religious causes?

Q33. In an average week how many hours do you spend in activities on behalf of your church or activities that you do for religious or spiritual reasons?

Organizational religiousness. This domain intends to assess participants' individual involvement in religious services. The organizational religiousness domain contains two questions with the following Likert scale options: 1 (more than once a week), 2 (every week or more), 3 (once or twice a month), 4 (every month or so), 5 (once or twice a year), and 6 (never). Table 11 presents the questions in this domain, participants' responses, and the mean and standard deviation for each.

Table 11

Participant Responses for the Organizational Religiousness Domain of the BMMR

	Q34	Q35
	M = 1.3	*M* = 2
Pseudonym	*SD* = 0.48	*SD* = 1.15
Ashyleigh	1	3
Atiya	1	1
Black Beauty	1	1
Grace	1	1
Lucy	1	1
Married	1	3
Mercedes	2	3
Revelation	1	4
Tiny	2	2
Victoria	2	1

Note. Questions from the organizational religiousness domain.

Q34. How often do you go to religious services?

Q35. Besides religious services, how often do you take part in other activities at a place of worship?

Religious preference. This domain requires participants to identify their religious preference. If they defined themselves as Protestant, they were also asked to give their denomination. Table 12 illustrates questions and participants' responses to this domain.

Table 12

Participant Responses for the Religious Preference Domain of the BMMR

Pseudonym	Q36	Denomination
Ashyleigh	Christian	Baptist
Atiya	Christian	Baptist
Black Beauty	Protestant	Baptist
Grace	Baptist	Blank
Lucy	Baptist	Blank
Married	Baptist/Christian	Blank
Mercedes	Christian Protestant	Baptist
Revelation	Christian	Baptist
Tiny	Protestant	Baptist
Victoria	Protestant	Baptist

Note. Questions from the religious preference domain.

Q36. What is your current religious preference? If Protestant, ask: Which specific denomination is that?

Overall self- ranking. This domain requires participants to rank the extent to which they consider themselves a religious and spiritual person. The Likert scale for the two questions in this section includes the following options: 1 (very), 2 (moderately), 3 (slightly), and 4 (not at all). Table 13 presents the questions and data from this domain.

Table 13

Participant Responses for the Overall Self-Ranking Domain of the BMMR

	Q37	Q 38
	M = 1.5	*M* = 1.2
Pseudonym	*SD* = 0.70	*SD* = 0.42
Ashyleigh	3	1
Atiya	1	1
Black Beauty	1	1
Grace	1	1
Lucy	1	1
Married	1	1
Mercedes	1	1
Revelation	2	2
Tiny	2	1
Victoria	2	2

Note. Questions from the overall self-ranking domain

Q37. To what extent do you consider yourself a religious person?

Q38. To what extent do you consider yourself a spiritual person?

Posttraumatic Cognitions Inventory (PTCI).

The PTCI (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) was developed to measure thoughts and beliefs related to trauma. The measure consists of three subscales

consisting of 33 statements. Negative cognitions about self is subscale A. The 21 items on this subscale seeks to identify "general negative views of self, permanent change, alienation, hopelessness, self-trust, and negative interpretation of symptoms" (Foa et al., 1999, p. 306). Negative cognitions about the world is subscale B. The seven items on this subscale focus on negative cognitions and beliefs about the world and other people. Self-blame is subscale C. This subscale consists of five statements that seek to identify negative cognitions and beliefs about self-blame.

All questions on the PTCI are measured by a Likert scale with the following options: 1 (totally disagree), 2 (disagree very much), 3 (disagree slightly), 4 (neutral), 5 (agree slightly), 6 (agree very much), and 7 (totally agree). There is a mean item response for each subscale and a total score consisting of the sum of all three subscales. Higher scores indicate greater endorsement of pathological cognitions. Atiya scored significantly higher than average on subscale A. Grace scored significantly below average on subscale B, and Ashyleigh, Atiya and Revelation scored higher than average on subscale C. Tables 14 through 20 will illustrate questions for each subscale, participants' responses to statements on each subscale, participants' mean item response scores for each subscale, and participants' total scores. Mean and standard deviations are also presented in each table.

Table 14

PTCI Subscale A, Negative Cognitions About Self

	S2	S3	S4	S5	S6	S9	S12
	M = 1.8	*M* = 2	*M* = 2	*M* = 2	*M* = 2.5	*M* = 1.7	*M* = 1.6
Pseudonym	*SD* = 1.31	*SD* = 1.88	*SD* = 1.63	*SD* = 2.16	*SD* = 2.46	*SD* = 1.63	*SD* = 1.57
Ashyleigh	3	2	1	1	1	3	1
Atiya	5	5	3	5	6	6	6
Black Beauty	1	1	1	1	1	1	1
Grace	1	1	1	1	1	1	1
Lucy	1	1	1	1	1	1	1
Married	1	1	1	1	1	1	1
Mercedes	2	1	2	1	1	1	1
Revelation	2	6	6	7	7	1	2
Tiny	1	1	1	1	1	1	1
Victoria	1	1	3	1	5	1	1

Note. Statements for Subscale A (Table 14 continues)

S2. I can't trust that I will do the right thing.

S3. I am a weak person.

S4. I will not be able to control my anger and will do something terrible.

S5. I can't deal with even the slightest upset.

S6. I used to be a happy person but now I am always miserable.

S9. I feel dead inside.

S12. I am inadequate.

Pseudonym	S 14 *M* = 1.7 *SD* = 1.56	S 16 *M* = 1.3 *SD* = 0.48	S 17 *M* = 1.8 *SD* = 1.93	S 20 *M* = 1.2 *SD* = 0.42	S 21 *M* = 1.8 *SD* = 1.61	S 24 *M* = 2.3 *SD* = 1.94	S 25 *M* = 1.5 *SD* = 1.58
Ashyleigh	1	1	3	2	3	3	1
Atiya	6	2	7	2	6	7	6
Black Beauty	1	1	1	1	1	2	1
Grace	1	1	1	1	1	1	1
Lucy	1	1	1	1	1	1	1
Married	1	1	1	1	1	1	1
Mercedes	1	1	1	1	1	2	1
Revelation	2	2	1	1	2	1	1
Tiny	1	1	1	1	1	1	1
Victoria	2	2	1	1	1	4	1

S14. If I think about the event, I will not be able to handle it. (Table 14 continues)

S16. My reactions since the event mean that I am going crazy.

S17. I will never be able to feel normal emotions again.

S20. I have permanently changed for the worse.

S21. I feel like an object, not like a person.

S24. I feel isolated and set apart from others.

S25. I have no future.

Pseudonym	S 26 *M* = 3.6 *SD* = 1.95	S 28 *M* = 1.6 *SD* = 1.26	S 29 *M* = 1.7 *SD* = 1.88	S 30 *M* = 1.7 *SD* = 1.56	S 33 *M* = 1.5 *SD* = 0.70	S 35 *M* = 1.4 *SD* = 1.26	S 36 *M* = 1.5 *SD* = 1.26
Ashyleigh	5	1	1	2	2	1	1
Atiya	6	5	7	6	3	5	5
Black Beauty	4	1	1	1	1	1	1
Grace	5	1	1	1	1	1	1
Lucy	1	1	1	1	1	1	1
Married	5	1	1	1	1	1	1
Mercedes	1	1	1	1	1	1	1
Revelation	5	2	2	1	2	1	1
Tiny	1	1	1	1	1	1	1
Victoria	3	2	1	2	2	1	1

S26. I can't stop bad things from happening to me.

S28. My life has been destroyed by the trauma.

S29. There is something wrong with me as a person.

S30. My reactions since the event show that I am a lousy coper.

S33. I feel like I don't know myself anymore.

S35. I can't rely on myself.

S36. Nothing good can happen to me anymore.

Table 15

PTCI Subscale B, Negative Cognitions About the World

	S 7	S 8	S 10	S 11	S 18	S 23	S 27
	M = 2.7	*M* = 3.4	*M* = 4.5	*M* = 3.2	*M* = 4.3	*M* = 2.8	*M* = 3.3
Pseudonym	*SD* = 1.70	*SD* = 1.95	*SD* = 1.50	*SD* = 1.61	*SD* = 1.94	*SD* = 1.98	*SD* = 1.49
Ashyleigh	1	7	5	4	1	2	5
Atiya	3	5	5	5	5	7	5
Black Beauty	5	4	4	4	6	4	4
Grace	1	1	1	1	1	1	1
Lucy	2	2	5	2	5	1	2
Married	1	1	6	1	6	1	4
Mercedes	2	3	3	3	3	3	3
Revelation	5	5	6	6	6	4	4
Tiny	2	2	5	3	5	1	1
Victoria	5	4	5	3	5	4	4

Note. Statements for Subscale B

S7. People can't be trusted.

S8. I have to be on guard all the time.

S10. You can never know who will harm you.

S11. I have to be especially careful because you never know what can happen next.

S18. The world is a dangerous place.

S23. I can't rely on other people.

S27. People are not what they seem.

Table 16

PTCI Subscale C, Self-Blame

Pseudonym	S 1 *M* = 1.5 *SD* = 1.08	S 15 *M* = 1.4 *SD* = 0.96	S 19 *M* = 3.5 *SD* = 1.84	S 22 *M* = 1.5 *SD* = 1.26	S 31 *M* = 1.6 *SD* = 1.26
Ashyleigh	3	4	4	1	4
Atiya	1	1	5	5	1
Black Beauty	1	1	4	1	1
Grace	1	1	1	1	1
Lucy	1	1	7	1	1
Married	1	1	4	1	1
Mercedes	1	1	1	1	1
Revelation	4	2	4	2	4
Tiny	1	1	3	1	1
Victoria	1	1	2	1	1

Note. Statements for Subscale C

S1. The event happened because of the way I acted.

S15. The event happened to me because of the sort of person I am.

S19. Somebody else would have stopped the event from happening.

S22. Somebody else would not have gotten into this situation.

S31. There is something about me that made the event happen.

Table 17

Mean Item Responses

Pseudonym	A *M* = 38.1 *SD* = 27.1	B *M* = 24.2 *SD* = 8.95	C *M* = 9.4 *SD* = 4.2	Total Score *M* = 71.8 *SD* = 36.1
Ashyleigh	39	25	16	80
Atiya	109	35	13	157
Black Beauty	25	31	8	64
Grace	25	7	5	37
Lucy	21	19	11	51
Married	25	20	8	53
Mercedes	24	20	5	49
Revelation	55	36	16	107
Tiny	21	19	7	47
Victoria	37	30	6	73

Semistructured interviews.

Developing a rich understanding of the participants' experience with CSA, participation in Christian faith, and the healing process are essential components of this study. This section of the data analysis will review the themes that were generated as a result of the semistructured interviews with the study participants. The six identified themes are the result of the following nine interview questions: (1) Do you believe in God? (2) What does that mean to you? (3) What is your current relationship with God and the church? (4) What was your experience with sexual abuse? (5) Can you describe how experiencing childhood sexual abuse changed how you felt about yourself? (6) What has been the role of religion or faith in your life before, during and, after your sexual abuse experience? (7) Describe how your relationship with God and church has affected your healing process. (8) Others cope with childhood sexual abuse by eating, using substances, engaging in sexual activity, working, etc. What ways have you found useful for coping in addition to faith? (9) Is there anything you would like to add about what we've been discussing that I have not asked you?

Theme 1: God is.

Within this theme, participants expressed their personal beliefs about God's role as their savior, creator, deliverer, and ruler. Beliefs about His triune nature and sovereignty were also shared. Ashyleigh described believing in God as having faith: "believing in the Trinity…having a belief in something I can't actually see, but just kind of knowing that it's there." Atiya's beliefs about God included the Trinity and His role as the ruler of her life.

When I say I believe in God, I'm saying that I believe in the Trinity: God the Father, God the Son and the Holy Ghost, um, and which is the foundation of Christian faith, um, it means for me that God is the ruler of my life.

Grace defined God by His attributes and actions.

God is the creator. He is a sustainer. He is the person who made me….I have a current relationship with God. I am a Christian so I have received the blood of Jesus as a pardon for my sins

[During the abuse] I found myself looking at myself, so my physical body was being raped, but another part of me was like above watching. And I don't know what it's called, I don't know what it actually means but, I believe it's something that kept me–that the things that he [the abuser] did, he did to my physical body, and the other part of me was kept from I guess maybe a level of trauma that I–maybe I wouldn't have been able to deal with. Since that time I have been able to merge the two people back….So I thank God that He's been able to put all of me back together–for a long time I was not like that at all.

Black Beauty's beliefs about God were expressed in the following way:

It means that I, uh, have a belief in something far greater than myself, that God creates all of us. And I believe in the Trinity. Um, I believe that He sent his son Jesus to die for us that we might have everlasting life um, and that we were cleansed of our sins.

Tiny's beliefs about God included her thoughts about the Trinity and God's ability to be a reliable savior.

I believe in the saving power of his son, Jesus, and the power of the Holy Spirit– You know, the Trinity.

God is just truly awesome. He is who He says that He is. And although I know the past happened, I am not stuck there anymore. I know that God is a savior who always keeps me. I experienced something that makes other people lose their minds and I'm whole. Nobody but Jesus can do that for you.

Married said:

I believe that Jesus Christ died for my sins on the cross so that I would be in right relationship with the Father. I believe that there is a Supreme Being much higher than me and that being is God.

Revelation expressed her belief in God by describing who He is and what she does in response to who He is. "I have accepted God as my personal Lord and Savior. I pray to God daily, as I believe prayer is a powerful tool." Victoria believes that "God is the ultimate creator. He's my ruler, not my ruler, but He's my Father, like He is in control of everything that I do and say and ask." Mercedes expressed her belief about God in the following way: "He is sovereign and that He sees all and knows all."

Theme 2: God is relational.

Within this theme, many participants shared their experiences and beliefs about God's relational nature in their lives. Some discussed their faith in God and His promises to be with them forever in any situation. Others spoke of His role as a dependable helper,

sustainer, and burden bearer. Others shared their thoughts about the developmental progression of their relationship and a desire to develop a closer relationship.

Atiya shared her thoughts on her transition from religiosity to spirituality and her understanding of God's presence in her life.

> *He [God] covers me, protects me, um, gives my life direction and, um, understanding of things that have happened in my life.*
>
> *Um, well, you know, I was always churched, baptized when I was 5 years old and, um, always went to church for the most part, um, I don't even know–I was churched, but I think that it was religious. So it was uh religiosity you know like the practice of going. I don't think I was taught the power of prayer um but I went to church, I went to Sunday school so I never- it wasn't until much later on that I understood what it was like to have a present savior. And so from then, I was able to really know that God was there for me, in me and through me.*

Black Beauty speaks of growth in her relationship with God, His mediational characteristics on her behalf, ability to bear her burdens, and constant presence at all times.

> *My current relationship with God has gotten more intense and profound and prominent in the last I would say 5 to 10 years. Um, as an adult where, um, I'm seeking God for myself and not for others or not because others tell me this is what I'm supposed to do.*
>
> *During times where I'm either at my highest high or lowest low that God is there sitting in intercessory position for me and, um, available to me at all times in a*

way that human beings can't be, and so it's a very comforting feeling that I don't have to shoulder the weight of life by myself.

Lucy shared her thoughts on God's omnipresent nature and their constant communication, especially in times of trouble.

I have a very personal relationship with Him. I know that He's always with me. He walks with me no matter what I'm going through–even when I'm in a storm, I know God is always there. He wakes me up in the middle of the night when He needs to personally show me or tell me something. And especially when I am going through, He always wakes me up just to let me know that He's there. So if I need Him, I can always call on Him.

The more I went [to church], the closer I got to God, to the point where, you know, I could actually just feel His arms around me. I could feel the healing, um, and He always put the right person, you know, in my path when I was at my lowest.

Tiny's view of her relationship with God also highlighted His omnipresent characteristics and His propensity to provide her with what she needs: "He talks with me, gives me hope, and what I need when I need it. He's always there when I need him and He's just awesome." Married attributed her healing and wholeness to her relationship with God:

I do know the healing process has had many faces for me, but today I'm convinced that without my relationship with God and the support of my church

family and my faith, I never would be where I am today –in a place of healing and wholeness.

Revelation attributes her sanity and her belief in God's promises to her relationship with God.

I believe in God and all He promised me. My relationship with God has kept me encouraged and sane (honestly). The things that race through my mind would have an unsaved person going nuts. However, my prayer for peace is one that has been answered by God and most helpful in this journey.

Regarding her relationship with God, Grace shared the following: "[God is] the person who knows me the best. Um God is ever present, supportive, full of life and love. A lot of conversations just knowing that God's will is perfect, and just talking to Him about it." Victoria explains her relationship with God as one in transition: "Um, [I'm] currently working on building a better relationship so that I'm not just like operating under like He's my ruler kind of thing. More like developing, like, a closer relationship with him."

Ashyleigh, conversely, discussed the negative change in the quality of her relationship with God after she was emotionally hurt by the actions of people in the church:

Yeah, I have a relationship with God and I think it's going okay not the best, but it's going okay.

> *Well–I think–it–before the incident happened when I was at church, from a person at church, which is not, I wouldn't consider rape or anything like that, I thought it was just inappropriate behavior. Before that happened, it [my relationship with God] was good and I thought it was really good, and I was learning and understanding God more and trusting men and stuff like that. But after that happened, I think everything went downhill and–it–I'm trying to work it back, I guess, but it's not really working too well.*

Theme 3: Stolen Innocence.

A significant body of research has found CSA to have significant, pervasive, negative effects on the lives of its survivors (Carver, Stalker, Stewart, & Abraham, 1989; Jones-Johnson, 2008; Paolucci et al., 2001). Consistent with the literature, all participants in this sample discussed the negative changes they experienced as a result of CSA. Within this theme, participants discussed the sequelae that occurred in their lives as a result of their experience with CSA.

Ashyleigh talked about how her cognitions and behaviors were negatively impacted as a result of her experiences with CSA:

> *I think it made me unsure of who I was. I think I had low self-esteem for a while because I didn't think I was good enough. And then I also was overcompensating because I wasn't sure how to act as a female. I didn't know what females was supposed to do, so it made me, like, just act on what I knew. So I felt like it started when I was like 4, so I was doing for that long (sex) I just–it seemed normal to like be a whore.*

Atiya explained how she later became aware of the impact that her multiple experiences with CSA had on her level of comfort in social situations:

> *I don't even know when I became conscious of it, so here's what –I guess–so now–like, in the last 10 years or more, I've become cognizant of um, how quiet I am. I have never–I mean, it sort of shocks me when people say, oh you're so quiet because I just, for whatever reason, um, I never–I don't know–it never came up for me. And I think mostly because, like, in academics settings I have for the most part felt pretty comfortable so, um, you know, I typically do well in those settings, but like, in social settings outside of an academic environment, I was really trying not to go in.*

Black Beauty discussed how CSA impacted her self-esteem and her ability to establish healthy friendships:

> *I would say part of the experience, um, contributed to my esteem because while I've always been smart, um, I didn't really think great about my body image, um, and so I would eat, um, as a young person, like, junk food and things like that and began to gain a lot of weight when I was in high school…. just really me feeling not great about myself and having to learn, um, to feel better about who I was as a woman, a young woman, um, a female and who I was as a child of God.*
>
> *I would sort of buy friendships, um, you know with candy or with doing people's homework and things like that. Rather than feeling that I could gain friendships on my own accord.*

Grace discussed how her CSA experience changed her ability to trust people and increased her level of sexual promiscuity:

> *I became very leery of what people said. I was somebody totally different. I didn't really care about a lot of things. Um, during that period of time um–uh, because I was with so many people [sexually] um, I became pregnant –something my daughters don't even know. So I had my first abortion shortly thereafter. Um and being a preacher's kid and knowing the Word and doing things that are so opposite of what you know becomes just like a weight–like a shame.*

Revelation shared the following:

> *I believe my level of confidence, trust, and security would be greater if I didn't experience sexual abuse as a youth. I sometimes struggle with not looking good enough or not being liked by others, as I always feel the need to have everything lined out and perfect. When they are not, I get stir- crazy. I have a hard time trusting many people; however, I have a particular distrust for men of the church. I know the reason for this is I always question is this man or that man a secret version of my abuser. I mean to me this makes sense my abuser was a freaking choir director. Lastly, I am very concerned about my son's safety, as some might define my over–protection as paranoia or crazy.*

Victoria talked about how her experience with CSA caused her to become guarded and introverted:

I don't think I was immediately aware of how it made me feel, but I do know that, basically listening to my mom, that there was a dramatic change after it happened, like I became more reserved. I wasn't outspoken like um almost qualified as being shy and before I would go up and talk to anybody. Like my inability to trust people, um, never been in love, um, always had my guard up when approaching people and always expecting the worse. Like my motto was prepare for the worst and hope for the best. Like, that's how I lived, sort of always on guard.

Lucy attributed her challenges with trust and aggression to her CSA experiences.

At first I didn't think that it affected me at all, once again because I was younger. But as I got older, I didn't trust men–well, I didn't trust the men in my family. As a teenager I was very mean. Uh, I would fight at the drop of a hat, and it was okay. Causing other people verbal pain helped me.

Tiny discussed the impact that CSA had on her self-esteem:

I always felt less than. This probably started at some point during my early adolescence and that feeling stayed with me for a while. I didn't initially connect

it to my abuse, one because I just thought it was who I was, even though I didn't feel that way when I was younger, I also probably didn't connect it because there were other things going on in my life that could have made me feel bad as well.

Married said that CSA impacted her self-image and caused her to engage in drug use:

I smoked crack (laughter)!!! But before my life took a drug addiction turn, how I felt about my being light skinned with a big butt was impacted by the abuse. I felt if I wasn't light skinned or had a big butt then they would not have abused me. I learned later that I had adopted a "things for things" mentality as a result of being granted anything I wanted out of the guilt my stepfather must have felt of abusing me. Not sure. Feelings of less than, settling for less, and low self-esteem were apparent symptoms of the abuse.

Mercedes explained how CSA changed her attitude about sex and her style of relating to others.

It [CSA] made me look at sexual acts a bit more flippantly, like not taking them seriously or valuing them–not seeing them as more–or as having any deeper meaning attached.

Like also trying to put on a hard front so that people wouldn't really know what was happening with me. Not trusting people, maybe that too. I like things done my way–is that controlling?

Theme 4: Change is possible.

Although CSA is often associated with devastating effects that are often long-lasting and pervasive in nature (Luterek, Harb, Heimberg, & Marx, 2004), it appears that participants in this sample were able to rely on their knowledge of and relationship with God to help mediate and modify negative thoughts, behaviors, and feelings related to their experiences. Within this theme, participants discussed changes that occurred in their functioning as a result of their beliefs about and relationship with God.

Ashyleigh described positive changes in her thoughts about God's responsibility for her CSA experiences and her self-perception.

It just caused me to try to understand that it really wasn't God's fault, and pretty much God didn't really have too much to do with it and people are people, so I try not to blame God for anything. Um, so it really helped cause then you kind of discover who God says you are and how I felt, how I felt about myself didn't match up with who God said I was, so then it got better, just trying to figure out what God wanted for me.

Atiya tearfully shared the following:

> *It's [relationship with God] given me another way to make meaning of my wounds, so I don't have to carry all the–I mean there is some chains, um there's a lot of remorse like you know wondering about how life would be–how different life would be if it hadn't happened and how much more whole I would be. But you know when I look at it through God's eyes um–you know, I know that I have value [tears streaming down her face] I know that I have value and um even when it gets hard no matter how low it gets, I can always pass the lows and get to the Promised Land. And, um, you know, the most pivotal thing that happened for me in the healing from the abuse is, you know, one day when the pain was just overwhelming, um, and I just said Lord why are you allowing this, you don't know how this pain feels and you're doing something to me that is so hard and confusing–like you don't have any concept of the depth of the pain. And, um, it was at that moment when I saw Christ on the cross and it, um, so for me, that made the pain remotely different. Knowing that God understands really makes a difference.*

Grace talked about how she relied on her faith in God to help her make sense of the devastating aftermath of CSA.

> *I remember the tenets of my faith were important, and they kept me during that time. So and after the rape, dealing with, um, not necessarily a why me, how are you gonna use this, and if you're gonna use it, then I need to understand what am I supposed to do with it. How am I supposed to figure it all out, so I can actually*

let you use it. And what I realize is, it really is not anything I can figure out, um, it's His grace that kept me and His grace that sustains me, and it's just a part of my story. And as a part of my story, um, the Scripture says 'If I be lifted up I'll draw all men,' so I have to believe that in it–with the pain, the problems, whatever that came with it, He's gonna be lifted up, as I allow the truth to be known, allow him to do the work that he wants to do.

But the reality for me also by the time I got raped, I had also been through so many other things, um, in my life knowing that I just had to trust God, um, so in some ways it had made it easier. Not easy, it just made it easier. Behavior change–um, the day I was raped, I had a yellow sweater on–I always wore colors, but I remember I just started wearing black. I mean I've never been thin, so black always looked good, but I always wore colors–red, yellow, green–I always wore colors, and I just remember as a part of the healing that God did through SAS [Sexual Abuse Survivors Ministry], it allowed me to go back to colors, the thing that I always liked that went along with my personality–but the rape did not kill my personality, I was still present, but I wasn't all of who God had for me. So He was delivering me, healing me, and I just find it was like a refining of the healing that he was doing, to go back to something that I love.

Black Beauty talked about how she was able to use resources provided by God to forgive herself.

> *Um, but then later down the line, um, I would say as an adult, as a full-fledged adult, and coming to know God as this powerful force in my life–I then felt like I used the resources that God gave me to help me get through some unforgiveness around not telling, you know, about this abuser–I don't say my [abuser] because he's not mine I don't own him–but the abuser. Uh, and I think I was holding myself hostage and feeling–not forgiving of myself for thinking that perhaps this man abused many more children than just myself and thought that had I told, that, you know, he might have been arrested and saved the other children some hardship. Um, so I definitely used God, um, to help me with that spirit of unforgiveness of myself and to deliver myself from that enemy.*

Married shared her thoughts about how her relationship with God strengthened her ability to face and overcome the consequences of CSA.

> *About 17 years ago, as my relationship with God became one I developed and wanted, I began to face my abuse head on with the help of therapy and a 12-step process. My relationship with God began to develop more, I began to see evidence of God working in my life on my own and not told by my grandmother. Thus, I began to ask God to help me heal from my past, which included in many forms was the manifestation of the abuse. I began to trust God for healing; going to church helped me by listening to the preached Word and learning how to apply it in my life. As I grew in recovery staying clean, my relationship with God grew and so did my belief that He would heal, restore, and deliver me. I learned about*

forgiveness and how important it was to my process, so I asked God to help me to cultivate a forgiving spirit so I could be free. I had to recognize where the hurt was really coming from and move forward.

Victoria discussed the freedom that came as a result of her transition.

I'm in a better place. And then dealing with all of that, then I was able to release all of the stuff I had been carrying around, and then I was free to serve. So now I'm active in ministry as a result of dealing with all the pain and the baggage that I was carrying around for so many years.

Tiny spoke of being released from the emotional distress the abuse caused.

I felt lighter. Later, with God's help, I forgave him and my mother and myself. I am not angry anymore, and I know that's because God really moved in me, because when I tried it [to get better] without him, I was still so very depressed. I am not stressed about being abused anymore. I mean, I know it happened, but I am still whole and free to be successful–just who God says that I am. He has made me view the abuse through new eyes that I never thought was possible. I just can't say enough about what God has done. He who the Son sets free is free indeed. I know that I am healed from the pain. I realize that I don't have a

heaven or hell to put the abusers in, and that they will have to answer for what they did to me.

And I still struggle with that [self-esteem] from time to time today, even though I would consider myself accomplished in many ways. But when I evaluate who I am in God, I realize that I have no reason to dislike myself the way I do at times. I'm a work in progress, though.

Mercedes shared the following:

Believing that God has a plan for me, that God loves me no matter what, um, has restored me, has forgiven me, and sees me created in His own image, has–well, been instrumental in healing and letting go of the past and not let it control me.

Then after, um, where God is still there, he's healing, but also that, um, God loves me no matter what, and evil happens in the world. That doesn't mean that God is any less good–it's just that sin does exist.

Revelation talked about how her relationship with Christ has helped her overcome the struggles associated with CSA.

Although I was in the church when I was abused, I did not have a clear understanding of my faith; the same applies during my abuse. However, several

years after my abuse, I found Christ for myself and since then, my faith has gotten me through this struggle

.

Lucy attributes her transition to being healed to her relationship with God.

Um, and from that point on, it was easy for me to then actually be transparent with God. Because I had never really even told him–even though you know I know He knew, I never spoke the words before to Him. And once I actually just shared everything with Him, I could actually feel the healing, you know–I think about the no more sheets thing and the layers of that God has to go through in order to reveal the real person–the person that He wants to use, and once I was able to share with my therapist and my godmother and then with God, He was able to do that because at that point, I was willing to let it go and to let Him do what He has been always trying to do from the beginning.

Theme 5: Strength in fellowship.

Within this theme, participants shared their thoughts about the significance of hearing other people's testimonies and their desire to be helpful to other people within their church community. One participant conversely discussed a negative encounter she had with people in her church.

Tiny talked about God's ability to transform a negative experience into something beneficial to help others. "Well, He [God] has used what was painfully bad for His good. I am able to help other people who have experienced this pain." Black Beauty also

talked about God's ability to use negative experiences as a means of helping others. She also expressed pleasure in her church.

> *And then to recognize that, you know, there's this wonderful thing that went on in our church around, um, having persons who have experienced sexual abuse come forward for such a time to help others. And so that connection between how God can take whatever experience you have–even the most horrific ones, and use it to His glory so that it turns into a testimony for–to help someone else who might be going through the same thing is just a wonderful thing.*

Lucy shared the following:

> *I counsel a lot of women , and I believe that God uses me as a vessel to share the word with them–to um–so they can experience, I wanna say one on one or firsthand, the blessings that God has done. I use some of the experiences that I've had to share with them, some of my trials are truly my testimonies now, and I share as often as possible so people will know–especially women will know that, um, God is there. He's there to be your anchor and He's there to carry you through.*
>
> *So I left the church I grew up in, joined _____, and um, started to get involved in Bible study and just different ministries. But most of all, started going to Bible study and really got to know who our pastor was and– you know before, the church got so large, could actually able to sit down and have conversations with*

him. And while he didn't know what was wrong, he always knew when something was wrong. And he just knew–always knew the right words to say, what Scripture to preach–I mean, the right Scripture to give me, the right sermon to preach on Sunday or whatever day I went to service, and just always knew the word, and with that–that opened a door –to draw me closer–I mean real–close to God to the point where I was always in His face, and you know just the word of God, and just being at church and around authentic, genuine people- like not just sisters, but people–that loved God.

And you know, meeting older sisters in Christ that, while they may not have gone through what I had went through, just had gone through some stuff that could share their testimony and how good God was, and how God had brought them through some difficult periods in their life–I knew that that was the place where I needed to be and you know, the more I went [to church], the more I wanted to go.

Married talked about the benefits of seeing God work on behalf of others and the helpfulness of having someone to.

As mentioned before, learning to trust God, seeing how He was moving in my life in other areas and in the lives of others helped me….Even today, I find it very helpful to talk to someone I trust very much to process my feelings when faced with feelings or even in helping someone else who's trying to heal.

Grace also talked about the encouragement she receives by knowing that God is working in the lives of others.

> *Knowing that there are other people who God is dealing with–other people that God is blessing–then the truth and the wholeness of all of it is available to me. So to me, that's one of the blessings, especially in the church that I go to. It's something that, um, I wouldn't say it's a club, but there is a safety in knowing that there are other women who've gone through the same struggle and God has actually blessed them. So you can see the manifestations of the wellness in them over time, which is just encou–it just encourages me with my own healing. It's no longer like a secret shame.*

Ashyleigh talked about the hurt and growth that she experienced after a negative interaction in the church.

> *I mean it [my progress toward healing] got slower and then it adjusted kind of–it really did slow up for like a year because I didn't really know what to believe or think about people or stuff–that's 'cause I thought the church was supposed to like, kinda 'posed to protect you and then soften the blows that youu get from the world. But if you getting the same stuff from in the world that you getting from in the church, you don't have nowhere to go. So I felt lost at that point. I think after a year it got–it didn't get better, I got better, um, and now it's kind of going back downhill.*

> *But then, like, a lot of people would blame God for what the church did and I try to make it a difference–'cause God isn't technically responsible for what people do 'cause people are still the church. So, I think I, putting my faith in God more and the church less would, um, kind of has helped me throughout this whole process.*

Theme 6: Sexual Abuse Survivors ministry (SAS).

All participants in this study were recruited through the Sexual Abuse Survivors ministry at a church in the Northeast region of the United States. This ministry provides spiritual group support to men and women who have experienced CSA through use of Biblical truths and the testimonies of others. Within this theme, participants discussed the advantages and disadvantages they experienced from participating in SAS.

Tiny spoke of SAS as a normalizing experience. "The church created a ministry with other people who have experienced this pain and normalized what I've been feeling by letting me know that I'm not alone." Victoria attributed her ability to deal with the sequelae of CSA to SAS. "I think it [SAS] helps now because I'm dealing with it [a history of CSA], and I was able to in essence be healed by it [SAS]. So I feel like the whole like SAS process helped." Atiya shared the following:

> *Well, I guess the other thing about what the church has made me do through being a part of the SAS ministry was to help me be around other people who get it [what it feels like to be sexually abused] and everybody's at a, um, different places, and, uh, even different places of consciousness I think, about in what they*

are dealing with. And being able to help and encourage people with their development no matter what level they're on has been helpful.

Black Beauty talked about feeling good about her CSA experience because it allows her to help others.

Um, and it's a little strange that in some ways, it's given me a vehicle to feel really good about that experience–that's odd because most people would say if you've been sexually abused or you have something horrific happen to you like that you wouldn't necessarily feel good about it. But it's given me an avenue to feel really good about the fact that if that experience had not happened, then I could not be used in the way that I am being used–um, as a vessel to help other women, other men, other children who experienced similar kinds of events.

Revelation discussed the dichotomy of finding SAS both helpful and traumatizing.

My church, no, members of my church [current church] have been very supportive and encouraging during my healing process also; in particular, those members who are on the SAS ministry. I joined our church's SAS ministry several years ago, and this ministry has made me comfortable with speaking out about my experience–speaking up in our ministry at least.

I do have some moments where I go to a session and then have a flashback or nightmare that night about my abuse. When this happens, I tend to shy away from my SAS ministry for a while. I had a moment when I would eat to cope with the feelings of sadness, anger, and frustration. I do not do that as much, however, has noticed if I go to SAS or encounter a sexually abused child at work, I revert towards food most times for comfort.

Grace discussed how SAS was able to help her continue with the healing process.

So to have persons that I can be honest with about how I'm feeling, and also um the ministry at the church, um, Survivors of sexual assault was helpful because what I hadn't realized is, um, even in as much as I trust God and as much as I believe Him, there was still a part of me that I allowed it to be like a overcast of me. His spirit was still present, He was still talking to me, He was still using me, but it was still a part of me that was dark because of it. And I ***know*** *being in that ministry allowed me to let God do extra healing that I didn't even necessarily know I needed. I believe I was supposed to be there, so I went.*

Lucy's comments about SAS were centered around her ability to help others heal as a result of her own experiences with CSA, and her personal healing process.

> *The Sexual Abuse Survivors' ministry at the church has been (pause) mm I'm looking for a word–besides one of the best ministries, one of the best places that I could volunteer, spend time. While I am a facilitator there, I am also a wounded healer. So while I help sisters and brothers that come, they also help me. Because, while I may be a little further along in my healing, I don't think I'll ever be totally healed. But just being there, being in the faith environment, being in a Christian environment where I know that everybody who comes through that door is really looking to be healed and they want to be better, they want to do better, they want to feel better, and I know that I play a part in them feeling better and helping them on their journey, but it also helps me in my journey.*

Married also spoke of SAS as a platform to help others and continue with her healing process.

> *These past 4 years, I've been able to participate in a sexual abuse survivor ministry at church where I've been not only able to heal more in my own process, but serve as facilitator to others who are on the journey for healing and deliverance. I often tell others that it never goes away, but I've become less charged by the memories, thoughts, or even television shows about sexual abuse.*

Chapter 5

Discussion

The purpose of this qualitative study was to investigate the effect that Christian faith has on the healing process in female, African American CSA survivors. More specifically, the investigator was seeking to identify and understand any aspects of Christian faith that participants were able to use to help mitigate the negative sequelae often associated with CSA experiences. The results of this study suggest that participants found involvement in Christian faith activities to be a beneficial factor in their healing process. The results further suggest that healing from CSA is a transitional process that is facilitated through a relationship with God and an understanding of His characteristics and promises for these females. To fully comprehend the findings of this study, one must first be aware of the convergent and divergent relationship that exists between religiosity and spirituality.

Religiosity is typically understood as the practice of a shared set of beliefs or rituals associated with God or gods, while spirituality is associated with the transcendent and an inner sense of a power greater than self (Ellison & George, 1994; Mattis & Jagers, 2001). Although these definitions are distinctively different from each other, the literature suggests that the experience of spirituality is usually predicated on the practice of religion. More specifically, frequently: attending worship services, studying and understanding the Bible, and interacting with other believers can be considered catalysts to establishing a meaningful relationship with God that is based on knowledge of who He is (Kennedy, 2000).

According to the results of this study, the participants' understanding of God and relationship with God, as well as other Christians, aided them in their transition to healing. These factors might have also helped facilitate the development of their faith, and faith may have acted as a mechanism allowing these participants to utilize their beliefs to mediate and reframe negative cognitions and behaviors related to CSA experiences.

In accordance with this understanding, the majority of the participants in this sample described their early experiences with Christian faith as more religious than spiritual in nature (i.e., going to church with caregivers, copying behaviors modeled by adults, being sent to Sunday school). However, as they matured in their Christianity, they grew to understand God more and developed the ability to utilize and apply God's promises to their lives. More specifically, 9 of 10 participants reported attending church all their lives, but they did not realize that their faith could be a resource for healing until after they developed and matured in their relationship with God. Another participant, who did not grow up attending church, also attributed her healing to her relationship with God. Although the majority of the sample was actively involved in church and religious activities at an early age, these behaviors alone did not aid in their healing process. It was only after they practically applied their understanding of God's character and promises to their lives that they were able to access, healing as it relates to their CSA experiences, through faith. Thus, even though religiosity can also be an avenue that leads to healing from the negative sequelae that are often associated with CSA, the results of this study suggest that participants attribute spirituality, not religiosity, as the factor that

led to their healing. Maturation in their relationship with God is a mediating factor for healing from the negative effects of CSA.

Within the six themes (Theme 1, God is, Theme 2, God is relational, Theme 3, stolen innocence, Theme 4, change is possible, Theme 5, strength in fellowship, and Theme 6, Sexual Abuse Survivors ministry), participants discussed how they were able to reframe negative cognitions and behaviors associated with experiencing CSA as a result of their relationship with God. With the exception of responses made within Theme 3, which focused on negative changes that occurred as a result of their experiences with CSA, participants described how the tenets of their faith and their trust in God's ability to be with them and protect them notwithstanding the fact that they had experienced CSA, helped in their healing process. Relationships with other Christians was another factor that was found to be beneficial in their healing process. As evidenced in previous literature on religious coping (Gall, 2006; Kennedy, Davis, & Taylor, 1998; Pargament et al., 1990), this sample also effectively used their Christian faith to help transform their beliefs about experiencing CSA, which allowed them to transition to a place of healing. Below are Scriptures from the Holy Bible, given its identification as the original religious and spiritual document for Christians. This original document was used to support the development of five of the six identified themes. Although the chosen scriptures provide insight into some biblical beliefs that may have aided in the healing process, there are numerous other Scriptures from the Holy Bible that could have additionally been used.

Scriptures related to themes.

Theme 1, God is, was developed to encompass responses participants made about their understanding of who God is. The underlying construct present in the nouns and adjectives that were used to describe and define who God is in their lives was an understanding of His love. For Christians, the greatest demonstration of God's love is evidenced in the birth, life, death, and resurrection of Jesus Christ. In addition to showing many examples of God's love for his people, the Holy Bible also provides illustrations about His attributes, many of which can only be accessed by faith. Hebrews 11:1 (Holy Bible, New International Version, 1984) proclaims "Now faith is the substance of things hoped for, the evidence of things not seen." Later, the 11 chapter states "…for he that cometh to God must believe that He is and that He is a rewarder of them that diligently seek him" (Hebrews 11:6, Holy Bible, New International Version, 1984). Faith can therefore be viewed as a fundamental necessity that gives believers access to God's love, grace, peace, and power. Based on the findings of this study, participants were able to use their faith to develop an understanding of who God is while experiencing His many attributes.

Scripture support for Theme 2, God is relational, can be found in Joshua 1:9 "for the Lord thy God is with thee whithersoever thou goest," and Matthew 1:23 "and they shall call his name Emmanuel, which being interpreted is, God with us" (Holy Bible, King James Version, 1984). Within this theme, many participants shared their experiences and beliefs about God's relational nature in their lives. Some discussed their faith in God and His promises to be with them forever in any situation. Thoughts about his caring nature and role as a provider were also shared. Believing that God is always

there and able to supply needs might have served as a source of comfort and resource for participants as they transitioned through the healing process.

Theme 4, change is possible, was generated as a result of the participants' ability to reframe negative cognitions and behaviors associated with their CSA experiences through their beliefs about and relationship with God. As participants in this sample began to move from religiosity to spirituality, results indicated that their ability to utilize their faith to mediate the negative aftermath related to their CSA experiences matured. This transition may have also helped strengthen their faith and improve their ability to apply what they knew about God and His promises to help them traverse through the adversity caused by CSA. Throughout the Holy Bible, there are Scriptures that speak of the troubles that humanity will face, but there are also Scriptures that speak of God's promise to deliver His children from those troubles. John 16:33 proclaims "These things I have spoken unto you, that in me ye might have peace. In the world ye shall have tribulation: but be of good cheer; I have overcome the world" (Holy Bible, King James Version, 1984). Psalms 46:1 declares "GOD IS our refuge and strength, a very present help in trouble" (Holy Bible, New International Version, 1984), and James 1:2 - 4 (Holy Bible, New International Version, 1984) encourages Christians to persevere through trials of many kinds because the testing of faith leads to maturity. These Scriptures provide a few examples of biblical principles that support Theme 4.

Theme 5, strength in fellowship, was generated as a result of the support that participants reported receiving from other Christians. God requires Christians to provide help to their sisters and brothers in their time of need. There are many examples of this mandate in the Holy Bible. Galatians 6:2 advises Christians to "carry each other's

burdens, and in this way you will fulfill the law of Christ" (Holy Bible, New International Version, 1984). Romans chapter 12: 10-13 says "Be devoted to one another in brotherly love. Honor one another above yourselves" and "share with God's people who are in need" (Holy Bible, New International Version, 1984). Isaiah 58:10 proclaims "and if you spend yourselves in behalf of the hungry and satisfy the needs of the oppressed, then your light will rise in the darkness" (Holy Bible, New International Version, 1984). These four scriptures coupled with participants' responses about the support they received and provided to other Christians, provide support for Theme 5.

Theme 6, Sexual Abuse Survivors ministry (SAS), was generated as a result of a call and need within the church community to more intimately address the needs of participants who have experienced CSA. The SAS ministry provides a safe place for CSA survivors to join together to discuss their journey. This ministry also encourages survivors to begin or continue with the process of transitioning to healing through use God's promises, tenets of Christian faith, biblical truths, and the testimony of other survivors. These tools are used to help reframe negative beliefs, cognitions, and behaviors associated with CSA sequelae. Examples of Scriptures that support Theme 6 and the reframing of negative situations include Genesis 50:20, "You intended to harm me, but God intended it for good to accomplish what is now being done, the saving of many lives," and Esther 4:14b "and who knows but that you have come to royal position for such a time as this" (Holy Bible, New International Version, 1984). Philippians 3:12-15 also encourage Christians to move toward maturity by forgetting what is behind and pressing toward what is ahead.

The data collected in the semistructured interviews suggest an overt reliance on God as it relates to participants' ability to reframe negative experiences and transition through the healing process. The findings also suggest that participants in this sample had both knowledge of biblical Scriptures and the ability to make use of that knowledge to aid them in reframing negative sequelae of CSA.

Theoretical models that support findings.

The findings of this study suggest that participants in this sample were able to use their Christian faith to help them heal from the negative sequelae associated with CSA. The data highlighted their ability to change negative cognitions and behaviors associated with their CSA experience(s) by using their relationship with God, their relationship with other Christians, and their ability to practically apply their understanding of biblical truths to their lives. These findings are supported by coping theory, the cognitive model, and social learning theory and constructivism theory. Below the findings will be conceptualized using each theory.

Coping theory.

The results of this study suggest that participants in this sample successfully used their Christian faith to help them cope with their CSA experiences. As they developed an understanding of God, and a relationship with God and other Christians, their ability to use these mechanisms to cope became more prevalent. More specifically, as they matured in their Christian faith, these relationships and their ability to apply their understanding of biblical truths to their lives helped them to make shifts in negative cognitions and behaviors associated with CSA. In 1984, Lazarus and Folkman defined coping as changes in cognitions and behaviors aimed at managing internal or external

demands that are perceived (by the person) to be too difficult to handle. Their transactional model of coping is based on cognitive appraisals that intervene between stressful encounters and reactions to the encounter.

According to their model, primary and secondary appraisals and reappraisals take place prior to any reaction being made (Lazarus & Folkman, 1984). Within this theory, appraisals are defined as cognitive evaluations of encounters as they occur. During primary appraisal, events are placed in one of the following three categories: irrelevant, benign-positive, and stressful. Irrelevant appraisals have no effect on the person's well-being. Benign-positive appraisals evoke pleasurable emotions, and stressful appraisals take account of harm, loss, threat, and challenge. Secondary appraisals seek to determine what can be done to mediate the stressful event. During secondary appraisal, outcome expectancy and efficacy expectation are considered. Reappraisals occur when the environment provides alternate information. This appraisal could result in a change of response to the situation by adding or removing pressure.

The following is a conceptualization of the findings of this study and Lazarus and Folkman's transactional model of coping. Based on responses made within Theme 3, all participants in this sample initially assessed their CSA experience(s) as stressful event(s). Even though the majority of the participants were religiously involved in church at an early age, they did not perceive their Christian faith or their individual environment as a resource to help them address the negative thoughts, feelings, behaviors, and pain they experienced as a result of CSA. This appraisal ultimately resulted in behaviors they assessed to be negative and difficulties in psychological and interpersonal functioning.

Once they realized that their Christian faith could be used to help them address the negative sequelae that are often associated with CSA, their cognitive appraisal of their experience(s) began to change. The results suggest that participants no longer viewed their CSA experiences as a threat. Their relationship with God and other Christians and their ability to practically apply God's promises to their lives enabled them to use their Christian faith as a resource to diminish the negative thoughts, feelings, behaviors, and pain that they have experienced as a result of CSA. The data supports that this reappraisal of their CSA experience(s) and their ability to utilize their Christian faith as a resource has helped remove the pressure that was present when the CSA initially occurred. As a result of changes in their cognitive appraisal, the majority of the participants in this sample reported a significant positive shift in their ability to cope with their CSA histories.

Cognitive model.

According to the cognitive model of psychology, thoughts and beliefs are responsible for shaping behaviors and emotions (Beck, 1964). The cognitive model also postulates that it is the perception of an event, not the event itself, that informs how situations are interpreted. In 1979, Beck, Rush, Shaw, and Emery suggested that psychological distress is likely to occur as a result of maladaptive thoughts and beliefs. They further suggested that negative thoughts and beliefs could be modified by replacing those beliefs and automatic thoughts with adaptive responses. This process, known as cognitive restructuring or reframing, entails learning to identify, evaluate, and adjust automatic thoughts and cognitive distortions that are causing distress (Beck, 1995).

The findings of this study suggest that all participants in this sample experienced psychological and/or interpersonal distress as a result of maladaptive thoughts and beliefs associated with CSA. For some participants, this distress led to the development of low self-esteem, difficulty in forming trusting relationships, sexual promiscuity, and drug abuse. In spite of the individual representations of CSA sequela, the results of this study also found that participants reported lower levels of distress as they developed the ability to use their Christian faith as a resource to help challenge and reframe negative thoughts and beliefs associated with CSA. Participants attributed the development of this skill to their transition from religiosity to spirituality. More specifically, the results suggest that participants used their relationship with God, their relationships with other Christians, and the Sexual Abuse Survivors' ministry to help modify negative thoughts and beliefs related to their CSA experiences. Their ability to reframe these experiences led to reports of lower levels of psychological and/or interpersonal distress.

Social learning theory.

Social learning theory (Bandura, 1977, 1986) emphasizes the importance of the reciprocal relationship among cognition, behavior, and the environment. According to Bandura, most human behavior is learned through observing, imitating, and modeling the behavior of others. He proposed that people learn to change cognitions and behaviors through the observation of others' behaviors, attitudes, and outcomes of those behaviors. Bandura (1973) also suggested that true vicarious learning occurs as a result of paying attention to the model without distraction, retaining what was observed, practicing and reproducing what was observed, and the motivation of the observer to imitate the behavior. The results of this study suggest that many participants were able to use

vicarious learning to change cognitions and behaviors related to their experience(s) with CSA. Hearing the testimonies of other Christians and observing the results of their relationship with God, as well as their ability to practically apply their understanding of biblical truths to their lives, highlighted potential factors that influenced the participants' ability to do the same while promoting similar outcomes.

Constructivism theory.

According to Neimeyer (2009), constructivism is a psychological approach that places emphasis on individuals' needs to impose meaning on their life experiences. He further suggested that constructing and maintaining positive self-narratives are imperative elements of individual identity and adaptive functioning. In grief and loss literature, meaning making is the process of resolving the incongruence caused by bereavement and mourning (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010). Meaning making can occur by assimilating loss into already formulated self-narratives through use of social supports or by expanding and reorganizing self-narratives to accommodate loss. Although variations in the type of grief and loss and symptom severity and duration may complicate the process of meaning making (Bonanno, Wortman, & Nesse, 2004), congruence in self-narratives can be established through social and professional support.

The results of this study suggest that many participants were able to make meaning of their CSA experiences through use of their relationship with God, other Christians, and the Sexual Abuse Survivors' ministry. Even though the severity and duration of their CSA experiences varied, many participants were able to make meaning of their experiences by assimilating biblical truths and the testimonies of other Christians into their self-narrative to help them reconstruct their beliefs about their self-worth and

their CSA experiences. Although other participants reported some degree of ongoing difficulty with assimilating and accommodating their CSA experiences into their self-narrative, they also credited their relationship with God and Sexual Abuse Survivors' ministry with the successes they have achieved with meaning making thus far.

Implications.

CSA is a devastating problem that tends to cause distress in a significant portion of the world's population. Although CSA sequelae vary from survivor to survivor, it tends to have negative effects that profoundly impacts psychological, physical, interpersonal, and behavioral functioning (Jones-Johnson, 2008; Paolucci et al., 2001). For many years, there was an imbalance between literature on CSA sequelae and literature on the efficacy of psychotherapeutic treatment with persons who experienced CSA; literature on treatment efficacy was underrepresented (Ardelt, Ai, & Eichenberger, 2008; Martsolf & Draucker, 2005). Though significant efforts have been made to address this imbalance, there is a still a gap in the literature regarding the relationship between participation in Christian faith and the healing process of CSA survivors. The findings of this study to address that gap.

According to the findings of this study, participants in this sample were able to use their relationship with God and their relationship with other Christians as a resource to help them overcome the negative sequelae associated with CSA. These findings are beneficial for clinicians working with patients who have experienced CSA and subscribe to the Christian faith. In response to the clinical and ethical mandate to be respectful and cognizant of cultural difference (APA, 2000), clinicians must first and foremost be

knowledgeable of the positive effect that religiosity and spirituality have been found to have on physical and mental health outcomes (Ellison & Levin, 1998; Holt, Levin & Chatters, 2008; Lewellyn & Rathweg, 2005; Mullen, 1990; Zullig, Ward, & Horn, 2006;). Clinicians must be willing to assess how participation in Christian faith affects/has affected their patients' beliefs, cognitions, and behaviors. This assessment should also seek to collect information on each patient's level of involvement with religious activities, ministry involvement, and involvement with other Christians. In addition to gaining insight into how patients conceptualize their Christian faith, this information could also be used to help with treatment planning. Given that this study found the transition from religiosity to spirituality to be a helpful aid in the healing process, patients assessed to have a low level of participation in Christian faith activities may wish to explore the possibility of increasing their level of involvement. With practice and consistency, this goal, coupled with other goals that address maladaptive beliefs, cognitions, and behaviors associated with CSA experiences, should help resolve negative sequelae and improve treatment outcome.

Limitations.

There were several factors that limit the transferability and ability to generalize beyond this sample population regarding the findings of this study. Those limitations include sample size, selection bias, self-selection, and sample homogeneity.

The sample size (N = 10) is too small to draw any definitive conclusions about the effect that participation in Christian faith may have on the healing process in female,

African American CSA survivors. Variability among subjects was compromised because of the size of the sample.

The inclusion criteria of this study resulted in selection bias. Participants in this sample were selected based on their race, gender, age, experience with CSA, and participation in the SAS ministry. Selecting participants from a group that was already formed resulted in skewed data.

Although the sample population participated on a voluntary basis, there are factors that might have influenced study participation. For example, individuals who had not yet made the transition from religiosity to spirituality and those concerned about experiencing unpleasant physical and psychological symptoms associated with discussing CSA may have opted not to participate in the study.

Although a homogeneous sample was selected to help develop a rich understanding of the processes that helped facilitate the healing process in this specific sample of CSA survivors, the homogeneity of their beliefs limits the transferability to the population at large. More specifically, these findings may not generalize across gender and other religions.

The investigator's familiarity with the participants may have also been an unintentional confounding influence that affected responses given by the subjects in this sample. Participants may have responded differently to an investigator whom they did not know.

Conclusion.

Notwithstanding these limitations, the findings of this study have generated insight into how participating in Christian faith positively affects the healing process of CSA survivors. More specifically, as participants in this study transitioned from religiosity to spirituality, they were better able to use their relationship with God and their relationships with other Christians to help minimize the negative sequelae associated with CSA. Regarding future directions, this study should be repeated with males, and persons of various ages and other religions to ascertain whether the findings of this study generalize to other populations.

Person of the Researcher.

According to Kazdin (2003), research conducted using qualitative methodologies requires investigators to explicitly state their perspective about the phenomenon being investigated. Aponte's (1987) person-of-the-therapist model also stresses the importance of self-awareness and recognition of the influence that personal history has on perception and interpersonal functioning. The following information is being shared in consideration of these facts. This researcher believes that Christian faith has the ability to fully mediate and resolve the negative sequelae associated with CSA. This researcher more specifically believes that this can happen as a result of having a relationship with God, understanding biblical truths, participating in religious activities, and engaging in relationships with other Christians. This researcher chose to conduct this study as a result of her Christian faith and her involvement with Christian CSA survivors. To address the concerns of validity as it relates to this bias, a coding team consisting of the researcher and two graduate students used grounded theory techniques to analyze the data collected prior to the generation of themes.

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Appendix A

RP & CSA DEMOGRAPHIC QUESTIONNAIRE

Please complete each question by providing some brief demographic information.

1. Age: _____
2. Marital Status: _____

3. Religious affiliation and denomination: _____

4. How often do you attend the following:
   Worship Service:
   ☐ Once a week
   ☐ Twice a week
   ☐ Twice a month
   ☐ Three times a month
   ☐ Once a month
   ☐ Other (Please explain) _____
   Private Bible Study:
   ☐ Daily
   ☐ Multiple times a day
   ☐ Weekly
   ☐ Twice a month
   ☐ Once a month
   ☐ Other (Please explain) _____
   Public Bible Study:
   ☐ Daily
   ☐ Multiple times a day
   ☐ Weekly
   ☐ Twice a month
   ☐ Once a month
   ☐ Other (Please explain) _____

5. How often do you engage in:
   Private Prayer:
   ☐ Daily
   ☐ Multiple times a day
   ☐ Weekly
   ☐ Twice a month
   ☐ Once a month
   ☐ Other (Please explain) _____

Public Prayer:

- ☐ Daily
- ☐ Multiple times a day
- ☐ Weekly
- ☐ Twice a month
- ☐ Once a month
- ☐ Other (Please explain) _____

6. Number of ministries you're involved in: _____

7. Previous or current participation in therapy: _____

   If yes, what was/is your diagnosis: _____

8. How old were you when you were sexually abused: _____

9. How long did the abuse last:
   - ☐ One time occurrence
   - ☐ More than one occurrence but less than a month
   - ☐ One to three months
   - ☐ Three to six months
   - ☐ Six to nine months
   - ☐ Nine to twelve months
   - ☐ Other (Please explain) _____

10. Identification of social supports:
    Check all that apply
    - ☐ Family
    - ☐ Friends
    - ☐ Church
    - ☐ Community
    - ☐ Other (Please explain) _____

Participants' Pseudonym: _____

Appendix B

Posttraumatic Cognitions Inventory

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

Likert Scale

1- Totally Disagree
2- Disagree Very Much
3- Disagree Slightly
4- Neutral
5- Agree Slightly
6- Agree Very Much
7- Totally Agree

---

1. The event happened because of the way I acted.
2. I can't trust that I will do the right thing.
3. I am a weak person.
4. I will not be able to control my anger and will do something terrible.
5. I can't deal with even the slightest upset.
6. I used to be a happy person but now I am always miserable.
7. People can't be trusted.
8. I have to be on guard all the time.
9. I feel dead inside.
10. You can never know who will harm you.
11. I have to be especially careful because you never know what can happen next.
12. I am inadequate.
13. I will not be able to control my emotions and something bad will happen.
14. If I think about the event, I will not be able to handle it.
15. The event happened to me because of the sort of person I am.
16. My reactions since the event mean that I am going crazy.
17. I will never be able to feel normal emotions again.
18. The world is a dangerous place.
19. Somebody else would have stopped the event from happening.
20. I have permanently changed for the worse.
21. I feel like an object, not like a person.
22. Somebody else would not have gotten into this situation.
23. I can't rely on other people.
24. I feel isolated and set apart from others.

25. I have no future.
26. I can't stop bad things from happening to me.
27. People are not what they seem.
28. My life has been destroyed by the trauma.
29. There is something wrong with me as a person.
30. My reactions since the event show that I am a lousy coper.
31. There is something about me that made the event happen.
32. I will not be able to tolerate my thoughts about the event, and I will fall apart.
33. I feel like I don't know myself anymore.
34. You never know when something terrible will happen.
35. I can't rely on myself.
36. Nothing good can happen to me anymore.

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Appendix C

Brief Multidimensional Measure of Religiousness/Spirituality: 1999

Daily Spiritual Experiences

The following questions deal with possible spiritual experiences. To what extent can you say you experience the following:

1. I feel God's presence.
   - 1 - Many times a day
   - 2 - Every day
   - 3 - Most days
   - 4 - Some days
   - 5 - Once in a while
   - 6 - Never or almost never

2. I find strength and comfort in my religion.
   - 1 - Many times a day
   - 2 - Every day
   - 3 - Most days
   - 4 - Some days
   - 5 - Once in a while
   - 6 - Never or almost never

3. I feel deep inner peace or harmony.
   - 1 - Many times a day
   - 2 - Every day
   - 3 - Most days
   - 4 - Some days
   - 5 - Once in a while
   - 6 - Never or almost never

4. I desire to be closer to or in union with God.
   - 1 - Many times a day
   - 2 - Every day
   - 3 - Most days
   - 4 - Some days
   - 5 - Once in a while
   - 6- Never or almost never

5. I feel God's love for me, directly or through others.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never
6. I am spiritually touched by the beauty of creation.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

Values/Beliefs

7. I believe in a God who watches over me.
   1 - Strongly agree
   2 - Agree
   3 - Disagree
   4 - Strongly disagree

8. I feel a deep sense of responsibility for reducing pain and suffering in the world.
   1 - Strongly agree
   2 - Agree
   3 - Disagree
   4 - Strongly disagree

Forgiveness

Because of my religious or spiritual beliefs:

9. I have forgiven myself for things that I have done wrong.
   1 - Always or almost always
   2 - Often
   3 - Seldom
   4 - Never

10. I have forgiven those who hurt me.
   1 - Always or almost always
   2 - Often
   3 - Seldom
   4 - Never

11. I know that God forgives me.
    1 - Always or almost always
    2 - Often
    3 - Seldom
    4 - Never

Private Religious Practices

12. How often do you pray privately in places other than at church or synagogue?
    1 - More than once a day
    2 - Once a day
    3 - A few times a week
    4 - Once a week
    5 - A few times a month
    6 - Once a month
    7 - Less than once a month
    8 - Never

13. Within your religious or spiritual tradition, how often do you meditate?
    1 - More than once a day
    2 - Once a day
    3 - A few times a week
    4 - Once a week
    5 - A few times a month
    6 - Once a month
    7 - Less than once a month
    8 –Never

14. How often do you watch or listen to religious programs on TV or radio?
    1 - More than once a day
    2 - Once a day
    3 - A few times a week
    4 - Once a week
    5 - A few times a month
    6 - Once a month
    7 - Less than once a month
    8 - Never

15. How often do you read the Bible or other religious literature?
    1 - More than once a day
    2 - Once a day
    3 - A few times a week
    4 - Once a week
    5 - A few times a month
    6 - Once a month
    7 - Less than once a month
    8 - Never

16. How often are prayers or grace said before or after meals in your home?
    1 - At all meals
    2 - Once a day
    3 - At least once a week
    4 - Only on special occasions
5 –Never

Religious and Spiritual Coping

Think about how you try to understand and deal with major problems in your life. To what extent is each of the following involved in the way you cope?

17. I think about how my life is part of a larger spiritual force.
    1 - A great deal
    2 - Quite a bit
    3 - Somewhat
    4 - Not at all

18. I work together with God as partners.
    1 - A great deal
    2 - Quite a bit
    3 - Somewhat
    4 - Not at all

19. I look to God for strength, support, and guidance.
    1 - A great deal
    2 - Quite a bit
    3 - Somewhat
    4 - Not at all

20. I feel God is punishing me for my sins or lack of spirituality.
    1 - A great deal
    2 - Quite a bit
    3 - Somewhat
    4 - Not at all

21. I wonder whether God has abandoned me.
    1 - A great deal
    2 - Quite a bit
    3 - Somewhat
    4 - Not at all

22. I try to make sense of the situation and decide what to do without relying on God.
    1 - A great deal
    2 - Quite a bit
    3 - Somewhat
    4 - Not at all

23. To what extent is your religion involved in understanding or dealing with stressful situations in any way?
    1 - Very involved
    2 - Somewhat involved
    3 - Not very involved
    4 - Not involved at all

Religious Support

These questions are designed to find out how much help the people in your congregation would provide if you need it in the future.

24. If you were ill, how much would the people in your congregation help you out?
    1 - A great deal
    2 - Some
    3 - A little
    4 - None

25. If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?
    1 - A great deal
    2 - Some
    3 - A little
    4 - None

Sometimes the contact we have with others is not always pleasant.

26. How often do the people in your congregation make too many demands on you?
    1 - Very often
    2 - Fairly often
    3 - Once in a while
    4 - Never

27. How often are the people in your congregation critical of you and the things you do?
    1 - Very often
    2 - Fairly often
    3 - Once in a while
    4 - Never

Religious/Spiritual History

28. Did you ever have a religious or spiritual experience that changed your life?
    No
    Yes

IF YES: How old were you when this experience occurred?

29. Have you ever had a significant gain in your faith?
    No
    Yes

IF YES: How old were you when this occurred?

30. Have you ever had a significant loss in your faith?
    No
    Yes

IF YES: How old were you when this occurred?

Commitment

31. I try hard to carry my religious beliefs over into all my other dealings in life.
    1 - Strongly agree
    2 - Agree
    3 - Disagree
    4 - Strongly disagree

32. During the last year about how much was the average monthly contribution of your household to your congregation or to religious causes?

$_____ per year OR $_____ per month Contribution Contribution

33. In an average week, how many hours do you spend in activities on behalf of your church or activities that you do for religious or spiritual reasons?

Organizational Religiousness

34. How often do you go to religious services?
    1 - More than once a week
    2 - Every week or more often
    3 - Once or twice a month
    4 - Every month or so
    5 - Once or twice a year
    6 - Never

35. Besides religious services, how often do you take part in other activities at a place of worship?
    1 - More than once a week
    2 - Every week or more often
    3 - Once or twice a month
    4 - Every month or so
    5 - Once or twice a year
    6 - Never

Religious Preference

36. What is your current religious preference?

IF PROTESTANT ASK:
Which specific denomination is that?

Overall Self-Ranking

37. To what extent do you consider yourself a religious person?
    1 - Very religious
    2 - Moderately religious
    3 - Slightly religious
    4 - Not religious at all

38. To what extent do you consider yourself a spiritual person?
    1 - Very spiritual
    2 - Moderately spiritual
    3 - Slightly spiritual
    4 - Not spiritual at all

Appendix D

Semistructured Interview

Interview Instructions and Questions

Interviewer's instructions to participant: Hello _____, I would first like to thank you for agreeing to participate in this study. For the next 90 minutes, I will be asking you a series of questions to learn about your experience with childhood sexual abuse, faith and the healing process. It is my hope that the information you provide during our interview today will improve the effectiveness of future help for other childhood sexual abuse survivors of the Christian faith. Please answer all questions as honestly and completely as possible because your responses will provide a basis for understanding the role of your faith in the healing process. If at any time you are unsure of what I am asking, please ask. You have the right to decide not to answer any question or stop the interview for any reason. However, with your permission, should this happen I would like to be able to ask you why you do not want to answer the question or continue with the interview.

Please understand that your participation in this interview may at times cause you to feel uncomfortable due to the nature of the topic. If you begin to feel emotionally overwhelmed please let me know. Remember that I will be audio taping the interview so that I can accurately write out what you said at a later date to help me understand your thoughts, feelings and experiences as much as I can. Your tape and transcript will not identify you by name, and will be kept confidential. Do you have any questions for me at this time? Okay let's get started.

Questions

1. Do you believe in God?
2. What does that mean to you?
3. What is your current relationship with God and the church?
4. What was your experience with sexual abuse?

➔ **Prompt:** were you familiar with your abuser prior to the abuse, how old were you, how long did it occur

5. Can you describe how experiencing childhood sexual abuse changed how you felt about yourself?
6. What has been the role of religion or faith in your life before, during and after your sexual abuse experience?
7. Describe how your relationship with God and church has affected your healing process.
8. Others cope with childhood sexual abuse by eating, using substances, engaging in sexual activity, working, etc. What ways have you found useful for coping in addition to faith?
9. Is there anything you would like to add about what we've been discussing that I have not asked that you?