Liberty University Baptist Theological Seminary

Surviving the Other War:
Group Intervention for Military Sexual Trauma
in the Local Church

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By

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Abstract

Surviving the Other War: Group Intervention for Military Sexual Trauma in the Local Church.

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Military Sexual Trauma (MST) is, together with the current military suicide epidemic, arguably the greatest danger to soldiers serving at home or abroad, and sadly the former is a contributing factor for the latter.[1] MST involves the sexual assault or sexual harassment of an individual by one or several fellow service members. An important avenue of assistance is through the local church; however, "the quality of mental health providers does not include a sufficient number of faith-based counselors (especially Christian) to serve the predominantly Christian demographic in the U.S. Armed Forces."[2] To assist in this, a psycho-educational support group has been developed for use in the local church. Intended to help survivors begin the road back, twelve two-hour sessions are outlined, which include rapport building, assessment, and discussion, under the leadership of an experienced individual. As the participants become more able to discuss and interact about the causes and effects of their trauma and the result on their life in the intervening years, any serious issues, including comorbid factors, will be dealt with outside the group setting by a trained professional. The desire is that this program may help many who find themselves in another type of "harm's way" to overcome the effects of MST.

[1] Helen Benedict, "The Scandal of Military Rape," *Ms. Magazine* 2008. 42.

[2] Major General Bob Dees, U.S. Army, Retired, "The Urgent Need for Christian Counselors for our Military." Accessed February 9, 2014, http://www.aacc.net/2012/11/12/the-urgent-need-for-christian-counselors-for-our-military/.

DEDICATION

To my wife, Gina, whose love, friendship, and support mean more to me than she will ever know.

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My thanks to several people whose involvement assisted greatly on this journey. Drs. Scott Hawkins and Dwight Rice, Mentor and Reader, respectively, whose encouragement and willingness to become involved were instrumental in completing this project. Dr. Clay Peters, whose encouragement and lack of direct involvement also greatly contributed to its completion.

A special thanks to Dr. Ron Hawkins, who was willing to serve as Mentor during the early stages of this thesis, despite his incredibly busy schedule. His example of academic and professional quality and concern has set the standard for what a Christian scholar should strive to be.

And finally, to the One who is the reason for everything. He changed my life when I was young by accepting me as family, He stayed with me through all the good and bad times, He established the greatest retirement plan ever, and He gives purpose to every day and every deed. Thank you, God of Abraham, Isaac and Jacob.

Contents

List of Abbreviations

NASB – NEW AMERICAN STANDARD BIBLE

D. MIN. – DOCTOR OF MINISTRY

PTSD – POST-TRAUMATIC STRESS DISORDER

DOD – DEPARTMENT OF DEFENSE

SWAN – SERVICE WOMEN'S ACTION NETWORK

MST – MILITARY SEXUAL TRAUMA

COC – CHAIN OF COMMAND

NCO – NON-COMMISSIONED OFFICER

OD – OFFICER OF THE DAY

NCOOD – NONCOMMISSIONED OFFICER OF THE DAY

STOP ACT - SEXUAL ASSAULT TRAINING OVERSIGHT AND PROTECTION ACT

Chapter 1

Introduction

Even my close friend in whom I trusted, who ate my bread,
has lifted up his heel against me.[3]

"Women serving in the U.S. military are more likely to be raped by a fellow soldier than killed by enemy fire in Iraq."[4] When this statement was originally made, it shocked many who had felt that the sexual harassment and assault that had recently been brought to the public's attention were isolated incidents.[5] Then a Veteran's Administration's National Center for Posttraumatic Stress study confirmed that the opposite was true.[6] Not only are female members of the service being assaulted, but same-sex assaults are occurring as well,[7] in greater numbers than ever before.[8] What is the effect of no longer having the enemy only located "out there", but also in the same uniform, in the same sleeping quarters, in the same squad? Add to this the fact that for the second year in a row, more soldiers commit suicide than are lost in combat situations, and it becomes obvious that there is a desperate need for the church to reach out and offer counseling and comfort to the set of wounded warriors whose wounds are unseen, but just as real.[9]

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[3] Ps 41:9 (NASB). Unless otherwise noted all passages referenced are in the New American Standard Bible.

[4] Rep. Jane Harman (D-CA). *LA Times* Mar 31, 2008.

[5] Jessica A. Turchik and Susan M. Wilson, "Sexual Assault in the U.S. Military: A Review of the Literature and Recommendations for the Future," *Aggression and Violent Behavior* 15, no. 1 (2010): 267-269.

[6] Andrew B. Einhorn, "Study Supports Claim Women in the Military More Likely To Be Raped by a Fellow Soldier Than To Be Killed by Enemy Fire in Iraq," *OhMyGov*, (October 30, 2008): 1.

[7] Michelle Tan, "Criminal Hazing: Raped by His Fellow Soldiers." *Army Times*, (April 25, 2012).

[8] Dave Bohon, "Homosexual Assaults Becoming a Problem in U.S. Military, DoD Survey Finds," *New American*, (May 23, 2013).

[9] Gail Sheehy, *USA Today*, July 5th, 2012.

Statement of the Problem and Limitations

When leaving behind family and friends in order to serve their country, soldiers cut themselves off from the support network that they have had for most of their lives and accept a new "family." They sleep, eat and go about their assigned tasks in close proximity. The level of privacy is far from what they had become used to. In the culture of the military, they are to be "battle buddies," assisting each other and trusting each other continuously. "I've got your back" is the phrase often identified with the members of a unit that are deployed "down range" or see a posting in the States. However, when this familial unit becomes torn apart, as the trust established among its members is betrayed by sexual assault, the wounds go deeper and inflict more pain than any bullet ever could.

Upon separation from the service and returning home, these servicemen and women, who put their lives on the line and sacrificed for the good of the nation, are for various reasons given marginal assistance by the Veteran's Administration (VA), which is not equipped or up-to-date enough to effectively serve the increasing numbers of women in the service in general and the sensitive nature of sexual trauma, specifically, whether the survivor seeking assistance is male or female.[10] Rather than getting proper treatment, their credibility is often questioned, or they are made to feel that they are the problem. In addition to suffering from the psychological and physiological effects of sexual trauma, many are also experiencing a profound sense of having lost their spiritual compass, their world having turned upside-down.

Part of the task of ministers, as reflected in the actions of the Levites, is to care for the warriors. In a description of the duties of the Levites as regarding fighting for their land, one

[10] Emily Wax-Thibodeaux, "Female Veterans Battling PTSD from Sexual Trauma Fight for Redress," *The Washington Post,* December 25, 2014, accessed December 26, 2014, http://www.washingtonpost.com/politics/female-veterans-battling-ptsd-from-sexual-trauma-fight-for-redress/2014/12/25/f2f22d8e-7b07-11e4-b821-503cc7efed9e_story.html.

writer said that "the Levites were not counted among those who were 'able to go forth to war,' but they offered reassurance to soldiers before battles."[11] While some churches attempt to address the needs of individuals, including service members, who have suffered from sexual assault, most are unaware of the specific needs of survivors and the best practices for assisting them on their journey to recovery. All traumatic events do not occur equally, and are also not treated equally. In the counseling field, scholars and practitioners recognize that military sexual trauma is a unique problem and they have not yet reached a consensus regarding how to best address its multifaceted and complex long-term effects. Churches are generally limited in the resources available for professional counseling, which creates an opportunity for Christian counselors to come alongside pastors to lend their expertise and to design counseling and intervention programs tailored for implementation in the local church.

The intent of the group intervention program contained within this project is to serve as a venue for survivors of military sexual trauma to begin the healing process. It may be adapted to one of two configurations, determined by the depth of therapeutic intervention that it is intended to provide. If a more therapeutic program is envisioned, then the leader should be a licensed professional, while if it is primarily intended as a psycho-educational support group, then a lay individual with experience in some area of mental health may be sufficient.

Upon completion of twelve group sessions of the psycho-educational support group, those individuals who have revealed severe comorbid issues or exhibited a need for additional mental health assistance may to be referred for further treatment to a licensed professional, either internally or externally. This limitation is intentional and exists because many of the survivors whose needs this program is designed to serve have already been further victimized by the VA

[11] P. J. Achtemeier, "Levites," in *Harper's Bible Dictionary,* 1st ed. (San Francisco: Harper & Row, 1985), 974–975

and others who are supposed to help and are, therefore, more likely to participate in an intervention structured as a support group facilitated by a caring church than to seek therapy. Church-based and specialized community programs for abuse survivors have been proven to be effective to reduce their symptoms.[12]

A second limitation of this project is that no primary data was collected. A thorough examination of the literature on military sexual trauma was conducted and applied to create this program, while the author was also drawing upon the knowledge gained from years of counseling individuals and groups.

Theoretical Basis

The principle foundation of the Christian worldview involves relationships. The vertical interaction through prayer of the believer with his Creator and Savior, and the horizontal outreach to one's fellow man in compassion through the guidance of the Holy Spirit are intended to emulate that of Jesus of Nazareth. The depth of the outreach is directly proportional to the depth of the "upreach". Nothing can be given unless it is first received. These relationships are a Christian's "raison d'etre" or purpose in existence. The local church is to be many things to those within its purview, and the pastoral staff is to serve in a number of capacities as well, with one of the loftiest being counselor to the flock. As Elwell states "In Bible times a counselor in a king's court was like a U.S. cabinet member today."[13] In many churches, the pastor and counselor on staff is one and the same person, intended to be the primary corporeal expression of the hand and

[12] Mary P. Koss et al., "Depression and PTSD in Survivors of Male Violence: Research and Training Initiatives to Facilitate Recovery," *Psychology of Women Quarterly* 27 (2003).

[13] W. A. Elwell and P. W. Comfort, *Tyndale Bible Dictionary* (Wheaton, IL: Tyndale House Publishers, 2001), 321.

heart of God on earth. "In Latin the word *pastor* means "shepherd" or "herdsman." The word is derived from the Latin word *pascere,* which means "to pasture" or "to feed."[14]

This author, when young, lived on a high-mountain valley ranch in Colorado, where the family took care of several hundred sheep. Among many lessons learned was that "pasturing" was much more than feeding the sheep. It also involved nurturing and protecting them, even from their own decisions. Following heavy rains, the sheep would wander into places where the grass was especially green and thick and would become bogged down in mud, where they would starve or be eaten by bears, coyotes or wolves. At the age of nine, one of this author's duties was to keep the sheep under his charge from this form of self-destruction, a task that was not appreciated by the sheep that only saw the beauty but not the danger. In a similar fashion, one task of the pastor is to address issues that the individual involved may not want to address, due to the pain of the process. As one writer stated, "The pastoral writers spoke often of the 'duty to disturb false peace.' However important may be the values of peace and tranquility, they are not absolute, and at times the pastor must deliberately penetrate the facade of false peace."[15] When a soul has been injured, the pastor must at times cause pain by calling up the issue in order to deal with it. Bringing the repressed trauma of sexual assault out into the open is painful, but that is the healer's job. A broken bone that was not set correctly must be re-broken, so that it may heal correctly. A pastor in a church, or a professional counselor serving on staff, must often confront and disrupt the false peace of repression, in order to truly serve the parishioner. "In Old Testament times the counselor was an employee of the royal court,"[16] and in a very real sense the pastor today is as well. Preaching is often thought of as being the pastor's primary task, but this

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[14] D. Hansen and D. L. Goetz, *The Power of Loving Your Church: Leading through Acceptance and Grace*, vol. 1, (Minneapolis, MN: Bethany House, 1998), 17.

[15] T. C. Oden, *Pastoral Counsel*, Classic Pastoral Care (New York: Crossroad, 1989), 180.

[16] A. C. Myers, *The Eerdmans Bible Dictionary* (Grand Rapids, MI: Eerdmans, 1987), 239.

author would argue that although "it pleased God by the foolishness of preaching to save them that believe,"[17] that care for the sheep after conversion is nearly at the same level of importance. The words of Proverbs reinforce this, "Where there is no guidance the people fall, but in abundance of counselors there is victory."[18]

His followers are to not only "Go therefore and make disciples of all the nations,"[19] but also to hold close the wisdom that asks "does any dimension of pastoral ministry so encompass the two hemispheres of soaring ideals and earthy reality as counseling? The hearts of pastoral counselors pound with compassion, healing, love, discipleship, wisdom, and comfort.[20] Foundational to all ministries of the church is to aid the broken hearted, as the Psalmist says "Reproach hath broken my heart; and I am full of heaviness: And I looked for some to take pity, but there was none; and for comforters, but I found none."[21] These words could have come from the lips of a present day victim of sexual assault. To this Jesus replies, "Come to Me, all who are weary and heavy-laden, and I will give you rest,"[22] and so the counselor stands in the gap.

This project rests on the premise that Biblically based pastoral counseling can—and should—be carefully and prayerfully integrated with principles and best practices for professional trauma counseling. Ample empirical evidence of such integration being effective in reducing trauma symptoms is available[23] along with examples of how to achieve this.[24] An

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[17] 1 Cor 1:21, KJV.

[18] Prv 11:14

[19] Mt 28:19

[20] C. B. Larson, Epilogue. *In Mastering Pastoral Counseling*, *Mastering Ministry* (Portland, OR: Multnomah Press, 1992), 171.

[21] Ps 69:20 KJV

[22] Mt 11:28

[23] Elisa Marie Litchfield, "Spiritual Integration in the Treatment of Combat-related Posttraumatic Stress Disorder" (PsyD diss., Regent University, 2009), 25.

[24] Nichole A. Murray-Swank and Kenneth I. Pargament, "God, Where Are You? Evaluating a Spiritually-Integrated Intervention for Sexual Abuse," *Mental Health, Religion & Culture 8, no. 3* (2005): 191-203.

integrated program designed for survivors of MST needs to incorporate ways to assist survivors in drawing upon God as a "coping resource"; reconciling their faith with their experiences; dealing with feelings of anger, abandonment, and spiritual disconnection; extending forgiveness; gaining hope and a positive outlook on life; strengthening their relationship with God; and experiencing spiritual renewal.

An emphasis on personal growth and the process of recovery from trauma has also been furthered by John Briere, whose work on trauma therapy and intervention provided the theoretical basis for this project.[25] He recognized that survivors typically employ a number of coping mechanisms to deal with the multifaceted and complex effects of trauma, but rather than focusing on pathology and symptom reduction, advocates an approach geared toward assisting survivors in developing constructive recovery strategies and skills. In addition, this project used a framework titled BASICS to address the Behavioral, Affective, Somatic, Interpersonal, Cognitive, and Spiritual effects of MST, adapted from the work of Lazarus.[26]

Statement of Methodology

The resources used to develop this church-based program were obtained through a comprehensive review of academic, professional, popular, and faith-based literature, including books, journal and newspaper articles, military reports, dissertations and theses, professional psychoeducational material, and congressional records. In addition, informal interviews with several current and former members of the Armed Services were conducted on the topic of military sexual trauma. While anecdotal in nature, these assisted greatly in understanding the

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[25] John N. Briere and Catherine Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment*, 2nd ed. (Thousand Oaks, CA: Sage Publications, 2013) and John N. Briere and Cheryl Lanktree, *Integrative Treatment of Complex Trauma for Adolescents (ITCT- A) Treatment Guide*, 2nd ed. (Torrance, CA: USC-ATTC, 2008), 7-10.

[26] Arnold Allen Lazarus. "Multimodal Behavioral Therapy: Treating the Basic ID," *Journal of Nervous and Mental Disease* 156, (1973): 401-411.

nature of the climate in the military towards this issue and the lengths to which some would go to "sweep under the rug" the entire problem. In synthesizing and applying this vast body of information to develop a group intervention manual tailored to the local church, the author also drew upon his own experiential background. This experience includes pastoral, evangelistic, and educational involvement in the local church; counseling in school, university, and human services settings; as well as teaching and curriculum development at the undergraduate and graduate levels, specializing in crisis and trauma counseling.

Chapter 2

Understanding and Treating Military Sexual Trauma

The following review of literature draws primarily upon scholarly sources. A brief synopsis of content that is particularly relevant to this thesis is included for key works. Particular emphasis is placed on scholarly literature produced from a Biblical worldview. In addition, scriptures relevant to the topic are reviewed and discussed.

Leaning on a definition provided by the U.S. Army, military sexual trauma (MST) is understood as follows:

> Sexual assault is defined as intentional sexual contact characterized by use of force, physical threat, or abuse of authority, or when the victim does not or cannot consent. Sexual assault includes rape, nonconsensual sodomy (oral or anal sex), indecent assault (unwanted, inappropriate sexual contact or fondling), or attempts to commit these acts. Sexual assault can occur without regard to the gender, spousal relationship, or age of the victim.[27]

Often, the term "sexual assault" and the term "rape" are treated as being synonymous; however, there are a number of forms of sexual assault that are not rape, as shown above. Additional definitions include those for rape as "sexual intercourse by force and without consent;" that of forcible sodomy as "oral or anal sex, by force, and without consent;" and indecent assault as "any non-consensual touching with the intent to gratify ones sexual desires."[28] While many accept the simplified statement that MST is simply sexual trauma while serving in the military, the reality is that because the military is a separate culture with disparate norms, it is something much more. There are a number of factors particular to the military context that will exacerbate or ameliorate the effects of a sexual assault. Therefore, in order to understand MST, this review of literature begins with an overview of sources addressing the

[27] Sexual Assault Definitions Accessed February 9, 2014, http://www.eur.army.mil/g1/content/Programs/sexualAssault/docs/saDefinitions.html

[28] Definitions of Sexual Assault, Ft. Gordon Army Community Service, Accessed November 17, 2013, http://www.gordon.army.mil/acs/SAPR/Definitions.htm

prevalence and nature of MST. Next, both short- and long-term effects of sexual trauma are briefly addressed. Finally, literature addressing appropriate interventions and treatments of sexual trauma are reviewed with particular attention to Christian perspectives.

The Prevalence and Nature of Military Sexual Trauma

Although not a new phenomenon, the occurrence of MST has received increased attention following several scandals. "It has not been until the last decade that research has focused on sexual assault in the U.S. military. Unfortunately, it took several high profile incidents, such as the 1991 Navy's Tailhook convention scandal, the 1996 cases of sexual harassment and assault at the Army training facilities at Fort Leonard Wood and Aberdeen Proving Ground, the 1997 sexual harassment accusations of Army Sergeant Major Brenda Hoster, and the 2003 Air Force Academy sexual assault scandal, to bring this issue to both the military's and the public's attention."[29]

One of the major difficulties present in any discussion of sexual assault in the military is the problem of obtaining accurate statistics. A recent study revealed that, "While a Pentagon survey found that 26,000 respondents cited instances of unwanted sexual contact, only 3,374 cases were reported."[30]

Amy Street, Jane Stafford, Clare Mahan and Ann Hendricks reported in their article "Sexual Harassment and Assault Experienced by Reservists During Military Service" that in a stratified random sample of 3,946 former reservists, 60 percent of female reservists and 27.2 percent of male reservists had experienced sexual harassment.[31] The rates for sexual assault were

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[29] Jessica A. Turchik and Susan M. Wilson, "Sexual Assault in the U.S. Military: A Review of the Literature and Recommendations for the Future." *Aggression and Violent Behavior* 15, no. 1 (2010): 267.

[30] Gabrielle Lucero, "Military Sexual Assault: Reporting and Rape Culture," *Sanford Journal of Public Policy* 6, no. 1 (Winter 2015): 1.

[31] Amy E. Street et al., "Sexual Harassment and Assault Experienced by Reservists during Military Service: Prevalence and Health Correlates," *Journal of Rehabilitation Research and Development* 45, no. 3 (2008): 409-420.

13.1 percent of females and 1.6 percent of males. Another source estimated that 25-50 percent of all military women experience some type of sexual harassment and that 20 percent are sexually assaulted.[32] These are not insignificant numbers, reinforcing the view that MST is highly prevalent in the military. Incident rates vary greatly depending on how sexual assault is defined and measured, resulting in some studies reporting similar rates of sexual assault across the five service branches and others varying rates.[33] For example, one study of sexual harassment found the highest rates in the Marine Corps and the lowest in the Air Force.[34] Personal and social factors often determine the degree to which experiences of sexual harassment, sexual coercion, and attempted rape—in addition to rape—cause trauma.

Although the incident rate of MST is significantly higher among women,[35] suggesting that counseling interventions need to primary and initially focus on assisting women, it is important to recognize that MST affects men as well. In fact, the actual numbers of male and female MST survivors are about even, because there are so many more men in the service.[36] One study, averaging reports covering the past 30 years, found that MST was reported by approximately 0.09 percent of male service members each year, with the range being 0.02 to 6 percent.[37] Amy Street, Jamie Gradus, Jane Stafford and Kacie Kelly indicated that a major reason for sexual harassment is to punish the individuals for deviating from their expected

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[32] Jennifer van Pelt, "Military Sexual Trauma," *Social Work Today* 11, no. 2 (2011): 9.

[33] Alina Surís and Lisa Lind, "Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans," *Trauma, Violence & Abuse* 9, no. 4 (2008): 251.

[34] M. S. Hay and T. W. Elig, "The 1995 Department of Defense Sexual Harassment Survey: Overview and Methodology," *Military Psychology*, 77 (1999): 233.

[35] Sally G. Haskell et al., "Gender Differences in Rates of Depression, PTSD, Pain, Obesity, and Military Sexual Trauma among Connecticut War Veterans of Iraq and Afghanistan," *Journal of Women's Health* 19, no. 2 (2010): 267.

[36] Rachel Kimerling et al., "The Veterans Health Administration and Military Sexual Trauma," *American Journal of Public Health* 97, no. 12, (2007): 2161.

[37] Tim Hoyt, Jennifer Klosterman Rielage, and Lauren F. Williams, "Military Sexual Trauma in Men: A Review of Reported Rates," *Journal of Trauma and Dissociation* 12, (2011): 244.

gender roles.[38] They argued that there is a greater likelihood of harassment of both genders when they work in a male dominated environment, such as the military. Also, the likelihood of developing PTSD following sexual assault was reported to be greater for males (65%) than for females (45.9%), due to the increased social disapprobation for male on male sexual assault.

Seeking to make accessible the available literature on MST, Turchik and Wilson compiled research, which provides details on prevalence rates, along with psychological and other factors that contribute to the incidence rates. These include demographic factors, higher likelihood of childhood sexual abuse as well as prior sexual perpetration, prevalence of alcohol use in the military, and a power-differential between men and women. They explained, "Service members who are not married, younger, and enlisted may be more likely to be at risk for a number of reasons, including that they are more likely to live on base in close quarters, have less power within the military, more likely to be exposed to dating violence, and more likely to be engaging in substance use for the first time."[39] The prevalence of alcohol use in the military is an especially important factor to consider, since approximately half of all sexual assaults are associated with the perpetrator's alcohol consumption, the victim's alcohol consumption, or both.[40]

Military culture is plagued by a pervasive mentality that sexual assault is permissible as a rite of passage and as a means of establishing one's authority over those under one's command, illustrated by a high-ranking officer on a conference panel stating a few years ago that women ought to expect this type of treatment when deciding to enlist.[41] Although the government has

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[38] Amy E. Street et al., "Gender Differences In Experiences Of Sexual Harassment: Data From A Male-Dominated Environment," *Journal of Consulting & Clinical Psychology* 75, no. 3 (2007): 464-474.

[39] Turchik and Wilson, "Sexual Assault," 270.

[40] Antonia Abbey et al., "Sexual Assault and Alcohol Consumption: What Do We Know About their Relationship and What Types of Research are Still Needed?" *Aggression and Violent Behavior* 9 (2004): 271.

[41] Van Pelt, 8.

implemented programs for MST prevention and education, the MST incident rates remain significantly higher than the sexual assault incident rates in the civilian population. It is unclear whether the MST incident rate is actually continuing to increase, or whether the increased media coverage and mandated reporting from the various military branches and academies is making the problem more obvious.

Based on interviews with seven female veterans who experienced sexual assault while serving in the military, Aktepy examined MST and provided information and insights to its nature.[42] She also argued that MST is well known to the media, military members, and health care professionals. She discussed the effects of the assault on the victims and how military culture fosters avoidance of confrontation of the perpetrators. A more in-depth, first-hand account of what it is like to be assaulted in a military environment, along with the military-related factors that conspire to eviscerate the one who chooses to come forward, was provided in a short, self-published book by Miette Wells, a Desert Shield and Desert Storm veteran who was herself assaulted but chose not to acquiesce to her superior's pressure.[43] The book does a good job of explaining some of the reactions that a survivor may have, including emotional and physical issues.

A review of MST research suggests that while the prevalence and psychological and physical health correlates are fairly well documented, research on treating MST, specifically, is lacking.[44] While treatment proven effective for sexual assault may be appropriate for treating many aspects of MST as well, MST is qualitatively distinct from other forms of sexual assault in

[42]Sarah Louise Aktepy. "A Rhetoric of Betrayal: Military Sexual Trauma and the Reported Experiences of Operation Enduring Freedom and Operation Iraqi Freedom Women Veterans," (MA thesis, Indiana University, 2010).

[43] Miette Wells, *MST: Military Sexual Trauma* (Lexington, KY: CreateSpace Independent Publishing Platform, 2011), iv.

[44] Carolyn B. Allard et al., "Military Sexual Trauma Research: A Proposed Agenda," *Journal of Trauma and Dissociation* 12, no. 3 (2011): 331.

terms of its relational and vocational context. The majority of sexual assaults on military personnel are perpetrated by fellow service members. This means that not only do survivors have a close relationship with, and prolonged exposure to, the perpetrators, but these have a great deal of control over their future, to a point where the survivors may depend on them for their very survival. These factors create "a conflict between adaptive responses to betrayal and the need to maintain attachment to the relied-upon other,"[45] which increases the severity of the trauma, particularly in terms of dissociation, depression, and impaired interpersonal functioning. Some victims are unable or unwilling to leave the abuser.[46] The unique aspects of MST therefore necessitate specialized treatment.

In a thorough and well-researched dissertation, titled "Soldier Rape, Our Own Worst Enemy,"[47] Tiffany Sanford Jenson examined the danger to women in the "workplace" of the military, where they seek to work at a man's level while remaining feminine. She discussed the pervasive nature of sexual harassment in an environment dominated by men and described the effects of the military culture on females. Viewed from this perspective, the "military way," including the hierarchical structure and chains of command of military organizations, fosters an environment where workplace violence and sexual harassment flourish while being largely tolerated.[48] Another important and helpful resource that removes the covers from the military drinking, macho culture that tends to categorize women into several marginalized areas is the book *Honor Betrayed: Sexual Abuse in America's Military* by Mic Hunter. He states that "the

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[45] Allard, 331.

[46] Sharon Valente and Callie Wight, "Military Sexual Trauma: Violence and Sexual Abuse," *Military Medicine* 172, no. 3 (2007): 261-262.

[47]Tiffany Sanford Jenson, "Soldier Rape, Our Own Worst Enemy: The Effects of Deployment, Sex Ratios, and Military Branch on the Sexual Assault of Active Duty Women in the US Military" (PhD diss., University of Oklahoma, 2011).

[48] Stephanie Lise Switzer, "Sexual Harassment and Sexual Assault in the Military" (PsyD diss., University of Hartford, 2007), 1.

acceptance of violence as a legitimate method for obtaining one's goals, whether with an enemy or with a comrade, creates a psychological environment where sexual abuse is likely to occur.[49] Although it reads as somewhat disjointed, it includes further first-person accounts of survivors and covers areas essential for one's understanding of how MST can occur and why it will most likely continue to do so. He identified several elements of the military culture that promote sexual violence, including sexualized and violent language, a general acceptance of violent behaviors, a learned ability to objectify people, rigid gender roles, and negative sexual norms and beliefs. He reasoned that the general emphasis on violence as a means to obtain one's goals creates an environment that fosters abuse of power by individuals trained in combat.

Margret Bell and Annemarie Reardon examine Sexual Harassment and Sexual Assault in the Military among OEF/OIF Veterans and present good information that assists in gaining understanding for dealing with MST among this demographic.[50] Specific factors related to military culture addressed in the article include the difficulty of avoiding repeated contact with the perpetrator, the lack of social support from those around, and the near certainty that the MST will react with any prior emotional baggage that the victim brought into the service.

In addition to dealing with the sexual assault itself, survivors must also combat the general belief that a large percentage of rape accusations are false, and motivated by the need for an alibi or excuse, revenge, or to gain attention or sympathy.[51] One source claims that "studies show that only 2 percent of rape reports are false, the same rate that is usual for other kinds of

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[49] Mic Hunter, *Honor Betrayed: Sexual Abuse in America's Military* (Fort Lee, NJ: Barricade Books, 2007), 19.

[50]Margret E. Bell and Annemarie Reardon, "Experiences Of Sexual Harassment And Sexual Assault In The Military Among OEF/OIF Veterans: Implications For Health Care Providers," *Social Work in Health Care* 50, no. 1 (2011): 40.

[51] E. Kanin, "False Rape Allegations," *Archives of Sexual Behavior 23,* no. 1 (1994): 81.

felonies."[52] This is reported widely, while other sources cite a false report rate of up to 5.8 percent. In one article, a physician noted that "the credibility of the parties involved is of major importance."[53] Factors lending credibility which were listed included age, previous sexual inexperience, emotional stability, and corroboration by witnesses. Male survivors face additional obstacles stemming from a number of myths aptly summarized by Jessica Turchik and Katie Edwards in "Myths about Male Rape: A Literature Review." A number of male rape myths are listed, including "(a) men cannot be raped, (b) 'real' men can defend themselves against rape, (c) only gay men are victims/perpetrators of rape, (d) men are not affected by rape, (e) a woman cannot sexually assault a man, (f) male rape only happens in prisons, (g) sexual assault by someone of the same sex causes homosexuality, (h) homosexual and bisexual individuals deserve to be sexually assaulted because they are immoral and deviant, and (i) if a victim physically responds to an assault he must have wanted it."[54] The fact that while the vast majority of rape accusations are true, but that those in law enforcement and the legal system tend to disbelieve first and verify later, is demoralizing to survivors, to say the least. Dealing with disbelief, prejudice, and animosity from those who should be supportive may be extremely destructive to the survivor. When a survivor's disclosure of sexual assault is disbelieved or ignored, the recovery process can be severely impeded. By contrast, a nurturing response facilitates healing and validation.

In military contexts, those who seek help are often made to feel as if the assault was their fault or that they deserved it. They may also be accused of seeking some sort of advantage, such

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[52] Mary D. Pellauer, *Sexual Assault and Abuse: A Handbook for Clergy and Religious Professionals* (San Francisco, CA: Harper San Francisco, 1987), 5.

[53] Charles R. Hayman, "Sexual Assaults on Women and Girls," *Annals of Internal Medicine*, (February, 1970): 278.

[54] Jessica A. Turchik and Katie M. Edwards, "Myths about Male Rape: A Literature Review," *Psychology of Men & Masculinity* 13, no. 2 (2012): 211–212.

as promotion or lighter duty and may be told to "learn their lesson" and not to continue to "cause trouble." These and other difficulties faced by survivors of MST were detailed in an article by Campbell and Raja, wherein, among other aspects, secondary victimization was discussed as a major factor leading to post-traumatic stress symptomatology.[55] Victoria Langston, Matthew Gould and Neil Greenberg further discussed the unwritten rules of the military culture that are basically understood and followed, together with examining the stigma associated with seeking medical care in the military.[56] An interesting observation is that "the level of stress felt by personnel is reflected by the nation's attitudes toward the military as well as unit morale."[57] This was also shown in the aftermath of the Vietnam Conflict when soldiers were abused upon their return to the US, leading to such a spate of PTSD that it became the defining event in recognizing and developing treatment for the disorder. As the authors put it, "Western culture has become more accepting and less stigmatic of mental health problems in recent years; however, many aspects of the military life remain potentially 'prostigmatic'."[58] This negative treatment of those seeking assistance for MST leads to a lack of trust and a tendency to avoid programs intended to assist them, which would suggest the necessity of intentionality recruiting those who are in evidentiary need of the intervention.

Another example of secondary traumatization was discussed by Kappleman,[59] with the essence of the article summed up in one citation, "When veterans develop PTSD caused by a

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[55] Rebecca Campbell and Sheela Raja, "The Sexual Assault and Secondary Victimization of Female Veterans: Help-Seeking Experiences with Military and Civilian Social Systems," *Psychology of Women Quarterly* 29, (2005): 97.

[56] Victoria Langston, Matthew Gould and Neil Greenberg, "Culture: What Is Its Effect on Stress in the Military?" *Military Medicine*, 172, no. 9 (2007): 932.

[57] Ibid. 932.

[58] Ibid. 932.

[59] Ben Desmond Kappelman, "When Rape Isn't Like Combat: The Disparity between Combat Veterans and Victims of Military Sexual Assault in Seeking Benefits for Post-Traumatic Stress Disorder," *Suffolk University Law Review* 44, (May 2011): 546.

sexual assault as a result of their military service, they are entitled to disability compensation. The current regulatory framework imposes a higher evidentiary burden on those veterans seeking compensation for PTSD because of sexual assault than on those seeking compensation for PTSD caused by exposure to combat."[60] Basically, the MST must be confirmed by outside sources while the veteran's lay testimony is sufficient for confirmation of combat-related PTSD. This is a double standard, if you will, by the VA Administration. One study showed that Veterans Health Administration's outpatient satisfaction was lower among MST survivors than among other veterans, specifically the coordination and provider–patient communication.[61] Schingle also examines the way that current VA regulations punish the female who tries to obtain help as a result of MST.[62] The VA's program was characterized as making the process for seeking help via first filing for, then obtaining benefits, and then getting an appointment as complicated, long and daunting. Schingle stated, "In theory every veteran has the same burden of proof to establish entitlement to service connection, in reality the circumstances of combat and military sexual trauma make these types of claims more difficult for female veterans to prove."[63] Written from a legal rather than a counseling perspective, the article nevertheless provides solid insights into why veterans might be in our churches without having received the help they need to deal with their MST.

When seeking to gain understanding about sexual trauma in preparation for preparing a church-based intervention program, it is also necessary to consider Biblical perspectives on

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[60] Kappelman, 546.

[61] Rachel Kimerling et al., "Military Sexual Trauma And Patient Perceptions Of Veteran Health Administration Health Care Quality." *Women's Health Issues* 21, no. 4 (2011): 147.

[62] Jennifer C. Schingle, "A Disparate Impact on Female Veterans: The Unintended Consequences of VA Regulations Governing the Burdens of Proof for Post-Traumatic Stress Disorder Due to Combat and Military Sexual Trauma" *William & Mary Journal Of Women And The Law* 16, no. 1 (June 1, 2009): 157, accessed June 24, 2011, http://dx.doi.org/10.2139/ssrn.1431600

[63] Ibid., 3.

sexual assault and the resulting trauma. Joy Schroeder explored the Bible's treatment of sexual violence by examining the scriptures and various cultural aspects that are tangential, such as how people at different times have viewed the verses through the lens of their art and homegrown perception.[64] Although somewhat less useful than first anticipated, this book still provides a valuable theological perspective on sexual assault and related issues, including stigmatization, which few other books address.

Following the rape of Dinah by a prince, her father waited until his sons came home and then told them the situation.[65] Since they were outnumbered, they lied and tricked the men of the area into becoming indisposed, whereupon they committed an act of mass murder. It is possible that Dinah felt badly about being responsible in a sense for the deaths of so many men. At the very least, it is a case of abuse of power with terrible consequences and emotional distress sure to follow. Another example of abuse of power is the account of Joseph and Potiphar's wife, which described a bored and lustful rich woman seeing a good-looking young man and trying to have her way with him. Joseph refused and she framed him and had him put into prison.[66] This story serves as an important reminder that the perpetrators are not always male and the survivors are not always women.

The Bible also includes accounts of men failing to fulfill their duty to protect and serve. In Genesis 26, Isaac lied and said that Rebecca was his sister.[67] Afraid that they might kill him to get her, he did not defend and protect his wife as a husband should, but instead put her in a very risky position and set her up to be sexually assaulted in order to save himself. Very often, when a

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[64] Joy A. Schroeder, *Dinah's Lament: The Biblical Legacy of Sexual Violence in Christian Interpretation.* (Minneapolis, MN: Fortress Press, 2007): 191.

[65] Gn 34:1–5.

[66] Gn 39:6–20.

[67] Gn 26:6–10.

man does not act towards his wife as God intended, she is endangered and also made to feel less important or cared for. This often leads to unfaithfulness or assault. Failure to fulfill his duty and abuse of power were also the underlying causes of King David's inappropriate actions towards Bathsheba and her husband Uriah.[68] Instead of doing his job, David lazed around the palace and turned voyeur by watching a pretty girl take a bath. He used his position to have her come to the palace, had sex with her and sent her off. She became pregnant and the verses that follow speak about the lengths he went to in covering up his sin, even murder. The primary point here is David's abuse of his position to get what he wanted. The power differential between David and Bathsheba was huge, not unlike that of officers and enlisted in the military.

Effects of Sexual Trauma

While the literature on the effects of sexual assault is too vast for a comprehensive review in this context, a brief overview of the short-term and long-term effects is appropriate in order to provide a backdrop for the program proposed herein and to equip those involved in the intervention to serve survivors effectively.

Short-term Effects

The short-term effects may be best understood as stages that survivors experience. In their classic work, Burgess and Holmstrom proposed four stages of "Rape Trauma Syndrome," i.e. acute, underground, reorganization, and development stages.[69]

Most obviously, the acute stage involves physical reactions, including flu-like symptoms, soreness, and aching, especially in specific areas that were abused or targeted by the assailant. Additional effects include disorganized sleep patterns, nightmares, decreased appetite, and nausea. Other immediate post-trauma physical effects include problems described by health

[68] 2 Sm 11:1–17.

[69] A. W. Burgess and L. L. Holmstrom, "Rape Trauma Syndrome," *American Journal of Psychiatry* 131, no. 9 (1974): 982-983.

experts as painful intercourse, urinary infections, uterine fibroids, and sexually transmitted diseases.[70] In addition, survivors also experience emotional and behavioral reactions in the acute stage. Following an assault to the very essence of the survivor, the first emotions to be confronted are shock and disbelief. Added to this is self-blame and feelings of guilt, together with shame, second guessing, fear of future assaults, fear for loved ones, a need to cleanse oneself (often by taking long showers while scrubbing the skin), anger with the attacker, anger with God for not preventing the assault, and anger with oneself for allowing it to happen. The emotions during this stage are "all over the place," with a pendulum swing between extremes often occurring.

The underground stage is characterized by avoidance, as survivors attempt to return to their lives and block out any thoughts of the assault. Difficulty concentrating and feelings of depression may result, since the emotional issues remain unresolved**.** At times, survivors will move away, change or give up previously enjoyable activities, and isolate themselves.

The reorganization often begins with a return to emotional turmoil, usually triggered by an assault-related event such as meeting the assailant, having a flashback, getting a subpoena, etc. It can be extremely frightening for survivors to have fear resurface, and nightmares, eating- and sleeping disturbances return. Violent fantasies of revenge may also arise, and survivors may experience an overwhelming sense of vulnerability, particularly if the assault was random and the assailant a stranger.

During the development phase, the survivor assigns meaning to the assault—a process that is highly dependent upon his/her developmental stage, socio-cultural background, and the context in which the assault took place. A child may place less emphasis on the sexual context of

[70] Effects of Rape, Healthy Place.com. Accessed December 21, 2014, http://www.healthyplace.com/abuse/rape/effects-of-rape-psychological-and-physical-effects-of-rape/#story

the assault and more on the harm and betrayal, while an adolescent or an adult may find issues of sexuality to be the most difficult part of the recovery. Depending on the survivor's age and particular circumstances, issues of trust, power, control, and independence may play a greater or lesser part. Another key factor during the development stage is the reactions of family, friends, and institutions and their level of support in the recovery process.

Long-term Effects

Not surprisingly, there are also numerous long-term effects of sexual trauma. In general, these are less pronounced or less likely to occur in cases where survivors have been able to effectively cope with the trauma, with or without the assistance of a counselor or therapist, and have experienced the stages of trauma discussed above. The long-term effects are ones most likely to be encountered within the context of a program such as the one proposed herein. This section will begin with a brief discussion of cognitive effects, followed by posttraumatic stress disorder (PTSD) and other affective, or emotional, effects. Next, various addictive and obsessive behavioral outcomes will be reviewed along with somatic, or physiological, effects. Interpersonal consequences will be discussed with particular attention to sexual revictimization. Finally, spiritual effects of MST will be discussed from a biblical perspective.

The most common cognitive effects of sexual trauma are self-blame,[71] a low self-esteem,[72] memory problems,[73] inability to concentrate, obsessive thoughts, paranoia, and suicidal

[71] Patricia A. Frazier, "The Role of Attributions and Perceived Control in Recovery from Rape," *Journal of Personal and Interpersonal Loss* 5 (2000): 205.

[72] Mary P. Koss, Aurelio José Figueredo, and Ronald J. Prince, "Cognitive Mediation of Rape's Mental, Physical, and Social Health Impact: Tests of Four Models in Cross-Sectional Data," *Journal of Consulting and Clinical Psychology* 70, no. 4 (2002): 927.

[73] Barbara Krahé, "Repression and Coping with the Threat of Rape," *European Journal of Personality* 13 (1999): 17.

ideation.[74] Survivors may also have flashbacks, or vivid memories, of the assault and may, in severe cases, develop dissociative identity disorder.

The link between sexual assault and PTSD is extremely well-documented. One study that compared rates of PTSD in female veterans who had experienced MST with rates of PTSD in women veterans who had suffered other types of trauma reported that 92 percent had symptoms of at least one trauma. Sixty percent of those who had experienced MST had PTSD and MST emerged as a stronger predictor of PTSD than other types of trauma.[75] The personalized invasion of an individual's intimate self opens them up for the development of PTSD, the symptoms of which are varied and serious and typically include feelings of helplessness, hopelessness, anxiety, anger, and depression. Wells, cited earlier, enumerates reactions to MST, including PTSD symptoms.[76] In essence, when an event of this magnitude occurs and the individual's previous coping skills are not sufficient, crisis emerges. When the crisis is not resolved within a period of several months after the traumatic event, the ensuing symptoms are categorized as PTSD. Sexually motivated violence, together with pre-existing anxiety disorders, have been linked to higher prevalence of PTSD.[77]

In military contexts, the only precipitating event that has a greater likelihood of causing PTSD than MST is serving on the frontline in a combat situation. Sexual assault during military service is also more damaging than sexual assault either before or after military service, according to a study by Naomi Himmelfarb, Deborah Yaeger, and Jim Mintz, in which it is

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[74] Terri L. Weaver et al., "Mediators of Suicidal Ideation within a Sheltered Sample of Raped and Battered Women," *Health Care for Women International* 28 (2007): 479.

[75] Deborah Naomi Yaeger, Alison Himmelfarb, and Jim Mintz Cammack, "DSM-IV Diagnosed Posttraumatic Stress Disorder in Women Veterans with and without Military Sexual Trauma," *Journal of General Internal Medicine* 21, (2006): 68.

[76] Wells, 28-29.

[77] Ulfert Hapke et al., "Post Traumatic Stress Disorder: The Role of Trauma, Pre-Existing Psychiatric Disorders, and Gender," *European Archives of Psychiatry and Clinical Neuroscience* 256, no. 5 (2006): 299-306.

suggested that various military factors exacerbate the effects of such assaults.[78] These include betrayal by those one trusted, incestuous aspects stemming from the closeness of those involved, lack of assistance, responses of disbelief, and marginalization. The main differences between incest and other forms of rape are that the abuse is often going on during an extended period of time, the victim is in a position of dependence and powerlessness, and the resulting trauma stems largely from the betrayal of trust.[79] Incest, along with acquaintance rape,[80] is considered one of the most devastating forms of sexual abuse with survivors often presenting a complex range of symptoms.[81]

The extent to which MST survivors develop PTSD, and the manner in which PTSD symptoms are managed vary based on gender and ethnicity, suggesting that demographics need to be considered when establishing a church-based intervention program. Women with MST-induced PTSD are more prone to develop eating disorders, anxiety issues, and depression, while men are more likely to self-medicate and develop some form of substance abuse disorder.[82] Examining the area of sexual trauma and the anticipated outcome of PTSD through a lens of ethnicity, Julia Floyd Jones noted greater levels of strength and resilience among women who choose a military career than among those in the general population.[83]

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[78] Naomi Himmelfarb, Deborah Yaeger, and Jim Mintz. "Posttraumatic Stress Disorder In Female Veterans With Military And Civilian Sexual Trauma." *Journal of Traumatic Stress* 19, no. 6 (2006): 837-846.

[79] Christine A. Courtois, *Healing the Incest Wound: Adult Survivors in Therapy,* 2nd ed. (New York, NY: W. W. Norton & Co., 2010): 26-30.

[80] Sandra L. French, "Reflections on Healing: Framing Strategies Utilized by Acquaintance Rape Survivors," *Journal of Applied Communication Research* 31, no. 4 (2003): 299-300.

[81] Kelli Beveridge and Monit Cheung, "A Spiritual Framework in Incest Survivor's Treatment," *Journal of Child Sexual Abuse* 13, no. 2 (2004): 106.

[82] Shira Maguen et al., "Gender Differences In Military Sexual Trauma and Mental Health Diagnoses Among Iraq and Afghanistan Veterans with Posttraumatic Stress Disorder," *Women's Health Issues* 22, no. 1 (Jan-Feb 2012): 61-66,accessed June 22, 2013. http://dx.doi.org/10.1016/j.whi.2011.07.010.

[83]Julia Floyd Jones, "The Relationship among Sexual Abuse, Ethnicity and Posttraumatic Stress Disorder in Female Veterans" (PhD diss., Texas Women's University, 2002).

Survivors of MST may suffer long-term emotional effects that are also symptoms of PTSD without necessarily having the disorder. In fact, some argue that many components of the complex responses to male violence—including the cognitive, social, sexual, physical, and spiritual effects reviewed in this chapter—fall outside the PTSD paradigm.[84] As far as affective responses, guilt and shame are the two prominent emotions following sexual abuse. Humiliation, anger, hostility, anxiety, and numbness are additional common affective responses. Numerous studies have also established that there is a link between sexual abuse and depression. An area which must not be ignored or taken lightly is depression, which is linked to self-harm and suicide.[85]

In examining the behavioral coping strategies of women veterans who had experienced combat stress and MST, Kristin Mattocks and colleagues classified the reactions into three categories.[86] The first, behavioral avoidance, involved replacing stressful feelings with individually chosen replacement actions. Most common were prescription drug abuse, over-exercising, compulsive spending and binge eating. The second method utilized was termed cognitive avoidance, and was basically characterized by isolation and withdrawal from others. Unfortunately, behaviors in isolation often included substance abuse and overeating, in addition to shopping. The third coping strategy, which was labeled behavioral approach, was the only one that included behaviors that were constructive in nature, such as exercise and usage of VA counseling resources.

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[84] Mary P. Koss et al., "Depression and PTSD in Survivors of Male Violence: Research and Training Initiatives to Facilitate Recovery," *Psychology of Women Quarterly* 27 (2003): 135.

[85] Gemma L. Gladstone et al., "Implications of Childhood Trauma for Depressed Women: An Analysis of Pathways from Childhood Sexual Abuse to Deliberate Self-Harm and Revictimization," *American Journal of Psychiatry* 161, no. 8 (2004): 1417.

[86] Kristin M. Mattocks et al., Women at War: Understanding How Women Veterans Cope with Combat and Military Sexual Trauma," *Social Science and Medicine* 74, (2012): 537-545.

The tendency to employ various "crutches" to cope with the effects of trauma is well-known in the counseling community and such negative coping behaviors are well-documented in the literature. Eating disorders include overeating, binge eating, anorexia nervosa, and bulimia. A large body of research has confirmed the relationship between childhood sexual abuse and binge eating[87] and bulimia, in particular.[88]

Various types of chemical dependency have been shown to be prevalent in survivors of sexual abuse as well.[89]A number of studies focus on the abuse of alcohol, in particular, by survivors of sexual abuse.[90] Survivors very often will seek refuge in alcohol rather than confronting the issues directly.[91] Alcohol, as is the case with other substances regularly abused, tends to dull awareness and memory, seeming to make life more bearable. The obvious reason for the use of alcohol in this fashion is its easy availability, low price and high level of social acceptance. This is particularly true in military contexts, where alcohol consumption abounds at all levels.

Fewer studies have been conducted about the use of illegal substances to cope with sexual trauma. One major study involving 1500 women, established a relationship between childhood sexual abuse and cocaine use.[92] Similar results were found when populations of

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[87] Erin L. Rowe et al., "Military Sexual Trauma in Treatment-Seeking Women Veterans," *Military Psychology* 21, (2009): 388.

[88] Karen A. Beckman and Leonard Burns, "Relation of Sexual Abuse and Bulimia in College Women," *International Journal of Eating Disorders* 9, no. 5 (1990): 487..

[89] Patricia A. Harrison, Jayne, M. Fulkerson and Timothy J. Beebe, "Multiple Substance Use among Adolescent Physical and Sexual Abuse Victims," *Child Abuse & Neglect* 21, no. 6 (1997): 536.

[90] Helen A. Bergen et al.," Sexual Abuse, Antisocial Behavior and Substance Abuse: Gender Differences in Young Community Adolescents," *Australian and New Zealand Journal of Psychiatry* 38 (2004).

[91] S. Pirard et al., "Prevalence of Physical and Sexual Abuse among Substance Abuse Patients and Impact of Treatment Outcomes," *Drug & Alcohol Dependence* 78, no. 1 (2005).

[92] Robert C. Freeman, Karyn Collier, and Kathleen M. Parillo, "Early Life Sexual Abuse as a Risk Factor for Crack Cocaine Use in a Sample of Community-Recruited Women at High Risk for Illicit Drug Use," *American Journal of Drug & Alcohol Abuse* 28, no. 1 (2002).

incarcerated women[93] and pregnant teenagers[94] were examined. Other studies have linked sexual abuse to injection drug use,[95] and risky, self-destructive behavior such as sharing needles during injection drug use.[96] The question arises whether survivors use illegal drugs, in part, to identify with those who exist at the margins of society because they feel that they don't belong with "normal" people. Although no known study has examined the link between MST and illegal drug use, there seems to be a direct relationship between being a survivor of sexual abuse and engaging in risky behaviors of various kinds.

As noted above, MST survivors may withdraw from relationships and seek isolation. They may also have a difficult time trusting others and experience other interpersonal problems, even in everyday social situations. The link between childhood sexual abuse problems with sexual intimacy and sexual dysfunction has been thoroughly documented in a number of articles,[97] one of which states that "sexual victimization in childhood or adolescence increases the likelihood of sexual victimization in adulthood between 2 and 13.7 times.[98]

While less documented, it is not far-fetched to assume that similar effects are experienced by adult survivors of rape or MST, specifically. Rebecca Campbell, Tracy Sefl, and Courtney Ahrens examined the effect of rape on women's post-incident sexual behavior, noting that all of

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[93] Nabila El-Bassel and Louisa Gilbert, "Correlates of Crack Abuse Among Drug-Using Incarcerated Women: Psychological Trauma, Social Support, and Coping Behavior," *American Journal of Drug & Alcohol Abuse* 22, no. 1 (1996).

[94] J. M. Smith, "Physical and Sexual Abuse as Predictors of Substance Use and Suicide among Pregnant Teenagers," *JAMA: Journal of the American Medical Association* 267, no. 23 (1992).

[95] Danielle C. Ompad et al., "Childhood Sexual Abuse and Age at Initiation of Injection Drug Use," *American Journal of Public Health* 95, no. 4 (2005).

[96] Hugh Klein and Betty S. Chao, "Sexual Abuse During Childhood and Adolescence as Predictors of HIV-Related Sexual Risk During," *Violence Against Women* 1, no. 1 (1995).

[97] Wendy Maltz, "Treating the Sexual Intimacy Concerns of Sexually Abused Survivors," *Contemporary Sexuality* 37, no 7 (2003).

[98] K. Lalor and R. McElvaney, "Child Sexual Abuse, Links To Later Sexual Exploitation/High-Risk Sexual Behavior, And Prevention/Treatment Programs," *Trauma, Violence, & Abuse,* 11, (2010): 159-177, accessed September 27th, 2012, doi:10.1177/1524838010378299

the women were affected by the assault, with their attitudes toward sexual intimacy being deemed low, moderate or high risk.[99]

Unknown to many, there is the likelihood that up to two out of three people who have been victimized sexually will later be re-victimized. Sexual revictimization refers to the heightened vulnerability of individuals who have suffered sexual abuse to be re-victimized or experience sexual assaults again disproportionately when compared to the general population. Reasons for this include a tendency toward risk-taking behavior, discussed above, a subconscious need to re-enact the incident, or possible spiritual factors. It is plausible that the predator senses something about the victim or perceives visual cues that cause the selection of the survivor over others. Researchers have reported a variety of factors that explain this link, including low self-esteem, a lack of assertiveness, PTSD, self-blame, trading sex[100] and other consensual sexual activity.[101] Janyce Vick addressed several of these mediating variables, and applied the revictimization aspect to female victims of MST, making this an extremely useful study[102] The link between childhood sexual abuse and MST has been reported by others as well.[103] In being aware of the revictimization aspect, a church-based intervention program may be tailored to reduce the likelihood of this occurrence.

For the purpose of this project, focus is placed on revictimization as a possible effect of MST; however, it needs to also be considered a possible cause of MST for obvious reasons.

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[99] Rebecca Campbell, Tracy Sefl, and Courtney Ahrens, "The Impact of Rape on Women's Sexual Health Risk Behaviors," *Health Psychology* 23, no. 1 (Jan. 2004): 67-74.

[100] Jennifer L. Strauss et al., "Is Military Sexual Trauma Associated with Trading Sex among Women Veterans Seeking Outpatient Mental Health Care?" *Journal of Trauma and Dissociation* 12, no. 3 (2011).

[101] Catalina N. Arata, "Child Sexual Abuse and Revictimization,"*Clinical Psychology: Science and Priactice,* 9, no 2 (2002).

[102]Janyce Vick, "Sexual Revictimization: A Clinical Dissertation" (PhD diss., Antioch University Seattle, 2008).

[103] Michelle Burke Milonas, "The Cycle of Abuse: The Relationship between the Types and Frequencies of Childhood Abuse and Military Sexual Trauma" (PhD diss., University of New Orleans, 2004).

As mentioned above, numerous studies have shown that women who were victims of sexual abuse when they were young are victimized as adults at roughly twice the rate as those who were not previously assaulted. An excellent major text on the subject speaks of increased rates of rape, sexual risks such as multiple sex partners or commercial sex work, as well as physical assault and crime victimization.[104]

As mentioned earlier, the incident rate of risk-taking behaviors is higher among survivors of sexual trauma, and this includes risky sexual behaviors. A variety of studies have shown that survivors are more likely to have unprotected intercourse, experience unwanted pregnancies, and to have had a greater number of sexual partners than the general population. One study showed that individuals who had undergone childhood sexual contact were more sexually active during both adolescence and adulthood.[105] Although current trends in society—including military contexts—unfortunately tend to minimize sexual purity, several factors must be mentioned regarding the effects of sexual promiscuity and pregnancy on survivors, including a host of health risks and issues related to abortions, adoptions, single parenthood, and premature marriages.

It is a given that when discussing consequences of long-term behavioral and interpersonal effects of MST,[106] physiological effects must be considered as well.[107] Street, Stafford, Mahan

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[104] Linda J. Koenig et al., *From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization, and Intervention* (Washington D. C.: American Psychological Association, 2004).

[105] Christopher R. Browning and Edward O. Laumann, "Trauma or Transition: A Life Course Perspective on the Long-term Effects of Adult-Child Sexual Contact for Girls," (paper presented at the Population Association of America, New Orleans, Louisiana, May, 1996).

[106] Ursula A. Kelly et al., "More Than Military Sexual Trauma: Interpersonal Violence, PTSD, and Mental Health in Women Veterans," *Research in Nursing & Health* 34, (2011).

[107] Rebecca Campbell, Tracy Sefl, and Courtney Ahrens, "The Physical Health Consequences of Rape: Assessing Survivors' Somatic Symptoms in a Racially Diverse Population," *Women's Studies Quarterly* 31, no. 1/2 (Spring 2003): 90-104.

and Hendricks's study,[108] cited earlier, showed that those who had been sexually harassed or assaulted in the military reported poorer health than their non-abused counterparts even ten years after their time in the service. In setting up the parameters for a church-based program, this finding suggests that it is important to pay attention to somatic complaints among survivors, including sexually transmitted diseases[109] and sleep disorders.[110] Also, in her article "Family Issues Associated With Military Deployment, Family Violence, and Military Sexual Trauma,"[111] Cira Fraser addressed several issues associated with MST, including obesity, weight loss, and hypothyroidism.

Lastly, and arguably most importantly when gaining understanding about the long-term effects of MST in preparation for setting up a church-based intervention program, spiritual factors must be addressed. First and foremost, the effects of MST on the survivor's view of God and ability to receive freely from Him must be considered.[112] Research has found that 53 percent of women who were sexually traumatized when they were young left their former religion.[113] The survivor often loses their belief that one is rewarded according to their actions, what is sometimes referred to as the "Just World Hypothesis." Stephanie Nowacki-Butzen poses the question, "What is God, what am I, and how do we relate?"[114] This question is critical for

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[108] Street et al., "Sexual Harassment," 409 - 420.

[109] Jessica A. Turchik et al., "Sexually Transmitted Infections," 46.

[110] Molly L. Paras et al., "Sexual Abuse and Lifetime Diagnosis of Somatic Disorders: A Systematic Review and Meta-analysis," *Journal of the American Medical Association* 32, no. 5 (2009).

[111] Cira Fraser, "Family Issues Associated with Military Deployment, Family Violence, and Military Sexual Trauma," *Nursing Clinics of North America* 46, no. 4 (Dec. 2011): 445-455, accessed September 27th, 2012. http://dx.doi.org/10.1016/j.cnur.2011.08.011.

[112] Carol Jaynes Byrd, "Reclaiming Souls: A Look at the Imagery of God of Women Survivors of Sexual Abuse" (DMin diss, Columbia Theological Seminary, 2002).

[113] Carolyn Holderread Heggen, *Sexual Abuse in Christian Homes and Churches* (Scottsdale, PA.: Herald Press, 1993): 44.

[114]Stephanie K Nowacki-Butzen, "God Image, Self-Concept, and Attachment to God in Female Survivors of Sexual Trauma." (PsyD diss., Regent University, 2009).

understanding the nature of survivors seeking posttraumatic counseling. The author suggested that if they are hostile toward God, they are unlikely to be good candidates for a group intervention in a Christian setting. On the other hand, if they feel thankful towards God for getting them through the trauma, they may be helpful in assisting others in the group to face the effects of their trauma in a constructive way. One group of researchers[115] were surprised to learn that while experiences of child sexual abuse among adult men were, as expected, associated with alienation from religion and God and spiritual hurt, the abuse was also correlated with increased frequencies of prayer and spiritual experiences. Similarly, another study found that while spirituality did not moderate the probability of sexual trauma, increased spiritual well-being was associated with lower psychopathology.[116]

From a spiritual perspective, sexual promiscuity and impurity, which tend to follow sexual trauma, impact many other factors that Christians believe play a major part in the destruction of society, the family and the individual. Intended for something better, mankind pays a heavy price for their insistence on sexual "freedom." Genesis 16:1-4 describes how Sarai, having lost faith in God, abandoned her role in the marriage and solicited the help of her maid as a surrogate in order to have a child. This led to the maid rightfully despising her and eventually to the entire Middle East conflict that is occurring today. The story shows how the abandoning of marriage roles may lead to issues that may grow beyond one's expectations. One of the ingredients in Christian counseling of any married individual when sexual aspects are in play is to emphasize the divinely ordained order. The Scripture, "Therefore, to one who knows the right thing to do and does not do it, to him it is sin," is a reminder that each individual is responsible for what

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

[116] Mark J. Krejci et al., "Sexual Trauma, Spirituality, and Psychopathology," *Journal of Child Sexual Abuse* 13, no. 2 (2004).

he/she has control over and that deliberately choosing a wrong course of action destroys that person. It is what we do, not what is done to us, that leads to sin.[117]

Arguably the most vivid Biblical account of the effects of sexual assault is that of Amnon and Tamar, in which several things are seen.[118] The lust of Amnon for his sister led to collusion with a friend, lying to King David, deception to get Tamar into his bedroom, forcible rape, hatred for the victim, compounded issues resulting from Amnon humiliating her by tossing her out, her trauma, and the stigmatization causing her to spend the rest of her days hiding away in her brother Absalom's house. The story is a graphic example of the driving force of lust and the crushing effects on the victim. As such, it serves as a sobering reminder of the need for a church-based intervention program, if for no other reason than to keep the Tamars of the world from retreating from everything in life.

Trauma Intervention and Treatment

The following is a selected, annotated review of the literature deemed especially appropriate for preparing a church-based intervention program for MST survivors. The review of academic literature is followed by a review of pertinent scriptures that will serve as guidelines to ensure that the proposed program is Biblically based.

While not intended to deal with MST exclusively, "*Living and Surviving in Harm's Way: A Psychological Treatment Handbook for Pre- and Post-Deployment of Military Personnel*"[119] by Sharon Morgillo Freeman, Bret Moore and Arthur Freeman is an excellent book on the treatment of a variety of issues that occur in pre- and post- deployment situations. There is some coverage of sexual assault, together with family issues, suicide, substance abuse, grief and loss

[117] Jas 4:17.

[118] 2 Sm 13:1–22.

[119] Sharon Morgillo Freeman, Bret A. Moore, and Arthur Freeman, *Living and Surviving in Harm's Way: A Psychological Treatment Handbook for Pre- and Post-Deployment of Military Personnel* (New York, NY: Routledge, 2009).

and much more. Everything is directly related to the soldier and their family, and no punches are pulled in describing the life they face. This is an extremely valuable text for understanding the military mystique and the various issues that are endemic to the military life, as well as a useful guide to treatment options. Another text that will be incorporated into the program discussed herein is T. S. Nelson's "*For Love of Country: Confronting Rape and Sexual Harassment in the U. S. Military*."[120] Although written from both a military and an academic perspective, it uses a primarily academic approach to cover the topic thoroughly. This is arguably the best treatment of this issue available.

In terms of treating trauma, the best text in this author's opinion is John Briere and Catherine Scott's "Principles of Trauma Therapy."[121] Together with an understanding of the effects of trauma with a military tie-in, this text will provide a theoretical basis for the program. To supplement, one of the best books available for understanding the issues involved in prevention and treatment of sexual trauma, specifically, is "The Trauma of Sexual Assault: Treatment, Prevention and Practice"[122] edited by Jenny Petrak and Barbara Hedge. Although not written from a Christian perspective, it is nonetheless a treasure of information, especially for a pastor or lay counselor interested in going deeper into understanding the levels of distress that a sexual assault may cause, and how to assist survivors. This text is not a "how-to" guide for treatment, but is extremely useful in a variety of ways in establishing a counseling program involving ministerial staff. Offering a different approach, "The Sexual Abuse Victim and Sexual

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[120] T. S. Nelson, *For Love of Country: Confronting Rape and Sexual Harassment in the U. S. Military* (Binghamton, NY: Haworth Maltreatment and Trauma Press, 2002).

[121] John N. Briere and Catherine Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment,* 2nd edition (Thousand Oaks, CA: Sage Publications, 2013).

[122] Jenny Petrak and Barbara Hedge, eds., *The Trauma of Sexual Assault: Treatment, Prevention and Practice* (New York, NY: John Wiley and Sons, 2002).

Offender Treatment Planner"[123] by Rita Budrionis and Arthur Jongsma is designed to assist the counselor in selecting what types of treatment to employ. Written much like a cookbook, suggestions are provided for between-session homework and in-session interventions that are useful to both the professional counselor and minister. Since many of the individuals involved in this ministry may have very little professional counseling training, this text provides ideas for helping survivors' progress.

The nature of relationships in the military, in most situations, more closely resembles those of family members, albeit dysfunctional, than those of colleagues in most other work settings involving non-related individuals. Working, eating, sleeping, fighting, and surviving together, the bonds to other service members for many, if not most, become familial. This helps explain why the effects of MST are particularly traumatizing. Since MST share characteristics with incest, it is appropriate to also draw upon literature on treating survivors of incest. "Healing the Incest Wound: Adult Survivors in Therapy" by Christine Courtois is arguably the broadest and most complete text available on this subject.[124] At nearly 750 pages, it provides an excellent reference text for those involved in counseling survivors. Another text on the same topic but with a different focus is "Ghosts in the Bedroom: A Guide for Partners of Incest Survivors" by Ken Graber.[125] This book addresses one of the more neglected areas of sexual trauma counseling, which is assisting the spouse. While they have not experienced the physical effects of the sexual assault, they have certainly been through the emotional aftereffects. Even if treatment of the survivor is successful, if the spouse and children are not also helped, there is a major danger of

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[123] Rita Budrionis and Arthur E. Jongsma, *The Sexual Abuse Victim and Sexual Offender Treatment Planner* (Hoboken, NJ: John Wiley & Sons, 2003).

[124] Christine A. Courtois, *Healing the Incest Wound: Adult Survivors in Therapy*, 2nd ed. (New York, NY: W. W. Norton & Co., 2010).

[125] Ken Graber, *Ghosts in the Bedroom: A Guide for Partners of Incest Survivors* (Deerfield Beach, FL: Health Communications, Inc., 1991).

relapse. Very specialized, this text is useful in reaching the "other victim," who is impacted by the life-changing events of the assault. Using the principles from Family Systems Theory, this book helps survivors as well as counselors understand that what happens to one member of a family affects them all.

A Christian treatment of the topic by Steven Tracy[126] emerges as an excellent text for understanding and dealing with effects of abuse. Unlike the majority of Christian texts on this issue, it does not condescend to or patronize the survivor as a victim or humbly portray Christian intervention as being at a lower level than mainstream professional intervention. Additionally, Gregory Peter Knapik's "*Being delivered*"[127] includes recovery case studies, both with and without the integration of a spiritualty factor. His research on the ways that individuals use spirituality to manage their responses to sexual violence is helpful for planning goals and methods for an MST intervention program.

Litchfield compiled evidence indicating that spiritual components frequently are incorporated into treatment programs, including her review of the literature on treating combat veterans for PTSD to determine if spirituality was included in the prescription.[128] The contents provide a good discussion of counseling intervention materials that emphasize spirituality. One example of successful integration of spiritual components was offered by Nichole Murray-Swank and Kenneth Pargament[129] who discussed a pilot program used by the authors to assist

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[126] Steven R. Tracy, *Mending the Soul: Understanding and Healing Abuse* (Grand Rapids, MI: Zondervan, 2005).

[127]Gregory Peter Knapik, "Being delivered: Spirituality in Survivors of Sexual Violence" (PhD diss., Kent State University, 2006).

[128]Elisa Marie Litchfield, "Spiritual Integration in the Treatment of Combat-related Posttraumatic Stress Disorder" (PsyD diss., Regent University, 2009).

[129] Nichole A. Murray-Swank and Kenneth I. Pargament, "God, Where Are You? Evaluating a Spiritually-Integrated Intervention for Sexual Abuse," *Mental Health, Religion & Culture 8, no. 3* (September 2005): 191–203.

victims of trauma framed as an "adjunct treatment for individuals in ongoing psychotherapy."[130] While not church-based or specific to Biblical spirituality, this study was nevertheless beneficial for the development of a church-based program. A number of studies have reported positive outcomes associated with such spiritual integration, such as reduced symptomology and posttraumatic growth.[131] Specifically, one qualitative researcher who examined the role of spirituality in posttraumatic growth, as identified by participants in a thirty-day intensive treatment program, reported beneficial outcomes in terms of experiencing communion with God, a connection with their inner self that promoted a sense of wholeness, and awareness of a spiritual presence or power.[132]

In reviewing the scriptures applicable to this topic, biblical perspectives on assisting survivors emerge along with principles to guide counselors. An excellent starting point is "But if out in the country a man happens to meet a girl pledged to be married and rapes her, only the man who has done this shall die. Do nothing to the girl; she has committed no sin deserving death."[133] This establishes the innocence of the victim as being a key to understanding the need for a counseling intervention. Those who have done no wrong are to be helped, and not punished. If they suffer from emotional pain, they need emotional aid. Arguably, the greatest verse providing a justification of counseling is, "Brethren, even if anyone is caught in any trespass, you who are spiritual, restore such a one in a spirit of gentleness; each one looking to

[130] Murray-Swank and Pargament, 193.

[131] Terry Lynn Gall, Viola Basque, and Marizete Damasceno-Scott, "Spirituality and the Current Adjustment of Adult Survivors of Childhood Sexual Abuse," *Journal for the Scientific Study of Religion* 46, no. 1 (2007).

[132] Sharon D. Baty, "Healing the Invisible Wound: Examining Spirituality in the Posttraumatic Growth of Sexual Trauma Survivors" (PhD diss., Northcentral University, 2012).

[133] Dt 22:25–26, NIV.

yourself, so that you too will not be tempted."[134] Those that are more spiritually aware help those who have erred. This reaching down to lift up and restore the fallen is the very essence of counseling. The final phrase also reminds that all are fallible and must guard against many temptations that lead one astray.

In his encounter with the woman caught in adultery, Jesus turns the tables and reminds his audience that they are sinners as well.[135] Caught "in flagrante delicto," the woman expects and deserves death, based on the laws at that time, at the hands of the crowd. Jesus extends mercy and pardons her to go on her way, with the only caveat being that she is to stop her sinful ways. When dealing with people who have been involved, perhaps even against their will, in something sexual in nature, it is easy to look down upon them as tarnished in some way, and to subconsciously feel that oneself is somehow of nobler stuff. The verse, "For all have sinned and fall short of the glory of God" serves as an important reminder that the counselor is in need of forgiveness along with everyone else.[136] Survivors need to be reassured that they are not lesser human beings because of what they went through; their trials were just different from those of others. Paul warns in his letter to the Galatians, "Do not be deceived, God is not mocked; for whatever a man sows, this he will also reap. For the one who sows to his own flesh will from the flesh reap corruption, but the one who sows to the Spirit will from the Spirit reap eternal life. Let us not lose heart in doing good, for in due time we will reap if we do not grow weary."[137] Each individual is responsible for his/her own actions, and is rewarded for what is done in His service. While counselors do not counsel to do good deeds, they should be aware that God sees and remembers all, and the good that is done without a selfish intent will be rewarded. The

[134] Gal 6:1.

[135] Jn 8:3–11.

[136] Rom 3:23.

[137] Gal 6:7–9.

importance of adding action to one's words is further stressed in the verse "But prove yourselves doers of the word, and not merely hearers who delude themselves. For if anyone is a hearer of the word and not a doer, he is like a man who looks at his natural face in a mirror; for once he has looked at himself and gone away, he has immediately forgotten what kind of person he was."[138]

Another pertinent counseling verse is "Bear one another's burdens, and thereby fulfill the law of Christ,"[139] which emphasize the stronger bearing the burdens of the weaker. Following MST, the broken need the help of the strong in order to right the ship that was faltering. "Where there is no guidance the people fall, but in abundance of counselors there is victory," according to the Proverbs.[140] If one wishes to creatively extrapolate, one might see in this the recommendation for collaboration and consultation in some trauma counseling settings. Two heads are better than one, especially if they are working together to help the client. The importance of the one who brings constructive help to one in need of the same cannot be overemphasized. The verse "But when I look, there is no one, and there is no counselor among them. Who, if I ask, can give an answer?" reinforces the importance of the counselor who gives a word in due season and advice to those hungry to receive.[141]

Isaiah prophesied, "For a child will be born to us, a son will be given to us; And the government will rest on His shoulders; And His name will be called Wonderful Counselor, Mighty God, Eternal Father, Prince of Peace."[142] Everything relates back to this verse. The hope that may be given through a counseling session is and must be in a church-based program

[138] Jas 1:22–24.

[139] Gal 6:2.

[140] Prv 11:14

[141] Is 41:28.

[142] Is 9:6.

anchored in the coming of One that restores the promise of a renewed relationship with the Creator. It is highly unlikely that it was merely happenstance that of all the possible expressions that could be used for the first name given to the Lord in this watershed verse was Wonderful Counselor. Finally, perhaps no verse is more special to this author than "Jesus wept."[143] Jesus comes to the grave of his good friend Lazarus and is overcome with emotion. He does not weep due to sadness, anger, fear, nervousness or anything else. In an act that sets the standard for counselors everywhere and in every time period, he sees the need and weeps out of love for a friend.

[143] Jn 11:35.

Chapter 3

Preparing for Intervention

Prior to launching a program to assist survivors of Military Sexual Trauma (MST), it is critical that the local church hosting the program carefully considers the context, staffing needs, admission process, and nature of running such a program. The most important factors that should be examined prior to any decision to initiate the program and the differences among professional, pastoral, and lay or non-licensed counseling are discussed in this chapter.

Factors to Consider Prior to Program Establishment

A program designed to assist MST survivors needs a foundation upon which it is established. There are a number of contextual factors to consider, including the theological and cultural orientation of the church that hosts the program. First, a congregation that is unaware of the concept of sin will not support a program designed to counteract the effects of sexual abuse and assault. During years of teaching and counseling in both secular and Christian environments, this author has on a number of occasions been asked why there is a need to counsel survivors of sexual abuse, since it is a normal part of life. The argument is made that sexual taboos are cultural and societal constructs and are relative to the circumstances. However, a church body that adheres to Biblical standards articulating what God says is right and wrong understands that there are absolutes and that everything is not relative. Without the support from the pulpit on the absolutes of sin and grace, there is little hope for a program of this nature to succeed, since the parishioners would not understand the involvement of sin in the assault and the need for grace in the response.

On a related note, comments such as “boys will be boys,” “men have needs,” “he’s just learning about right and wrong,” and “that will stop once he’s sown his wild oats” are sentiments coming from pastors who don’t wish to anger parishioners. These are highly problematic, and

contribute to the severity of the problem. To minimize the seriousness of sexual sin is to marginalize the value of survivors. It should never be "three strikes and you're out" in matters like these; rather, it must be "one and done" for individuals involved in leadership. In several instances, this author was informed that the offenders were too important to the church to discipline or remove from fellowship. Repeatedly, the comment was made, "we must forgive as Jesus did" when the correct act to enforce a Christ-like care for His people may be to take the whip and drive them from the Temple. There must not be any hesitation in protecting the Body of Christ. The offender can leave, get help, show over a prolonged period that this is no longer an issue and then return, with care taken as he/she proves himself/herself. While many may think this is harsh and unloving, is it not better to err on the side of helping the survivor than to err on the side of enabling the offender? In order for the church to be a safe haven for MST survivors, which is a critical prerequisite, there must be a policy of zero tolerance.[144] Also, whether assisting men, women, or both, only a church culture that is characterized by hope, empowerment, restoration, and healing—rather than pity, nonchalance, or condemnation—provides a context suitable for this program. Spiritual traditions that promote silence, based on a view that all expressions of anger are inappropriate, are also problematic for survivors who have been silenced and unable to give expression to their experiences.[145]

Along with clear, Bible-based presentations from the pulpit should be the availability of sound Christian psychoeducational materials that explain the effects and the treatments of sexual trauma. These should be made available in the same fashion as materials on giving and tithing, baptism and doctrine, and should not be hidden away in a corner because some people find the

[144] Jennifer Beste, "Recovery from Sexual Violence and Socially Mediated Dimensions of God's Grace: Implications for Christian Communities," *Studies in Christian Ethics* 18, no. 2 (2005): 104.

[145] Beth R. Crisp, "Spirituality and Sexual Abuse: Issues and Dilemmas for Survivors," *Theology & Sexuality* 13, no. 3 (2007): 305.

topic "disturbing." This is understandable, and people in church should be disturbed that it is occurring. These materials should include information from a biblical perspective, such as Scriptures and illustrations from biblical events; professional information describing the effects of sexual trauma and the importance of dealing with them constructively; and resources integrating the two. Materials that contain only one or the other will not be sufficient for this context.

Selecting Staff for the Program

Of critical importance is the selection of the individuals who will head up a counseling program hosted by a local church. In order to understand the rationale for the recommendations provided herein, the differences among professional counseling, pastoral counseling, and lay/non-licensed counseling, respectively, will briefly be discussed. Understanding the distinctions among these three groups is important, especially since Christian counselors can be found in all three categories.

Licensed professional counselors and clinicians undergo extensive training to be able to understand and treat their clients' mental health needs, but also to understand the nature of the counseling relationship, including transference and countertransference phenomena, the limits of their professional competence, and the importance of avoiding dual role conflicts. Continued education and adherence to professional codes of ethics are required for these professionals, who generally operate in formal settings with clear processes and referral procedures, while maintaining detailed documentation.

In contrast to professional counselors, pastoral counselors often operate in informal settings where they move among a multiplicity of roles with parishioners. One of the most crucial tasks for pastors is establishing relationships with congregational members and demonstrating genuine care and concern for their wellbeing. Unlike most professional

counselors, pastors typically counsel from the basis of ongoing, established relationships, and they also serve as a community resource for non-church members. Churches have an important role in providing assistance to people in their communities and respond to individuals, couples, and families who are seeking help to deal with problems in their relationships or crises caused by unexpected life events. In fact, clergy members are the most frequently sought-after expert—outranking medical and mental health professionals as well as social service agencies—for assisting with personal problems causing psychological distress, according to one study.[146]

In most cases, unless the church is large enough to support a pastor designated to do counseling, it is the senior pastor who will perform this task. At the same time, congregations place a high priority on the abilities of the senior pastor to lead and perform a wide range of other of ministerial tasks. Their core function as pastors is rooted in a spiritual discipline that is defined by their ordination and centered on the ministry of the Word of God and the sacraments.[147] The counseling practice, therefore, does not originate in scientifically grounded personality theories or psychotherapeutic treatment models. While it has long been assumed that all pastors have the counseling skills needed to assist community residents with all categories of personal or family problems, this has not been shown to be the case.[148] In fact, a study on counseling skills among the clergy reported that over 40 percent of pastors spend more than six hours a week in counseling, but the average pastor is not cognizant of basic counseling skills due

[146] H. Paul Chalfant et al., "The Clergy as a Resource for Those Encountering Psychological Distress," *Review of Religious Research* 31, no. 3 (1990): 309.

[147] Saundra D. Nelson Cherry, "The Development and Training of Christian Lay Leaders to Provide Pastoral Counseling for the Members of Living Waters Christian Fellowship in Newport News, Virginia" (DMin diss. Regent University, 2002).

[148] Craig Younce, "The Significance of Developing Core Counseling Competencies in Pastoral Care Ministry" (DMin thesis, Liberty Baptist Theological Seminary, 2012).

to most seminaries requiring few, if any, counseling-related courses.[149] The study showed that it is only after a three such classes that counseling performance increases significantly. The level of counseling training appears to be a major indicator of clergy's perceptions of their adequacy in carrying out counseling tasks, including caring for sexual abuse survivors.[150]

Historically, clergy and clinicians have not seen eye to eye, but rather, viewed the other's profession with suspicion. Clergy members have been found to underutilize counseling services because contemporary clinicians are less religious than the general public and pastors may have been concerned that counselors and psychologists who did not share their beliefs would minimize, discount, or even pathologize their religious views. A study of Virginia pastors' views of clinical counseling showed, however, that while most pastors believe that counseling is an important part of their ministry and enjoy counseling church members, they do not feel that they are adequately prepared to deal with many of the issues encountered when doing so.[151] Even though they generally agreed that counseling and psychology classes should be a part of the core curriculum for a degree in ministry, as such training helps them serve their members, the study also reported that the number of psychology, counseling, and pastoral counseling classes that a minister has completed is correlated with a positive attitude toward professional counseling and a likelihood to refer members who need it. Most pastors participating in this study—while reluctant to recommend members to seek counseling outside of Christian beliefs and perspectives—believed that Christians can be helped by non-Christian counselors for most

[149] Elisa J. Seibert, "Clergy Knowledge of Basic Counseling Skills: Helping and Brethren in Christ Pastors" (PhD diss., Gannon University, 2004).

[150] Lisa Rudolfsson and Inga Tidefors, "'Shepherd My Sheep': Clerical Readiness to Meet Psychological and Existential Needs from Victims of Sexual Abuse," *Pastoral Psychology* 58 (2009).

[151] Clay E. Peters, "Religion and Mental Health: What are Virginia Ministers' Perceptions of Counseling and Psychology?" (EdD diss., University of Sarasota, 1999).

difficulties and tended to disagree with the notion that Christians should only seek counseling from a pastor or a Christian counselor.

The third category of counseling practitioners is made up of non-licensed counselors, who may be certified in counseling or human services-related professions. Counseling programs or centers that are identified as Christian or church-based—established to meet the needs of those desiring help from a counselor with a Christian orientation—are often staffed either by such individuals or else by lay counselors with varying degree of training and experience. One examination of Christian counseling centers in Texas revealed that most of the practicing counselors were ordained clergy who did not pastor churches. While most counselors had obtained some supervised counseling experience prior to beginning practice, a significant number of them had little prior preparation, and many were not licensed.[152] Some trained lay counselors have been found to be quite effective, especially when relying on proven professional models.[153] Other lay counselors who seek to minister wholeness to the Body of Christ are practicing counseling using a nouthetic model that emphasizes the authority of Scripture. One study that examined the experiences of sexual abuse survivors with Christian counseling, explained, "There is a radical distinction between this biblical approach used by the Christian counselor and that of the non-directive therapeutic approach of the pastoral counselor, who seeks an integration of psychological and spiritual insights in the care and counsel of individuals."[154] The study reported negative outcomes from receiving Christian counseling by practitioners emphasizing the prescriptive use of prayer and Scripture over relationship-building, as compared

[152] Ann Jacquelyn Canepa, "The Preparation of Counselors Practicing in Christian Settings in Texas" (EdD diss., Baylor University, 1983).

[153] Jane B. Jung, "A Program Evaluation of a Church-Based Lay Counseling Ministry" (PsyD diss., Wheaton College, 2009).

[154] Patricia Fouque and Martin Glachan, "The Impact of Christian Counselling on Survivors of Sexual Abuse," *Counseling Psychology Quarterly* 13, no. 2, (2000): 202.

to experiences with professional counseling. Christian counselors were perceived as significantly more directive, controlling, and powerful and less trustworthy than professional counselors, and as having an agenda that was different from that of the survivor. The survivors ended up feeling blamed or condemned for continued distress and ongoing problems and more vulnerable, as the trauma from the sexual abuse was exacerbated in certain situations. The researchers reasoned that counselors practicing in these settings were less aware of the importance of building a clear, strong alliance and allowing time for a trusting relationship to be established. They said, "counselors with psychological insights and a degree of self-awareness who have the capacity to tolerate their own inner conflicts, are less likely to manipulate the counseling process, albeit unconsciously, and more likely to hold the analytic space as non-abusive servants of the process."[155] They suggested that prayer and Scripture be used as a response to the survivor's own process and agenda, rather than as a prescriptive tool.

With the above in mind, along with the life-and-death nature of the intervention considered, it is recommended that a person with specific qualifications in the counseling field is recruited to head up this program. Regardless of the size of the church, the decision as to the level of qualifications to require for the head of the program should be rather straightforward. For the therapeutic program, a Licensed Professional in the field would normally already have the training and knowledge needed to oversee and conduct the program. This is preferable for a variety of reasons, not the least of which is acceptance by local and other authorities and liability issues. For the psycho-educational support group, non-licensed lay counselors should be appropriate as they normally have experience in a number of areas, including financial counseling, marriage enrichment groups, substance recovery, etc. The nature of this approach requires a different, yet equally important, set of skills.

[155] Fouque and Martin, 214.

While it is preferable that the counselor in charge has a military background, this is not an absolute requirement, provided that the individual has experience working with sexual trauma and PTSD survivors. That said, the vast majority of churches do not have a licensed professional on staff, but may seek to utilize lay counselors or volunteers under the leadership of a pastor or professional. Lay counseling, usually with volunteers, is the most likely option for most churches. It is beyond the scope of this thesis to deal with the training needs for such models. Suffice to say that the trainers may be brought in from outside the church or may be members of the pastoral staff, but they must have the proper educational and experiential background. One cannot give what one doesn't have.

Another matter to consider is the amount of time required by staff and volunteers. As any pastor will attest to, it is difficult to demand and enforce commitments from unpaid lay leaders or volunteers. Building a sense of rapport and community is critical for the group process prescribed in this program, and the trust gained will quickly be lost if the leaders are missing on occasion on other church business or for personal reasons. As a father of four and grandparent of five, this author can attest to the fact that when a child needs you, excuses don't matter. You need to be there, since the matter is often one they cannot solve themselves. Participants who have invested themselves in a group of this nature are in a similar position of need, in that during the times of the prescribed meeting, the leaders must be there. Assuming a once a week meeting, that time is set aside and must not be interfered with if the purpose of the group is to be met.

Group Admission Process

A major question to be considered is whether to make the program available to members of the congregation only or to the general public as well. The former allows for greater control and oversight, while the latter will reach more individuals in need of the intervention. This is a matter that the pastoral staff must decide upon after prayer and careful consideration, since either

option may be acceptable. Allowing only church members makes it easier to manage the program and build rapport within the groups, since members already may either know or be aware of each other. Allowing outsiders into the group may help with anonymity but may also allow for easier disruption to the group process, particularly as this may affect the diversity of the group in terms of faith and spiritual maturity. The recommendation of this author is to limit the program to church members the first few times it is run, and when the entirety of those involved feel more comfortable with the requirements upon them, open it to a wider audience, if desired. Since homogeneous groups function more smoothly than heterogeneous groups, each group should be offered only to survivors of the same gender. Several reasons supporting single-gender groups include: 1) Single-gender tends to facilitate group cohesion; 2) Depending on a survivor's identity and experience, a single-gender group may feel safer or more comfortable than a mixed-gender group; 3) Because of gender socialization, it may be easier for people who subscribe to traditional gender roles to fully participate and to focus on meeting their own needs in a single-gender group.[156] If possible, and in situations where the demand is such that several groups may be conducted simultaneously, it is also recommended that group members are matched with regards to age, severity of the effects of MST, level of external support, etc. It is critical that a survivor is not placed in the same group as his/her offender, even if the offender was also victimized.

Due to the high number of female survivors and the somewhat lower number of admitted male survivors, it might be advisable to limit the program to females, at least initially. It is also advisable to have a female facilitator for a female group and a male facilitator for any eventual male group. While the necessity of these arrangements may be obvious, it is still important to

[156] Washington Coalition of Sexual Assault Programs, *Circle of Hope: A Guide for Conducting Psycho-educational Support Groups*, 2nd ed., (Olympia, WA: Washington Coalition of Sexual Assault Programs, 2014).

state them clearly and then to adhere to them consistently. This is the ideal and should be the goal of the program. If the facilitator is to be of the opposite sex from the group for any reason, it should be evaluated more carefully than usual to ensure that the participants are comfortable with this. If this arrangement should prove necessary, having a co-leader or assistant leader of the same gender as the group is essential.

While utilization of an intake form and a pre-inclusion interview may seem like a great deal of unnecessary work, especially to those who have not previously been involved in a similar activity, the rewards in aiding a smoothly running intervention and avoiding potentially dangerous situations and liability issues are immeasurable. A great resource to utilize in the admission process is the equivalent of the standard intake form used in professional counseling. A modified sample of such a form is included in Appendix A. The form should be tailored to the specific needs of the church hosting the program. Some information included on traditional intake forms may be unnecessary, while additional information, such as church membership status, relationship to any of the individuals involved, etc. might prove invaluable. Knowledge gained from this form will assist in determining which survivors might interact well in a group setting, and which might not.

A second admission component is an intake interview, which is basically a face-to-face meeting between the prospective group member and one or more counselors. The core of the interview is a set of standard questions that are asked of every participant, with clarifying questions added as the need arises. In addition to gaining information about the participant's background and idiosyncratic specifics, the interview may be used to prepare the member by explaining the parameters and intent of the program and addressing any specific questions or concerns that they might have, thereby alleviating their natural apprehension.

It is recommended that members of the group sign an informed consent form, also supplied in Appendix A, which serves as a commitment agreement, basically indicating that they agree to allocate the time that the group will be meeting, as well as committing to attend each session for the entire duration of the program. This may be critical, as changes in the group following initial bonding may, at best, be a distraction or, at worst, compromise the rapport established among members. A penalty for breaking the agreement may be assigned, but it is not recommended. The strongest factor is the desire of the members to receive help and, following bonding, to support their fellow members.

Of major importance is to decide whether to offer the program free of charge to the participants, or to charge for participation. The recommended position is to perhaps charge for materials, but not for participation in the group itself. Not only should this be seen as a ministry, but legal liability is increased if there is a charge for inclusion in the group. If the desire is to charge for the services, then a lawyer should be consulted about setting up an LLC or something similar.

On a practical note, the privacy of those inquiring about or participating in the program needs to be protected. Most churches have rooms that are available for sessions, but care should be taken that during meetings, no one enters who is not in the group, nor should people drift about the area. Guilt and shame are two of the hallmark emotions following sexual assault, and these do not react well to everyone talking about the "poor souls" who have been so violated and are so pitiful, meeting in their little room. Therefore, a private area with restricted access for anyone — including church staff — not involved in the group meetings is a must. If there is no room in the church, extreme care must be taken in locating a suitable meeting place. In addition to the privacy factors just discussed, the susceptibility to further trauma requires a safe environment in a good part of town and preferably, pleasant surroundings. Depression is a big

enough threat without putting everyone in an industrial park in a drab, dark room only dimly lit by a few swinging bulbs.

Referrals, Concurrent Counseling, and Liability Insurance

This program is designed as a first step towards addressing the effects of MST among survivors who have not successfully dealt with their trauma, with or without the help of a clinician, and not as a substitute for individual counseling or trauma therapy. Regardless of the skill set of the pastor or staff involved, there are times and circumstances where it is better for everyone involved to refer the member to another source of help. While reasons for referral may be numerous, several of the most often encountered ones include indicators of severe mental health issues either outside of or beyond the scope or abilities of those providing care; counselor-group member dual-relationship issues or inability to establish rapport; or the counselor being uncomfortable with the nature of one or more presenting issues.

In the interest of group-member bonding, addressed earlier, it is best if such referrals are made prior to program admission. However, the decision to remove a member from the group may be necessary should he or she act in a disruptive, uncontrolled, or unruly fashion that affects the counselor, the intervention or other group members. It is important that the decision to refer or to remove a member from the program be delivered in as supportive a manner as possible.

Ideally, individual counseling should be offered concurrently with or following the conclusion of the group. While participation in the program may be sufficient for members to begin to constructively cope with the effects of their trauma and to obtain normal functioning, it may, in certain situations, cause members to become acutely aware of comorbid issues, the seriousness of which requires specialized treatment. Rather than dealing with specific, secondary effects of MST in the group setting, it is recommended that they either be addressed in a separate

format and time, or that referrals are made to a counselor or another qualified professional such as a physician, nutritionist, substance abuse specialist, etc.

An area that is often overlooked, with the omission having destroyed numerous ministries, is that of liability insurance. In the current litigious atmosphere, the likelihood of a misstep or a deliberate attempt to gain funds through the court system is highly likely. To be as prepared as possible, those involved in hosting or facilitating this program should be covered by some form of liability insurance, either as an individual or under the corporate umbrella of the church. While many do not feel that this is an issue that needs to be included, the Bible says "Behold, I send you out as sheep in the midst of wolves; so be shrewd as serpents and innocent as doves."[157] So don't leave home (or do counseling) without it.

While "it can never happen here" rings from pew to pulpit, the reality is that this is a fallen world. Even the most trusting individuals know that bad things do happen to good people. As previously discussed, individuals that have been sexually assaulted are at a far greater risk than those who have not been sexually assaulted of future sexual victimization. As one expert stated, "What is not understood is the manner in which a victimization history creates this vulnerability."[158] With this higher probability of sexual harm, it is endemic to the very nature of counseling to take every reasonable precaution. It is therefore strongly recommended that those assisting survivors through this program, and every member of the pastoral staff for that matter, undergo a thorough background check with specific targeting of previous sexual offenses in the criminal background check portion. If possible, this should be kept current at least annually, especially in larger cities where offenses can be hidden in the midst of large populations.

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[157] Mt 10:16.

[158] Cindy L. Rich et al., Child Sexual Abuse and Adult Sexual Revictimization in Linda J. Koenig et al., *From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization and Intervention*, (Washington D. C.: American Psychological Association, 2004), 66.

Chapter 4

Theory and Best Practices for Group Trauma Intervention

While there exists no universally accepted theoretical framework for trauma intervention, there is somewhat of a consensus of opinion on the basic approach to assisting survivors in understanding and dealing with the varied effects of trauma, and the coping mechanisms employed by the survivors. As articulated by John Briere, "such behaviors can represent an attempt to cope with triggered or sustained posttraumatic emotional states, perhaps especially when these states overwhelm internal affect regulation capacities and thereby motivate the need for avoidance."[159] This perspective on trauma treatment was based in part upon the foundational works of Pierre Janet,[160] Sigmund Freud,[161] Abram Kardiner,[162] and Bessel van der Kolk, who coined the term "traumatic stress." Briere's[163] philosophy of trauma treatment focuses less on pathology and symptom reduction and more on aiding survivors in moving toward recovery and growth in a safe, caring, and supportive environment.

The greater the understanding of the difficulties a trauma survivor is facing and how he or she is currently coping in a number of areas, the better the intervention may be tailored to meet the needs presented in these areas. This author, while teaching graduate classes in Crisis

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[159] John N. Briere, M. Hodges, and N. Godbout, Traumatic Stress, Affect Dysregulation, and Dysfunctional Avoidance: A Structural Equation Model. *Journal of Traumatic Stress* 23, (2010): 767.

[160] Pierre Janet, *L'Automatisme Psychologique* [The psychological automatism] (Paris: Alcan, 1889).

[161] Sigmund Freud, *Introduction to Psychoanalysis and the War Neuroses*, *vol. 17,* ed. and trans. Strachey (London: Hogarth Press, 1954).

[162] Abram Kardiner, *The Traumatic Neuroses of War.* (New York: Hoeber, 1941). Abram Kardiner & H. Speigel, *War Stress and Neurotic Illness*. (New York: Hoeber, 1945), Bessel A. van der Kolk et al., "Dissociation, Affect Dysregulation and Somatization: The Complexity Of Adaptation To Trauma" *American Journal of Psychiatry* 153, (1996): 83–93.

[163] John N. Briere and Catherine Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment,* 2nd ed. (Thousand Oaks, CA: Sage Publications, 2013).

and Trauma counseling, has adapted an acronym—BASIC ID— introduced by Lazarus[164] for his multimodal therapy in the 1970s. The acronym originally referred to Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal Relationships, and Drugs/Biology. For the purpose of teaching counselors to look for aspects of dysregulation in need of addressing, this author is using the metamorphosed acronym BASICS, which stands for Behavioral, Affective, Somatic, Interpersonal, Cognitive, and Spiritual. The BASICS thus describe the modalities or domains in an individual within which the effects of trauma may be experienced and then externalized and exhibited. When planning treatments and interventions, the typical starting point is to address the most primal need of understanding what happened and recognize abuse as a traumatic experience (Cognitive). By correcting inaccurate thoughts about the trauma-induced incident, the survivor can begin to uncover and understand his/her feelings (Affect) that may be overwhelmed in many ways. Once the emotions are stabilized to allow a less obstructed process, his/her ways of coping (Behaviors) may be addressed, so that the survivor can move towards normalized and restored interactions with others (Interpersonal). Physiological (Somatic) problems in areas such as sleep and weight regulation may be attended to and lastly, but arguably most importantly, the ways in which the trauma has impacted the survivor's (Spiritual) relationship with God may be uncovered, thus enabling him/her to confidently receive healing and restoration in ways that only He is able to provide.

Utilizing this framework in the intake interview for this program will assist facilitators in identifying potential problem areas and determining follow-up questions needed in order to gain a comprehensive understanding of the adjustment difficulties currently present among prospective participants. In addition, the program is designed to assist survivors in examining

[164] Arnold Allen Lazarus, "Multimodal Behavioral Therapy: Treating the Basic ID," *Journal of Nervous and Mental Disease* 156, no. 6 (1973): 401-411.

trauma responses affecting these six areas, thus ministering to the whole person. In this chapter, a few treatment models, elements of which are incorporated into the various group sessions, are described, followed by a discussion of spirituality and biblical principles integrated in the program. Next, benefits and best practices for group intervention are discussed, followed by an overview of important considerations for assisting MST survivors, specifically. Lastly, guidelines for group facilitators are provided.

Treatment Principles and Models

While the program proposed herein is not designed to offer comprehensive therapeutic treatment, it is important that the program facilitator is familiar with some of the agreed-upon best treatment practices.[165] This group intervention draws upon principles gleaned from cognitive-behavioral therapy (CBT), which is widely endorsed as the best-practice treatment of PTSD, relational disturbances, and other trauma-related symptoms identified by researchers,[166] the VA, the Department of Defense, and professional organizations, including the American Psychological Association.[167] CBT is suitable for group settings and, in general, focuses on reducing trauma-related symptoms by teaching survivors to employ new coping skills. In short, cognitive restructuring techniques are employed to assist group members to challenge and counter false beliefs that have developed, e.g. that the sexual assault was their own fault. Commonly used cognitive behavioral techniques include cognitive processing therapy,

[165] Irene Williams and Bernstein Kunsook, "Military Sexual Trauma among U.S. Female Veterans," *Archives of Psychiatric Nursing* 25, no. 2 (2011): 145.

[166] Janet K. Cater and Jerry Leach, "Veterans, Military Sexual Trauma and PTSD: Rehabilitation Planning Implications," *Journal of Applied Rehabilitation Counseling* 42, no. 2, (2011).

[167] Mary Alice Fernandez and Melissa Short, "Wounded Warriors with PTSD: A Compilation of Best Practices and Technology in Treatment," *The Professional Counselor* 4, no. 2 (2014).

assertiveness training, stress inoculation, and affect management.[168] Difficulty identifying feelings has been shown to be related to persistence of MST symptoms.[169]

In their review of effective counseling practices for treating sexually traumatized female adolescents, Lee Underwood, Sarah Steward, and Anita Castellanos, discussed the benefits of incorporating narratives of disclosure.[170] This approach rests on the principle that when survivors seek to make sense out of their traumatic experiences and deal with the negative feelings associated with the assault, they tend to interpret and construct narratives that facilitate shame, self-blame, self-hate, self-doubt, isolation, confusion, and worthlessness. As they recount these narratives in a group setting, the group facilitator helps the survivors re-interpret and re-construct the traumatic events into unjust violent actions and re-assign the responsibility to the assailants, thereby developing a new perspective and instills hope. This technique is effective for decreasing self-destructive behaviors and negative feelings, as it allows new meaning to be created about the trauma.[171] It has been reported that all attributions — both self-blame and external blame (e.g. blaming the rapist) — are associated with higher symptom levels following an assault, whereas a sense of control is associated with lower distress levels. Therefore, it is important to help survivors process and makes sense out of their experience and to empower them to reduce their

[168] Patricia Logan Russell and Cindy Davis, "Twenty-Five Years of Empirical Research on Treatment Following Sexual Assault," *Best Practices in Mental Health* 3, no. 2 (2007).

[169] Carol O'Brien et al., "Difficulty Identifying Feelings Predicts the Persistence of Trauma Symptoms in a Sample of Veterans Who Experienced Military Sexual Trauma," *Journal of Nervous and Mental Disease* 196, no. 3 (2008): 252.

[170] Lee Underwood, Sarah E. Stewart & Anita M. Castellanos, "Effective Practices for Sexually Traumatized Girls: Implications for Counseling and Education*," International Journal of Behavioral Consultation and Therapy* 3, no. 3 (2007): 410.

[171] Diya Kallivayalil et al., "Preliminary Findings from a Qualitative Study of Trauma Survivors in Treatment: Changes in Personal Narratives," *Journal of Aggression, Maltreatment & Trauma* 22 (2013): 271.

sense of vulnerability, increase a sense of control over themselves and their future, and move forward.[172]

Kelli Beveridge and Monit Cheung recommended conducting treatment of adult incest survivors around the concept of integration to assist them in reclaiming their sense of self, personal power, and autonomy. The treatment includes a three-step healing process of first building alliance with the survivor in a safe environment, then disputing faulty assumptions in a learning process, and lastly, addressing the needs for reconnection.[173] They explained, "The integration process begins with the survivor's cognitive awareness of how she functions within her environment in relationship to self and others. The focus of work is primarily on the examination and modification of maladaptive distortions. Concepts and definitions of spirituality and religion are often bound up in the bundle of beliefs, feelings, prejudices and distortions that make up a survivor's worldview."[174] By addressing issues of secrecy, shame, and body-image disturbances; unpacking feelings of rage and despair, and confronting irrational beliefs about self-worth, the survivor gains self-awareness, control of her environment, freedom from "emotional blindness," and an open attitude toward herself. Treatment techniques include rituals to resolve complex feelings and artworks to process internal struggles. The survivor is encouraged to develop a positive view of self through daily healing activities and reconnection within a supportive environment. Viewing herself as a survivor is not sufficient in and of itself, as the lost self ultimately needs to be redefined and restored into a multifaceted human being. The integration framework thus guides and empowers the survivor to renew her life, reclaim lost strengths, and connect to a healthy environment.

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[172] Patricia A. Frazier, "The Role of Attributions and Perceived Control in Recovery from Rape," *Journal of Personal and Interpersonal Loss,* 5 (2000).

[173] Kelli Beveridge and Monit Cheung, "A Spiritual Framework in Incest Survivor's Treatment." *Journal of Child Sexual Abuse* 13, no. 2 (2004).

[174] Ibid., 110

Another approach that has been shown effective, particularly for group interventions involving female sexual abuse survivors, is a "body-focused model," which is designed to address cognitive, emotional, physical, and spiritual effects of trauma.[175] This model emphasizes the importance of balance in all aspects of life, personal boundaries, and "being present." Group participants are taught how to cope with dissociation and flashbacks by stopping or getting away from whatever or whoever has triggered the reaction and then to use deep breathing techniques to becoming aware of their five senses, bring their focus back to the "here and now" and use positive self-talk to calm themselves and take control. Guided visualizations may be used during sessions to explore themes of safety, wisdom, and containment. This approach is conducive to reaching the goal of empowering MST survivors, many of whom struggle with a sense of helplessness, powerlessness, and loss of control. A survivor needs to regain control of her body and personal environment, and must be actively and willingly involved in recovery activities, rather than coerced or manipulated into participation. In general, solution-focused models are appropriate in this context, as they emphasize self-care and survivor strength. These models often incorporate Socratic reasoning techniques to guide survivors in a process of identifying their own path toward recovery.[176]

Integrating Spirituality and Biblical Principles

Biblical principles and Scriptures are incorporated in this program, not as an appendix or afterthought, but as a central, unifying theme. The rationale for this is two-fold. Firstly and most importantly, while the counselor may aid in the survivors' recovery process, only God can heal their broken hearts and restore their wounded souls in a supernatural way. Secondly, both trauma

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[175] Elizabeth Westbury and Leslie M. Tutty, "The Efficacy of Group Treatments for Survivors of Childhood Sexual Abuse," *Child Abuse & Neglect* 23, no. 1 (1999).

[176] Kelli Beveridge and Monit Cheung, "A Spiritual Framework in Incest Survivor's Treatment," *Journal of Child Sexual Abuse* 13, no. 2 (2004).

experienced in a military context and trauma suffered as a result of sexual assault profoundly impact the survivors at the core of their beings, and the combined effect of the two is particularly devastating. MST survivors often harbor an intense anger toward God, feel alienated from him, struggle to reconcile their worldview with their experiences, and question the meaning of life.

Litchfield's research suggested that when chaplains and others involved in Christian trauma intervention encounter survivors who are looking for meaning, purpose, and a renewed spiritual connection, they inquire about their spiritual beliefs as part of the initial assessment.[177] If the survivors do have religious beliefs, the questions turn to past experiences, whether they distanced themselves from their faith, and how their faith is affected by their current situation. Counselors must be mindful about not imposing their own beliefs or project their own existential questions onto the survivors, but rather listen empathetically in order to gain understanding.

In terms of program content, Beveridge and Cheung, cited earlier, discussed spirituality as a therapeutic foundation, emphasizing that incest survivors often struggle with ambivalent and hostile feelings toward God, religion, and spirituality.[178] Many reject their Christian upbringing, because they feel as though they have been abandoned by God. It is therefore important to help survivors identify their religious beliefs to better understand how these affect their view of themselves in their world and their daily living. Prayer alone is not sufficient as the survivors work through their distortions about love, religious beliefs, and images of God as these relate to their self-perception. However, when incorporated in the treatment plan, survivors may find a focus on spirituality a way to replace what was stolen from them and forgiveness a means to reduce anxiety and depression. To this end, Susan Turell and Cassandra Thomas provided a nuanced framework for integrating scriptures and biblical principles in helping survivors deal

[177] Elisa Marie Litchfield, "Spiritual Integration in the Treatment of Combat-related Posttraumatic Stress Disorder" (PsyD diss., Regent University, 2009).

[178] Beveridge and Cheung, 110-111.

with trauma-related issues such as abandonment, anger, self-blame, and low self-esteem in their article "Where Was God? Utilizing Spirituality with Christian Survivors of Sexual Abuse."[179]

Further guidance was gleaned from Murray-Swank and Pargament's spiritually-integrated intervention for female survivors of sexual abuse,[180] provided opportunities for participants to express their spiritual struggles, views of God, attributions of abandonment, spiritual disconnection, and anger at God. The sessions included opening and closing prayers, spiritual imagery, poems and reflection, journaling to God, spiritual affirmations, focused breathing, spiritual rituals, and other activities designed to enhance participants' sense of connection with God and others, reduce feelings of isolation, explore and restructure distorted cognitions, reduce shame-based views of sexuality, and reduce body disparagement.

The program proposed herein is based on a committed moral stance that evaluates all sexual abuse as fundamentally unjust. It also approaches topics typically covered in sexual trauma treatment, including self-esteem, sexual identity, guilt, shame, and forgiveness from a Biblical point-of-view. Tracy recognized three forms of forgiveness—i.e. judicial, psychological, and relational forgiveness—that a Bible-based intervention program must distinguish among.[181] Not surprisingly, when principles of forgiveness are incorporated in treatments, symptomology is reduced.[182] It is important, however, that those involved in interventions understand the inter-

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[179] Susan C. Turell and Cassandra R. Thomas, "Where Was God? Utilizing Spirituality with Christian Survivors of Sexual Abuse," *Women & Therapy* 24, no. 3/4 (2001).

[180] Nichole A. Murray-Swank and Kenneth I. Pargament, "God, Where are You? Evaluating a Spiritually-Integrated Intervention for Sexual Abuse," *Mental Health, Religion & Culture 8, no. 3* (2005).

[181] Steven R. Tracy, *Mending the Soul: Understanding and Healing Abuse*. Grand Rapids, MI: Zondervan, 2005.

[182] Suzanne R. Freedman and Robert D. Enright, "Forgiveness as an Intervention Goal with Incest Survivors," *Journal of Consulting and Clinical Psychology* 64, no. 5 (1996).

relationship among guilt, shame, and forgiveness[183] and are able to assist survivors in navigating and processing these delicate cognitive, emotional, and spiritual and issues.[184]

Benefits of Group Intervention

There are a number of reasons why a group approach is preferred for the initial intervention involving MST survivors. One practical reason is that several individuals may be assisted in a group setting in situations where funding and resources for individual counseling are limited or lacking altogether. There are also a number of therapeutic principles behind group counseling to consider, described by Yalom as follows:[185]

1. *The instillation of hope* – People start at different places and move at different speeds in dealing with the aftereffects of trauma. Seeing others who are in the recovery process or coping in some ways with similar issues often brings about a sense of hope in those just at the start of their own journey.

2. *Universality* – Members of the group realize they aren't alone in this process as they see others going through the same thing.

3. *Imparting information* – The sharing of knowledge or information helps in awareness.

4. *Altruism* – By using their strengths to help others going through the same thing, members increase their own self-esteem and self-confidence.

5. *The corrective recapitulation of the primary family group* – The therapy group becomes a substitute family in some ways, where members may explore how childhood experiences contributed to personality and behaviors and learn to avoid in real life behaviors that are destructive or unhelpful.

6. *Development of social skills and techniques* – Group members can practice social skills in a supportive and safe environment group without worrying about failure.

7. *Imitative behavior* – Individuals can model the behavior of the therapist or other members.

8. *Interpersonal learning* – Interactions with and feedback gained from others in the group

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[183] Keree Louise Casey, "Surviving Abuse: Shame, Anger, Forgiveness," *Pastoral Psychology* 46, no. 4 (1998).

[184] Catherine M. Causey, "Covenant, Community, and Forgiveness: A Pastoral Theology of Healing for Sexually Abused Persons" (PhD diss., The Southern Baptist Theological Seminary, 1996).

[185] Irving D. Yalom & M. Lesczc, *The Theory and Practice of Group Psychotherapy* (New York, NY: Basic Books, 2005).

and the therapist assists the members in gaining a greater understanding of themselves.

9. *Group cohesiveness* – Working together to accomplish a common goal helps one gain a sense of acceptance and belonging.

10. *Catharsis* – The sharing of feelings and experiences may lead to an emotional release and accompanying sense of relief.

11. *Existential factors* – Working within a group lends support and guidance, and helps group members process the deeper aspects of life, helping them to accept responsibility for their own choices, actions and lives.

Trauma group interventions may be conducted with various goals in mind, but regardless of the therapeutic techniques utilized, interventions are typically aided by the group process that allows members to validate and support one another, thereby reducing alienation and isolation. Less emphasis is placed on the details of traumatic events; instead, the impact of the traumatic experiences remains at the center. Group members take part in trauma processing both directly by verbalizing their own trauma event and indirectly by listening to the experiences of others, thereby capitalizing on the power of group cohesion, mutual respect, and "standing together" without judgment. Groups that are conducted primarily for support place limited demands on participants in terms of homework and advanced skill building and the group environment generally remains comfortable. The goal is to provide participants with a safe place where they can begin to address trauma symptoms that interfere with everyday functioning. Group topics and activities are designed to diffuse and contain overwhelming emotions and help participants normalize their reactions to the trauma experience, while encouraging self-care. Furthermore, support groups provide information carefully selected to assist participants in acquiring new coping strategies and increasing their self-awareness and confidence. The psychoeducational mode1 has been identified as providing an optimal balance between the intellectual understanding and the emotional awareness necessary for survivors to rework their trauma experiences. The facilitator has the dual responsibility of providing thematic content and

attending to the group's process.[186] Common topics for sexual trauma groups include self-blame, self-loathing, powerlessness, stigmatization, betrayal, anxiety, and boundary disturbances. While working through these topics, the facilitator needs to identify and gently confront dissociative behaviors among participants that impair the relational integrity of the group.

Considerations for Intervention Involving MST Survivors

As discussed earlier, the U.S. military is made up of highly specialized organizations with their own culture, complete with a history, values, beliefs, attitudes, behavioral norms, and language. Veterans feel that civilians do not understand or appreciate the sacrifices associated with military service and, as a result, often feel alienated or alone in civilian contexts. Therefore, it is of critical importance that clinicians, prior to treating veterans with trauma, orient themselves to this culture and acquire some degree of fluency and understanding of rank, terminology, and core values. In a dissertation devoted to this topic, the author reported that only 44% of surveyed veterans were comfortable receiving treatment from civilians, and 88% affirmed the importance of the clinician being familiar with military culture in order to understand their experience.[187] She identified military values as emphasizing honor, collectivism, stoicism, and heroism, illustrated by mottos such as, "never abandon your fellow warriors," "the mission and the unit always come before the individual," and "never show weakness to fellow warriors or the enemy." She also found that veterans distinguish between appreciation and respect. In order to establish trust and rapport, genuine appreciation, characterized by an empathetic and informed stance, is required beyond basic respect. She goes so far as to

[186] Wayne Scott, "Group Therapy for Survivors of Severe Childhood Abuse: Repairing the Social Contract," *Journal of Child Sexual Abuse* 7, no. 3 (1999).

[187] Amanda Tomei Stewart, "Developing Military Cultural Competence in Civilian Clinicians: Working with Returning U.S. Military Populations with Combat-related PTSD" (PsyD diss. California Institute of Integral Studies, 2012): 72-73.

recommend that therapists working with the military should develop military cultural competence, which is tied to her view that the military is essentially a "foreign" culture.

MST survivors represent an extraordinarily vulnerable population. While perhaps effectively covered by a tough exterior cultivated by necessity within the military context, many of these individuals feel as though the pain of their trauma will never subside to a point that they will feel normal again. Their sense of helplessness is often accompanied by humiliation, shame, and self-blame. Research has shown that sexual assault survivors are reluctant to seek professional counseling because they are concerned about the quality of the therapeutic relationship.[188] Wanting to be highly involved in their own recovery, they are more interested in support, validation, and empowerment than merely the amelioration of their symptoms. It is of critical importance for the success of this program that those involved in running it are mindful of the need to convey hope, appreciation, and support in all interactions with group members.

It is critical that all those involved in a helping relationship, participating in assisting trauma survivors through a church-based program, are cognizant of and willing to abide by the appropriate ethical standards of the profession. There are a number of organizations that have developed ethical standards relevant to group intervention, with the American Counseling Association being at the forefront. However, for an intervention hosted by a local church, the established standards of two other organizations—the American Association of Christian Counselors (AACC) and the American Association of Pastoral Counselors—may be more directly relevant, as these organizations advocate ethical principles from a Christian perspective. This program will utilize the AACC Code of Ethics[189] and make it available to participants.

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[188] Claire Burke Draucker, "The Psychotherapeutic Needs of Women Who Have Been Sexually Assaulted," *Perspectives in Psychiatric Care* 35, no. 1 (1999): 27.

[189] American Association of Christian Counselors, AACC Code of Ethics, 2014, accessed February 19, 2015, http://aacc.net/files/AACC%20Code%20of%20Ethics%20-%20Master%20Document.pdf

For a number of reasons, it is recommended that once the makeup of the group is established and they have begun to meet, no visitors be allowed. This refers to outside visitors such as friends and family, but also to members of the pastoral staff who might just want to "drop in". This is normally distracting for any support group. One of the great strengths of the group process is the closeness that develops, and intrusion by an "outsider," even with the best of intentions, is usually disruptive and counterproductive. For a group is made up of MST survivors, such intrusions may be detrimental to the process. Allowing visitors into the session also raises concerns about confidentiality, which is one of the basic ethical requirements for a group intervention.

When addressing the group members, it is important to use proper terminology. The primary terms, "victim" and "survivor", seem to be used arbitrarily and interchangeably in psychoeducational materials. It has been suggested that "the term 'victim' is used to refer to the early stages of impact and the word 'survivor' is used to refer to later stages of recovery."[190] Since group members participating in this program have already recognized their need for assistance in addressing traumatic symptoms, the term "survivors" will be used herein. As is the case with any potentially pejorative label, it is important to allow the individual to decide between the two, and in all other circumstances to refer to them by his or her name. Also, while MST survivors are of both genders, as stated earlier, this program will likely initially and primarily assist females; therefore, "she" and "her" will apply throughout the manual.

Conducting the Group Intervention

The manual in the following chapter is comprised of information and materials from a wide variety of literature, including works reviewed in Chapter 2. Additional notation should be

[190] Idaho Coalition Against Sexual and Domestic Violence, "Sexual Advocacy Curriculum," accessed January 2, 2015, http://idvsa.org/wp-content/uploads/2013/01/Sexual-Assault-Advocacy-Curriculum.pdf.

made of the work of Arnold Lazarus[191] from which the author's dimensions of intervention were derived, and the work of John Briere and Cheryl Lanktree.[192] The program also incorporates Mary Harvey's seven essential elements of recovery, which include: 1) authority over the remembering process; 2) integration of memory and affect; 3) affect tolerance; 4) symptom mastery; 5) self-esteem and self-cohesion; 6) safe attachment; and 7) meaning-making.[193] The manual is designed for twelve two-hour sessions. However, the number of meetings may be adjusted with additional meetings added should it be deemed necessary or desirable. The optimal number of participants in each group is 10, plus the counselor-facilitator and one co-leader.

This group intervention requires the counselor-facilitator (also referred to as leader) to take an active leadership role in identifying the tasks involved in the group work, creating a warm and welcoming environment, keeping the group on schedule, and ensuring that the group process does not re-traumatize any of the participants as it enfolds. The program is designed to shift the initial reliance on the leader to member-to-member learning as the group progresses. This model facilitates communication, interaction, understanding, and mutual support, which encourage members to empower and help one another rather than looking to the leader to "solve their problems."

As mentioned previously, the co-leader may be a counselor in training, a lay counselor, or a licensed mental-health professional. Her primary role is to assist the leader as directed and take notes during each session for later review with the leader. The co-leader should also take responsibility for hosting the group, which means that she needs to be the first on site each week

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[191] Arnold Allen Lazarus, "Multimodal Behavioral Therapy: Treating the Basic ID," *Journal of Nervous and Mental Disease,* 156, (1973): 401-411.

[192] John N. Briere and Cheryl Lanktree, "Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) Treatment Guide," 2nd ed. (Torrance, CA: USC-ATTC).

[193] Mary R. Harvey, "An Ecological View of Psychological Trauma and Trauma Recovery," *Journal of Traumatic Stress* 9, no. 1 (1996).

to set up the room as needed and greet participants upon arrival. During each session, the co-leader is in charge of managing interruptions, such as outsiders accessing the room, participants leaving a session unexpectedly, etc., thus allowing the leader to maintain her focus on what is going on with the group as a whole and to continue to lead the session.

All forms, handouts, and instruments are available in appendices, beginning with the Group Intake Form and Informed Consent, discussed in the previous chapter. The Guidelines for the Group will serve as a contract among participants and regulate group interactions. Most instruments included are produced under grants from the government and are therefore not copyrighted and are royalty-free to use, the exception being the TSI-2. However, they are intended only to be administered by qualified health professionals who have completed advanced graduate training in psycho-diagnostic assessment. This reinforces the need for a qualified LPC or psychologist to head the program.

The Life Events Checklist for DSM-5[194] (LEC-5) is a self-report measure intended to determine potentially traumatic events in an individual's lifetime. It assesses exposure to 16 life events that have been shown to potentially result in the development of PTSD or cause significant distress in those exposed or involved. This form also includes one additional item to cover any other extraordinarily stressful event that was not captured by the first 16 items. The main reason behind the inclusion of this instrument in the program is to assess traumatic experiences that may compound the effects of the MST. A broadband measure, the TSI-2 is designed to evaluate posttraumatic stress and other psychological sequelae of traumatic events, including the effects of sexual and physical assault, intimate partner violence, combat, torture,

[194] F. W. Weathers et al., *The Life Events Checklist for DSM-5 (LEC-5)*. Instrument available from the National Center for PTSD at www.ptsd.va.gov, (2013).

motor vehicle accidents, mass casualty events, medical trauma, traumatic losses, and childhood abuse or neglect.[195]

Also utilized is the Subjective Units of Disturbance (or Distress) Scale (SUDS), a thermometer-like scale from 1 to 100 that enables the participants to indicate their level of discomfort at any given time using agreed-upon terminology, thus allowing the facilitator and fellow group members to easily understand and appropriately respond to their expressed feelings.[196] This is useful in a group discussion process on topics that may trigger varying levels of anxiety and emotional discomfort. [197] Another tool that will be used throughout is the Survivor's Measure of Growth, which will help participants measure their starting point, develop their own list of goals for the intervention, and monitor their progress.[198] Several additional handouts will be distributed and used as bases for group discussions, including a list of common myths about rape[199] and psychoeducational materials from PsychologyTools,[200] Healthwise,[201] and Changing Minds.[202]

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[195] Accessed October 23, 2014, http://www4.parinc.com/Products/Product.aspx?ProductID=TSI-2

[196] Joseph Wolpe, *The Practice of Behavior Therapy* (New York: Pergamon Press, 1969).

[197] This information was drawn from multiple sources. The handout was prepared for the ISTSS Resources for Clinicians Website by the Australian Centre for Posttraumatic Mental Health, June 2008.

[198] From the New York City Task Force against Sexual Assault.

[199] University of Minnesota Duluth, accessed November 21, 2014, http://www.d.umn.edu/cla/faculty/jhamlin/3925/ myths.html

[200] Accessed February 12, 2015, Psychology Tools Worksheets. http://psychology.tools/download-therapy-worksheets.html

[201] D. J. Anspaugh et al., *Wellness: Concepts and Applications,* 7th ed (New York, NY: The McGraw-Hill Companies, Inc., 2009), accessed November 27, 2014, http://www.cbhcare.com/files/u2/Coping_Strategies_Assessment.pdf on February 12, 2015.

[202] Accessed February 12, 2015, Changing Minds, http://changingminds.org/explanations/behaviors/coping/coping.htm on Feb. 12, 2015

Chapter 5

Manual for Military Sexual Trauma Group Intervention

The information contained herein outlines a twelve-week program designed to provide basic and initial assistance for survivors of Military Sexual Trauma (MST) within the context of a local church. While drawing upon some of the best practices for treatment of MST discussed in the previous chapter, the understanding is that participants will pursue individual therapy targeted to treat deeper mental health issues that may emerge during the course of this intervention, concurrent with or after this program.

The objectives are listed at the beginning of each session followed by a brief summary of session topics, which provide overall direction in two areas of group activity: content and process. Each session, which commences with prayer, is approximately two hours in length, which includes a minimum of one fifteen-minute break. Sessions include individual, paired, and group activities, discussions, and opportunities for sharing-listening. Recommended scripts for the counselor-facilitator are in italics and all referenced handouts are included in the appendices. A few sessions conclude with homework assignments in which participants employ recovery strategies throughout the following week(s).

The first session begins with introductions and an overview of the program and group guidelines. The second session is devoted to assessment and psycho-education on long-term effects of sexual trauma. In the third session, participants examine the cognitive effects of MST as they begin sharing trauma narratives one-by-one. This process continues during the following two sessions. Session six is devoted to affective responses to trauma and session seven to interpersonal effects, including boundaries and safety. In session eight, participants examine spiritual aspects and are encouraged to reconcile with God and extend forgiveness. Session nine is devoted to identifying and changing negative coping behaviors. In session ten, issues of self-

awareness and self-acceptance are addressed with attention to both cognitive and affective trauma responses. Session eleven provides opportunities for participants to examine and share resources in regards to common somatic effects of trauma, and session twelve concludes the program with self-assessment, celebration, and looking ahead.

Session 1: Introducing the Group

Objective: Establishing rapport and building trust.

Topics: Introductions and overview of the program. Discussing group rules and confidentiality.

Introduce yourself and your co-leader.

All of you are here because you are a survivor of Military Sexual Trauma, and want to begin to come to terms with the aftereffects of what happened. In a few minutes, we will start to get to know each other a bit better, a process that will continue for the duration of this program.

Open with prayer

It is critical to know that everything that happens during these times together is confidential. My associate and I are not allowed to discuss anything that happens unless we hear something that indicates that there is the potential of danger to one of you or someone else. We can direct you to the Code of Ethics of the American Association of Christian Counselors so you may see exactly the standard to which we subscribe. Those of you who attend [Church Name]*, you may be acquainted with other members of the group. However, we ask that you don't discuss what happens during the sessions with anyone outside of the group, in order to protect everyone's privacy. Each of you may also be at different places in your journey of recovery, so it is possible that reactions to what takes place may differ widely.*

- Distribute Guidelines for the Group

To begin, each of you pick someone that you didn't know before today, and take a few minutes to interview them. Then let your partner interview you. Questions to ask may include first name, state they were raised in, family status, branch of service, hobbies, etc. Everyone has the right to not answer any questions that make them uncomfortable, but limited early disclosure may reduce the sense of anxiety that may otherwise occur when sharing traumatic experiences later. One of the key aspects in overcoming the effects of trauma is to be able to speak about the events in a safe environment to begin the recovery process. When everyone is ready, you will introduce your interviewee to the group.

(15-minute break)

Give an overview of the group sessions.

This group is a first step on the journey, and we will be taking the time that is needed to process each aspect. As the nature of MST is severe and invasive on many levels, it is quite likely that one or more areas that are either uncovered or touched upon during the course of the sessions will require individual intervention for thorough treatment. This will be separate from these sessions and will involve licensed professionals who may or may not be affiliated with this church.

We will be meeting for several weeks. The purpose is to initiate the healing process following a previous incident of MST. The intent is to have a supportive and non-threatening environment where everyone will feel welcome and, because of the nature of the members, understood. While everyone here is a veteran, there is no hierarchy of rank whereby one is worth more than another, although respect for accomplishments is welcome. Since everyone reacts differently to abuse, some will be more emotionally fragile, or angry, or trapped in low self-esteem than others. Let's be sure to follow the basic group guidelines and adapt them to fit our needs.

- Distribute the SUDS scale and explain how it will be used during sessions. It may be found at http://at-ease.dva.gov.au/professionals/files/2012/12/SUDS.pdf

Activity: Dream Trip (15-20 minutes)
Describe how you would spend your time and money if you were given one month away from usual work and domestic routines and responsibilities with an unlimited budget. Mention what you would look forward to and what you would avoid.

Activity: Goal List (15 - 20 minutes)
Everyone will compile a list of personal goals to work toward accomplishing during their time in the group. These should be in two categories, those that deal with intrinsic change and values, (i.e. attitudes, fears, hopes, etc.), and those that deal with extrinsic change and values, (family, friends, society, etc.). A copy of these is be kept by the co-leader, and they are updated throughout the course of the program.

- Distribute Survivor's Measures of Growth handout, and explain its purpose. It may be found at http://www.newhorizonscrisiscenter.org/index.php/get-help/suvivors-measure-of-growth

Session 2: Understanding Sexual Trauma

Objective: Learning about the most common responses and long-term effects of MST.

Topics: Trauma assessment to identifying the most prevalent and salient trauma symptoms present in participants, as well as psycho-education on the long-term effects of sexual abuse.

Open with prayer

The purpose of the assessments conducted in this session is to allow the leaders to be able to identify the most prevalent and salient trauma symptoms present in the participants, and for the group members to gain an overview of common trauma symptoms and to begin to learn about the general and person-specific aspects of MST through psycho-education.

The first thing we are going to do today is to complete two questionnaires. The first is called the Life Events Checklist for the DSM-5 (LEC-5) and it is basically an overview of a wide range of life experiences that may cause trauma, including sexual assault. Although this group is focused specifically on MST, the information on this survey will help us understand you better by learning more about your trauma history. The sexual trauma that you have each experienced is a part of all of the experiences that together form your life, many of which affect your ability to satisfactorily cope with day-to-day existence.

- Administer the LEC-5, which may be obtained by professionals free of charge from http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

The second questionnaire is called Trauma Symptom Inventory™- 2 (TSI™-2) and lists some of the most common long-term effects of trauma. This information will help tailor our discussions so that you will get the most out of this support group. It's important that you answer each question as honestly as you can. There is no right or wrong answer and you are not being tested.

- Administer the TSI-2 which may be obtained at http://www4.parinc.com/Products/Product.aspx?ProductID=TSI-2

(15-minute break)

Let's talk about some of the common long-term effects that MST survivors have reported.

Using the BASICS (i.e. behavioral, affective, somatic, interpersonal, cognitive, and spiritual) categorization, describe common long-term effects including self-blame, low self-esteem, memory problems, inability to concentrate, obsessive thoughts, paranoia, dissociation, stress and anxiety issues, hyper-vigilance, depression, substance abuse, prescription drug overuse, eating disorders, sexual activity extremes (promiscuity/abstinence in marriage), self-harm, suicidal ideation, sleep disorders, over-exercising, compulsive spending, etc. Be prepared to answer questions. Participants may realize for the first time that some of the difficulties they have had are caused by their trauma.

For the next meeting, I'd like two volunteers to be the first from the group to share their MST story. This should have a 15-minute time limit, and the method for sharing is at the member's discretion. This should be in a format that you are comfortable with, and may be read from a written manuscript, played as a newly-recorded video or audio recording, or presented as a slideshow or montage of pictures with verbal annotation.

Activity: Scripture Reflection (5-10 minutes)
Have jar with several Bible verses that are topically appropriate and suitable for reflection (see examples in appendix). Ask one or several participants to draw one, read it out loud and relate it to something they have experienced or felt.

After the session: Score and review the assessments, cross-reference with the group intake forms. Create a profile of the group that will serve to guide remaining sessions.

Session 3: Constructing Trauma Narratives

Objectives: Changing false beliefs about the trauma. Achieving a balanced and realistic perception of the world.

Topics: Providing opportunities for participants to voice their trauma by talking about what happened to them. Addressing cognitive effects of MST, particularly self-blame and conscious or sub-conscious beliefs that they are responsible or, at some level, deserving of the abuse/assault.

Open with prayer

The purpose of the next three sessions is to provide participants the opportunity to explore their experiences and interpretations of their traumatic event(s) and to begin addressing the cognitive effects of their trauma. Most importantly, participants will begin to accept or entertain the idea that the trauma was not their fault. They may intellectually know it wasn't their fault, but this needs to translate into an emotional belief. It is very important that the survivors understand that the abuse/assault was not their responsibility but the responsibility of the perpetrator.

Today you will start sharing your MST stories. We have two volunteers who offered to go first, but before we begin sharing, we will review some common misconceptions about sexual assault and abuse. First, even if your trauma did not involve rape, it's important that you allow yourself to acknowledge that experiencing a traumatic event of a sexual nature may affect you just as severely. Many sexual trauma survivors believe that the abuse or assault was somehow their fault. Consciously or subconsciously, they believe that their behavior either initiated the attack or that they deserved it because they are bad in some way. This belief that it is the victim's fault is often supported or confirmed within the environment. Perpetrators typically tell the victim it is their fault. When you reported or spoke out about it, perhaps the very people you turn to either did not believe you or said you had yourself to blame. Let's look at some other common myths and misconceptions about sexual assault and abuse. Our goal over the next couple of weeks is to see things for what they really are, to identify false beliefs we may have held, and to examine our own accounts about the traumatic event. The Bible says "you will know the truth and the truth will set you free." Let's be open to the possibility that the way you think about what happened may not be the way God saw it and let's help each other in this group to allow our mind to be renewed by gaining an accurate understanding of what really happened. So, let's take a few minutes and examine the myths about rape and other forms of sexual assault and abuse. These are common misconceptions that many people, including survivors, believe, and that, therefore cause many survivors to hold on to self-blame.

- Distribute Rape Myth handout which is located at http://www.d.umn.edu/cla/faculty/jhamlin/3925/myths.html

Ask the participant to your left to read the first myth and corresponding fact. Continue around the circle until the end of the list. Ask participants if they think there are additional myths that are missing from the list.

(15-minute break)

Part of the recovery process is anchored in sharing the narrative of what caused the trauma. Just as roaches scatter when the light is turned on, so is the destructive power of trauma lessened by sharing about what happened in a safe environment with people who can empathize and identify with you. As we discussed last week, it is important that you feel comfortable to use a format and level of detail that you are comfortable with. It is your story and you can tell it in whatever way you choose. Some of you may have kept this a secret for many years. Speaking out is a very powerful step toward recovery. Keep in mind that it often provides the most relief if you include as many details as you can remember and what you were thinking and feeling at the time.

Now let's talk about listening. You may think this is a passive role, but you actually play a very important role in this process. Our job is to affirm and validate, which is something that many survivors never experience. When someone is sharing a very emotional experience, we want to relieve that person's suffering in some way. It is important during this group not to do so. I ask that you do not invade the personal space of any member, touch or hug them in any way during the story. If you choose to connect after the group that is fine, but during this phase, we need to stay in our own space. When the first member has concluded her story, we will validate her by providing positive feedback, letting her know that we heard her and feel her pain. Feel free to give supportive feedback, identify similarities, affirm her for being courageous enough to share and remind her that she, in no way, is responsible for what happened. Don't ask for additional details about the event itself, but together let's create a safe and structured environment where each of you may experience being heard and believed in a supportive community of your peers. Listening to someone else's story can be very anxiety-provoking, but we ask that you refrain from talking about yourself at this time, as we want to give our attention to the member who just shared her story.

As you listen, pay particular attention to harmful thought patterns that cause maladaptive emotions and behaviors. At the conclusion of the story, you should be the first person to provide positive feedback. Make genuine and real comments in support of the participant, and then allow each group member to briefly give them feedback as well. Gently challenge distorted beliefs about what happened, why it happened, and what the consequences are with the goal of helping them identify and reassess such misconceptions and over time reconstruct their trauma narrative into a more accurate one.

(5-minute break between the two participants sharing)

You will need a short break between stories. Listening to the trauma disclosures of others in the group may trigger participants into an excessive emotional or cognitive state. When sharing stories is completed for the day, most of the participants will have an increase in anxiety and it important to end with a time of calming reflection before they leave the session.

Activity: Scripture Reflection (5-10 minutes)
Have 2 or 3 participants draw scriptures from the jar and read them out loud. Invite participants to reflect on how the scripture speaks to them.

Sessions 4-5: Constructing Trauma Narratives

Objectives: Achieving a balanced and realistic perception of the world. Recognizing the importance of affiliation with others for personal and social support.

Topics: Providing opportunities for participants to voice their trauma by talking about what happened to them. Addressing cognitive effects of MST, particularly self-blame and conscious or sub-conscious beliefs that they are responsible or, at some level, deserving of the abuse/assault.

Open with prayer

Continue the process of participants sharing their MST narratives described in Session 3 with four participants sharing for 15 minutes each week, followed by about 10 minutes of affirmation from the group members. All group members should have an opportunity to share their story.

Session 6: Identifying and Expressing Emotions

Objectives: Understanding trauma-related affect. Recognizing persistent and distressing emotional responses. Reducing dissociation of emotions.

Topics: A guided process in which participants explore and express feelings with the goal of experiencing emotional release, while learning strategies to calm themselves and regulate their affective systems.

Open with prayer

Survivors of trauma have a tendency to avoid any feelings or events that might remind them of the traumatic experience, as a way to cope. Because repressed emotions of terror, betrayal, anger, and abandonment are often powerful, the survivor may equate feeling with a loss of control. Having sealed off their emotions, they often try to operate strictly on a rational basis. Although it may be an overwhelming experience, the processing and release of emotions is necessary for full recovery. With constant encouragement and support, the survivor learns to acknowledge her feelings, identify them, and label them.

During the last few weeks, all of you have shared about terrible things that were done to you, which, no doubt, stirred up strong emotions. It is important to remember that an emotion is not an action. Sexual trauma survivors often feel extremely angry and want to hurt someone, or they feel so depressed that they just want to die. However, just because you feel something, it doesn't mean that you are going to act on that emotion. Sometimes we are afraid of feeling, because the emotions hurt so much or because they make us feel out of control. We may think that if we allow ourselves to feel the anger or sadness, we will be overwhelmed and unable to pull ourselves together. God made us in His image with a full range of emotions, and it is important that we reclaim the ability and right to feel and be fully human. Emotions themselves aren't wrong, as they are a reaction to external stimuli based upon our personality and our previous experiences, but what we feel and especially how we act upon these feelings may be more or less constructive, or even destructive. A key to all that follows is to understand what it is that we really feel. So today we will examine trauma-related emotions.

Activity: Empty Chair and Color-My-Feelings (45 minutes)
Place an empty chair in the middle of the circle. Ask participants to imagine their perpetrator sitting in it. Have paper, colored pens, crayons, a number of magazines with a variety of pictures, scissors, and glue available. Instruct participants to use the supplies to illustrate how they feel toward the perpetrator or within themselves. Some may prefer to write down their emotions, write a poem, or write a letter to the perpetrator (not to be sent to them). The important thing is that participants are able to identify and give expression to emotions related to the trauma. Common emotions for trauma survivors, in addition to anger, are grief, shame, guilt, fear, and anxiety.

We don't want to rush this process, so take your time to reflect about how you really feel. This is a very personal exercise, and it is best if you don't talk with one another. After the break, there will be an opportunity for those who want to briefly share about what they created and why. Don't be afraid to cry if you feel the need to.

(15-minute break)

Provide an opportunity for participants to share about their creative process and to show/read the outcome if they want to. For some, it is helpful to articulate their emotions verbally; while others may prefer to remain in their own space and just listen and observe.

People often say that something or someone "made them feel" a certain way, but while other people may "push our buttons," it is important that we learn to own our reactions and take responsibility for how we respond. Each one of us has the ability to change the way we feel and not let people or circumstances "get to us." Anger is typically a secondary emotion, which means that we feel something else first. Because anger is a powerful and overwhelming emotion, it is sometimes the only emotion we are able to identify. In order to control our anger, we need to identify the primary emotion that triggered it. As you learn to recognize, understand, and label your emotions, it is important that you also learn to regulate them. This will keep you from over-reacting or dissociating.

- Distribute Emotional Regulation Systems which is found at http://psychology.tools/emotional-regulation-system.html
- and Stop, Think, Breathe handout which is found at http://psychology.tools/stop-think-breathe.html.

Explain the drive, threat, and soothing systems. Ask participants to fill out the Stop, Think, Breathe form.

Activity: Deep Breathing Exercise. (5-10 minutes)
Next, we will practice a deep breathing exercise that you can use when you experience high levels of stress, anxiety, fear, or anger. The way we breathe is strongly linked to the way we feel. When we are relaxed, we breathe slowly and the levels of oxygen and carbon dioxide in our bodies are balanced. When we are anxious, we breathe faster, causing us to take in more oxygen and breathe out more carbon dioxide. Since the body is not working any harder, it is not using up the extra oxygen nor producing any extra carbon dioxide. As a result, the carbon dioxide level in the blood goes down, and this causes us to feel light-headed, tingly and clammy. To begin, make sure that you are sitting comfortably with both of your feet on the floor, your back straight, and your hands resting in your lap. Take a deep breath. As you slowly let it out, close your eyes and let your body relax as much as possible. Continue to breathe in slowly and deeply. As you breathe in, focus on what you are feeling and sensing physically here and now. As you breathe out, release the tensions. If you feel very tense, it helps to focus on one part of your body at a time, starting with your feet and working your way up. As you allow yourself to relax more and more deeply, resist the temptation to let your mind wander; remain present and continue to feel. Enjoy the feeling of peace and rest. Give yourself permission to feel good about yourself; your body and your person. When you feel ready, you may open your eyes. Remain quiet until everyone has completed the exercise.

Homework: Ask participants to start journaling about their emotions, making an entry at least once a day. Encourage them to make note of strong emotions, along with the events and situations that caused them. They should also write down positive feelings and things that make them feel good, as well as tendencies to dissociate, i.e. "turn off" their emotions. This exercise

will help them become increasingly mindful of their emotions throughout the remainder of the program. Check in from time to time and ask how their journaling is going. Recommend additional resources, such as the T2 Mood Tracker smart phone app by the National Center for Telehealth and Technology.

- Distribute Emotions Journal handout.

Session 7: Establishing Boundaries, Personal Safety and Healthy Relationships

Objectives: Establishing boundaries and personal safety. Moving toward equilibrium in personal, social, and intimate relationships. Developing strategies to prevent revictimization.

Topics: Identifying interpersonal difficulties resulting from MST, including boundary issues and a distorted self-concept or perceptions of how others see them. Guided discussions and activities exploring issues related to boundaries, social identity, and effective communication.

Open with prayer

Boundaries exist everywhere. Countries, states, personal property, and individuals all have boundaries, an edge that defines inclusion. The MST was essentially an invasion of your "essence," of the personal and private part of what makes you unique. Part of the trauma experienced was centered upon the sense of disequilibrium brought into being by this assault. How can anyone exist as a separate entity when there is no established and enforced boundary? What is an appropriate liberty taken by another without permission, and where should the boundary exist, beyond which permission must be sought and granted for interaction? Walls and doors control access to our homes and property, but what controls access to us as people? Is a certain attitude enough so others will leave us alone, or do we need other indicators?

Activity: Boundary Exercise (10 minutes)
Have participants form pairs and line up in two rows about 10-15 feet apart, each pair facing each other. Instruct everyone in row 1 to pick a spot on the floor that they do not want crossed, but to keep the location to herself. Instruct the people in row 2 to walk towards those in row 1. When the counterpart in row 2 reaches their spot, those in row 1 will use body language to indicate that they cannot come any closer. The people in row 2 will stop, respecting the boundary. Repeat the exercise changing roles. Identify some of the cues that were used, such as putting up one hand, turning their back to them, walking away, etc. Repeat the exercise, but this time using verbal cues. Repeat the exercise a third time, using either verbal or nonverbal cues, instructing those in row 2 to ignore the cue and keep walking, thus requiring those in row 1 to re-set their boundary using a combination of clear verbal and nonverbal cues. Ask participants to share how they felt when their initial cue was ignored.

This simple exercise illustrates the importance of personal space and setting boundaries to protect that space. I'm going to ask you a few questions. If your answer to any of them is "yes," this is an indication that you may have difficulty communicating interpersonal boundaries:

1. *Do you find it difficult to say "no"?*
2. *Do you share personal information with acquaintances too quickly?*
3. *Do you take on other people's problems or pain?*
4. *Are you reluctant to tell people in your life what you want and need?*
5. *Do people tell you what to think or feel?*
6. *Are you in a relationship that robs you of your ability to feel good about yourself?*

Let's talk about some different ways that we use to communicate our needs and wants to others and to make it clear to them that "no means no."

- Distribute Assertive Communication handout, and review together. It may be found at http://psychology.tools/assertive-communication.html
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Lead the group in a discussion of how to effectively communicate boundaries.

Part of the importance of boundaries is being clear when communicating them and not having a "gray area" where these limits are open to multiple interpretations. How do you believe that others see you? Are you firm and decisive in relationships, or vague when setting limits? On a piece of paper, write down words or phrases that you feel that people use to describe you, and then write down a list of words or phrases that you remember them using about you.

Ask group participants to share what they wrote. Make sure everyone has an opportunity to speak as they feel comfortable.

Arguably, the perception of ourselves by others is strongly influenced by how we perceive ourselves. Take a few minutes and write down on a piece of paper the words or phrases that you would use to describe yourself in relationship to others.

Ask participants to share what they wrote.

Are there similarities between the lists? Why or why not? When do you feel that these two sources of perceptions originated? Are these carved in stone or can they be changed? How?

Lead the group in a discussion of perceptions and presenting oneself in a more assertive way.

(15-minute break)

Often, with MST, the military environment isn't under our control to a very great degree. We go where we are told, we do what we are told, and we sleep where we are told, exposing us to potential danger. Think about where you live and work now. Is there any way that you could make it safer through basics like better lighting, deadbolt locks, self-defense weapons or a big dog? Are those options that you are comfortable with, or would you feel manipulated if you "gave in" to any of these measures?

Ask participants to share about safety measures they have taken after the assault and situations/relationships in which they feel safe versus unsafe.

According to the Department of Justice, *"Women who become victims of sexual assault are at much higher risk than other women of being victimized again. Research has suggested that psychological processes initiated by sexual victimization, especially in childhood and adolescence, result in behaviors that can increase victims' exposure to potential offenders and make them more vulnerable to the tactics of the offenders they encounter." With this a very real possibility, what do you think you could do to reduce the likelihood of revictimization?*

Lead participants in a discussion on steps they can take to reduce the risk of revictimization.

Learn to anticipate and recognize unsafe situations where you may be victimized, plan to avoid or escape from potentially risky situations by withdrawing as soon as you recognize them, saying "no" assertively, and calling for help. It is recommended if you are in danger that you yell "fire" rather than "rape" or "help" as people are more likely to respond.

Session 8: Enhancing Relationship with God

Objectives: Identifying effects of MST on survivors' image of God and relationship with Him. Entering into or re-establishing a relationship with God through forgiveness and faith in Christ.

Topics: Presentation of a Bible-based view of who God is and how He views people. Participants are invited to explore how their MST experience may have distorted their image of him and are encouraged to seek and extend forgiveness.

Open with prayer

Many people in the world today feel that there is nothing beyond the natural that we can perceive using our five senses of taste, hearing, sight, touch, and smell, but even more feel that there is a higher power. For the Christian, there is no confusion or disagreement, since the very definition of a Christian, or Christ-follower, includes a relationship with a Heavenly Father. While many of our friends and even family members may reject us or at least be uncomfortable around us during difficult times, it is the opposite with God. Psalm 46:1 says, "God is our refuge and strength, a very present help in trouble." He is there when we need Him, and 2 Corinthians 1:4 takes it a step further as it says "who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God." He comforts us, and we in turn use what we have come through to comfort others.

- Distribute Footprints in the Sand poem, and then discuss.
- Available from http://www.footprints-inthe-sand.com/index.php?page=Poem/Poem.php..

When we've been attacked and taken advantage of, especially by people that we have trusted, there is a destruction of innocence, a crushing of trust. The question naturally arises of whether we are alone in this misery, or is there anybody out there who cares, who will stand with us for the long haul? The reality of a living God who died for you, loves you, and wants to be involved in your daily life, who has said that He will be with us, is reflected throughout His word.

- Distribute Ten Scriptural References about God Never Forsaking or Abandoning Us

Perhaps even more important is learning about who you are in Christ, what you can be in Christ, and the inner journey to get there. Look at the following from His Word.

- Distribute Who I Am in Christ handout. Discuss.

As important as it is to become aware of who we are in the eyes of God, it is every bit as important to examine our image of God, and to determine where it came from, and why. Since the early part of the 20th century, evidence has shown that our image of God is primarily influenced by the individual's relationship with their flesh and blood father. However, when sexual trauma occurs, the survivor's image of God is affected. In fact, survivors of sexual abuse have been found to experience more distant, disapproving, and punishing images of God when compared with those who haven't endured sexual assault. To help with understanding any fluctuations in your relationship to God, it might be good to begin keeping a "Letters to God" journal.

(15-minute break)

As Christian MST survivors, questions often asked when putting our lives together are "Can I and should I forgive, and does it matter?" Two aspects to remember are who are you forgiving and who are you approaching regarding forgiveness? Should you approach God and forgive the person who wronged you? Yes, because until you do the bitterness from not forgiving will hinder your relationship with God. Should you go to the person who wronged you and forgive them to their face? Normally, no, because of the danger of being re-victimized, among other factors, although some would disagree with this. In any case, forgiveness should not be encouraged until you have reached the point where you are ready to forgive. One other aspect that is very import has to do with forgiving oneself. It should be clear that regarding sexual assault, it is never the victim's fault. Yet, most victims blame themselves for all or most of the assault, and punish themselves for years. It is often much easier to forgive the perpetrator than to forgive oneself. Until you forgive yourself before God for whatever perceived ill-advised personal actions are present, there will be no closure.

Activity: Forgiveness Exercise (20-30 minutes)

1) *Make a list of people and circumstances in which forgiveness is needed.*
2) *Assign a SUDS score to each, with 100 being a situation that torments you constantly, 50 being a case that causes moderate pain about half of the time, etc.*
3) *Start with the highest rated.*
4) *Find a quiet place to focus on the issue.*
5) *If desired, prayerfully read the following verses to gain a better understanding of Biblical forgiveness.*
    a. *Matthew 6:14-15 – "For if you forgive men when they sin against you, your heavenly Father will also forgive you. But if you do not forgive men their sins, your Father will not forgive your sins."*
    b. *Isaiah 43:25 - "I, even I, am he who blots out your transgressions, for my own sake, and remembers your sins no more."*
    c. *Micah 7:18-19 – "Who is a God like you, who pardons sin and forgives the transgression of the remnant of his inheritance? You do not stay angry forever but delight to show mercy. You will again have compassion on us; you will tread our sins underfoot and hurl all our iniquities into the depths of the sea."*
6) *Ask your Heavenly Father to help you to forgive this person for this situation, in accordance with His Word, where He said "Forgive us our debts even as we have also forgiven our debtors."*
7) *State to Him that you forgive them, and do so.*

- Distribute Forgiveness Is… handout, available at http://psychology.tools/forgiveness-is.html.

Activity: Let it Go (10-15 minutes)
A stone is passed from person to person, with each participant stating something they choose to let go of. The rock is then collectively thrown away outside.

Session 9: Identifying and Changing Negative Coping Behaviors

Objective: Developing constructive behavioral strategies that will aid recovery and restore mastery and self-control.

Topics: Identifying and examining negative coping behaviors. Engaging in problem-solving activities and discussions designed to instill courage to abandon "crutches" in favor of constructive recovery strategies.

Open with prayer

When overwhelmed by traumatic circumstances, we have been designed by God to find ways to allow us to cope with these thoughts and feelings that are far outside the boundaries of our "normal" lives. We first try strategies that we have used before in similar situations, and if these continue to work to relieve the stress, then we return to whatever is normal for us. If these no longer work, due to higher severity, longer duration, acclimation or some other factor, then we have to find another means. Some of these do not cause damage or complicate additional areas of our lives and are considered positive coping behaviors. Others lead to problems that are destructive and potentially debilitating, and are referred to as negative coping behaviors. Today, we will examine how you choose to cope.

- Distribute Coping Mechanisms handout, available from http://changingminds.org/explanations/behaviors/coping/coping.htm.

Review and explain different categories and ways of coping.

- Distribute Coping Modalities for Stress

Ask participants to complete the assessment. This is mainly a self-assessment that will not be collected, so encourage participants to be as honest with themselves as possible. When everyone is finished, give participants opportunities to share both positive and negative coping strategies. Participants may be reluctant to admit that they employ destructive, or even illegal, ways of coping. The purpose of this discussion is to reduce the shame associated with such behaviors as they realize that they did what they had to do to survive and having been caught up in addiction in the process does not make them "bad" people.

We are complex creatures living complex lives in which we are not always able to cope constructively with the difficulties that we face. As a result, we are subject to feelings of tension and stress, cognitive dissonance and, possibly, shame for doing something outside our values.

(15-minute break)

One of the ways we can constructively deal with the effects of our trauma is to replace any negative coping mechanisms with positive ones. Obviously, not all negative coping mechanisms are equally destructive, just as not all positive coping behaviors work with, or are enjoyable by, everyone who attempts them. Finding the most suitable positive coping practices for you and your personality and lifestyle is a key component in rewriting the aftereffects of trauma. It is

important to not only remove the negative, but also to implement the positive. First, we will review a chart that shows the general process of evaluating our behaviors.

- Distribute Problem Solving for Coping Behaviors handout.

Review and discuss.

If the coping skill used does not make you want to spend time doing it, if it is not enjoyable, or if it does not fit your lifestyle or environment (playing the tuba in an inner-city apartment), then find something you do enjoy. The key to positive coping behaviors is that you implement them and continue to do so to avoid a lapse into negative behaviors. While this may sound simplistic, it literally may be the difference between life and death.

- Distribute Stages of Change and Lapse and Relapse Management handouts. Available from
- http://psychology.tools/stages-of-change.html
- http://psychology.tools/lapse-and-relapse-management.html

Look at the Stages of Change depicted here, which illustrate the cycle that we often perpetuate. In the maintenance stage, if the positive behavior is one that is both enjoyed and possible to incorporate into our lives, it will eliminate—or at least reduce significantly—the rate of relapse. Remember that what works for one person may not for another, so it is important to find out what you enjoy and what suits you.

Let's complete the lapse and relapse management form, using the last time you went through this. If you never have lapsed back into a compulsive behavior after trying to replace it with a constructive one, then anonymously use the information that you may have obtained from a friend or acquaintance's experience.

Activity: (5-10 minutes)
As we wrap up today's session, we will reflect on a quote by Danieli:
"Having been helpless does not mean that one is a helpless person; having witnessed or experienced evil does not that the world as a whole is evil; having been betrayed does not mean that betrayal is an overriding human behavior; having been violated does not necessarily mean that one has to live one's life in constant readiness for its reenactment; having been treated as dispensable does not mean that one is worthless."(Y. Danieli, "As Survivors Age," *National Center for PTSD Clinical Quarterly* 4, no. 1, 1994)

When one breaks a leg, crutches are necessary tools to relieve pressure to prevent further injury. When the fracture is healed, it's necessary to put away the crutches and rebuild the muscles. Today you may have realized that you have continued to rely on various kinds of crutches. Putting them away can be a scary experience at first; however, the sense of freedom and empowerment that follows the realization that you are stronger than you thought is well worth the risk. Hebrews 12:12-13 says:" Therefore, strengthen your feeble arms and weak knees. Make level paths for your feet, so that the lame may not be disabled, but rather healed. Make every effort to live in peace with everyone and to be holy; without holiness no one will see the Lord."

Take a moment in silence before the Lord and ask him what area of change He would like you to pursue next, while keeping in mind that He is with you every step of the way.

Session 10: Increasing Self-awareness, Self-acceptance, and Self-esteem

Objectives: Increasing personal empowerment. Identifying positive qualities of the "real" self.

Topics: Challenging faulty assumptions about self and self-worth. Identifying Bible-based and appropriate perspectives on self-awareness and self-acceptance. Participants are encouraged to become more transparent, find their strengths, and develop a positive self-image. By verbalizing personally meaningful insights, their sense of competence is reinforced.

Open with prayer

Viewing yourself as a survivor is an important point of departure on the journey toward recovery from MST; however, in your quest to reclaim your life and identity, it is just a beginning. Today, you will explore beliefs and feelings about yourself that may be hindering your growth, and together identify strategies that are helpful to re-discover, re-build, and redeem who you really are.

- Distribute Unhelpful Thinking Styles handout, available from http://psychology.tools/unhelpful-thinking-styles.html

Which of these thought-patterns do you recognize as going on in your mind?

For each thinking style mentioned by a participant, ask who else tends to think this way (it's important for participants to know they are not the only ones struggling). Guide the group in a process of, first, refuting false beliefs and destructive thought patterns and, second, formulate a true and constructive alternative mindset.

1. *Why is this way of thinking problematic?* Alternative/additional probing questions include: *Where is this idea coming from? By what reasoning did you come to this conclusion? Who can provide evidence to support this view? How does this way of thinking affect you?*
2. *What is a better alternative to this assumption?* Additional probing questions include: *Is there another way of thinking that is more fair and constructive? How could you think differently in this situation?*

A self-image and self-concept that is distorted by MST may be especially vulnerable to thought-patterns that sustain a negative body image, a low sense of self-worth, and negative view of the future. Explore further these and other related distorted beliefs:

"Christians have to be perfect (or 'Christ-like')."
"God let this happen to punished me."
"I must be a bad person."
"I am ashamed (or "damaged goods")."
"Appearances are everything."
"I am ugly."
"It's too late for me."
"I will never be able to reach my goals."
"It is wrong to show too much emotion."

"It is wrong to be angry."
"I must respect my superiors, even if they treat me badly."

For an MST survivor, the "default position" in regards to their thoughts about themselves seems to be what has been termed a "low self-esteem." You may see yourself as "damaged goods", a second-class individual, or someone unworthy of respect because of what has been done to you. Today's society emphasizes the upper range of absolutes, and demands attention and praise for the richest, most beautiful, smartest, "most spiritual" and most powerful. Self-esteem, therefore, becomes a seeking after the attainment of qualities and items valued in this world. Even traditional Christianity has glorified the extremes, including those who are at the nadir, or lowest point, and have minimal worldly possessions and few, if any, skills. So, in our desire to raise our self-esteem, are we as Christians taking an unnecessary or ill-informed journey? What is the basis for self-esteem for a Christian?

Discuss a Biblically-based view of self-acceptance and self-esteem.

(15-minute break)

Activity: Describing and Presenting the Real Self (45 minutes)
Instruct participants to begin this activity by listing several aspects of their identity that represent who they really are. "MST Survivor" should not be one of them, but encourage them to consider their family roles (wife, mother, daughter, sister), an aspect of their personality that they like and affirm, an identity related to their career/profession, their identity in Christ/body of Christ, an identity associated with their background/ethnicity, and, importantly, their identity as a soldier/veteran. Ask them to focus on the last one in addition to two others from the list that are particularly salient to them.

Whether or not you are currently active in the service, being a soldier and/or veteran is an important part of who you are. You invested time and great effort in training followed by sacrificial service to our country, and for that you deserve to be honored. You have earned the right to be strong, courageous, and proud of your accomplishments. It is likely that your MST experience has cast a dark shadow on that part of your identity, robbed you of opportunities, or perhaps cut your time in the service short. Now is the time to come out of those shadows and reclaim the honor that is yours.

Have paper, colored pens, crayons, magazines with a variety of pictures, scissors, and glue available, along with a computer and a color printer for locating and printing pictures off of the Internet. Instruct participants to use the supplies to create three (letter-size) collages that in words and pictures (may be symbolic) illustrate three aspects of their true identity. Instruct them to include strengths, accomplishments, and things they admire about themselves. End the session by asking each participant to present their "self-portraits" to the group, and share strategies that she will use to become this person more fully and freely. If they seem unsure, encourage them to think about activities and relationships that make them feel "in-tune" with their true self.

Session 11: Dealing with Somatic Effects

Objectives: Exploring and developing strategies and resources to heal from the physiological effects of MST.

Topics: Emphasizing the whole person and a healthy life-style. Discussing issues with weight—including those caused by eating disorders—healthy vs. excessive levels of exercise, and sleep disturbances. Sharing resources and strategies that participants have found helpful when seeking assistance with longer-term health challenges.

Open with prayer

The focus for today's session is our relationship with our physical self. Many women, even those who have never experienced sexual assault, carry negative thoughts and feelings in regards to their body. It is not surprising then, that experiences with MST leave a woman especially vulnerable to self-loathing, which may cause her to, consciously or subconsciously, mistreat her body. That is in addition to any lasting injuries from the assault itself. Before we get into ways to recover from the multifaceted somatic effects of MST, let's affirm and encourage each other.

Activity: Balloon Game (20 minutes)
Each participant writes a complimentary message about something they like, admire, or appreciate about each of the other group members, identified by name, on a piece of paper. Each participant folds and inserts her piece of paper into a deflated balloon, blows it up, and tosses it around the room. Each participant then takes one balloon (not her own) and pops it. She then reads aloud all the messages. At the end, each participant is asked to share a brief response to what her peers have said about her.

Last week, we emphasized the importance of "taking your life back" rather than being "stuck" or stigmatized as merely an "MST survivor." Another way to move forward and cultivate posttraumatic growth is to redeem the experience. We have all heard the phrase, "What doesn't kill you makes you stronger." At a point when we feel safe enough to give ourselves fully to Christ, he redeems us. As a result, we begin to notice that there may be a silver lining. MST experiences should never be trivialized as "not that big a deal." Quite contrary, because Christ carried the pain of each of your traumatic occurrences onto the cross, he is able to restore you to a point where you end up stronger and better than you would have been otherwise. If you are comfortable—and this is optional—would any of you like to share how your experience has made you a stronger person or given you opportunities to assist other survivors, etc.?

It is important to instill hope in participants that it is possible to recover fully from MST and move beyond the abuse. However, be aware that all participants may not have reached that point. It's important that they have permission to grieve and process their experience for as long as they need to and don't feel rushed to put on a "happy face."

Several studies on MST have suggested that the VA has been ill equipped to assist MST survivors and many of you may have been further victimized by how you were treated when seeking help after you were assaulted. Nevertheless, it is important that you are aware of benefits and services available to you.

- Distribute handout with information on disability compensation from the VA. Available at http://www.index.va.gov/search/va/va_search.jsp?NQ=URL%3Ahttp%3A%2F%2Fwww.benefits.va.gov%2FBENEFITS%2FApplying.asp&QT=Disability+Compensation+for+Personal+Assault+or+Military+Sexual+Trauma&submit.x=0&submit.y=0&submit=Search

(15-minute break)

The remainder of our session today will be devoted to exchanging ideas and insights and sharing tools that you have found helpful in dealing with the somatic effects of MST. First, let's talk about sleep. Good sleep is critical for physical health. Sleep disturbances are very common among MST survivors, whether a result of nightmares or flashbacks or secondary effects of negative coping behaviors, interpersonal problems etc.

- Distribute Checklist for Better Sleep, available at http://psychology.tools/checklist-for-better-sleep.html. Discuss and ask participants to share additional tips on how to improve sleep.

Next, let's talk about diet and exercise. Many MST survivors go to extremes in an attempt to deal with the pain within. While "no pain, no gain" may be true when it comes to achieving a healthy level of fitness, all of you have gone through basic training and perhaps subscribe to the motto "pain is weakness leaving the body." The Bible identifies our physical bodies as "temples for the Holy Spirit" (1 Corinthians 6:19). This means that we need to treat our bodies well and, acting as faithful stewards of His temple, seek to find balance and a healthy way to get comfortable in our own skin.

Guide participants in a time of sharing strategies and tools that they have found helpful in achieving posttraumatic physical health and well-being. For each strategy discussed, explore the extent to which it applies to the other participants and what alternatives exist to achieve similar outcomes. Be sensitive to the fact that a wide range of somatic issues may be represented among participants. Seek to uncover underlying problems in the areas of self-loathing and dissociation.

Activity: Identifying Self-Care Activities (15 minutes)
Give each participant a pen and paper and instruct them to list activities that they do or could do to nurture and soothe themselves. Examples may include taking a hot bubble bath, lighting scented candles, listening to spiritual music, reading an inspirational book, going for a walk, painting/drawing, or journaling. Ask each participant to share their list and, on the back of the paper, write down activities that they did not think of themselves but want to consider.

Homework: Instruct each participant to create her own "menu" of 7-10 activities and to complete one of them each day for at least 30 minutes. This activity is an opportunity to "check in" with herself, thereby learning to take time to listen to the needs of her soul and body.

Session 12: Reflecting on Growth and Conclusion

Objectives: Celebrating healing and recovery. Empowering with hope for the future.

Topics: Looking back, reflecting on what participants have gained from the program and looking forward, establishing goals for the future.

Open with prayer

The last session should be kept light and upbeat. Bring healthy finger foods to share with participants (having inquired about allergies and special dietary needs ahead of time). Ask each participant to briefly share what they have learned from the group and what progress toward recovery that they have observed in themselves. You may also encourage participants to provide affirmative feedback about positive changes that they have noted in their peers.

- Distribute Survivor's Measures of Growth handout, and explain its purpose. It may be found at http://www.newhorizonscrisiscenter.org/index.php/get-help/suvivors-measure-of-growth

Ask participants to complete the checklist while reflecting on how their perspective and disposition have change since the first time they filled it out. Ask participants to formulate a goal for themselves for the coming year and to list strategies they will employ to reach it.

This group has been a first step on your journey toward recovery from MST. It does not end here; this is merely the beginning. Philippians 4:13 says, "I can do all this through Him who gives me strength." I am confident that each one of you will continue taking steps to get your life back and to enjoy your freedom in Christ. While none of us can turn the clock back, we can determine to come back from the trauma stronger than before and better equipped to reach our life goals, while perhaps serving and supporting other survivors.

Chapter 6

Evaluation and Conclusions

Following the completion of the twelve sessions, it is important to look at the process and the results to see what could be improved. Whenever working with hurt people, there is the possibility of not succeeding with one or several participants, or of only bringing them part way to where they need to be. In order to determine this, the program and all of its components should be examined for validity (does it do what it is supposed to do) and reliability (does it do so consistently). To conclude, this chapter ends with a review of the purpose of this thesis project.

Evaluation of the Group Intervention

In order to measure and evaluate the success of this program, there needs to be a clear goal, established at the beginning of the group intervention. The counselor-facilitator may formulate measurable objectives for the program upon reviewing the intake forms and intake interview notes or upon scoring the LEC-5 and TSI-2 assessments collected in Session 2. In order for such objectives to be realistic and achievable, they should be formulated based on the participants in the group, their symptomology, and their expressed expectations for the group. Another approach is to involve participants by discussing and agreeing on program objectives as a group, perhaps using the Survivor's Measures of Growth as the basis. This handout is already incorporated in Sessions 1 and 12 as a tool for participants to formulate their own goals for their participation and to monitor their progress. The Washington Coalition of Sexual Assault Programs' "Circle of Hope: A Guide for Conducting Psycho-educational Support Groups" suggested that appropriate objectives for these types of psychoeducational support groups should emphasize increased understanding of the effects of sexual assault, an increased use of healthy

coping skills, and a decreased sense of isolation.[203] They said,

> Objectives can be determined by considering the steps that need to be taken to get to the goal, the reason that key components of the program exist, and the hopes that providers have for participants. For instance, psychoeducational support groups may be offered because providers hope that it will help participants realize that they are not alone in their experiences, feelings or reactions. Feeling less alone can help a participant move toward the goal of being better able to cope with the effects of sexual assault. Therefore, decreasing isolation could be a measurable objective of the group.[204]

Evaluation of each group intervention may be done informally or formally. Either way, it's important to make the evaluation a meaningful process that serves to further empower and encourage participants rather than making them feel like test subjects. It's important to let participants know that you really value their input and that it will help future groups. A time of sharing about program outcomes is already built into Session 12. The facilitator may also ask for written feedback. If objectives were formulated as part of the group process, it is important to make the evaluation a part of the group process as well. A more formal evaluation may be conducted by re-administering the TSI-2 at the conclusion of the program and comparing pre- and post-program scores. These assessment results should be reviewed with each participant individually.

Regardless of the type of measurement that is evaluated, it is a good idea for the leader and co-leader to jointly examine and discuss all aspects of the group during the evaluation phase, scrutinizing the demographics of the group members, the absence rate, along with barriers to attendance mentioned by group members, such as transportation or child care, as these may affect the participation rate for subsequent groups. After the results are compiled in an evaluation report (that protects the privacy of group participants), program facilitators and the overseeing

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[203] Washington Coalition of Sexual Assault Programs, "Circle of Hope: A Guide for Conducting Psycho-educational Support Groups," 2nd ed. (2014).

[204] Washington Coalition of Sexual Assault Programs, 56.

pastoral staff should evaluate the program and make changes as needed. Such a review should be conducted on a regular basis, ideally upon the conclusion of each program. Evaluation is done to determine strengths and weaknesses and to provide opportunities to improve.

The program proposed herein may be adapted to fit the needs of the hosting church, the characteristics of a particular group cohort, and to address concerns articulated by prospective participants. Although the session sequencing was determined with best practices in mind and after reviewing a large number of group intervention programs serving similar populations, additional sessions may be interjected and the sessions re-ordered as needed.

Although beyond the scope of this project, this program could be further developed with guidelines and resources for referrals for assistance-seeking MST survivors whose symptomology and comorbidity issues make them unfit for program admission or continued group participation, as previously discussed. Also, while a firm recommendation to have this program headed up by a licensed professional counselor for reasons discussed earlier remains, it may be supplemented with a program designed to train lay counselors serving in co-leader capacity.

Conclusion

The role of the church is multifaceted, but one of the primary functions is perhaps best illustrated by the Lord saying, "What do you think? If any man has a hundred sheep, and one of them has gone astray, does he not leave the ninety-nine on the mountains and go and search for the one that is straying? If it turns out that he finds it, truly I say to you, he rejoices over it more than over the ninety-nine that have not gone astray. So it is not the will of your Father who is in heaven that one of these little ones perish."[205] As Christ spoke these words, He showed the compassion for the outsider, the sheep that strays, or is driven, from the flock. In this work, the

[205] Mt 18:12-14.

focus is on the wounded warrior, the soldier who was brutalized by those that should have been the most protective. In the church today, very little accommodation is made for survivors of MST, some saying they should just "get over it". But unless the people of God intervene, that survivor may never know the peace that is their birthright in Christ.

As shown earlier, the military is rife with abusers, who either through the use of physical strength or superior rank, as evidenced by the Tailhook and Aberdeen Proving Ground abuses, selfishly betray trust and "steal, kill, and destroy."[206] While some survivors are able to recover from the sexual abuse, its effects are exacerbated when the incest-like aspect of molesting one who has your trust and is your "battle buddy," is added. The very number and severity of the long- and short-term effects are testaments to the scope of the personal destruction.

Intervening, then, is not "optional" when the intended nature of the Church is examined. To do so effectively is to do so with care and concern, with the criteria for the leaders and the group participants carefully evaluated to allow for as successful a process as possible. The importance of a two-step approach is central. While it may be successfully argued that individual psychotherapy, as traditionally practiced, might be sufficient, both the survivor and the church will benefit from this group intervention, designed to be first step toward recovery. Not only does the survivor get the support of a group who truly understand what they have gone through, the church gains knowledge and experience that can be applied to others, together with the tremendous benefit of extending love and care to many of those most in need.

The use of a number of assessments during the sessions allows for greater participant and leader understanding of how the MST has affected the survivor's worldview perspective, as well as allowing for more targeted intercession. The integration of Biblically sound principles

[206] Jn 10:10.

together with thoroughly Bible-oriented content also reinforces the necessity of emphasizing the spiritual domain together with the practical.

While there may be group interventions that approach this or a similar issue from either a psychotherapeutic or a nouthetic perspective, little has been done that this author has found that is an integrated approach of this nature. The purpose of the 12 sessions is to allow for a directed, spiritual approach that will address many issues and also lay a foundation for additional individual intervention. It is hoped that utilization of this program may assist both the church and the survivor to grow closer to what He has intended for His people to be.

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Military Sexual Trauma Group Intake Form

All information herein is confidential and is intended only to help ensure the safety of the members of the group. Please note that this group is not intended as psychotherapy but rather as the initial step to dealing with MST related issues. The intent is for this to be complemented by individual therapy, if needed.

Name: _____ Gender: ____ Date of birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____

Marital status: _____ Number of household members (including yourself): ____

Primary care physician: _____ Mental health provider: _____

Current medical problems: _____

List all medications that you are currently taking: _____

_____

Please circle the symptoms/feelings you are currently experiencing:

Self-blame Sleep Problems Change in Appetite Compulsive Behavior

Panic Attacks Feelings of Hostility Inability to Concentrate Suicidal Thoughts

Hopelessness Sadness or Depression Weight Change Spiritual Issues

Obsessive Thoughts Tension/Anxiety Memory Problems Strange Thoughts

Helplessness Social Isolation Anger Guilt Flashbacks Sexual Problems

Other: _____

_____

Alcohol Use Frequency: Never A few times per month 2-4 times per week Daily

Intoxication Frequency: Never A few times per month 2-4 times per week Daily

Recreational Drug Use: Never A few times per month 2-4 times per week Daily

Do you or anyone in your family have a history of alcohol or substance abuse? _____

Have you ever been arrested? _____

Please indicate which of these best describes you:

☐ Practicing Christian

☐ Believe in God

☐ Non-believer

☐ Other/Unsure

Please add any additional information you wish to share about yourself:

_____

_____

_____

Informed Consent

Thank you for deciding to enter the Military Sexual Trauma Support Group. This document is intended to inform you of our policies and your rights. If you have questions or concerns, please ask and we will try our best to give you all the information you need.

This group is being run under the auspices of a local church, and is being provided at no cost to you, or only minimal cost for materials, if any are used. Each of the meetings will last approximately 2 hours, including a 15-minute break. The leader of the group is a professional in the Mental Health field, and is either a Licensed Professional Counselor or a Clinical Psychologist, while the co-leader may be either a professional or lay counselor. However, this is intended to primarily be a support group and not psychotherapeutic intervention. By signing this form you acknowledge your awareness of this distinction.

All information shared in this group, unless you sign a separate release, is covered under the rules of confidentiality described in the AACC Codes of Ethics that we follow. It stipulates that information will be divulged is in case of danger to you or others, as a result of mandated reporting of physical or sexual abuse of children, as outlined in the HIPAA Notice of Privacy, or as otherwise required by law. Copies of these documents are available to you upon request at any time.

There are many benefits to membership in this group, which is specifically designed to help you deal with the consequences of Military Sexual Trauma. Being a part of this group may help you make positive lifestyle changes, develop new coping skills, reduce symptoms of mental health disorders, manage anger, and improve the overall quality of your life.

However, while participation in the group may lead to a return to normal life free from the effects of the MST, it is also possible that previously hidden issues may be uncovered, which may require professional intervention either simultaneously with the group meetings of following the conclusion of the same. These would not be under the auspices of the church unless specifically stated as such.

Group work of this nature is an intensely personal process that can bring unpleasant memories and emotions to the surface. There is no guarantee that this group will be exactly what you need. Group members sometimes make improvements only to go backwards after a time. Progress may happen slowly. Recovery requires a very active effort on your part, and in order to be most successful, you may have to work on things we discuss outside of sessions.

It is strongly recommended that you inform your Primary Care Physician or Mental Health Provider that you are in this MST Support Group, especially if there are any physical or stress-related challenges with which you are dealing. Should an emergency arise between group sessions, please call 911, or whatever emergency services are available in your community, or if necessary, go immediately to the nearest emergency room.

The nature of support groups makes it difficult to maintain confidentiality. If you choose to participate in these group sessions, be aware that we cannot guarantee that other group members will maintain your confidentiality. However, we will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in the group confidential. We also reserve the right to remove any group member from the group should we discover that a group member has violated the confidentiality rule.

Consent to Group Membership

Your signature below indicates that you have read this consent form and agree to all of its terms.

Group member signature _____ Date_____

Guidelines for the Group

In order for any group to function at its best capacity, members have to agree on rules and guidelines that will serve as the basis for expected attitudes and behaviors in the group. These rules and guidelines serve to provide structure to the group and safety for members. The rules and guidelines for this group are as follows:

1. What is said in this room stays in the room. What is said in a dyad stays in the dyad. Do not share any information about anyone else in the group. You are free to talk about your experience and tell your story only. The exceptions to this rule include:

- Threat of harm to self or others
- Report of abuse/neglect of a minor, elderly or disabled person.

2. Withhold judgments about others. Groups are always composed of a variety of people, from a variety of backgrounds. Those sitting beside you in this group may hold values and beliefs that are different from yours. You are asked to allow all members in this group to express their own thoughts and feelings without being required to change them. Likewise, you are to withhold judgments about yourself. Do not compare yourself or your experiences to others.

3. Avoid giving advice unless the leader asks for comments on a situation. It may make us feel better about ourselves but leave the other person feeling discounted. Instead, sit quietly while listening and trusting that God is involved in the process of that person's life.

4. Be on time for each session and after each break. Because the group meets only once a week, every meeting and part of a meeting is important, so please be on time as a courtesy to the others. As a policy, the group will not begin without everyone present.

5. It is natural that the topic of this group will make you feel uncomfortable at times. In order to help you monitor your level of stress or anxiety and to effectively communicate what you are experiencing to others in the group and to the leaders, we will use a standard scale called the SUDS (Subjective Unit of Distress Scale). So, instead of looking for words to describe how a discussion of trauma may make you feel, simply say, "That puts me at a SUDS of 70", or "I'm only at a 30, I can handle that."

6. This group is guided by the principles articulated in Galatians 6: 2-5: "Carry each other's burdens, and in this way you will fulfill the law of Christ. If anyone thinks he is something when he is nothing, he deceives himself. Each one should test his own actions. Then he can take pride in himself, without comparing himself to somebody else, for each one should carry his own load." In this group, we prioritize and support each other, but you are here to improve your own life as well. As you grow, you bring the others in the group up with you. It is important that you consider how your sharing and expressing anger and other emotions in this setting affects the other members. You will have the best experience when you support their growth while allowing them to support you.

Scriptures for Group Reflection

Psalm 139:13-14: For you formed my inward parts; you knitted me together in my mother's womb. I praise you, for I am fearfully and wonderfully made. Wonderful are your works; my soul knows it very well.

Matthew 11:28-30: Come to me, all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light.

Psalm 27:10: For my father and my mother have forsaken me, but the Lord will take me in.

Matthew 10:29-31 - Are not two sparrows sold for a penny? And not one of them will fall to the ground apart from your Father. But even the hairs of your head are all numbered. Fear not, therefore; you are of more value than many sparrows.

John 3:16: For God so loved the world, that he gave his only Son, that whoever believes in him should not perish but have eternal life.

John 13:34-35: A new commandment I give to you, that you love one another: just as I have loved you, you also are to love one another. By this all people will know that you are my disciples, if you have love for one another.

Psalm 100:3: Know that the Lord, he is God! It is he who made us, and we are his; we are his people, and the sheep of his pasture.

Zephaniah 3:17: The Lord your God is in your midst, a mighty one who will save; he will rejoice over you with gladness; he will quiet you by his love; he will exult over you with loud singing.

1 Timothy 1:5: - The aim of our charge is love that issues from a pure heart and a good conscience and a sincere faith.

Psalm 27:1-3: The Lord is my light and my salvation; whom shall I fear? The Lord is the stronghold of my life; of whom shall I be afraid? When evildoers assail me to eat up my flesh, my adversaries and foes, it is they who stumble and fall. Though an army camp against me, my heart shall not fear; though war rises against me, yet I will be confident.

Psalm 91:1-2: Whoever dwells in the shelter of the Most High will rest in the shadow of the Almighty. I will say of the Lord, “He is my refuge and my fortress, my God, in whom I trust.”

Psalm 34:7: The angel of the Lord encamps around those who fear him, and delivers them.

Psalm 125:2: As the mountains surround Jerusalem, so the Lord surrounds his people, from this time forth and forevermore.

1 Corinthians 16:14: Let all that you do be done in love.

1 John 4:16: So we have come to know and to believe the love that God has for us. God is love, and whoever abides in love abides in God, and God abides in him.

Psalm 27: 4-5: One thing have I asked of the Lord, that will I seek after: that I may dwell in the house of the Lord all the days of my life, to gaze upon the beauty of the Lord and to inquire in his temple. For he will hide me in his shelter in the day of trouble; he will conceal me under the cover of his tent; he will lift me high upon a rock.

Emotions Journal

Date / Time	**Trigger** What just happened?	**Emotion** How did you feel?	**Body sensations** Feelings in your body?	**Thoughts** What were you thinking?	**Behavior** What were your actions?	**Consequences** How did this make you feel?

Ten Scriptural References about God Never Forsaking or Abandoning Us

1) Deuteronomy 31:6 Be strong and courageous. Do not be afraid or terrified because of them, for the LORD your God goes with you; "**He will never leave you nor forsake you."**

2) Deuteronomy 31:8 The LORD himself goes before you and will be with you; He will never leave you nor forsake you. **"Do not be afraid; do not be discouraged."**

3) Joshua 1:5 No one will be able to stand up against you all the days of your life. **"As I was with Moses, so I will be with you; I will never leave you nor forsake you."**

4) 1 Kings 8:57 "May the LORD our God be with us as he was with our fathers; may He never leave us nor forsake us."

5) 1 Chronicles 28:20 David also said to Solomon his son, **"Be strong and courageous,** and do the work. **"Do not be afraid or discouraged, for the LORD God, my God, is with you. He will not fail you or forsake you until all the work for the service of the temple of the LORD is finished.**"

6) Psalms 37:28 For the LORD loves the just and will not forsake his faithful ones. **"They will be protected forever, but the offspring of the wicked will be cut off;"**

7) Psalms 94:14 "**For the LORD will not reject his people; he will never forsake his inheritance.**"

8) Isaiah 41:17 "The poor and needy search for water, but there is none; their tongues are parched with thirst. But I the LORD will answer them; "**I, the God of Israel, will not forsake them."**

9) Isaiah 42:16 "I will lead the blind by ways they have not known, along unfamiliar paths I will guide them; I will turn the darkness into light before them and make the rough places smooth. These are the things I will do; I will not forsake them."

10) Hebrews 13:5 Keep your lives free from the love of money and be content with what you have, because God has said, **"Never will I leave you; never will I forsake you."**

(Retrieved from http://www.thejourney2grace.com/index.cfm?i=11059&mid=1000&id=324730)

Who I Am in Christ

I Am Accepted

John 1: 12 I am God's child.
John 15: 15 I am Christ's friend.
Romans 5: 1 I have been justified.
1 Corinthians 6: 17 I am united with the Lord, & I am one spirit with Him.
1 Corinthians 6: 20 I have been bought with a price. I belong to God.
1 Corinthians 12: 27 I am a member of Christ's Body.
Ephesians 1: 1 I am a saint.
Ephesians 1: 5 I have been adopted as God's child.
Ephesians 2: 18 I have direct access to God through the Holy Spirit.
Colossians 1: 14 I have been redeemed and forgiven of all my sins.
Colossians 2: 10 I am complete in Christ.

I Am Secure

Romans 8: 1-2 I am free from condemnation.
Romans 8: 28 I am assured all things work together for good.
Romans 8: 31-34 I am free from any condemning charges against me.
Romans 8: 35-39 I cannot be separated from the love of God.
2 Cor. 1: 21-22 I have been established, anointed, and sealed by God.
Philippians 1: 6 I am confident that the good work God has begun in me will be perfected.
Philippians 3: 20 I am a citizen of heaven.
Colossians 3: 3 I am hidden with Christ in God.
2 Timothy 1: 7 I have not been given a spirit of fear, but of power, love and a sound mind.
Hebrews 4: 16 I can find grace and mercy in time of need.
1 John 5: 18 I am born of God and the evil one cannot touch me.

I Am Significant

Matthew 5: 13-14 I am the salt and light of the earth.
John 15: 1,5 I am a branch of the true vine, a channel of His life.
John 15: 16 I have been chosen and appointed to bear fruit.
Acts 1: 8 I am a personal witness of Christ.
1 Corinthians 3: 16 I am God's temple.
2 Corinthians 5: 17-21 I am a minister of reconciliation for God.
2 Corinthians 6: 1 I am God's coworker (see 1 Corinthians 3: 9).
Ephesians 2: 6 I am seated with Christ in the heavenly realm.
Ephesians 2: 10 I am God's workmanship.
Ephesians 3: 12 I may approach God with freedom and confidence.
Philippians 4: 13 I can do all things through Christ who strengthens me.

(Compiled by Neil T. Anderson, "Victory Over the Darkness: Realize the Power of Your Identity in Christ" *Gospel Light. Kindle Edition.* (2000) p. 39.)

Coping modalities for stress

Positive Method	Utilization Regularity				Benefit level
	Daily	Frequently	Sporadically	Never	1 – 10 Low - High
Reading fiction	☐	☐	☐	☐	1_____5_____10
Eat out	☐	☐	☐	☐	1_____5_____10
Watch TV at home	☐	☐	☐	☐	1_____5_____10
Play organized sports	☐	☐	☐	☐	1_____5_____10
Listen to music	☐	☐	☐	☐	1_____5_____10
Relaxation techniques	☐	☐	☐	☐	1_____5_____10
Journaling	☐	☐	☐	☐	1_____5_____10
Game or indoor activity	☐	☐	☐	☐	1_____5_____10
Go out for a movie	☐	☐	☐	☐	1_____5_____10
Play with child or pet	☐	☐	☐	☐	1_____5_____10
Exercise (Sit ups, push ups, etc.)	☐	☐	☐	☐	1_____5_____10
Sleep	☐	☐	☐	☐	1_____5_____10
Surf the web	☐	☐	☐	☐	1_____5_____10
Phone, Skype, Chat	☐	☐	☐	☐	1_____5_____10
Out in nature	☐	☐	☐	☐	1_____5_____10
Pray or meditate	☐	☐	☐	☐	1_____5_____10
Shopping (including online)	☐	☐	☐	☐	1_____5_____10
Bath or shower	☐	☐	☐	☐	1_____5_____10
Play video games	☐	☐	☐	☐	1_____5_____10
Attend concert, play, etc.	☐	☐	☐	☐	1_____5_____10
Paint or draw	☐	☐	☐	☐	1_____5_____10
Walking	☐	☐	☐	☐	1_____5_____10
Physical labor	☐	☐	☐	☐	1_____5_____10
Writing poetry/stories	☐	☐	☐	☐	1_____5_____10
Other _____	☐	☐	☐	☐	1_____5_____10

Examine most & least utilized as well as highest perceived benefit levels. Rank order and evaluate based on your preferred outcomes, as well as comparing positive and negative aspects.

Negative Method	Utilization Regularity				Benefit level
	Daily	Frequently	Sporadically	Never	1 – 10 Low - High
Alcohol use	☐	☐	☐	☐	1_____5_____10
Punch, throw, kick object	☐	☐	☐	☐	1_____5_____10
Overeat or Neglect eating	☐	☐	☐	☐	1_____5_____10
Yell or use profanity	☐	☐	☐	☐	1_____5_____10
Listen to destructive music	☐	☐	☐	☐	1_____5_____10
Use marijuana	☐	☐	☐	☐	1_____5_____10
Negative Journaling	☐	☐	☐	☐	1_____5_____10
Destructive sexual activity	☐	☐	☐	☐	1_____5_____10
Go out looking for trouble	☐	☐	☐	☐	1_____5_____10
Abuse illegal drugs	☐	☐	☐	☐	1_____5_____10
Experience irritability	☐	☐	☐	☐	1_____5_____10
Sleep excessively	☐	☐	☐	☐	1_____5_____10
View pornography	☐	☐	☐	☐	1_____5_____10
Gamble	☐	☐	☐	☐	1_____5_____10
Risk taking behavior (Speeding)	☐	☐	☐	☐	1_____5_____10
Negative self-talk	☐	☐	☐	☐	1_____5_____10
Emotional extremes (Cry/laugh)	☐	☐	☐	☐	1_____5_____10
Become depressed	☐	☐	☐	☐	1_____5_____10
Play violent video games	☐	☐	☐	☐	1_____5_____10
Tobacco use	☐	☐	☐	☐	1_____5_____10
Suicidal thoughts	☐	☐	☐	☐	1_____5_____10
Social isolation	☐	☐	☐	☐	1_____5_____10
Physical self-abuse (Cutting)	☐	☐	☐	☐	1_____5_____10
Abuse prescription drugs	☐	☐	☐	☐	1_____5_____10
Other _____	☐	☐	☐	☐	1_____5_____10

Examine most & least utilized as well as highest perceived benefit levels. Rank order and evaluate based on your preferred outcomes, as well as comparing positive and negative aspects.

Problem Solving for Coping Behaviors